2025

A Pilot Program in Los Angeles County

YEAR 3 EVALUATION REPORT ON SCALING THE PROGRAM IN SERVICE PLANNING AREA 2 (2024)

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Acknowledgments

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Finally, we extend our gratitude to all participating hospitals, including Providence Hospital, Valley Presbyterian Hospital, Kaiser Permanente Panorama, Pacifica Hospital, and Northridge Hospital Medical Center (Dignity Health)

Background

Program Origins & Purpose

The Patient Navigation (PN) Pilot program was conceived to strengthen coordination between healthcare systems and homeless services, working together to improve health and housing outcomes for people experiencing homelessness. Specifically, the Patient Navigation program focuses on supporting and coordinating the health and housing needs of unhoused patients coming to the emergency department of the local hospital on a consistent basis. By providing a "holistic" approach, connecting patients to various supports, the central goal of this program is to improve the housing and health outcomes of these individuals and potentially reduce costs for hospitals that are serving as a first point of contact for issues arising from homelessness.

Supported by United Way of Greater Los Angeles, the program was initially pilot tested for 2.5 years in Service Planning Area 3 of Los Angeles in fiscal years 2020-23. At its core, the program involved Union Station Homeless Services as the local service provider for the program navigation and five partner hospitals-- Emanate Health, Huntington Health, Kaiser Permanente Baldwin Park, USC Arcadia Hospital, and Pomona Valley Hospital Medical Center (PVHMC). Collectively, they treated over 8,700 homeless patients though these Emergency Department visits represented a fraction of total visits for an entire year. In the first year, the Patient Navigation (PN) program 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, while in the second year, the program narrowed services to unhoused patients aged 50 years or older. Other key changes introduced in the second year of implementation based on key learnings the year before included (1) renegotiating with hospital partners the patient information needed at time of referral to assist the hospital liaison and patient navigators with their case management, and (2) standardizing patient referrals through a central portal only for processing before connecting the patient to a Patient Navigator.

Yearly evaluations, in partnership with the Center for Nonprofit Management (CNM), explored the overall effectiveness of the pilot, the value of PN positions to the health care sector, and insights into the financial benefit of the program. These studies highlighted the great benefits of the program, including key steps required to make the program successful, though the program was not without its challenges as well. The program found that a Patient Navigator has value as a dedicated point of contact for patients experiencing homelessness, collaboration between hospitals and service providers is important, and many patients had issues with mental illness. However, the program also found that hospitals were inconsistently using the LAHSA portal for referring patients to services, and referrals to the Patient Navigator must occur before discharge because of the challenges of finding this population of patients after they leave the hospital. For a greater review of all the program findings during the first 2.5 years of this pilot implementation, please see the following reports:

SPA 3 Patient Navigation Pilot:2020-23 Evaluation Report

SPA 3 Patient Navigation Pilot: 2022-23 Qualitative Evaluation Report. Key Learnings from Second Year of Implementation

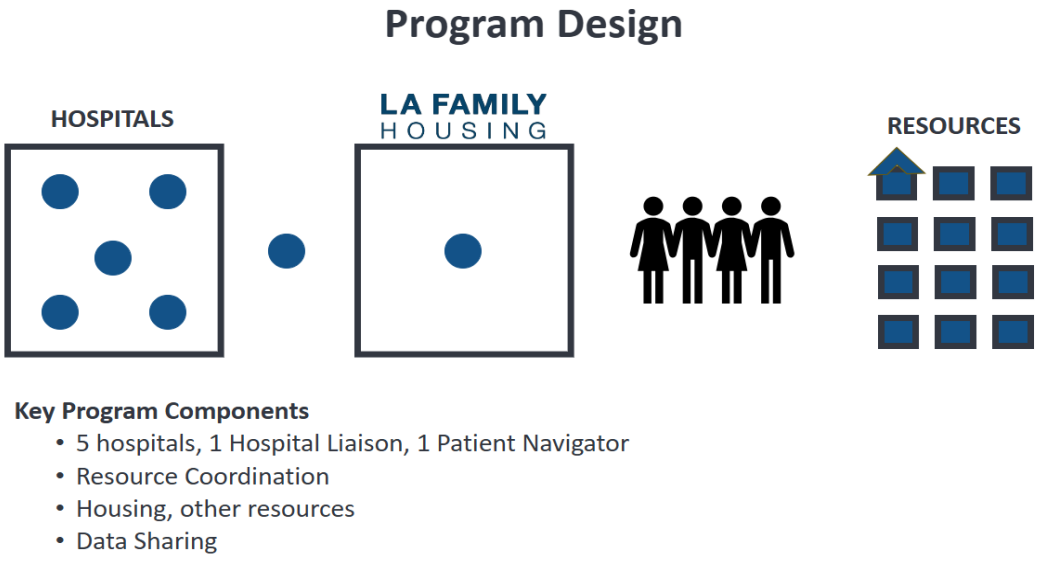
This year, United Way explored if the program could be scaled in another region of Los Angeles County. United Way sought partners in Service Planning Area 2 (SPA 2) to implement the same program for the eligible population of unhoused "high utilizers" of hospital emergency services aged 50 years or older. This evaluation report serves to document the experience during this third year of implementation.

Program Design

As in the prior years, the United Way of Greater Los Angeles (UWGLA) 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 in Service Planning Area 2 (SPA2) of Los Angeles County 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 hospital partners that referred patients to Los Angeles Family Housing (LAFH) to provide the post-discharge case management services and support to patients. Hospital partners included[1]:

- Providence Hospital
- Valley Presbyterian Hospital
- Kaiser Permanente Panorama
- Pacifica Hospital
- Northridge Hospital Medical Center (Dignity Health)



[1] Please note that Adventist Health Glendale Hospital was not officially part of the program, though they were offered to participate informally.

