2023

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.

2022-23 Qualitative Evaluation Report:
Key Learnings from Second Year of Implementation

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Prepared for United Way
1000 N. Alameda Street, Suite 250
Los Angeles, CA 90012

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Introduction

The housing and homelessness crisis continues in Los Angeles County with nearly 69,144 people experiencing homelessness. While the growth rate of homelessness has decreased from 25.1% in 2018-20 to 4.1% in 2020-22, more people are in shelter than ever before. Officials warn that recent policies and investments, such as pandemic era safety nets and one-time shelter funding, may be ebbing and placing these gains at risk.

Despite these gains, hospitals continue to confront the complex health and housing needs of unhoused patients coming to the emergency department on a consistent basis. In 2020, partner hospitals Emanate Health, Huntington Health, Kaiser Permanente Baldwin Park, USC Arcadia Hospital, Pomona Valley Hospital Medical Center (PVHMC) collectively treated approximately 8,731 homeless patients though these Emergency Department visits represented a fraction of total visits for the year.[1]

The Service Planning Area 3 Patient Navigation (PN) Pilot program was developed to strengthen coordination between healthcare systems and homeless services and improve health and housing outcomes for people experiencing homelessness.

In the first year of implementation, the Patient Navigation (PN) Pilot supported post-discharge care coordination and case management for 100 homeless "high utilizers" of hospital emergency services in the San Gabriel Valley/SPA 3 area of Los Angeles County. With coordinated support from the Health Consortium of the Greater San Gabriel Valley (Health Consortium-SGV), hospital and homeless service partners co-designed, planned, and implemented an 18-month pilot program from October 1, 2020 through June 30, 2022. The pilot program increased service capacity with three full time Patient Navigators embedded within hospital teams and workflows, and connected target patients to shelter/housing placements, primary care services, public benefits, and more.

Now in its second year, the pilot program provided the same services but to a narrower eligible population of unhoused patients aged 50 years or older. This qualitative evaluation report serves to assess this second year of implementation. Based on stakeholder feedback, the evaluation explores the overall effectiveness of the pilot, demonstrates the value of PN positions to the health care sector, and provides insight for future advocacy around financial sustainability of the program.

[1] Inpatient Hospitalizations and Emergency Department Visits for Persons Experiencing Homelessness in California: Patient Demographics By Facility. (2020). Last accessed at www.hcai.ca.gov.

Program Design, Learnings & Changes

How the Pilot Program Works

In this second year, the United Way of Greater Los Angeles (UWGLA) San Gabriel Valley (SGV) Patient Navigator Pilot program provided case management services to high-utilizing hospital patients who were 50 years of age and older and homeless or at-risk of being homeless. The program connected with these patients during or 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.

The pilot project involved five 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 five hospital partners to ensure commitment and the effective co-location of Patient Navigators within hospital settings as well as to enable data sharing.

Hospital partners included:

1. Emanate Health including Foothill Presbyterian Hospital, Queen of the Valley, and Intercommunity Hospital
2. Huntington Health
3. Kaiser Permanente Baldwin Park
4. USC Arcadia Hospital
5. Pomona Valley Hospital Medical Center

In this second year, the program also included partnerships with Community Health Alliance of Pasadena (ChapCare) and East Valley Community Health Center, two large Federally Qualified Health Centers in the SGV, as key primary care medical service providers that could support follow-up care of unhoused patients, particularly those without medical insurance and/or a primary care provider, after discharge.

Key components of the project were:

1. Patient Navigators

Two Patient Navigators (PNs) worked "in the field" with four hospitals in SPA 3, each managing two hospitals. A third navigator, working half-time, was available to work with a fifth hospital..

Patient Navigator's core responsibilities were to provide case management to high utilizers of hospital services who are experiencing homelessness. Patient Navigator roles included:

- Provide case management to high utilizers of hospital services who are experiencing homelessness. Patients were identified by participating hospitals. Parameters included: Patients who 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 enrolled patients until they are placed and stabilized in shelter and/or housing and are regularly connecting with a medical provider 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 create an action plan and share information/resources for enrolled patients; strategize about what can be done for patients in the future and share updates on housing.

2. Resource Coordination

The pilot project explored 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 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 this pilot program, the SPA 3 Hospital Liaison received referrals from and provided high-level referral support (no caseload) to partner hospitals. The Hospital Liaison performed the following core responsibilities:

- Screened referred patients from hospitals to determine eligibility for enrollment into the Patient Navigation program. If not eligible, patients were referred into other programs;
- Built relationships and identified opportunities for partnership with community health care providers;
- Convened hospital partners and Patient Navigators monthly for case conferencing and problem-solving;
- Screened, tracked, and monitored high frequency hospital homeless patients, and documents referrals for services and resources;
- Documented practices for shared learning; and
- Worked closely with Patient Navigators, social workers and hospital discharge planners and provide technical assistance on homeless services.

The Patient Navigators, in turn, provided intensive case management and connected patients to homeless services and coordinated services for the homeless patients assigned to their care.

