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# SPA 3 PATIENT NAGIVATION PILOT

A collaborative effort in the San Gabriel Valley to connect people experiencing homelessness exiting hospital emergency rooms to shelter & housing.

## 2020-22 Evaluation Report

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## Introduction

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Los Angeles County continues to face a growing housing and homelessness crisis. The COVID-19 pandemic not only deepened disparities, but also exposed the inequity felt across many communities, especially the unhoused. The homeless population grew to 67,197 in 2020, which is an 18.7% increase in three years. The largest growth, in this time period, occurred among unsheltered homeless, at a rate of 24.4%. As homelessness increases throughout LA County, hospitals are increasingly confronted with complex health and housing needs of patients in emergency departments on a constant basis. In 2020, 4% of all hospital emergency visits in Los Angeles County were by homeless patients (a total of 113,903 visits)<sup>1</sup>.

Efforts to strengthen coordination between healthcare systems and homeless services are vital to improving both health and housing outcomes for people experiencing homelessness. The patient navigation model yielded positive results, as evidenced through pilot programs, and past investments point to an increasing need for comprehensive coordination of care and supports between hospitals and homeless services to improve outcomes for unhoused patients. However, hospitals did not adopt it broadly across the County due to the prevailing misconception that the model would not be effective until challenges around data sharing, lack of recuperative care beds, and improved coordination to access shelter/housing resources were addressed first.

As a response, The SPA 3 Patient Navigation (PN) Pilot was developed and spearheaded by United Way of Greater Los Angeles's Home for Good Initiative which unifies the community around a bold vision of ending homelessness in L.A. County. The PN Pilot pioneers approaches, coordinates across diverse, multi-sector coalitions, and scales the most transformative and equitable solutions. It is a groundbreaking cross-sector effort between the Union Station Homeless Services (USHS) and five San Gabriel Valley hospitals to address some of these challenges, particularly around housing coordination and other resources. The project brings together the need to coordinate services between two sectors that understand very little about each other – homelessness and healthcare.

The PN Pilot was designed to support post-discharge care coordination and 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. With coordination support from the Health Consortium of the Greater San Gabriel Valley (HCGSGV), hospital and homeless service partners co-designed, planned, and implemented an 18-month pilot program from October 1, 2020 through June, 2022 by increasing service capacity with three full time Patient

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<sup>1</sup> Emergency Department Volume and Capacity by Facility, Health Category and Health Professional Shortage Area (2019). Last accessed at [www.hcai.ca.gov](http://www.hcai.ca.gov).

Navigators embedded within hospital teams and workflows, and connecting target patients to shelter/housing placements, primary care services, public benefits, and more.

To better capture the overall impact and value of the pilot, project partners collaborated with the Center for Nonprofit Management (CNM). CNM conducted a formal evaluation to explore the overall effectiveness of the pilot across varying metrics, to demonstrate the value of PN positions to health care sector, and to provide insight for future advocacy around financial sustainability of cross-sector role. This report serves as the summary of findings.

## **How the Pilot Program Works: An Overview**

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The United Way of Greater Los Angeles (UWGLA) San Gabriel Valley (SGV) Patient Navigator Pilot program provided case management services to 110 high-utilizing hospital patients. These patients are homeless or at-risk of homelessness. The program connects with them post-discharge to effectively create linkages with housing services, healthcare (e.g., medical homes, mental health, oral health, substance use disorder services, etc.) and other related services.

Pilot project partnership centered around 5 hospital partners that referred patients to Union Station Homeless Services (USHS) to provide the post-discharge support to patients with these linkages. Union Station established Memorandums of Understanding (MOUs) with the 5 hospital partners to ensure commitment and the effective co-location of Patient Navigators within hospital settings and enable data sharing.

Hospital partners included:

1. Emanate Hospital that included (Emanate Health Foothill Presbyterian Hospital, Emanate Health Queen of the Valley, and Emanate Health Intercommunity Hospital)
2. Huntington Memorial Hospital
3. Kaiser Permanente Baldwin Park
4. Methodist Hospital of SoCal
5. Pomona Valley Hospital

The key project components are:

### **1. Patient Navigators**

Two Patient Navigators were hired as full-time employees to work “in the field” across four hospitals in SPA 3, with two hospitals assigned to each navigator. A half-time navigator was added when a fifth hospital joined the pilot six months into implementation.

Patient Navigator's core responsibilities were to:

- Provide case management for approximately 25 patients identified as high utilizers of hospital services who are experiencing homelessness. Patients were identified by participating hospitals. Parameters included: Patients who have an average two or more ED or inpatient visits a month, patients known for routinely seeking services in multiple hospitals, patients who present at hospitals frequently for non-emergency needs, etc.
- Provide case management to patient pool until they are placed and stabilized in shelter and/or housing and are regularly connecting with a medical home for primary care services.
- Create consistent/standardized processes for referrals and information sharing around patients with local clinics and other key partners by building relationships and formalizing partnerships.
- Host/lead case conferencing meetings with local partners (clinics and homeless service providers) to action plan/share information and resources to target for the patient; strategize about what can be done for the patient in the future and share updates on housing.

The plan for this pilot project was to have hospitals integrate Patient Navigators into internal staff meetings to enhance coordination and create direct relationships between hospital discharge staff, social workers, and the navigators.

The first two months of the pilot served as a "ramp up period" where Patient Navigators received training on homeless services, onboarding by the hospitals(s), establishing relationships and developing workflow. Patient Navigators could also use that time to target a caseload list, map assets, and smooth out other process and procedures. Hospitals participated in periodic meetings with all project partners to share progress, challenges, and lessons learned during the duration of the pilot.

## **2. Resource coordination**

The pilot project explores a more comprehensive approach to care coordination. For hospitals with high volumes of patients experiencing homelessness, the Los Angeles Homeless Services Authority (LAHSA) funded a new Hospital Liaison position in each Service Planning Area (SPA) with one local homeless service agency serving as lead contractor in each respective SPA. Union Station Homeless Services is the contracting agency for Service Planning Area 3.

In the pilot, the SPA 3 Hospital Liaison helps patients experiencing homelessness discharge smoothly from participating hospitals to the L.A. coordinated entry system (CES), and subsequently, into stable and permanent housing. The Hospital Liaison acts as the "air-traffic controller" who receives referrals from partner hospitals and coordinates hospital Patient Navigators who work intensely with a cohort of patients using data and community

relationships. The Hospital Liaison provides high-level referral support (no caseload) to hospitals. The Patient Navigators, in turn, connects patients to homeless services and coordinates services for the homeless patients assigned to their care.

Among the many tasks performed, the Hospital Liaison:

- Builds relationships and identify opportunities for partnership with community health care providers;
- Convenes hospital partners and Patient Navigators monthly for case conferencing and problem-solving;
- Screens, tracks and monitors high frequency hospital homeless patients, and documents referrals for services and resources;
- Documents practices for shared learning; and
- Works closely with Patient Navigators, social workers and hospital discharge planners and provide technical assistance on homeless services.

### **3. Recuperative care, housing and other resources**

One of the goals of this pilot project is to facilitate a process of healthy recovery for pilot participants that is often jeopardized by homelessness. To provide this coordinated service at a lower cost than hospitals, Patient Navigators link participating patients to existing resources, linkages to housing, and resources that they otherwise may not access.



### **4. Data sharing**

Through this pilot, project partners would establish data sharing practices and standards wherein hospitals could, within the context of patient privacy and confidentiality, share with the Hospital Liaison and Patient Navigators certain types of information to allow greater coordination of care with hospital staff and other resources needs by the patient. Patient Navigators form an information hub to support healthcare and homeless service providers and make better informed decisions around comprehensive care of homeless patients. The Hospital Liaison and Navigators, by having access to patient information, can facilitate this care coordination across systems by leading and/or participating in case conferencing with homeless case managers and clinic-based care coordinators.

The plan for this pilot was to give Patient Navigators 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).

## Methods

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The Center for Nonprofit Management (CNM) conducted an evaluation of the pilot project to capture and understand the overall impact and value of the program by exploring the effectiveness of the pilot across varying metrics, demonstrate value of Patient Navigation positions to health care sector, and providing insight for future advocacy homeless sectors and provide insight for future advocacy around the financial sustainability and scaling of cross-sector roles. Given that the evaluation team joined the project 10 months into implementation, as a first step, CNM conducted learning meetings with project partners to collect information about the pilot project, the implementation plan and available data and tracking systems. This process was participatory in nature and responsive to necessary programmatic changes during implementation.

CNM then formulated a mixed-methods approach and incorporates both process and outcome evaluation in the study of this pilot project.

Four key areas of this evaluation included:

- 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 (i.e., expectation setting and data agreements) worked to create a replicable program structure
- Project Impacts & Outcomes – analyzing health and housing outcome data for patients served
- Cost Effectiveness – providing insight into whether and how the pilot reduced health care costs by meeting social, health, and/or housing needs of patients

Based on these key areas, the evaluation study focused on the following research questions:

- How were the various program components implemented?
- What did stakeholders perceive as the successes and challenges of the program?
- What recommendations do stakeholders have for improving program?
- How did the program impact participating patients and/or partners?