Key components of the program were:

1. **Patient Navigation:** A hospital liaison processed eligible hospital referrals received through a central portal to the patient navigator, who, housed at LAFH, provided intensive case management to program participants.
2. **Resource coordination**: The program offered an opportunity to coordinate continuum of care regionally between the hospital liaison, a position funded by the Los Angeles Housing Services Authority (LAHSA), the patient navigator employed by LAFH, and key staff with hospital partners. United Way provided overall oversight of this coordination, creating spaces for partners to work and collaborate with one another.
3. **Housing placements and 0ther resources:** To provide this coordinated service at a lower cost than hospitals, Patient Navigators linked participating patients to different types of available housing, opportunities to apply for or update government documents vital to receiving benefits including healthcare insurance, social security etc.., and other resources (e.g. medical appointments or mental health treatment) that they otherwise may not have accessed.
4. **Data sharing:** Project partners established data sharing agreements wherein hospitals could share limited data with the Hospital Liaison and Patient Navigators to allow greater coordination of care of patients with hospitals as well as myORG and the HMIS systems. By having access to patient information, the Hospital Liaison and Patient Navigator facilitated care coordination across systems; they led and/or participated in case conferencing with homeless case managers and clinic-based care coordinators.

Roles of key Personnel of the Program

Hospital Liaison

- Screen referred patients from hospitals to determine eligibility for enrollment into the Patient Navigation program.
- Build relationships and identified opportunities for partnership with community health care providers.
- Convene hospital partners and Patient Navigator monthly for case conferencing and problem-solving.
- Document practices for shared learning.

Patient Navigator

- Create consistent/standardized processes for referrals and information sharing around patients with local partners by building relationships and formalizing partnerships.
- Provide intensive case management for enrolled patients with the primary goals of placements in shelter and/or housing and are regular connections with a medical provider for primary care services.
- Provide other support, as needed, including government document preparation & readiness.
- Host/lead case conferencing meetings with hospital partners 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.

Methodology

The third year of this pilot program focused on expansion into SPA 2. As in the prior two years, the evaluation employed a mixed-methods approach, gathering the best information possible despite the limitations in the available data.

Organization of the Analysis

The four key areas, the research questions raised by each, and the data employed to answer those questions are as follows. They are intended to organize the analysis of this project into related points of interest for ease of reporting and understanding.

1. Implementation Target- Assess whether the program achieved the threshold outcomes that were set out for this program. The research questions were (1) Did the program serve at least 50 high-utilizer older adults experiencing homelessness? and (2) What were the patient characteristics? This section also covers other descriptive statistics such as number and types of services provided and program length of stay across patients. Data employed to answer these questions included the Patient Navigator's case note data collected by LAFH and MyOrg referral data provided by Los Angeles Homeless Services Authority (LAHSA). These data sources represent the raw information that was recorded through the activities of the hospitals in making referrals and of the Patient Navigator in providing services.

2. Project Design and Implementation-- Determine how effectively the program worked. Research questions included (1) how effective was the program design and coordination of services? and (2) what lessons, challenges, and successes were learned? The primary data collected to answer these questions were more qualitative, including interviews with program partners, interviews with participants, and short surveys from hospitals. However, MyOrg/HMIS data and LAFH case note data were also useful here because they measured how often hospital partners were making referrals through the LAHSA portal and how often the Patient Navigator was able to connect with these referrals.

3. Program Impact- Analyze the health and housing outcomes that could be attributed to this program. The research questions posed included (1) did the program support 40% of patients being matched/placed in permanent housing? (2) Did the program increase referrals to mental health services? and (3) What did patients think of the services offered? The primary source of information for the first two questions was LAFH case note data. The interviews of the patients were primarily used to answer the third question.

4. Cost Effectiveness. provide insight into whether and how the program reduced health care costs by meeting social, health, and/or housing needs of patients. Conceivably, participants in this program may have experienced improvements in services which would then lead to fewer hospital visits. However, because the evaluation team did not have access to data from the hospitals or LAHSA indicating each time a participant was admitted to a hospital, this area of the report was not able to clearly specify this impact.

Instead, the evaluation team used a variety of data sources to present various indicators of cost savings, including feedback from hospitals, LAFH case note data, and interviews with stakeholders. To help illustrate this potential impact, data published at the hospital-level from the California Department of Health Care Access and Information (HCAI) were reviewed.

As indicated, the data sources for these four areas include:

- Program outputs, LAHSA data and case notes that directly spoke to the tangible and quantifiable results achieved by monitoring and tracking program referrals and intervention (e.g. number of individuals served etc).

- Key stakeholder interviews and surveys were planned with program partners including United Way, LAFH and each hospital, all of whom could speak to the successes and challenges of the program from their respective perspectives. Instruments were developed to capture stakeholders' perceptions around program coordination, effectiveness, and impact. Interviews followed a semi- structured discussion protocol to solicit maximum information about the key topics of interest. Interview data were analyzed across groups by using simplified content analysis to capture emerging thoughts and themes. It is important to note that hospital partners did not participate in the interviews, and only 2 of 5 partners completed the survey, thereby making it difficult to incorporate their perspective in this evaluation.
- Interviews with individual unhoused patients. Nine patients enrolled in the Patient Navigation program were briefly interviewed to share their feedback on their experience as participants. Since Patient Navigator had an established relationship with the patients, they were given a structured interview protocol to guide the interviews. The patients who agreed to participate were likely those who had developed rapport and trust with the Patient Navigator, which means the sample may not fully represent patients who had weaker relationships or less positive experiences. Despite this limitation, the interviews offer a valuable insight into the program from the patients' perspective, especially those who felt comfortable with it.

Data Limitations and Notes

Data collection and analysis efforts had limitations. This section highlights the various quantitative data available to the evaluation team, important limitations to that data, and any necessary assumptions made in interpreting the results.

LAFH Case Notes: Case note data describes the actions and observations of the Patient Navigator, recorded on the day the activities occurred. The notes helped the navigator maintain and manage individual cases, meaning that the navigator would have the resources and motivation to record data into this system accurately. The case note system consistently captured a variety of data, including an anonymized identifier for which patient being served, the date the service occurred, and the date of birth and demographic information for each patient. The case notes field allowed for open response text entries describing what happened

in full detail. The Patient Navigator generated a "title" for each case note, allowing for categorization of each action taken.