3. Recuperative Care, Housing and Other Resources

One of the goals of the pilot project was to facilitate a process of healthy recovery for program participants. To provide this coordinated service at a lower cost than hospitals, Patient Navigators linked participating patients to existing resources, linkages to housing, and resources that they otherwise may not have accessed. Concurrent with this program, the SGV Hospital Collaborative worked to identify possible recuperative care services that could be brought to the SGV to serve as an important component of the continuum of care for these patients.

4. Data Sharing

Through this pilot, project partners established data sharing practices and standards wherein hospitals could share limited data with the Hospital Liaison and Patient Navigators to allow greater coordination of care with the hospital staff and better support services for the patient. This plan allowed Patient Navigators restricted, read-only access to hospital EHR systems with some capability to enter case notes; PNs also had access to the homeless services database (HMIS). By having access to patient information, the Hospital Liaison and Navigators facilitated care coordination across systems; they led and/or participated in case conferencing with homeless case managers and clinic-based care coordinators. Patient Navigators formed an information hub to support healthcare and homeless service providers and make better informed decisions around comprehensive care of homeless patients.

Key Takeaways from Year 1 Evaluation

Some of the key takeaways from Year 1 implementation are as follow:

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

2. Patient Navigators were 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.

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

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

5. The partnership between hospitals and Union Station led to a strong collaboration, leaving many program partners wanting more.
6. Partnership between hospitals and Union Stations not only led to improved coordination of care within the program network but also extended efficiency of care to “out- of-program network” organizations.
7. The Patient Navigator is the key asset to the program’s success and the continuity of care with the patient.
8. 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.
9. 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.
10. 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.
11. Access to hospital and program data proved to be 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.
12. The pilot project succeeded in improving housing outcomes and connections to homeless services for enrolled patients. The success of the housing and other homeless service outcomes and placements was directly attributable to the perseverance and frequent case follow-up of Patient Navigators.
13. 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.
14. Hospital partners perceived time savings for their own staff since the involvement of the Patient Navigator which translated into potential cost savings for the hospitals. Hospital partners also perceived improved overall outcomes for participating patients that hospital staff could not replicate without severe burden and opportunity cost.

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

Changes in Program Design

In this second year of implementation, some changes to the program model were introduced.

Patient eligibility: Guidelines for patient eligibility were narrower for the program in Year 2, focusing solely on older adults. To be eligible, a patient had to be 1) over the age of 50 at time of referral; 2) chronically homeless (i.e. unhoused more than one calendar year over the course of the last three years) in Service Planning Area 3; and 3) a frequent utilizer of hospital services (at least 4 interactions in a 12-month period involving receiving health care at an emergency department, being taken by an ambulance to the hospital and/or being hospitalized as an in-patient). Active patients who were under 50 in the first year of implementation were grandfathered into the second year.

Referral information: Union Station renegotiated with hospital partners the patient information needed at time of referral to assist the hospital liaison and patient navigators with their case management. Year 1 implementation confirmed that limited access to patient information allowed the Patient Navigator to be better prepared in engaging the patient and providing vital resources. The requested information or "face sheet" for each patient would now include:

- Contact information (hospital room or bed number, patient cell phone number if available, nursing station number if no direct line was available).
- Patient room number and floor.
- Discharge plan including admission date.
- General location: Address or cross streets where patient stays when not at hospital (and include city and zip code if possible).
- Physical description (such as height, weight, noticeable physical features etc.)
- History of homelessness.
- Substance use or incarceration.
- Any mobility (such as use of wheelchair) or isolation (i.e. Covid) information.

Referral process standardization: In the first year of implementation, hospitals had greater flexibility in how they referred eligible patients to the program even though the program design called for all referrals to be processed through the LAHSA web-based system, Once in the system, referrals would go directly to the Hospital Liaison for eligibility screening and assignment to a patient navigator. However, because of a vacancy in the Liaison position and end-user challenges with the LAHSA portal, referrals occurred in a mixed approach involving direct referrals to 1) the LAHSA portal, 2) the Hospital Liaison or 3) the Patient Navigator. The

flexibility posed challenges in efficiently managing case referral process across multiple hospitals.

In this second year, the process was corrected by reintroducing hospitals to refer patients through the LAHSA portal only and referrals being processed by the Hospital Liaison for approval into the program before connecting the patient to a Patient Navigator. Hospital partners were also reoriented to this more standardized approach.

In addition, the point of initial screening occurred differently. Hospital partners often determined eligibility of patients in the first year before sending the referral. With a more widespread adoption of the portal, hospitals could now refer all unhoused patients in need, and the Hospital Liaison could then make the eligibility determination for any available program, not exclusively the Patient Navigation program. Patients not eligible for the Patient Navigation project could be referred by the Hospital Liaison to other programs or services that may carry more favorable eligibility requirements for the patient.

Primary Medical Care Providers: The Patient Navigation program added medical care provider ChapCare and East Valley Community Health Center as partners to the project. These providers were seen as essential resources for patients that did not have medical insurance or a primary care physician. If the unhoused patient had a primary care physician, then the patient would be reconnected to their provider.

Qualitative Evaluation Methods

The second year of this pilot program evaluation extended the mixed method approach from the previous year. 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.

