Evaluation of Health Pathways Expansion

Final Report

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harder + co | community research

United Way GREATER LOS ANGELES

HOME FOR GOOD POWERED BY UNITED WAY

Contents

Introduction

Health equity, a term often used when addressing access to health care, refers to the absence of unfair and avoidable differences in health among population groups defined socially, economically, demographically or geographically.[1] While many groups experience disproportionate health inequities, homelessness is not only a key driver of poor health outcomes, but is also often associated with shorter life expectancy, high morbidity, and increased use of acute hospital services.[2] Decreasing health disparities and improving health outcomes among people experiencing homelessness (PEH) will require equitable access to health care. Many inadequacies in the health care system in the United States result in PEH encountering barriers to accessing the medical care they need.

In Los Angeles County, and nationwide, the need to better connect PEH to health care became even more urgent during the COVID-19 pandemic, as medical providers were challenged to address ongoing health care needs and meet the demands of the pandemic. In response to this urgent need, a group of stakeholders from philanthropy and health care came together to develop the Health Pathways Expansion (HPE) program. HPE was designed to increase health care access and continuity for PEH, deepen partnerships between health and homeless services providers, and create a more integrated system of care. A total of 16 health care providers - including primary care, mental health care, and substance use treatment providers - from across Los Angeles County received funding to bring services onsite at interim shelters setup to protect PEH who were older and/or had underlying medical conditions, with priority given to Project Roomkey (PRK) sites, and through street-based services.

Background and Context

According to the January 2020 Point-In-Time (PIT) Count, on any given night there were at least 66,436 people in Los Angeles County experiencing homelessness.[3] Despite the fact that the homeless system has doubled the number of housing placements in the past three years with the support of Measure H and Proposition HHH, this was a 12.7 percent increase from 2019.[4] A history of systemic and structural racism, economic conditions, and the affordable housing shortage continue to contribute to the inflow of individuals, and families into homelessness.[5]

The COVID-19 pandemic exacerbated the already urgent need to move as many PEH into housing as possible, especially those at high risk of being hospitalized should they contract COVID-19. This included people over the age of 65 and those with underlying health conditions, such as respiratory issues, chronic diseases, or lowered immune system functioning. Los Angeles responded by establishing PRK (see callout box for a more detailed description of PRK). More than 6,000 people

Health Pathways Expansion Funders

The Health Pathways Expansion grants were made possible through investments and collaborations from the following partners:

- California Community Foundation
- California Health Care Foundation
- Cedars-Sinai
- L.A. Care Health Plan
- Providence
- UniHealth Foundation
- United Way of Greater Los Angeles

[1] World Health Organization. (2019, May 30). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3
[2] Stafford, A., & Wood, L. (2017). Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants. *International journal of environmental research and public health*, *14*(12), 1535. https://doi.org/10.3390/ijerph14121535
[3] 2020 Greater Los Angeles Homeless Count Results (lahsa.org).
[4] LA County did not complete a PIT count in 2021 due to the COVID-19 pandemic. See HUD Exempts Los Angeles From 2021 Unsheltered Point-In-Time Count (lahsa.org).
[5] 2020 Greater Los Angeles Homeless Count Results (lahsa.org).

received interim housing via PRK. PRK also included onsite supervision, supportive services, and three meals a day. In response to this urgent need, United Way of Greater Los Angeles developed the Health Pathways Expansion (HPE) program in partnership with a group of stakeholders from philanthropy and health care to increase immediate access to critical health care services at PRK sites (or nearby clinics with transportation support) to ensure the health needs of PEH were addressed while they sheltered in place. Throughout this report, we refer to "the HPE model" – which is defined as public-private partners doing the following:

- Providing funding to primary care and behavioral health providers serving PEH to mobilize healthcare services at PRK/interim shelter sites;
- Supporting coordination and collaboration between healthcare and homeless service providers at PRK/interim shelter sites;
- Creating the conditions to strengthen the system of care to be more integrated and accessible for PEH.

HPE's approach shares many key characteristics with the established field of street medicine, which brings services out of the clinic and provides care directly on the streets or encampments.[6] As with street medicine, the goal of HPE providers was to meet PEH where they are to prevent their medical conditions from deteriorating to the point of needing emergency care.

In addition, HPE activities were intended to create a more integrated system of care for PEH by strenghtening relationships among health care providers (including both primary care and behavioral health providers) and other homeless services providers. The level and quality of integrated care is often examined in three conceptual domains: Organizational, Treatment, and Care-Coordination/Management.[7]

- Organizational characteristics include structural aspects of the implementation of integrated care, such as the presence of explicit organizational philosophy related to integrated care, integrated health information systems and technology, and organizational policies and procedures intended to support integrated care.
- Treatment characteristics include both the presence and quality of the clinical implementation of integrated care. Some examples of characteristics in this domain include comprehensive identification of patient needs, holistic integrated care plan, integrated stage-appropriate treatment, and outreach.
- Care coordination/management characteristics include specific activities intended to increase access, improve health-related outcomes and decrease fragmentation of care. Specifically, this includes practices such as care coordination, laboratory and test tracking, referral facilitation and tracking, and medication reconciliation.

Project Roomkey

Project Roomkey (PRK) was a collaborative effort by the State of California, Los Angeles County, the City of Los Angeles, and the Los Angeles Homeless Services Authority (LAHSA) to secure hotel and motel rooms for the highest need individuals experiencing homelessness, including those who are at higher risk for health complications due to age or pre-existing health conditions.

By providing a way for PEH to stay inside, the project aimed to both protect high-risk individuals and prevent further spread of COVID-19 in the community, in turn helping protect the capacity of hospitals and the health care system.

[6] Withers, J. (2011). Street Medicine: An Example of Reality-based Health Care. *Journal of Health Care for the Poor and Underserved 22*(1), 1-4. https://www.muse.jhu.edu/article/414326.

[7] Center for Evidence Based Practices, Case Western Reserve University (2010). *Integrated Treatment Tool. https://case.edu/socialwork/centerforebp/sites/case.edu.centerforebp/files/2021-03/ipbh-itt.pdf*

HPE provided a total of $2.3 million in grants to 16 health care provider organizations, including 13 primary care providers and three mental health/substance use disorder (i.e., behavioral health) providers, to deliver care in PRK sites and other interim shelters and/or to provide street-based services. All grants began in August 2020, and grant periods ranged from 3–12 months, with all grant periods ending by June 30, 2021 (see Table 1 in Appendix 1 for a more detailed description).

Evaluation Objectives, Questions, and Data Sources

In this evaluation we explored the extent to which HPE achieved its key program objectives for PEH and health care and homeless service systems. We also identified key considerations for replicability and scalability of HPE as a health service delivery model more generally. HPE's primary program objectives spanned the individual and systems levels:

Individual-level objectives seek to improve health care for PEH on a one-to-one basis. The individual-level HPE program objective was:

1. **Increase health care access and continuity**. HPE was intended to increase access to health care and the continuity of care for high-risk PEH by bringing services to interim shelter sites. This evaluation describes the population of PEH who received health care, mental health, and substance use treatment services from HPE providers, and the connections HPE providers were able to foster between clients and health-related services.

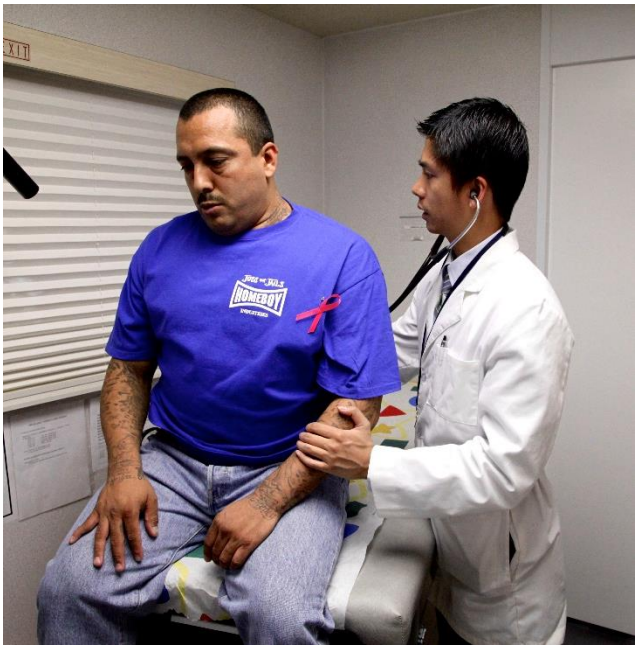
Systems-level objectives focus on improving care for PEH more broadly through changes in large-scale practices and policies. The systems-level program objectives for HPE were:

1. **Deepen connections between health care and homeless services providers.** The system of care for PEH is largely fragmented, disconnected, and uncoordinated. HPE was intended to deepen connections among providers as a first step to increase the quality and continuity of care available to PEH. This evaluation explores the successes and challenges experienced by health and homeless services providers in collaborating to serve PEH in interim shelters and through street-based services. Evaluation activities explored the presence and quality of integrated care along the three domains of organizational, treatment, and care coordination typically used to assess the presence and quality of integrated care.

2. **Create a more integrated system of care.** Ultimately, the goal of HPE was to create, pilot, and evaluate a flexible funding model for health service delivery that has the potential to innovate the current system of care for PEH in Los Angeles County and beyond. As the desire to improve health and housing outcomes for PEH remains a high priority among public and private stakeholders, it is important to identify the initiative's key lessons learned. This evaluation explores the key facilitators and barriers with respect to delivering health services in interim shelters and identifies key considerations for potentially scaling this model of service delivery more broadly.

Together, these individual- and systems-level evaluation objectives helped guide our approaches to data collection and analysis, shaped our understanding of the impacts of PRK's efforts, and determined where efforts can be focused moving forward to scale HPE as a health service delivery model.

Evaluation Questions



Specific evaluation questions for this study were developed in collaboration between the funding and evaluation teams within each of the core evaluation objectives:

Objective 1: Increase health care access and continuity for PEH

1. Who was served by HPE providers and what services did they receive? To what extent do the demographics and characteristics of those served align with the larger population of PEH in Los Angeles County?

2. How has HPE impacted the health and substance abuse outcomes of PEH? What housing-related outcomes result for those who were served by HPE?

Objective 2: Deepen connections between health care and homeless services providers

1. How do HPE providers describe their experience providing health care services in interim shelter settings or via street-based services? What do HPE providers report as the facilitators and barriers with respect to delivering services onsite?

