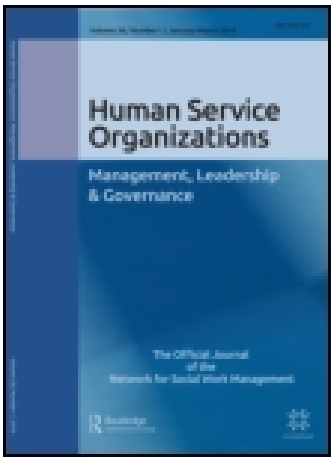

Human Service Organizations: Management, Leadership & Governance
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wasw21

Service Integration to Reduce Homelessness in Los Angeles County: Multiple Stakeholder Perspectives

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Published online: 14 Jan 2014.

Human Service Organizations: Management, Leadership & Governance, 38:44–54, 2014

ISSN: 2330-3131 print/2330-314X online
DOI: 10.1080/03643107.2013.853009

Routledge
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Service Integration to Reduce Homelessness in Los Angeles County: Multiple Stakeholder Perspectives

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Homeless people are among the most marginalized individuals in the United States and experience significant rates of morbidity and mortality. Los Angeles County, California, has the highest concentration of homeless individuals in the nation, and although it features the largest health and social services system available to homeless people, it faces significant challenges to provide cost-effective integrated care. Housing and highly coordinated or integrated care represents an efficient and effective way to serve homeless individuals. Based on content analysis of symposium proceedings that included multiple stakeholders who engaged in a daylong structured conversation about challenges and opportunities related to the development of a fully integrated system of care, this manuscript presents insights about the state of service integration in the largest county in the United States. We discuss implications for the health and social services system, including a call for developing an strategic plan to vertically integrate care to address issues of homelessness.

Keywords: administration, homelessness, service integration, stakeholders, system change

INTRODUCTION

Homeless people are among the most marginalized individuals in the United States and experience significant rates of morbidity and mortality. Homelessness is also costly to society, both morally and financially in terms of tax revenue for hospitals, psychiatric facilities, and social services that attempt to meet the emergent needs of this population (Los Angeles Homeless Services Authority, 2011). Populations affected by homelessness range from youth to older adults, and the experience of homelessness often intersects with serious mental illness, substance use, and a host of other health risks, thus presenting many challenges to service integration.

One of the central challenges facing homeless services providers as well as health and social service systems more generally is how to provide integrated care. Integrated care broadly refers to the efficient, coordinated, and proactive delivery of comprehensive health care services tailored to an individual's needs (Andrulis, Siddiqui, Purtle, & Duchon, 2010). Providing integrated care has the potential to improve outcomes at reduced costs; for homeless individuals with significant disabilities, research has demonstrated that access to permanent housing as part of an integrated approach is an efficient strategy that can deliver evidence-based mental health care, effectively

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monitor physical health indicators, and result in significant cost offsets (Andrulis et al., 2010; Craig, Eby, & Whittington, 2011; Weinstein, LaNoue, Collins, Henwood, & Drake, 2013). Drawing from analysis of symposium proceedings, the current paper provides insights from providers and county administrators on the current state of service integration.

BRIEF REVIEW OF SERVICE INTEGRATION

Despite significant efforts to increase service coordination and integration in health care settings during the past 50 years, the extant literature has revealed multiple system and organizational barriers to integration, including the bureaucratic process of service delivery, professional and philosophical differences among providers, and inadequate resources (Axelsson & Axelsson, 2006; Banaszak-Holl, Allen, Mor, & Schott, 1998). More specifically, in the mental health field, effective coordination is generally affected by limited incentives for communication among providers, poor network infrastructure to establish effective coordination of services across agencies (Grudzinskas, Clayfield, Roy-Bujnowski, Fisher, & Richardson, 2005), and the time-consuming and resource-intensive nature of building partnerships (Steadman, 1992). However, when implemented successfully, coordinated care has been associated with lower cost and positive treatment outcomes, prompting policy makers, administrators, providers, and clients to pursue coordination efforts in health and human services (Burt, Resnick, & Matheson, 1992; Kusserow, 1991).

