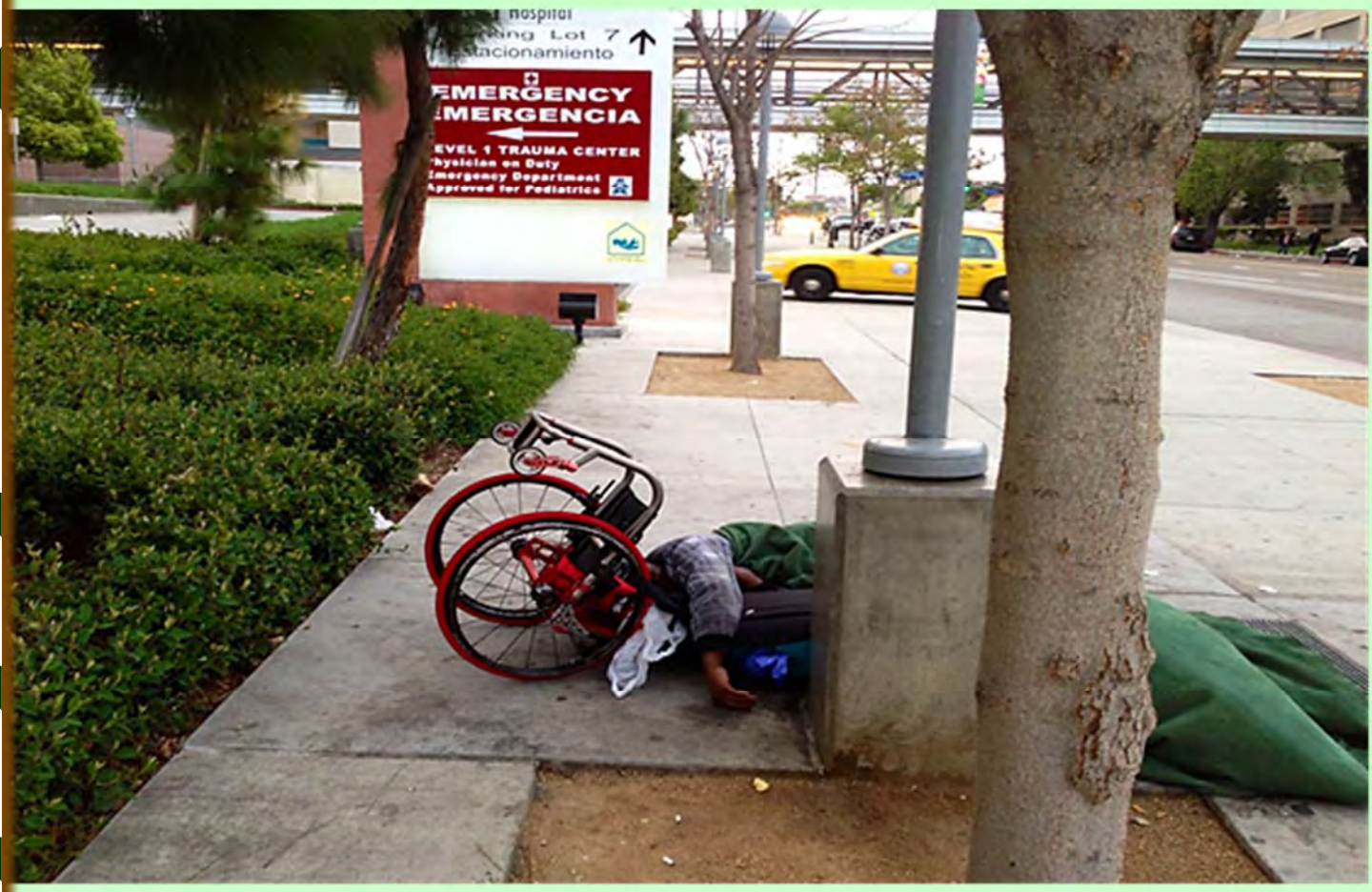
COMMUNITY CENTERED EMERGENCY ROOM PROJECT

a program of Social Model Recovery Systems, Inc.

BARRIERS TO WELLNESS:

RESULTS FROM A COMMUNITY NEEDS ASSESSMENT



FINAL REPORT
APRIL 22, 2014

"

A STRANGER HAS BIG EYES BUT SEES NOTHING.

--AFRICAN PROVERB

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On behalf of our Agency, we thank you all.

Zelenne L. Cárdenas
Director of Prevention Services

EXECUTIVE SUMMARY

Throughout the United States, many emergency rooms have become the "place of last resort" for homeless people seeking relief from the streets. According to the U.S. Department of Housing and Urban Development (HUD), on any given night in the country, there are more than 610,000 homeless people. Of these individuals, 65% are residing in emergency shelters or transitional housing programs while 35% are living in locations not designed for human habitation. For many, the hospital emergency room is not only a safe refuge but a place to get a hot meal, clothing, shower, and social support -- the basic Maslow hierarchy of needs we all require. The utilization of these resources comes at exorbitant costs both to the institutions and to the patients whose long-term health needs remain unmet.

To this end, on February 1, 2013, the County of Los Angeles, Department of Public Health, Substance Abuse Prevention and Control (DPH-SAPC) awarded Social Model Recovery Systems, Inc. (SMRS) a grant to establish a community prevention project surrounding Los Angeles County + University of Southern California Medical Center (LAC+USC MC) entitled: *Community Centered Emergency Room Project* (CCERP). The project's two-pronged approach is to provide targeted outreach to the Needs Special Assistance (NSA) population to establish linkages and enhance community engagement in order to reduce risk factors. Addressing the factors that shape health and safety outcomes can reduce overcrowding in the emergency room and simultaneously increase positive health results.

As part of this project, SMRS conducted a six-month community assessment process in the vicinity of LAC+USC MC, specifically in the communities of Boyle Heights and Lincoln Heights. A mix of qualitative, quantitative, and archival data informed this report. A series of focus groups were conducted with members of the NSA population, hospital staff, enforcement officers, and community residents with permanent homes. In addition, survey data collected by Exodus Recovery, Inc. (Exodus) were included in the analysis. A series of Street and Park Environmental Scans were conducted, and then coupled with Los Angeles Police Department (LAPD) crime data.

Additionally, interviewer-administered surveys were conducted. One hundred-fourteen homeless resident and 186 housed resident surveys were administered.

FINDINGS

HOMELESS RESIDENTS SURVEY

- 75% were male;
- 68% were between 41 and 64 years of age;
- 44% identified as Latino and 31% as African American;
- 58% lived in the vicinity of LAC+USC MC for 4 or more years and reported using the hospital's emergency department (ED) significantly less than those who have lived there 3 or fewer years;
- 36% had relatives living in the area. Latinos were more likely to have family nearby;
- 40% indicated a need for shelter/housing and 21% perceived the hospital as "where they stayed/lived";
- Of frequent users, men used the ED 6.83 times per year while women averaged 2 visits per year. African Americans used the ED significantly more than Latinos and White non-Hispanics;
- 38% reported LAC+USC MC as the place to go for psychological problems; and
- 15% were concerned about drug use and 16% were concerned about alcohol use.

HOUSED RESIDENTS SURVEY

- 89% identified as Latino;
- 25% were 18 – 25 years of age (26% between 26 - 40 years old);
- 79% lived in the neighborhood for 4 or more years;
- When asked to report the "biggest problems with substances" in their neighborhood, 68% reported alcohol and 60% reported marijuana;
- About 30% reported they had used the LAC+USC MC ED.
- 38% were concerned "a lot or a tremendous amount" about homeless in the neighborhood yet 91% never experienced a conflict with them; and

- When asked what the homeless needed most, 69% reported assistance with shelter.

Built Environment

- Environmental Scans documented public drinking 23% of the time, while marijuana use was noted 31% of the time;
- The evening observations at local parks revealed a dramatic increase in nuisance activity;
- When responding to questions about what community space was present in the neighborhood, 78% of housed residents reported parks were available;
- 23% of housed residents reported liquor stores to be a major problem; and
- 26% of housed residents reported they knew of an establishment that "sold alcohol to intoxicated persons"; however, only 21% would be "very likely" to call the authorities to report the site, with 52% stating they would not call because they do not think it would help.

Recommendations

- Housed residents care about those who are homeless in their community; they have expressed a need to develop opportunities to engage the homeless population and identify resources to address their needs.
- Access to and use of culturally appropriate resources for the homeless community is imperative, particularly with respect to services that provide long-term benefits.
- Aspects of the built environment present barriers to the health and safety of homeless and housed residents.
- It is important to build additional relationships and partnerships between LAC+USC MC and other local human service providers.

Conclusion

The issues associated with the homeless population in the LAC+USC MC and surrounding community present an opportunity to develop steps toward building a sense of community beyond boundaries of residency status. This report hopes to stimulate discussion and inspire

public debate about the issues of poverty, lack of affordable housing, health and safety impacting our communities, and the need to capitalize on the emerging approaches provided by the Affordable Care Act. These approaches depend heavily on authentic voices of the community engaged in efforts to improve their community and shape health outcomes. This grassroots approach recognizes the accumulated knowledge of individuals, be they homeless or not, and builds on the reciprocal relationships needed to succeed collectively. In addition, to address excessive ED visits by homeless members of the community, the health care system should expand its paradigm and promote prevention initiatives that address community risk factors while also enhancing access to primary health care.

The recommendations herein span multiple domains covering a broad-range of issues which will require a coordinated effort among stakeholders focused on developing a comprehensive system of care. These recommendations seek to expand the lifeline currently being provided by the ED, by extrapolating and weaving it into the social fabric of the community.

INTRODUCTION

The Los Angeles County + University of Southern California Medical Center (LAC+USC MC) Emergency Department (ED) has become a site used frequently by the local homeless population. Homeless patients are receiving medical care but are also using the ED to meet their social and interpersonal needs (i.e., showers, food, emotional support, etc.). This situation is contributing to ED overuse, increased costs to the County, and repeated use of the ED by homeless patients presenting with disorders that cannot be addressed by short-term, urgent care treatment. Overall, this pattern of inappropriate ED use has detracted from the core objective of the LAC+USC MC ED: to provide high quality medical care to patients experiencing acute medical or psychiatric crisis.

On February 1, 2013, the County of Los Angeles, Department of Public Health, Substance Abuse Prevention and Control (DPH-SAPC) awarded Social Model Recovery Systems, Inc. (SMRS) a grant to establish a community prevention project entitled *Community Centered Emergency Room Project* (CCERP). A large proportion of homeless residents around LAC+USC MC can be classified as Needs Special Assistance (NSA) individuals, which DPH-SAPC defines as individuals with co- occurring mental health and substance use disorders and/or chronic physical ailments. The purpose of CCERP is to reduce the risk factors that contribute to overuse of the LAC+USC MC ED by local homeless residents as part of a larger NSA coordination of care effort.

SMRS provides a comprehensive, community-based approach with specific strategies aimed at engaging homeless individuals, creating cooperative relationships with organizations, coordinating care, building leadership, improving community conditions, and addressing the overuse of LAC+USC MC ED. This report will include: 1) a review of the overall SMRS/CCERP Community Assessment process; 2) background information about the target problem; 3) a history of the targeted CCERP areas; 4) the methodology used in this project; and 5) key findings from a cross section of data sources.

The NSA work group was established at the request of Supervisor Gloria Molina to help alleviate overcrowding of the LAC+USC MC ED. The work group members include representatives from the following agencies: LAC+USC MC Emergency, Psychiatric and Social Services Departments; Department of Mental Health and mental health workers assigned to LAC+USC MC psychiatric ED; Department of Public Social Services; Los Angeles Housing Services Authority (LAHSA); and mental health service providers.

BACKGROUND

According to the Prevention Institute, a national nonprofit center, the health and well-being of individuals depend on both the quality of coordinated health care services in the community and the conditions within the community that may affect individuals' health and safety. A successful, equitable health system should fuse these two domains by merging efficient, accessible, and culturally appropriate care with comprehensive efforts to prevent illness and injury through improved community environments (Cantor, Cohen, Mikkelsen et al., 2011).

HEALTH CARE REFORM

The Affordable Care Act offers an opportunity to create new integrated and culturally informed health care systems by supporting increased health care research and development. This report addresses the need for greater health care research by examining how community characteristics and conditions such as the availability of quality health care services play a role in preventing community health problems for individuals. More specifically, this report gathers information about the available health care services and other community conditions of Boyle Heights and Lincoln Heights which may play an important role in promoting positive health and safety outcomes.

