INTEGRATED CARE AND HOUSING
for Homeless Persons in Los Angeles

A report on the forum convened
April 19, 2012, by the USC School of Social Work
and sponsored by J. Scott and Obaida Watt
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I. Executive Summary
Homeless persons are among the most marginalized individuals in the United States and experience remarkable rates of morbidity and mortality. The occasional media report on the death or beating of a homeless person underscores the danger associated with such an existence. Homelessness is also costly to society—morally, certainly, but also financially in terms of tax dollars spent to meet the emergent needs of this population in hospitals and psychiatric facilities. Populations affected by homelessness range from youth to older adults, and the experience of homelessness intersects with serious mental illness, substance use, and a host of other health risks, thus presenting many challenges to service integration.

In no other city than Los Angeles are these points more salient. Los Angeles is regarded as the nation’s capital of homelessness due to the numbers of people experiencing homelessness in our city on any given day.

Integrated care and medical home models advanced through health care reform legislation hold great promise in facilitating cost-effective provision of comprehensive health care and behavioral-health services for homeless persons. Integrated care refers broadly to the efficient, coordinated, and proactive delivery of comprehensive health care services tailored to an individual’s needs. Research has demonstrated significant cost offsets in providing integrated care and permanent housing to homeless persons who have significant disabilities.

On April 19, 2012, the USC School of Social Work convened a forum on homelessness at the USC Davidson Conference Center. The forum, Integrated Care and Housing for Homeless Persons in Los Angeles, focused on the current status of integrated care provision to adults experiencing homelessness in Los Angeles, and on the intersection of integrated care with temporary and permanent housing. The goals of the forum were to increase understanding of integrated care for homeless persons residing in temporary and permanent housing in Los Angeles, and to identify key challenges and strategies for advancing and sustaining integrated care.

The daylong forum brought together more than 100 experts, including government officials, agency administrators, research scientists, direct-service providers, and other advocates focused on serving the diverse needs of the region’s homeless persons.

This report summarizes the day’s events, with highlights from the forum’s speakers and panels.

The forum was generously underwritten by J. Scott and Obaida Watt.
II. Agenda

Welcome
Suzanne Wenzel, Professor, USC School of Social Work
Marilyn Flynn, Dean, USC School of Social Work

Keynote
Jan Perry, Councilwoman, Ninth Council District, City of Los Angeles

Panel: Agency & Administrative Overview on Integrated Care in the Housing Continuum
Elizabeth Boyce, Homeless Services Coordinator, Los Angeles County Chief Executive Office
Chris Ko, Program Officer, Housing Stability, United Way of Greater Los Angeles
Peter Lynn, Director, Section 8 Department, Housing Authority of the City of Los Angeles
Marvin Southard, Director, Los Angeles County Department of Mental Health
John Viernes, Director, Substance Abuse Prevention and Control, Los Angeles County Department of Public Health

Panel: State of the Science on Integrated Care
John Brekke, Frances G. Larson Professor of Social Work Research, USC School of Social Work
Michael Cousineau, Associate Professor of Research, Keck School of Medicine of USC
Lawrence Palinkas, Albert G. and Frances Lomas Feldman Professor of Social Policy and Health, USC School of Social Work
Suzanne Wenzel, Professor, USC School of Social Work

Breakout Sessions: Building Partnerships for Sustainable Integrated Care

Breakout Session 1
Ben Henwood, Postdoctoral Fellow, NYU Silver School of Social Work
Jessica Brown-Mason, Director of Programs, Hope Gardens, Union Rescue Mission
Jonathan Wolf, Program Manager, Skid Row Housing Trust
Nikki Shipley, Consultant, Community Research, Homeless Health Care Los Angeles
Cherry Short (moderator), Assistant Dean, Global and Community Initiatives, USC School of Social Work

Breakout Session 2
AI Ballesteros, Chief Executive Officer, JWCH Institute
Ervin R. Munro, Director of Social Services, SRO Housing Corporation
Herb L. Smith, President and CEO, Los Angeles Mission
Ruth Schwartz, Executive Director, Shelter Partnership
Eric Rice (moderator), Assistant Professor, USC School of Social Work

Discussion: Next Steps in Achieving a Sustainable Integrated Care Strategy
III. Introduction

Welcome

Suzanne Wenzel, PhD
Professor, USC School of Social Work
Director, Research Cluster on Homelessness, Housing, and the Social Environment

Professor Suzanne Wenzel opened the forum by welcoming participants and setting out the aims of the day. She noted that Los Angeles is one of the most ethnically and racially diverse cities in the United States. It is the largest manufacturing center in the western U.S., home to some of the best colleges and universities and some of the best health care in the nation, and overall has an abundance of resources.

Yet, since the mid-1980s, said Wenzel, Los Angeles has also had the distinction of being the homeless capital of the United States. “There are more people homeless in Los Angeles than in any other city in our nation, but even in the face of that dire situation, there is much to be proud of,” she said. “There are so many people like you and organizations and agencies like yours that are dedicated to serving homeless people and to ending homelessness. We are rich with human resources in Los Angeles, rich with human potential.”

Wenzel said that the forum would focus on integrated care for people in temporary and permanent housing. “Integrated care broadly refers to the coordinated, proactive delivery of comprehensive health care that is tailored to an individual’s needs,” she said. “No matter where people are living, they should be able to access primary care and behavioral health care and services, including HIV-prevention programs, vocational training, and other assistance.”

Wenzel said that significant accomplishments in achieving services integration have occurred, but numerous challenges remain on multiple levels—individual, social, organizational, systems, and policy. “Our goal today is to enhance our collective understanding of integrated care for homeless persons in Los Angeles and to identify key challenges and strategies for advancing and sustaining integrated care in our city,” she said.

“Our goal is to enhance our collective understanding of integrated care for homeless persons in Los Angeles and to identify key challenges and strategies for advancing and sustaining integrated care in our city.”

—Suzanne Wenzel
Dean’s Welcome
Marilyn Flynn, PhD
Dean, USC School of Social Work

In her welcome and overview of the USC School of Social Work, Dean Marilyn Flynn noted that the school currently has more than 2,000 students enrolled in its Master of Social Work program, half based on campus and half in the web-based, virtual academic center, which includes students across 38 states. She added that the school has partnerships with more than 1,000 private, nonprofit, and public organizations, as well as with colleagues in the California State University system and at the University of California, Los Angeles.

“We have one of the most accomplished groups of researchers of any school of social work in the country,” she said. “We have particularly distinguished work in depression, schizophrenia, homelessness, child maltreatment, aging, health disparities, and addictions. However, it's one thing to carry out research, it’s another thing to use it productively.”

Flynn continued:

This brings to mind the story of the little girl who lived on the plains and one day got lost in her father’s wheat field. It had grown very high; it was taller than she was. Many searchers were called out to look through the wheat fields to see if they could find her. The day passed, with no sight of the little girl. It grew colder and people realized that because she was so little, if she remained there, she would likely not survive the night. Finally, the farmer called all of the searchers out of the wheat field and asked them to join hands and together they combed the wheat field, and in 10 minutes they had found the little girl.

So we’re here today as searchers. We’re here together, and we have greater hope together of aiding those who are lost. The concept and the promise of integrated care give us a sense of possibility about finding those in need in a more effective way and organizing our care around them in a more effective way, of finding solutions and bringing answers to light.

Flynn noted that in gatherings such as this homeless forum, attendees often find that they have “never seen each other before, because all of us work in our silos.” Although attendees may all be working with homeless persons—in housing, mental health services, addiction treatment, employment assistance, or veteran services—they don’t often have opportunities to meet. “These kinds of gatherings give us a sense of untapped collaborative potential,” she said.

"These kinds of gatherings give us a sense of untapped collaborative potential."

—Marilyn Flynn

The National Institute of Mental Health reported a gap of 20 years between clinical discoveries and research in universities and what psychiatrists, psychologists, and other practitioners actually do in practice. “Somehow knowledge wasn’t making its way into the community and into practice, and at the same time the accumulated knowledge in the practice community was lost and not being translated to people who are
defining problems and framing research questions,” said Flynn. “We need a process that allows us to influence each other and exchange ideas. . . . I hope one of the outcomes of today will be a process that allows us to begin this mutual translation.”

Flynn noted that the USC School of Social Work has established research clusters and centers that organize faculty members around common research themes. Forum organizer Suzanne Wenzel leads the homelessness cluster; panelist John Brekke leads the persistent mental illness cluster; and panelist Larry Palinkas leads the cluster in behavioral health. “We’re hoping to engage RAND and UCLA and other research institutions locally in these clusters,” she said, “but also you as partners.”

Flynn continued:

We can’t change poor public policy rapidly. We can’t change international upheavals. We can’t change the climate. We can’t change the economy. At least not today.

But perhaps we can be like the man who was walking along the ocean. He saw another man in front of him. The man was bending down and picking something up and throwing it and bending down and picking something up and throwing it. The first man approached, and what he saw was the man picking up starfish that had been washed onto the shore and were dying. He bent over, picked up a starfish, and threw it back into the ocean. So the observer called out to him: “It’s not worth doing that. It won’t do any good. There are too many of them.” And the other man kept bending down, lifting and throwing, bending down, lifting and throwing. He responded: “Never mind. Each one counts.”

He was talking about individual lives. In our case this morning, and over many mornings and afternoons from now on, we’ll be saving stranded lives through the power of research and collaboration.
Keynote Address

Jan Perry
Councilwoman of the Ninth District of Los Angeles

Councilwoman Jan Perry’s remarks appear below in full.

It’s a pleasure to just share a few thoughts with you this morning about my experiences going back to 2001, when I was first elected and my district included Central City East, or “Skid Row.”

The homeless count for Los Angeles County at the time was 78,000 people. These were people who were defined as those without a permanent home. And the number was tossed around a lot by people in political places, like it meant nothing and there were no alarm bells ringing; there were no late-night, breaking-news stories about our region being the homeless capital of the country. And no one, with the exception of a very few good people—and one of them is here in the room, and I have to call her out: Ruth Schwartz. Ruth is an angel; she just left her wings at home today. Ruth Schwartz has been a mentor and a guide, and she woke us all up.

At the time we had a new mayor. His name was Jim Hahn, and many members of the City Council were just newly elected, including myself. Skid Row was seen to be the answer to everybody’s homeless problem in the region. If you’re homeless, you just go to Skid Row and you live on the street or maybe you’ll get into a cot somewhere or get some help. That brought thousands of people from jails in other jurisdictions throughout Los Angeles County, hospitals, mental institutions. People just got dumped on downtown Los Angeles in Skid Row. And there was no plan in place for managing this issue, no coordination or effective housing efforts, not a lot of concern. The politics of homelessness had been to defer to the nonprofits and the faith-based agencies just to deal with the problem. On their part, the agencies, the missions, they were drowning—they were drowning in clients and lack of funding, and so this is where I started.

My chief of staff and I spent time meeting, talking, trying to figure out a framework to attack this issue with lots of people—homeless care providers from both faith-based and nonprofit communities—to hear what they had to say and have them tell us what they felt they needed.

We examined the continuum of care—and found that there was no continuum. We were trying to find a starting point and trying to work toward the goal of ending homelessness. It was a new City Council, and it was trying new things. There were members like myself who knew that the city had to do far more to develop affordable housing and examine how homeless services were provided. I knew that we had to work with L.A. County in a more effective way to get the resources that we needed for homeless health and mental health care.

I wanted to extend the cold, wet weather emergency shelter program to a year-round program, and it seemed odd to me that we, in the city, only used federal money to shelter the homeless from mid-December to mid-March. I felt that this had to change. I went to the board of supervisors and asked them to join the city in an effort to shelter homeless year round and to add services.
I was advised at that time, and that was a long time ago, to hold a fundraiser. How do I say this? I thought that was just a really stupid thing to say. It was 2002, though, so hopefully we all got a lot better. Mayor Hahn and the council members began working to put together something called an Affordable Housing Trust Fund as a means of stimulating affordable housing production. I worked to extend the emergency shelter program year round, Mayor Hahn agreed to fund it, and then slowly we began to add services: case management, health care, mental health care services—and the program grew.

By 2005, the Housing Trust Fund was implemented, and there was a dual program established in the fund for affordable housing and permanent supportive housing, and a more specific, more dedicated stream of funding—a high-leverage fund that combines local resources with federal resources, state resources, rental subsidies like Section 8, and Shelter Plus care to provide nonprofit, affordable-housing developers the opportunity to compete for loans and grants.

The Housing Trust Fund has been an enormous success. We have built thousands of units of affordable housing and permanent supportive housing that include services on site for people who are homeless. Not every homeless person needs permanent supportive housing; it’s really intended for people who need on-site supportive services.

In Los Angeles, about 35% of the homeless population is chronically homeless. These are people who have experienced episodes of homelessness chronically and with frequency. That’s our greatest challenge. Chronically homeless people in our city and county are homeless, on the average, for eight years. Twenty years ago, that number was six months. The longer a person with mental illness or chronic physical illness or substance abuse issues is homeless, the more it costs and the harder it will be to house them. We had to appeal to housing providers to work on housing the most vulnerable and chronically homeless individuals. It’s very, very hard work but, in my view, it is what is needed for us to truly have an impact on the issue of chronic homelessness in our city and in the region.