Providing housing and highly coordinated or integrated care offers an efficient and effective way to serve individuals suffering from chronic homelessness (Substance Abuse and Mental Health Services Administration, 2013), who generally enter treatment with serious mental illnesses and higher rates of early mortality and medical comorbidities (Henwood, Weinstein, & Tsemberis, 2011; Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005; Rosenheck & Dennis, 2001; Rosenheck et al., 2002; Rosenheck, Resnick, & Morrissey, 2003; van Laere & Withers, 2008). Despite service disparities among homeless individuals, evidence regarding treatment use and outcomes of homeless individuals is in short supply. Research on the treatment process, such as retention in and completion of treatment, has indicated that the homeless population generally benefits from receiving services, with greater reduction of psychiatric symptoms and fewer days spent homeless (Rosenheck et al., 2003). However, this population requires a wraparound approach to help them meet their basic needs of housing and health (Rosenheck et al., 2003). The service system also faces challenges to comprehensively serve a population that, due to its socio-psychological and environmental characteristics, can be difficult to engage. Although a given program may have achieved some measure of integrated care (e.g., permanent supportive housing and health and social services integration), the larger system of care is not designed to address the need for coordinated care that is necessary for improved and cost-effective outcomes related to homelessness.

SERVICE INTEGRATION IN THE CONTEXT OF LOS ANGELES COUNTY

Los Angeles County, California, has the highest concentration of homelessness in the nation (County of Los Angeles, 2010), with 48,000 homeless individuals on the street any given day (LAHSA, 2011). Data provided by the Los Angeles Homeless Services Authority (2011) suggested that of the more than 50,000 homeless individuals identified in 2011, approximately 24% were chronically homeless, 33% had mental health issues, and 34% had substance abuse problems. L. A. County also features the largest health and social services system available to homeless people. Funded by more than $23.3 billion during the 2011–2012 fiscal year, this infrastructure includes

more than 280 mental health programs, 480 substance abuse treatment programs, and 5,300 social service agencies (e.g., domestic violence, job readiness; County of Los Angeles, 2010). L. A. County's Continuum of Care Homeless Assistance Program has overseen more than 13,000 emergency, safe haven, and transitional housing placements and more than 17,000 permanent supportive housing placements. Shelters, outreach teams, and food pantries are explicitly designed and funded for the homeless population. Other health and social service providers that serve as part of the de facto homeless service system include primary care clinics, mental health and substance abuse treatment providers, domestic violence service providers, and emergency rooms. In 2011, publicly funded substance abuse treatment programs reported that of 36,256 treatment episodes, 16.69% involved individuals experiencing homelessness at intake (County of Los Angeles, 2010). Estimates from mental health programs also have suggested significant use of this system by the homeless population; more than 10,387 homeless people reported experiencing mental illness in 2011 (County of Los Angeles, 2010). Similar to other major metropolitan areas, despite the use of significant resources, the lack of a coordinated approach has limited the efficiency and effectiveness of current efforts to serve the homeless population.

Although extensive, L.A. County's health and social services infrastructure is separated by different funding streams and county agencies. Mental health programs are administered and regulated by the County Department of Mental Health, whereas health and substance abuse treatment programs are supervised by the Department of Health Services and Department of Public Health, respectively. Social services, which include domestic violence and shelters, are managed by different departments (e.g., Department of Children and Family Services, Department of Public Social Services), making it difficult to integrate services based on diverse sources of funding and divergent regulatory guidelines.

Coordination among service providers has been one of the most significant challenges affecting standards of care and elevating costs. In 2006, county leaders developed the Homeless Prevention Initiative (HPI) to address some of the challenges resulting from disjointed health and social service delivery. HPI has allocated more than 90% of its $95.4 million in funding to develop innovative programs to accomplish two goals: 1) preventing homelessness through housing assistance and effective discharge planning from transitional supportive services, and 2) reducing homelessness through community capacity building, regional planning, innovative program design, and supportive service integration linked to housing (County of Los Angeles, 2010). Although targeted interventions such as HPI seek to prevent and reduce homelessness using a capacity-building and integrative model, neither this intervention nor the current health and social service system available for homeless individuals in Los Angeles County has been able to effectively prevent and eliminate homelessness.