HOMELESSNESS IN LOS ANGELES COUNTY

The crisis of chronic homelessness is alarming throughout the nation. According to the U.S. Department of Housing and Urban Development, on any given night in January 2013, there were more than 610,000 homeless people in the nation. Of these individuals, 65% were residing in

emergency shelters or transitional housing programs while 35% were living in unsheltered locations (U.S. Department of Housing and Urban Development [HUD], 2013). Many of these individuals are considered chronically homeless, meaning they have experienced homelessness for a year or longer, or have a disability and have experienced more than 4 episodes of homelessness in the prior 3 years (National Alliance to End Homelessness [NAEH], 2013). This includes those suffering from serious mental illnesses, substance abuse disorders, and physically disabling conditions (NAEH, 2011).

According to HUD, homelessness in Los Angeles County increased 15% (57,737) between 2011 and 2013 (Holland, 2013). Similarly, the area surrounding LAC+USC MC has also seen an increase in its homeless population. Although difficult to know the exact number of homeless people residing in this community, the makeshift shelters, mattresses, and the accumulation of belongings at underpasses and elsewhere reveal their presence. The exact causes and risk factors of homelessness differ across the population, however, LAHSA suggests that high housing costs coupled with a vast number of people earning incomes that fall near or below the poverty level are prominent contributors to the rise of homelessness (Holland, 2013).

Among the homeless community, chronically homeless individuals are extremely vulnerable and susceptible to health concerns due to living on the street (NAEH, 2011). Despite this vulnerability, they are familiar with services to address their needs, such as frequenting local emergency rooms to seek access to care. Typically, the ED becomes the main safety net provider when chronically homeless individuals lack access to primary care (NAEH, 2011). The health care system would benefit from promoting prevention initiatives that address the community risk factors that lead to increased ED visits while also enhancing access to primary health care.

OUR APPROACH

SMRS conducted an extensive Community Assessment consisting of reviews of existing homeless needs assessment questionnaires in order to conduct a valid, reliable, and culturally sensitive analysis of the targeted communities. This report captures CCERP's assessment process and describes the instruments used to gather information about homeless residents' length of time in the community, use of the hospital emergency services, housing status, health, and substance use disorders. Many of the questions in the survey were adapted from various surveys developed and field tested by both RAND Corporation and the Robert Wood Johnson Foundation. In addition, a web-based "data repository" was developed to document the findings.

SOCIAL/HISTORICAL DESCRIPTION OF THE ADJACENT NEIGHBORHOODS TO LAC+USC MC: BOYLE HEIGHTS AND LINCOLN HEIGHTS

Boyle Heights, a neighborhood in Los Angeles County, is geographically situated between Chinatown, Commerce, Downtown Los Angeles, East Los Angeles, El Sereno, Lincoln Heights, and Vernon (Figure 1). Boyle Heights spans 6.52 square miles and is predominantly comprised of people of Latino descent. The population of 94,000 in Boyle Heights is notably youthful, with a median age of 28.3 years (U.S Census Bureau, 2011). There are 25 public and 10 private schools serving the area (Los Angeles Times [LAT], 2013a). Boyle Heights is considered to be a low income neighborhood with 38.6% of households averaging less than $20K a year in annual income, and a median household income of $32K (U.S Census Bureau, 2011). Because of the cultural diversity of the residents, Boyle Heights is a space and place imbued with social, cultural, and historical

meaning for the people that have established their livelihoods there. However, it is not a community without challenge. Between September 2, 2013, and March 2, 2014, there were 102 violent crimes reported per 10,000 persons of Boyle Heights, which is higher than the neighboring areas of Chinatown, Lincoln Heights, El Sereno, and Downtown Los Angeles (LAT, 2014a).

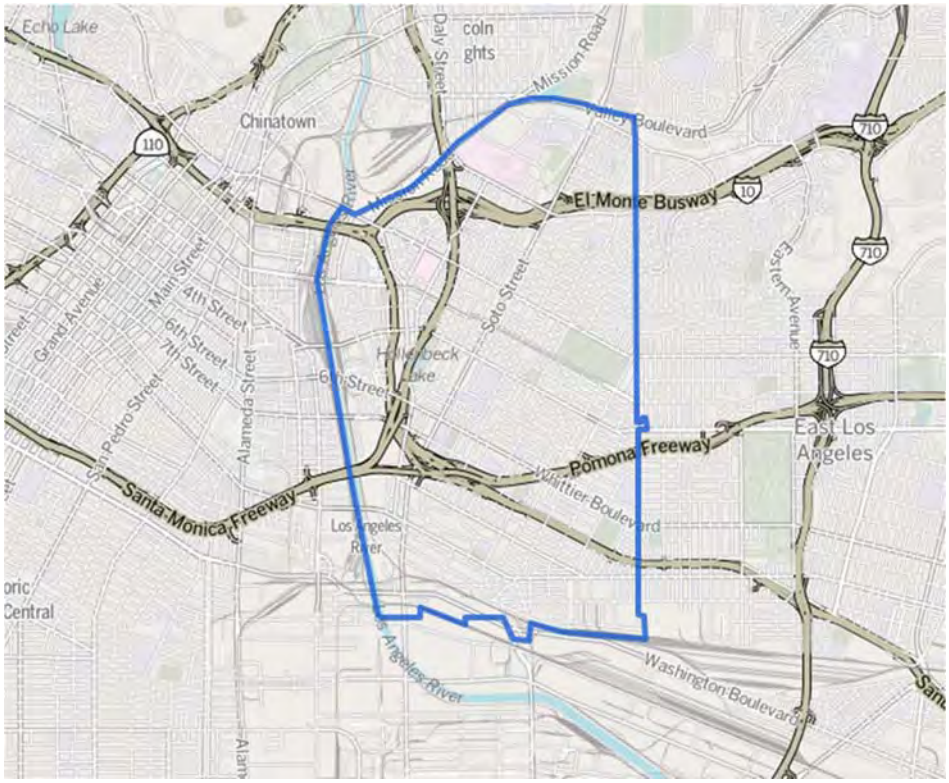

Figure 1: Map of Boyle Heights and surrounding areas (OpenStreetMap.org, CC-BY-SA)

The history of the Boyle Heights community that led it to its current state can be traced back to the 1930s. Due to race-based laws from this period, such as redlining practices stemming from the National Housing Act of 1934, people of ethnic minority status established multi-ethnic/cultural communities throughout Los Angeles-based neighborhoods often secluded from areas inhabited by White non-Hispanics. Boyle Heights, which was a racially diverse neighborhood largely consisting of people of Jewish heritage, but also containing residents of Latino, African American, and Japanese heritage (Hise, 2004; Wild, 2002), was one of the communities that received an influx of ethnic minority individuals. Boyle Heights maintained its diversity through the 1950s due to another influx of ethnic minority individuals, predominantly

African Americans and Latinos, migrating to Los Angeles; eventually becoming a concern for the dominant White class.

The 1950 U.S. Census showed a change in the demographic characteristics of the Boyle Heights neighborhood as the number of people of Latino heritage increased significantly. Yet, quite curiously, Census data does not reflect any significant population increases among the African American and Japanese American populations in Boyle Heights as ethnic minorities became increasingly segregated into ethnic enclaves (Hise, 2004; Sanchez, 2004). Thus, a strong, insular Latino community emerged at this time (Sanchez, 2004). As a result, 97% of the neighborhood is now Latino (U.S. Census Bureau, 2012). In the 1960s, this historical area was the epicenter of Chicano-Latino activism, as depicted by the many outdoor murals that blanket this community.

Lincoln Heights sits immediately north of Boyle Heights and is also surrounded by El Sereno, Chinatown, Elysian Park, Cypress Park, and Montecito Heights neighborhoods (Figure 2). Lincoln Heights' origin dates back to the 1880s. It is one of the first neighborhoods in Los Angeles. There are an estimated 30,000 residents living within its 2.5 square miles (Lincoln Heights Neighborhood Council [LHNC], 2013). Residents are predominantly of Latino heritage (58%), but a sizeable proportion is of Asian descent (16.3%) (LAT, 2013b). Lincoln Heights is a fairly young community, with a median age of 27 years and an average income of $30K (LAT, 2013b), considered low for LA County. The area is served by 9 public and 4 private schools (LAT, 2013b). Additionally, the area is not free of crime. For example, between September 2, 2013, and March 2, 2014, there were 94 violent crimes per 10,000 people reported in Lincoln Heights (LAT, 2014b).

Much like its neighbor Boyle Heights, Lincoln Heights is comprised of historic homes and buildings dating back to the early 1900s. Perhaps nowhere else in Los Angeles is there such a rich variety of architecture reflective of the vast diversity of Angelinos to have resided in Lincoln Heights throughout the years. Initially, Irish, French, and Italian Americans called this area home. Today, the population is predominantly comprised of people of Latino or Asian heritage. Socioeconomic changes also occurred in Lincoln Heights as wealthier residents departed to more affluent

communities, leaving behind a homogeneous immigrant working class. These individuals continue to enjoy the vibrant activities at Lincoln Park, which serves as its social mecca.

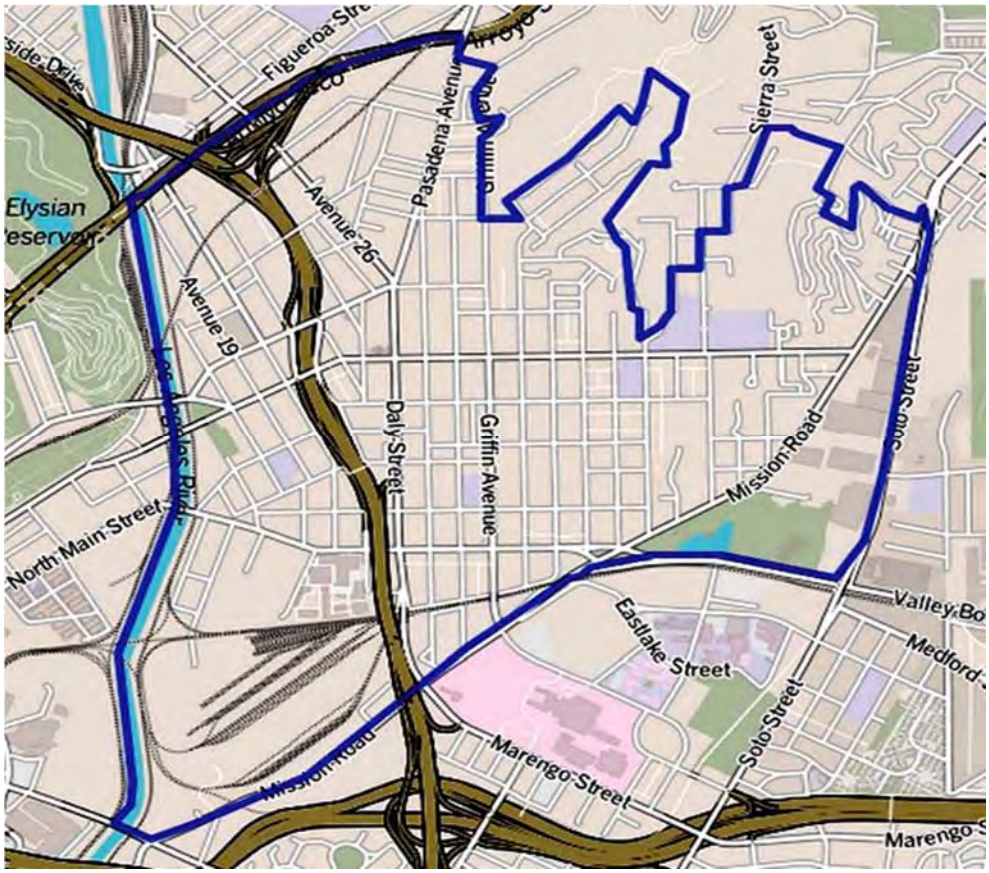

Figure 2: Map of Lincoln Heights and surrounding areas (OpenStreetMap.org, CC-BY-SA)

COMMUNITY NEEDS ASSESSMENT METHODOLOGY

A mix of qualitative, quantitative, and archival data informed this report. Interviewer administered surveys were conducted with community residents who identified as either having a permanent home or not having a permanent home (homeless residents). A series of focus groups were conducted with: 1) members of the NSA population who received ED services; 2) hospital staff; and 3) community residents with permanent homes referred to in this report as housed residents. Additionally, survey data collected by Exodus Recovery, Inc. was solicited and included in the analysis. A series of Street and Park Environmental Scans were conducted within the vicinity of LAC+USC MC ED and then coupled with Los Angeles Police

Department (LAPD) crime data. Below is a brief description of the measures and methods used to collect the data cited in this report. Additional details can be found in Appendix A.