In order for us to get our arms around the problem, I knew we had to push hard on the county for services because that’s where the money flows from the federal government. The homeless population was not high on their list of priorities. The county tends to favor boutique homeless programs like Project 50. Project 50 proved to them that it’s really hard to successfully house chronically homeless individuals, but we already knew that. I wanted to be able to leverage people we already had in emergency or temporary housing and have them become housing-ready and move them through Project 50, but we could not strike an agreement with the county. I’m not in for Project 50; I am in for a project in the thousands, because that’s what we need—thousands of housing units for very low-income people who are at risk of becoming homeless, as well as for the chronically homeless.

We already know that single head-of-household families are at risk of becoming homeless. Single mothers with poor education are at great risk. We know that older adults are now at greater risk of homelessness. We know that 47% of the homeless population is African-American men. We also know that cutbacks in federal funding will place more people at risk of becoming homeless. Funding formulas are a challenge for us, as well as the
City of Los Angeles. **The city has received 50% of the [region’s] homeless population, but we do not receive 50% of the resources to be able to take care of this population.**

L.A. County continues to mount new initiatives on homelessness, and I’m hopeful now but a little bit skeptical, but I’m going to try to believe that if Los Angeles County were to adopt new policies, like increasing general relief, a major cause of homelessness, from $221 a month, it would be a beginning. That number has not changed in more than 20 years. I have asked for years that county departments be represented on the Los Angeles Homeless Services Authority Commission so that they can guide resources into homeless programs. It has not happened yet. But I am a pragmatic person and I know the government can do better and get more out of their investment. The City of Los Angeles cannot bear this burden alone—and Los Angeles County is far too big—and it requires that other cities in the county, 83 of them, should do the same. It would be much better for families and individuals to receive homeless-prevention services where they live. It is no longer legal for institutions to transport people to Skid Row against their will, and, as was mentioned, I authored that legislation and it’s working.

There has been a change at the county now with a new medical director. His name is Dr. Mitchell Katz, and I feel that he already understands the nature of these issues. He worked in San Francisco, which was one city, one county, with a far better arrangement for the allocation of resources and policy and program planning. And I told him that medical services at the shelter will dramatically reduce paramedic calls and hospital visits and it makes sense. For my part, I have never rejected a homeless housing project for my council district. Thousands of units have been built in the past 10 years. Many of these projects have won awards for their design and the way that they help their clients recover.

**Permanent supportive housing does work. However, I want to stress again that not every homeless person needs permanent supportive housing.** Some people who are homeless get on their feet directly out of a shelter, and for some it is a matter of finding a job and saving money and being able to move forward. For some, like the 83-year-old twin sisters who became homeless last winter—I met them at the homeless shelter in my district—the best placement is in an extended-care facility because of their age. This is why I think that year-round shelter is so important. A well-run, year-round shelter can provide a portal for services and establish priorities for homeless clients. We fund housing-location specialists at the shelter to place clients in the best possible living situation with the long-range goal of successfully maintaining them in housing. It works with about 80% of the clients maintained in housing long term, and it’s a wonderful outcome for people who are chronically homeless.

We’ve built specialized housing for populations. One project at the historic 28th Street YMCA, just off of Central Avenue, will house transitional-age youth with support services on-site for both the community and clients. The Downtown Women’s Center at 5th and San Pedro serves homeless women with case management and health care services, and it provides respite care and permanent supportive housing for women with mental illness. It’s their new home and it’s in the Renaissance Building that was once owned by the city. I worked to convert it to the Downtown Women’s Center. If you have time, I urge you to go see it. In fact, of the many housing projects in downtown—the New Carver, the Abbey
Apartments, the Charles Cobb Apartments—this is one of the most beautiful. I have a list of projects that goes on and on and on, and I would build more if we had more resources.

I’m happy to say that right now, on top of everything else, I’ve got five new homeless projects in production—they’re called the Star, the Genesis, Gateways, the rehabilitation of the Pershing Hotel, and of course the Roslyn Hotels.

We’re using every dollar available to address this need for housing because I think we know it works—and we know what doesn’t work. Ignoring this problem as long as our city and our county did brought us to this day, and now we’re digging our way out. **Every new project brings the promise of a future for many people who have been forgotten or thrown away. I think that’s part of a social contract. I think we’re obligated to help people who need our help the most.**

The face of homelessness is not what most people think. It’s too easy to dismiss the problem by characterizing the lives of people who are homeless in simple terms, like drug addicts, substance abusers, no good, or all those things. A lot of people do suffer from substance abuse, but we can’t forget that many people are simply in unfortunate situations and they don’t have a support system, or they have aged out of foster care, or they are poorly educated, or have suffered from a reversal of fortune.

It’s always interesting to me to ask other elected officials, “What projects have you supported in your area, your district?” And I always say to people, **“Watch how people vote”—it says volumes about their level of commitment to solving this issue of homelessness, whether they voted to fund or build or support homeless projects in their own districts.**

Our city is about to undergo the budget process. Last year the money for the year-round shelter was taken out of the budget by the mayor, and I had to work very hard to restore it. I have no doubt that I will have the same battle again this year. It is ongoing. The problems of the homeless are many, and I hope that some of you will help me take this cause up. As I’ve said, things have gotten better—we are receiving more rental subsidies for veterans and we’re building housing, and L.A. County is beginning to work to place homeless, mentally ill people into housing that we have built, as well as placing them in scattered-site housing.

**Of all the work I’ve done, this has been the most meaningful because there is no political advantage for doing this work.** This is not a demographic from which I get a lot of votes. I don’t raise a lot of money, and most of the time they don’t even know who I am. But it’s fulfilling to see people move into housing and get services and get their health back, get their social skills back, and to be able to get back on their feet and to be able to live meaningful lives. But I have to tell you, if homelessness did become something that had some political advantage, I think it would be the centerpiece of many people’s political careers.

I never forget stories of people I meet. I remember this from several years ago and it’s one of those stories where you think, wow, if I had only stayed there five more minutes and maybe looked right instead of left. We go on homeless walks with providers and the police. Once we met a lady, and I talked to her for a while and said to her, “It's not safe out here for a woman. You need to come in. There are beds tonight. We can get you a bed right
now. Would you please come in?” She said, “No, no, no.” All of you know, I’m sure, you can’t force people to take services against their will. So she walked off and it was twilight. Two days later I saw her face in the Los Angeles Times because she had been murdered about an hour after we left her, stomped to death by someone out on the street. I never forget those stories, and I think about her every day.

I think about a 90-year-old woman who stayed at New Image Emergency Shelter and insisted on staying there because her drug-addicted son slept outside the shelter, on the street, in the car every night because he wanted to be near her. Now, she would not move into housing until he died. Once he did, she could move on. And I told you about the 83-year-old twin sisters.

So many people, people who’ve lost their jobs or their employment, their apartment, living in their car. We’ve had an entire generation of people who have no financial plan and they may retire or be forced to retire or have to rely on their children to sustain a living situation, and that’s happening right in front of us. So many young adults are living with their parents for the same reason, more now than ever before, and if they did not have the support of family or friends, they might be homeless. That’s quite likely.

We can continue to count the homeless by the thousands here, but I think all of us can be part of the solution. You can ask anyone who’s running for office what their position is on homelessness and whether they will support affordable housing projects in the districts or the areas that they represent. We have not stopped and, again, I couldn’t have done this without the help of people like Ruth Schwartz, the Los Angeles Homeless Services Authority, the now-deceased Redevelopment Agency, the Corporation for Supportive Housing, Shelter Partnership, the Housing Trust Fund, the General Fund of the City of Los Angeles, and the matching state and federal housing programs that have helped us to build all of this housing.

It takes a bulldozer to get all this done, but you know what? This is an eight-ulcer job on a four-ulcer pay—from our former President Harry Truman—I think this applies. I admire people with the stamina to hang in there and to do the work, to do the planning, the development, and implement the policies that help people recover their lives. That’s not attractive work. It’s not easy work. What you’ll find, as I do, it’s the simplest ideas that often make the most sense and are easy to implement, where the results can be achieved for less money. Those are the ones that are most often ignored for the very fancy, high-cost programs.

It takes more than one person, it takes more than me, it takes all of us pushing hard, making a demand that the issue of homelessness remain front and center, because it is a worthy cause and one that should be supported by all of us. Thank you very much.
IV. Agency and Administrative Overview on Integrated Care in the Housing Continuum in Los Angeles

Opening Remarks from Panel Members

Elizabeth ("Libby") Boyce
Homeless Services Coordinator
Chief Executive Office of Los Angeles County

In response to passage of the Mental Health Services Act and renewed media attention on Skid Row in the mid-2000s, the county's Chief Executive Office and related administrative entities created the 2006 Homeless Prevention Initiative, a $120 million plan to assist communities with development of programs to address their homeless populations and implement effective service-delivery systems. This ongoing initiative currently has funding of about $50 million per year.

“What we learned is that housing with the right level of integrated support services is the solution and what will end homelessness,” said Libby Boyce. “That’s no easy task, but we have many pilot projects that we conducted that helped us figure out how to do this. One of those projects is Project 50, which now has been replicated to the tune of about Project 600 or Project 700.”

Boyce noted that Project 50 marked the first time the county focused on providing housing for the most vulnerable, chronically homeless individuals. The Chief Executive Office learned that integrated services are critical to success. “You’ve got to identify who you want to house, you’ve got to work with them and engage them to be interested in housing, to accept housing without strings attached, and you’ve got to wrap services around them to keep them, retain them in housing, and meet their needs,” said Boyce. “It has to be an integrated team: health, mental health, substance abuse, case management.”

Twenty-four partner agencies are involved with Project 50, and Boyce noted that the collaboration of such a large group requires continual attention, political will, and good leadership. “But the outcomes show that it works, both from a financial perspective and from a humane place,” she said. “We know the anchors to end homelessness are housing, rental subsidies, supportive services, and benefits. . . . How you apply that, depending on the homeless population you’re trying to serve, how you make those wheels come into motion, how you put all those pieces together—that is the tricky part.”

Boyce noted that her team:

- has worked with communities throughout the county to develop service-delivery systems that utilize the communities’ existing resources;
- has demonstration projects under way for transition-age youth in San Fernando Valley and San Gabriel Valley;

“There’s a lot of collaboration going on. . . . It’s an amazing time to be doing this work and I’m really optimistic about the future.”

—Libby Boyce
works with city and county housing departments, the Department of Mental Health, and the Department of Health Services to implement rapid rehousing programs and ensure that individuals are getting the health care and government benefits they need;

• is working with United Way on a funding collaborative that has public as well as private partners; and

• is part of an L.A. County interagency council on homelessness to continue improving efforts to assist homeless persons.

“There’s a lot of collaboration going on,” said Boyce. “It’s an amazing time to be doing this work and I’m really optimistic about the future.”

Chris Ko
Program Officer, Housing Stability
United Way of Greater Los Angeles

Chris Ko began by saying how nice it was to see the day’s participants “smiling and enjoying being in each other’s company. I think that’s just an anecdotal indicator of the progress that’s been made.”

Ko described being in a focus group of people who had been chronically homeless but were newly placed in permanent supportive housing. The tenants were telling their stories, describing what it took for them to reach that point. “Something that really stood out at me is that for every success story that was shared, they mentioned four to five different agencies,” said Ko. “Even if they were at Housing Works or at a PATH site, their story included visits to a DMH [Department of Mental Health] clinic, or they were meeting with a case manager at another agency, and they were very clear on how much each of those things were turning points.” He said he realized that “full-service partnerships and integrated care” seem intuitive to the process. “Why don’t we just do it?”

He believes that the following five main elements are crucial for collaborations to work: vision, levers, resources, safe spaces, and celebrating success.

1) **Vision:** Home for Good is a five-year initiative of United Way of Greater Los Angeles and the Los Angeles Area Chamber of Commerce to end chronic and veteran homelessness in Los Angeles County. “It’s our community’s plan—all of our plan—and I think the biggest contribution that we’ve brought is having a county-wide goal—just the idea that we were going after something big. One way of spotting if real integrated care and full-service partnerships are ongoing at your program level, in your community: Is there a big goal? Is there a vision that is bigger than any one group? If you see that vision, I think it’s an indicator that there is collaboration going on, because it’s bigger than any one group can accomplish.”

2) **Levers:** United Way aims to act as a lever to make partnerships work, advocating and organizing in collaboration with all of the organizations involved in a project. “We really take it upon ourselves to listen to each side and translate that story to the people who hold that in place.”
3) **Resources:** Ko mentioned the persistent problem of lack of resources, concern for how to best use the resources already available, and how to ask for more. “Early on, when I was working for nonprofits, I hated asking for money,” he said. “I think when you come together with a big goal or vision, you finally have a reason to ask for money.” He gave an example of approaching the federal government for further resources to match the county’s needs: “Upcoming with the SuperNOFA [Notice of Funding Availability]—we really pitched hard with the federal government, can you give us our fair share? Can you give us something that aligns much more with the problems we’re facing? ... So stay tuned for what comes out of the LAHSA [Los Angeles Homeless Services Authority] SuperNOFA.”