2. How do HPE providers and homeless services providers describe coordinating and collaborating to serve PEH at PRK sites? What do they describe as being the key lessons learned for successfully partnering to serve PEH?

3. To what extent do HPE providers and homeless services providers believe that HPE deepened the connection between them and improved the accessibility of health care for PEH?

    a. How did this play out in cases where there were strong pre-existing relationships compared to new relationships? How has the way homeless services providers and HPE providers work together changed?

Objective 3: Create a more integrated system of care

1. What are the key considerations with respect to scaling and replicating this model of health care service delivery? To what extent do client health and housing outcomes show promise for this approach?

2. From a financial perspective, what structures exist to support scaling of the HPE model? How can safety net structures or government entitlement programs, such as Medi-Cal, support financing and reimbursing services provided under this model?

3. What considerations must be taken into account related to sustainability for HPE providers leveraging this model? What role can the private and philanthropic sectors play in creating and supporting a more integrated system of care?

Note: The evaluation questions and design were determined before the team was fully aware of the status of available data and the extent to which it could be analyzed to report on individual-client level health and housing outcomes. We include the original evaluation questions above to honor the intent to evaluate this aspect of the HPE

initiative, however we were unable to answer some questions due to lack of data.

Data Sources

This mixed-methods study utilized a combination of quantitative data (reported by HPE providers using online surveys) and primary qualitative data collected by the evaluation team via individual and small group interviews.

- **Grantee Reports.** We analyzed data from progress reports submitted to United Way of Greater Los Angeles (UWGLA) by the 16 HPE providers. Each grantee submitted up to five progress reports documenting its activities while receiving HPE funding. The reports summarized grantee work during each period, including number of clients served, client demographics and health conditions, and referrals made to other services. Data were reported at an aggregated level, meaning that total number of clients served and visits provided were reported by each grantee for each reporting period. This limited our ability in some cases to sum across reporting periods and to report program outcomes for subgroups. The lengths of the reporting periods differed between reports: Reports 1 and 2 spanned one month each, Reports 3 and 4 spanned two months each, and Report 5 spanned four months. See Appendix 1 for a detailed presentation of data by grantee over time and Appendix 2 for additional data limitations.

- **Comparative Data.** To understand the population that HPE served, we compared the demographic and health characteristics of HPE clients to those of clients served by PRK overall and the greater population of PEH in Los Angeles. The overall PRK sample included 3,749 adults who enrolled in and exited from PRK between April and November 2020.[8] The greater population of PEH in Los Angeles data came from the annual PIT count conducted by the Los Angeles City and County Continuum of Care (CoC) on January 22, 2020.[9] We compared characteristics of these samples with characteristics of HPE clients in grantee Report 3 (covering October and November 2020) because this report presents data from all HPE providers and a relatively large number of clients (n=1,530), and because it overlaps in time with the available PRK sample.

- **HPE Provider Interviews.** Individual and small group interviews were conducted with HPE providers (n=16). These interviews were used to understand successes and challenges of program implementation from the lens of providers. Additionally, the interviews incorporated topics that aided the evaluation team's understanding of how well this model worked in supporting more integrated service provision for PEH, including implications around the relationship between services providers and how that impacted integration. The interviews also informed evaluation recommendations that speak to the scalability and replicability of the HPE model, as well as HPE grantee perceptions about sustainability of continuing to do similar work beyond the HPE grant. We used thematic coding to identify themes within and across the provider interviews.

[8] Max Stevens and Andrew Perry. "Older Adults Sheltered through Project Roomkey: An Initial Analysis of their Characteristics and Service Use Patterns." Los Angeles County Chief Executive Office. April 2021.
[9] US Department of Housing and Urban Development. "CoC Homeless Populations and Subpopulations Reports." https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/

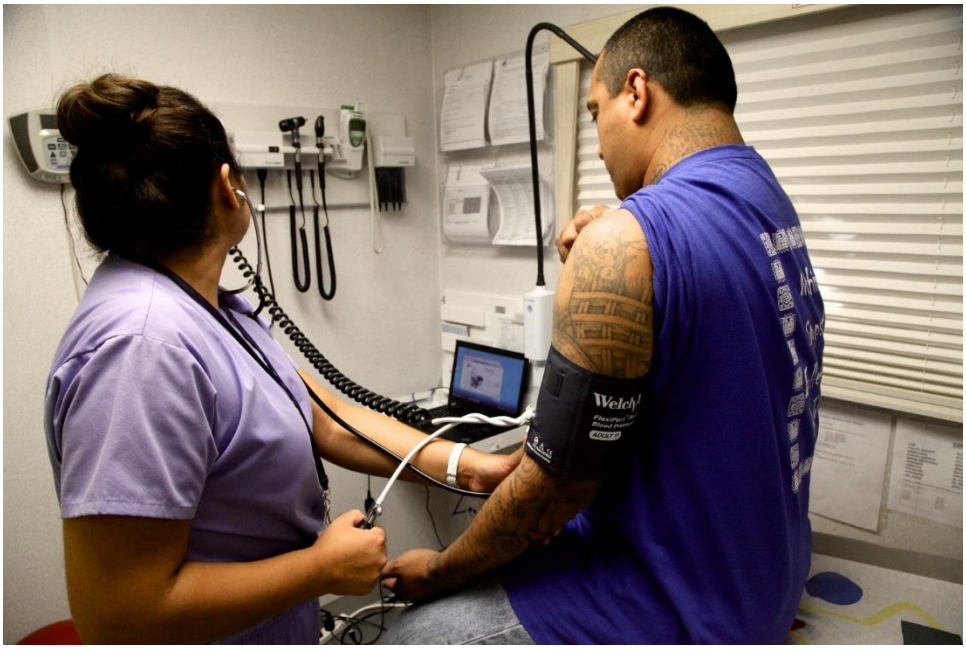
Note: This evaluation design did not include data collection with persons experiencing homelessness, which we acknowledge is a limitation and does not allow us to fully report on HPE's impact on clients from their perspective. Due to the COVID-19 pandemic and closure of PRK sites during the data collection period, and the fact that many PRK sites had been demobilized by the time the evaluation began, the evaluation team and funders prioritized data collection with providers.

Homeless Service Providers Case Studies

As part of the evaluation, we planned to integrate the perspective of homeless services providers as case studies throughout this report. A case study approach allows us to examine the experience of selected homeless services providers in-depth in the context of the HPE grant. To that end, we identified a sample of homeless services providers based on the following criteria:

- Homeless services providers that worked at multiple PRK sites being served by HPE providers
- Homeless services providers that had a long history of onsite services and/or providing street medicine services
- Homeless services providers serving sites where HPE providers reported serving the largest number of clients

Homeless Services Provider Interviews. Two interviews were conducted with homeless services providers that worked at PRK sites during the HPE grant period. These structured interviews explored the homeless services providers' experiences working in partnership with HPE providers and perspectives on bringing integrated care to emergency and interim shelters, such as PRK sites.



Service Delivery and Implementation

A key component of this evaluation was to understand and describe primary care, mental/behavioral health, and substance abuse treatment service delivery at PRK sites under the HPE grant. We leveraged grantee reports and interview data to provide insight into how services were launched and ramped up at sites across LA County, as well as implementation successes and challenges, amid the rapidly changing environment created by the COVID-19 pandemic.

Launch and Ramp Up at Project Roomkey Sites

- **The HPE grants supported rapid and more complete entry into PRK sites.** Most sites served by HPE were PRK hotels and motels in seven of Los Angeles County's eight Service Planning Areas (SPAs). Exhibit 1 shows the number of PRK sites served by HPE providers in each SPA. HPE providers reported the grant allowed them to enter PRK sites quickly and robustly. While some HPE providers had been serving one or a few clients they previously established care with, HPE allowed for entry into the site to serve the broader population experiencing homelessness. Some HPE providers also expressed appreciation that grant funding came with fewer restrictions than funding from government agencies, which supported their ability to be flexible and provide a wider array of client supports.

Exhibit 1. Project Roomkey sites served by HPE providers in Los Angeles County Service Planning Areas (SPAs).

NOTE: Data from UWGLA tracking of Project Roomkey sites.

- **Some HPE providers experienced staffing challenges early on.** These challenges included recruiting and hiring qualified staff while launching services at PRK sites. Some HPE providers attributed this to the general shortage of qualified health care and human service personnel at the height of the COVID-19 pandemic. In their final reports, HPE providers were asked to rank the following challenges from most to least impactful: coordination, bureaucratic, logistical, and staffing. Although some HPE providers alluded to staffing as a hurdle in the interviews, among the 12 HPE providers that filled out a final report, none said that staffing was their number one challenge over the course of the grant.[10] Two listed staffing as their second biggest challenge, one listed it as their third biggest challenge, and two listed it as their fourth biggest challenge.

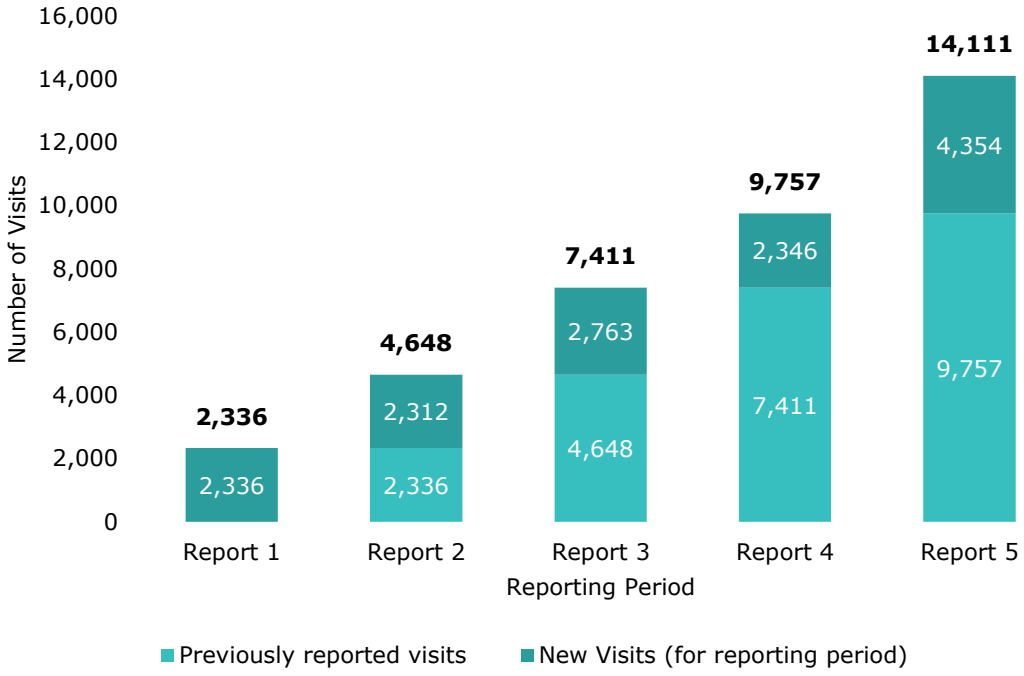
- **HPE providers developed a range of strategies to reach onsite clients.** Some HPE providers noted that having a presence onsite made services readily accessible. However, other HPE providers needed to conduct active outreach to make PRK clients aware of and comfortable with accessing those services. A few HPE providers noted challenges with getting PRK clients to leave their rooms to set-up or attend appointments. Outreach strategies included hosting information tables, distributing fliers, and resident engagement in common areas of the site. HPE providers underscored awareness and relationship building as mechanisms for engaging clients in services/treatment.