HOMELESS RESIDENT NEEDS ASSESSMENT

A total of 114 needs assessment survey interviews were completed during a 4 month period (May - August 2013). Survey teams interviewed homeless residents at 5 street locations (Marengo St., N. Main Rd., E. Valley Blvd., Alhambra St., N. Mission Rd.), 2 parks (Lincoln Park, Hazard Park), and at the LAC+USC MC ED. Participants were asked about their use of the LAC+USC MC ED, the environmental and health factors that contributed to their ED use, and the availability of resources and services in the surrounding community. Based on these factors, measures concerning mental health problems and basic resources were created.

HOUSED RESIDENT NEEDS ASSESSMENT

The resident needs assessment was conducted with local housed[1] residents in the Boyle Heights/Lincoln Heights neighborhoods. Going door-to-door, a total of 186 surveys were collected during a 4 month period (May - August 2013) on 24 streets. Housed residents were asked to describe their daily interactions with homeless residents and their perceptions of them. They were also asked about the environmental/health factors in the community that affect them and the homeless, and the availability of resources and services for homeless persons.

STREET/PARK OBSERVATIONS

A total of 40 street Environmental Scans and 26 Park Environmental Scans were collected during a 2 month period (May – June 2013). The purpose of these scans was to assess the overall safety and conditions of establishments, residences, and public spaces on the streets and in 2 parks. Total scores were generated for each observation site, and these scores were compared across time and type of establishment.

[1] "Housed" refers to residents who live in stable, living conditions while "homeless" refers to residents without stable, living conditions.

Reported Crime Data

Crime data for the area in and around LAC+USC MC was obtained from the LAPD and included all reported crimes in the 90033 zip code from June 2012 to June 2013. Crime information was compiled based on the following: date and time, address, description, type, level (felony or misdemeanor), and whether it involved interpersonal violence.

Vulnerability Index (Exodus)

To expand on information gathered from the needs assessment survey, data collected by Exodus was solicited and incorporated into this report. Exodus staff surveyed a total of 224 homeless people between January 2011 and May 2013. These surveys utilized the Vulnerability Index, a tool designed to assist in "identifying and prioritizing" homeless residents' housing needs according to circumstances related to housing, physical and mental health, and safety (O'Connell and Hwang, 2007).

Focus Groups

A series of focus groups were conducted with several different constituent groups. Participants were questioned about their experiences with homeless individuals, on issues such as LAC+USC MC ED patient capacity, concerns regarding homeless patients' use of the ED, safety/sanitation conditions, common diagnoses of homeless patients, availability/knowledge of resources for homeless patients, hospital policies and procedures regarding patient care, etc. Participants were also asked questions regarding community conditions that contribute to health and safety.

Emergency Department Medical Staff – A focus group was conducted on September 11, 2013, with 13 medical personnel (doctors, nurses, pharmacists, and social workers, all selected by the Nurse Supervisor) that primarily work in the LAC+USC MC ED. Participants were asked a series of structured questions developed by Loyola Marymount University/Psychology Applied Research Center (LMU-PARC) regarding their experiences of working with homeless patients in the ED. Confidentiality was assured to the

participants at the start of the focus group, and each participant was asked to complete a demographics sheet. The focus group lasted approximately 1 hour.

EMERGENCY DEPARTMENT SOCIAL WORKERS – Due to the unexpectedly large turnout, the focus group of approximately 50 social workers from the Department of Social Work at LAC+USC MC was conducted as a question and answer forum on September 18, 2013. Participants were asked a series of structured questions developed by LMU-PARC regarding their experiences of working with homeless patients in the ED. Participants for the focus group were selected by the Head of the Department of Social Work at the hospital. Confidentiality was assured to the participants at the start of the focus group, which lasted approximately 1 hour.

EMERGENCY DEPARTMENT SECURITY – A modified focus group was conducted on October 9, 2013, with 2 privately contracted security guards who primarily work in the LAC+USC MC ED and 1 Los Angeles Sheriff Department (LASD) deputy responsible for patrolling the hospital campus. The participants were asked a series of structured questions developed by LMU-PARC regarding their encounters with homeless patients in the ED and hospital grounds. A hospital administrator selected the focus group participants. Confidentiality was assured to the participants at the start of the focus group, and each person was asked to complete a demographics sheet. The focus group lasted approximately 1 hour.

HOUSED RESIDENTS FOCUS GROUP – A focus group was conducted on September 18, 2013, with 10 residents from the community adjacent to LAC+USC MC. Participants, who were between 17 and 64 years of age, were asked a series of structured questions developed by LMU-PARC regarding their experiences with homeless residents in the community. SMRS staff selected participants for the focus group. Confidentiality was assured to the participants at the start of the focus group, which lasted approximately 1 hour.

NSA REFERRALS ENROLLED AT ANTELOPE VALLEY REHABILITATION CENTER – A focus group was conducted on September 13, 2013, by SMRS researchers with 5 program participants of the Antelope Valley Rehabilitation Center (AVRC) in Acton, California. This is the designated residential program for NSA individuals. Focus group participants noted they were referred by LAC+USC MC social workers, Exodus, and LA County's 211 information line. Participants were asked a series of structured questions developed by LMU-PARC regarding the referral and admission process, benefits, challenges, and recommendations to enhance the program. The questions were designed to better understand why this NSA population accepted services, stayed in the program once admitted, and to identify program benefits. AVRC staff selected focus group participants. Confidentiality was assured to the participants at the start of the focus group, and each person was asked to complete a demographics sheet. The focus group lasted approximately 1 hour.

LOS ANGELES POLICE DEPARTMENT KEY INFORMANT INTERVIEW – SMRS researchers conducted a key informant interview on September 25, 2013, with the Captain and Senior Lead Officer of the Hollenbeck Police Station in Boyle Heights. LAPD shares patrol duty with LASD around LAC+USC MC. The officers were asked a series of structured questions developed by SMRS researchers regarding crime and safety, community assets, and the relationship between LAPD, LASD, and hospital staff/security. Researchers explained the purpose of the project and were given verbal consent to use the information gathered. The interview lasted approximately 1 hour.

RESULTS

(Additional details regarding the results can be found in Appendix G)

1. COMMUNITY VOICES

One hundred-fourteen homeless residents participated in the survey (75% male, and 7% were married). Sixty-eight percent of participants were between 41 - 64 years of age and 20% were between 26 - 40 years of age. The racial composition of the sample consisted of: 46.3% Latino,

32.4% African American or Black, 13% White, and 8.3% Other. Fifty-eight percent of participants identified as parents, yet only 14% of these participants (*n* = 8) reported currently caring for children.

Many of the homeless individuals were longtime residents of the LAC+USC MC adjacent community, with 58% reporting having lived in the area for 4 or more years. Additionally, 36% of the group reported having relatives who lived in the area. On average, Latino homeless residents reported living in the neighborhood significantly longer than African American homeless residents (i.e., Latino homeless residents reported living in the neighborhood an average of 4 plus years, while African American homeless residents reported an average of 1 - 3 years) and Latino residents were more likely to have family living in the area. Notably, 21% of the homeless residents reported the hospital as "where they stayed/lived" (Figure 3).

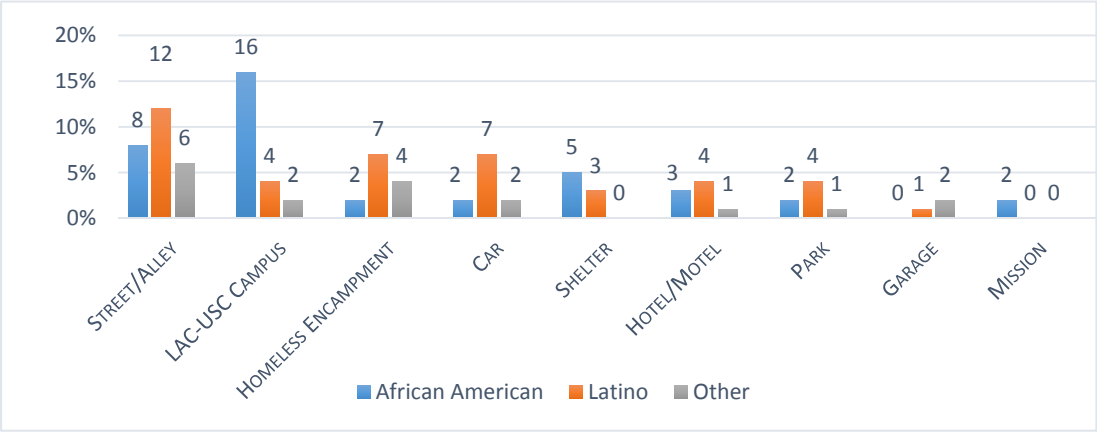

Figure 3: Where do you live? Racial Breakdown of Responses

Housed residents were also surveyed to obtain their perspectives concerning homeless residents. Thirty-two percent of housed resident participants were married, and 89% reported being Latino. As a group, housed residents were younger than homeless residents. That is, 25% of housed residents were age 18 - 25 years old, 27% were 26 - 40, 18% were 41 - 50, 16% were 51 - 65 and 7% were over 65 years of age (7% were under the age of 18 and not included in the sample). The housed resident participants were somewhat balanced with respect to gender (44% male). Sixty-nine percent of housed residents reported having children and 79% of the housed residents had lived in the neighborhood for 4 or more years.

With regard to existing neighborhood problems, as indicated in Figure 4, housed residents were least concerned about racial tensions in the neighborhood; likely because the great majority of respondents were Latino. However, 28% were concerned "a lot or a tremendous amount" about housing quality and 38% were concerned "a lot or a tremendous amount" about homeless individuals living in the neighborhood. In comparison, only 13% were concerned about violent or general crime, 21% were concerned about gangs, and 22% were concerned about drug sales. When asked to report the "biggest problems with substances" in the neighborhood, 60% reported marijuana and 68% reported alcohol. About 30% of housed residents reported prior use of the LAC+USC MC ED.

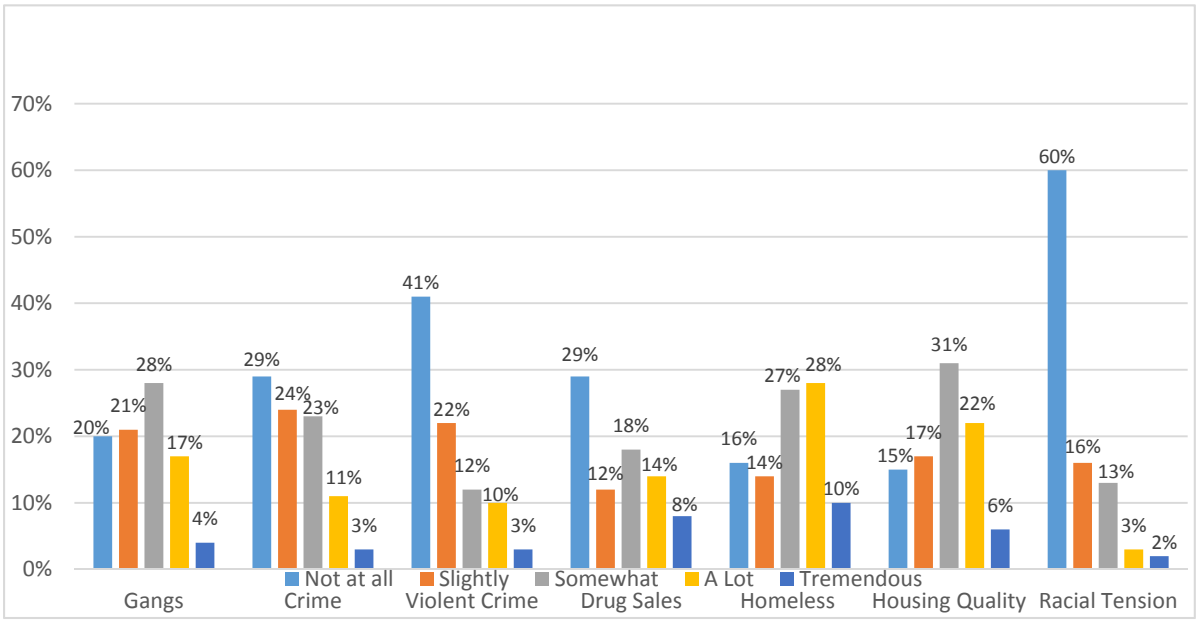

Figure 4: Percent of Housed Residents that Reported Each Issue as a Neighborhood Problem.

