"Hospital Liaison" – Bridging Hospitals & Coordinated Entry System (CES) (November 2018)

Background

- South Bay private hospitals identified the need to understand the County's homelessness system. In Fall 2016, they began discussions with the region's CES lead Harbor Interfaith Services (HIS) and the South Bay Coalition to End Homelessness (SBCEH).
- Bi-monthly meetings were initiated to discuss challenges ED staff faces, and to educate hospital staff about connecting to homelessness resources such as shelter, recuperative beds, and supportive housing.
- In Summer 2017, HIS received a one year grant through United Way (FY '17-'18) to pilot the Hospital Liaison position. The following year, the importance and value of this coordinator was recognized by all the private hospitals, resulting in their collective funding of it to ensure sustainability.
- Bi-monthly meetings continue with hospital staff to stay current on CES and other large health system programs (e.g., DHS' Substance Abuse Prevention & Control, Whole Person Care, Health Homes, etc.), and to discuss advocacy for additional regional resources and system change.

Hospital Liaison Primary Duties

- Works with private hospital discharge planners, and clinical and social worker staff to link patients to appropriate homeless, health and housing services through CES. Works with County Harbor/UCLA staff to connect persons to other resources who are not eligible for its own housing programs.
- This expedites the referral process since the Hospital Liaison understands the client eligibility and access doorways to the resources, relieving hospital staff from understanding the complicated and evolving world of homeless services.
- "Frequent Flyers" who use more than one hospital are identified and tracked.
- Maintains connections with broader Countywide health care initiatives, such as CSH's "Health System Integration Learning Community."

Challenges

- Severe lack of interim housing in the South Bay, including crisis housing and recuperative beds.
- Patients reluctant to leave the South Bay for these resources, requiring temporary displacement from their familiar community, friends and family/children, and possessions (sometimes including a vehicle).
- Lack of hospital staff direct access to the backbone Homeless Management Information System (HMIS).

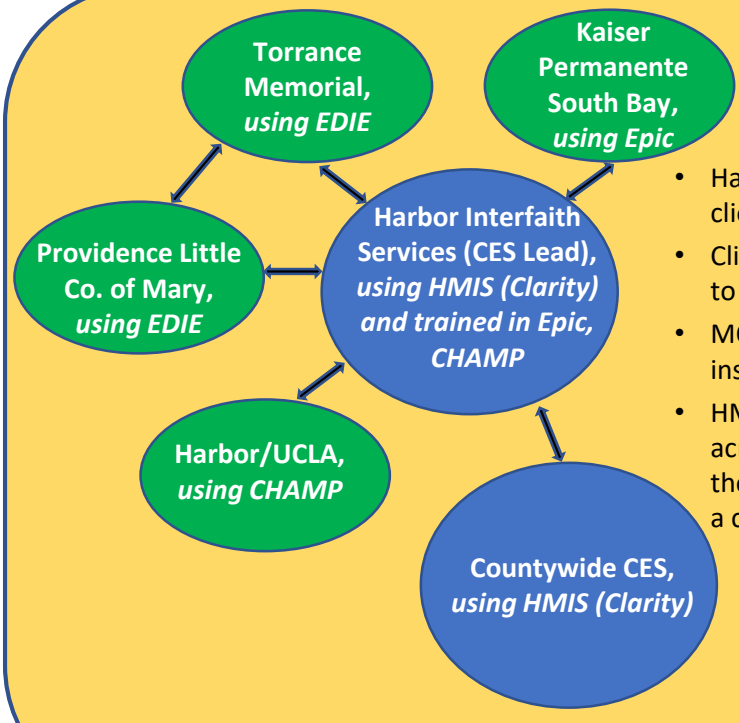
First 12 Month Outcomes: Number of Patients Seen = 207

Number of "CES Assessments" Completed: 71

- Number Linked to Permanent Housing: 17
  - Moved into Housing: 5 (others in pipeline)
- Number Referred to Interim Housing: 64
  - Interim Housing Approved: 32

Emerging Best Practices Gleaned from Hospital Liaison Experience

- Connect discharge planner with the Hospital Liaison, begin discharge planning once a patient is admitted.
- Determine if the patient has an existing homelessness case manager; contact this person ASAP to reconnect them, providing a "warm handoff."
- Hospital Liaison should not carry a client caseload so she can focus fulltime on being the bridge between the hospital staff, the community services and the client's homelessness case manager.
- Have the Hospital Liaison complete the "CES Assessment" rather than hospital staff. She generally has more time to spend with patients to complete this lengthy questionnaire. She is also viewed as different from the hospital staff so a different kind of relationship can be quickly established, sometimes yielding more candid responses.
- Have the Hospital Liaison follow-up with the assigned CES case manager and be an advocate for these clients in regional CES case conferencing meetings.
- Keep the hospital staff looped-in on the clients once they leave the medical center. Staff typically does not get any updated status once patients are discharged. Share success stories.
- Encourage hospitals to have their own on-site patient homelessness navigator to enhance the case management provided to the patients while they are still at the medical center.
- Be flexible: priorities shift daily depending on the needs of each hospital.



Current Information Sharing Process

- Harbor Interfaith's Hospital Liaison functions as the client information hub.
- Clients give signed consent to a hospital social worker to share information with the Hospital Liaison.
- MOUs between the hospitals and HIS allow ED staff to instantly discuss clients with the Hospital Liaison.
- HMIS is the common homelessness database used across LA County (except in Long Beach). "Clarity" is the HMIS product name. Through HMIS, one can view a client's homelessness history.

Other Notes

- Used EDIE and HMIS to post patient alerts when looking for a client.
- In the near future, optimistic AB 210 (2018) will allow hospitals to directly share non-medical client information.

Contact Info and Advocacy

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