Service Delivery

- **HPE served 3,581 first-time clients and provided 14,111 health care visits.** In each progress report, grantees reported number of first-time clients served, number of returning clients served, and number of health care visits provided. Over the course of the grant period, 3,581 first-time clients were served, and 14,111 health care visits were provided by the 16 HPE grantees (see Exhibit 2). We were unable to report total unique clients served over the course of the grant period because unduplicated client counts were not reported.

[10] Grantees completed two types of reports: a progress report and a final report. The final report asked the same questions as the progress report as well as additional reflection questions, including asking grantees to rank the challenges they faced. Due to an administrative error, four grantees filled out a progress report instead of a final report for their last reporting period and therefore did not respond to this question.

Exhibit 2. First-Time Visits, Previously Reported Visits, and Cumulative Visits by Reporting Period (All HPE providers)

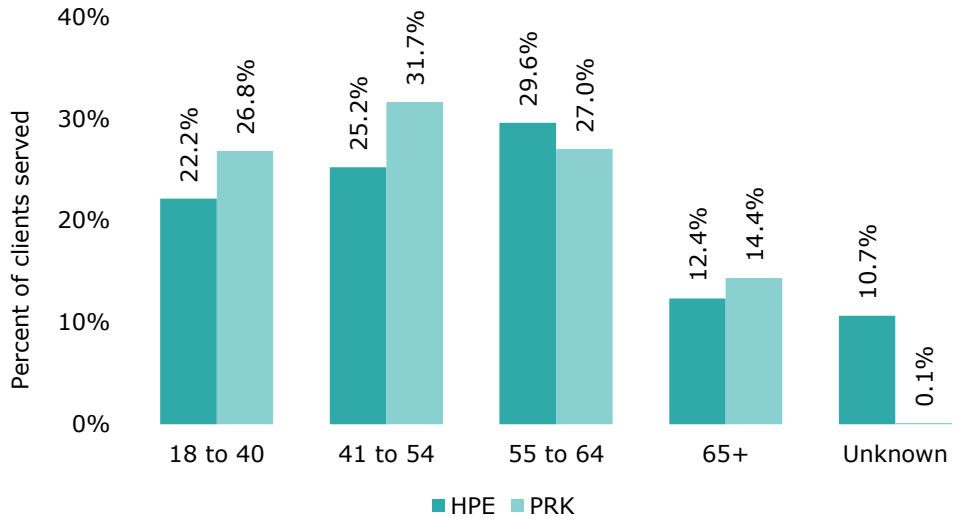


- **HPE served clients who represented a subset of PEH in greater Los Angeles County.** PRK was designed to prioritize enrolling individuals with the highest need, including those who are at higher risk for health complications due to age or pre-existing health conditions. As a result, the demographic and health conditions of HPE clients may reflect the higher level of need associated with those enrolled in PRK. However, grantees also served interim shelters and provided street-based services, which may mean they reached a wider population of PEH. To gain a better understanding of who HPE was reaching, we examined data released by Los Angeles County on PRK enrollees as well as the larger population of PEH. Here we compare HPE, PRK, and LA County PEH (where possible). However, due to the amount of missing age and race/ethnicity data in the HPE grantee reports (see Exhibits 3 and 4) and different measures of race/ethnicity and health conditions between the data sets, conclusions drawn from these comparisons should be treated cautiously.

    - The age distribution of HPE clients was similar to the overall population of PRK enrollees (Exhibit 3).[11]

[11] This does not account for the 10.7 percent of HPE clients for whom no age data were reported in Report 3.

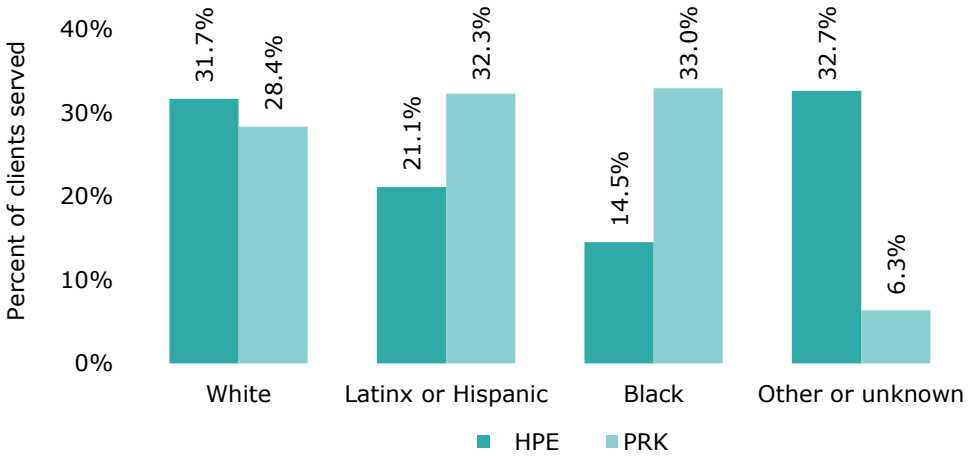
Exhibit 3. Percentage of HPE and PRK Clients by Age Category



Note: Analysis of HPE clients from grantee Report 3 (for October and November 2020), (n=1,530) and PRK clients who enrolled in and exited from PRK between April and November 2020 (n=3,749).

- Compared to the PRK population, a smaller proportion of HPE clients were identified as Black (14.5 percent versus 33.0 percent) and Latinx/Hispanic (21.1 percent versus 32.3 percent) (Exhibit 4). However, 32.7 percent of HPE clients in Report 3 were identified as being of another race/ethnicity or had no identifying racial/ethnic data compared to only 6.3 percent of the PRK population examined.[12]

Exhibit 4. Percentage of HPE and PRK Clients by Race/Ethnicity



Note: Analysis of HPE clients from grantee Report 3 (for October and

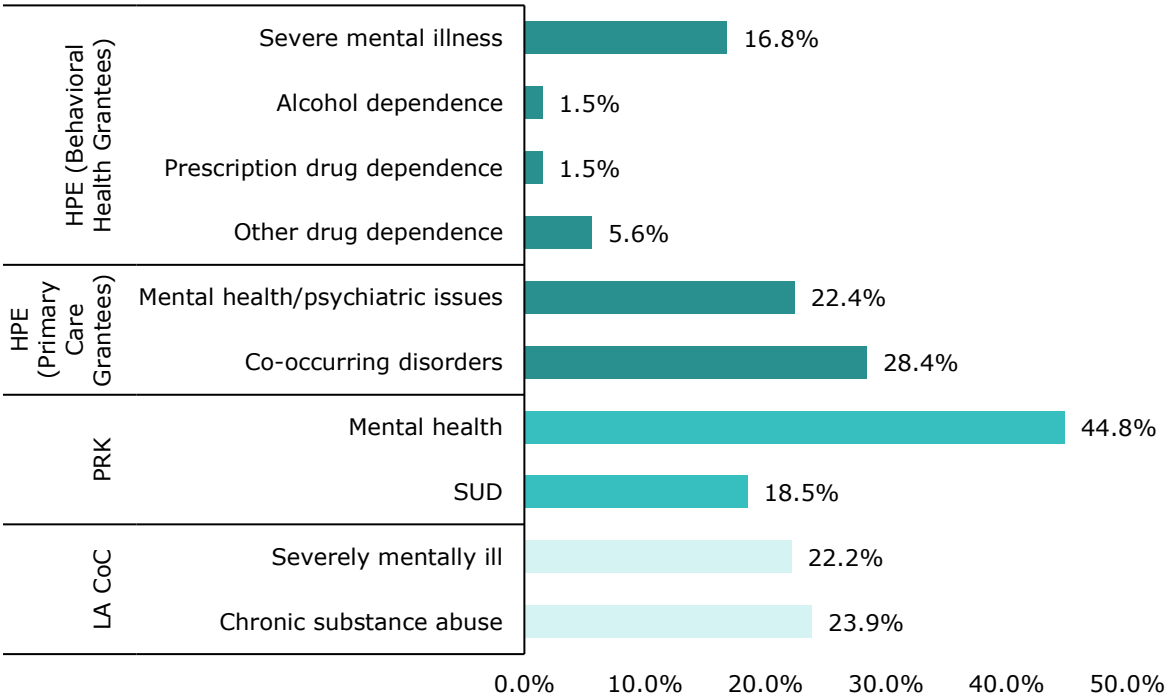
[12] Because age and race/ethnicity categories used in HPE progress reports and PIT count reporting were different, we were unable to compare HPE clients and the Los Angeles County Continuum of Care population on age and race/ethnicity.

November 2020), (n=1,374) and PRK clients who enrolled in and exited from PRK between April and November 2020 (n=3,749)

- **A large proportion of HPE clients were age 55 or older and high rates of clients experienced serious physical and behavioral health conditions.** Data on the demographics and health conditions of HPE clients indicates that the program achieved its goal of serving PEH with serious physical and behavioral health conditions.