2. Community Voices: Assessing the Social and Psychological Needs of Homeless Residents

Mental illness was a concern among homeless individuals surveyed as 45% of homeless participants reported having a mental illness (with 15% of them having multiple mental illness diagnoses). Over half of the homeless residents reported "very much trouble" with stress (55%), while 32% and 34% reported "very much trouble" regarding psychological problems and emotional issues, respectively. Women reported having greater problems than men with emotional issues (M = 3.07 versus M = 2.44, respectively) and with stress (M = 3.56 versus M =

2.93, respectively). In addition, homeless women reported significantly higher mental health total scores (indicating greater severity of emotional issues, psychological problems, and stress) compared to men (*M* = 3.02 versus *M* = 2.47, respectively).

On average, Latino homeless participants (*M* = 1.64) reported significantly lower scores on "knowing where to obtain support for emotional issues and stress" than African American homeless participants (*M* = 1.64 versus *M* = 1.31, respectively). When homeless participants were asked if they knew "where to get help" for various mental health-related needs, 54% did not know "where to get help" for emotional issues, 45% did not know "where to get help" for stress, and 50% did not know "where to get help" for psychological problems. Latino participants knew less "where to get help" for psychological problems and African American participants knew less "where to get help" for stress and emotional issues.

Many of the homeless participants surveyed, however, cited the LAC+USC MC as the place to go for mental health care. Specifically, 29% of the 46 homeless participants who said they knew "where to get help" for emotional issues, 30% of 44 for stress, and 38% of 32 for psychological problems reported the LAC+USC MC as the place to go for help. In addition, 22% of the 44 homeless participants who said they knew "where to go for help" with personal safety reported the hospital as the place to go (Figure 5).

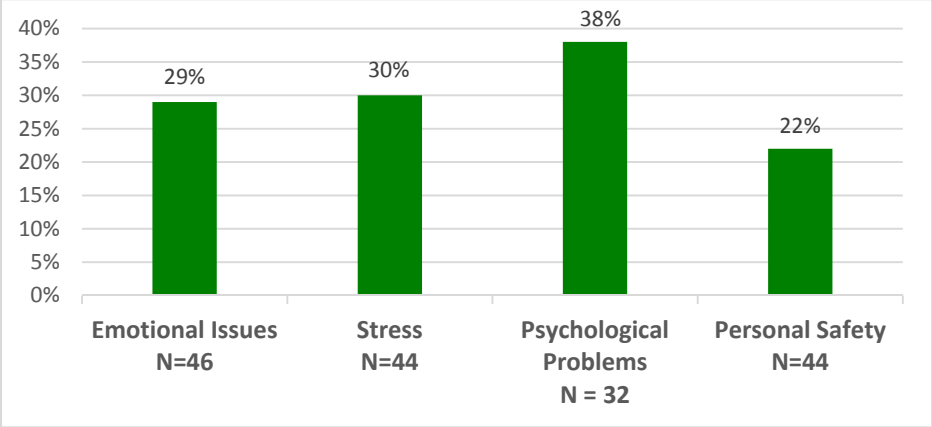

Figure 5: Total (N) of Homeless Who Reported Knowing Where to Get Help x Percent of Homeless Who Reported Hospital as Place to Go for Help

Homeless residents also participated in a survey conducted by Exodus. Nearly 90% of these residents had received treatment for mental health issues and the average ED use (for any reason) was 2.75 times per year. The remaining 10% of homeless residents who did not receive treatment for mental health issues visited the ED an average of 2.06 times per year.

Although the SMRS survey showed that many homeless residents knew were to get help for many of their health-related issues, they were less likely to know where to turn for help with social needs. Too frequently, homeless residents indicated not knowing where to seek help regarding: 1) needing someone to talk with (63%), 2) their relationship with their spouse (71%), 3) childcare (85%), and 4) personal safety (58%).

Housed residents who lived near LAC+USC MC reported having a distant, albeit non-conflicted relationship with homeless residents. The vast majority, 91%, never experienced a conflict with homeless residents. Even though about 49% never avoided homeless residents, 75% of the housed residents never offered information to homeless residents and 54% never spoke with homeless residents. When housed residents were asked what services they felt homeless residents in the area needed most, 69% reported that they needed assistance with shelter, 13% reported food service assistance, and 7% reported drug rehabilitation services.

3. Community Voices: Assessing the Medical Needs of Homeless Residents

A significant number of homeless residents indicated that health problems (49%) and dental issues (51%) were a concern. Most indicated that they knew where to get help for health issues (67%), with the hospital being the most frequently reported response. However, 59% indicated that they "did not know where to get help" for their dental issues. Problems accessing dental services were also documented in a recent report released by the Pat Brown Institute (2013) which states that "providing access to dental services is another major challenge, especially since the state — due to budget circumstances — eliminated its adult dental benefit in 2009" (p.3). Thirty one percent of the homeless residents indicated that they were "very" troubled at the lack of healthcare benefits, but only 51% of them knew where to get the benefits and of

these, 42% incorrectly identified the hospital as the site from which they would receive their benefits. There was a gender difference with men (*M* = 1.56) significantly more likely to report not knowing where to get healthcare benefits than women (*M* = 1.30). In reference to substance use, only 15% were concerned about drug use and 16% were concerned about alcohol use (Figure 6). About half of the respondents indicated that they knew where to get help for substance use issues. Of those reporting knowing where to get help, about 15% reported the hospital for drug use, and 7% reported the hospital for alcohol use.

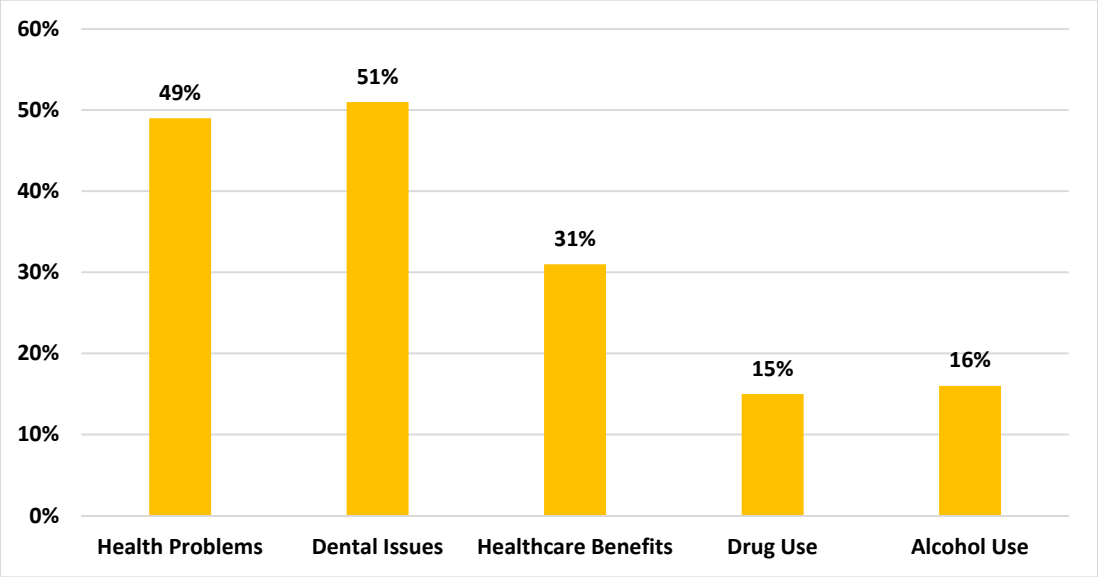

Figure 6: Percent of Homeless who Reported Healthcare and Substance Abuse concerns

4. Community Voices: Understanding Homeless Resident's Use of the LAC+USC MC ED

Length of homelessness in the community was broken up into three categories: 1) less than 1 year; 2) 1 - 3 years; and 3) 4 plus years. Interestingly, homeless residents who had lived in the community for 4 plus years used the ED significantly *less* than homeless residents who lived in the community for shorter periods of time (Figure 7). Men in the homeless resident group reported significantly higher frequency of use of the ED (*M* = 0.95 visits per year) than did women (*M* = 0.55 visits per year). On average, men reported visiting the ED 6.83 times per year, while women averaged 2.00 visits per year. Further, African Americans used the ED (*M* = 1.34 visits per

year) significantly *more* than Latinos (*M* = 0.50 visits per year) and White non-Hispanics (*M* = 0.71 visits per year).

	No Use	Moderate Use	Frequent Use
< 1 year N=28	5 (18%)	14 (50%)	9 (32%)
1-3 years N=16	5 (31%)	3 (19%)	8 (50%)
4+ years N=64	33(52%)	19(30%)	12(18%)

Figure 7: ER Frequency x Time in Community

Homeless residents who used the ED "frequently" (more than 5 times) reported significantly more problems with personal safety and having someone to talk to. "Moderate" users of the ED reported not knowing where to get help with emotional issues significantly more often than non-ED users. "Frequent" users of the ED reported not knowing where to help with relationships significantly more often than non-users (Figure 8). Unsurprisingly, those who did not use the ED reported significantly more support (n=23) than "frequent" users of the ED (n=19).

Individual Needs (To what extent are you having problems with…)			
	No Use	Moderate Use	Frequent Use
Health Problems*	2.67	3.00	3.41
Personal Safety*	1.70	1.89	2.63
Having Someone to Talk to*	1.69	1.53	2.18
Do Not know where to get help with… (% Reporting "No")			
Emotional issues*	43%	24%	33%
Stress*	48%	22%	30%
Relationship w/ mate/spouse*	47%	19%	34%
*Indicates Significance to the .05 level -Mean Scores Reported-			

Figure 8: Individual Needs X ED Frequency of Use

5. Community Voices: Understanding the Impact of the Built Environment

The research team also conducted an observation-based assessment of the immediate environment surrounding LAC+USC MC to determine the safety of the environment. Observational data was collected during varying times of day (see appendix A). Positive

characteristics of the local environment included the presence of video cameras, well maintained facilities and equipment, and security. Negative characteristics of the environment included visible waste and trash accumulation, inadequate lighting, and observed drug/substance use. A total of 401 individual observations were completed at 149 unique sites (Figure 9).

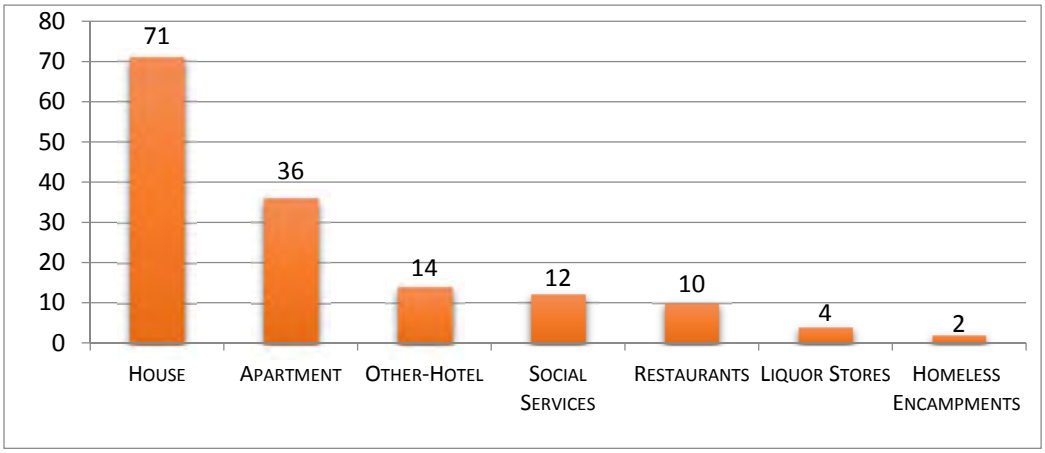

Figure 9: Unique Sites Observed

Each site was scored on positive and negative traits to reach a total nuisance score, indicating to what extent the site would be deemed "unsafe or unregulated." Differences were identified between observations during varying times of day. The results indicated significant differences between the "nuisance rating" during the day versus at night, with scores of negative traits increasing by an average of 1.5 points across all establishment types at night.