4) **Safe spaces:** Ko talked about the importance of partner organizations finding “safe spaces” to meet and talk. “We fill a unique role as United Way of just being a neutral place, a safe place where people can talk honestly and openly about the challenges they face with us or with one another or with other groups—and we enjoy that role.”

5) **Celebrating success:** Finally, Ko suggested that organizations should find ways to celebrate their successes—and the successes of their partner organizations. “The people I work with genuinely and honestly celebrate and want the success of others. We get excited at seeing what other people do,” he said. “I think that makes a difference—genuinely celebrating and being excited at the success of other people.”

**Peter Lynn**  
**Director, Section 8 Department**  
**Housing Authority of the City of Los Angeles**

Peter Lynn began by discussing his work with Los Angeles’s Section 8 Department, the second-largest Section 8 program in the country. He described Section 8 as a rental subsidy program that is the nation’s leading low-income housing strategy, with more than two million American families involved. “It is the biggest chunk of HUD’s [the Department of Housing and Urban Development] budget and it houses more people than any other program,” he said. “Public housing is a distant second with about half that many folks.”

Lynn said that families must get on a waitlist for Section 8 housing vouchers and usually wait a long time, “because the resource is outstripped by the size of the income-eligible population by—depending on the community—probably 10 to one, maybe something worse.”

Section 8 housing does not typically address homelessness. “Most agencies across the country are focused on the low-income, particularly the extreme low-income, 30% of variant median-income population,” said Lynn. “That’s the administrative funding model that we have to work with.”

A different HUD program, Veterans Affairs Supportive Housing (VASH), specifically targets homeless veterans. In addition, Shelter Plus Care is a HUD-funded program that provides some services to homeless persons who are disabled.
Lynn said that his department has been “carving out pockets of our regular Section 8 vouchers to attach to capital and services to construct long-term permanent supportive housing in project-based or sponsor-based settings.” Some 4,000 vouchers are now associated with housing homeless persons. He credited Councilwoman Jan Perry with championing these efforts. “That’s taking an administrative decision to allocate resources from one pool to another, so, right off the bat, you have to have the political will to do that, you have to have the policy authority locally, and you have to have some support to do those things,” he said.

He said that providing Section 8 vouchers to homeless persons requires that the person have a referral from a “contracted homeless-services sponsoring agency,” but that those persons only receive limited support once they are in Section 8. “There’s a high degree of expectation that this family is housing self-sufficient after that.”

Lynn said that integrated services are crucial to keep people housed. “The deeper into a service-needy population we go—the deeper the services we need to support them.” He said that once formerly homeless persons are in a “tenant-based environment, they’re out next to ordinary folks who have to get up in the morning and go to work and, [if] they violate their leases, that’s going to push them back into a situation of homelessness.”

Lynn continued:

> We’re dependent on the goodwill of the community, as embodied in the landlords. We’re dependent on the public support for this program and the acceptance of what we’re doing. So we need to show results in terms of street homelessness. We have to show results there or what’s the good of what we are doing—we’re investing resources that didn’t do anything.

He said that what his organization needs most are “extraordinary partners. . . . The relationships that we can develop in the process are really important to us.”

**Marvin Southard, DSW**
**Director, Department of Mental Health**
**Los Angeles County**

In 2004, Marvin Southard was working in Los Angeles, while his wife was running a homeless outreach team in Kern County. The couple was driving the streets of Bakersfield one day and he observed that his wife knew by name many of the homeless individuals they saw. “Her team had done engagement and outreach in such a way that it was personal and connected with each person’s story,” he said. “She knew through her team where they were in the process of getting housed and the next obstacle that had to be overcome.”
This experience, combined with a trip to see New York City’s Beyond Shelter program, “turned the light on” for Southard. The two main things he realized were:

1) **Homeless persons must be treated as individuals.** “When you talk about homeless people, the emphasis should be on people, not homeless—those individuals are human beings. The outreach team, and later on the treatment team, needs to know them as individual humans with individual stories and not a generic ‘the homeless,’” he said. “It really does take a change to move from the generic to the specific, to looking at people as individual human beings. I think that was really the strength of Project 50 as it began—that model forced you to look at individual human beings.”

2) **"You can do a lot better with a team than you can do by yourself."** His team at the Department of Mental Health learned that they could not achieve their goals without partner organizations. “Our definition of who our important partners needed to be kept on growing and growing and growing,” he said. “The county mental health department has very strong partnerships with the city in a variety of areas, and both of us are able to do better because of that.”

“We’ll find these individuals housing, working together, but if there’s a new cohort that exactly replaces them, we don’t know that we have been successful because our streets will look the same.”

—Marvin Southard

He believes that integrated care is crucial to success in relieving homelessness. “I think everybody recognizes that integrated care is the only kind of care that makes sense in the long run from a clinical perspective, as well as from a financial perspective,” he said. For example, if someone has diabetes and also is struggling with alcoholism, the damage from diabetes is not going to be contained unless that person first has substance abuse treatment and also has mental health treatment that helps them to be more compliant with their medications, then is brought into permanent supportive housing.

Southard said that his department is going to begin—possibly in partnership with USC—using peers as care coordinators, or promotoras, to provide coordination of health, mental health, and substance abuse treatment. He also noted that the department is going to try new approaches to assist individuals who are leaving prison, a population at high risk for homelessness. One approach would be to begin anti-craving medications for those with substance abuse problems while they are still in prison. Finally, he noted the need to find specific solutions for young people who are coming out of the foster system or the juvenile justice system.

“We’ll find these individuals housing, working together, but if there’s a new cohort that exactly replaces them, we don’t know that we have been successful because our streets will look the same,” said Southard. “We have to look to the springs that drive homelessness, as well as the current pools.”
John Viernes  
**Director, Substance Abuse Prevention and Control**  
**Los Angeles County Department of Public Health**

John Viernes pointed out that many homeless persons who need substance abuse services go to hospital emergency rooms. His program often takes them from the ER to a county facility in Acton, where they can have shelter as well as substance abuse treatment. He noted that one recent individual who had come to the Acton facility had cost the county more than $1 million over three years by using the ER for shelter and treatment. “We’re trying to document how the million dollars was accumulated, because I want to show Dr. Katz [director of the Los Angeles County Department of Health Services] the savings that he’s incurred by providing a homeless person shelter and treatment.”

Viernes discussed the **uncertainty about the exact number of homeless individuals in Los Angeles**. “On any given night, there’s around 58,000 people who are homeless in Los Angeles,” he said. “The Weingart Center puts the number at 82,000 on any given night, and the Los Angeles Times yesterday talking about AB-109 said that about 52,000 people are homeless on any given night.” He cited other data about the homeless population in Los Angeles:

- 20% are physically disabled
- 25% are mentally ill
- 33% to 66% have a substance abuse problem
- most live in south and metro Los Angeles
- 50% of the population is African American
- 42% to 77% do not receive the public benefits to which they are entitled

Viernes said that **collaboration among those serving the homeless population is essential**. He works closely with Marvin Southard, his colleague at the Department of Mental Health, to distinguish which of their departments can best serve those who have substance abuse disorders and co-occurring mental disorders.

Viernes also touched on the discussion of anti-craving medication. “Ninety percent of the folks on the anti-craving medication actually complete treatment,” he said. “The biggest obstacle is that the medications work, but many substance abuse counselors believe that you can’t treat an addiction with another drug. So we’ve got to eliminate some of those types of ideas, so that evidence-based practices that take 20 years to come into service happen more frequently and more rapidly. It will actually reduce the costs of providing services to all populations.”

**Attendee Questions and Panel Discussion**

**Doris, an outreach worker to homeless persons in our communities**, said Project 50 “was one of the greatest projects I ever worked on,” because she found that people could be greatly helped by getting into housing with a safety net to help them stay there. In fact, she
noted that the main problems she and other outreach workers are facing are people who have to go through the system repeatedly, who are “constantly falling out of housing” and becoming disqualified for Section 8 housing vouchers. If they are simultaneously battling drug addiction and mental health conditions, and are “self-medicating,” they often get denied access to housing and treatment programs.

**Marvin Southard** said that it is policy at the Department of Mental Health that individuals who have a mental illness and a co-occurring disorder will be helped. “If, on the other hand, they have a substance abuse disorder and don’t have a mental health disorder, that’s a separate issue, and we have to find a way to address that collaboratively,” he said.

Southard noted that homeless individuals with substance abuse disorders often end up detoxing in the ER, and, if they are found not to have a mental illness, they are released. “That is a really expensive way of getting detoxed—sitting in the ER of County Hospital—so we have to find another methodology for accomplishing that,” he said. “It’s a work in progress. I was speaking to people from the health department yesterday about this very issue, about how we evolve a response that’s not an emergency-room response for individuals like you’re describing.”

**Doris** said she has had problems with calling the Department of Mental Health to have an assessment team come to see an individual who then rejects treatment. Sometimes these individuals are in danger and need help, but calls to the police are not effective. **Chris Ko** said that providers other than the Department of Mental Health can help when DMH cannot. “Providers have developed radically innovative practices to be able to reach out and develop relationships with those kinds of persons. So even if DMH can’t serve them, there are other groups that you can call that have that skill and expertise.”

**Doris** said, “I’ve been doing this work for 24 years…. I love everything you guys are saying, and it’s wonderful, but the actual practice of it is another story.”

**Libby Boyce** said that a concern and challenge for everyone working with homeless individuals is helping those people who “are out there isolated, completely decompensated, and who don’t fit into one of our methods.” She said much improvement needs to be made in street-based engagement. “It’s something that I wish we could fix right now, but it is absolutely a problem, it is absolutely something that I believe will come up in our Interdepartmental Council on Homelessness, because this all starts at street-based engagement.” Boyce said that while it’s something that needs attention, “Do I see a solution six months down the road? No. Do I see one in a few years? I really hope so.”

**Southard** said that legislation has been proposed to broaden his department’s ability to take people in for treatment without their consent. “Then our authority to do more of the things that you would want us to do would be widened,” he said. “**I just need to make it clear, it’s not because we lack a heart or we lack the willingness to do it. It’s that we**
are constrained by the laws as they currently exist, not the laws as we would wish them to be.”

Another attendee asked what initiatives were in the works to integrate services and improve interagency communication. “That is, for providers and especially in your role as directors, establishing this structure and the guidance of these service providers to actually work together, either with linkages, partnerships, or co-location of services,” he said, so that “the customer can come in and be able to have access to housing, psychiatric services, and substance abuse [services] in a simple and easy and effective way.”

Southard said that as of July 1, 2011, the Department of Mental Health is working on several initiatives to integrate care, including:

1) co-locating staff at the Comprehensive Health Clinics run by the health department to integrate primary health care and mental health care;
2) “brokering partnerships between our community agencies and primary health clinics and practices throughout the community”—for example, forming partnerships between Didi Hirsch Mental Health Services or Pacific Clinics and federally qualified health centers (FQHCs) to provide integrated care on the grounds of the FQHCs; and
3) providing community health clinics, primarily FQHCs, with funding to hire mental health staff.

“Some are working very well but none of them are working perfectly,” said Southard. “We had an idea, we put it into place, and then we need to adjust it to the reality of the situation, so that’s what’s going on right now.”

He noted a triple collaborative model on Skid Row of substance abuse, mental health, and primary care all in one facility, which is working well. For the future, DMH hopes to import “primary care health into our mental health clinics, so that we create what is equivalently a behavioral health home,” he said. “First the primary care needs are met in that setting and then the linkage to whatever specialty care is needed for deeper care happens out of that practice.”

Addressing the housing side of integration, Peter Lynn said that the “easiest and fastest way we do that is to delegate that to DMH with a direct agreement.” He said that more than 1,000 families in his department’s housing programs have come through such coordinated programs. “We have several agreements through DMH for Shelter Plus Care, where they’re providing the supportive services through supportive housing,” he said.

Viernes said that the Department of Public Health is working with LAC+USC Medical Center on a “needs special assistance program that integrates the Department of Health’s care services with mental health and substance abuse.” The program assesses individuals who come into the county hospital emergency room for shelter and care and proposes treatment plans for them. It also relies on peer advocates to explain the benefits of treatment. In addition, beginning July 1, 2012, “we will implement a standardized rate
through the county for substance abuse services. Attached to those rates are modifiers that increase the rate, based on population served, so there is a modifier for homeless individuals that means that if they're coming for treatment for substance abuse services, the modifier will actually increase the rate for services for that population.”

Ko said he believes that “technology is critical to helping actual integrated care happen, beyond just the goodwill and day-to-day, in-person relationships.” He has seen strong partnerships in cities where technology is in place to facilitate information sharing. “A reason why we involve the business community and a reason for us as a social service stakeholder to involve people not in this room is that there are things to be learned outside. The Hubble telescope was fixed when a guy looked up at his showerhead.”

Viernes said that his department is working with a technology called Treatment Probation Parole Reporting Exchange (TCPX) for interagency tracking of individuals who are coming into treatment programs, primarily from the justice system, to insure that they’re receiving services. “We’re one of the few jurisdictions in the country that has this integrated technology,” he said.

Another attendee, addressing her question to Peter Lynn, said that she’d read that there are 50,000 units of Section 8 housing in the City of Los Angeles and wondered, “What is the waitlist for Section 8 housing?” especially considering the fact that there are 50,000 to 80,000 individuals who are homeless in the city on any given night.