However, the case notes analysis provides some limitations in that events were not recorded if the Patient Navigator did not observe them directly. Possible events include (1) if a hospital made a referral to the Patient Navigator but the patient was discharged before the navigator could complete an intake and there was no means of contacting him/her/them post-discharge; (2) If a patient was admitted to a hospital and neither the patient nor the hospital informed the Patient Navigator; and (3) If a patient stopped participating without telling LAFH and the Patient Navigator continued to make case notes recording her attempts to contact. Because the presence of case notes is used as the indicator of time in the program (rather than defined start and end dates), this would indicate ongoing participation even though the participant effectively stopped participating.

LAHSA MyOrg data: The dataset provides a running record of unhoused patient referrals made by hospitals to local community-based organizations (such as Union Station, LAFH etc.) that support the homeless. However, it cannot be assumed that all hospital referrals are in fact recorded and channeled through the MyOrg system. As observed in this study, hospital staff often bypassed the system by making referrals directly to organizations through other modes of communication (such as email, phone call). Therefore, the data cannot describe all hospital visits for unhoused patients, as indicated by LAHSA representatives who informed shared data and informed on the data's limitations. Instead, this data describes referrals for services made by hospitals through the LAHSA/MyOrg portal. And like the LAFH data, this data only includes the data entered into the system. In the first two years of this pilot in SPA 3, hospital partners reported frustration with this portal, and the interviews and surveys collected for this evaluation would indicate that SPA 2 hospitals also used the system inconsistently. Thus, it is expected that not all referrals and certainly not all hospital visits could be expected to appear in the data.

Despite the flaws and incompleteness of the above data sources, the evaluation team was able to leverage these data sources together based on the following logic and assumptions. Though neither LAFH nor LAHSA provided personal identifiable information for patients or patients in the data, both datasets consistently included date and year of birth for participants. By identifying a person as a unique date of birth in both systems, the evaluation team was able to do the following:

1. Track individuals from MyOrg referral to LAFH services. When a date of birth was the subject of a MyOrg referral and then that same date of birth appeared in LAFH case notes, this indicates that the hospital likely used the LAHSA portal to request referrals.
2. Quantify the number of patients successfully referred to LAFH without going through the LAHSA portal (i.e., a hospital representative contacted LAFH or the Patient Navigator directly to start services). This would occur when a date of birth appeared in LAFH data without also appearing in MyOrg data.
3. Quantify the number of patients who received a referral through MyOrg but then were discharged without an address or phone before the Patient Navigator was able to

connect them to services. This is indicated by a date of birth appearing in the MyOrg Data and then also not appearing in the LAFH data.

As previously mentioned, both the LAFH and MyOrg data may incorrectly indicate that a referral did not happen because people entering data into each dataset likely did not always record every referral. Missing data is tricky to address. Consider, for example, if a referral was made outside the LAHSA portal and the Patient Navigator did not make contact prior to discharge, then that event would not appear in the data. Missing data is typically hard to quantify because it is not recorded or indicated anywhere. However, by measuring the amount of overlap (common dates of birth) and lack of overlap (unique dates of birth) between the LAFH and MyOrg datasets, the evaluation team was able to estimate how much data was missing from each dataset.

To conduct this analysis, the evaluation team needed to make two central assumptions: (1) one person did not provide a different date of birth to each organization, and (2) two or more different people did not have the exact same date and year of birth.

The first assumption seems reasonable. Because professionals on either end (hospitals and homelessness services) use and/or help patients recover official documentation, it seems unlikely that a patient would provide a different date of birth to each. Furthermore, every unique date of birth that shows up in both datasets had a MyOrg referral date that was within a week of their LAFH start-of-services date. Finally, the dates of birth do not even need to be accurate so long as they are reported consistently across the two datasets.

The second assumption can be measured statistically and also proved to be reasonable. The first datapoint supporting this assumption was that no two patient identifiers had the same date of birth in the LAFH data. Further support comes from a statistical test: Given the small number of unique dates of birth in the data (59 in MyOrg and 54 in LAFH), and the large number of possible birthdays (365 multiplied by each year between age 50 and 80 is over 10,000 possible birthdates), it was highly unlikely that two or more people would have the same date of birth.[2]

Because the data supports these assumptions, the evaluation team was able to draw insights into the data missing from LAFH and MyOrg data, addressing what would have been a key weakness in the analysis. Though the quantitative data available to the evaluation team had potential gaps, these limitations were addressed through the research design.

Results and Key Takeaways

The following results describe how the quantitative and qualitative data served to answer the research questions originally defined for this project.

[2] The evaluation team measured this assertion with a statistical test called a Poisson approximation and found a miniscule chance that a single date of birth would represent two different people.

Implementation Target

The program did not reach the expected target of patients to be served. The implementation targets describe the uptake of activity supported by this program. As detailed in this subsection, the number of older adults referred to and served by Patient Navigation approached but did not reach the target goal set forth at the outset of this project. This program set out to serve at least 50 high utilizer older adults experiencing homelessness. Only 37 received identifiable services from the Patient Navigator. Reasons for this outcome as well as details about patient demographics are addressed in this subsection.