Figure 10: Map of Lincoln Park and Hazard Park

Environmental scans were conducted in Hazard Park and Lincoln Park, which are located in the vicinity of the LAC+USC MC. The information collected included park condition, assessment of lighting, trash accumulation, field and grass conditions, and the quality of park facilities and equipment. Park facilities and equipment were rated on a scale of "very poor" to "very good", and also note the presence of specific amenities and equipment available in the parks. Over the course of 26 separate observations, 5 distinct homeless encampments were observed (3 in Lincoln Park, 2 in Hazard Park) and a total of 40 homeless residents were encountered during the observations. An analysis of the park observations revealed that many community members predominantly utilized Hazard Park and Lincoln Park during daylight hours. However, the presence of homeless residents seemed to decrease at night with a corresponding increase of presence in the ED at night. Public drinking was reported 6 times and public use of marijuana was reported 8 times, comprising 23% and 31% of observations, respectively.

Overall, parks were rated as "somewhat safe" by the research team. This means the areas were well maintained, with proper signs, a public presence that created a general atmosphere devoid of apparent threats, and was in overall "somewhat good" condition. Hazard Park was observed 12 times and Lincoln Park 14 times. The night observations of Lincoln Park revealed inadequate lighting, unsanitary conditions, public drinking, and an observed homeless encampment. This may point to similar issues of safety concerns for homeless residents that were revealed by the

street observations when considering the effects of nightfall on the total nuisance scores of establishments in the neighborhood.

Housed residents reported that the majority of homeless residents gathered in either parks (17%) or under bridges/freeway overpasses (20%). These unregulated public spaces were the sites of several semi-permanent homeless camps, with makeshift shelters, mattresses, and an accumulation of belongings such as seating and various collected items. Housed residents reported that homeless residents also gathered in restaurants (9%) and liquor stores (10%). Additionally, 8% of housed residents indicated that homeless residents commonly gathered at LAC+USC MC. When responding to questions about what community space was present in the neighborhood, 78% reported that parks were available, with only a few housed residents indicating that any other types of community spaces exist. Furthermore, 28% of the housed residents noted poor quality housing being a major problem (i.e., a lot or tremendous amount) with liquor stores and gangs reported at 23% and 21%, respectively.

COMMUNITY-LED SOLUTIONS

One interesting finding was that 26% of the housed residents indicated they knew of an establishment that sold "alcohol to intoxicated persons." But only 21% (of the 26%) responded that they would be "very likely" to call the authorities to report the site, with 52% (of the 26%) stating that they would not because they did not think it would help. Moreover, only 20% of the housed residents reported that the police would be "very likely" to respond if they called them with an emergency. This apathy and/or lack of confidence in government enforcement has prompted innovative community-led solutions.

One such solution observed on the front door of an alcohol outlet, La Fiesta Market near Lincoln Park, is the "Hall of Shame" photographs depicting shoplifters. This intervention was implemented by the market owner who serves customers from inside an enclosed Plexiglas cage. While the cage protects the store clerk from harm, it invites thieves to grab packages of beer and dash away from the store. Unfortunately, the owner's past experiences with police

has taught him that law enforcement view shoplifting as a minor infraction and are generally more concerned with violent crimes. The owner has been left with no other alternative than to implement his own community-led solution to stop these alcohol thefts ("beer runs"). As part of his "Hall of Shame" intervention, if a thief returns to the store, the culprit is offered a choice: repay the debt or have their photo placed on his "Hall of Shame" to face public shame and possible prosecution. The owner claims this intervention has succeeded in reducing crimes at his store from once per week to once per month. Perhaps unbeknownst to the owner, this intervention may also prevent underage drinking, impaired driving, and high-risk behavior as well as poor decision-making leading to personal injury.

Another example of a community-led solution was found in the business complex that houses a 7-Eleven and Little Caesar's on the corner of North Main and Daly Streets. Operators of the complex implemented a system of restricting public access to the trash bins by installing large metal doors. The open space had become a public nuisance and a threat to community health and safety, but as a result of their intervention, loitering, public drinking, and crime has decreased. More significantly, restrictions at 7-Eleven limit the hours of alcohol sales from 9 a.m. to 10 p.m. as well as completely banned the sale of single alcoholic beverages.

CRIME DATA

The crime data obtained from LAPD showed that the most significant crimes reported in the area were property theft, followed by motor vehicle theft. Crimes at night comprised 42% of reported crimes, with 28% of reported crimes involving interpersonal violence. The majority of motor vehicle thefts and assaults occurred during the afternoon/night, although general theft was most prevalent in the morning. Further analysis of the LAPD crime data revealed that major crimes in the target area, predominantly felonies, occurred at night. The data also revealed that rates of crime involving interpersonal violence were significantly higher in the afternoon and at night than in the morning (Figure 11).

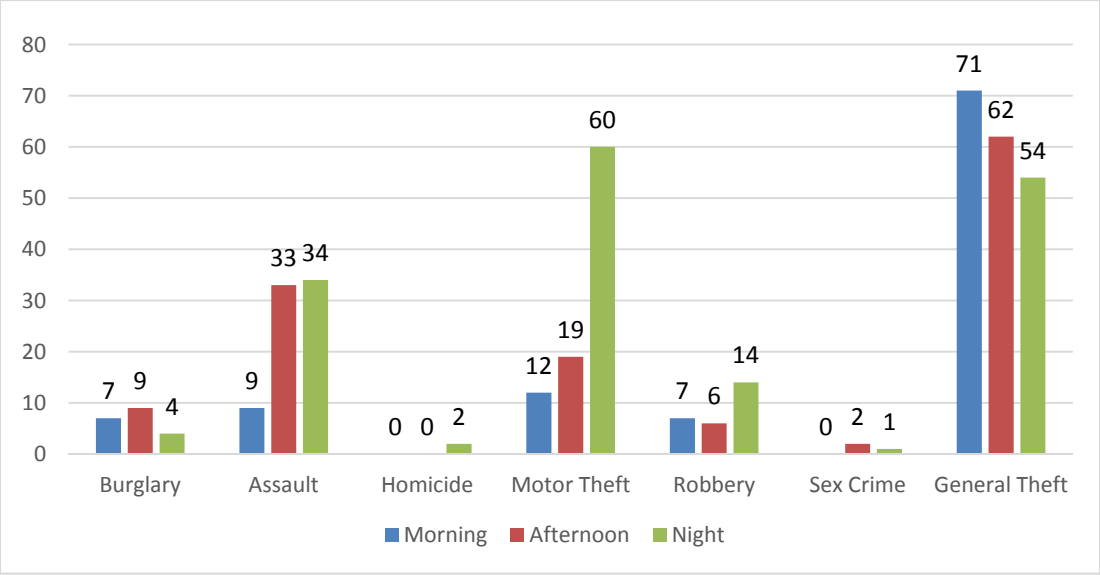

Figure 11: Number of Crimes X Time of Day

FOCUS GROUPS

LAC+USC MC ED overuse appears to affect multiple segments of the community including individuals who live and/or work in the area, the hospital staff, and social service providers. Individuals from these diverse sectors of the community and some formerly homeless people who were in-treatment at the time were invited to participate in focus groups. These focus groups were designed to elicit community members' perspectives on the root causes that drew homeless residents to the area, particularly around LAC+USC MC, and explore remedies to alleviate the situation.

Five focus groups were conducted. Three focus groups were conducted with LAC+USC MC medical staff – general staff (i.e. nurses and doctors), security, and social workers – which took place at separate dates and times on the hospital campus. The majority of medical staff worked in the ED. Another focus group with the housed residents was conducted at LAC+USC MC while the final focus group of former NSA individuals was conducted at an in-treatment center located outside the City of Los Angeles. Four themes emerged across the focus groups: Care, Safety, Mental Illness and Self-medication, and Institutional Misalignment. Although not

exhaustive, these themes characterize homeless residents' use of the LAC+USC MC ED. (See Appendices B-F for information on the complete data set.)

CARE

Community members who both worked and permanently resided in the area consistently expressed concern for the well-being of homeless residents. Hospital staff varied in the degree to which they believed that the homeless patients' unmet needs were due to lack of knowledge about available services or the logistics of existing service provisions (e.g. transportation and location, operating hours, capacity of shelters or substance abuse programs). Some medical staff and security suggested that providing more information about services to homeless residents (e.g., specially designed pamphlets) could reduce inappropriate use of the ED. Although housed residents were ambivalent about personally engaging with homeless residents, they expressed interest in having homeless residents receive services such as temporary housing, psychiatric treatment, and meals.

Certain medical staff, particularly social workers, and housed residents noted that there are barriers restricting access to social services. Participants in both the housed resident and social worker focus group noted that citizenship status may be one barrier to accessing social services. As a result, some residents revealed that they preferred to donate to homeless residents who appeared to be Latino. Similarly, social workers found it difficult to connect undocumented homeless residents with available resources due to their legal status.

SAFETY

Safety was a chief concern across focus group participants and involved either "safety from the aggressive or mentally disturbed homeless" or "personal safety for the homeless." Homeless residents may be drawn to the hospital in general, and the ED in particular, as it represents a safe space where all basic needs, both physiological and relational, can be temporarily met. The emergency room is a welcoming environment in contrast to short-term housing/shelters that 1) may be located in areas with high rates of violent crime, 2) often have bed shortages, and 3) may

require the separation of families or domestic partnerships. When the ED is fully staffed, homeless residents receive hot meals, are attended to by staff, and can tend to their personal hygiene. Even when the ED is understaffed, homeless residents can stay overnight in a warm, safe environment and not be disturbed until the morning.

On-the-other-hand, the growing influx of homeless patients in the ED has made personal workplace safety a chief concern among nurses, doctors, and security personnel. Although the vast majority of homeless patients are not violent or disruptive, enough violent incidents occur to merit concern. Medical staff have expressed little faith in security or the sheriff's ability to protect them and/or resolve combative situations. For example, LAC+USC MC medical staff have at times been forced to make a citizen's arrest if a homeless patient injures them (often related to consumption of alcohol and/or drugs). This inconsistent enforcement of security within the hospital was reported to stem from a lack of clear administrative policy and alignment with LASD.

Mental Illness and Self-medication

The medical staff were aware of the drug "commerce" occurring on the hospital grounds. Social workers, nurses, and doctors were able to point to the places immediately outside of the hospital where licit and illicit substances could be acquired. Coupled with this awareness, they expressed a sense of powerlessness to curtail this usage and the acquisition of prescription drugs. Although staff may suspect homeless patients of malingering and drug seeking, they often do not have the evidence or confidence to withhold prescription drugs. Some will even dispense a short-term supply to remove the nuisance of a disruptive homeless patient, rather than engage in a combative exchange from which they could be injured and/or will delay their attending other patients. Social workers particularly suggested that the prevalence of drug seeking is to some degree indicative of the incidence of untreated mental illness in the NSA population. Here also, the nurses and doctors mentioned the shortage of psychiatric facilities to meet the needs of NSA patients as one cause of their overuse of the ED. To the extent that many of the issues presented by homeless patients in the ED are related to substance abuse and

comorbid mental illness, staff felt they were unable to perform their "mission" of treating critical injuries and disease. In fact, some social workers believe NSA patients may be manipulating the hospital by receiving prescription medications, such as pain killers. Likewise, former NSA homeless patients now in treatment disclosed that some of the homeless frequently return to the emergency room for prescription medication as they believe it is easily accessible. Cleary this drug-seeking theme exemplifies the complexity of assisting the NSA homeless population.

INSTITUTIONAL STRUCTURE

Participants reported that the ED was often a place of last resort for homeless residents without alternatives for housing, meals, and treatment for chronic-if-not-dire ailments. Although LAC+USC MC is affiliated with numerous County agencies that can provide social services to homeless residents, the current system does not adequately meet their needs. Although the hospital possesses formal ties with social service providers there are inconsistent internal policies about dealing with homeless residents who use the ED for temporary housing and meals.

Unlike many private hospitals, LAC+USC MC does not have contracts with social service organizations that are equipped to meet the complex physical and psychological needs of homeless residents. Therefore, the task of linking homeless patients to services falls on ED social workers. Participants reported that the immediate lag time between when a homeless patient presents for treatment is interviewed and vetted and then begins to receive services, varies. This delay reportedly forces homeless patients to wait for long periods of time until program representatives can assist them. Thankfully, while waiting, security staff are compassionate towards homeless patients and do not actively remove peaceable, homeless patients as long as they do not sleep in a prone position. Typically, there is an unspoken understanding of tolerance and mutual respect between homeless patients and security when enforcing existing policies against individuals continuing to occupy the ED waiting rooms after being discharged.