A program Logic Model was developed to map resources against program objectives and outcomes and co-design an evaluation plan. Please see Appendix A. The logic model included program resources, outputs, intermediate and long-term impacts.

An evaluation plan was developed informed by the logic model and the four key evaluation areas. Please see Appendix B. The plan includes:

- Data indicators for monitoring and tracking (i.e., Hospital readmission rates, patient connections and access to housing support, Medi-Cal and health plans, medical homes, mental health services, and other social support benefits) for impact and cost/benefit assessments. In partnership with Los Angeles Union Station, CNM collected specific output measures. CNM also requested data from each hospital on the homeless population pool and readmission rates.
- Focus group instrument and protocol to capture stakeholders' perceptions around program coordination, effectiveness, and impact. Each focus group followed a semi-structured discussion protocol to solicit maximum information about the key topics of interest. Focus group data were analyzed across groups by using simplified content analysis to capture emerging thoughts and themes.
- Key informant interviews and/or focus groups with program partners who can speak to the successes and challenges of the program. Due to the relatively low number of participants, certain salient points are included in the summary if they were mentioned by two or more participants across groups, a lower threshold than typically used in focus group analysis.

## Results and Key Takeaways

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The following results are presented by the four key areas of the project.

**Value/Impact-** Project partners expressed their perceptions of the SPA Patient Navigation project and its value.

**Hospital patient referrals were successful but at times, referrals based on the eligibility criteria were inconsistent resulting in an opportunity cost for Patient Navigators.**

Not all patients referred to the Patient Navigators met the program eligibility criteria. Patient referrals based on the eligibility criteria for the program were not always consistently followed by hospital staff or social working team.

- In the first months of program implementation, hospitals referred ineligible patients and some patients who did not meet the strict criteria were admitted in the program. In addition, some hospitals had other similar patient programs and staff were confused which patient to refer to what program. The program operated more smoothly once staff had a better understanding of program eligibility (and that only

the chronically homeless patients were to be referred to this program). Overall, referral consistency improved between and across hospitals as program implementation progressed.

- Referral consistency dipped at times throughout the project based on hospital staff's ability to filter patients that met the criteria. The consistency was affected by:
  - o Hospital staff experience with homeless patients. Social workers/staff may have had different understanding or experience with the 'chronically homeless' or the subtle nuances in a patient's homeless situation based on how the patient expressed their current living situation. For instance, if a patient is bouncing from house to house, it implies that they are couch surfing, but that does not make them homeless. As a result, staff may have applied differing levels of filter into the patient's homelessness situation.
  - o Changes in hospital staffing. With staff turnover, new staff may not always have been familiar with the strict eligibility criteria for this program.

Consequently, cases were not always properly vetted at the hospital site under the guidelines of the program. Referral inconsistency created some program inefficiencies with an opportunity cost. In some cases, the Patient Navigator spent valuable time trying to call and search for patients when they did not qualify as "chronically homeless" as defined by the program. And while the Hospital Liaison knows how to probe questions and listen to patient responses for subtle cues, not all hospitals are equally versed or comfortable.

A renewed focus on the "eligibility criteria" allowed for program correction. As the program continues, hospital staff could receive intermittent 'refreshers' on program eligibility and tips on how to better interpret patient responses as a means to maintain higher rates of referral fidelity and improve program efficiency.

Lastly, while hospitals respect the eligibility requirements set for this program, many spoke about wanting more flexibility in how "chronically homeless" is defined in order to be able to refer more patients. For example, some patients live in their car, but it limits their ability to be navigated because they have been deemed to have some sort of shelter.

**Patient Navigators have been successful in connecting patients to critical services including placement housing, despite persistent challenges in addressing specific needs that require further exploration and thinking to mitigate.**

The Patient Navigator provides patients with many resources, connections, and proactive support to address individual needs: taking patient to medical appointments, helping patients complete government forms, etc. In some cases, the Patient Navigator has placed some homeless patients in housing. One hospital focus group member said, “We notice that they [patients] don’t come as frequently when they are housed.”

Another hospital member expressed, “the greatest value of the program is placing patients in housing.”

The Patient Navigator works within the finite resources available at any given moment. As such, connecting the patient to certain services has been challenging throughout program implementation.

- *Shelter placement.* The challenge of placing patients in shelter is multifaceted. Shelter beds are in very limited supply and the demand in Los Angeles County from all the hospitals, prison system and foster care for this limited resource is far greater. In addition, SPA 3 has limited winter shelters or walk-ins for people experiencing homelessness. More placements are available in the City of Los Angeles, but patients do not want to be relocated out of the area. In addition, the COVID-19 pandemic exacerbated the availability of this limited supply. Hospitals are unable to send patients to recuperative care or a nursing facility because some of the cost must be borne by the hospital. As one focus group participant stated, “How do you address your health when you don’t have a bed or can’t

“The number of patients connected to housing is important. Other organizations don’t really do this. That’s what makes the Patient Navigator so helpful.”

– Hospital partner

shower.” A focus group participant explored the possible collaboration with motel or Project Room Key partners to provide temporary housing for Patient Navigators to immediately support and access patients who would find some stability (rather than be discharged to the street). Another also hypothesized that adopting a 24-hour shelter where a “frequent utilizer” homeless patient could be placed for immediate service by the Patient Navigator would be a major ‘game changer’ because it would free hospital beds and staff to support other patients.

- *Obtaining Birth certificate and other Government ID.* Patient Navigators create opportunities for patients to get the necessary ID to secure housing and other related benefits. For example, the birth certificate is critical for access to services/support, but time delay in obtaining appointment with the proper local government administration is difficult, extending well over a month for that initial meeting. Requests by mail take over a month. Consequently, the Patient Navigator must start the process as close to the beginning of a patient’s enrollment in the program, thereby making the Initial Point of Contact at the hospital so critical.

- *Locating patients.* Despite Patient Navigators’ best efforts, locating can prove challenging and time consuming. Patients do not always follow a specific pattern of behavior. In

a limited set of cases, the Patient Navigators found it challenging advancing the case forward due to limited access to the patient. In these cases, patient may have been sleeping during times when Patient Navigator is working, hiding within the community to avoid police by bouncing around or not staying consistently in their regular locations, unable to charge their phones or refusing to have a cell phone, skipping appointments, refusing to engage, and/or refusing to share their location.

Other challenges include:

- The Patient Navigator, despite best efforts, is unable to motivate the patient to engage for some cases. Often times, the patient may: 1) feel that they have tried before and it has led to empty promises; 2) have unrealistic expectations such as immediately receiving permanent housing; 3) just not be ready or willing to change their circumstance.
- Pomona Valley faces a unique ‘geographic’ challenge that may hinder many patients from benefiting from this program. Pomona Valley is on the outer cusp of the San Gabriel Valley service area closer to the San Bernardino County. The hospital draws a lot of patients who do not want to relocate outside of Pomona, which limits access to resources. Some of the patients are coming from San Bernardino, Orange County or Riverside and don’t qualify for services through this program because of where they typically reside.

**Access to patient information, though not consistently available at the start of the program, has allowed the Patient Navigator to be better prepared in engaging the patient and providing vital resources.**

At project launch, hospitals varied in how much access they were able or willing to provide Patient Navigators to patient medical records. The navigators needed the medical information to better assist the patient, particularly in placing patients in shelter through LAHSA. Delays in access to patient information caused delays in placements. A few hospitals granted medical access as they would to any other hospital staff person.

Access to patient information that includes patient’s medical history and reason for their most current visit allows the Patient Navigator to

- Better assist the patient. The reasons for a “frequent utilizer” homeless patient to visit the hospital are many, and not always primarily driven by an underlying medical condition. For example, a patient may repeatedly visit for alcohol poisoning (because he/she is an alcoholic) and be flagged as a frequent utilizer. A patient profile allows for the Patient Navigator not to be blind-sided and be able to help the patient, even when they may be lying about or misremembering their history.

- Build better rapport with the patient. Access to medical information helps with the patient engagement because the patient perceives that the Patient Navigator already has an interest in them.

Ultimately, the challenge was resolved with a compromise. All hospitals now provide access to patient ‘face sheets’ that provide basic medical information about the patient that includes date of birth, family contact (if any), patient income, patients’ support system, goals, reasons for hospitalization, medical follow-up needs, any mental health conditions. The face sheets provide sufficient patient details for the Patient Navigators to conduct their work efficiently.

**As the dedicated Point of Contact, the Patient Navigator builds greater connection and trust with the homeless patient.**

The program offers a dedicated navigator for each hospital partner and its patients. The Patient Navigator, as the Point of Contact (POC), offers unique advantages. The navigator:

- Is perceived as a member of the hospital staff by the patient and able to parlay that relationship to build trust with the patient.
- Builds a relationship at a time when the patient feels most vulnerable.
- Develops a positive connection with the patient. The POC is the one person that the patient can continually go back to for help or assistance. Patients do not have a dedicated resource otherwise. As the navigator guides the patient to get better, the patient feels invested and works more closely with the navigator.