Developing a highly integrated system of care for one of the most vulnerable populations in Los Angeles County remains an ongoing challenge. Large-scale efforts to effect change such as integration of care have emphasized the need for professionals, scholars, administrators, and policy makers to cooperate and work together more effectively to coherently enact changes at each level, thus compounding the system-wide effect (Shortell, 2004). In particular, Shortell (2004) highlighted system and environmental factors (e.g., Medi-Cal reimbursement, legal and regulatory policies related to integration), organizational structure strategies (e.g., workforce development), and the coordination, knowledge, and skills of providers as critical to effecting service delivery changes (see Figure 1). Using this conceptual framework of system change that requires action on different levels—individual, group, or team, organizational, and larger political and economic systems—this report considers the perspectives of L.A. County administrators, researchers, and providers about the challenges of and possible strategic responses to improving their system of care for homeless individuals. These perspectives were shared during a daylong symposium in spring 2012 on homelessness and integrated care that involved a diverse set of participants and stakeholders.

FIGURE 1 Model of System Change (Shortell, 2004).

DESCRIPTION OF SYMPOSIUM

The forum, which was hosted by a local university, focused on the current status of integrated care provision to adults experiencing homelessness in Los Angeles, as well as the intersection of integrated care with temporary and permanent housing. The stated goals of the forum were to increase understanding of integrated care for homeless individuals residing in temporary and permanent housing in Los Angeles and to identify key challenges and strategies related to advancing and sustaining integrated care for this vulnerable population.

Participants

Through the recruitment and systematic engagement of nearly 30 participants, including providers of health and social services to homeless persons, local government officials, health and social services agency administrators, research scientists specializing in homelessness and services for homeless persons, and client advocates (who reported experiencing homelessness themselves), the daylong symposium systematically elicited unique views on the state of integrated care in L.A. County and the challenges and opportunities to develop better service integration to serve homeless populations.

We generated a sampling frame of participants based on contact lists from Los Angeles County departments, nonprofit and for-profit providers, researchers specializing in homelessness issues, and administrators of mental health, substance abuse, and social services. The final sample ($N = 30$) was invited to participate in the symposium via invitational letters. The analytical sample included 26 individuals who attended and participated throughout the day. See participants by role in Table 1.

Structure of Symposium

Participants were informed of the symposium's goals and structure. The symposium featured three presentations by researchers specializing in service integration and three panel discussions with administrators of mental health and substance abuse treatment services in Los Angeles County and managers representing organizations serving the health and social services needs of homeless individuals. These stakeholders self-selected into panel discussions that focused on agency and administrative perspectives on integrated care in the housing continuum and building partnerships for sustainable integrated care.

Trained moderators employed by the university posed questions, kept workgroups focused on the task, and took field notes to identify challenges and develop overall themes to be presented

TABLE 1
List of Participants

Formal Title	*Type of Agency*
Dean	Higher Education
Professor of Social Work Research	Higher Education
Professor	Higher Education
Professor of Social Policy and Health	Higher Education
Associate Professor of Research	Higher Education
Assistant Professor	Higher Education
Assistant Dean	Higher Education
Assistant Professor	Higher Education
Councilmember	City Government
Homeless Coordinator	City Government
Director of Programs	Housing
Executive Director	Housing
President/CEO	Housing
Program Manager	Housing
Chief Executive Officer	Nonprofit Medical Organization
Director	Nonprofit Community Organization
Program Officer	Nonprofit Charitable Organization
Community Research Consultant	Nonprofit Healthcare Organization
Director	Mental Health System
Director	Public Health System

back to participants during the day's discussion (Palinkas et al., 2011). Moderators were university faculty members with research expertise in homelessness. They were trained to establish the group structure with standard questions, e.g., what are the challenges that L.A. County faces to integrate services for homeless individuals? The symposium proceedings were digitally audio-recorded and transcribed verbatim.