Lynn said that the site-based waitlists, such as at Shelter Plus Care, vary. “Some of them have no waiting list in the sense that the referrals are coming through providers that are doing triage within their portfolio of clients and sending over the referrals through there. We take them in and serve them as they come.” He noted that since most of the housing units are occupied, people who need housing must wait for turnover in the program. “People leave the program for a variety of reasons, some good, some bad, and we use that attrition to put resources into this program.”

Lynn said that the housing program is not traditionally directed to homeless persons but that “the homeless programs have 12,000 units.” Homeless persons must depend “on the outreach of organizations that bring folks into these programs through the set-aside that I talked about—4,000 tenant-based vouchers or relatively low social service-need populations.”

He noted that there are occasional new infusions of resources, like this year’s additional 600 vouchers for housing homeless veterans, for a total of 2,000 units available for this population. “We apply for every new voucher that’s available, every new Shelter Plus Care certificate that’s available through the continuum,” he said.
V. State of the Science on Integrated Care

Opening Remarks from Participants

John Brekke, PhD
Frances G. Larson Professor of Social Work Research
USC School of Social Work

John Brekke said that his team at USC, in collaboration with Pacific Clinics and the Department of Mental Health, has spent four years “developing, manualizing, and testing a peer health navigator intervention for linking health care services and mental health care services for individuals with serious mental illness who are living in the community.”

He said that when setting out on this work, his team spoke to many different stakeholders about services integration. Hospital administrators they met with suggested that the seriously mentally ill would have to go to Skid Row to get health care services. “While some of our folks have in fact been homeless and probably will be in the future, they don’t choose to get their health care on Skid Row. And, actually, not all homeless people live in Skid Row, and certainly not all people with serious mental illness live in Skid Row,” Brekke said. “We began to see this issue of stigma as really rather dramatic.”

Brekke related the stories of three individuals who had been brought into integrated care through his team’s interventions:

1) A man who was using emergency care repeatedly for a severe lesion on his foot but who would not go to follow-up appointments. “By the time we engaged him, the next plan was to amputate his foot,” said Brekke. The team brought him into their Health Navigator Intervention. “He still has his foot, thank goodness, and is engaged with a primary care provider, and has learned to self-manage his own medical care.” From this experience, Brekke’s team learned that comprehensive health services fail without adequate follow-up care.

2) A woman who died from a tumor in her chest, but because she was brought into the integrated system, she did not die alone. “She died in hospice care that we were able to connect her with so that she didn’t die alone or on the streets,” said Brekke.

3) A woman who had a lump in her breast but decided she didn’t want care. “She decided it was too much trouble, there was too much stigma, it was too complicated. And she really was just going to live with whatever the outcome was,” said Brekke. The team got her into specialty care at City of Hope. She was found to be in a very early stage of breast cancer and is now receiving treatment.

Homeless individuals “die 25 years earlier than the rest of us. And they die due to preventable health conditions,” said Brekke. “We have learned that we have to keep getting better than this. We’ve learned that there is a problem at every single stage, from consumer awareness to assessment to the office visit to the exam room experience to follow-up. There are challenges everywhere in that process.”
Brekke and his team are encouraged by their efforts to use peers as health navigators. He said the Bridge Intervention uses a method they call “for them, with them, by them”: “The first time, you do it for them. The second time, you do it with them. The third time, they do it themselves,” he said. “That goes for everything from making an appointment to getting to the doctor to doing follow-up care.”

Brekke continued:

Sometimes when I present this idea of health navigation and peer health navigation, people say, “Oh, I know. We need to get a van.” And, yeah, that’s right. Transportation is a big issue, but that’s actually in some ways the least problematic issue that our consumers face. Just getting them to the right door is absolutely not enough, because we have seen the problems before the door, after the door, and once they walk back out in terms of managing health care issues.

The other issue is the notion that we just need everything under one roof and our problems of integration will disappear. I think the issue there is that, Lord, are we ever going to have enough roofs? Even under one roof, we still have problems of financing, training, scope of practice, and stigma that can remain.

Yet Brekke noted that this work is worthwhile. “The successes are remarkable. To watch people get good integrated care and the impact that has on their lives and their mental health is extraordinary. It’s been, frankly, the most rewarding work that I’ve done in 30 years in the field of mental health.”

Michael Cousineau, PhD
Associate Professor of Research
Keck School of Medicine of USC

Michael Cousineau addressed health care reform and the “opportunities and challenges” that it will bring to homeless service providers. He said he believes that, as health reform unfolds, “it’s going to grant us new opportunities not just to experiment with projects but also to come up with new ways of measuring the outcomes as well as the process indicators that can help determine what is successful and what’s not.”

He noted how compartmentalized the system currently is for helping homeless individuals. “We’ve got housing and we’ve got substance abuse and mental health, and everybody works out of different organizations with different budgets,” he said. “We really need to get to a point where somebody has to develop some level of accountability and responsibility in order to drive the integration.”
Cousineau laid out some significant opportunities for integration under health care reform.

1) **Expansion of Medicaid.** In Massachusetts, 95% of homeless persons are covered by Medicaid; in California, it’s about 20%, said Cousineau. Under health care reform, “essentially anybody who is under a certain poverty level, but basically 135% of poverty, unless you’re an undocumented immigrant, will become eligible for Medicaid,” he said. “The opportunity to significantly expand people into the Medicaid program provides the opportunity for services not only to the individuals, but also allows us to connect them to broader systems of care, including housing.”

2) **Patient-centered medical homes.** This model will provide a “home base,” a single entity that coordinates an individual’s care using a team-based approach. “This is going to require a significant transformation in the way we organize and deliver services,” Cousineau said. “How we do that for homeless individuals and vulnerable populations is really unknown.” He also noted: “What’s different here in terms of health care reform is that we want to begin to hold the individual provider accountable for that integration.” He said that the peer navigator system might be of help with this aspect of integration, “by providing a person that a homeless individual can relate to on an individual basis.”

For many years, Cousineau led Health Care for the Homeless clinics in 23 cities across the country. The clinics used a team-based approach in the 1980s that today is seen as innovative. “We know how to do it. Many of you know how to do it. But **what’s key is that we begin to institutionalize and formalize this so it begins to make sense on a broader basis, and also to bring in new types of providers like navigators and case managers who can help connect the dots with all these organizations,**” he said.

He also noted it’s important that, in this process, quality be improved, not just access. As health care reform’s changes are implemented, “Are people achieving satisfaction with the care that they’re getting? Are homeless people getting into housing? Are they staying in the housing? Are they beginning to get their health and their mental health status under control? Are they becoming more functional?”

He said that achieving success is “going to take a lot of advocacy. It’s going to take some research in terms of understanding what works and what doesn’t, new ways of measuring some of these outcomes, and I think an approach that is going to require a lot of creativity, innovation, and a real cross-disciplinary way to engage this population and see if we can really make a difference.”

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**Lawrence Palinkas, PhD**
**Albert G. and Frances Lomas Feldman Professor of Social Policy and Health**
**USC School of Social Work**

Lawrence Palinkas said that his current work is looking at services integration, and he mentioned two of his projects. One involves an evidence-based practice known as “multidimensional treatment” in foster care, which involves county child welfare programs in California and Ohio, county mental health departments, and juvenile justice systems.
The other study looks at the Housing First model in full-service partnerships in California. “That project as well is looking at the integration of services—more specifically and more related to why we’re here today, to the issue of housing for the homeless, for older adults, severely mentally impaired, and so forth,” said Palinkas.

Palinkas said that from these projects he’s learned that three elements are key to successful services integration:

1) **Communication.** Partners must be willing to communicate with one another, but also must seek to speak a common language. “In the panel this morning, I could detect subtle linguistic differences in the terms being used to refer to the same group of individuals and the same approach to delivering services,” said Palinkas. “We’re each equipped with a different set of terminology, languages that we employ in our day-to-day work with the people that we serve.”

2) **Collaboration.**
   a. **Outer context:** an outside demand for collaboration from stakeholders or a mandate from the law. “The Health Care Affordability Act now mandating services integration is an illustration of that outer context,” said Palinkas.
   b. **Inner context:** leadership within agencies and organizations who believe in integrated service, “who preach it every day in every way not only to one another but to their staffs,” said Palinkas. “Much of the research that I’ve been doing has shown that systems leaders who can tap into people they know who are doing similar things, who can advise them on whether they should adopt new programs and how they should do it, are much more likely to move further along than systems leaders who don’t have that.”
   c. **Format:** how people get together and how they work out the details of their collaboration. “Do they meet on the fly over lunch? Or do they meet once a month? Or is everything conducted by email? These are all elements that have a major role to play in the challenge of actually working together effectively,” said Palinkas.

3) **Compromise.** Partner organizations must be willing to negotiate and perhaps not always get everything they want. “Successful collaborations involve some form of what I call a cultural exchange,” said Palinkas. “You not only exchange knowledge about how to serve these clients, in this case the homeless, but you begin to transform your own systems of care, begin to exchange ideas about what you know and what’s appropriate, your attitudes toward services delivery, and your ability to provide services in collaboration with one another.”

In closing, Palinkas said that today’s conference was a good first step in bringing stakeholders together for more communication about problems and solutions, and more collaboration to identify common resources and overcome barriers. “And even though compromise has become a dirty word—at least in the political context these days—perhaps a little bit more compromise,” he said.
Audience Questions/Panel Discussion

An attendee asked for thoughts about how to help formerly homeless clients who have been placed into permanent housing “build a network of supportive relationships outside of the ones where people are paid to have a relationship with them.”

John Brekke said that while he hadn't conducted any research specifically into helping build peer networks, he noted that “peers engage with peers in a very unique way.” Such relationships are rewarding to the navigator and the consumer, “There's a connection, an understanding that really is very remarkable to watch.” Brekke said that although peer networks are not used often enough in mental health care, they are frequently used in cancer and HIV/AIDS.

Seth Kurzban, an assistant professor in the USC School of Social Work, said that he is developing an intervention to increase peer contact for homeless and at-risk individuals who typically rely on people who are paid to interact with them. The 12-session intervention, which he is currently testing, is “based on the principles of psychoeducation and mindfulness.” Clients meet as a group to learn self-care skills and are encouraged to rely on each other for problem solving. “There's a very large decrease in the isolation they feel. The other finding is that there's an increase in their treatment engagement, and how much they're willing to actually begin to take care of themselves, because it becomes motivated through their peer network. . . . Just sharing their stories and sharing some of the self-care skills that they've all learned is actually very beneficial to the group as a whole.”

Brekke said that he agrees that clients often become “intensively reliant” on mental health providers for social support and that interventions such as Kurzban’s are valuable for cultivating relationships among peers.

Addressing his question to Lawrence Palinksas, Michael Cousineau asked how a “cultural transformation” in organizations could take place “to really begin to facilitate their move toward a more integrated approach to how they work with each other as well as work with clients?”

Palinkas said that sometimes such transformations occur by happenstance, such as when a person moves from one agency to another and is able to facilitate contact between the agencies. But such transformations can also happen by design, through interventions and strategies to build integrated systems. “The California Institute of Mental Health, for instance, developed something called Community Development Teams . . . essentially providing a step-by-step process of building those collaborations and influence networks.”

Palinkas continued: “The fact that they're working together in this context is more likely to produce changes. It’s a learning experience for all of those who are involved. And with that increased opportunity for learning, there are documented changes in the belief systems of the individual organizations involved in this collaboration as well.”
VI. Building Partnerships for Sustainable Integrated Care

Breakout Session 1—Cherry Short, moderator

Opening Remarks from Panelists

Ben Henwood, PhD
Assistant Professor
USC School of Social Work

Ben Henwood was previously director of clinical services for Pathways to Housing in Philadelphia, a Housing First agency that provides permanent supportive housing and mental health support services. “We were able to build and sustain a partnership with an academic medical center to provide integrated care out in the community,” he said.

Henwood emphasized four important elements of integrated care in his remarks:

1) **Involving “end users” or “consumers” as key partners in gatherings like this forum.** “They really should be included in venues such as this when we’re trying to figure things out,” said Henwood. “Having consumers as equal partners sometimes can require added work and effort and accommodation, but ultimately it’s worth it and I think necessary for our collective success.”

2) **Providing good, humane care.** “Many people turn away from services because they’re not treated with dignity and respect,” he said. “When building partnerships, we need to choose partners that have shared values around those issues. . . . I think we also have to hold our partners accountable when there are breaches, however small, in the way we treat people.”

3) **Recognizing and learning from the strengths of partners.** “I think institutional medicine has a lot to learn from people who do community work,” said Henwood. “I worried that this whole integration of care led by health care reform might lead to what I think of as the medicalization of psychosocial intervention. What do I mean by that? That our medical model is great. It’s led to the development of a lot of innovation in health interventions. But managing chronic issues is really about person and environment.”

