OVERVIEW

Launched in October 2020, the SPA 3 Patient Navigation Pilot was designed to support post-discharge care coordination & case management for 100 people experiencing homelessness who are “high-utilizers” of hospital emergency services in the San Gabriel Valley/SPA 3 area of Los Angeles County.

Spearheaded by United Way’s Home For Good, the SPA 3 Patient Navigation (PN) Pilot is a groundbreaking, cross-sector effort between Union Station Homeless Services (USHS) and five San Gabriel Valley hospitals.

With coordination support from the Health Consortium of the Greater San Gabriel Valley, hospital and homeless service partners co-designed and implemented the 18-month pilot, which increased service capacity with three full-time Patient Navigators who are embedded within hospital teams and workflows and have connected over 125 patients to shelter/housing placements, primary care services, public benefits, and more.

KEY ELEMENTS

**Partnership**
Union Station established MOUs and BAA with five hospital partners to ensure the effective co-location of PNs within hospital settings and enable data sharing.

**Communication**
Hospitals integrated PNs into internal staff meetings to enhance coordination & create direct relationships between hospital discharge staff, social workers, and the PNs.

**Data Access**
PNs have restricted, read-only access to hospital EHR systems with some capability to enter case notes; PNs also have access to the homeless services database (HMIS).
Patient Navigation Pilot Evaluation
The Center for Nonprofit Management will conduct an evaluation. Goals include exploring the overall effectiveness of the pilot across varying metrics, to demonstrate the value of the Patient Navigator positions to the health care and homeless services sectors, and to provide insight for future advocacy around the financial sustainability and scaling of cross-sector roles, especially as Cal AIM is implemented. The evaluation is expected to be completed by Spring 2022.

Value/Impact
Assessing the perceived impact of the pilot on patients and hospital/homeless service staff

Project Design & Implementation
Understanding how/whether partnerships, program design, and coordination worked to create a replicable program structure

Cost Effectiveness
Providing insight into how/whether the pilot reduced health care costs by meeting patients’ social, health, and/or housing needs

PROGRESS AS OF JULY 2021

- 139 patients connected to PNs
- 25 patients re-connected to homeless caseworker
- 27 patients receiving primary care via PN transport support
- 35 patients taken to DMV, SSA, & DPSS for documents and benefits enrollment

“The work of the patient navigators is incredibly, incredibly impressive. It’s a startling difference in the quality of outreach and actual follow-up.”
- Hospital Partner

STAFFING MODEL

Hospital Pair #1
Huntington Hospital & Methodist Hospital + USHS 1 FTE Patient Navigator

Hospital Pair #2
Kaiser Permanente Baldwin Park & Emanate Health + USHS 1 FTE Patient Navigator

Stand-Alone Hospital
Pomona Valley Hospital Medical Center + USHS 1 FTE Patient Navigator Supervisor

LEARNING & SCALING SOLUTIONS

Value/Impact
Assessing the perceived impact of the pilot on patients and hospital/homeless service staff

Project Impacts & Outcomes
Analyzing health and housing outcome data for patients served

Project Design & Implementation
Understanding how/whether partnerships, program design, and coordination worked to create a replicable program structure

Cost Effectiveness
Providing insight into how/whether the pilot reduced health care costs by meeting patients’ social, health, and/or housing needs

OUR PARTNERS

Health Care
Emanate Health
Health Consortium of Greater San Gabriel Valley
Huntington Hospital
Kaiser Permanente Baldwin Park
Methodist Hospital
Pomona Valley Hospital Medical Center

Homeless Services
Union Station Homeless Services
Los Angeles Homeless Services Authority

Funders
Well Being Trust
UniHealth Foundation