The evaluation plan included:

- 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. The output measures were collected and reported by Union Station Homeless Services.
- Key stakeholder interviews and/or focus groups with program partners who can speak to the successes and challenges of the program. Focus group instrument and protocol were revised 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. Due to the relatively low number of stakeholder 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.
- Case studies of individual unhoused patients. Ten patients enrolled in the Patient Navigation program were briefly interviewed to provide feedback on their experience as a program participant. Given their existing relationship with the patients, Patient Navigators were provided a structured interview protocol to conduct the interviews. Naturally, patients who agreed to be interviewed were individuals who built rapport and trust with the Patient Navigators, so the interview sample may exclude patients who did not have the best relationship and benefits from the program. Despite this subject sampling limitation, the interviews provide a rare glimpse of the program from the patients' perspective, particularly those who felt comfortable with the program.

This report includes a summary of all the qualitative components of this evaluation plan.

Results and Key Takeaways

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

Value/Impact

Project partners expressed their perceptions of the SPA 3 Patient Navigation project and its value.

Referrals of unhoused patients were successful.

Unhoused hospital patients were successfully referred to the Hospital Liaison through the LAHSA portal and the eligibility criteria were applied consistently, though hospital partners had misgivings over the age requirement. The standardized referral process allowed hospitals to

freely refer unhoused patients to the Hospital Liaison who determined whether the patient was eligible for the Patient Navigation program.

- The Hospital Liaison provided a brief program presentation to staff at participating hospitals so that they were better informed of the program goals and objectives.
- Hospital staff typically conducted an initial assessment to inform the patient of the program opportunity and gauge level of interest. For interested patients, hospital staff (usually the social worker engaged with the patient's safe discharge) obtained the patient's authorization and consent to be referred.
- With the Hospital Liaison vetting each referral, the program had more consistency in the cases accepted into the program across all hospitals. Although total referrals submitted by hospitals increased, not all referred patients met the program eligibility criteria. The Hospital Liaison attempted to link patients who were ineligible for the PN program to other programs or services when applicable. The Patient Navigator no longer needed to worry about spending time with ineligible patients and hospitals could be certain that the eligibility requirements (including the interpretation of the "chronically homeless" standard) were being applied consistently across hospitals.
- Though hospitals did use the LAHSA portal to make their referrals, the internal procedures for referral entries may have varied. For some hospitals, social workers managing a patient's discharge directly accessed the LAHSA portal to enter the referral, while for others, referrals were handled centrally by a case manager or designated personnel who received the requests (usually via email) from social workers regarding patient interest with the authorized consent and release of information ready to go. In both approaches, referrals often included the social worker who referred the case and/or the nurse station number. Upon receiving the referral, the Hospital Liaison could then contact the social worker, nurse station or the case manager for any follow-up related to the referral.
- Hospital staff found the referral process through the LAHSA less cumbersome than last year. Staff expressed, "the referral board is fantastic", "super-easy", and not requiring "too much data" entry. Staff expressed that the LAHSA referral portal appeared to have been simplified, "removing the minutiae" that made it harder on end users. In general, program participants found the portal helpful with feedback, updates, but "it's only as good as when they [information] are already entered." Participants can see if patients have been on the system before.

Despite the success of the referrals, many hospital staff found the age limit restriction of the PN program disappointing, feeling that the age limit made the program feel more exclusionary. Some spoke about the benefits of reaching younger patients in their 30s and 40s to make a long-term or lifetime difference in their lives and on the health care system. Others felt that

while the unhoused population over the age of 50+ is significant, the eligibility restriction left many patients unserved. During one patient interview, a patient exclaimed, "Some of us are not old, or are not veterans, but we deserve housing too."

The standardized referral process had unintended consequences.

The referral process through the Hospital Liaison resulted in unexpected negative consequences in the program including an overburdened caseload for the Hospital Liaison, delays in response time to hospital referrals, and reduced perceptions of program benefits (such as time savings) by hospital staff.

The Hospital Liaison has a much larger role beyond the PN program. By design, the position, funded by LASHA, acts as the high level "air traffic controller" helping to connect unhoused patients to services and resources in the homeless service system, known also as the Coordinated Entry System (CES), in Los Angeles County. Each Service Planning Area has a dedicated Hospital Liaison. The Hospital Liaison for Service Planning Area 3 is connected to the community through Union Station Homeless Services and is responsible for referrals from 7 hospitals The Hospital Liaison responsibilities included to 1) train hospital staff; 2) reconnect patients to providers with whom they may already have a relationship; and 3) help to create coordinated care plans for high utilizers of the hospital system, particularly emergency departments.

As noted, the Hospital Liaison is not solely dedicated to the Patient Navigation program and the eligibility criteria that define it. The Patient Navigation is just one program of many to which the Hospital Liaison has access for patient referrals. Of course, each resource had different eligibility criteria.

The standardized referral workflow adopted in this second year of implementation, whereby all referrals go to the Hospital Liaison first for processing before connecting the Patient Navigator to a patient, resulted in unexpected bottlenecks in the Patient Navigation program that negatively impacted the program for the following reasons:

The demands placed on the Hospital Liaison position and the competing priorities resulting from these demands were significant, resulting in less attention to PN program referrals. Patients referred from the PN program "could fall through the cracks" as one partner expressed.