4) **Remembering that housing is not separate from integrated health interventions.** “Having a place to live is fundamental to health. It is a health intervention,” he said. “People who have serious mental health conditions—it’s probably 25% because of poor health care. But housing itself and the conditions that people live in also contribute to their health outcomes. . . . Our health care, housing, and social policies have to reflect this broader notion of health. And these policies themselves also must be integrated.”
Jessica Brown-Mason
Director of Programs, Hope Gardens Family Center
Union Rescue Mission

Jessica Brown-Mason has worked with homeless persons for 25 years. Currently, she is at Hope Gardens Family Center, a transitional living program in Sylmar. “I am a frontline person,” she said. She had hoped more of the morning’s panelists would have stayed for the breakout sessions because “we want you to hear what the frontline battle feels like.”

She said she believes that frontline providers, and the clients they serve, should participate in the process of designing programs. “You have a vision. You have the research, and you’re looking at it from an academic standpoint. I’m just a practical person on the frontline,” she said. “I respect the professors. I respect the research. I respect all of that. I just want us to have a voice in the process.”

Brown-Mason said a program that looks great on paper might need to be tweaked by those on the frontline in order to serve the people it is intended for. “Visionaries are wonderful people, but there’s always somebody behind that visionary that brings that program to life. That person needs the flexibility to make it work.”

Often those on the frontlines are asked to make a client fit into a program that may not necessarily be the best match for that client. Brown-Mason noted that we may be creating a sense of “unnecessary competitiveness which creates barriers for our clients’ well-being.” “For me, integrated strategy means that we do what we do best.”

Brown-Mason continued:

What speaks to my heart—as I’m on the frontline and I’m serving women and children and people in need—is that the success of every program that I have worked for has been healthy, happy relationships. If you’re a mental health provider, if you don’t have a really good connection with that client, they don’t want to talk to you. They don’t want to listen to you. They’re not hearing what you’re saying. Just because a person is homeless does not mean that they don’t have a choice. They do have a choice. We need to make them welcome and come into our integrated system of care.

Brown-Mason also noted that programs often run into problems when they are required to change what works for them in order to obtain funding. “We wipe out a system that worked for many years, and then we start over,” she said. “When we have momentum with something, use that, tweak it, change it, let it keep moving forward.”

“You have a passion to be a street outreach worker. You have a passion to be a homeless service provider. You have a passion to be a clinician. But if somebody asked you to change that passion to just get the dollars, it has a negative effect on the relational aspect.”
Jonathan Wolf
Program Manager
Skid Row Housing Trust

Jonathan Wolf has been in Los Angeles in his role at Skid Row Housing Trust for about six months, having previously worked for the Boston Health Care for the Homeless Program. Through this work, he has learned that to build working partnerships around homelessness it’s important to find organizations and people “that share your beliefs.”

Wolf said that Skid Row Housing Trust partners with the JWCH Institute to provide integrated, on-site health care, and that the Trust and JWCH have made a good match. “They want to be serving the people that we’re serving, and that shows,” he said. “If health care professionals are not interested in or really invested, that shows to the patients coming in. People don’t want to open up to them.”

Wolf shared a story about the founder and president of Boston Health Care for the Homeless, Dr. Jim O’Connell:

When he graduated medical school, he was the chief resident at Mass General Hospital. He started Health Care for the Homeless in a clinic at the Pine Street Inn, the city’s largest shelter. He went in thinking, “I’m going to make everybody well.” They already had a nurses’ clinic there. For the first three months, all the nurses would let him do was wash feet. He just sat and washed people’s feet who were coming into the shelter, and slowly building up relationships with patients as well as the staff. By the end of those three months, when he was finally able to start seeing patients, the residents of the shelter knew he was invested. The staff knew he was invested. It opened a lot of doors for him.

Wolf mentioned an experience with a psychiatrist who quit after two days working at the Trust. “She wanted a very sort of traditional psychiatric setting where people would come on time, they’d be med-compliant, they wouldn’t pose any risk to her,” he said. “She wouldn’t even close the door so that people could speak in private because she was too scared to be in a closed room with them. It’s important to find people who are comfortable.”

As counterexamples, he said that his team in Boston included psychiatrists who had sessions on park benches, doing whatever it took to connect to patients. The psychiatrists at the Trust understand that people might be intoxicated and not medication compliant, but they find ways to improve these patients' situations by prescribing appropriate medications.

“It’s important to find good partners, people who want to be doing the work,” he said.
Nikki Shipley  
Consultant, Community Research  
Homeless Healthcare Los Angeles

Nikki Shipley describes herself as a community researcher. “I’ve made it my point to take evidence-based practices and best practices and apply them out in the community,” she said.

Currently she works primarily with Homeless Health Care Los Angeles, an agency that started out providing training and outpatient substance abuse treatment but has “evolved to be almost like a large demonstration project of evidence-based integrated care.”

She described their model of integrated care as providing for a person’s immediate needs, whatever they may be. “When somebody walks in the door and they say that they need certain things, we give them what they need. We use stages of readiness. We use motivational interviewing. We use harm reduction. Wherever that person’s at, they get what they tell us they need. They can get psychiatric care ... acupuncture, child care services, and parenting, just to name a few.” She also mentioned using mindfulness therapy with clients.

The staff at Homeless Health Care conducts training for other agencies’ staff, including Skid Row Housing Trust, on bringing evidence-based integrated care practices into their everyday work.

On the subject of funding, Shipley said that Homeless Health Care relies primarily on private support. Although government agencies approve of the kinds of services provided by Homeless Health Care, “they don’t want to pay for them. It’s up to you to figure out a way to pay for them.”

Last year, Homeless Health Care helped 100 people get housed using Section 8 vouchers. The organization also relies on scattered-site housing at places like Skid Row Housing Trust. Although their clients are housed all over the city, “they’re in constant contact with us,” said Shipley. “Of those 100 people, 98 of them are still housed one year later.”

Shipley described her organization’s “ALL Program,” also referred to as FUSE, or Frequent Users Systems Engagement: “That is where homeless people who are chronically ill and have co-occurring disorders are referred to case managers who go to the hospital. When they’re ready to be discharged, they’re immediately housed. They have intensive case management and assistance to access all of our other services,” said Shipley. “These are people who are high users—10th percentile—frequent users of health care who are now being housed.” Within this program, 140 people have been housed over the past year, she said, and only three have dropped out of housing.

“Integrated care does work,” said Shipley.
Dialogue with Workshop Participants

Moderator Cherry Short welcomed attendees to join in the discussion of how integrated care can assist the community of persons experiencing homelessness. “This is really a good time to bring everybody together. We can focus on some of our strengths and try and make something happen here,” she said.

The first attendee to speak was Carmen Navarro, program manager of the Westminster Transitional Living Center, part of the Venice Community Housing Corporation. While the day’s forum was focused on integrated services, she observed that few researchers and agency administrators remained for the breakout sessions. “They’re some of the stakeholders. I think for the future, if you’re going to have an integrated one-day conference, it really should start here,” she said. “It’s more of a comment that, hopefully, if there is a next step, that there really be a dialogue.”

Julie Cederbaum, assistant professor in the USC School of Social Work, noted that for a number of years she was a social worker for the Alegria transitional-housing program for HIV-affected families. She said that perhaps what was needed for change was a “ground-up swell and not a top-down swell. We keep assuming that it’s Section 8 that needs to find more vouchers, or it’s County Mental Health that needs to do something. Maybe it’s that we need to make noise and move up instead of expecting it to come down.”

Short said that this conference was a starting point. “But what we’re trying to do now is to capture some of the things that we feel strongly about so that we can actually report those things,” she said. “We would like others to know what’s going on. . . . So let’s step up and say how we actually feel.”

Chris Ko said that, since leaving the university setting, he has missed reading journals that are too expensive to access independently. “I was trying to read up on the studies that have been produced by some of the faculty and panel, and I would say 90% of them were locked into an e-journal subscription,” he said. He noted that not being able to read the latest studies could contribute to the difficulties in translating research into practice. “Part of the reason it takes 20 years is that’s just how long it takes for those articles to become free.”

Ko further noted that he enjoys his work at United Way because he feels he can make a direct difference. “I think these systems challenges that providers often identify are very different than the sort of systems challenges that policymakers talk about in a room. A lot of the day-to-day challenges are not at the legislative level. They’re often at the administrative level. . . . I think a lot of times we can do as much work on small obstacles as we can on major, humongous ones.”
Ben Henwood wanted to reiterate some of the emphasis from earlier in the day on the importance of speaking a common language when forming partnerships. “Even how we are referring to different populations we serve makes a big difference,” he said.

He also noted that a speaker from the Department of Mental Health had mentioned a proposed law giving more power to mental health workers to act for clients or consumers who refuse care. “I think if there were consumers in the room, they would probably not like to hear that. I don’t know how the provider population thinks about that,” he said. “There are alternative ways to deal with certain issues.”

Pilar Buelna, executive director of Social Services for the Salvation Army Los Angeles Area Command, said that one of the Salvation Army’s housing sites, Alegria, is an integrated model. “We now have a clinician onsite. We have a nurse. We can’t afford a doctor … it’s a very expensive model.” She said that she didn’t hear a lot in the day’s sessions about funding.

Brown-Mason said that her organization partially copes with costs through agreements with the Ostrow School of Dentistry of USC and the Pepperdine University School of Psychology. “Believe me, I know it costs money. But the schools need places for their students,” she said. “I believe that the students who come to Hope Gardens are receiving different hands-on applications, because now they’re not afraid of the homeless population. We get excellent care for our target population. … The government does need to hear that you need money to be able to bring those services in.”

Henwood acknowledged that integrated care can be expensive and that new funding models are needed. He mentioned innovation grants from the Center for Medicare and Medicaid Innovation; the first wave was released last year and a second wave of grants was expected soon. “As far as the research goes, I think, as community-based organizations, we can’t be afraid to have research done and learn the outcomes of what we’re doing,” he said. “I think we should be open to change if it needs to change.”

An attendee noted that some who are effective in their work in homelessness don’t necessarily have advanced degrees. “There are some amazing people that are putting their feet on the street every day that don’t have your educations but can connect with people and connect to the systems in ways that a PhD may not be able to,” she said. “There are other forms of integrated models that we also need to be thinking about, like models that are really rich in linking people to services and walking them through it.”

She further noted that there may be some changes needed that are unconventional and uncomfortable: “We all have to be much more open to things that scare us, like shelters that allow people to be intoxicated and people having the right to choose to use drugs … Even in Los Angeles, it’s moving toward beautiful things, but the goal is sobriety.” She also emphasized the need for street medicine: “We need people that go out into the street and do medicine, including psychiatric care. That’s got to be part of our solution.”
Ko noted that “they finally passed the Mental Health Parity Act, meaning that all states have to fund mental health equally to funding health, which has been a long fight coming. The other one is incentives for reducing emergency room use.” He said those incentives might provide an opportunity to do more than just meet a mandate, but to “think forward in terms of ways we could save the city, the county, and the state money and fund some nontraditional services.”

Ko felt that a missing element in the integrated care forum was the Sheriff’s Office. “We all know that the release of prisoners from jails to the community is going to lead to an increase in homelessness... We need to begin to have more dialogues with nontraditional partners.”

Jonathan Wolf brought up the need for more outreach of all kinds. “I work right in the middle of Skid Row on the 600 block of San Pedro Street. I’ve only been there six months, but I’ve not seen any outreach being done in the neighborhood.” He reiterated that he had previously led a clinical outreach team in Boston. “I think agencies like Skid Row Housing Trust, SRO Housing, and others are doing a good job with the support of housing aspects. But there are so many people on the streets that are just sort of sitting there in limbo,” he said. “If there’s more engagement of those people, they’ll be better prepared to move into housing. They’ll see that there’s some hope.”

He observed that often the only contact that homeless persons have is with the police. “There needs to be more positive people out there on the streets interacting. If you start small with that, you can then build into an integrated medical team,” he said. Building a foundation of outreach workers in at least the downtown area would really benefit the entire community, both from the missions to the drop-in centers to going all the way up to the permanent housing providers.”

Jessica Brown-Mason said she would like to see more evaluation of practices as they are implemented. “If we look at the research after 10 or 20 years and we go, ‘That didn’t work,’ well, we didn’t revisit it to see what didn’t work and to change the process to continue to have it move forward. We end up scrapping it.”

Ko believes that one element that has been left out of the conversation is volunteering among the general public, that is, community members who want to make a difference. “How can we involve them in responsible, appropriate, but meaningful ways? Part of the reason I think we continue to emphasize more traditional modes of service delivery is that’s still where the volunteers go.” Currently, there is little more for them to do than volunteer in serving meals at a shelter, for example, although that is a valuable activity. “If there are things that other cities have done to engage the general public, I think that would be a tremendous way forward in providing in-kind services and also potential future advocates.”
Breakout Session 2—Eric Rice, PhD, moderator

Opening Remarks from Panelists

Ervin R. Munro
Director of Social Services
SRO Housing Corporation

SRO Housing Corporation is an affordable housing provider in the Skid Row area of Los Angeles. Ervin Munro said that the organization operates 29 residential facilities with more than 2,000 housing units for homeless and very low-income individuals and has about 60 supportive services staff who work with residents on integrated care services.

“I don’t know if we thought about it as an integrated program when we first started,” said Munro. “It was based on the need of the individuals that we served.”