The program allows for a warm hand-off to the Point of Contact/Case Manager for face-to-face interaction. Prior to this program, follow-up consisted of calling Union Station and providing patients a pamphlet with resources and information. For a warm hand-off to succeed:

- The patient needs to feel a sense of comfort with the navigator and a face-to-face interaction, either as first point of contact or second point of contact, helps in engaging the patient. As one Patient Navigator stated, “Building a rapport and treating them with respect. They have difficulty trusting because in the past, doors have been shut even by closest family members.”
- The patient needs to be pre-screened for program eligibility before the navigator is involved. The filtration process mitigates incidents of ghost patients.
- The navigator needs to explain the Patient Navigation program in its entirety to the patient.

- The navigator must be patient-ready by knowing their history before speaking with them. The patient feels that the navigator already knows them, and it helps to build trust, interest, and willingness.

**Project Design & Implementation** – The SPA 3 Patient Navigation project was implemented over an 18-month period. Pilot partners carried the following perceptions on the partnership, program design and the coordination of care.

**Partnership between hospitals and Union Station has led to a strong collaboration, leaving many program partners wanting more.**

All partners expressed that the partnership across organizations has been a resounding success. Hospitals appreciated the monthly meeting with partners to identify commonalities and observe trends (e.g. uptick in homeless patient pool).

Hospitals also expressed high praise and gratitude to the Union Station Patient Navigators and the tremendous role that they have played in linking the homeless patient population in this program to vital services, resources, and in some cases housing. One hospital member said, “it’s impressive what [Patient Navigator] has done.”

Patient Navigators:

- Have access to patients at the hospital, whenever possible. All hospital partners have given access to Patient Navigator at their facility.
- Have access to patient information. Hospital staff have been open to collaborate with Patient Navigators and share information about patients as part of a coordinated care.
- Play a vital role as patient advocate. They ensure the patient is connected to services, has medicine or refills needed, and is attending medical follow-ups.

With the exception of Pomona Valley, the remaining four hospitals co-shared a Patient Navigator. Based on the results of their performance, and the observed outcomes, hospitals

- Evoked a great desire to have one dedicated Patient Navigator for each hospital in order to be able to refer more patients. Similarly, the Patient Navigators expressed that one dedicated to each hospital would allow greater time to attend to the hospital’s eligible patient pool and provide hyper-focused attention to each hospital’s specific needs.

- Expressed interest in loosening the eligibility restrictions to utilize the Patient Navigator more than they have been. One focus group member stated, “There are lots of visits and time spent at patient bedside. It would be helpful for someone to take over. Making a plan and discharging a patient are two different things.”

In addition, partners indicated stronger teamwork and collaboration within their respective organization. Partners spoke about

- Working together, supporting each other as team members, discussing problematic cases, getting feedback, and getting reminders on next steps.
- Pushing for follow-up as far as medical and mental health of the patient.
- Building greater awareness in taking care of this patient pool.

**Partnership between hospitals and Union Stations has not only led to improved coordination of care within the program network but also extended efficiency of care to “out- of-program network’ organizations.**

Hospitals and Union Staff both perceived improved coordination of care of homeless patients. Relationships with the hospital partner through the program allowed the hospital to provide better care to the eligible patient and for Union Station to better prepare and direct much needed services to the patient.

Before the PN program, hospital staff called the Union Station main number and went through the whole Union Station system to determine right contact person for a specific patient. Now the Patient Navigator acts as the gateway or access point to all the information available through Union Station, even if the Patient Navigator is not directly involved with the specific patient.

“One person is following [up] with the patient and knows the patient’s compliance and non-compliance.”

-- Stated as a strength of the program by one partner

The collaboration offers the following key programmatic elements:

- *Meet patients on site.* Before this pilot, hospitals provided mainly referrals. They targeted patients that were very sick. Hospitals had a specific person assigned towards safe discharge. In the pilot, the patient navigator meets with the patient for a “warm hand-off” which, according to hospital partners makes all the difference.
- *Catch patients early.* The patient does not get lost in the referral process. The Patient Navigators make every attempt to connect with the patient at the hospital before discharge. In

instances when patient is discharged without a warm hand-off, the patient navigator makes every attempt to connect in the field. The hospital partner is able to flag the case and notify the patient if the patient is ever readmitted.

- *Access patient information.* Patient history provides context and background to speak with patient about their ailments.
- *Coordinate care and referrals to medical providers.* Before the pilot, Union Station had no information about the referred patient. Union Station has no information on the patient being referred (e.g. medical issues, medical diagnosis etc.), the source of the referral at the hospital, and the patient's specific needs.
- *Access paperwork needed by LAHSA for interim housing placements.* LAHSA requires specific documentation if the patient is coming from an institution or hospital. Prior to this project, Union Station was either unable to obtain the information from hospital partner, or access to the information took much longer, and by then, it was often too late to assist the patient with placement.
- *Reconnect patients with other out-of-program network services or case managers.* If patient had an established relationship with a case manager from any number of organizations, then for the sake of continuity, Union Station could refer the patient to that program and case manager. Union Station could still provide support on services that the previous case manager may not have connected the patient to, if needed.

However, hospital partners did mention limits to this coordination of care. For instance, social worker staff are not a 24/7 service. They typically are not available during graveyard shifts and weekends. One hospital partner also pointed out that the Patient Navigator is off one Friday every other week. As such, referrals freeze or get delayed.

**The Patient Navigator is the key asset to the program's success and the continuity of care with the patient.**

Hospitals recognize that the target population is extremely challenging. But, as one provider stated, "With a warm hand-off something happens. From a hospital discharge point of view, to be able to reach out to somebody and know that there is going to be at least an attempt to follow-up and maybe more is a very good resource for the hospital."

The Patient Navigators have many skills that distinguish them in their work. Hospital staff have grown increasingly more dependent on them. "The success of the program is predicated on the way the Patient Navigator is seeing the patients, placing them in resources within the community (...) They deliver on what they said that are going to deliver," said another hospital focus group member.

The Patient Navigators offer vital skill sets that make them an indispensable partner

- *Patient Navigators are persistent.* This persistence in working with the patients and finding them the appropriate resources usually paid off in the end.
- *Patient Navigators are knowledgeable about the services available and the patient.* The Patient Navigator can keep hospital staff updated on any specific case. They have a strong connection with the community. They often know what resources are available before they are disclosed at large which saves time and effort.
- *Patient Navigators are resourceful.* Hospitals have no real means of keeping track of available resources. The Patient Navigators have the pulse on resources in the community and respond quickly in a way that hospital staff would be unable to match or know about. Hospitals can provide linkages in ways that they did not do before.
- *Patient Navigators go the extra mile.* They went above and beyond the program requirements. Even if they were not navigating a case, they would still call that patient, provide resources, complete documentation for another organization to take over. In one case, the navigator outreached to the patient, built a rapport and enrolled him in the program. The navigator tried to get the patient into interim housing, but he refused. He went to SNIF and then disenrolled from the program. He went back to the hospital as he had a lot of medical conditions including substance abuse and mental health. Though he did not want to re-enroll in the program, the Patient Navigator was able to enroll him into another, more specialized program offered at Union Station.

In another case, a patient needed to be placed in shelter during COVID shut-down orders, but none of the shelter staff could be reached by hospital social workers. The Patient Navigator drove to the shelter site, connected the direct of the shelter with the hospital social worker, and provided support for safe discharge.

**Union Station provided maximum flexibility to hospital partners in the patient referral process at a cost. Standardizing the process as originally intended through the Hospital Liaison would save Patient Navigators time in case management and improve program scalability.**

Hospitals were selected based on high homeless patient utilization of emergency room and/or inpatient hospital services. Hospital social workers were supposed to submit referrals through the LAHSA “myorg” portal to the SPA 3 Hospital Liaison stationed at Union Station. The liaison would serve as the air traffic controller who works intensely alongside hospital social workers to prescreen for and recruit patients into the program. Intended as the first point of contact, the Hospital Liaison is able to capture/review the patient’s basic information, such as their age,

social security number, their living situation and location, length of time homeless etc. Once enrolled, the liaison is to assign the patient to a Patient Navigator.

However, this referral process broke down mainly because the Hospital Liaison was temporarily unavailable or staff at partner hospitals found the myorg interface challenging to incorporate into their workflow and did not uniformly adopt the system as expected in the program implementation. Consequently, hospital staff found workarounds to communicate about patients with Union Station that in many cases bypassed the Hospital Liaison.