    - Significant proportions of HPE, PRK, and the greater Los Angeles populations of PEH had mental health issues. Due to differences between HPE, PRK, and CoC data in terms of the mental health conditions identified in the data, direct comparisons across populations are not possible. However, 22.4 percent of HPE clients served by primary care providers had mental health/psychiatric issues, 28.4 percent of HPE clients served by primary care providers had co-occurring disorders, and 16.8 percent of HPE clients served by behavioral health providers had a severe mental illness (Exhibit 5). By comparison, 22.2 percent of the larger Los Angeles City and County Continuum of Care Population from the annual PIT count had a serious mental illness and 44.8 percent of PRK enrollees had a mental health condition.

Exhibit 5. Percentage of Clients with Behavioral Health Conditions for HPE Behavioral Health Providers, HPE Primary Care Providers, PRK, and LA CoC Populations



Note: Definitions vary by program. Analysis of HPE clients from grantee Report 3 (for October and November 2020), (n=1,374) and PRK clients who enrolled in and exited from PRK between April and November 2020 (n=3,749). LA Continuum of Care data are from January 2020 (n= 63,706).

Implementation Successes

Grantees identified and described the successes of HPE based on their unique

experiences. Across grantees, the following themes emerged:

- **The HPE grant allowed HPE providers to connect with "harder to reach" clients and serve the site more comprehensively.** Many HPE providers described being able to reach more PEH than they would have been able to reach from their primary clinic or office location. Since PRK sites focused on housing the most vulnerable PEH, this enabled HPE providers to connect in-person with them to establish a relationship and understand their needs. Some HPE providers also reported being able to provide site-wide services to both site staff and clients, including services like overdose prevention kits and education and health insurance enrollment.

- **HPE broke down barriers to accessing medical, mental/behavioral health, and substance abuse treatment services.** HPE providers generally agreed that the HPE model improved service accessibility by eliminating barriers like transportation, lack of insurance coverage, and difficulties in scheduling and attending appointments. HPE was also generally successful in assisting uninsured PRK clients with accessing insurance coverage since most HPE providers facilitated enrollments in health plans such as Medi-Cal or My Health LA and connections to primary care medical homes.

    - **Telehealth played an important role in service delivery when sites entered lockdowns and quarantines.** Based on analysis of grantee reports, 10 out of 16 HPE providers used telehealth to serve HPE clients. Although telehealth became widely adopted throughout the pandemic, it did not come without challenges. HPE providers reported that implementing telehealth came with logistical challenges such as lack of access to stable broadband and IT support, lack of devices and technical proficiency to use them among clients, and lack of HIPAA compliant space to conduct telehealth visits. Some HPE providers also reported that although telehealth has many benefits, especially in times of lockdown and quarantine, it does have disadvantages in terms of the intensity of care providers can give clients when compared to in-person visits.

    - **HPE providers were successful in establishing medical homes for many PRK clients, thereby breaking down barriers for clients previously unable to access coordinated care opportunities.** Medical homes deliver patient-centered, comprehensive, coordinated care to patients. Based on analysis of grantee reports, HPE providers established medical homes for 2,968 clients throughout their work on the HPE grant.

- **HPE providers agreed that being onsite supported relationship development with PEH.** Many HPE providers reported that being onsite regularly resulted in increased opportunity to develop and deepen relationships with their clients, many of whom were very high need. HPE providers reported that relationship and rapport building with clients was a big factor in their decision to participate in services and being onsite allowed them to better engage and build trust with clients and address their unique needs and concerns.

HPE At a Glance: Service Statistics

According to HPE Grantee Reports, services at PRK sites totaled:

3.5K	First Time Clients Served
14K	Total Healthcare Visits
2.6K	Medical and Social Service Referrals
2.9K	Medical Home Establishments
1.9K	Medi-Cal Enrollments

Based on analysis of grantee progress reports, primary care providers made 2,693 referrals.

These included:

- **1,401** referrals to specialty care
- **454** referrals to mental health services
- **470** referrals to dental/oral health services
- **217** referrals to substance use disorder services
- **151** referrals to nutrition and/or other lifestyle change

Implementation Challenges

- **HPE providers reported logistics were sometimes difficult, and factors like physical space, equipment, and scheduling did present challenges.** Many HPE providers reported that they sometimes lacked adequate or safe working space and equipment (i.e., lab equipment), which made providing services difficult. Another logistical challenge mentioned by many HPE providers was scheduling and coordination with either the homeless services provider running the site or other medical or behavioral health providers working with clients. Some HPE providers noted that lack of coordination sometimes resulted in confusion about roles and schedules. In their final reports, HPE providers were asked to rank the following challenges from most to least impactful: coordination, bureaucratic, logistical, and staffing. Six HPE providers ranked coordination as their number one challenge, two HPE providers ranked logistics as their number one challenge, and one grantee ranked bureaucracy as their number one challenge.

- **HPE providers noted that mandatory quarantines and site closures disrupted the momentum of services.** Many HPE providers noted that they experienced either temporary or permanent site shutdowns, sometimes very soon after rollout of the HPE grant. This required HPE providers to transition to a new site or wait until the site reopened, which took a long time in some cases. Some HPE providers also reported serving sites that experienced COVID-19 outbreaks and were required to go into mandatory lockdown/quarantine. This required the HPE providers to pivot to telehealth services on short notice.

Referrals and Insurance Enrollment

- **Most HPE providers reported conducting health insurance enrollments, and most often enrolled PEH in Medi-Cal or My Health LA.** Many HPE providers had the internal capacity and expertise to facilitate insurance enrollment and navigation at PRK sites during intake with new clients. HPE providers noted that applications and enrollment are most often through Medi-Cal. In some instances, HPE providers mentioned enrolling patients in My Health LA when they were ineligible for other types of coverage. Based on analysis of grantee reports, HPE providers enrolled 1,961 clients in Medi-Cal, My Health LA, or other insurance coverage throughout their work on the HPE grant.

- **While many HPE providers successfully facilitated insurance enrollments at PRK sites, some noted barriers that make the process challenging.** Common challenges arose in the administrative process of applying for insurance coverage, for example, identifying a viable address or having a valid form of identification (see callout). A few HPE providers also noted relationships as being a key factor in getting clients engaged with and amicable to the enrollment process. For example, one grantee noted "it [takes] awhile to build the rapport and for patients to trust us [with their information]."

- **HPE providers reported that referrals were most often made for clients to receive a form of specialized medical and behavioral health care.** HPE providers noted often referring patients to specialty medical providers, mental or behavioral health programs, or substance abuse and recovery providers when a need was identified (see callout box on page 12 for more information on referrals). In some cases, providers

Note on Medi-Cal Eligibility Verification

California residency is a requirement for Medi-Cal eligibility. Documents showing CA residency and identity are needed for eligibility verification. However, the DHCS provider manual states that "the address on the document need not be the current address" and "document provided by a homeless person must be considered even if it does not include an address for the applicant/beneficiary."

A variety of documents can be used for ID, but a California driver's license or ID card issued by DMV is the first choice (Medi-Cal Eligibility Provider Manual, Article 4: Application Process). Covered California has a list of documents that can be used as proof of identity. Covered California's mail-in application requires a mailing address, but not a home address.

could refer within their organization or clinic, and in other cases needed to refer and follow up with an external provider. HPE clients who had an existing primary care provider (PCP) that was different from the HPE provider sometimes experienced delays in the referral process, since this required additional coordination between the HPE provider and the PCP. HPE clients were not required to change their PCP to receive services.

Data Tracking and Documentation

- **Nearly all HPE providers reported using an electronic health record (EHR) system to document client information and service data.** HPE providers widely employ various types of EHR systems to track client information and service delivery. EHRs were critical for enabling HPE providers to track client characteristics and services/treatments provided. In some instances, EHRs enabled multiple providers at some PRK sites to collaborate in addressing clients' needs. HPE providers also relied on their EHR systems to fulfill reporting requirements to UWGLA and other funders. Some HPE providers mentioned difficulty with grant reporting initially due to reports being monthly. However, this challenge was largely resolved once reporting shifted to every two months.

Provider Collaboration Successes and Challenges

- **HPE providers had mixed experiences working with the homeless services providers running PRK sites.** As previously mentioned, six HPE providers ranked coordination as their number one challenge. This may reflect some of the issues that HPE providers had coordinating with homeless services providers that ran the sites where HPE providers delivered care. While many HPE providers had positive experiences working with the homeless services providers running the PRK sites (some of which they had previous working relationships with), some HPE providers experienced challenges with communication and coordination. Breakdowns in communication sometimes resulted in HPE providers being unable to access sites. Some HPE providers also noted that frequent staff turnover on the homeless services providers' end made it challenging to establish a strong working relationship and stable lines of communication.
    - **Some HPE providers reported that a memorandum of understanding (MOU) was a helpful tool for formalizing partnerships at PRK sites.** These HPE providers reported establishing MOUs with homeless services providers ahead of receiving the HPE grant, which enabled the partnership to ramp up quickly at the site once funding was awarded. Some HPE providers also mentioned establishing MOUs for continued work in serving PEH once the HPE initiative concluded and PRK sites closed.

- **HPE providers also noted the importance of strong connections to and coordination with other onsite HPE providers**. Many HPE providers noted the benefit of having other health care and behavioral health providers onsite, which created opportunities for coordinated care and streamlined referrals. One HPE primary care provider reported that this supported provider collaboration because "a holistic approach to care and care plan is a common language. We were able to describe very quickly what [care] was going to be needed [for a patient] on our end. [Other providers at the site] were able to [support that plan] because we speak the same language". Unfortunately, a few HPE providers reported not having strong communication or coordination with other providers,

such as the Department of Mental Health or other medical service providers, which created confusion and discontinuity for clients.

- **HPE providers shared key strategies for establishing strong relationships with homeless and other types of service providers**. HPE providers reported using the following strategies to establish or strengthen relationships with homeless services providers running PRK sites: 1) scheduling a meet-and-greet with both higher level administrative and frontline staff upon rollout, 2) identifying points of contact when issues arise, and 3) scheduling regular check-ins among all providers onsite to discuss logistics and ensure operations run smoothly.