He gave examples of the many partnerships that SRO Housing Corporation currently has for services to residents:

We work in conjunction with different agencies on substance addictions. We work very closely with the county Department of Mental Health. We have very close collaborations with the Veterans Administration for veterans’ services, and we have a 60-bed program that’s specifically for veterans. We also work with JWCH for primary medical care, as well as with the Department of Aging for senior services. And we have many, many other types of collaborations.

Munro said that many of these partnerships began informally as his organization began sending residents to different agencies for services. “Over time, it developed into very formal, very well-coordinated types of collaborations,” he said. “This is an evolution that occurred over many years and ... was [not] preplanned in advance. We started in 1984 and here we are today with the integrated care model that we have.”

He said that while many organizations that provide housing have integrated services on-site, SRO Housing Corporation prefers to have services close by, but off-site. “First and foremost, we believe that these are people’s homes and that they should be treated as homes and not as a service entity,” he said. “However, there are case management folks and service coordinators on-site who help them navigate to get services.”
Al Ballesteros  
Chief Executive Officer  
JWCH Institute

Al Ballesteros described the integrated services that his organization, JWCH Institute, provides for homeless individuals. JWCH runs the Center for Community Health in downtown Skid Row, a 21,000-square-foot, federally qualified community health center that opened in 2009. He said that on-site at the center are representatives from county departments, including the Department of Mental Health, the Department of Public Health, Substance Abuse Prevention and Control, and HIV early intervention services and HIV primary care. Faculty and students from the Ostrow School of Dentistry of USC and the USC School of Pharmacy provide dental and prescription services. Optometry services are provided by the Doheny Eye Institute.

“When we opened the site, it was important that we had an integrated approach to care,” said Ballesteros. “Our philosophy at the center is that if you put all the disciplines together that homeless and vulnerable populations need, the collaboration, the coordination, and the seamless manner in which that’s delivered really is beneficial for the outcomes of that patient.”

Ballesteros said that, through tremendous coordination and hard work, the JWCH Institute implemented electronic record keeping so that each individual who came through the system—“11,000 unduplicated individuals” so far—had one chart that could be shared among the various providers in the center and across the county. Patient information is collected into a master record, then “if they need services that are not available in the building, they can be scheduled and booked into other sites [electronically].”

JWCH Institute also takes care teams into other facilities, like the Skid Row Housing Trust and SRO Housing locations, to provide on-site “mini-clinics.”

He said that the center’s approach is to see the people they’re serving as falling somewhere within an inverted pyramid. “You look at the sickest within the site and wrap services around those individuals,” he said. “That, in our philosophy, keeps them healthy, keeps them out of emergency room settings, and improves outcomes.”

Ruth Schwartz  
Executive Director  
Shelter Partnership

Ruth Schwartz said that her organization, Shelter Partnership, primarily serves the role of fostering collaborations. “We work with community-based organizations and local governments to help develop housing and resources for people who are homeless.”
She said that the primary lesson she’s learned from collaboration is the need for leadership and vision. “You heard [keynote speaker Councilwoman] Jan Perry—why have we gotten things done downtown? Because there’s leadership and vision,” said Schwartz. “Why are we so far behind on homelessness? Because there wasn’t leadership and vision at the places that mattered.”

Schwartz also spoke about other lessons she’s learned about integrated care and organizational collaborations based on many years of work in addressing homelessness.

Many integrated models of care are based on honorable motives but hastily arranged agreements. Schwartz noted an example of a very quickly organized collaborative in which there was much goodwill and several reputable agencies and organizations involved. The people who wrote the plans for the collaborative, however, were not the same people who needed to implement the plans. The extent of miscommunication that ensued led to a breakdown in the collaborative.

Productive collaboration with agency directors may additionally require that a significant amount of financial resources be available to invest in that collaboration. “People don’t play well unless there are significant financial resources available.”

Adding to the challenge is that “funders can occasionally misunderstand the programs they fund,” which can contribute to further miscommunication among the organizations that are implementing the programs.

Communication problems overall are partly due to different organizations speaking different organizational languages. “I can’t tell you how often that happens and how important it is to get those language barriers resolved at the very beginning,” said Schwartz. “You’ve got to do fun things with people, you’ve got to know people, you’ve got to go do more with them than just sit around a table, if you’re going to ever be successful.”

Herb L. Smith  
President and CEO  
Los Angeles Mission  

Herb Smith said that, in addition to his role at the Los Angeles Mission, he serves as president of the Los Angeles Central Providers Collaborative in Skid Row. As a relative newcomer to homelessness services, he said he was spending the day “learning as much as I’m contributing.”

The Los Angeles Mission is a faith-based organization that provides emergency services for men and women and, to a lesser degree, families. It provides overnight shelter and other services to try to help homeless persons into transitional programs—people whom Smith
says the mission considers to be “students.” They additionally offer day services for people whom they consider to be “friends and neighbors.”

He said that, when forming partnerships, the first thing to acknowledge is that “there is no one best model. There is no one solution to homelessness. There are multiple solutions, and therefore we need to incorporate those and respect those.”

Smith continued: “We believe that the solution to homelessness for many is job skills, job training, perhaps life skills, and that, although a distributed model or permanent supportive housing, a housing-first model, is good for some, we don’t necessarily believe that it’s good for all.”

Smith noted that his background is in business and higher education. He has learned a lot about forming partnerships, which he said is essentially team building, from management consultant Patrick Lencioni. “Fundamentally he says there is no success in any team, whether it’s in business or whatever else, unless there’s a fundamental level of trust,” said Smith. “I would put out there that if we’re going to build any kind of model, we first have to be able to trust each other, and that is part of communication—spending time. It’s not just showing up and signing a piece of paper; it’s getting to know the other person and appreciating their differences and recognizing those and establishing that level of trust.”

The second thing Smith said he’d learned from Lencioni’s method was in regards to conflict—and the fear of conflict. “Any good partnership, any good working relationship, is going to encounter difficulty,” he said. “A healthy sense of conflict and conflict resolution, frankly, is what makes stellar managers. When I’m looking at people to hire for management roles, I don’t want to know that they can count beans; I want to know that they can deal with those issues of conflict and conflict resolution.”

Third in Lencioni’s management method is commitment. “If we allow conflict to fester and there’s no commitment to getting the job done, there’s no sense of focus to the goal that we’re trying to get to, then nothing’s ever going to happen because we’re really not committed,” said Smith. He said that everyone involved in a partnership must understand the goals, pay attention to the details along the way, and commit to achieving results.

Dialogue with Workshop Participants

Moderator Eric Rice welcomed attendees to join in a conversation with panelists about strategies for integrated care.

A student attendee asked about the issue of funding in partnerships: “When you have all these agencies that want to collaborate and work together, is there a concern about how
jobs will be affected, how someone’s budget is going to be impacted, and in the end result, do you lose staff because you have people who perform similar functions?”

Ruth Schwartz noted that she has faced such issues in the past when not all stakeholders were well informed about the goals of a collaboration and felt threatened by competition for their jobs. As a leader, she explained to her employees that new approaches and additional personnel were meant to complement their work.

Ervin Munro said it’s important that partners come to an agreement before they begin working together. “We sit down and spend weeks and weeks together in different types of planning meetings where we determine exactly who the staff are going to be, what the roles of the staff are going to be, what services are going to be provided—so that there’s not conflict down the road as to who’s doing what and for what purpose.”

A second student attendee asked: “What kind of political support is there as far as financing, initiatives, and policies to make sure that [integrated and wraparound] programs and services have a degree of longevity?”

Al Ballesteros noted that while it seems like a lot of money is being spent on care services, the money is not as coordinated or efficient as it could be, so it may not be going to the most meaningful aspects of care. “If you cut out the bureaucracy and make it easier to communicate, then theoretically you have some efficiencies and you have better outcomes.” He also noted that changes would be coming with the Affordable Care Act, including that, while everyone will be covered, focus also will be on efforts to reduce costs. He said that funding needs to be directed to help the most needy and complex populations and to ensure the best wraparound services for them.

Schwartz said there have been strides forward because of funding for housing from redevelopment agencies, a state bond issue, and the federal government, but all of those sources have been eliminated or greatly reduced. The councilmembers and mayor will determine what will happen in the near future, she said.

Another attendee asked the panel to address the steps that service providers in the community, like social workers, could take to change the thinking of government agencies. “Where do we go from here, now, in terms of bridging the gap between your agencies and your on-the-front-lines knowledge and the bureaucracy that’s so many steps removed from seeing that?” she asked.

Schwartz believes that it is important to develop relationships with councilmembers and leaders in government agencies so you can share your experience and opinions with them. “We spend a lot of time with government people...”, “You’ve got to confront people. You’ve got to go out and tell people—elected staff, elected officials—and you’ve got to have them come out and see how you do it, and advocate.”
Elizabeth Owens, manager of best practices at Tri-City Mental Health Center in Pomona, asked for ideas to enhance relationships with colleagues in partner organizations. “We do have community partners who are committed to making this work, but I want to make it fun. I don’t want meetings where we’re just sitting around talking every month about integrations; I really want us to get to know each other—but we all have full schedules.”

Ballesteros said that in his organization’s partnerships, they brought people together from all levels of the organizations. “Not just the CEOs, the COOs, and the medical directors, but bring folks that are going to be more on the direct service side as well. Have them do some of the planning,” he said. “I don’t think you can get around the fact that you’re going to need to spend the time.” He also noted that effective planning also comes from asking clients what their barriers and needs are, perhaps through focus groups that partners can run together.

Herb Smith also had ideas for team building. “Maybe it’s as simple as taking your team and volunteering in another agency that you have no involvement with and experiencing a different perspective,” he said. “Go serve a meal at a mission or what have you. I think that bonds the group and also helps tear down some of the barriers.”

Schwartz suggested having celebrations. “When we started one collaborative, we had a party with a band; it was a luncheon and included the clients, too. They were getting their Section 8 certificates and vouchers, and we had all the line workers and everybody, and we had a dance party,” she said. “You have to make time, because it’s not a waste of time; it’s really important time.” She also noted that communication among partners is very important, whether it was follow-up meetings or having agendas and meeting minutes.

Troy Vaughn, vice president for community development and public policy at the Weingart Center Association, suggested community service projects as a way to bring partners together. “We did a community service project together called Project Homeless Connect,” he said. “From that project we were able to learn how our agencies begin to think and process, and really begin to experience working together as a team and just find something in common.”

Rice wondered whether the lessons learned about integration by service providers who are doing hands-on work could be shared with the administrative organizations to help them integrate services more effectively. “Do we think that there are lessons from these sorts of collaborations that can be passed along to the more bureaucratic level?” he asked. “In the conversation this morning I heard a lot of goodwill about collaboration but not a lot of specifics about collaboration.”

Smith related a time when a collaborative initiative on Skid Row had staff interest but administrative reluctance. “That project never really got off the ground because fundamentally the funders and the parties involved never really understood the cultures of the two organizations and what drove the mission of those two cultures.”
Schwartz said, “It’s taken a long time for those County departments to collaborate.” She said that certain collaborations between departments took many years before they worked effectively. “Those early years were not very smooth. It required a lot of organizational changes.”

Munro noted that administrators at the county and state levels may be more pre-occupied with policy and budgets, in contrast to those on the frontlines: “We have to do the direct service provision and so things become a little bit more concrete to us and less abstract. We are hitting the road and getting the services out to the clients.”
VII. Next Steps in Achieving a Sustainable Integrated Care Strategy

Suzanne Wenzel welcomed attendees back from the breakout sessions and invited the session’s two moderators to share what their panels had discussed.

Breakout Session 1—Cherry Short, moderator

Cherry Short briefly described the barriers and strategies to integrated care that her group discussed.

- **Dialogue.** More dialogue needs to occur with nontraditional stakeholders. Dialogue should include policymakers—“people who can change the dynamics of what we’re doing”—social workers, other people in society who are willing to give their time and effort, and clients, the users of these services. “Forums like this are very important for beginning dialogues.”
- **Outreach.** Outreach work is going well overall but we should be looking at all elements of outreach, on scales large and small.
- **Systemic change.** “We would like to see the system changed—and how do we actually make that change happen?” In addition, the system is “disjointed.”
- **Training.** “An essential part of integration is training for integration.”
- **Funding.** “We shouldn’t just rely on single funding sources,” but should investigate the breadth of available funding.
- **Collaboration.** “How can we work together as a group?”
- **Research.** Service providers need to be informed about new evidence-based practices.
- **Empowerment.** “There are good people that are working hard to make a difference. That is really important in this line of work, and we should acknowledge this.”
- **Policy.** “Are [policymakers] listening to what is needed in the care of the homeless? Are they listening to what makes a good wraparound service?”
- **Costs.** There was discussion earlier in the day about the high cost of homeless individuals using emergency services for their health care. “If we devise a proper health care system, it means that we’ll be saving a lot of money.”

Breakout Session 2—Eric Rice, moderator

Eric Rice observed that much of his group’s discussion was around “barriers and strategies for organizations engaged in these collaborative partnerships, as opposed to the earlier discussion of this morning that was more about systems-level collaboration.” His group’s discussion was primarily focused on the “clients being served in these efforts.”