ANALYSIS OF SYMPOSIUM PROCEEDINGS

Content analysis (Hsieh & Shannon, 2005) of the transcribed symposium proceedings was conducted to identify how presenters characterized the challenges of integration along with proposed solutions. Initially, one of the first two authors summarized the main issues that each group addressed, which was then shared with the other for review. After agreement was reached between the two first authors about the most salient points made by each group, the summaries were reviewed by the third author, who was responsible for convening the symposium and was present throughout the proceedings.

Perspective of Administrators

Administrators of county mental health and substance abuse treatment services and leaders of social services organizations agreed that provision of integrated health and social services is the best strategy to reduce homelessness and address the comorbidities present in the homeless population. They highlighted the need for top-level, system-wide regulatory processes and coordination of the current structure of services, representing a common vision to enhance skill levels as well as the formal and informal infrastructure of service delivery. They agreed with the research literature that to accomplish integrated care, several approaches are necessary.

Solutions

To achieve system-level change and develop a highly integrated care system for homeless individuals, administrators suggested three main approaches based on process and engagement. The first strategy was to generate buy-in related to integrated care from county and service providers by jointly developing a shared vision with encompassing goals greater than any individual group could accomplish. This approach highlighted the interdependence necessary to achieve a reduction in homelessness. To develop a shared vision and commitment to integrated care, administrators noted the need to create an interorganizational process that is safe and engaging for all stakeholders; provides guidance via policy, validation, and technical support from experts; and acknowledges successes for sustainability and quality-control purposes by agency leaders. As one administrator explained:

> One way of spotting if real integrated care and full-service partnerships are ongoing at your program level, in your community: Is there a big goal? Is there a vision that is bigger than any one group? If you see that vision, I think it's an indicator that there is collaboration going on, because it's bigger than any one group can accomplish.

Administrators reported that recent pilot tests conducted within the county showed that "anchors to end homelessness are housing, rental subsidies, supportive services, and benefits." However, to deliver these services effectively,

> It has to be an integrated approach that includes health, mental health, substance abuse, case management, and that there is built-in support from decision makers with city and county housing departments, the Department of Mental Health, and the Department of Health Services to implement rapid re-housing programs and ensure that individuals are getting the health care and government benefits they need.

Increased collaboration is needed across service fields and government, nonprofit, and for-profit service sectors to respond to the service needs of currently homeless individuals. Equally important is a focus on the service needs of those at high risk of becoming homeless. Integrated care models require investment by a wide variety of partners such as universities and research institutes. For example, one administrator cited a specific initiative to increase coordination of care by using peers as care coordinators, or *promotoras*, to coordinate health, mental health, and substance abuse treatment—a model developed at a local university. Research that enables looking "up-stream" was also viewed as important (e.g., serving people who are incarcerated or in the foster care system before they experience homelessness). For instance, one strategy may be providing anti-craving medications to individuals with substance abuse problems while they are still in prison or investing in full service, also known as wraparound or partnership approaches, for young people leaving the foster system or the juvenile justice system. As one administrator described:

> We have to look to the springs that drive homelessness, as well as the current pools. . . . We'll find these individuals housing, working together, but if there's a new cohort that exactly replaces them, we don't know that we have been successful because our streets will look the same.

Finally, county department leaders should work collaboratively to develop and implement appropriate policy on high standards of integrated care for homeless individuals and also develop strategies to respond to political challenges to accomplish administrative integration. Administrators underscored that only by aligning administrative policy and practice would a coherent framework of integrated care be achievable.