- *Increased referral volume.* By all counts, partner hospitals were making greater use of the referral service to the Hospital Liaison. The increased referrals placed greater stress on the Hospital Liaison to process and connect patients to appropriate resources and services. The Hospital Liaison sorted through all the referrals received. Not all referrals were for the Patient Navigation program. Hospital staff felt that they were submitting

more referrals than last year, but the eligibility criteria was narrower for patient enrollment.

- *Increased expectations & system limits***.** LAHSA's focus on increased requests for data entry and collection from the Hospital Liaison diverted time away from the referral and program enrollment process. Additionally, some of the various systems (such as Clarity and LAHSA portal) were not connected resulting in certain information having to be entered into two different systems.

- *Reduced resources to process hospital referrals.* The caseload ratio and the expectation to respond to referrals from multiple hospitals hindered patient connection and increased the risk of missing individuals in need. In the first year, three patient navigators were fielding the hospital referrals. That entire workload rested now with one Hospital Liaison in this second year to manage referrals from hospitals in Service Planning Area 3.

- *Equity and Fairness.* Concerns arose about the fairness and equity of the system if not everyone has easy access, potentially resulting in missed opportunities for assistance based on referral timing and limited resources. As one partner stated, "if everyone does not have access to the front door easily, how can you say it's fair and equitable because it's really a matter of whether that person was able to respond to that referral."

In many cases, the delayed response to the hospital referral and a warm hand-off of patient to the PN prevented the ability to connect with the patient PRIOR to discharge. One of the key findings from Year 1 was that the initial contact with the Patient Navigator needed to happen quickly and before the patient was discharged from the hospital. Early access to the patient helped to establish trust and improved the likelihood of program enrollment. Patients often perceived the Patient Navigator as an extension of the hospital staff. Over 68% of patients enrolled in the first year of the program had been contacted by the Patient Navigator at the hospital.

- *Increased time spent locating patient post-discharge*. With the response delay, the Hospital Liaison now needed to connect with the patient post-discharge which meant that the liaison had to spend additional time and effort locating the patient in the community taking precious time away from processing other referrals. Despite Patient Navigators' best efforts, locating patient in the community proved challenging and time consuming. Additionally, as noted above, the elapsed opportunity is met with more resistance to participation if patient is located.

- *Timing of referrals, time of discharge and geographic area of SPA 3.* At times, referrals were made too close to discharge, leaving the Hospital Liaison inadequate runway to meet with the patient in advance of discharge, particularly since the Hospital Liaison was contending with increased demands and workload. The referral process can be

delayed if some of the key requested information from the hospital partner is not included in the referral. In addition, as noted in last year's evaluation, the hospital liaison service was not designed to be available 24/7 though hospital discharge planning may occur at any time. The Hospital Liaison is a 9-5 job and therefore typically not available during graveyard shifts or weekends. Additionally, Union Station is closed every other Friday. Only one Liaison is available to process requests from all the hospitals, so the 'limited' access compounded the response delays of patient referrals. Furthermore, Service Planning Area 3 spans a large geographic footprint that caused delays as the Hospital Liaison moved between hospitals to reach patients.

Most of the time in Year 2 of this pilot, patients were not connected with the liaison or navigator until after discharge. The Hospital Liaison had increased difficulty tracking down patients who did not have cell phone access or a physical address. Despite this, the Hospital Liaison was accessible by phone to any patient with a cell phone to ensure connections were not missed if the patient was discharged without that first touchpoint.

The delayed response, and limited connections prior to discharge reduced the perceptions of any time savings and tangible benefits for hospital partners. In the first year, hospital staff expressed perceived time savings in their caseload when the patient was connected to the Hospital Liaison or Patient Navigator prior to discharge. These savings occurred because 1) the Patient Navigator and hospital staff could connect quickly to discuss a case; 2) the Patient Navigator acted as the connecting point or bridge between various hospital staff involved with a particular case; 3) the Patient Navigator was the gateway access to critical resources available in the community which meant that they did not have time to research how to provide safe discharge for a patient; and 4) the Patient Navigator helped expedite the safe discharge planning and process.

Because of the delays in response time to referred cases, hospital staff had to proceed with the safe discharge process without the immediate assistance of the Hospital Liaison or Patient Navigator. Consequently, the perceived time savings, estimated by staff to be approximately 30 minutes per patient encounter, no longer held true. Hospital staff no longer felt the cumulative impact of that savings in a given week or month. More importantly, the connection and collaboration with the Hospital Liaison or Navigator prior to discharge provided hospital staff with more options for discharge planning which no longer existed. As one hospital staff stated, "Not being able to provide options brings us back to our norm which is just providing a list [of resources] and feeling that not a whole lot can be provided." Another staff member said that by having the Patient Navigator available before discharge and supporting the discharge process in the prior year, "the level of individual care felt more impressive."

All of these challenges created a systemic disconnect whereby the speed to connection to the partner and the patient was limited because information being received in the form of referrals could not be processed quickly enough. The program has received more referrals, but the Hospital Liaison needs to receive them much earlier (not the day before or the day of discharge)

to have any hope of reaching the patient before discharge. But hospitals do not always have the luxury to send referrals so far in advance; that is when the bottleneck often begins.