Hospital Referrals

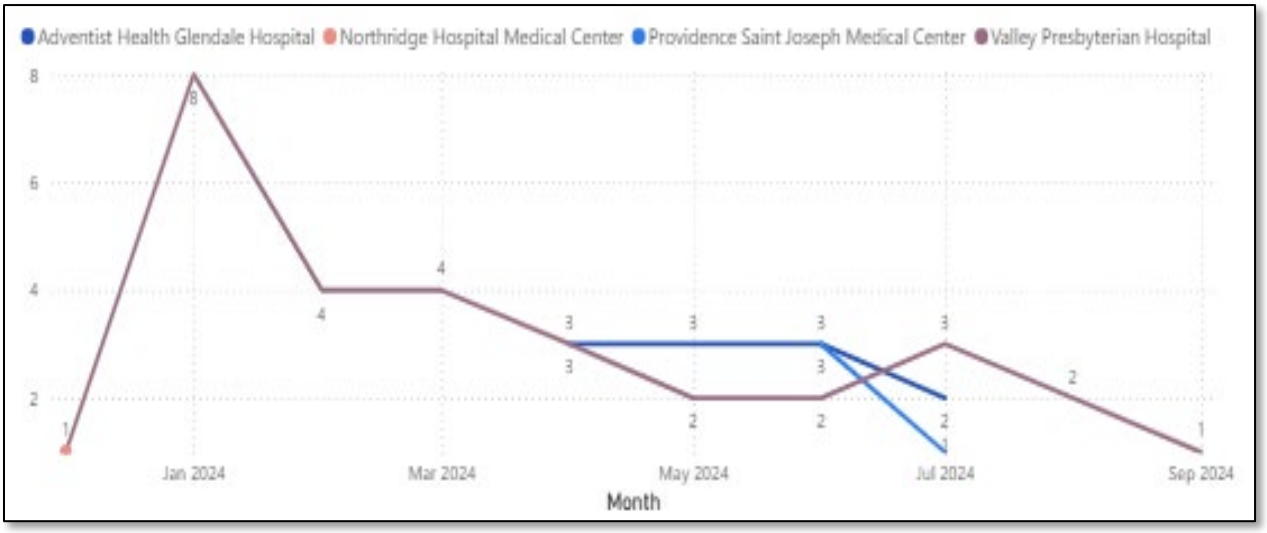
The rate of hospital referrals through the universal portal increased from the previous year but varied greatly from hospital to hospital and month to month. During the program period, from 12/6/2023 to 12/04/2024, MyOrg data indicates 59 referrals for 57 individuals in SPA 2 who were at least 49 years of age at the time of the referral.[3] Note, this is a 78% increase in MyOrg referrals by participating hospital partners (Valley Presbyterian, Glendale, Providence St Joseph, and Northridge)[4] relative to the same period from the previous year (32 referrals from 12/6/22 to 12/4/23).

During the program, LAFH processed and attempted to provide services to 54 patients referred from the hospitals. Of these, 30 were also processed through MyOrg (i.e., their dates of birth appear in both datasets). Similar to a Venn diagram representation, the overlap of dates of birth in both MyOrg and LAFH data, as well as the lack of overlap in each can be employed to estimate the amount of data missing in both datasets.[5] This statistical approach for estimating missing data would indicate that there were approximately 103 people referred to LAFH by the hospital partners.[6] Please note that this is an approximate total because the data does not contain unobserved events (i.e., when a hospital made a referral outside of MyOrg and the Patient Navigator was not able to make contact and enter that patient into the case note system).

A key reason that the program did not meet its target appears to be a decline in referrals by hospital partners. The graph below shows the number of referrals in MyOrg during the program period in SPA 2 for target patients at the time of referral for the hospital partners.

[3] The target population for this program were people 50 years of age or older. The program allowed in a person who was 49 and turned 50 while participating, so this the cutoff for this aspect of the analysis.
[4] Note that these hospitals are not the only hospital partners for this program. However, they are the only partner hospitals that appear in the MyOrg data for the time period under analysis.
[5] This statistical process is named the Lincoln-Petersen estimator or Lincoln Index. It is used in social sciences and ecology to estimate the size of a full population based on characteristics observed in two samples. See https://pubmed.ncbi.nlm.nih.gov/24833434/ and https://en.wikipedia.org/wiki/Lincoln_index
[6] Because 57 DOBs appear in MyOrg, 54 DOBs in LAFH data, and 30 DOBs shared by both datasets, then (57 X 54)/30 = 102.6, which rounds to 103. This is an application of the Lincoln-Peterson estimator described in the previous footnote.

Figure 1: Referrals Per Hospital Per Month



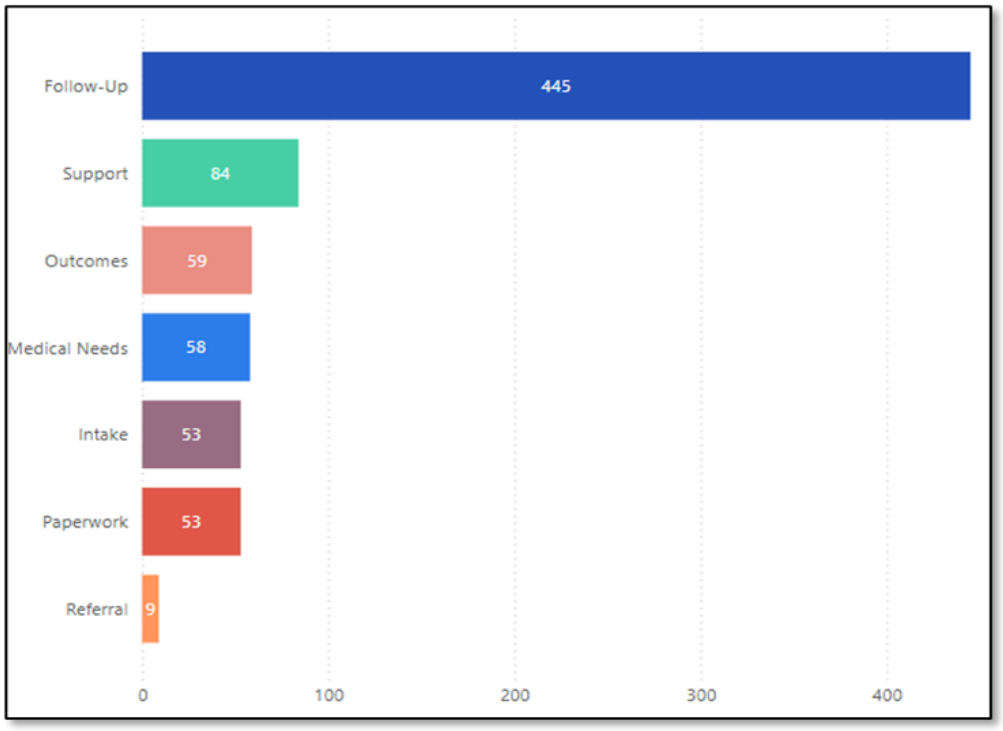
Please note that the MyOrg data depicted in Figure 1 only covers the referrals properly made through the LAHSA portal – if a hospital made all of their referrals to LAFH directly, then they will not appear in this visual. As indicated in Figure 1, this program coincided with an almost immediate increase in MyOrg referrals from Valley Presbyterian, the hospital noted by the Patient Navigator as participating the most in this program. However, referrals from Valley Presbyterian declined over the months and halted after September 2024. Similarly, Glendale and Providence St. Joseph's started making referrals in April and June respectively, but then neither hospital made any referrals after July. This decline in participation was also noted in interviews with LAFH.