- **Funding**
  - **Finding funding.** Finding funding is stressful. “It’s difficult to think about how you are going to do something new if you can’t pay for it.”
  - **Bureaucracy.** When seeking funding, bureaucratic structures can be intimidating.
• **Fear of job loss.** As integration occurs, there will be redundancies. “Some folks are going to be doing the job better than others, and that creates anxiety among those who are actually doing the work.”

• **Communication.** This was a dominant theme for this panel, Rice said.
  o **Communication within organizations.** Often there is a disconnect between those at a “higher level” of an organization who plan integrated-care partnerships and the people who are going to be working directly with clients.
  o **Communication between organizations.** When organizations come together to accomplish work, they may have different organizational cultures, languages, and philosophies. “And so there needs to be a dialogue to understand the philosophy of each organization.”
  o **Communication with clients.** The consumers of integrated care should be involved in discussions. “Ask the people who are suffering under the burdens of homelessness and poor health what their barriers are.”
  o **Communication from the outset.** With enough communication early on in “formative stages,” many problems can be avoided down the road.

• **Working together**
  o **Team building.** “How does one create new teams and new organizational entities, and how do you create trust within those teams, and really being active and thoughtful about team building and trust building.”
  o **Having fun.** “When building collaborations, spend time together as people, not just around a table planning, but also doing fun things together.”
  o **Time and commitment.** “Put in the time. This one came up over and over again. It was just a sense that there needed to be a commitment on the level of the organizations..., that simply signing a document that says, ‘We’re going to have a collaboration,’ is not sufficient.”
  o **Physical proximity.** It’s easier to integrate services when you can interact with one another. “If it’s not in one neighborhood or under one roof, how do you get from place to place?”
  o **Information sharing.** “Coordinating integrated care becomes much easier if you can share records.”

**Attendee Questions and Discussion**

*Suzanne Wenzel* began by opening further discussion on engaging policymakers. “How do we engage policymakers?” she asked. “They may have little idea of the challenges that are occurring within agencies or on the ground in engaging clients. How can we make that connection with policymakers to obtain additional resources or to discuss legal obstacles in trying to care for people with multifaceted problems?”

*Julie Cederbaum* asked, “How do you get the people who are directly affected as part of the dialogue? Because we’re making a lot of decisions for people and not letting people help in determining what their futures are going to be.” She believes that **policymakers especially need to hear from—and see for themselves—service providers on the frontlines and the experiences of homeless individuals themselves.**
Attendee Sharonda Bazzell said she is an intern in a congressional office. Members of Congress, as well as state and county leaders, need to see those most affected in person so they can be better informed to make legislative decisions, she said: “When you can bring a face to the conversation and have that person come and present it to the Congress member and get them involved and interested in the issue, I think that elevates it.”

Chris Ko said that his organization brings policymakers together with diverse stakeholders. In one instance, representatives from a local homeowners’ group came to a session. “It made a big difference,” Ko said. Policymakers may become accustomed to hearing the views of only certain kinds of stakeholders. Inviting someone that policymakers may have less opportunity to interact with can be very productive for all concerned.

He said that his organization values conversations with stakeholders. They have regular meetings with a local business council, hold focus groups with people who were formerly homeless, have boot camps, host “interactive world café style conversations,” and created a Funders Collaborative.

Ko additionally mentioned the importance to some stakeholders of accessing important research information in a timely fashion. He mentioned the lack of access to e-journals for many organizations that cannot afford subscriptions. “To the degree that something very significant and relevant comes out of research, the passing on of that information in a one-pager with bullets to a listserv that some of us might subscribe to would be wonderful.”

At the conclusion of the discussions following the Breakout Sessions, Wenzel thanked all of the attendees for their participation. “I hope it’s been helpful for you as it has been for us,” she said. “We’re committed that this not end here but that the dialogue continue and be of value in moving forward to enhance and sustain integrated care.”
VIII. Concluding Statement

Homeless individuals often face multiple and intertwined challenges in addition to lack of housing. The Forum’s participants implicitly agreed that housing and integrated care are critical in alleviating homelessness in Los Angeles County. Success in providing housing and integrated care unarguably entails the collaborative efforts of multiple stakeholders. Based on the discussions throughout the day, key ingredients of success include the following: trust, understanding, and effective communication among all collaborating stakeholders; sufficient resources; political will and effective leadership; program and systems performance monitoring and calibration as necessary; and a commitment to address the multi-faceted needs of each consumer, and to respect and uphold the dignity of each consumer as a partner in his or her care.

The Forum began with a clarion call for all attendees to exercise their collaborative potential and ended with an accumulation of insight into the challenges and strategies for advancing and sustaining integrated care for persons experiencing homelessness in Los Angeles County. This one-day forum provided an opportunity for dialogue and learning among diverse stakeholders. The participation and dedication in evidence among the attendees will prove valuable as we move forward together to enhance the well-being of homeless persons and, ultimately, to end homelessness.
IX. Participant Biographies

Al Ballesteros, MBA
Chief Executive Officer
JWCH Institute
Al Ballesteros is chief executive officer of the JWCH Institute, Inc., a Los Angeles-based nonprofit medical organization. With more than 12 program sites and six primary care clinics, JWCH provides medical services to more than 35,000 persons annually. The organization is a Section 330-funded community health center. It receives direct HRSA, CDC, and HUD funding and has contracts in place with all major health plans for Medi-Cal managed-care patients. JWCH offers services in primary care; HIV assistance, prevention, and education; mental health; health education; housing; recuperative care; case management; family planning; teen pregnancy prevention; and transportation services. Ballesteros provides executive leadership to all functional areas of the organization.

For 18 years, Ballesteros has served as a commissioner for the Los Angeles County Commission on HIV, and has served three terms as co-chair. Previous professional positions include associate vice president of HIV and substance services for AltaMed Health Services Corporation, and program director for Being Alive: People with HIV/AIDS Action Coalition.

Ballesteros is a native of Los Angeles, and attended Los Angeles City College, San Jose State University, and the University of Phoenix. He has a BA in public relations and a master’s degree in business administration.

Elizabeth Boyce, LCSW
Homeless Services Coordinator
Los Angeles County Chief Executive Office
Libby Boyce is the homeless coordinator for the Los Angeles County Chief Executive Office. In this role, she advises the Board of Supervisors on all homeless-related policy, planning, and programmatic issues that affect the county. This includes facilitating all interdepartmental workgroups, such as the Special Needs Housing Alliance, the Project Review Committee, the Homeless Deputies meeting, and public and private workgroups and activities related to homelessness, housing, and supportive services. In addition, she and her staff ensure that the chief executive officer, the board, and county departmental representatives have a current and strong understanding of federal, state, and local strategies, activities, and policy implications affecting how homeless housing and services are planned and delivered.

Boyce’s past achievements include the development and implementation of a homeless recuperative care program; implementation of Access to Housing for Health, a hospital-to-home demonstration project; co-founding United Homeless Healthcare Partners (UHHP); assisting in the development and implementation of Los Angeles County’s Project 50 housing program; development and implementation of a homeless benefits entitlements
program (BEST) to increase the number of street-based and shelter-based homeless individuals on Social Security; and development of multiple partnerships among Federally Qualified Health Centers, mental health providers, and substance abuse treatment providers to implement integrated services within supportive housing environments.

John Brekke, PhD
Frances G. Larson Professor of Social Work Research
USC School of Social Work
A member of the USC School of Social Work faculty since 1984, John Brekke teaches research and clinical courses in the Master of Social Work program and PhD courses on treatment-outcome research and research grant writing. Prior to assuming an academic appointment, Brekke held a number of clinical positions working with persons diagnosed with severe and persistent mental illness in inpatient and outpatient settings. He has also served in clinical practice and program development in the area of domestic violence, specializing in the structured treatment of men who batter.

Since 1989, Brekke has been principal investigator on five longitudinal studies funded by the National Institute of Mental Health (NIMH) as well as on one study funded by the Substance Abuse and Mental Health Services Administration. His work focuses on the improvement of community-based services for individuals diagnosed with severe mental illness.

Brekke is currently a principal investigator on three NIMH grants: 1) a study on the integration of biological aspects of mental disorders into psychosocial rehabilitation for individuals with schizophrenia; 2) a project that seeks to speed the use of evidence-based practices into community-based treatment for individuals with schizophrenia; and 3) a project that uses mixed methods to study the transformation of community-based mental health services at the levels of policy implementation, organizational change, and consumer outcomes. Brekke also is the functional outcomes core director on the NIMH-funded Center for the Study of Cognition and Emotion in Schizophrenia.

Jessica Brown-Mason, MBA
Director of Programs, Hope Gardens
Union Rescue Mission
Jessica Brown-Mason is director of programs for Hope Gardens at Los Angeles’s Union Rescue Mission. She oversees daily operations, program implementation, long-range planning, statistical reports, and fiscal accountability for Hope Gardens, where she also develops protocols and procedural manuals, assesses program implementation, and evaluates overall program delivery.

Brown-Mason has more than 20 years of experience in administration and business management. She has worked in contract and financial management, human resources, and program development and implementation.
Michael Cousineau, PhD
Associate Professor of Research
Keck School of Medicine of USC

Michael R. Cousineau is associate professor of research in the Department of Family Medicine and Preventive Medicine at the Keck School of Medicine of USC. He directs the USC Center for Community Health Studies and teaches in both the Master of Public Health Program and the Professionalism and the Practice of Medicine curriculum.

Cousineau’s work focuses on health policy; health services and evaluation research; access to care for the low-income uninsured; governance and operation of safety net providers, including public hospitals and community-based clinics and health centers; and health needs of vulnerable populations, including homeless persons. His work includes studying the impact of initiatives designed to expand health insurance to adults and children, the dynamics of insurance-coverage decisions by small businesses, alternative governance of safety net hospitals, and the health and mental health needs of the homeless. His publications have appeared in American Journal of Public Health, Medical Care, Public Health Reports, Evaluation Review, and the Journal of Community Health.

Cousineau earned a master’s degree and PhD from the UCLA School of Public Health.

Marilyn Flynn, PhD
Dean
USC School of Social Work

Marilyn L. Flynn was first appointed dean of the USC School of Social Work in 1997 and was reappointed in 2011. Under her leadership, the school significantly expanded its Hamovitch Center for Science in the Human Services and recruited a nationally recognized faculty to conduct clinical and intervention studies in health, mental health, aging, and child maltreatment. She established new graduate academic centers in San Diego and at the Skirball Cultural Center in West Los Angeles, and then in 2010 launched a full web-based Master of Social Work (MSW@USC) degree program through the new Virtual Academic Center. The school now graduates nearly 40 percent of all social workers in California and, with the Virtual Academic Center, has become the first truly national program in the profession.

Under her leadership, the school received three congressionally directed appropriations to establish the Center for Innovation and Research on Veterans and Military Families, focusing on the mental health needs of service members and their families. The global outreach of the school has expanded under her leadership to incorporate important research agreements with leading Chinese and Korean institutions, a summer global immersion for MSW students, and continuing sponsorship of major international conferences.
Flynn serves as president of the National Network of Social Work Managers, president of the Los Angeles Center for Nonprofit Management, board member of the Crenshaw Educational Partnership, and a faculty member in the Academy of the National Association of Deans and Directors of Social Work, which is sponsored by the New York Academy of Medicine.

Ben Henwood, PhD, LCSW
Assistant Professor
USC School of Social Work

Ben Henwood is a licensed clinical social worker who has served as a direct-service provider, an administrator, and a researcher for organizations serving adults experiencing homelessness and serious health conditions, including mental illness, physical disease, and addiction. He served as the principal investigator of a clinical research study that sought to develop more effective models of integrating primary and behavioral health care.

Henwood received a dissertation-training grant from the National Institute of Mental Health (NIMH). At the time of the Forum, he was a postdoctoral fellow at NYU’s Silver School of Social Work. He also is co-investigator of the five-year, NIMH-funded New York Recovery Study of homeless adults with serious mental illness and co-occurring substance abuse.

He previously served as the clinical director for Pathways to Housing, Inc., a Housing First agency in Philadelphia.

Henwood is an assistant professor at the USC School of Social Work. He will continue his research on the complex service environment for individuals with serious mental illnesses who have experienced homelessness.

Chris Ko
Program Officer, Housing Stability
United Way of Greater Los Angeles

Chris Ko is a program officer for United Way of Greater Los Angeles, where he is responsible for managing the Systems Change components in Home for Good, a five-year plan to end chronic and veteran homelessness in Los Angeles. He also manages the grantmaking portfolio for United Way of Greater Los Angeles’s Rapid Rehousing partners.

Previously, Ko served as the banking and investment strategies coordinator in the office of Los Angeles Mayor Antonio Villaraigosa. In that role, he helped develop Bank on L.A., which helps individuals and families enter the financial mainstream by opening starter bank accounts so they can begin saving, build a credit history, gain access to low-cost sources of credit, and invest for the future. Ko also coordinated a study for the mayor’s office that uncovered $1.9 billion in hidden spending power in South and East Los Angeles.
Ko was chosen by the Coro Foundation to be a Public Affairs Leadership Fellow and worked on projects for the Los Angeles District Attorney’s Office, the Service Employees International Union, public radio station KPCC, and Los Angeles Unified School District Vice President Yolie Flores Aguilar.

He received a BA in urban studies from the University of Pennsylvania.