Patient were connected to critical services, but housing placements, which hospital partners deem as the most important outcome, were more challenging than in the prior year.

The Patient Navigators continued to connect patients with many critical resources. They are, as one partner noted, “the people who are the last line of defense for people who don’t have another option.”

1. **Social services** include government document assistance, birth certificates, homeless verification, government ID, social security card, and referrals for benefits, education, and legal services.
2. **Health care services** include referrals to mental health care including alcohol and drug abuse, general mental health, physical disability etc.
3. **Transportation services** include bus passes and direct transportation.
4. **Housing services** include referrals to bridge housing, crisis housing, rapid re-housing as well as housing search and placement.

This year, these connections, particularly to housing, have been especially challenging. Shelter beds continue to be in limited supply in SPA 3 and patients do not want to relocate to another area. One program partner stated, “funds and services provided in this area are minimal.”

Immediate housing placements are most critical and defined by some hospital staff as “a game changer” because it allows hospitals to provide a safe discharge option quickly. For hospitals, the Patient Navigation process worked well when the Hospital Liaison connected with the patient and supported the discharge plan by visiting the patient, contacting housing service coordinators in different locations and referring patients. However, housing or shelter is not always immediately available, and 211 calls are limited in their assistance. As one hospital staff stated, “The value [of the program] is changing people's situations by directly connecting them to housing, getting them benefits etc. to help change their circumstance.” When the homeless patient does finally receive housing, the discharge process is expedited at less cost if the patient ever does return to the hospital. “If the patient has housing, then we don’t have to worry about sending them to recuperative care because we’ve been having to do that a lot these days and it’s costing us a lot,” said one hospital partner.

The entire system is fraught with cases, however, that require the patient to have an immediate safe place to go. One hospital has secured a contract with a temporary shelter to hold two beds (male and female) for viable response to an immediate placement. If the patient requires more advanced need, then the hospital may need to refer patients to recuperative care which is a paid program. One hospital partner has a contract with a recuperative care

organization with a 10-day minimum policy. In instances where the hospital sends patients to recuperative care or a nursing facility, most of that cost is borne by the hospital.

Housing placements have been difficult to complete because of the limited resources from market shifts, social stigma, and mismatch of eligibility to resources.

- *Vouchers ending.* The Patient Navigator applies for every housing placement opportunity that is available, but many vouchers, particularly those from the COVID-19 era, have ended. The LAHSA Emergency Housing Vouchers are no longer being issued and no additional extensions are being provided. As a result, a lot of clients are coming back because they have lost their vouchers while waiting for housing placement. Patient Navigators have been scrambling to find alternative vouchers, but no new programs are available yet to remedy the demand gap.

- *Waitlists and Placements*. Short term housing supply is limited. The waitlists and lottery list for longer term housing are long. There is strong competition in the market for a limited supply with patients waiting eight to nine months just to receive a voucher. Additionally, patients need credit history, and they often have either poor or no credit history.

- *Stigma & Rental Cost*. Within the housing market, Patient Navigators seek vouchers for patients, but not all landlords are willing to accept vouchers. Some landlords struggle with the stigma of renting to an unhoused client. In many cases, rentals are too expensive for the patients' budget. Some clients have had vouchers before and did not find housing, so they get discouraged. Working with the Patient Navigator gives them motivation to continue with the housing search.

- *Resource Mismatch*. Patients who are 50 and over may have more specific housing needs that are scarce in the SPA 3. The system does not support the needs of the community (aged 50 and over). More than likely, if they are in this age group, and "high utilizers" of hospitals, they need boarding care, a nursing care facility, or intensive case management. These resources continue to be sparse.

Project Design & Implementation

Pilot partners had the following perceptions about the partnership, program design and the coordination of care for this second year.

Program partners valued the collaboration.

Partners highlighted the tremendous value of hospitals working together and in partnership with community service providers. The Patient Navigation program brought the hospitals and community partners together in a unique way. Partners expressed the direct benefits of this relationship.

- **Strong advocacy for patients.** Program partners were strong advocates for the patient population. In particular, hospital staff spoke about the strong dedication of Union Station Homeless Services personnel to patients and the community. In one case, a patient in the program had gone missing. The Hospital Liaison reached out to all the hospitals with a profile description in the event the patient returned to one of the hospitals. "The Hospital Liaison and Patient Navigator genuinely care and use whatever resources are available to find patients," stated one program partner.

  Additionally, clients leaned on the Patient Navigators to be their medical advocate when needed, often wanting the Patient Navigator present during medical appointments for fear of being discriminated against or dismissed by a health professional. The Patient Navigators champion the dignity and autonomy of patients. The Patient Navigators help patients who may feel vulnerable or exposed in the healthcare setting. For example, there have been cases where patients wanted access to a shower prior to going to their appointment and being examined.

- **Opportunities for collective meetings & exchange.** Program partners appreciated the monthly meeting which provided an opportunity to learn how the program is working overall, how other partners are working the same population, how other partners benefit from the program, and what trends or commonalities are observed (e.g., uptick in homeless patient pool). As one program partner suggested, "the collaboration is very valuable because it helps [us] be aware of resources and opportunities that we would not be aware of in our own silos." The partnership also allows health providers to have a better understanding of the challenges of working with the vulnerable population.