Patients Served

The program successfully served 37 patients with follow-ups being the predominant activity conducted by the Patient Navigator. LAFH identified services provided in each case note entry for patients. Case notes not reflecting services include incomplete actions (e.g., attempted engagement) and information updates (e.g., discharged from hospital, referral received, contact number changed). The full list of case note types that are considered services are listed in Appendix A.

To analyze the full list of activities conducted for all patients who received one or more defined services, activities were grouped into seven larger categories based on a review of the full text of associated case notes. Figure 2 provides a frequency count of these categories. As illustrated below, the Patient Navigator spent approximately half the time conducting follow-up with patients. Follow-ups constitute 58% of the coded observations.

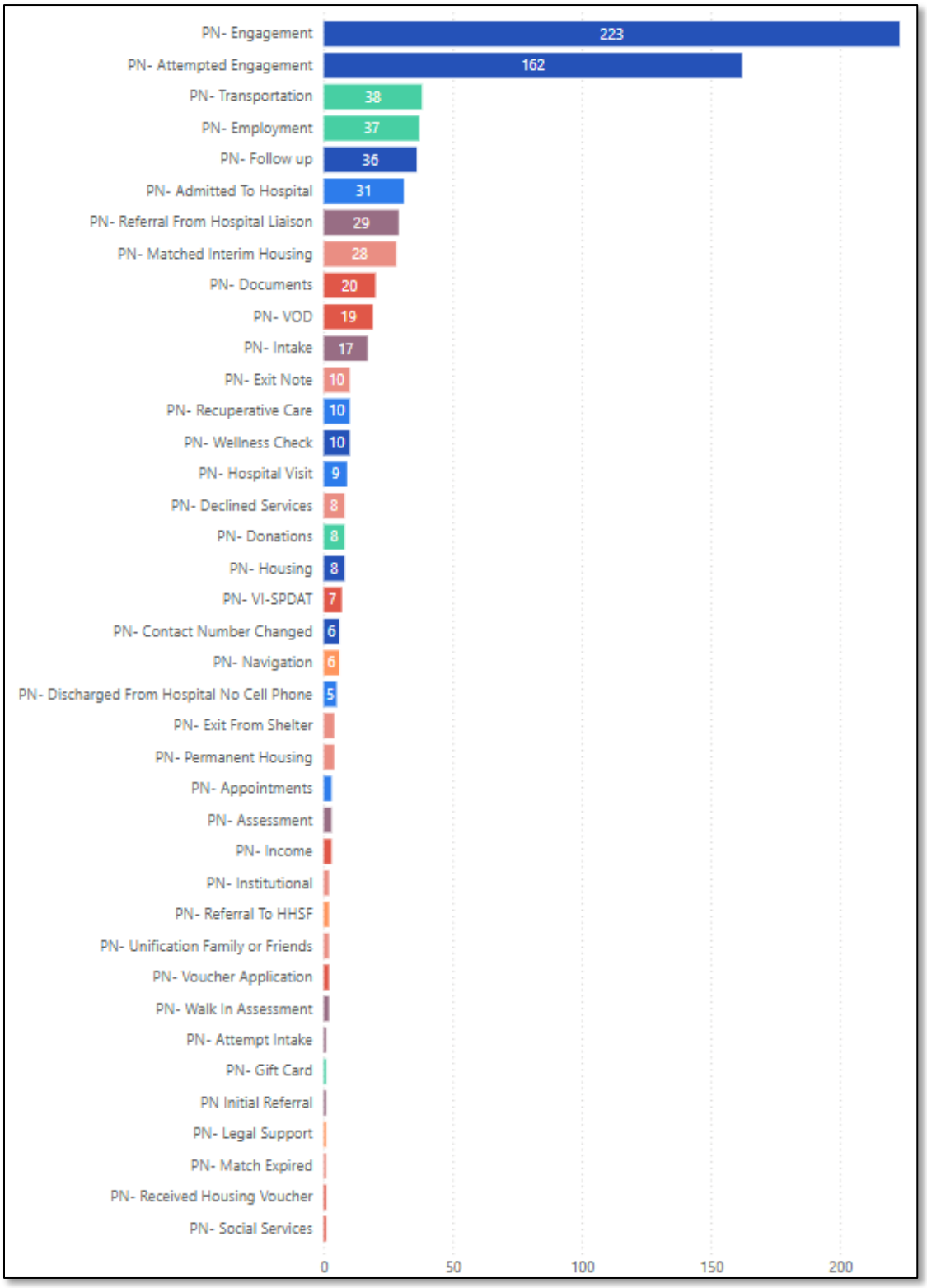
Figure 2: Count of Each Type of Service Category



A more detailed list of the Patient Navigator's actions and notes, and their frequency counts from the data, are illustrated in Figure 3. Please note that the color of each bar in Figure 3 reflects the aggregate categories listed in Figure 2. This color-coding allows the two charts to be examined together – Figure 2 provides a big-picture perspective, and Figure 3 provides more detail about the types of services composing each category. The visual above depicts the wide range of actions and information recorded by the Patient Navigator. Like Figure 2, the visual also indicates that much of the Patient Navigator's actions involved checking in with patients (i.e., Engagement) or attempting to contact them. In an interview, the Patient Navigator self-reported engagement and attempted engagement as the bulk of case time was spent.