Each hospital partner communicated patient referrals to Union Station differently. Hospital staff ended up connecting with the Patient Navigator in one of three ways:

- **LAHSA portal.** The LAHSA website is available to all hospital partners to use for referring patients. It offers a centralized approach for patient referrals, wherein the referral is submitted by the hospital and reaches the Hospital Liaison at Union Station for review, acceptance, and dispatching. However, not all hospitals are taking full advantage of this resource. Hospitals reported that the site is cumbersome to use and it takes too much time to complete a referral. One provider stated, “the website portal is not my favorite.” Some staff had difficulty accessing the site or processing a referral on the site. Other hospital staff had misconceptions around how to populate information for a care referral within the site. Improving the staff user experience as well as conducting intermittent access audits to ensure all staff have access and providing trainings may mitigate the challenges and improve adoption.
- **Hospital Liaison.** Typically, but not always, the hospital social worker talks to the Hospital Liaison who speaks with the patient, as first contact, then refers the patient to the Patient Navigator. The Patient Navigator engages the patient who may already know something about the program because of what the Hospital Liaison may have shared. But SPA 3 Hospital Liaison often filters patients for the project, so the Patient Navigator does not end up with a ghost patient (patients who are not actually homeless). In addition, hospitals typically do not employ a Hospital Liaison on their own. In this project, only 2 of the five hospitals had a Hospital Liaison. In other hospitals, the social workers did the work of the Hospital Liaison based on their respective caseloads. The Union Station Hospital Liaison position responsible for filtering eligibility of cases referred to the program was vacant for a period. The role was being fulfilled by the Patient Navigators.
- **Patient Navigator.** In a few hospitals, social workers directly communicated with Patient Navigators. Given the professional relationship and trust established with Patient Navigators, hospital social workers felt comfortable to directly connect with their Patient Navigator using various modes of communication including (email, text, or phone) when making referrals.

More clarification is needed around who vets the patient, the social worker or the Hospital Liaison regarding homelessness and eligibility for the program. Staffing is not static; new social workers are hired or leave, and institutional knowledge of the program is not always passed along, resulting in expected protocol to not be followed.

While Patient Navigators have been flexible and accommodating to these varying workflows with the number of current patients served in the program, a standardized procedure would allow for greater uniformity across hospitals and greater efficiency in processing patients, pre-identifying eligible patients, and scaling the program either by increasing enrollment capacity at a given hospital or expanding the partnership to include other hospital partners. Discussed options by focus group member include:

- Revisiting the use of LAHSA portal and re-educating hospital staff to correct misconceptions and streamline process challenges.
- Accessing the SPA 3 Hospital Liaison only to manage the “pre-screening” and filter eligible patients to Union Station.
- Preparing a submission form to funnel referrals directly to Union Station in lieu of the portal.

**Referral to the Point of Contact/Patient Navigator must be immediate, or at the very least, occur before the patient is discharged from the hospital because early access to the patient establishes trust and improves likelihood of program enrollment.**

Patient Navigators, in the initial phase of the program, could not, at times, connect with patients in time. In these cases, the patients were discharged before the Patient Navigator had an opportunity to meet and confer with the patient. Once discharged, it was more difficult for navigators to locate the patient, extend an enrollment offer and provide the coordination of care.

“If we don’t get them right at that moment where they are willing to get help, then we lose the opportunity. PN helps support that patient and provide service or resources that same day.”

-Hospital Partner

The patient is a captive audience at the hospital, and the Patient Navigator has more opportunity to convince the eligible patient to enroll in the program. If the patient speaks with the Patient Navigator while at the hospital, then the rate of acceptance to participate in the program is much higher. The Patient Navigator can set the patient on a path to success in the program.

If that connection has not been established by discharge, once a patient is on the street, old patterns of living resurface, and it becomes much harder to reconnect and convince patient to participate. The path is made more difficult if the patient was discharged before the navigator

has an opportunity to connect with them, because the navigator has to then set aside more time to locate them and convince patient to enroll. Elapsed opportunity is met with more resistance to participation. As one hospital focus group member stated, “If we don’t get them

right at that moment where they are willing to get help, then we lose the opportunity.” The Patient Navigator helps support that patient and provide service or resources that same day.

The Patient Navigator can establish trust more quickly with the patient at the hospital because

- Face to Face interactions provide a greater sense of security and comfort which then leads to more positive patient engagement
- Patients inherently view the navigator as part of the medical care team instead of a social service professional and appear more amenable to receive the planned care or service from a “medical professional.” Often, the patient carries preconceived notions about social services given that they may have had experience in receiving services or promise of services that did not necessarily work out as the patient expected. As one Patient Navigator noted, “As we guide them to get better, they work better and more closely with us.”

The workflow was corrected allowing the Patient Navigators to be informed much earlier in the process so they could connect with the patient before discharge. In addition, having the Hospital Liaison more engaged will further help with this dynamic.

**High proportion of patients have mental illness and need direct access to better mental health support. The Patient Navigator would have more success in outcomes and placements with access to a Psychiatric Specialist who would help address a critical service gap.**

Patients with mental illness appear to have a more difficult time with follow-up and return back on the street. A psychiatrist or other mental health professional within the program could work with the team to connect and engage with patients and provide easier “sign-off” for specific guidance and necessary services that the patient needs, more than what the Patient Navigator can provide or is qualified to provide. There are limits to the service a Patient Navigator can provide without the proper medical and psychological support. These patients return back on the street because they don’t know how to follow-through and need more help/guidance than a Patient Navigator can provide.

One focus group member noted that patients are fearful of and frustrated with mental health clinics. If they leave, the patient cannot go back and get their medication from this clinic. They are asked to go to another clinic. “It’s like you open a door and it shuts down on you,” stated this member. “At the very least provide the meds to the patient in hand before they walk out of the facility.”

**Access to hospital and program data has proven a larger obstacle than expected for project partners. Establishing specific agreements and involving the evaluation team earlier in the project implementation lifecycle to set data collection parameters may be helpful.**

Hospital partners use different data systems. Some use the Cerner Powerchart while other use the Epic platforms. While hospital staff believed they could access Emergency Department data to provide information around readmission rates and costs, the process was much more involved than anticipated. Access to this data largely depends on whether the hospital is already tracking the information in their system. To gain access to the specific unique data metrics, hospital staff would need to 1) make a special request to their Information Systems department; 2) generate data reports from scratch; and/or 3) access specific case files to retrieve the information manually.

The problem was further exacerbated by the uneven adoption of the LAHSA platform thereby placing the burden of tracking, monitoring and reporting participant data and outcomes on hospital staff and Union Station. Additionally, some outcome data were not collected throughout project implementation and required further commitment from Union Station staff to provide towards the end of the project.

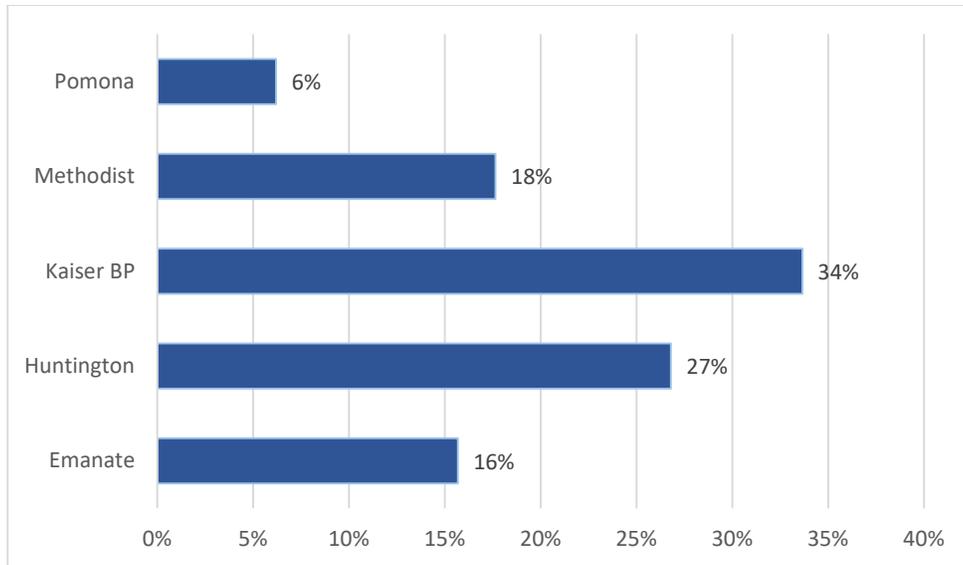
Future iterations of this work would benefit from project-wide adoption of the LAHSA system and involvement of the evaluation team earlier in the process to set specific metrics to track.

## **Project Impacts & Outcomes**

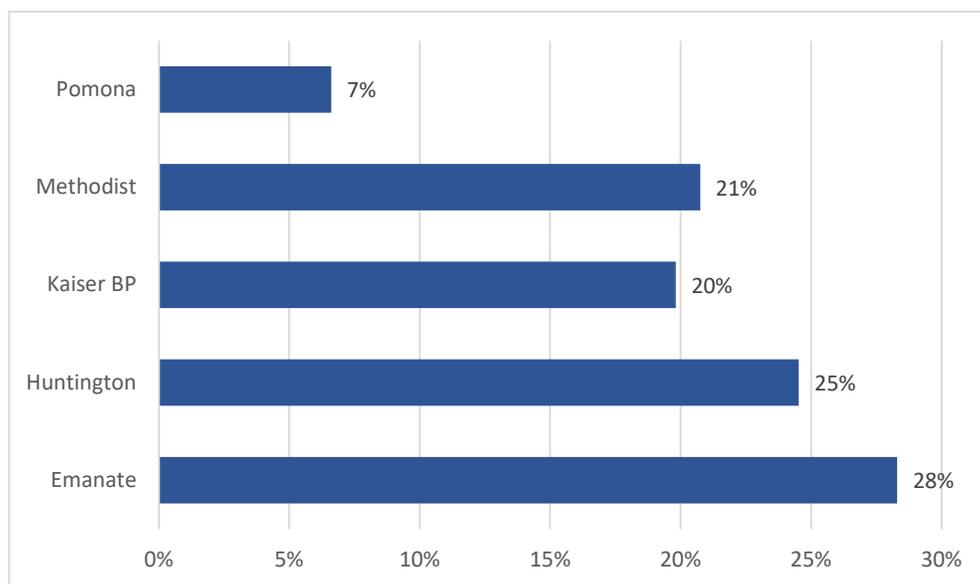
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The project captured basic implementation metrics (i.e. number of referrals, enrollments, etc. ) as well as data on the health and housing outcomes of the participating patients for the program running December 1, 2020 to April 30, 2022. Patients were not enrolled during the planning and preparation phase (October and November, 2020); there are no metrics for the first two months of the project.