- **Maximized resources.** Some partners expressed how the Patient Navigation program created the opportunity for more streamlined case management and follow-up in the region. Having access to a Hospital Liaison and Patient Navigators allowed for a streamlined effort instead of having to search and filter through the entire homeless landscape for resources and support. For instance, it afforded hospitals a direct linkage and communication to available shelter resources and other patient benefits. The Hospital Liaison could also share updates on shelter availability.

- **Valued relationships**. Hospitals do not have the capacity to access resources, such as community beds, in the same way that a community provider can (for instance through the LAHSA centralized intake system). Having a partner that can connect patients to housing (i.e. shelter, hotel voucher, short term housing) is valuable. As one hospital partner stated, "I just want to give the information and for them to figure out if this patient is appropriate for navigation or something else. I don't want to do that work. I don't know what's available in the community. I look to them [Union Station as the community partner] to figure out and see what's appropriate for the patient."

The program provided greater continuity of care with key benefits and some challenges.

Hospitals and Union Staff both perceived improved continuity of care of homeless patients. Despite the challenges in connecting with patients early, the program did provide much needed process for referrals, direct connections to much needed services to the patient, and better health care. One hospital partner expressed it this way: "When the follow-ups do occur, the Hospital Liaison and Patient Navigator are on point."

Program partners uplifted the benefits of the continuity of care provided through this program:

- *Direct linkage to patient.* The Hospital Liaison was the gateway or access point to all the information/resources available through Union Station, unlike the first year when this role fell to the Patient Navigator. The program offers linkage to a person to build rapport and continue the navigation. "It doesn't mean that we don't see them [patients] again, but they at least have a foundation to work on some form of housing," stated one hospital partner. One unique aspect of the program model is how the Hospital Liaison directly visits the patient at bedside, when possible, to speak to him/her/them.
- *Connection to an informed community partner.* The Hospital Liaison and Patient Navigators had strong connections to SPA 3 communities. They were well informed about available resources even before these resources were disclosed more broadly. They therefore responded quickly, saving time and effort, in a way that hospital staff would have been unable to match. A program partner said, "I can't imagine not having a Hospital Liaison supporting patients and providing warm handoff or having to contact different agencies for the patient (…) we don't have the expertise. To now have the expertise and the resources … to know what to do with it is essential."
- *Importance of geography*. Hospital partnerships with community providers are very localized. In the case of outpatient services, the relationships are driven by both location and reach of services in the community. Hospitals gauge where patients live and want services. One program partner said, "people who live in this community want to be in this community." Another partner state, "They [patient navigators] link them to the SPA that they want to stay in." In fact, among ten enrolled patients participating in a case study, all defined their community primarily as a connection to a geographic area, either as the Greater San Gabriel Valley or a specific city such as La Puente, Arcadia, Monrovia, Whittier, etc.
- *Data sharing & the LAHSA portal*. Hospitals have to restrict a lot of information shared even if it is an active referral. Hospitals provided access to some patient information which allowed the Hospital Liaison to be better prepared when reaching out to the patient. The face sheets provided sufficient patient details for the Patient Navigators to conduct their work efficiently. The data shared is basic information in order to proceed with the referral such as name, date of birth, last known address, and contact

information. The consistent use of the portal for referrals this year provided better continuity of care particularly if staff changes occurred among hospital partners. To help with greater adoption early on in the second year, Union Station worked with hospitals to help untangle misconceptions about making referrals through the portal. Trainings were available to hospital staff to ensure better user experience and to mitigate any challenges with portal use. As on hospital partner stated, "Lot of times, there's nothing we can do about their [patients] situation, but we can at least make this referral, and give patients some hope and connection."

- *Medical Follow-up*. The focus by Patient Navigators on medical follow-ups after discharge from the hospital ensured that enrolled patients in the program are linked to their outpatient medical appointments and actually are receiving those services. “"A lot of times, if patients cannot have that connection, they will come back to the ER or their medical condition is progressing,” said one program partner.

The program did also present some challenges:

- *Defining better workflow with medical clinics.* Two medical clinics were invited into the Patient Navigation program to ensure greater access to medical follow ups of patients. However, those relationships were not fully formalized within the program. In cases where patients did not receive a warm hand-off before discharge, hospital staff needed to ensure medical follow ups were part of the discharge planning. Hospital staff typically ask patients to follow up with their medical provider or primary care provider. But if the patient does not have a provider, then hospitals refer the patient to a medical provider for follow ups. Hospitals have established relationships with certain providers who are their “go-to” organization. These relationships are driven by proximity of the medical provider to the hospital or the patient. For instance, the Pomona Valley Hospital Medical Center made direct referrals primarily to Park Tree Community Clinic which provides high quality preventive and primary health care services to the underserved at four locations, two in Ontario and two in Pomona. Kaiser Permanente, on the other hand, has an established partnership with Chapcare for patients who are not members.
- *Overcoming LAHSA Portal Limitations*. Despite more widespread usage of the LAHSA portal, program staff pointed to some limitations with the system. First, some staff felt the portal eliminated some of the accountability when a live person is not available at time of referral. Second, portal access is more cumbersome for hospitals that have more limited administrative personnel. Then when staff changes occur, access to the portal for the new personnel requires a two-step registration process involving a supervisor whose time is already impacted by a host of tasks that take priority. Third, the query, reporting and notification functions within the portal are very limited. The user must scroll through case entries to access needed information.