A shared commitment to a trauma-informed approach key to effective partnership

For nearly 50 years, Union Station Homeless Services has helped adults and families facing hunger, homelessness, and poverty in the Los Angeles and San Gabriel Valley areas. During the HPE grant period, Union Station served The Garvey Inn and Lincoln Plaza PRK sites in partnership with the USC Street Medicine Team. This partnership flourished, at least in part, because both organizations shared a deep commitment to the use of a trauma informed approach and as such, to treat PEH with respect and dignity. Trauma informed care recognizes and responds to the signs, symptoms, and risks of trauma to better support the health needs of patients who have traumatic experiences.[1]

The day-to-day presence of health care providers on-site, made possible by HPE funding, allowed health care service providers to build authentic relationships with PRK residents and Union Station staff. PEH developed trusting relationships with health care providers which allowed for more consistent care. In contrast, Union Station Homeless Services staff interviewed highlighted how many PEH report a history of negative experiences receiving emergency care in hospitals – "a lot of our clients are afraid to go see doctors or go to hospitals. They've had terrible experiences with these providers, going to hospitals or going to their primary care physician and them not taking it serious or dismissing them." The Union Station staff also recalls "I've gone to a hospital where they won't even touch them [PEH]." Too often, PEH are discharged from hospitals or emergency departments without treatment or a clear post-hospital care plan that recognizes the complexities of their lives.[2] The partnership between Union Station and USC Street Medicine ensured that the care people received at PRK sites recognized their past history of trauma, current living situation, and goals for the future.

The HPE initiative not only facilitated more effective care for PEH by enabling on-site triaging and treatment, referral, and support, but also allowed homeless services providers to focus on the things they do best. Union Station staff noted that in non-HPE sites, "[The lack of on-site health services] made case management very difficult, the main focus got [away] from case management and housing barriers, and instead it was like 'let's just keep you safe and alive' whereas at the PRK sites they had nurses to go and do wellness checks." This freed up the staff to work with residents to address other needs, including removing barriers to permanent housing, education, and job training, and connecting with social supports.

Key Lessons Learned:

- Being trauma informed was a key part of effectively bring a human-centered approach to services for PEH.
- The success of on-site services for people experiencing homelessness requires rapport building with patients and setting a trusting relationship with providers.
- Providing on-site medical and social services to PEH creates a sense of consistency that is often not present when services must be accessed at different locations.

[1] Trauma Informed Care. (2021, May 7). National Coalition for the Homeless. Retrieved January 21, 2022, from https://nationalhomeless.org/issues/trauma-informed-care/
[2] Jenkinson, Jesse et al. "Hospital Discharge Planning for People Experiencing Homelessness Leaving Acute Care: A Neglected Issue." *Healthcare policy = Politiques de sante* vol. 16,1 (2020): 14-21. doi:10.12927/hcpol.2020.26294

Outcomes and Opportunities to Sustain the Impact of HPE

The HPE initiative was intended to increase PEH's access to primary care, mental/behavioral health, and substance abuse treatment services at PRK sites at the height of the COVID-19 pandemic. In addition, the grant was intended to deepen the relationships between health care and homeless services providers in pursuit of more integrated approaches to care for PEH. Because we lacked quantitative data on health and housing outcomes, we used grantee interviews to understand outcomes for both PEH and the providers working together to serve this population at PRK sites.

Integrated Care, Outcomes for Persons Experiencing Homelessness

- **HPE providers reported important outcomes for PEH at PRK sites** include re-engagement in care or treatment, positive interactions with service providers, and referrals/linkage to specialized care or other supportive services. While clinical or medicalized outcomes are being tracked in electronic health records systems, HPE providers reported that a more proximal outcome is reengagement in care or treatment for unmanaged conditions, with the ultimate goal of ongoing or sustained care that supports long-term health and wellbeing.

- **HPE providers also reported that establishing relationships and having positive interactions with providers** are important outcomes considering "there's so much institutional mistrust, understandably, among PEH." HPE providers also reported that because of the relationships they developed, this allowed for PEH to feel seen and heard, sometimes for the first time.

- **HPE providers reported that bringing services onsite reduces barriers to accessing medical and behavioral health services.** HPE providers largely agreed that "meeting clients where they are" is a powerful strategy. Since this approach eliminates the need for transportation and allows for more intensive relationship building, HPE providers agreed that it supports the health and wellbeing of the most vulnerable PEH in LA County. In addition to providing primary care services, some HPE providers were also able to host vaccine clinics onsite for the seasonal flu, tuberculosis, as well as COVID-19 once it was available in early 2021. One grantee also noted a possible reduction in COVID-19 vaccine hesitancy among HPE clients more specifically, given the relationships and trust they had developed with the onsite providers.

- **HPE providers reported that the HPE model allows for more integrated care, including real-time referrals to other HPE providers, case management, and Medi-Cal enrollment services.** Many HPE providers noted that the ability to refer to other onsite HPE providers who provide complementary or more intensive services with a "warm handoff" was an important benefit to clients. HPE providers reported that being onsite also

"It gave us the opportunity to connect with more individuals, not just the ones that come into the clinic or the outreach that we do. It helped us connect immensely with other individuals that are out there experiencing the same situation. But it's just different because sometimes [PEH are] reluctant to ask for help, or they're reluctant to come into a clinic. So that's why I think it gave us the ability to be able to connect at another level with them, where we met them at these motels. It helped us bridge that gap."

-HPE Provider

allowed for more intensive and streamlined case management since clients are more readily accessible and likely to engage with staff that they have strong relationships with.

HPE Provider-Focused Outcomes

- **HPE providers reported that the grant allowed them to establish or deepen relationships with other organizations** – which in some cases created opportunities for continued partnership**.** Some HPE providers reported that HPE resulted in new or deepened relationships with either homeless services providers or county departments like LAHSA, the Department of Mental Health, or the Department of Health Services – which they believed to be a benefit. In a few instances, HPE providers entered into MOUs with homeless service organizations to continue their partnership after HPE had concluded and PRK sites closed.

- **Some HPE providers reported that the grant allowed them to test or strengthen new or existing mobile team approaches to offer more intensive care at interim shelter sites.** While many HPE providers reported that they encountered logistical and coordination challenges to some extent, HPE providers were also appreciative of the opportunity to pilot a new field-based approach in response to the pandemic. For providers who had an established field-based or street medicine model, it afforded them the opportunity to reach more clients in PRK sites and serve sites more comprehensively.

- **Some HPE providers reported that they were able to extend their impact to the broader site** by providing education to the homeless services providers, specifically around substance abuse overdose. Since some PRK sites were considered "low barrier," meaning that substance use was allowed onsite, instances of client overdose did occur. HPE's substance abuse treatment providers reported having the opportunity to educate staff on overdose prevention and response as well as providing supplies like fentanyl test strips and Narcan kits.

"We're really grateful that we had this experience because it's been something we've been thinking of and [the HPE grant] allowed us to basically test drive [this approach to serving persons experiencing homelessness]."

-HPE Provider

Intent to Continue Field-Based Services

- **Most HPE providers served PRK sites until they closed or were planning to continue serving the site in some capacity until it was phased out.** At the time of grantee interviews, some PRK sites had closed or were in the process of transitioning to Project Homekey sites, which means services from HPE providers had concluded. For those sites that were still open and were served by HPE, HPE providers reported planning to serve the site in some capacity until it closed later in 2021.

    - **There was difficulty, in some instances, anchoring long-term care when PEH move back to their original communities.** Some PRK participants were housed at sites that were geographically distant from where they had been previously living. Subsequently, some PRK participants expressed the desire to return to their home community once PRK ended if they weren't provided permanent housing. In these cases, HPE providers expected that they may not be able to provide ongoing care for HPE/PRK participants that move out of their immediate service

areas. These concerns were exacerbated by what felt like rapid demobilizations at some PRK sites which did not afford opportunity for longer-term care planning. A longer, more intentional demobilization process would allow time for providers to better address some of these concerns.

- **Some HPE providers reported being interested in continuing to explore new and different approaches to field-based services.** For some HPE providers, HPE was an opportunity to pilot a field-based service approach beyond their brick-and-mortar locations. Based on their experience implementing services at PRK sites and the ongoing need to find better ways to serve PEH, some HPE providers expressed interest in continuing to explore possible approaches to meeting clients where they are. Mobile clinics were noted as a potential approach among a few HPE providers, along with the key considerations that come along with running a mobile clinic, such as licensing requirements and capital startup costs.

    - **Most providers reported not planning to partner with a Project Homekey site at the time of interview.** Some HPE providers noted that they would be open to exploring the possibility of partnering with a Project Homekey site in the future and looked forward to learning more about these opportunities and related funding. Some HPE providers were also unclear about when Project Homekey sites will become operational, where they will be located, and whether health care services would be integrated onsite.

Key Considerations for Sustaining Field-Based Services

- **HPE providers reported that key considerations for sustaining onsite or field-based services include funding, workforce, and relationships with other health and social service providers.** HPE providers acknowledged that identifying a combination of public and private funding and reimbursement for services rendered is one of the most important elements of sustaining onsite field-based services for PEH.

    - **Some HPE providers noted that costs for mobile vans, equipment/supplies, and administrative support are not reimbursable through Medi-Cal.** A few HPE providers reported being interested in exploring the telehealth van approach, but acknowledged the capital needed to purchase and maintain the vehicle as well as secure the proper licensing to operate it as a barrier. Additionally, supplies, medical equipment, and the administrative support to provide field-based services are costs that would likely not be covered by any reimbursement mechanism, which means it would likely require the flexibility of grant funding.

    - **Some HPE providers acknowledged finding highly qualified staff is a challenge due to comparatively low salaries in nonprofit health care.** While having staff that are willing and qualified to provide high-quality health care to PEH is a key aspect of working towards integrated care for this population, it can be challenging for FQHCs and nonprofit health care organizations when the demand for health care workers is high across the board (even more so amidst the pandemic) and salaries are not as

Medi-Cal Reimbursement

State Medicaid programs are required to cover services provided by FQHCs, regardless of whether they are an enrollee's primary care physician. If a Medi-Cal managed care plan enrollee presents themselves to an FQHC for treatment, the FQHC can render services and submit a claim to the Medi-Cal program. However, the FQHC must redirect the patient back to their in-network provider and document the referral in the patient's medical records.

In California, Medi-Cal managed care plans may set their own payment rates with FQHCs and must reimburse FQHCs at a rate paid equal to similarly contracted non-FQHC providers. If the rate paid by an Medi-Cal managed care plans is lower than the rate paid by Medi-Cal's prospective payment system, the state provides an FQHC with a "wrap-around" payment equal to the difference between the prospective payment system and Medi-Cal managed care plan rates.

competitive when compared to privatized health care.