**The pilot project accepted 306 unduplicated patient referrals.** The largest proportion of referrals came from Kaiser Permanente (34%), followed by Huntington Hospital (27%). Pomona hospital joined the project 6 months into implementation and therefore had the fewest referrals.



**The pilot project met its target enrollment of 110 participants, as of April 30, 2020 with two additional months remaining to surpass this threshold.** Patient Navigators served 104 unduplicated patients and 38 still remain active in the program. The remaining 6 patients were re-enrollments. The rate of conversion from referral to enrollment was 33.9% though this rate may be affected by the “quality” of referrals since some patients may have been referred but did not necessarily meet the eligibility criteria of the program. On April 30, 2022, the project had 38 active patients. Emanate hospital had a larger proportion of enrollments despite having referrals rates that were lower than both Huntington and Kaiser BP hospitals. Kaiser BP may have found it particularly challenging to convert referrals to enrollments and may require further exploration.



**The 104 unduplicated patients in the pilot project differed in their demographic profile from the total population of patients visiting the five partner hospitals, but not enough information is available to determine profile similarities or distinctions to only the total homeless population pool at these hospitals.**

Majority of enrolled patients were male, White, and older.

- 83.6% identified as male, and 16.4% identified as female. By contrast, the typical hospital partner ED patient (irrespective of homelessness) is 47% male and 53% female.
- 49% identified their ethnicity as Hispanic/Latino(a)(x) and 51% identified as Non-Hispanic/Latino(a)(x). By contrast, the typical hospital partner ED patient is 53% Hispanic/Latino(a)(x) and 45.6% Non-Hispanic.
- The majority of patients identified their race as White (60.6%) and 16.3% identified as black or African American. Another 17.3% did not know or refused to identify. By contrast, the typical hospital ED patient is 54.9% White, 26.9% Other Race, 8.2% Asian, and 6.7% African American.
- The majority of patients were over 45 years of age, with 28.8% between 45-54 years old, 24% between 55-61 years old, and 20.2% 62 and over. The project did not enroll any adult patients between 18-24 years of age. By contrast, at partner hospitals, 12.5% of ED patients were 40-49, 13.4% were 50-59 and 29.6% were 60 and over.

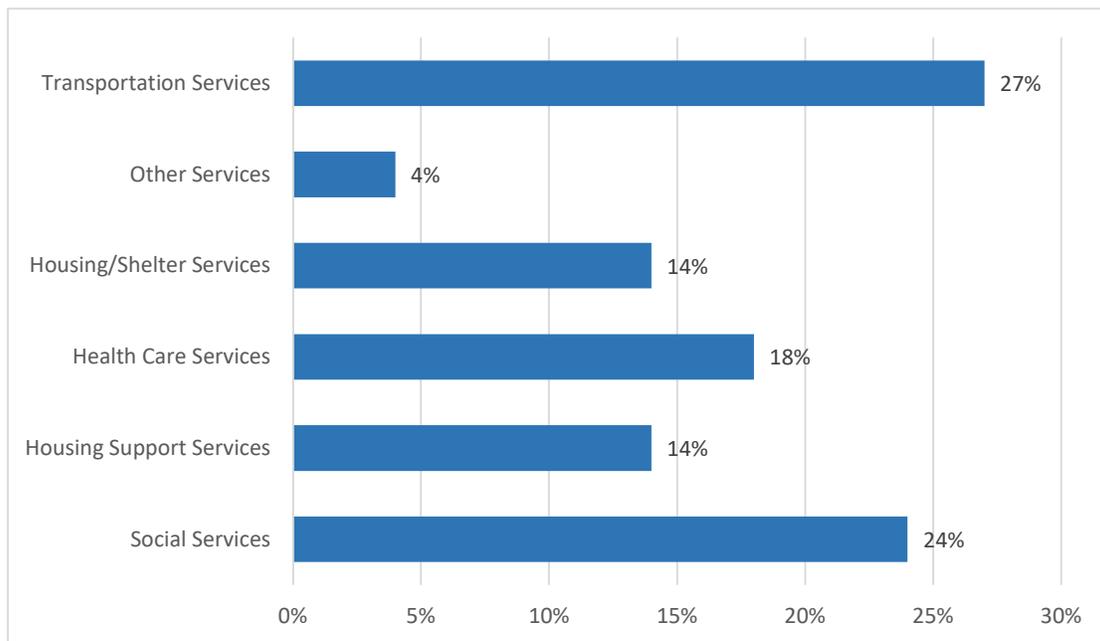
“Seeing more 50 and over homeless patients (...) have one in their 80s, and very sick. People that age should not be homeless.”

-Hospital Partner

**Patient Navigators succeeded in making their first point of contact with most patients at the hospital before discharge which allowed them to establish a relationship early with the patient and encourage them to enroll in the program.** In fact, over 68% of patients enrolled in the program had been contacted by the Patient Navigator at the hospital. If patients were discharged prior to first point of contact, the Patient Navigators had to locate them in the field which took significantly more time and effort. There were a few cases where the first point of contact occurred by phone only, at a skilled nursing facility, or sober living facility.

Location	Count	%
Field	23	21%
USHS Facility	5	5%
No Response	3	3%
Phone Call Only	2	2%
Skilled Nursing Facility	1	1%
Sober Living Facility	1	1%
<b>Total</b>	<b>110</b>	

**The pilot project succeeded in improving housing outcomes and connections to homeless services for enrolled patients.** Enrolled patients collectively received 288 referrals and placements. The chart below represents the proportional allocation of referrals to specific services. Patient Navigators made the most referrals for transportation (for direct transportation) and social services with a particular interest in document assistance for birth certificate and ID/Driver’s License as well as CBEST referrals.



The table on the next page illustrates specific breakdowns of linkages made by the Patient Navigator and their subsequent outcomes because of these linkages.

Referrals and Placement Outcomes	Subtotal	Total	%
<b>Social Services</b>		<b>69</b>	<b>24%</b>
Document Assistance		<b>47</b>	
Birth Certificate	<b>18</b>		
Homeless Verification	<b>5</b>		
ID/Driver's License	<b>18</b>		
Social Security Card	<b>6</b>		
Referrals		<b>22</b>	
Benefits: Referrals Made	<b>4</b>		
<i>Benefits: Attained</i>	1		
<i>Benefits: Not Attained</i>	3		
CBEST: Referral Made	<b>16</b>		
<i>CBEST: Attained</i>	9		
<i>CBEST: Not Attained</i>	6		
Educational Services: Referral Made	<b>1</b>		
<i>Educational Services: Attained</i>	1		
<i>Educational Services: Not Attained</i>	0		
Referral - Legal Services: Referral Made	<b>1</b>		
<i>Legal Services: Attained</i>	0		
<i>Legal Services: Not Attained</i>	1		
<b>Housing Support Services</b>		<b>39</b>	<b>14%</b>
Housing and Services Plan: Housing and Services Plan	33		
Housing Search and Placement: Housing Search and Placement	6		
<b>Health Care Services</b>		<b>51</b>	<b>18%</b>
Mental Health: Mental Health	<b>18</b>	<b>18</b>	
Referrals		<b>33</b>	
Alcohol and Drug Abuse Services: Referral Made	<b>16</b>		
Alcohol and Drug Abuse Services: Attained	5		
Alcohol and Drug Abuse Services: Not Attained	11		
Mental Health Services: Referral Made	<b>9</b>		
Mental Health Services: Attained	5		
Mental Health Services: Not Attained	4		
Other Health Care Services: Referral Made	<b>7</b>		
Other Health Care Services: Attained	6		
Other Health Care Services: Not Attained	1		
Physical Disability Services: Referral Made	<b>1</b>		
Physical Disability Services: Attained	0		
Physical Disability Services: Not Attained	1		
<b>Housing/Shelter Services</b>		<b>40</b>	<b>14%</b>
Referrals			
Bridge Housing: Referral Made	<b>4</b>		
Bridge Housing: Attained	3		
Bridge Housing: Not Attained	1		
Crisis Housing: Referral Made	<b>27</b>		
Crisis Housing: Attained	19		
Crisis Housing: Not Attained	8		
Housing Search and Placement: Referral Made	<b>5</b>		
Housing Search and Placement: Attained	2		
Housing Search and Placement: Not Attained	3		
Rapid Re-Housing Program: Referral Made	<b>4</b>		
RRapid Re-Housing Program: Attained	0		
RRapid Re-Housing Program: Not Attained	4		
<b>Other Services</b>		<b>12</b>	<b>4%</b>
Referral - Other Services: Referral Made	<b>12</b>		
Referral - Other Services: Attained	5		
Referral - Other Services: Not Attained	7		
<b>Transportation Services</b>		<b>77</b>	<b>27%</b>
Bus Pass	<b>1</b>		
Direct Transportation	<b>76</b>		
<b>Total</b>		<b>288</b>	

In Housing/Shelter Services, Patient Navigators made 40 referrals to bridge housing, crisis housing, housing search and placement and rapid rehousing yield a positive placement outcome for 60% of enrolled patients.