- *Impact of discontinued funding*. The lack of funding to continue the Patient Navigation program negatively impacts work with the patient population. The end of the program feeds the perpetual cycle of patients shifting in and out of programs further degrading any trust in the healthcare system. Patient Navigators work hard to gain the patients' trust during the program. Lack of funding eliminates all of that effort. Additionally, the cyclical nature of these programs often means that patients must retell their life story to a new case worker and relive their trauma.

Internal communication and feedback about patient cases between Patient Navigators and Hospital Partners has been lagging and could benefit with the adoption of a more formalized process.

The communication between the Patient Navigators and individual hospitals was informal and fluid in the first year. The direct communication meant the Patient Navigator and hospital staff could connect quickly to discuss a case, available resources, or the program workflow, from referral submissions to patient's exit from the program. Patient Navigators also joined hospital staff in intermittent (usually monthly or bimonthly) meetings for case conferencing.

In this second year, these case conferences occurred less frequently. The regular meetings between the Patient Navigator and hospital staff were no longer happening in the same way. In fact, hospital staff were not fully familiar with the coordination of care process; some hospital staff had a hard time identifying their assigned Patient Navigator. As one hospital partner discussed, "we rarely connect with the Patient Navigator once the navigation starts." If they needed to, hospital staff would outreach to the Hospital Liaison instead. One partner stated, "We won't know what's going on with a patient unless we connect with the Hospital Liaison who has access to the system will all the information." Hospital staff would have no updates on enrolled patients unless they spoke with the Liaison or the Navigator. Hospital staff do have access to the Coordinated Entry System (CES) through LAHSA and could check on specific cases in the system. But the system does not currently provide the option of receiving case entry notifications for hospital staff to know which case to check for updates to the case history.

Hospitals did want to receive more frequent feedback on patient outcomes. All program partners agreed that monthly communication and feedback between the Patient Navigator and individual hospitals (i.e. the social workers and case managers) on patient outcomes would be beneficial. In addition to case sharing, these communications would also provide an opportunity to educate or refamiliarize hospital staff with the full range of case data access, to learn the process of connecting patients to resources, to share trauma informed training and de-escalation training in working with the homeless population, to ensure better coordination of services, and to manage expectations of program outcomes (particularly as it relates to housing placements).

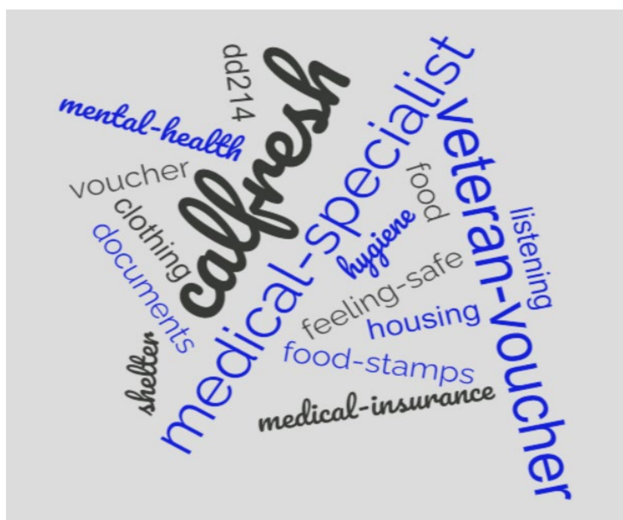
While all partners believed some form of regular feedback was warranted, hospital partners were less clear on the best format for that coordination and feedback (in person or virtual meeting, email, direct calls, direct to portal etc.). Further discussions on what would work best may be necessary. One partner asserted, ""if I knew more of the outcomes and results of referral, that would be helpful."

Project Impacts & Outcomes

In addition to program metrics (including health and housing related outcomes) collected by Union Station Homeless Services to gauge the impact of the program, this year's evaluation included a case study wherein 10 enrolled patients were interviewed.

Interviewed patients perceived positive changes in their lives because of the support received from Patient Navigators despite their frustration with the slow pace of housing placements.

Patients perceived benefits from participation in the program. The chart below shows the benefits that they felt the program offered. Mainly, these patients spoke about connecting with a medical specialist, receiving food related benefits (such as Calfresh or food stamps) and veteran vouchers. As one patient expressed, "You guys help me out and get things done and that's what I like about the program."



Interviewed patients highlighted some of the key benefits of the program and their motivations to participate.

- **Stability and security despite frustration with housing placements**. Almost all case study patients talked about their need to be housed as the single biggest motivation for enrolling in the Patient Navigation program. One patient stated, "I want my own place already; it's not safe to be on the street." Another said, "I was desperate. I need to get off the streets." For housed patients, the transition to having stable housing resulted in feeling safer. Patients expressed their challenges with being unhoused such as fear of

personal safety, food insecurity, general health, and harassment from law enforcement. Patients did feel frustrated with the long process of getting housing placement. Some advocated for more temporary solutions, such as access to motel vouchers, until the search for permanent housing is completed. Some patients also talked about the connection to medical services: "The help. Medical help got me all the way to where I am now."