To analyze program length of stay, the time spent between the first case note and the last case note was examined. This approach defined program participation more as the length of time during which the Patient Navigator was providing or attempting to provide services for participants who received one or more services. These amounts of time for which each patient received services are depicted in Figure 4 (on the next page) and are measured in full days. The height of each bar in the below visual represents the frequency count of patients who fit into each category.

Figure 3: Count of Each Type of Service



The bar graph at the top of Figure 4 indicates the length-of-stay categories. Notably, 70% of participants served fell in the first or last category—less than 30 days and more than 190 days. None participated between 151 and 180 days. It appears that participants tended to engage with patient navigation either briefly or over a long period of time. This finding may also be partially explained by the drop-off in total referrals to the program over time since very few patients were being referred to services during the last six months of the program. To provide more detail about these outlier segments, the two graphs at the bottom of figure 4 break these timelines down further. Also, note that zero days of reported service means that all their notes and services happened on the same day, which are read by the analytical software as not comprising a full day.

Patient Demographics

Patient profile was disproportionately male, African American (or two or more races) compared to the profile of people 55 and over in SPA 2. The LAFH case note data consistently recorded demographic information about each participant, including their gender, race/ethnicity, and veteran status. To provide context for this data, the demographic profile of the population in SPA 2 that is 55 years of age or older was also reviewed.[7] A comparison of the patient demographics to the larger SPA 2 data indicates that the population served by this program was disproportionately male, African American, or two or more races.

Of the patients served, 62% were male, 35% were female, and 3% (1 person) were transgender. In contrast, 46% of people 55 or over in SPA 2 are male, indicating that men were disproportionately in the group of people served. Also, among the 17 potential patients for whom LAFH recorded data but did not provide an identifiable service (i.e., the person declined to participate), 94% were male and 6% were female. While males are more likely to present as needing the services offered in this program, they were also more likely to resist participation.

[7] See Los Angeles County Public Health Department, Population Estimates (July 1, 2022) (available at http://www.publichealth.lacounty.gov/epi/docs/2022-LAC-Population-8RE.pdf). Please note that the available population data provided population totals across 10-year increments that began at ages ending in 5 and ended at ages beginning in 4. Thus, 55 years of age is the closest cutoff available to describing the demographics of the population of older adults in SPA 2.

Figure 4: Program Length of Stay in Days

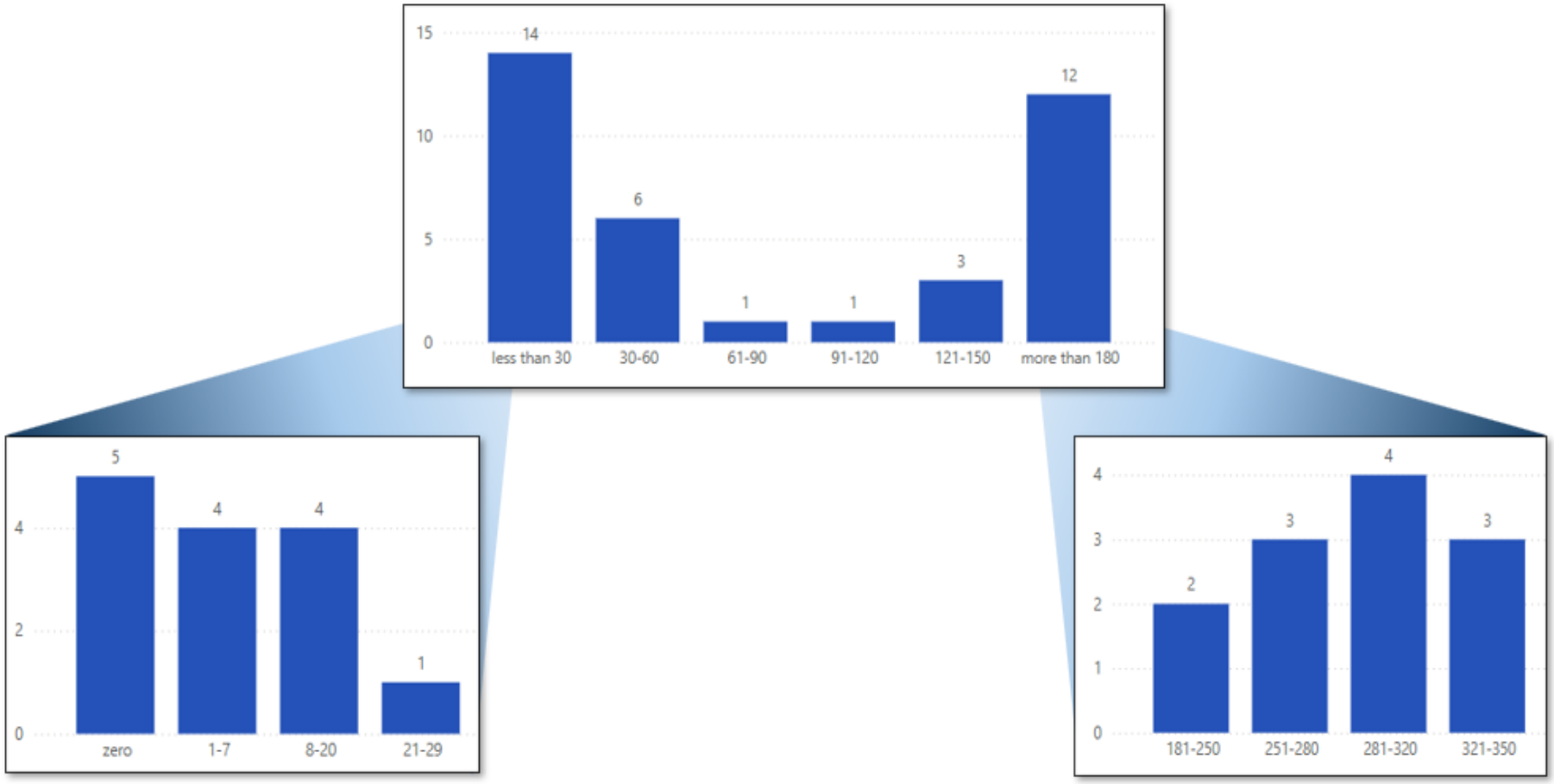
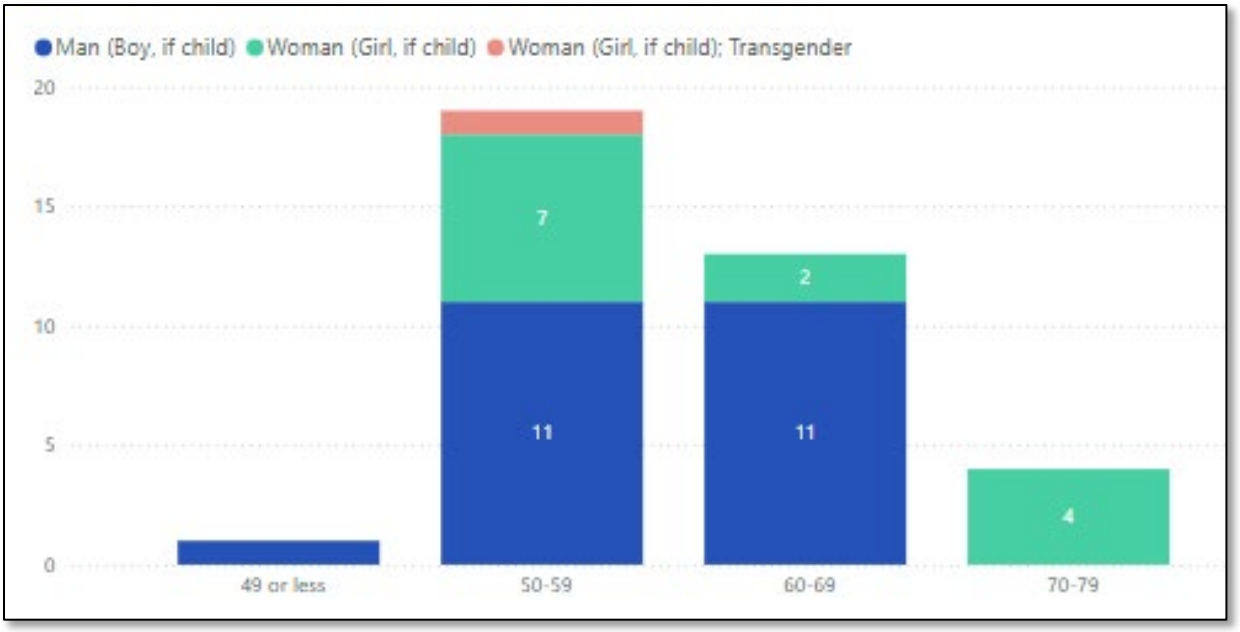