In Housing Support Services, Patient Navigators provided 39 patients (or 37% of enrolled unduplicated patients) either a housing and services plan (33) or housing and services search and placement (6).

In Health Care Services, Patient Navigators connected 18 patients to mental health providers, and referred 33 patients to alcohol and drug abuse services (16), mental health services (9), physical disability services (1) or other health services (7). These linkages proved more difficult for generating positive placements though some success was achieved. Patient Navigators spoke about the challenges for them to really address these particular needs without a specialist, particularly in Mental Health, to provide expertise and technical support.

Approximately 66 patients were exited out of the program. At time of patient exit, 20 (33%) among them exited to a positive housing destination. Patient either had

- permanent destination such as permanent housing or living with family permanently,
- temporary situation such as paid emergency shelter with voucher or other funded program, transitional housing, living temporarily with family or friends, or other place not meant for habitation (e.g. vehicle, abandoned building),
- institutional setting such as a substance abuse treatment facility, hospital or other medical facility, jail or prison, or long-term care facility, OR
- other destination designation such as patient is deceased, patient does not know or refuses to respond, or exit interview is not completed.

Overwhelming majority of patients coded as other destination were because the exit interview was not completed which speaks to the general challenge of long-term case monitoring of case outcomes with patients as they are go on to receive care or other services.

Exit Destination	4/2022
Permanent Destinations	3
Temporary Destinations	15
Institutional Settings	13
Other Destinations	35
<b>Total</b>	<b>66</b>

The following table provides further breakdown of the exit destinations:

Exit Destination	Count
Permanent housing (other than RRH) for formerly homeless persons	1
Staying or living with family, permanent tenure	2
Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter	2
Transitional housing for homeless persons (including homeless youth)	1
Staying or living with family, temporary tenure (e.g. room, apartment or house)	4
Staying or living with friends, temporary tenure (e.g. room, apartment or house)	2
Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	6
Substance abuse treatment facility or detox center	3
Hospital or other residential non-psychiatric medical facility	2
Jail, prison, or juvenile detention facility	2
Long-term care facility or nursing home	6
Deceased	4
Data Not Collected (no exit interview completed)	31
<b>Total</b>	<b>66</b>

Successful housing and other homeless service outcomes were also captured in anecdotal accounts of patients' experiences in the program:

**SUCCESS PATIENT #1**

Female patient repeatedly frequented the hospital and staff were frustrated with her case. When the Patient Navigator began working with her, hospital staff heard about the case progression post-discharge, and learned that the patient was stabilizing and not frequenting the hospital as before.

### **SUCCESS PATIENT #2**

Older adult was having psychotic episodes and had probably wandered away from a facility. He was homeless for a couple of years, and was experiencing psychosis at the time of his last visit to the hospital after he was hit by a bus. The Patient Navigator helped him get into a nursing home. While there, he continued taking his medications and felt fine. Technically, he physically still didn't belong in the nursing home, but the Patient Navigator was able to advocate for the nursing home to keep him there for the long term. The home has become his family; he hasn't wandered away and is still on his medications. The patient reached an overall improvement of his mental health.

### **SUCCESS PATIENT #3**

Male patient was homeless for a couple of years, had several strokes, and then made a good connection with the Patient Navigator. The Navigator was able to get all the documentation that the patient needed. Patient was willing to work towards getting himself housed. The Patient Navigator worked very hard, navigated the patient to secure housing and kept him away from the hospital. The patient engaged fully and despite getting housing, he passed away. Staff commented that, at least, the patient was provided dignity for his continued healthcare needs until the end of his life.

### **SUCCESS PATIENT #4**

Young male homeless patient had substance abuse disorder. It took time for the Patient Navigator to build a rapport. The Navigator visited him every other day and brought him lunches. The Navigator was able to place him in housing with a faith-based organization. One year later, he is still in the program, employed and has access to a car. The Patient Navigator helped him get a driver's license and ID. He is a great role model for the youth in the housing organization. The patient has re-established a relationship with his son, has a girlfriend, and is thinking about his future (employment, marriage, etc.). He is currently taking online classes for medical billing. He still reaches out from time to time asking for assistance with food, hygiene kits, etc.

### **SUCCESS PATIENT #5**

Young male homeless patient was looking for employment but had no documentation. The Patient Navigator was diligent and secured the necessary paperwork for the patient. The patient was eventually employed and housed. The Patient Navigator still follows up with him.

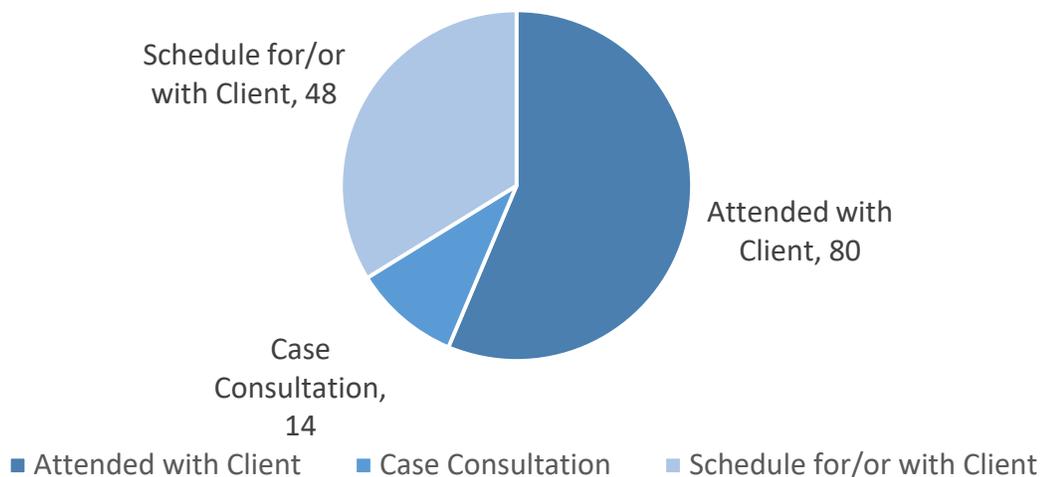
### SUCCESS PATIENT #6

Mentally disabled homeless patient was always seen near or around Target in Pasadena. He used to live with his mother, who was his caretaker, until she passed away. He had no one else to help. He was evicted from his home and ended up in the streets. He was hospitalized and referred to Union Station. The Patient Navigator helped the patient after discharge to go into SNIF long term and receive other services, including an identification card and connecting him to an ombudsman for his social security benefits. The Patient Navigator still intermittently checks on the patient who lives in the same long-term facility.

He got housed, but unfortunately passed away after a month of housing.

**The success of the housing and other homeless service outcomes and placements is directly attributable to the perseverance and frequent case follow-up of Patient Navigators.**

- Patient Navigators offered patients follow-through on their appointments by directly attending appointments with patients, ensuring case consultation follow-up, and scheduling patients' appointments with them or for them.



- Patient Navigators were very active within their caseloads. They frequently met with their patients (also known as touchpoints). The chart below indicates the number of days before the Patient Navigator refocused time and energy on a case. Most touchpoints occurred with 9 days from the prior touchpoint, with a touchpoint occurring every 6.38 days on average.

Days Range	Count
0-9	1709
10-19	259
20-29	108
30-39	30
40-49	14
50-59	5
60-69	1
70-79	5
80-89	1
90-99	0
100-109	0
110-119	1
<b>Total</b>	<b>2133</b>
<b>Average</b>	<b>6.38 days</b>

- Patient Navigators committed many hours to any given case from the moment of patients' entry into and exit from the program, more so than any hospital social worker could do in a hospital setting. Navigators spent over 2,070 hours with 110 patients generating 2,249 case notes. On average, a Patient Navigator spent 18 hours and 19 minutes per patient to achieve the referrals, outcomes and placements outlined throughout this report. Navigators generated 19.9 notes per patient requiring approximately 55 minutes per note.

Staff Member	Total Time Tracked	# of Notes	# of Patients	Average Time Per Note	Average Time Per Patient	Mean # of Notes per Patient
Patient Navigator 1	1019h 30m	1353	50	45m	20h 23m	27.06
Patient Navigator 2	994h 15m	836	46	1h 11m	21h 37m	18.17
Patient Navigator 3 <sup>2</sup>	56h 45m	60	16	57m	3h 33m	3.75
<b>Total</b>	<b>2070h 30m</b>	<b>2249</b>	<b>113</b>	<b>55m</b>	<b>18h 19m</b>	<b>19.9</b>

<sup>2</sup> Patient Navigator 3 was involved part time for Pomona Valley Hospital. The hospital itself joined the project 6 months into implementation.