- **Improved basic needs and health despite challenges with access.** Patients perceived improvement in their health because of access to healthcare services, regular doctor appointments and better nutrition. Some patients highlighted how access to resources like CalFresh and meals alleviated their food insecurity. Patients also discussed how assistance with basic needs such as food, hygiene products, or clothing impacted their overall well-being and ability to focus on other aspects of their lives, such as attending doctor appointments regularly and maintaining good health. One patient talked about the positive aspects of feeling busier with medical and other service appointments. Another housed patient explained how being housed enabled him to keep better track of his medical appointments.

  Despite better access, a few patients did point to some challenges. Some expressed mistrust and discrimination of the health care system, feeling that their concerns were being dismissed. One patient stated that unhoused patients do not go to hospital until it's too late or fatal. Patients did feel support from the Patient Navigators who served as advocates for their medical needs. Others expressed frustration with long wait times for medical appointments. Patient Navigators described needing to keep medical schedules for their cases and sending frequent reminders to patients to avoid missed appointments and rescheduling.

- **Empowerment and positive outlook**. Patients who fully embraced the Patient Navigator's support generally felt better. They described their general mood as "optimistic", "out of trouble", "looking better", "less stressed", "less anxious", "stay grounded." Many patients were focused on the future. One patient talked about pursuing hobbies or a side business while another found employment and was recently promoted. When asked about what they were hoping to achieve by next year, most patients stated permanent housing. "I hope to have my own apartment," said one patient, while another stated, "I should be housed." Others hoped for employment or new meaningful relationships, and "just to get back on my feet."

- **Improved support and community**. Patients emphasized feeling grateful for the connections that they have made and the support system now available to them through the Patient Navigator. Patients also expressed making friendships with individuals facing similar life experiences. They generally felt less alone and that they had people to turn to for assistance and guidance.

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.

Hospital partners perceived little or no time savings for their own staff and consequently no cost savings resulting from program participation.

Despite monthly meetings, hospitals did not feel that they could see the impact or benefit of the program. Safe discharge planning is time consuming when completed by hospital staff. The time staff spend on discharging patients varies depending on the complexity of each case.

Program partners reported mixed results in cost savings. “"I don't think I can speak to the impact,” said a hospital staff member. Most hospital staff, while appreciative of the support provided by the Patient Liaison, did not perceive huge time savings when working towards discharging the patient. What made the program critically effective in the first year was the response time to a referral and the active engagement by the Hospital Liaison or Patient Navigator in the discharge process which they helped facilitate and arrange. One hospital staff recalled ““It took a lot of the burden off of us; I am not calling 17 places [shelters] that might not be able to help us." Another staff stated, “It's nice to have a community partner; that is still a connection that, in general, if we didn't have, we would have to do our own searches." With response delays, the hospital staff often shouldered the full discharge process, including trying to connect patients to shelter. Staff were doing the discharge planning, figuring out shelter placements for patients, and then getting into contact with the managed care plans. One hospital staff said, “it feels like [hospital] staff are doing same amount of work.”

Patient discharge is reliant in part on the attending physician and whether he/she/they require shelter for patient's safety. Of course, staff have to honor patient's right to self-determination. If a patient is open to shelter (i.e. boarding care, recuperative care, nursing facility etc.), then part of the safe discharge process involves finding appropriate options and processing the shelter placement. The challenge for hospital staff is locating shelter options quickly when the discharge planning is in motion. Shelters are limited in supply—approximately 200 shelter beds are available in the entire County of Los Angeles. For each patient being discharged, the hospital staff could be on hold for 30 minutes to 1.5 hours on the phone to determine if there is any shelter availability. “It’s a huge chunk of the work, especially during cold weather,” said one hospital staff. More shelter options would provide greater time savings for hospital partners because placements (as part of a patient discharge) would happen more quickly. It would also streamline entrance into the Patient Navigation program because the Hospital Liaison could locate and meet with the patient post-discharge. What made the Patient Navigation program cost effective in the first year was the ability of the Hospital Liaison and/or the Patient Navigator to locate shelter and support the discharge process. The Hospital Liaison or Patient

Navigator had at their fingertips, updates on shelter availability. It saved hospital staff time from prolonged call holds to find out what is available.

Perceived cost savings occur when the Hospital Liaison connects with the patient prior to discharge and helps with the discharge plan. In the absence of this immediate connection, hospital staff conduct the discharge plan. Sometimes, this requires paying to send the patient to a shelter. In the case of recuperative care connections, cost is approximately $250-300 per day for typically a minimum of 10 days for a total cost of $2,500-3,000 that the hospital will pay instead of paying potentially 10 times that cost for continued hospitalization. Recuperative care has a lot of moving parts: following -up on appointments, being on hold with the managed care plans, sending referrals, following up with the recuperative cares to see if there is an approval, waiting for authorization from insurance, all of which added time to labor.

Hospital partners did not perceive significant changes in readmission rates among the high utilizer patients.

Hospital partners did not perceive 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 as it related to their medical care, which were equally important.

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