Two additional institutional structural themes were expressed during the focus groups. First, hospital staff expressed the belief that many homeless individuals do not have acute problems

requiring emergency care, but rather present with chronic medical issues requiring long-term care. Helping homeless patients' access services that address either non-medical or chronic medical conditions is challenging. In particular, medical staff had difficulty accessing/contacting shelters on weekdays after 5:00 pm and on weekends. Second, availability of rehabilitation facilities were another issue due to long waiting lists. Participants indicated that even if space were available, several facilities would refuse LAC+USC MC patients due to their contract policies with other hospitals.

Responses within and across the focus groups conducted suggest that the hospital could play a more effective role in meeting the needs of area homeless residents, if social service relationships and internal, administrative policies were properly aligned. To the extent that LAC+USC MC establishes relationships with other non-profits or develops a system like that of Whittier Presbyterian Intercommunity Hospital[2], multiple sectors of the community will benefit as the needs of the homeless will be met, allowing the ED to focus on its mission of providing high quality emergency medical care to all community members. The success of this partnership is predicated on a collective and integrated team approach that builds on mutual respect, understanding and professional credibility.

OVERVIEW OF THE FINDINGS

To better understand the phenomenon of homeless residents' use of the LAC+USC MC ED, an evaluation was designed using a mixed-methods strategy to examine qualitative and quantitative data from a number of different sources including crime data, surveys, focus groups, and environmental scans. Taking these nuanced data points in context, there are several themes that warrant further reflection:

[2] The Presbyterian Intercommunity Hospital in Whittier affiliates with First Day, a local homeless program, by providing a nurse practitioner that works closely with the program's homeless liaison to screen, assess, and refer participants to appropriate services, including uninsured participants.

- Housed residents care about those who are homeless in their community; they have expressed a need to develop opportunities to engage the homeless population and identify resources to address their needs.
- Access to and use of culturally appropriate resources for the homeless community is imperative, particularly with respect to services that provide long-term benefits.
- The built environment surrounding the LAC+USC MC ED presents barriers to the health and safety of homeless and housed residents.
- It is important to build additional relationships and partnerships between LAC+USC MC and other local human services providers.

NEIGHBORHOOD CONTEXT

The surrounding neighborhoods examined in this study include Lincoln Heights and Boyle Heights. As noted earlier in this report, Boyle Heights, is predominantly a low-income community with approximately 94,000 residents —39% of households average less than $20K annually, with a median household income of $32K. The population is largely Latino (91%) with the majority of whom having lived in the area for four or more years (81%). Lincoln Heights has an estimated 30,000 residents, predominantly comprised of individuals of Latino heritage (58%) with a sizable population of individuals of Asian descent (16%). Lincoln Heights is a fairly young community, with a median age of 27 years old and an average income of approximately $30K. Combined, these cover 9.03 square miles within which lives a sizeable and growing homeless population.

According to the study results, the majority of the homeless population lived in the area for 4 or more years (60%). While the homeless population is ethnically representative of the broader community population (46% Latino), there has been an increase in the number of African American homeless residents relative to the broader community. Furthermore, many homeless residents who participated in this study reported high psychological and medical needs.

FINDINGS OVERVIEW

Housed residents care about the homeless; they have expressed a need to develop opportunities to engage them and identify resources to address their needs.

Homelessness ranked higher in importance among housed residents than any other issue on the community survey. Despite their concerns involving the homeless population (i.e., observations of public drunkenness and marijuana use), there is an apparent lack of interaction between housed and homeless residents (54% reported never speaking to homeless people, and 75% have never offered information to homeless people). Although housed residents expressed concern over homeless residents' restricted ability to access a range of services in the community, they expressed a certain sense of apathy with respect to interacting or engaging with them. For example, housed residents rarely connect homeless residents with support services or resources, though these services may directly address some of the housed residents' broader concerns. Furthermore, housed residents rarely contact law enforcement concerning problems. Additionally, while some of the housed residents indicated that the presence of homeless residents inside the ED was an issue, the survey proved that this was not a significant barrier that limited housed residents' use of the ED. Other issues, such as insurance and quality of care, were cited by housed residents as to why they chose to access other hospitals in the surrounding area.

A number of factors may explain these findings. For example, housed residents may not know what and where the most accessible and appropriate resources are for addressing the needs of homeless residents. In addition, as these two populations rarely interact, housed residents may not be aware of the best practices for engaging with homeless residents and directing them to available resources and interventions. In Boyle Heights, 74% of the households speak Spanish at home, while 55% of households in Lincoln Heights speak Spanish and 38% speak an Asian/Pacific Island language (American Factfinder, 2012). This language barrier perhaps further divides the housed and homeless residents. Finally, as the surrounding neighborhoods are low-income, the housed resident population may have more pressing personal concerns, such as maintaining their own basic needs.

Access to and use of culturally appropriate resources for the homeless community is imperative, particularly with respect to services that provide long-term benefits.

Access to and use of services related to health care, psychological counseling, safety, and shelter were the top concerns for the homeless residents who participated in this study. The data also indicates that there may be some ethnic and cultural differences between the Latino and African American homeless populations. Homeless Latino participants reported not knowing where to access services that address multiple service needs in the areas of physical health, mental health, housing, etc. This finding is troubling as it is clear that on their own, the Latino homeless population is unaware of how to negotiate the bureaucratic morass and access services available to them (e.g., transitional and permanent housing, psychological support services, health clinics), which would also benefit the broader community in the long-run. In contrast, African American participants reported frequently relying on the LAC+USC MC ED to provide critical services that lead to short-term fixes, such as immediate shelter, medical, psychological, and relational support. Although the services received may be only short-term, African American homeless individuals have created an informal network of care which extends to the Central City East area of downtown Los Angeles, known as Skid Row. Much like their Latino homeless counterparts, the African American homeless population would also benefit from accessing services with permanent long-term benefits rather than meeting their short-term needs at the ED.

A number of factors may explain some of these ethnic and cultural differences. The Latino homeless participants appeared to have more established community and familial ties in the neighborhood compared to African Americans. This may lead to more awareness and use of informal, community-based systems by the Latino homeless population to address some of their basic needs. Additional explanatory factors may be related to Latino participants' citizenship status and/or the lack of culturally and linguistically appropriate services in hospitals. It is well known that because most undocumented immigrants lack health insurance, they are forced to rely on safety net providers and folk healers for care versus hospitals and social service providers that cannot serve non-citizens.

The over-reliance on LAC+USC MC ED by the African American homeless population may be related to the lack of culturally competent services for them in the community, which is a predominantly Latino neighborhood. Whether conscious or unconscious, community-based systems of care may be geared more toward properly documented Latino individuals, presenting a perceived barrier to care for the African American population. Evidence points to LAC+USC MC ED as being a safe space and place that accepts African American homeless residents. Focus group data indicates little resistance on the part of hospital staff and security concerning the presence of homeless residents in the ED. There may also be fewer restrictions in the ED environment, such as the policy of separating families or forced exposure to religious doctrine that is practiced by many homeless shelters.

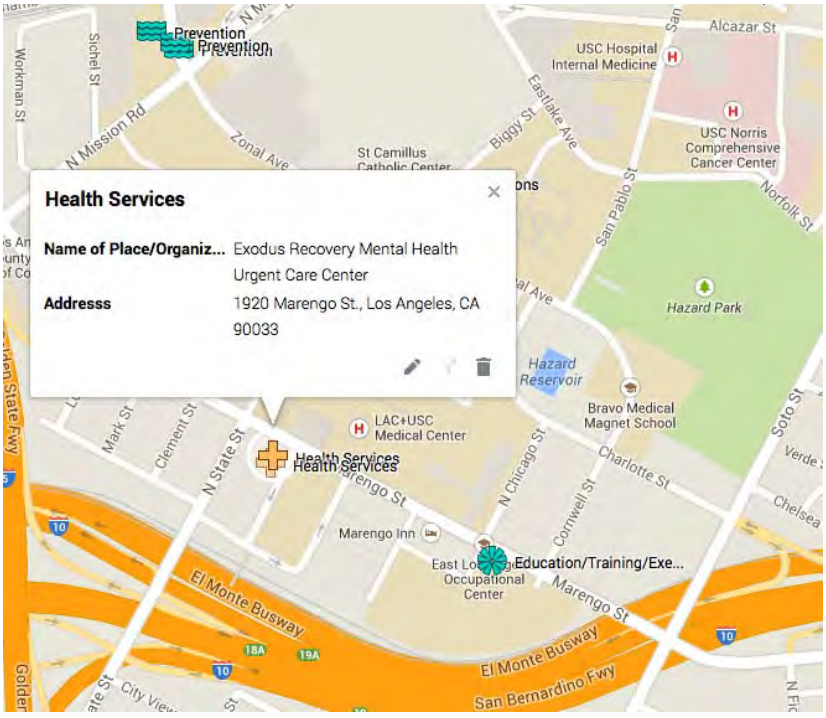

Figure 12: Proximity of the LAC+USC Medical Center Emergency Department to Exodus Inc.

Furthermore, the proximity of LAC+USC MC ED to Exodus (Figure 12) plays a critical role for the African American homeless population. While located in an area that is predominantly Latino, 63% of those who completed intakes and received services were African American (Exodus,

2013). Perhaps due to inadequate funding at Exodus, many of the homeless participants expressed frustration with their backlog, which may prompt them to seek help elsewhere.

The built environment presents barriers to the health and safety of homeless and housed residents.

The built environment surrounding the LAC+USC MC was also a factor affecting homeless participants. In general, parks are a popular haven for the homeless population. However, only a small percentage of the homeless participants "stay" in local parks at night due to safety concerns (e.g., lack of lighting and available sheltered areas). About half of the homeless participants in our survey reported residing on the streets/alleys or the LAC+USC MC campus, 31% and 21%, respectively. In the latter example, the well-lit campus with visible security staff and well-maintained facilities presented an environment where the homeless could reside without the safety concerns that are present in other local areas, such as parks. The remaining homeless resident participants indicated that they live in homeless encampments, cars, shelters, hotels and motels, garages, and missions.

A priority issue facing homeless communities that emerged from the data concerned the lack of appropriate and accessible services and resources. In addition to the variables addressed in this report, SMRS research team identified and mapped a list of 32 community resources within the target area (Figure 13). These resources span a range of services including addiction treatment, education, vocational training, recreation, health services (mental health and family planning), violence prevention, and faith-based institutions. While these resources offer valuable services to the general community, they may not be as accessible—geographically and socially—to homeless residents.

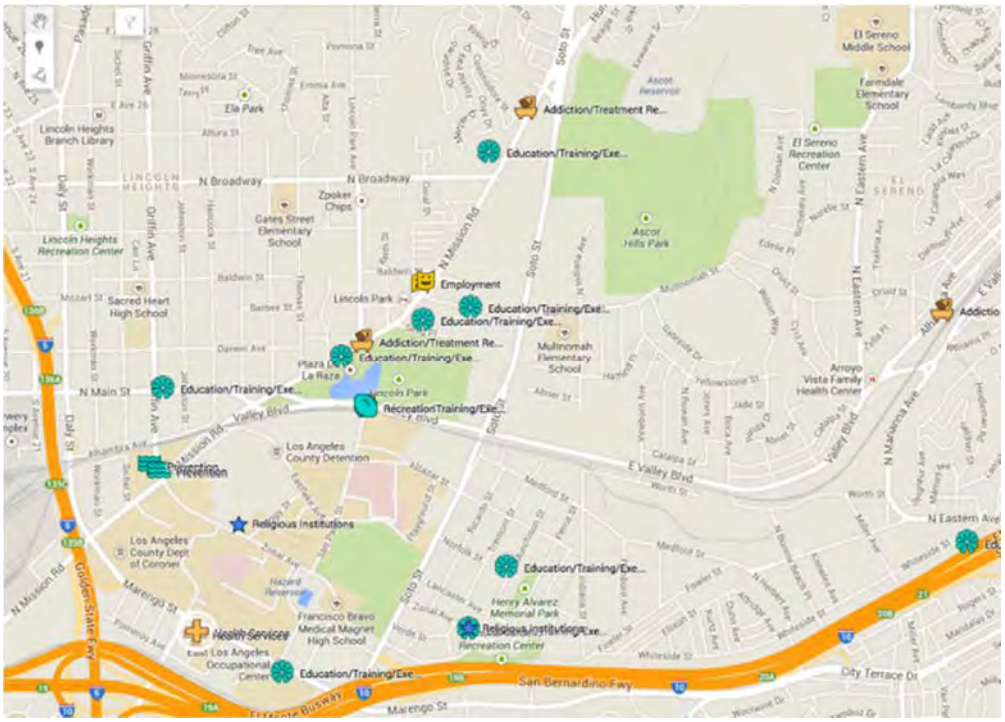

Figure 13: Community-based Resources

The built environment also presents problems for housed residents adjacent to LAC+USC MC. As noted earlier, when responding to questions about what community spaces were present in their neighborhood, 78% of housed residents reported that parks were available, while only a few described any other type of community spaces. Our environmental scans of Hazard Park and Lincoln Park noted public drinking and nuisance activity, which pose a threat to community spaces. Furthermore, observers noted an increase in crime in parks at night which poses a threat not only to housed residents, but homeless residents as well.