## Cost Effectiveness

One of the goals of this evaluation project was to examine any actual or perceived changes in cost to hospital partners in providing services to high ED utilizers who are homeless.

As indicated in the chart below, these patients represent a very small proportion of patient volume in emergency department visits. In Los Angeles County, homeless patients (not just high utilizers) represent 4% of total visits in the County. The hospital collaborative in this project represents 7% of all hospital (Emergency Department and Inpatient) visits by homeless patients in LA County. As illustrated in the column “2019 Median,” the median for patients experiencing Homelessness ED visits per treatment station, a measure of burden on emergency departments at respective hospitals, has been significantly higher in LA County hospitals (median= 32) than for all California hospitals. (median=24) However, the proportion of visits among partner hospitals in this project has grown by 14% in one year, with Pomona Valley Hospital and Methodist Hospital of SoCal seeing the largest percentage changes. It is possible that these increases are partially related to COVID-19 and the pandemic effect may vary from hospital to hospital.

Homeless Emergency Department & Admit Visits	2019 Median	2019	2020	% Change
Huntington Memorial Hospital	31	2,595	2,531	-2%
Kaiser Permanente Baldwin Park	21	672	570	-15%
Methodist Hospital of SoCal	27	703	942	34%
Emanate Hospital	22	1,969	2,374	21%
Emanate Health Foothill Presbyterian Hospital	19	455	578	27%
Emanate Health Queen of the Valley	22	954	970	2%
Emanate Health Intercommunity Hospital	31	560	826	48%
Pomona Valley Hospital	15	703	1,123	60%
SGV Collaborative Total	22	6,642	7,540	14%
<b>Los Angeles County</b>	<b>32</b>	<b>114,186</b>	<b>113,903</b>	<b>0%</b>
<b>California</b>	<b>24</b>			

Source: HCAI, 2019, 2020

**Hospital partners did not have immediate access to ED cost measures to gauge the direct cost benefits and retrieval of this data was more burdensome than originally anticipated by partner staff.**

The hospital ‘data’ universe is very complex and hospital staff found it challenging to obtain readily available data on the cost structure (such as cost per ED discharge or average cost per

ED visit) related to total homeless ED patients and homeless ED patients in the program. Measuring any potential savings was difficult to process. High utilizer visits (to emergency department or hospital admission) potentially present an outsized expenditure of time. Resources could be used more effectively given that high utilizers have other prevailing social service needs that the hospital cannot address or could be better addressed by a community-based organization or resource. In addition, hospitals may partially be reimbursed or not at all be reimbursed for services rendered to a homeless patient based on their health insurance status and the number of repeat visits in a specified time period. Future projects could explore the various reimbursement structures for a homeless patient such that Patient Navigators could, in the same way that they find housing placements, optimize resources (such as obtaining health insurance for the patient) that would also support hospitals better financially when they do receive homeless patient ED visits.

On a basic level, however, the five hospital partners collectively have a net inpatient revenue per discharge of \$18,485, a net inpatient revenue per day of \$3,642, and an estimated average length of stay of 5.08 days for each patient. By using the Inpatient Revenue per Discharge as a proxy measure, the collective lost revenue on 104 homeless patients could be as high as \$1.9 Million after one hospital visit. This figure would multiply by the total number of home patient revisits in a year to determine the combined annual loss among the five hospitals for this patient pool.

**Hospital partners perceived time savings for their own staff since the involvement of the Patient Navigator which translate into potential cost savings for the hospitals.**

Time with patients varies from case to case based on how complex each case may be. All hospital partners reported general time savings for hospital staff since working with the Patient Navigator for the patients in the pilot program. Partners describe savings as having occurred in a few ways:

- **The dedicated direct relationship meant the Patient Navigator and hospital staff could connect quickly to discuss a case.** Hospital staff did not have to access Union Station’s main number and connect with any number of Union Station employees to determine the right Point of Contact for a particular patient.
- **The Patient Navigator acted as a bridge between hospital staff.** Hospital staff do not have access internally to all internal data systems. They do not have time to talk to other co-workers on any given day to find the proper linkages for a particular case and get the patient connected.
- **Hospital staff had a ‘gateway’ access point through the Patient Navigator to information and resources.** Hospital staff cannot possibly know all the resources available to plan for safe discharge. For example, the process of calling shelters as part

of this plan, as required by law or get fined for failure in doing so, is time consuming. Often, the Patient Navigators had information at their fingertips, and could connect hospital staff to the right resources to ensure continuity of care, even if it meant putting hospital staff in touch with another service or group offering similar services. In some cases, Patient Navigators knew availability of some resources before they were even distributed widely throughout the Service Planning Area.

- **Patient Navigators have assisted in expediting patient discharges.** Hospital staff contend with some homeless patients who linger which extends time to safe discharge. The Patient Navigator offered options to patients during the discharge planning. In one case at a partner hospital, the social worker, a case manager, and a coordinator all had several meetings with the patient throughout one day to get discharged, but the patient was lingering, and hospital staff could not the patient discharged. The Patient Navigator took on the case and convinced the patient within an hour.

Patient Navigators simplify access to information and communication for continuity of care. Hospitals expressed that, while case workers do spend on average up to 2 hours per patient encounter on a given day, the involvement of the navigators helped reduce staff burden cumulatively by 15 m to 1 hour per case (depending on the hospital, staff involved and the case), with an average cumulative savings of approximately 30 minutes per patient encounter. If we assume one unduplicated encounter per business day, the monthly savings equal to 10.8 hours per month. At a payment rate of \$45 per hour for a licensed social worker, the savings would equal to \$487.5 per month or \$5,850 per year for one staff person. Of course, this is a rather simplified assessment. A true cost analysis would require further detailed study measuring, for instance, actual time spent per patient by each hospital staff and the Patient Navigator, and then extrapolate any savings between homeless patients in the program and patients who are not in the program.

**Hospital partners perceived improved overall outcomes for participating patients that hospital staff could not replicate with severe burden and opportunity cost.**

Based on the amount of time spent by a Union Station Patient Navigator to run the program, the opportunity cost to hospital social workers to obtain similar results as the navigators presents another form of cost savings. Patient Navigator spend 6 to 10 times more time with patients than hospital case workers to obtain the types of results outlined in this report. A Union Station Patient Navigator spent on average 18 hours and 19 minutes on a single case. To obtain a similar result, the case worker would need to spend an additional 16 hours or \$720 per case. At 2 hours spent per case, the hospital case workers tend to an additional 8 patients in that timeframe.

What Patient Navigators do that hospital staff do not have the time to do include:

- Taking patients to medical providers
- Taking patients to get documentation
- Taking patients appointments
- Working with patients in making appointments
- Helping patients obtain housing
- Assessing patient perceptions based on services provided
- Building rapport with patient over a period of time
- Visiting with patients
- Providing patients with resources (i.e., Food, water etc.)

**Hospital partners perceived lower readmission rates among the high utilizer patients.**

Hospital partners perceived lower readmission rates among patients who participated in the program. Many reported that, beyond the readmission rate, patients in the program experienced other positive outcomes, particularly housing placement, which were equally important.

The following two hospital profiles validate perceptions around lower readmission rates.

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## Huntington Hospital Readmission Profile

Between October 1, 2020 and April 30, 2022, Huntington Hospital had approximately 70 unduplicated referrals for whom data could be retrieved from the hospital case management system.<sup>3</sup> 25 patients had been enrolled in the pilot program. The hospital tracked readmissions in three locations: the Emergency Department, the Inpatient Hospital, and the Huntington Ambulatory Care Center (HACC).<sup>4</sup>

The tables below illustrate the number of readmission encounters between patients who enrolled in the program and patients who were referred to the program but were not enrolled. In total, fewer readmission encounters per patient were tracked among enrolled patients (3.24) than likely peers not enrolled (4.18). Specifically, the emergency department return visits were much lower, but modestly higher for inpatient visits for enrolled patients.

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<sup>3</sup> The referral list includes duplicated patients and several patients that could not be fully identified within the hospital data system and had to be excluded for the purposes of this analysis.

<sup>4</sup> HACC is a full service medical clinic staffed by the hospital's internal medicine and surgical residents. Services include medications and refills, preoperative and postoperative ostomy services, blood transfusion clinic, scheduling for mammography and, radiology, and tobacco treatment and counseling.

	ED Return		Inpatient Return		HACC Visits		TOTAL	
	Not		Not		Not		Not	
	Enrolled	Enrolled	Enrolled	Enrolled	Enrolled	Enrolled	Enrolled	Enrolled
<b>Readmission encounters per patient</b>	2.33	1.96	0.84	0.92	1.00	0.36	4.18	3.24

The number of homeless patient hospital encounters did not decrease across the hospital’s three entry points for the observed patient pool. Over half (56%) of homeless patients were readmitted either the Emergency Department, the Inpatient Hospital, and the Huntington Ambulatory Care Center. However, and notably, the readmission rate to the Emergency Department was 8% lower among enrolled homeless patients than referred patients who were not enrolled.