- **Time to build and maintain relationships with other health and social service providers is important.** Effective collaboration with other health and social service providers at PRK sites was key to providing meaningful services and improving the health and wellbeing of PEH. HPE providers emphasized that having time to build relationships with other providers was important.

Cal-AIM's Potential to Impact Care and Services for PEH

California Advancing and Innovating Medi-Cal (Cal-AIM) is a package of interrelated reforms proposed by California's Department of Health Care Services (DHCS) to improve health care and outcomes for Medi-Cal enrollees.[13] It focuses on addressing the needs of complex, high-need patients, including people with co-occurring medical and behavioral conditions, chronic illnesses, and disabilities. As designed, Cal-AIM would integrate Medi-Cal's different health care delivery systems—including systems that deliver physical health care, mental health care, and substance use disorder treatment—to provide more seamless access to needed services and provide non-medical interventions that target social determinants of health. DHCS states that these reforms would ultimately improve health outcomes and reduce health care costs among Medi-Cal enrollees.

While multiple Cal-AIM reforms could improve health care and outcomes among PEH, the following Cal-AIM reforms could be especially impactful:

- In Lieu of Services (ILOS): ILOS are non-medical services that can substitute or reduce the need for more costly medical services, such as hospital, skilled nursing facility, or emergency department care. Beginning in 2022, specific ILOS would be covered by Medicaid managed care plans. These ILOS would include some services that could help PEH or people at risk of homelessness to find housing and stay housed. Examples include housing transition navigation services, such as development of a housing support plan and assistance securing benefits like SSI or Section 8 vouchers; housing deposits, such as security deposits and setup fees; housing tenancy and sustaining services, such as coordination and dispute resolution with landlords; and short-term post-hospitalization housing for people with high medical or behavioral health needs. Although ILOS would not include rent payments or room and board, they could help reduce homelessness and related medical problems among Medi-Cal enrollees.

- Enhanced Care Management (ECM): ECM is intended to be a collaborative, interdisciplinary approach to managing patient care. Under Cal-AIM, Medicaid managed care plans would identify enrollees who could benefit from ECM and contract with community-based providers who have ECM expertise. These providers would coordinate all services needed by ECM beneficiaries, including medical services and ILOS. ECM would target specific populations, including PEH and people at risk of homelessness.

Billing for Street Medicine

DHCS recently issued clarification on billing guidelines for Medi-Cal providers engaged in street medicine. DHCS affirmed that providers can determine presumptive eligibility for Medi-Cal outside of hospitals and clinics, through mobile clinics, street teams, or other locations. Presumptive eligibility allows clients immediate access to temporary, no-cost services while they apply for permanent Medi-Cal coverage. DHCS also clarified the place-of-service codes that may be billed to Medi-Cal when rendering services for street medicine. These include homeless shelters, mobile medical units, and temporary lodging, such as a hotel or campground where the patient receives care. DHCS may publish updates on billing and other policy related to street medicine on its provider news webpage.

[13] This summary is based on the most recent publicly available version of the Cal-AIM proposal: California Department of Health Care Services. "California Advancing & Innovating Medi-Cal (CalAIM) Proposal." California Department of Health Care Services, January 2021. https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-1-8-21.pdf.

ECM would be implemented in some counties beginning in January 2022 and statewide beginning in 2023. This reform could help ensure that PEH can access needed services and that different kinds of services for PEH are well integrated.

Other Cal-AIM components would reward Medicaid managed care plans with incentive payments for quality and performance improvements; integrate management and financing of mental health and substance use disorder care at the county level; and improve the continuum of behavioral health care from inpatient to community-based settings. These reforms could improve access to care and quality of care for high-need Medi-Cal enrollees, including PEH.

HPE was intended to increase health care access and create a more integrated system of care for PEH. By connecting different kinds of health care services and providing services that address the social determinants of health, Cal-AIM could help future programs like HPE to achieve their goals.

Turning it around: from crisis response to accessible and integrated care for PEH

The COVID-19 pandemic highlighted the layers of complexity and racism in our existing health care system. In addition, it made clear how challenging it is for specific groups, such as people experiencing homelessness (PEH), to access primary and mental/behavioral healthcare services. Building on the street medicine approach, the integrated care brought to PRK sites served as an opportunity to meet PEH where they are and in turn remove many existing barriers to accessing care.

For decades, the Salvation Army has been providing services to PEH in the Greater Los Angeles area. When the Salvation Army entered five PRK sites across the county -- LA Grand, Quality Inn, Signal Hill, Sunrise Hotel and America's Best Value Oak Park -- they quickly recognized the opportunity, given the design of PRK, to respond immediately to many of the needs of PEH on site through coordinated and collaborative efforts with the HPE grantees and other key entities. The first step in organizing the collaborative work was aligning on the desired outcomes for partnership and identifying roles, since all the providers on-site brought different expertise and approaches to serving this population. The Salvation Army's staff shared that "once we were able to see what everybody's level of expertise was and how we could become more powerful by learning how to work together, it was then when we understood 'this is how you're an asset.'"

The collective knowledge and on-site nature of the HPE program allowed staff to more closely monitor and promptly address the needs of PEH, successfully fostering a more integrated system of care for individuals living at the PRK sites. About this, the Salvation Army's staff added: "I don't think there was one [provider] more important than another. I just think that all were equal in some sense because we wouldn't have been able to make it if we would have had a missing component." Working in partnership and collaboration with health care providers funded by the Health Pathway Expansion initiative including East Valley Community Health Center, Homeless Health Care Los Angeles, St. John's Well Child and Family Center, and Harbor Community Health Centers, the GoRN nurse teams, and the Department of Mental Health, allowed for more comprehensive and effective care to be offered to PEH, whose care is often provided piecemeal.

Key Lessons Learned:

- Working collaboratively with multiple service providers for PEH significantly improves each providers' ability to support clients more holistically.
- Addressing and clarifying the roles and expertise of each entity providing services on-site is imperative for effectively delivering services in settings such as PRK sites.
- Setting boundaries and prioritizing clear communication became key in successfully working together.
- Having multiple providers on-site allows for close coordination with case managers to plan for a client's transition into housing once their more immediate needs have been met and they have been stabilized.
- Centering the humanity of PEH and recognizing the complexity of their needs is key to supporting and serving this population.

Recommendations

The evaluation of HPE provided an opportunity to hear from the front-line health care workers who served PRK clients. Their collective successes, challenges, and lessons learned were used to craft the following recommendations for Providers, Funders, and Systems Partners, and recommendations to strengthen data collection and evaluation of future efforts.

Recommendations for Health Care and Social Service Providers

HPE was a responsive initiative that, in the end, was perceived by participating providers as being effective at expanding care access to PEH. Yet, some of the challenges experienced by health care providers, especially in terms of collaboration with other health providers and onsite social service providers, could have been mitigated by paying more attention to the existing literature and documented best practices on integrated care. Our recommendations center around some of these best practices.

- **Engage organizational leaders and use intentional strategies to develop relationships with other providers.** Integrated care requires intentional relationship building and ongoing communication among all who provide care and services[14], but not all PRK sites were able to develop the relationships necessary to foster true integrated care. Sites that were most successful in this regard reported having formal meetings between organizational leaders in advance of delivering care onsite, which set the stage for better collaboration by onsite staff. Creating space for this relationship at the outset results in more seamless service delivery and a more positive experience for onsite staff across the board. Both the integrated care literature and anecdotal data from interviews illustrate that when organizational leaders know one another they leverage these relationships to address challenges that arose onsite, allowing for more effective problem-solving and resolution.

- **Prioritize data sharing to enhance care coordination.** Concerns related to HIPPA and the short-term nature of HPE created reluctance among some health care providers to put robust data sharing mechanisms in place. However, having a shared EHR is a well-established best practice in integrated care hat results in better coordination of care across providers and better health outcomes for clients[15]. Several HPE providers were able to work through data sharing challenges in ways that allowed social service providers to upload information directly into their EHR system. Invest the time at the front end of initiatives like this to establish meaningful data sharing systems. If access to the EHR is not feasible, then develop another way to track services and share information about clients.

- **Develop communication and coordination protocols.** The conditions

[14] Center for Evidence Based Practices, Case Western Reserve University (2010). *Integrated Treatment Tool. https://case.edu/socialwork/centerforebp/sites/case.edu.centerforebp/files/2021-03/ipbh-itt.pdf*
[15] Ibid.

at HPE sites changed rapidly, primarily due to the pandemic (specifically COVID-related quarantines) but also incidents of social unrest after the murder of George Floyd, all of which severely impacted service delivery. Sites without strong systems of communication and clear communication protocols that were shared among LAHSA, social service providers, and HPE experienced challenges coordinating their services in general. This was even more acute during emergency response conditions and resulted in confusion and frustration for providers who showed up and either had no clients to serve or were unable to serve clients with pressing needs. Communication protocols and systems should be developed at the outset of the work, before services launch, to support care during emergencies or unusual conditions.

Recommendations for Funders and System Partners

HPE providers appreciated the flexible funding and support received through the grant and identified other ways in which HPE funders could support their work.

- **Create a "home base" for HPE providers to access information and assistance and to create a community of practice.** Given the rapidly changing landscape of service delivery in PRK sites, HPE providers really valued the opportunity to share information with and hear from their peers in the field. They appreciated the grantee convenings that were held and wished that the funders had done more to hold this space for them. Some suggestions include setting up a closed website where they could get and share information and more regular (i.e., monthly or quarterly) and issue specific "community of practice" type virtual convenings. HPE providers were often "building the plane as they were flying it" and would have benefitted from more time and space to learn together.

- **Leverage position as a convener to promote relationship development across orgs, county, and city departments.** Funders bring relationships and credibility to the table. HPE grantees would have appreciated funders taking a more active role to promote the partnerships needed to do this work across organizations and the county and city departments in the jurisdiction of each PRK site. This may have created a "shortcut" in the relationship building phase that would have been especially helpful in a responsive initiative like PRK/HPE.

Recommendations to Strengthen Reporting and Evaluation

HPE providers appreciated that the grant reporting requirements for this project were modest given the challenging service delivery context. However, as noted earlier (and more fully detailed in Appendix 2), the streamlined reporting format limited our ability to evaluate some of the key outcomes of HPE with precision, such as the specific services received by clients and outcomes for different subgroups of clients, which subsequently limited our ability to conduct equity-focused analyses. Here we offer recommendations for data reporting that would allow for more robust evaluation of outcomes and lessons learned from future programs.