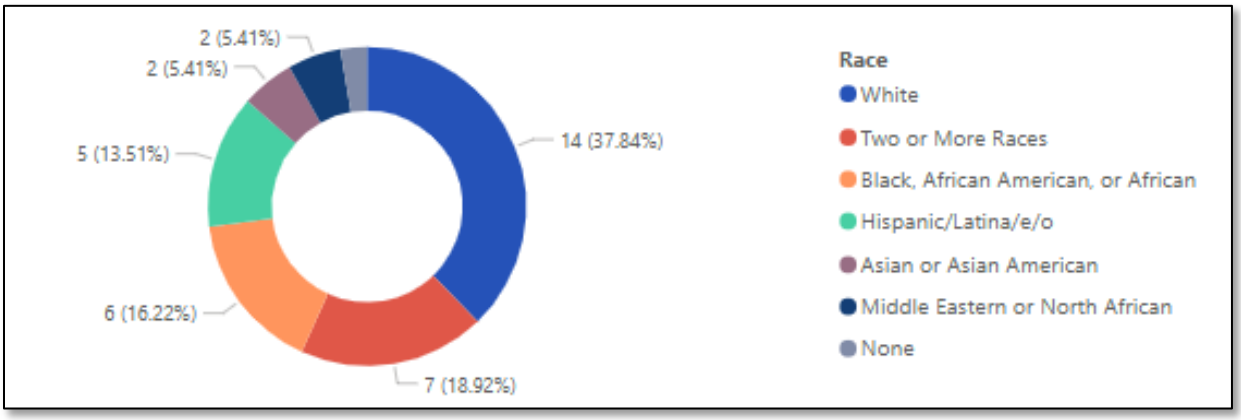
Figure 5 displays the age distribution of participants based on the age at the time they started services. This distribution of ages would be expected because the program had a cut-off of 50 years of age for participation. Note that, though one person was 49 years old when they were initially assessed, this person was 50 years old during most of the time they participated in the program. Also, it is noteworthy that the program did not serve anyone 80 or over. Finally, Figure 5 is color-coded based on gender, revealing that all the participants who were 70 or older were female.

Figure 5: Age Ranges and Genders of Patients Served



The relative proportion of different racial categories were also different between the 37 patients served and the larger population of older adults in SPA 2. Figure 6 displays the racial makeup of the patients served in this program.