Homeless Patient Hospital Encounters				
	ALL (ED, INPT, HACC)		ED Only	
	Not enrolled	Enrolled	Not enrolled	Enrolled
<b>Readmitted</b>	<b>56%</b>	<b>56%</b>	<b>40%</b>	<b>32%</b>
<b>Not Readmitted</b>	<b>44%</b>	<b>44%</b>	<b>60%</b>	<b>68%</b>

In addition, while a total of 49 Emergency Department readmission encounters were logged during the pilot period, 68% of enrolled patients did not return to the ED between their pilot enrollment and April 30, 2022 (near the end of the pilot program). Similarly, 68% of enrolled patient did not return for a hospital inpatient visit in the same time period.

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## Kaiser Permanente at Baldwin Park Readmission Profile

Between October 1, 2020 and April 30, 2022, Kaiser Permanente Hospital at Baldwin Park reported overall 573 homeless patients utilizing the Emergency Department, of which 409 were unduplicated patients. The average length of stay for all encounters was approximately 0.79 days.

The overall rate of readmission encounters during this period within the Emergency Department was 11.7%. Interestingly, this rate decreased over time between the three trimesters (each 6 months long) of the pilot project. As shown below, the rate was highest in the first 6 months of the pilot program (at 15.7%) and lowest in the last 6 months of the program (9.8%). Further data collection would help reveal whether this trend has a causal connection to the pilot program

Pilot Program Period	First ED Admission	ED Readmission				Readmission Rate
		1	2	3	4	
First 6 months	134	21	2	0	2	15.7%
Second 6 months	163	16	2	1	0	10.4%
Third 6 months	129	8	5	1	0	9.8%

The hospital also saw a reduction in readmission rates among enrolled patients. The table below illustrates the trajectory of patients after enrolling in the pilot program, with each row representing one unduplicated patient. While a total of 32 readmission encounters were logged during the pilot period, readmission to the Emergency Department among enrolled patients was reduced by at least 50%.<sup>5</sup> The No Readmission Rate among enrolled patients was 44.4%. Additionally, 61.1% of enrolled patients had a positive housing outcome.

Status of Enrolled Patients after Enrollment during Project Period <sup>6</sup>		
# Re-Admissions	Housing	Housing (or Other) Outcomes
0	1	In permanent housing
3	1	Refused SRO, went to hotel, got CalFresh
2	1	Sober Living
1		In PRK Site
3	1	Was in sober living, then got own apartment
0	1	Went to sober living, then left
5	1	Offered tiny home housing, but refused housing
1		Got resource for shared room
0		Enrolled in Family Services because pregnant
6 (in 11 months)	1	Placement in SNF, then passed away in SNF (20 admissions in year prior to enrollment)
1		No housing outcome
4	1	Living in motel with family
3	1	Got housing voucher, on probation
0		No housing outcome
0	1	Sober living, already connected to VA
0		No housing outcome
3	1	Referred to tiny homes, in hotel, then left LA
0		Got ID. No housing outcome
<b>32</b>	<b>11</b>	<b>TOTAL</b>

<sup>5</sup> A more accurate measure could be determined if hospitals could provide patient ED visits one year prior to enrollment.

<sup>6</sup> The program enrolled 21 patients from Kaiser Permanente at Baldwin Park. Three patients could not be fully identified within the hospital data system and had to be excluded for the purposes of this analysis.

# Appendix A—Logic Model

Inputs	Activities	Output/Participation	Short Term Outcome	Long term Outcome
Resources needed to accomplish set of	Activities in place to run the program	Activities will produce the following evidence	Activities will result in the following changes	Activities will result in the following changes
Hospital partnership	<b>Patient Screening</b>	# screened for homelessness	<b>Increased access to screening</b>	
Patient Navigators	<b>Patient outreach</b>	Patient demographics		
Grantee infrastructure	<b>Patient Enrollment</b>	# of patients referred, enrolled, refused	<b>Reduced barrier to entry/Increased access to Case Manager (or PN)</b>	<b>Reduced readmissions</b>
Patient population		Barriers to enrollment		
Local community medical resources	<b>Service/Need identification</b>	Types and # of barriers identified for enrolled patients		
Local community nonmedical resources	<b>Intervention Services (medical)</b>	# and type of services patients connected to	<b>Increased patient knowledge about available services</b>	
Baseline data		Time from enrollment to exit	<b>Increased compliance/engagement with recommended services</b>	<b>Increased self efficacy homeless pop</b>
Funding			* Total # of appointment while in program & # of appointments missed	
	<b>Intervention Services (non-medical)</b>	# and type of services patients connected to	<b>Increased connection to resources housing, benefits and finance, outpatient health care, mental health care, basic needs (e.g meal, meds)</b>	<b>Improve health or perceptions of better health among homeless pop</b>
		Time from enrollment to exit	* Number connected to housing	
		# of patients and reasons at program exit	* Number of patients enrolled into Medi-Cal and health plan or other health insurance	
			* Number of patients connected to medical homes for primary care	
			* Number of patient appointments for mental health and substance use disorder services, as	
			* Number of patients linked to other social health benefits and/or appointments (e.g., food, income)	<b>Reduction of ED use--- for pre/post PN support; social health needs in homeless pop; chronic conditions in homeless pop</b>
	<b>Coordination of Care</b>	Time of patient navigator spent on activities	<b>Increased efficacy in coordination of care</b>	<b>Reduction of ED cost</b>
		Trained and culturally sensitive PNs		<b>Reduction of staff burden</b>
				<b>Increase knowledge of how best to serve homeless pop.</b>

# Appendix B—Focus Group Protocol

## CONSENT PROTOCOL

### INTRODUCTION

Good Afternoon.

My name is \_\_\_\_\_ and I am a researcher at the Center for Nonprofit Management.

The Center for Nonprofit Management has been contracted to learn more about the impact of the Patient Navigation program on hospitals. You were selected as a possible participant in this study because you are a key stakeholder to the program.

### WHAT SHOULD I KNOW ABOUT A RESEARCH STUDY?

- We are conducting a focus group/interview today to get your perspective on the program.
- Your participation may help the program to continue and grow.

### YOUR RIGHTS

- Your participation is voluntary.
- You can choose whether or not you want to be in this study, and you may withdraw your consent and discontinue participation at any time.
- Whatever decision you make, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled.
- You may refuse to answer any questions that you do not want to answer and still remain in the study.

### LENGTH OF FOCUS GROUP

- We expect this focus group/interview to take approximately 60 minutes.
- There are no anticipated risks or discomforts from participation.

### CONFIDENTIALITY OF PARTICIPATION

- We are planning on recording today's session. However, the recording is for the purpose of the researcher and/or CNM staff to complete notes from today's session.
- No other individuals or agencies may access them.
- Your responses may be combined with responses from others, but you will not be personally identifiable. No personally identifiable information will be collected or stored.

- Research records provided to authorized, non-CNM personnel will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name. While it is possible that we use quotes from the focus group to illustrate data, the quotes will be kept anonymous.
- Data may be stored for up to 3 years.
- Study data will be physically and electronically secured. As with any use of electronic means to store data, there is a risk of breach of data security.

### **WHO TO CONTACT FOR QUESTIONS ABOUT THE STUDY?**

If you have any questions, comments or concerns about the study, you can talk to the project director, Maura Harrington at 213-266-8450.

If you have questions about your rights as a research subject, you may contact Maura Harrington at (213) 266-8450.

### **DO YOU HAVE ANY QUESTIONS?**

**DO YOU CONSENT TO PROCEED WITH THE FOCUS GROUP AND THE RECORDING? IF YOU ARE NOT CONSENTING, PLEASE SPEAK NOW.**

### **LET'S PROCEED**

## INTERVIEW/FOCUS GROUP QUESTIONS

### IMPLEMENTATION

1. What do you think are the program's strengths?
2. Can you highlight a bright spot or a positive memory with a patient from the program during the past year?
3. What do you think are the program's weaknesses or challenges?
4. What do you think are the service gaps that still exist for the homeless patient served?
5. What do you think the program should be doing more or less of?

### ACCESS

6. Can you explain your relationship with the [hospitals/patient navigator]?
7. [Patient Navigators only] Were you able to gain access to hospital data?
  - a. What were the challenges and successes?
  - b. How was patient data been shared with you?
8. What data has been most important to share/get access to for coordinating patient care?

### COORDINATION OF CARE

9. How has the referral process worked for you?
10. Can you describe the coordination of care? How has that worked?
11. Can you describe your relationship with the Hospital Liaison?
  - a. What about it worked?
  - b. What didn't work?
  - c. Do you feel there is overlap or duplication in the work with the patient navigator? In what way?
  - d. Is there clarity in the distinction of the roles?

### IMPACT

12. What do you think affects attendance of homeless patient into the program?
13. In what ways do you feel the program has helped the homeless patient?
14. How can the program be improved?
  - a. What do you need to be more successful?