- **If feasible, report individual-level data.** Future providers could be asked to report on the demographics, health conditions, and services received by each client in each reporting period. In health care settings,

these data may be captured in EHRs and health care claims from providers to payers. While extracting and transmitting these kinds of data to an external evaluator in a useable form is challenging in a rapid-response project like HPE, establishing data sharing agreements between providers and the evaluator at an early stage in the evaluation would minimize these barriers. Importantly, sharing these kinds of data across organizations requires technical safeguards and legal agreements that the evaluator should have the experience and capacity to implement. Alternatively, providers could report de-identified data (i.e., data without direct personal identifiers such as names and health record numbers) to a central database, possibly maintained by a funder or external evaluator. This would require setting up a database, assigning unique IDs to clients served by different providers, ensuring that unique IDs were used consistently (which may be challenging when serving PEH), and agreeing on a reporting format. These activities would require planning and incur costs. However, such a database would provide much greater flexibility for evaluation and answering important questions but might be infeasible for a rapid-response project.

- **As a second-best solution, use a data collection template that helps HPE providers report complete and valid data.** This could be an Excel file where HPE providers enter total clients and clients by subgroups, set up such that it displays an error message if the number of clients in each subgroup does not sum to total clients. This would require some advanced planning and user testing but could greatly improve data completeness and validity. We would also recommend asking about the total unique clients served by each grantee over the course of the grant in order to be able to calculate the total number of individuals reached by grantees.

- **In the data collection instrument, provide definitions for terms that respondents might misinterpret, especially health conditions.** This would improve consistency and confidence in the data.

- **Identify priority service provision, outcome and impact measures in advance and ensure data collection tools and process are aligned with those measures.** While the responsive nature of HPE meant that things needed to move quickly on the service side, it also meant that the evaluation team was engaged when the initiative was nearly over. Consider retaining a professional evaluator, even if for a few hours, to provide consulting around data collection tools and measures prior to beginning data collection. This would ensure that priority outcomes and impacts can be adequately assessed while the full evaluation procurement process proceeds. Additionally, for categorical variables we recommend checking the categories used against those employed by other agencies and researchers whose data might be used in comparisons, such as the Los Angeles CoC.

- **Standardize the length of reporting periods whenever possible.** Requesting data from HPE providers at consistent intervals will allow for better comparison across time periods.

- **Collect data about the services provided to clients.** This would provide insight into the needs of PEH and allow reporting on an important set of program outcomes.

Appendix 1: Data Tables

Table 1. Grantee participation and Data Reporting Timeframes

Grantee	Approved Project Length	2020 Aug.	Report 1 Sept.	Report 2 Oct.	Report 3 Nov.	Dec.	2021 Report 4 Jan.	Feb.	Report 5 Mar.	Apr.	May	Jun.
Primary Care Providers												
Central City Community Health Center[a]	3 months		■	■	■							
East Valley Community Health Center	4 months		■	■	■		■					
Center for Family Health & Education	6 months		■	■	■		■					
JWCH Institute, Inc.[b]	6 months*		■	■	■		■		■	■	■	■
Keck School of Medicine USC Street Medicine[c]	6 months		■	■	■		■					
Los Angeles Christian Health Centers[d]	6 months		■	■	■		■					
St. John's Well Child and Family Center	6 months		■	■	■		■					
Venice Family Clinic	6 months		■	■	■		■					
Saban Community Clinic[e]	4 months*		■	■	■		■					
Community Health Alliance of Pasadena	6 months*		■	■	■		■		■	■	■	■
Harbor Community Health Centers	7 months*		■	■	■		■		■	■	■	■
Central Neighborhood Health Foundation[f]	12 months		■	■	■							
Northeast Valley Health Corporation	12 months		■	■	■		■		■	■	■	■
Behavioral Health Providers												
Southern California Health & Rehabilitation[e]	4 months		■	■	■							
Tarzana Treatment Centers, Inc.	7 months*		■	■	■		■		■	■	■	■
Homeless Health Care Los Angeles	12 months		■	■	■		■		■	■	■	■

NOTE: Unless otherwise stated, the grant term started July 29, 2020. July-August 2020 was considered a startup period and was not included in Report 1. *Project contract was extended during the course of the program. [a] Project ran 3 months from August 19, 2020, to November 19, 2020. [b] Grant term started on August 4, 2020. [c] Grant term started on July 22, 2020. [d] Grant term started on August 1, 2020. [e] Grant term extended due to delays in starting.
[f] This grantee initially identified themselves as a behavioral health provider in Report 1 but subsequently reported being a primary care provider in future reports. Their initial contract length was 12 months but was shortened to 5 months during the period of the grant.

Table 2. Report availability for HPE providers and exclusions due to data quality.

Grantee	Report 1	Report 2	Report 3	Report 4	Report 5
Primary medical care providers					
Center for Family Health & Education	✓	✓	✓[a]	✓	-
Central City Community Health Center	✓	✓	✓	-	-
Central Neighborhood Health Foundation	b	✓	✓[c]	✓[d]	-
Community Health Alliance of Pasadena	✓	✓	✓	✓	✓
East Valley Community Health Center	✓	✓	✓		
Harbor Community Health Centers	✓	✓[c]	✓	✓	✓
JWCH Institute, Inc.	✓	✓	✓	✓	✓
Los Angeles Christian Health Centers	✓	✓	✓	✓	
Northeast Valley Health Corporation	✓	✓	✓	✓	✓
Saban Community Clinic	✓	✓	✓	✓	-
St. John's Well Child and Family Center	✓	✓	✓	✓	-
Keck School of Medicine USC Street Medicine	✓	✓	✓	✓	-
Venice Family Clinic	✓	✓	✓	✓	-
Number of reports (primary care)	*12*	*14*	*14*	*11*	*4*
Behavioral health providers					
Central Neighborhood Health Foundation	✓[b]				
Homeless Health Care Los Angeles	✓	✓[e]	✓	✓	✓
Southern California Health & Rehabilitation Program	✓	✓	✓	-	-
Tarzana Treatment Centers, Inc.	✓	✓	✓	✓	✓
Number of reports (behavioral health)	*4*	*3*	*3*	*2*	*2*
Number of reports (all HPE providers)	*16*	*17*	*17*	*13*	*6*

- Report period after end of grantee's contract.

[a] Counts of individuals were unexpectedly large for some race categories; data on race were therefore excluded. For example, the grantee reported serving 1,535 Latinx/Hispanic individuals, but the total number of individuals served across all age groups was only 175.

[b] The grantee reported being a behavioral health provider in Report 1 and a primary care provider in subsequent reports. They were therefore included in behavioral health analyses for Report 1 and primary care analyses for Reports 2 and 4. Responses were missing for Report 3 (see footnote c).

[c] The grantee submitted two reports in reporting period two on separate days; we excluded the earlier report from analyses and treated the later report as an update or revision to the earlier report. Responses were similar but not identical across the two submissions.

[d] The grantee's contract ended at the conclusion of the reporting period covered in Report 3. They subsequently submitted a Final Report for Report 4 that was identical to what they had submitted in Report 3. We did not include this data in our analyses.

[e] Responses were available only for questions related to primary medical care providers, although the grantee reported being a behavioral health provider. Hence, although three behavioral health HPE providers submitted reports in reporting period 2, data on behavioral health-specific questions are available for only two HPE providers. The responses provided by this grantee to primary care questions were dropped from analysis.

Appendix 2: Health Pathway Expansion Service Data Fact Sheet

Service Data

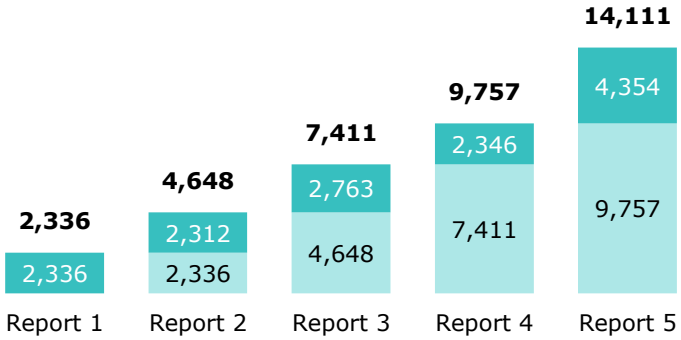
Over the course of the grant period, **3,581 first-time clients** were served, and **14,111 health care visits** were provided by the 16 Health Pathways Expansion (HPE) providers.

1,961 **clients enrolled in Medi-Cal, My Health LA, or other insurance coverage**

2,968 **medical homes established for clients throughout their work on the HPE grant.**

10 out of 16 HPE providers reported using telehealth services to serve HPE clients

# of First-Time Visits, Previously Reported Visits, and Cumulative Visits by Reporting Period (All Grantees)



Primary care providers made **2,693 referrals**, including:

1,401 referrals to specialty care

454 referrals to mental health services

470 referrals to dental/oral health services

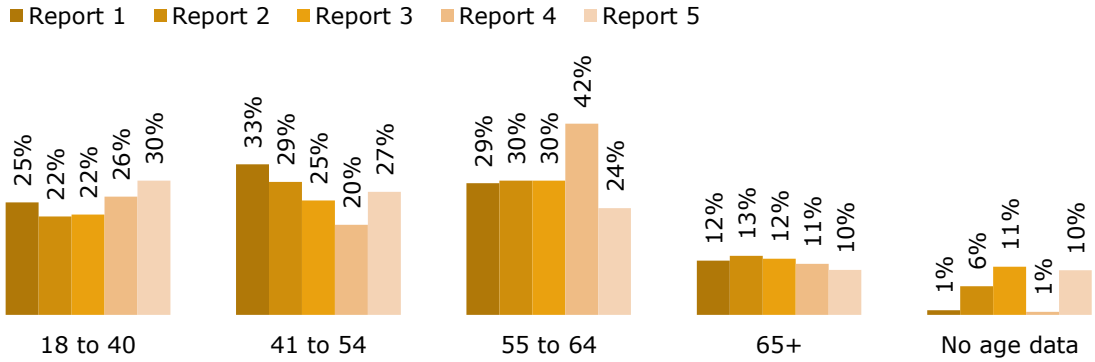
217 referrals to substance use disorder services