**Peter Lynn, MBA**  
**Director, Section 8 Department**  
**Housing Authority of the City of Los Angeles**  
Peter Lynn is director of the Housing Authority of the City of Los Angeles Section 8 Department. He manages the nation’s second-largest housing-choice voucher program, which provides decent, safe, and sanitary housing to 50,000 very low-income Angeleno families. Previously, he served as director of operations at the New York City Department of Housing Preservation and Development.

In 2012, he received the inaugural Trailblazer of the Year award from Home for Good, an initiative that aims to end chronic and veteran homelessness in Los Angeles by 2016.

Lynn earned a BA from Vassar College and an MBA from the NYU Stern School of Business.

**Ervin R. Munro, MS**  
**Director of Social Services**  
**SRO Housing Corporation**  
Ervin Munro is director of social services at SRO Housing Corporation, a nonprofit, community-based organization dedicated to building a vibrant community for homeless and very low-income individuals in the Central City East community of downtown Los Angeles—more commonly known as Skid Row. He oversees and directs the daily operations and management of all supportive services for homeless and low-income individuals, including specialty services for persons with mental illnesses, persons with HIV/AIDS, veterans, persons with substance addictions, frail and dependent adults, and the elderly.

Munro was co-founder and co-chair of the Case Management Task Force of Los Angeles County, and co-founder of AIDS Project Los Angeles, where he served as the first acting executive director. He has worked as a private consultant and trainer for numerous social service agencies and has received several awards and commendations for his workshops. He also has served as a school psychologist and educator. He has held positions at AltaMed Health Services Corporation, Portals, Travelers Aid Society of Los Angeles, Labor Immigrant Assistance Project, and Catholic Charities of Los Angeles.

He earned a BS and an MS from the University of Wisconsin-Whitewater, which honored him in 2011 with the Distinguished Alumni Award for Community/Regional Service for his 35 years of community service.
Lawrence Palinkas, PhD  
Albert G. and Frances Lomas Feldman Professor of Social Policy and Health  
USC School of Social Work

Lawrence Palinkas is the Albert G. and Frances Lomas Feldman Professor of Social Policy and Health at the USC School of Social Work. He also holds secondary professorial appointments in the departments of Anthropology and Preventive Medicine at USC. He also is an adjunct professor of medicine and family and preventive medicine at UC San Diego.

A medical anthropologist, his primary areas of expertise lie within preventive medicine, cross-cultural medicine, and health services research. Palinkas is particularly interested in health disparities, implementation science, community-based participatory research, and the sociocultural and environmental determinants of health and health-related behavior, with a focus on disease prevention and health promotion. His research has included studies of psychosocial adaptation to extreme environments and manmade disasters; mental health needs of older adults; cultural explanatory models of mental illness and service utilization; evaluation of academic-community research practice partnerships; and the dissemination and implementation of evidence-based practices for delivery of mental health services to children, adolescents, and underserved populations. His work has been funded by the National Science Foundation, NASA, the National Institutes of Health, the MacArthur Foundation, and the William T. Grant Foundation.

His current research encompasses mental health services, immigrant health, and global health. He also provides expertise to students and colleagues in the use of qualitative and mixed research methods.

Jan Perry, MPA  
Councilwoman, Ninth Council District  
City of Los Angeles

Jan Perry is serving her third term as councilwoman of the Ninth District of Los Angeles. She represents some of the most diverse and vibrant communities in the city, including Bunker Hill, Little Tokyo, and South Los Angeles. She has responded to the district's needs by ensuring access to basic city services, making major improvements in the district's infrastructure, driving efforts for quality job development and job training, and supporting the development of housing at all income levels.

Perry understands that tackling the challenges of homelessness is an essential part of creating a healthy city. A champion for the homeless, she successfully fought to keep the city's emergency shelter program open on a year-round basis and has been a strong advocate for the development of affordable housing with supportive services to for chronically homeless individuals. Her unwavering political will on the issue of housing the homeless has resulted in the development of more than 1,000 units of housing with support services on-site. Additionally, she has fought to ensure that the Central City Community, known by many as Skid Row, is treated as a true neighborhood, defending the
rights and safety of the homeless, formerly homeless, and those in recovery. In 2008, Perry authored city legislation to end the practice of dumping homeless individuals in Skid Row by hospitals and other institutions.

Perry earned a bachelor’s degree from the USC School of Journalism, cum laude, and a master’s degree from USC in public administration.

**Eric Rice, PhD**  
**Assistant Professor**  
**USC School of Social Work**

Eric Rice is an expert in social-network theory, social-network analysis, and the application of social-network methods to HIV prevention research. He joined the USC School of Social Work faculty in 2009.

Rice is committed to community-based participatory research, with a special interest in HIV prevention in high-risk adolescent populations. He works closely with community-based organizations—including My Friend’s Place, a drop-in center for homeless youth in Hollywood, and the Division of Adolescent Medicine at Children’s Hospital L.A.—on HIV prevention for homeless youth and on impoverished families affected by HIV/AIDS. Rice has served as an external reviewer for Los Angeles County’s Office of AIDS Programs and Policy and has conducted program evaluations and consultations with organizations working with homeless youth and high-risk adolescents.

Rice’s current work focuses on the social networks of homeless youth. Specifically, he is looking at how youth use social media and cell phone technologies to access networks outside of street life and how these connections affect their health and well-being. This work is funded by the National Institute of Mental Health.

He holds a BA from the University of Chicago and an MA and PhD from Stanford University.

**Ruth Schwartz, MA**  
**Executive Director**  
**Shelter Partnership**

Ruth Schwartz is the founder and executive director of Shelter Partnership, Inc., a unique nonprofit organization established in 1985 that develops strategic housing solutions and resources for Los Angeles County’s homeless population. Shelter Partnership’s research and planning efforts are widely utilized by public officials, the media, and business leaders. Currently, Shelter Partnership is focusing on the needs of individuals with a dual diagnosis of mental illness and substance abuse, as well as homeless families and the growing population of homeless adults over age 62.

Schwartz has been active in the field of low-income housing development and policy for more than 25 years. She has served on a number of boards and advisory committees, including the Senate Bipartisan Task Force on the Homeless; the California Department of
Housing and Community Development’s Loan Advisory Committee; the Los Angeles Homeless Services Authority commission; the Southern California Association of Non-Profit Housing Developers board; and the Los Angeles Emergency Food and Shelter local board.

She accepted the 2002 Nonprofit Sector Achievement Award from the National Alliance to End Homelessness on behalf of Shelter Partnership.

Schwartz received a master’s degree from the UCLA School of Architecture and Urban Planning.

Nikki Shipley, PhD
Consultant, Community Research
Homeless Healthcare Los Angeles

Nikki Shipley is a community research consultant for Homeless Healthcare Los Angeles, a nonprofit organization that aims to improve the health of homeless people through direct services, education, and advocacy.

Shipley’s research interests are in developing a comprehensive understanding of health, health care, access to care, and health behaviors among diverse populations, particularly in Los Angeles, in order to aid efforts to tackle the enormous problem of minority health disparities. As a consultant for numerous nonprofit and for-profit agencies over the last 25 years, Shipley has been involved in the submission of hundreds of successful proposals to all types of funders for research and demonstration grants ranging from $500 to $13 million.

Her training and experience provide a unique perspective for turning fledging ideas into successful, theoretically based program models that have been implemented throughout the United States. The models focus on a wide range of public health issues, including access to health care, cancer prevention and control, primary and secondary HIV/AIDS prevention, treatment adherence, violence prevention, teen pregnancy prevention, family planning and early access to prenatal care, tobacco control, and rehabilitation and reintegration of homeless persons into the community.

Shipley received a BS in psychology from UCLA, a master’s in epidemiology from California State University, Northridge, and a PhD in health behavior research from the Keck School of Medicine of USC.

Cherry Short, MSc
Assistant Dean, Global & Community Initiatives
USC School of Social Work

Appointed assistant dean for Global & Community Initiatives for the USC School of Social Work in 2006, Cherry Short has extensive knowledge in leadership, governmental organizations, and the community. Accomplished in virtually all aspects of social work, including direct practice, policy development, and accreditation, she utilizes her network of
colleagues to build new relationships between the school and social work programs internationally, expanding employment and internship opportunities for students.

Short has served on the Commission of Racial Equality in the United Kingdom since 1998 and was appointed race commissioner for Wales, UK, in 2002 under Tony Blair’s administration. In 2005 she was awarded the CBE (Commander of the British Empire) Award, the United Kingdom’s highest award for public service, in a private ceremony at Buckingham Palace, for her work in equality and anti-discrimination work. The award was sanctioned by the Queen and the prime minister.

She was an elected official for Cardiff City Council, Wales, for 17 years, involved in policymaking and legislative decisions. Short is also a forensic social worker and has worked in various capacities in both local and state government in the UK, specializing in serious offenders.

In 2007, she was awarded an honorary doctorate by the University of Wales for her public policy achievements in human rights.

Herbert L. Smith  
President and CEO  
Los Angeles Mission
Herb Smith serves the people of Skid Row as president of the Los Angeles Mission. He knew that his life would never be the same when he first began work for the Los Angeles Mission in 1999. After spending his earlier years as a missionary in Brazil, Smith was no stranger to witnessing poverty, but was even more affected and deeply moved when he saw the same poverty on the streets in our own nation. Smith held the positions of chief financial officer and chairman of the board of directors before taking his place as president in 2006.

With more than 25 years of nonprofit experience, including positions with Wycliffe Bible Translators, St. Andrew’s Presbyterian Church, and Vanguard University, Smith has built a strong foundation for his responsibilities as president of the Los Angeles Mission. He has the experience it takes to help oversee the vision of the mission as well as a driving passion to be part of helping meet the diverse needs of people on the streets, particularly those who battle with mental illness.

Marvin J. Southard, DSW  
Director, Department of Mental Health  
Los Angeles County
Marvin Southard joined the Los Angeles County Department of Mental Health as director in 1998. He leads the largest public mental health system in the country, serving more than 236,000 clients annually in one of the most ethnically diverse counties in the nation, with a budget of more than $1.9 billion.
Southard is a governing board member of the California Mental Health Directors Association, and the president of the board of directors of the California Social Work Education Center. He also serves as a commissioner on the Los Angeles County Children and Families First–First 5 LA Commission. He has served as an associate clinical professor at the UCLA School of Medicine, Department of Psychiatry and Biobehavioral Sciences; senior fellow in public policy at the UCLA School of Public Policy and Social Research; and clinical associate professor of psychiatry and the behavioral sciences at the Keck School of Medicine of USC.

Southard has been recognized with numerous awards, including the National Alliance on Mental Illness’s 2003 Award for Excellence in Community Mental Health Services, in recognition of ongoing efforts to building a comprehensive, community care mental health system in Los Angeles County.

A licensed clinical social worker, Southard received a master’s degree in social work from UC Berkeley and his doctorate in social work at UCLA.

**John Viernes, MRC**
**Director, Substance Abuse Prevention and Control**
**Department of Public Health, Los Angeles County**

John Viernes is the director of Los Angeles County’s Substance Abuse Prevention and Control within the Department of Public Health (DPH). He has been with the DPH since 2008.

For 34 years he has worked in government positions that have assisted developmentally disabled persons and those with mental health disorders, and for nearly 20 years has assisted individuals with substance-use disorders. He previously served as the single state authority of addiction and as the state methadone authority for the Department of Mental Health and Addiction in Indiana.

A native of Hawaii, Viernes served three years in the United States Army. He received a BS in sociology from Brigham Young University and a master’s degree in counseling from the University of South Carolina.

**Suzanne Wenzel, PhD**
**Professor**
**USC School of Social Work**

Suzanne Wenzel is a professor in the USC School of Social Work and holds a joint appointment in the Department of Psychology. She teaches research methods to doctoral students in the School of Social Work, and leads and participates in community-based research projects sponsored by the National Institutes of Health (NIH) and other organizations and foundations, including that of J. Scott and Obaida Watt. She also directs the school’s research cluster focusing on homelessness, housing, and social environment.
Wenzel received a PhD in community psychology from The University of Texas at Austin and was awarded a National Institute of Mental Health postdoctoral fellowship at the Rutgers/Princeton Program in Mental Health Research. She has devoted her career over the past two decades to interdisciplinary research that seeks to understand and address the health of vulnerable populations, including women, men, and youth experiencing homelessness.

She has served as the principal investigator of nine projects sponsored by the National Institutes of Health, including current projects focusing on the social context of HIV risk and protection among homeless men in Los Angeles, and a community-based participatory effort with service providers and consumers to adapt evidence-based HIV prevention programming for women experiencing homelessness in Los Angeles. She serves on several community advisory boards and contributes as a scientific reviewer for the NIH.

**Jonathan Wolf, MPH**  
**Program Manager**  
**Skid Row Housing Trust**

Jonathan Wolf is program manager for Skid Row Housing Trust, which aims to end homelessness in Los Angeles by providing affordable homes along with the help needed to permanently break the cycle of homelessness. Wolf joined the Trust in 2011.

For 20 years he has served on the board of trustees for Camp Jabberwocky, a summer camp in Massachusetts for people with disabilities.

Wolf received a BA in psychology from Connecticut College and a master of public health degree from the Boston University School of Public Health.