The principles of Crime Prevention Through Environmental Design (CPTED) can provide us with an opportunity to address this activity. Increased lighting could be applied at these parks and local streets/alleys to reduce criminal behavior by improving visibility to observe and thereby deter unwanted behavior such as drinking and/or drug use in public spaces. Additionally, to further enhance park usage, promoting alcohol and other drug-free activities could increase the health and wellness of the community and also help to decrease crime.

Our observations at alcohol outlets adjacent to LAC+USC MC documented people loitering, using/selling drugs, and/or panhandling. All too often, in low-income communities, liquor stores also serve as grocery stores. Posting signage that informs the community that "public drinking/drug use" is not permitted, combined with a telephone number to call and report this behavior is another CPTED strategy that could prove beneficial. However, the apathy of community members toward law enforcement documented in our assessment would require a strong galvanizing strategy to provide information, enhance relationships, instill trust, and support civic participation. Community engagement is an influential vehicle for "bringing about environmental and behavioral changes that will improve the health of the community and its members" (Centers for Disease Control and Prevention [CDC], 2011, p.7). Where there is broad community support, particularly from community "insiders," the likelihood to achieve successful collaboration and change is higher (Zahm, 2007). Therefore, building capacity through a cadre of well-informed community members (i.e. a Coalition including homeless residents) is vital to CCERP's ability to address the identified concerns in the Needs Assessment Report as well as target neighborhood health and safety threats affecting both housed and homeless residents living adjacent to LAC+USC MC.

As such, the following has been learned:

1. The African American homeless community has come to rely almost exclusively on the LAC+USC MC to meet their medical, psychological, safety, relational and housing needs. This over-reliance is challenging to the LAC+USC MC ED as it was not designed to address these non-medical or psychiatric crisis-related needs.

2. The undocumented Latino homeless community uses the LAC+USC MC ED services with far less frequency, and are relegated to family-based care within the surrounding neighborhood. To fully address the needs of the Latino homeless population may require the development of formal, community-based support systems that look beyond legal status.

It would be instrumental to build additional relationships and partnerships between LAC+USC MC and local human service providers.

Reflecting on gaps in the continuum of care, the data reveals the need for building additional mutually supportive relationships and partnerships between LAC+USC MC and local service providers. Therefore, it is suggested that LAC+USC MC formally develop in-house relationships with other service providers in the area. Furthermore, as there may be limitations to the service offerings in the area, it will be prudent to analyze the cultural and geographical accessibility of all currently available service providers. This may include the creation of a homeless/housed resident centered facility on the LAC+USC MC campus to meet the holistic range of needs of this population. Although no one knows exactly how such a facility would affect the growth or decline of the homeless population, without any changes to the existing policies the long-range prognosis of homeless residents in the area is poor.

The Affordable Care Act provides an opportunity for expanded Medi-Cal services in LA County and can help LAC+USC MC provide services that better meet the needs of eligible homeless residents. Currently, single, childless, and lower-income adults who qualify for the Medi-Cal health plan can access "uncapped" mental health and substance abuse treatment services, expanding the number of treatment sessions. LA County's major Medi-Cal insurance providers, LA Care and Health Net, are proactively accessing these services which can provide further support to the NSA homeless population as well as to LAC+USC MC. Another possible solution to connect services to LAC+USC MC could come from reigniting the Substance Use Disorder Network. This could expand services and meet the specific needs of the NSA population, while alleviating inefficient use of LAC+USC MC ED.

CONCLUSION

In conclusion, our findings suggest that the strategies for lessening the impact of the homeless population must include a formal network of services between the LAC+USC MC ED and a broader base of social service providers that would comprehensively address the myriad of health, safety, and psychosocial needs of homeless residents. A comprehensive set of initiatives

must be implemented to address the issues regarding the built environment (e.g., the drug "commerce", nuisance activity at parks, and problematic alcohol outlets). Moreover, engaging community residents (homeless or not) to challenge systemic conditions and social disparities that threaten health and safety is critical. Furthermore, implementing initiatives such as permanent supportive housing, counseling, and job training/placement can begin to address the varied issues that contributed to their current homeless status and maintain them in their community versus in treatment settings. The success of this approach would help homeless residents in Boyle Heights and Lincoln Heights overcome existing health and social barriers, reduce their use of the LAC+USC MC ED for non-emergency reasons, and gain the skills and confidence to fully participate in society. Problems of this magnitude cannot be solved by one entity alone; rather it requires the collective energy of the entire village.

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APPENDIX A: METHODS

A mix of qualitative, quantitative, and archival data informed this report. Interviewer administered surveys were conducted with community residents who identified as both having a permanent home and those who did not (homeless population). A series of focus groups were conducted with residents, hospital staff, and community residents with permanent homes. Additionally, survey data collected by Exodus were solicited and included in the analyses. A series of Street and Park Environmental Scans were conducted within the vicinity of LAC+USC MC ED combined with LAPD crime data. Below is a brief description of the measures and methods used in the collection of data used to inform this report.

Homeless Needs Assessment:

A total of 114 needs assessment survey interviews were completed during a four month period (May-August 2013). Survey teams interview homeless persons at five street locations (Marengo St., N. Main Rd., E. Valley Blvd., Alhambra St., N. Mission Rd.), two parks (Lincoln Park, Hazard Park), and at the LAC+USC MC ED.

Participants were asked about their use of the LAC+USC MC ED, the environmental and health factors that contributed to their use, and the availability of resources and services in the surrounding community. Composite scores were generated from these questions to create two measures, Mental Health Problems (a = .804) and Basic Resources (a = .716).

Housed Resident' Needs Assessment:

The resident needs assessment was conducted with local residents living in established residences surrounding the LAC+USC ED. Going door to door, a total of 186 surveys were collected during a four month period (May-August 2013) on 24 streets.

Housed residents were asked about their daily interactions with and perceptions of the homeless population in their neighborhood, the environmental/health factors in the community that affect the homeless as well as residents, and the availability of resources/services for homeless persons in the surrounding community.

Street/Park Observations:

A total of 40 Street Environmental Scans and 26 Park Environmental Scans were collected during a two month period (May-June). The purpose of these Environmental Scans was to assess the overall safety and conditions of establishments and residences in the streets and two parks surrounding the LAC+USC MC. Total Scores were generated for each observation site, and these scores were compared across time and type of establishment/site.

Reported Crime Data:

Crime data for the area in and around LAC+USC MC (zip code 90033) was obtained from the LAPD and included all reported crimes from June 2012 to June 2013. Information was compiled on the date and time of the crime, a description of the crime, including type, level of crime

(felony or misdemeanor), whether the crime involved interpersonal violence, and the address where the crime occurred.

Vulnerability Index (Exodus):
To expand on information gathered from the needs assessment survey, data collected by Exodus was solicited and incorporated into this report. Between January 2011 and May 2013, Exodus staff surveyed a total of 224 homeless people. These surveys utilized the Vulnerability Index, which is a tool designed to assist in "identifying and prioritizing" the homeless populations housing needs according to circumstances related to housing, physical and mental health, and safety.

Focus Groups:
A series of focus groups were conducted with several different constituent groups. Participants were queried about their experiences working with homeless patients in the ED (e.g., Hospital/ED patient capacity, concerns regarding the use of the ED by the homeless, safety/sanitation conditions, common diagnoses of homeless patients, availability/knowledge of resources for the homeless, hospital policies and procedures regarding patient care, etc.).

Emergency Department Medical Staff – A focus group was conducted with 13 medical personnel (i.e., doctors, nurses, pharmacists, and social workers) that primarily work in the LAC+USC MC ED. Participants were asked a series of structured questions developed by LMU-PARC regarding their experiences of working with homeless patients in the ED (e.g., Hospital/ED patient capacity, concerns regarding the use of the ED by the homeless, safety/sanitation conditions, common diagnoses of homeless patients, availability/knowledge of resources for the homeless, hospital policies and procedures regarding patient care, etc.). Focus group participants were selected by the Nurse Supervisor of the ED. Confidentiality was ensured to the participants at the start of the focus group, and each person was asked to complete a demographics sheet. The focus group lasted approximately one hour.

Emergency Department Social Workers – A question and answer forum was conducted with approximately 50 social workers from the Department of Social Work at the LAC+USC MC. Due to the unexpectedly large turnout, the focus group was conducted as a Question & Answer Forum. Participants were asked a series of structured questions developed by LMU-PARC regarding their experiences of working with homeless patients in the ED (e.g., concerns regarding the use of the ED by the homeless, common referrals made for homeless patients, availability/knowledge of resources for the homeless, hospital policies and procedures regarding patient care, etc.). Participants for the focus group were selected by the Head of the Department of Social Work at the hospital. Confidentiality was ensured to the participants at the start of the focus group. The focus group lasted approximately one hour.

Emergency Department Security – A modified focus group was conducted with two privately contracted security guards that primarily work in the LAC+USC ED, and one sheriff deputy responsible for patrolling the hospital campus. The participants were asked a series of structured

questions developed by LMU-PARC regarding their encounters with homeless patients in the ED and hospital grounds (e.g., incidences regarding the homeless, safety concerns, attitudes/behaviors towards the homeless, availability/knowledge of resources for the homeless, hospital policies and procedures regarding homeless use of the ED and habitation of the hospital grounds, etc.). A hospital administrator selected the focus group participants. Confidentiality was ensured to the participants at the start of the focus group, and each person was asked to complete a demographics sheet. The focus group lasted approximately one hour.

Housed Residents Focus Group – A focus group was conducted with 10 residents from the community surrounding the LAC+USC MC. Participants, who were between 17 and 64 years of age, were asked a series of structured questions developed by LMU-PARC regarding their experiences with the homeless population in the community (e.g., attitudes/behaviors towards the homeless, safety/sanitation concerns regarding the homeless, availability/knowledge of resources for the homeless, thoughts on homeless people's use of the LAC+USC MC ED, common gathering places of the homeless, recreation spaces available in the community, etc.). SMRS staff selected participants for the focus group. Confidentiality was ensured to the participants at the start of the focus group. The focus group lasted approximately one hour.

APPENDIX B: SOCIAL WORKERS' FOCUS GROUP THEMES

General Note: The LAC+USC MC ED Social Workers primarily refer to the homeless as "patients" and occasionally with the acronym NSA (Needs Special Assistance). In contrast, the security and medical staff typically make a distinction between patients (i.e. housed residential community members) and "the homeless."

On NSA/Homeless:

The homeless population is multifaceted. Optimal approaches for reducing their collective hospital use is to link them with other services that address their nuanced, unmet needs.

Drug users (men and women) who are not interested in sobriety tend to seek drugs at the hospital rather than critical services. Pregnant drug users on the other hand who want to continue to use will refuse these services. Drug users who are interested in sobriety may seek services but often fail to abide by program rules, relapse, and lose their housing and services.

Safety and family unification are reasons that some homeless residents forgo entering shelters.

A need for and sense of community influences the NSA hospital use or their continued homelessness. For some NSA, especially longtime substance users, routine use of the hospital supports and fosters their relationships with staff. Their personal attachments and substance use becomes a substitute relational support, because they are often estranged from family.

Some of the homeless "patients" are mentally ill. Mental illness may lead to neglect of basic self-care needs, whereby homeless patients end up in the hospital but are not ill enough to be placed in involuntary confinement via social services [51-50]. Additionally, some patients need inpatient psychiatric care, but do not have access to those services.

Overuse by homeless residents is thought to inhibit use by housed/insured potential patients.