151 referrals to nutrition and/or other lifestyle change resources

Clients

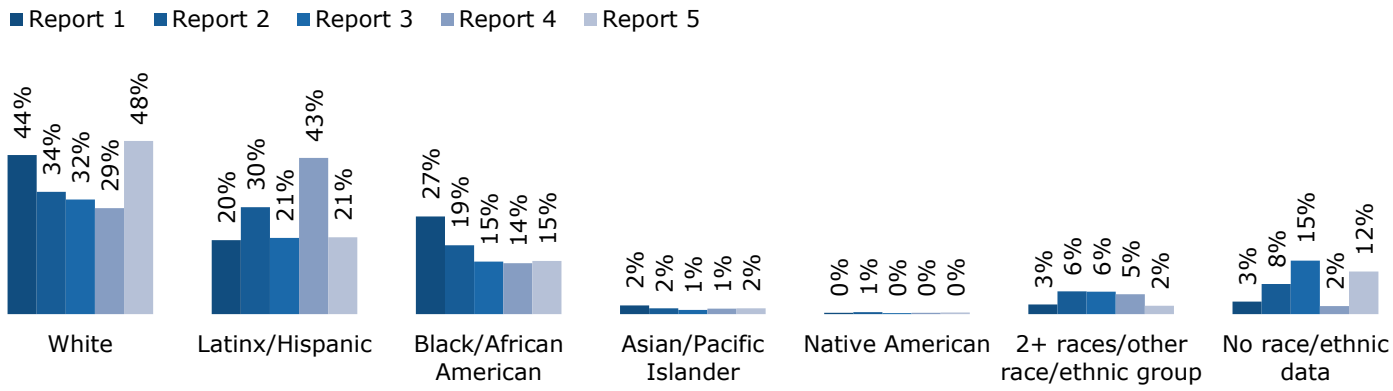
Many clients served by HPE providers were ages 55+

% of Clients by Age Category and Reporting Period (All Grantees)



Clients who identified as **white formed the largest racial/ethnic group served** by HPE providers in most reports (Reports 1, 2, 3, and 5). Clients who identified as **Latinx/Hispanic** were the second largest racial/ethnic group served by HPE providers in Reports 2, 3, and 5, and the largest group in Report 4. Clients who identified as **Black** formed the second largest racial/ethnic group in Report 1 and the third largest group in all other reports.

% of Clients by Race/Ethnicity and Reporting Period (All Grantees)

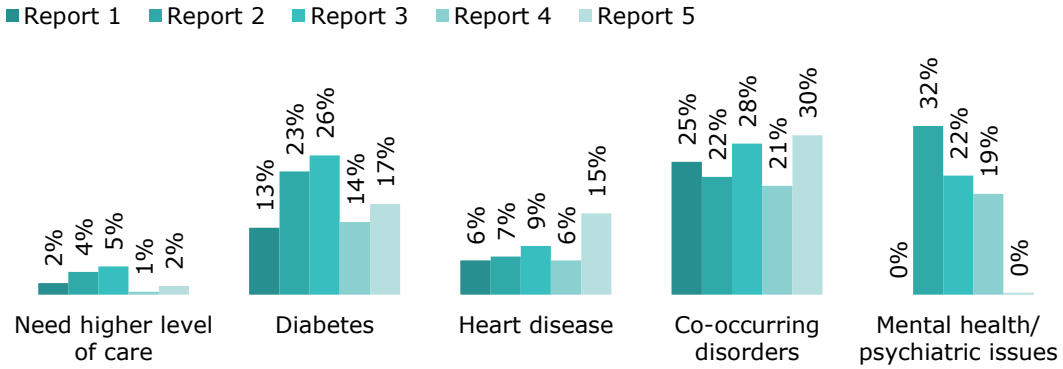


Primary Care

Primary care providers reported that a high proportion of clients served had diabetes, heart disease, co-occurring disorders, and mental health/

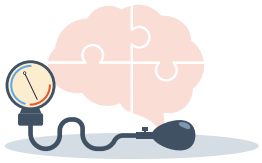
psychiatric issues.

% of Clients with Reported Health Conditions Served by Primary Care Grantees

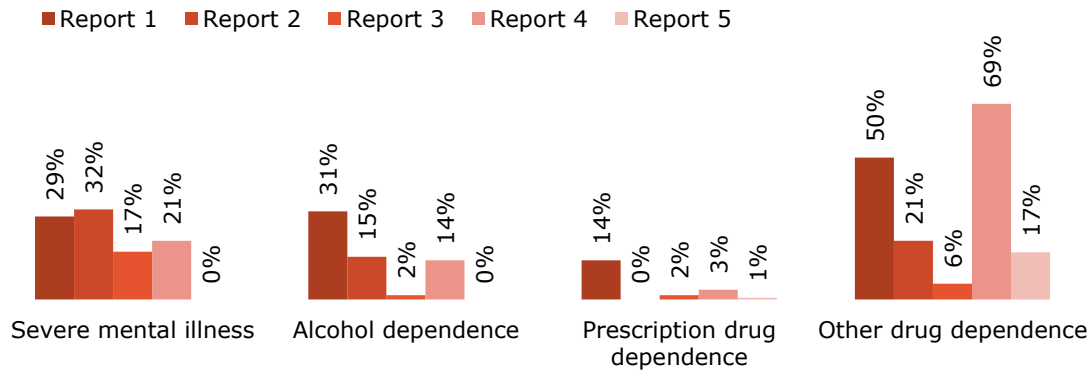


Behavioral Health Care

Collectively, behavioral health providers served a high proportion of patients with severe mental illness, alcohol dependence, and other drug dependence.



% of Clients with Reported Health Conditions Served by Behavioral Health Care Grantees



Appendix 3: Data & Reporting Challenges

We recognize that HPE funders were eager to learn about the impacts of HPE services on the health outcomes for participants. While the grantee progress reports were effective tools for gathering data to describe the work of HPE in the aggregate, they had some limitations that impeded our ability to fully assess the impact of HPE services. These limitations are detailed here to support learning for future efforts. We also offered recommendations for future data collection efforts in the recommendations section of the report.

- **Grantees were asked to report data in the aggregate, which made it impossible to link client characteristics to individual clients.** HPE providers were not asked to report client-level data. Rather, they were asked to report total new clients and total returning clients in each reporting period, as well as total clients in each age and race/ethnicity group and total clients with different kinds of health conditions and referrals. This method of data reporting introduced several challenges for analysis. First, we were often unable to sum across reporting periods without potentially double counting some clients. Second, we could not conduct subgroup analyses (e.g., percentage of clients with diabetes by race/ethnicity group) or otherwise describe associations between variables (e.g., between race and health conditions) because we lacked individual-level data. This limited our ability to report on equity impacts and other important outcomes.

- **Demographic data were incomplete.** In each reporting period, the total number of clients for whom responses on age and race/ethnicity were available—including clients for whom the response was "no data"—was below the reported total number of clients served as calculated by summing the counts given by HPE providers for "number of individuals served that were current or previously enrolled patients" and "number of first-time individuals served (unduplicated contacts and visits)." The percentage of clients with responses for age and race/ethnicity ranged from 70 percent to 91 percent of the latter measure of total number of clients served across report periods. The percentage of clients with responses for age and race/ethnicity varied among HPE providers. Moreover, some HPE providers reported large percentages (ranging from 20 percent to 100 percent among those that included clients in the "no data" category) of clients with a response of "no data" for race/ethnicity in some periods.

- **Denominators for calculating percentages were not clearly defined.** For example, when calculating the percentage of clients by race/ethnicity groups, the total unique number of clients for whom race/ethnicity was reported was unknown. As an alternative, we used total clients with age responses (including "no data" for age) as the denominator for this calculation. Due to missing race/ethnicity data and the option for HPE providers to report more than one race/ethnicity for each client, the race/ethnicity percentages do not sum to 100 for all periods. To compute rates of health conditions and referral to other services, the appropriate denominator was also unclear. For consistency with the demographic data,

we again used total clients with age responses as the denominator for these calculations. While other denominators available in the data could have been chosen (e.g., the total number of individuals served), we found the age total to be the most consistent and reliable both within and across HPE providers.

- **Other omissions or errors affected the completeness of results.** There were several instances of data entry and user errors. There were multiple cases of HPE providers submitting more than one report in a reporting period and in each case, we excluded the earlier report from analyses and treated the later report as an update or revision to the earlier report. Responses were similar but not identical across the two submissions. As mentioned above, there were also inconsistencies within HPE providers regarding the number of clients served and the number with reported demographic data. For one grantee in Report 3, the errors were too large to include them in the analysis of client demographic data, as they reported serving 1,535 Latinx/Hispanic individuals but gave a total number of individuals served across all age groups of only 175 for that reporting period. Finally, there were two cases where HPE providers were given the wrong set of questions based on their provider type. One of these instances was due to user error (a grantee reported they were a behavioral health grantee when they were actually a primary care provider) and in the other case it was a technology error where the grantee was shown the questions for primary care providers even though they reported being a behavioral health grantee. These data entry and user errors led to the exclusion of HPE providers from all or some of the analyses for a reporting period, which limits our ability to confidently discuss trends and reduces the reliability of some of the findings.

- **The length of time between reporting periods differed.** Reports 1 and 2 span one month each, reports 3 and 4 span two months each, and Report 5 spans four months. This made it challenging to compare changes over time. Coupled with the lack of individual level data, this limited our ability to identify short-term issues that may have arisen during the longer reporting periods, particularly as some HPE providers experienced closures and service disruption due to quarantines over the course of the grant.

- **The survey used to collect grantee progress reports did not include definitions for health conditions or referrals.** For example, behavioral health HPE providers were asked to report the number of individuals with severe mental illness. However, the term "severe mental illness" was not defined, leaving open the possibility that HPE providers may have interpreted this term differently. Similarly, HPE providers were asked to report the number of individuals with "co-occurring disorders" without this term being defined. These missing definitions allow for different interpretations by HPE providers. As a result, data on health conditions or referrals may not be directly comparable across HPE providers.

- **HPE providers were not asked to report on the kinds of services clients received, an important outcome of the program.** While HPE providers reported on clients' health conditions, reports did not capture whether those conditions were treated during visits or were referred out to other specialists for treatment. Without a clear picture of the types of services that HPE providers provided or individual level data where we could track clients over time, we are limited in our ability to discuss any clear health outcomes that may have been affected by the program.

Acknowledgements

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