Perspective of Researchers

Leading researchers noted that health care reform has provided both opportunities and challenges for the delivery of integrated care to homeless populations. Expanded insurance coverage will allow more people to access care, but the quality of that care must also improve. Concepts such as the "patient-centered medical home" are useful and worth pursuing, yet developing models that work with diverse populations will require experimentation. In addition to new models for service delivery, new metrics must be developed to establish markers for success. As one leading researcher noted,

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

Researchers remarked that integrated care does not mean simply providing multiple services under one roof, and there are challenges at every stage of service delivery, "from consumer awareness to assessment to the office visit to the exam room experience to follow-up. There are challenges everywhere in that process." Bridging gaps within the current systems of care requires addressing language and cultural differences that exist among care providers. Furthermore, accountability and responsibility for patient care cannot be diffuse and must be assigned to propel integrated and coordinated care.

Solutions

Rather than focusing on top-down, system-level reform, researchers emphasized the difficulty of large-scale change and the need for small-scale innovations that increase the likelihood of successful implementation. In some cases, innovation may mean using existing technologies; a multidisciplinary, team-based approach has been known to be effective with this population. Recent initiatives such as peer models and peer health navigation also hold great promise (Brekke et al., 2013). Researchers underscored the need to promote informal forms of support, including peer support, that are external to formal service delivery. Although reform efforts sometimes require external influences such as health care reform that mandates change, individual efforts by "champions of change" within the service delivery system have also been shown to be effective. Champions of change include agency, local, and state leaders who show ownership and poise to make system changes. Lastly, researchers acknowledged that the success of newly formed partnerships in integrated care will be determined in part by the ability to negotiate and compromise.

Perspective of Providers

Not surprisingly, providers focused on the context of frontline service provision, revealing a complexity of issues not fully recognized by either researchers or administrators. It was noted that other stakeholders had top-down perspectives, and that it is important to consider bottom-up innovation. Providers felt that regulation and funding mechanisms do not have the flexibility required when serving a homeless population, even when implementing established best practices. For example, participants noted the lack of resources needed to establish and maintain ongoing collaboration with a larger provider network: "People don't play well unless there are significant financial resources available." Several providers described how funding sources often require or promote services that are not always consistent with the needs of those being served. Service providers stated that they may be forced to seek private sources of funding or raise money themselves to avoid those limitations.

The discussion among providers also reflected a sense that the perspectives of some stakeholders are disproportionately considered and valued. "You have a vision. You have the research. . . . I respect all of that. I just want us to have a voice in the process."

Some providers noted the absence of the population being discussed—individuals who have experienced homelessness were not specifically invited to the symposium. The absence of this perspective prompted the opinion that, "We need to make them welcome and come into our integrated system of care."

Solutions

Despite identifying gaps between policy and practice and the need for local leaders to capitalize on the current climate in which policy makers appear open to input and accommodation, providers mainly focused on "horizontal" issues of working together. Challenges to collaboration included establishing a basic level of trust between partners and the shared belief that they are similarly invested in serving a homeless population. Concerns about job loss as a result of new service arrangements, for example, may produce anxiety and impede progress if not addressed. Providers also cited good intentions as necessary but not sufficient for integrated care, and that ongoing communication and consistent execution are key factors. Resources, time, and team-building activities were considered as essential components of the process of integrating care that often go overlooked. Most importantly, given that the homeless population is diverse rather than homogenous, providers endorsed developing multiple solutions for multiple problems.

DISCUSSION

Symposium participants agreed that housing and integrated care are critical to alleviating homelessness in Los Angeles County. Based on discussions during the event, key ingredients of success include relational and resource factors. Relational issues include trust, understanding, and effective communication among all collaborating stakeholders; a commitment to address the multifaceted needs of each consumer; and political will and effective leadership. Resource factors include sufficient financial and program resources, program and system performance monitoring and calibration, and implementation. Nevertheless, stakeholders representing different levels of the service system had different perspectives that were not always complementary. In particular, administrators highlighted the importance of developing a shared vision and integrating financial and service delivery goals. Researchers, however, stressed that without an organizing framework inclusive of enhanced cross-sector communication and ongoing monitoring of quality and accountability, integration would falter. Service providers underscored complex relational issues (e.g., the need to establish trusting relationships among service organizations and invest in case-coordination activities) that were not fully recognized by either researchers or administrators.