- This is present in the Medical Staff Focus Group*
- This is present in the Security Focus Group*

Awareness of drug-exchange at the hospital.

There is an acute lack of psychiatric facilities to which patients can be referred.

- This is present in the Medical Staff Focus Group*

Updated and up-to-date references to services (entry criteria, capacity, phone numbers, etc.) are needed. Relatedly, having representatives from these services, especially safe, temporary housing, on site to speak with the potential referees would help. For those with substance abuse problems, a key missing link is an association with rehabilitation programs. A joint-operated clinic modeled after Whittier Presbyterian Intercommunity Hospital could alleviate most of these problems.

APPENDIX C: SECURITY GUARDS' FOCUS GROUP THEMES

General Note: Conducted with morning shift security staff (Securitas) who state that most of the homeless issues occur during the night shift, when there is less ED staff in general.

- This theme is present in the Medical Staff Focus Group*

There is no "streamlined" policy or process for how to deal with people who are using the ED for non-emergency or non-medical purposes. There is no policy from administrators, but [the security supervisors set the tone]. They would like more of a dialogue or collaborative relationship between Security and the Sheriff's Department. This is the process that they want streamlined.

- This theme is present in the Medical Staff Focus Group*

The homeless often come in to the ED to bathe or sleep.

Sometimes the guards are officious. It appears they enforce laws randomly and sometimes may give citations. Other times, they let homeless residents slide, like letting them sleep sitting up. The interaction is determined by how cordial, cooperative, hostile, or aggressive the person is.

Securitas provides information on how to deal with people and difficult situations to staff. The Sheriff's Department did not cite any specific training, however, noted that they relied on mutual respect and experience when dealing with people in general. Specific mention of training to deal with patients including the homeless to keep the environment calm by Securitas is Code Green. Securitas staff mentioned working with "Search Staff" to maintain a calm, functioning environment.

The hospital security staff believe that a single reference pamphlet of available services is the best way to curb homeless overuse of the ED.

They are primarily concerned with weapons screening (i.e. homemade knives, shanks pepper spray, sticks, etc.). The working policy is that if the homeless are admitted all property including weapons are returned to them upon discharge. Curiously, those who aren't admitted and attempt to enter with weapons, have their weapons confiscated and thrown away.

There was some disbelief that mental illness was the root cause of some of the behaviors, especially around hygiene.

They do not believe that the staff contribute to the problem; Part of the congestion is caused by the policy of calling a person three times before a person can be asked to leave.

APPENDIX D: HOMELESS PARTICIPANTS' FOCUS GROUP THEMES

Although homeless participants describe frustration related to the backlog at Exodus, they praised the case workers efforts. Exodus has been instrumental in connecting homeless individuals to the substance abuse rehabilitation services at the AVRC program. Potential program participants must be clean in order to be referred.

Participants opted to be sent to AVRC because of the peaceful country life it offers, opposite of the stressful city life in Los Angeles.

Participants made the following recommendations for improvement of the AVRC program:
1) cleaner restrooms in the facility; 2) varying program activities at regular intervals to reduce monotony; and 3) more recreational and athletic activities such as softball and volleyball.

The best aspects of the AVRC program are: 1) the food; 2) ease of the program; and 3) one-to-one counseling.

Participants that stay in the program: 1) realize they need help; 2) are ready to receive help; 3) see the program as a lifeline; and 4) have goals such as get custody of their children or reuniting with a spouse.

The reasons participants leave the program: 1) they are not ready for treatment and leave to use their substance of choice; 2) they miss their families and/or significant other; and 3) family issue or crisis.

Participants think highly of AVRC and would recommend the program to others in need of substance abuse rehabilitation.

Homeless participants' perceptions and experiences with the ED at LAC+USC MC:
The ED functions as a halfway house for recently incarcerated individuals who were released and a steady homeless shelter for others who are displaced.

Homeless residents are using the ED for legitimate medical services. Overall, homeless residents are satisfied with the care they receive with few exceptions.

The ethnic disparities in hospital treatment described consist of Latino patients being served first regardless of severity of illness.

The ED medical staff may inadvertently contribute to drug abuse by inappropriately prescribing homeless patients narcotics.

APPENDIX E: MEDICAL STAFF FOCUS GROUP THEMES

ED meets homeless patients' physiological needs: Homeless patients frequent the ED multiple times per day to have their basic physiological needs met. These needs include food, shelter, clothing, shoes, blankets, showers, and laundry. They are also provide assistance with transportation by receiving or requesting bus tokens during their visit.

Impact on other patients and ED resources: Homeless patient overuse of the ED is interfering with the department's primary function of caring for those who need immediate emergency services by depleting ED resources (space, supplies, and staff's patience and time). The behavior of some of the homeless patients makes housed ED patients uncomfortable.

Safety concerns associated with homeless patients: Medical staff members are threatened with violence or assaulted by homeless patients in the ED. Most of the homeless patients use intoxication as an explanation for their behavior. Since law enforcement is restricted until there is clear criminal activity, medical staff are expected to protect themselves and make citizens arrests.

Medical staff is connected to and has compassion for homeless patients: The medical staff cares about the homeless patients but believes their needs should be addressed in the appropriate context, utilizing appropriate resources in an effort to serve patients who have medical issues that need to be addressed immediately. It is also hindering positive health outcomes for homeless patients because they are not receiving consistent care for chronic conditions.

Substance abuse, rehabilitation and mental illness: Homeless patients use the ED to address their substance use issues, and receive treatment for intoxication and withdrawal symptoms. The medical staff also believes that the hospital needs a better system for communicating with community pharmacies to minimize substance abuse by tracking prescriptions.

Resources medical staff believes homeless patients need: The medical staff would like the hospital to be able to offer homeless patients resources for the following: food, showers, storage for medicine for chronically ill patients, a charging station for wheelchairs and cell phones, substance abuse treatment and/or Alcohol Anonymous. They believe that the cost of providing these services would be cheaper than treating homeless patients multiple times each day in the ED.

APPENDIX F: HOUSED RESIDENTS' FOCUS GROUP THEMES

Housed residents are compassionate, empathetic and connected to homeless residents in their community: The housed residents have a sincere desire to help homeless residents in their community. Sometimes, the housed residents provide food, water and supplies to homeless residents. Many housed residents embrace the homeless residents as meaningful members of the community. The strong connectedness stems from housed residents who were formerly homeless or had/have homeless relatives. Many of the homeless residents have lived in the Boyle Heights community all of their lives.

Housed residents are cautious around homeless residents: Even though housed residents occasionally reach out to homeless residents, safety is still a concern. Housed residents are careful about how they interact with the homeless population. Hospital law enforcement is limited based on the boundaries of jurisdictions. The housed residents discussed the possibility of expanding law enforcement's presence to the community just outside of hospital boundaries.

Housed residents believe many of the homeless residents suffer from mental illness and substance abuse issues: Housed residents believe that drug sales/abuse are the major contributing factors to homelessness in their community. Homeless patients with substance abuse and mental health issues often do not stay to receive services at Exodus or the hospital. Housed residents believe that these homeless patients are unstable and threaten their safety.

Housed residents highlight resources needed and currently available for homeless residents: Homeless residents have housing opportunities through community centers and a housing unit that has a waiting list specifically for homeless families. Although some housed residents possess resource-related knowledge, they would like to be informed of available community resources, so they can offer referrals to homeless residents. They also recommend that services (food, shelter, clothing, and substance abuse treatment) be brought to the homeless through outreach.

Homeless use of the ED impacts ED patients and their families: Being a patient or a loved one supporting a patient in the ED is a stressful experience for housed residents that is worsened by homeless residents occupying the ED waiting room. Housed resident patients and their families have to stand, wait outside and feel uncomfortable around the homeless. Many of the homeless residents have poor hygiene, some are rude and do not want to remove their personal items from seats in the waiting room. Some housed resident patients are going to a different hospital to avoid the overcrowded waiting room.

Disparities related to housed residents' treatment of the different homeless population: Some housed residents only help the Latino homeless population. Homeless individuals of Latin descent have a lower likelihood of being subsidized by government programs if they are undocumented. For this reason the housed residents readily become their support system.

The homeless residents are an asset to the community who are valued in certain contexts.

APPENDIX G: RESULTS

Assessing the Social/Psychological Needs of Homeless

Women reported mean score of 3.07 versus men's 2.44 on emotional issues (t = -2.355, p < .05) versus males' mean scores of 2.93 (t =-2.493, p < .05).

In addition, female homeless (M=3.02, SD = 0.95) people reported significantly more problems in the Mental Health Total (comprised of emotional issues, psychological problems, and stress.) when compared to men (M=2.47, SD =1.08). (t= -2.484, p < .05).

On average, Latino homeless residents (M= 1.64, SD = 0.48) indicated significantly lower scores on knowing where to obtain support for emotional issues and stress than did the African American (M = 1.31, SD = 0.47) homeless residents. (F =5.12, p = .003).

Among those who reported having a trusted outreach worker at the hospital, 79% reported visiting the ER an average of 3.17 times, while among those without a trusted outreach worker 65% reported using the ER an average 2.94 times.

Assessing the Medical Needs of Homeless Residents

There was an interesting gender difference, whereby men (M = 1.56, SD = 0.5) were significantly more likely to report that they did not know where to get healthcare benefits than women (m = 1.30, SD = 0.47) (t = 2.016, p < .05).

There were no significant differences between respondents of different racial-ethnic groups in their concerns about medical, dental, healthcare, drug or alcohol use.

Understanding Homeless Resident's Use of the LAC+USC ED

An Independent samples t-test was conducted to identify whether there were gender differences in the frequency of use of the ER. Results indicated that men in the homeless resident group reported significantly higher frequency of use of the ER (M = 0.95) than did women (M= 0.55).

Homeless residents who have lived in the community longest, (4+ years) reported using the ER significantly less than homeless who reported living in the community either 1-3 years or less than 1 year. (F = 5.096, p = .008).

An Analysis of Variance (ANOVA) was conducted to examine the extent to which the use of the ER varied by racial/ethnic groups. Overall there were significant differences between racial groups [F (3, 103) = 7.97, p=.000]. Post hoc comparisons using Tukey's HSD test indicate that African Americans used the ER (M = 1.34, SD = 0.12) significantly more than Latino's (M = 0.5, SD = 0.11) and White non-Hispanics (M = 0.71, SD = 0.19). No other differences were found between racial ethnic groups.

Individual ANOVAs were run to examine the differences between homeless who were categorized as non-users, moderate users, or frequent users.

An ANOVA was used to examine the differences between people who were non-users, moderate users or frequent users of the ER on their level of social support using the ISEL. Overall significant differences were discovered between groups on the ANOVA [$F(2,102) = 3.13$, $p = .048$].

Homeless residents who used the ER "frequently" (more than 5 times) reported significantly more problems with personal safety ($F(2, 105) = 4.97$, $p = .009$) and having someone to talk to ($F(2, 105) = 2.96$, $p < .05$).

In addition, Moderate Users of the ER reported that they did not know where to get help with emotional issues significantly more that Non- Users($F(2, 95) = 3.71$, $p = .028$) and that frequent users of the ER reported that they did not know where to get help with relationships significantly more than Non-Users.

Unsurprisingly, we found that those who did not use the ER had significantly more support ($M = 23.00$, $SD = 5.68$) than did those who had frequent use of the ER ($M = 19.00$, $SD = 6.27$).

Understanding the Impact of the Built Environment on the Homeless Resident Population

Using ANOVA analysis to identify differences between observations during different times of day, the results indicate that there were significant differences between the "nuisance rating" of sites during the day and night, [$F(2, 397) = 14.45$, $p = .001$], with scores of negative traits increasing by an average of 1.5 points across all establishment types at night.

Of the 40 homeless people that were observed, 8 were female (25%), which is consistent with the findings of the homeless needs assessment.

The equipment at the parks, such as the basketball courts, trash cans, bike racks, and permanent bathrooms was on average reported as "good" quality or better, except for the open grass areas, which were either patchy or overgrown, and received a "poor" rating.

Crime Data

Further analysis of the LAPD crime date revealed that "grand" crimes, predominantly felonies, occurred at night ($X^2(1, N = 406) = 26.44$, $p = .000$). Results found that rates of interpersonal violence in crime were significantly higher in the afternoon and at night, than in the morning ($X^2(1, N = 406) = 7.48$, $p = .024$).

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SOCIAL MODEL RECOVERY SYSTEMS

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