This one-day forum provided an opportunity for dialogue and learning among diverse stakeholders, as well as direction for social action at different levels. Although the voice of homeless individuals was only represented by a few client advocates with histories of homelessness, it is necessary to frame integration from a client-centered approach. Most participants agreed that a client-centered approach to integration will be most likely to yield better implementation and cost-effectiveness results.

A salient issue raised during the symposium was the need for collaboration to move from a horizontal (e.g., among service providers) to a vertical (e.g., among policy makers, county administrators, services providers, and clients) model to achieve service integration. Yet, a specific plan was not clearly articulated, possibly because constituents were in an early stage of contemplation regarding the most feasible and effective approaches. Future strategic events may follow up on

these discussions and call on attendees to engage in a structured development process that can lead to concrete solutions to integrate care. Promising models to consider in such a planning process include the "homeless placement boot camps" that have taken place in several cities as part of the 100,000 Homes Campaign (Kanis, McCannon, Craig, & Mergl, 2012).

The boot camp is a full-day event in which all stakeholders use a magnetic game board representing the housing placement process from start to finish. Participants are given magnets that contain many basic steps in the housing placement process as well as blank magnets to fill in other steps if needed. Teams, consisting of representatives from all agencies present, build the game board to accurately reflect every step of the process, from first contact with a person experiencing homelessness to the moment that person is handed the keys to an apartment.

To ensure that this process leads to a concrete plan to deliver integrated care, the boot camp requires the following six steps: 1) all representatives from agencies involved in the housing placement process in each city come together; 2) each agency has a representative; 3) no single agency owns the process of housing the homeless entirely; 4) at a minimum represented organizations should include a public housing agency, Veterans Administration, continuum of care agencies, and the city office responsible for homelessness services; 5) include the voices from the people who actually do the most navigation of this system, including veterans and others who have experienced homelessness, landlords, outreach workers, insurance companies, etc.; and 6) the meeting is hosted by an entity that has the appropriate reach and drive to push the policy recommendations forward in the months following the boot camp.

Health care reform has provided the stage to develop client-centered services, and engaging stakeholders in a process that leads to vertical integration is critical to its success. Researchers and social work practitioners need to consider such a framework of collaboration to develop realistic and comprehensive plans for change to achieve integrated care for homeless persons.

Finally, service providers should highlight how ambiguous policy expectations, contradictory funding and regulation objectives, and other problems with integration efforts may undermine attempts to increase access to safe and affordable housing for homeless individuals and help them navigate the health and social services system with ease and agility. L.A. County has become one of the largest systems of health and social services delivery in the nation, yet the challenges inherent in serving the largest population of homeless individuals in the United States remain. Although it is clear from the symposium proceedings that stakeholders are in the contemplation stage of those challenges, they seem eager to develop concrete solutions to improve the current system of care for the benefit of vulnerable populations.

Conclusions

Symposium proceedings highlighted core challenges and general solutions to achieve an integrated service delivery system for homeless individuals in L.A. County. Developing such a system requires significant investment from all stakeholders to come together and develop a concrete and client-centered plan to support service integration. Overall, the discussion seems to be the first step to establishing a basic understanding among this community of leaders of the steps necessary to achieve a well-coordinated system of care to eliminate homelessness in Los Angeles County.

These preliminary findings have significant implications for social work practice, health care policy, and future research. Social work managers need to show leadership in developing a comprehensive approach to evaluation, analysis, and implementation of integrated solutions. Macro-social work practice has been characterized by the ability to promote system change vis-à-vis policies and practices that consider the situational context of vulnerable populations (Austin, Coombs, & Barr, 2006). Because developing and coordinating a coalition of stakeholders and tailoring solutions for vulnerable populations are key challenges of integration, social work management can contribute greatly to this process.

Health care policy needs to be informed by the current realities of service delivery and the service needs of clients. It is only through the development of tailored policies that administrators and service providers will have the guidance and incentives to integrate care. Finally, by investigating best-practice models of collaboration across disciplines and administrative and service delivery roles, researchers can inform systematic approaches to achieving cost-effective service integration.

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