Figure 6: Race/Ethnicity of Patients Served

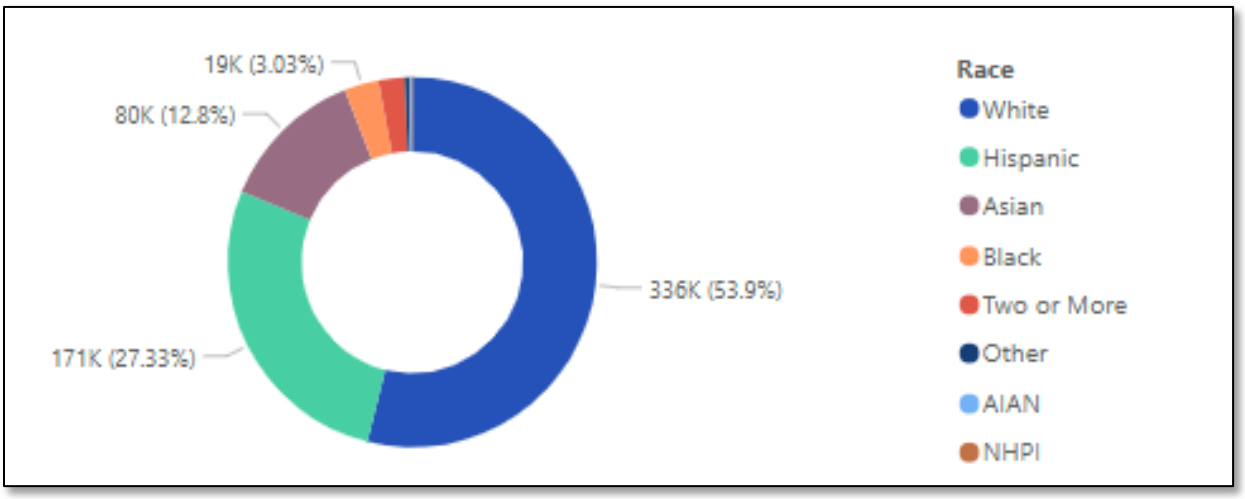


As illustrated above, more than a third of program participants identified as White. The program also served persons identifying as Two or More Races (19%), and identifying as Black/American (16%).

The proportions of people in the various racial/ethnic categories among patients served largely do not differ from the smaller group of potential patients who did not participate in services, except that 65% of these non-patients were White.

The racial makeup of the 55-and-older population in SPA 2 is depicted in Figure 7. While these categories do not entirely coincide with the categories offered in the LAFH data, the data does indicate that African American and multiracial individuals were disproportionately more likely to appear in the Patient Navigation program. Hispanic/Latino people appeared in the patient group at half the proportion they appear in the larger population-level data. Finally, persons identifying as White, the majority in SPA 2 and the program, were proportionately less likely to appear in the pool of patients served. This may partially be attributed to the tendency of this group to disproportionately decline services.

Figure 7: Race/Ethnicity of Older Adults in SPA 2



Consequently, the people served by this program were disproportionately male and people of color. These findings align with research about the demographics of the homeless population in the United States.[8]

Project Design and Implementation

The next key questions for this analysis regarded the effectiveness of program implementation, a description about how the program partners worked together, and insights for the implementation of future programs.

[8] See https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/inequality/ and https://www.usich.gov/guidance-reports-data/data-trends

Coordination of Services

Program partners expressed mixed feelings for or did not prioritize the coordination of services efforts. Hospital partners had unmet expectations regarding the program, which impacted their overall satisfaction and engagement. The Patient Navigator reported that hospitals were frustrated with the pace of the assessment process. When hospitals made referrals, they expected immediate placement, but the process took longer than anticipated. While survey responses from hospital partners indicated more positive feedback about the Patient Navigator's role, there was significant dissatisfaction with the referral process itself, particularly regarding the delays and the limited availability of beds through the program. This last reflection was also noted by the Patient Navigator who mentioned that referring hospitals tended to want beds immediately.

Over the course of the program, hospital participation gradually declined. Initially, participation showed promising growth. For example, there was a 78% increase in hospital referrals (through MyOrg portal) during the program period compared to the same period the previous year. A notable spike in referrals from Valley Presbyterian occurred shortly after the program launched, with 8 referrals in January 2024 compared to an average of just 2 referrals per month in the preceding six months.

However, after the early increase in referrals, participation from some hospital partners began to drop off. Some hospitals, which had not made any referrals in the year leading up to the program, began referring 1-3 cases per month from May to July 2024. Unfortunately, these referrals ceased entirely after July 2024, signaling a decline in ongoing participation.

Despite monthly meetings scheduled by United Way for all program partners to attend and discuss aspects of the program implementation, and particularly the coordination of services, only a few meetings were well attended.

Coordination of services was impacted by waning referrals in the second half of the program year. Overall coordination was "difficult at times" because of a lack of referrals from the hospitals, according to the Patient Navigator. According to the MyOrg data, an average of 6 referrals per month were made for the first 7 full months of the program (January to July 2024) with an average of 0.75 referrals per month for the last 4 full months of the program (August to November 2024).

Declining hospital participation coincided with declining referrals into the program**.** During the first 6 months of the program, there were an average of 4.7 referrals per month that led to services being received. During the last 6 months of the program, an average of 1.5 referrals per month were made that led to services being received. During the last 2 full months of the program, no referrals were made.

The structure of the referral process had flaws that impeded program progress. Some hospital partners provided no feedback to a survey and the few who did felt tepid about the overall process. Participating hospitals somewhat disagreed (2 responses) or felt indifferent (1 response) to the statement "the referral process from our hospital the Patient Navigator is straightforward and efficient." When asked to rate (on a 7-point Likert Scale) whether "The

coordination of care between our organization and the Patient Navigator is effective," two respondents rated "somewhat agree" and one rated "somewhat disagree".

Two specific challenges with the referrals emerged. It is important to note that these same challenges were identified in implementation of the program in SPA 3.

1. Referrals Bypassing LAHSA Portal. Some referrals, as noted by the Patient Navigator, came directly from the hospital to the navigator, bypassing the HMIS/LAHSA portal. This pattern is apparent in the My Org data which shows that 44% of participants, for whom LAFH provided or attempted to provide services, were not referred through the portal.

   Referral systems could be easier to use and connect people to resources better. Hospital staff who responded to surveys consistently noted complaints about the application process (e.g., taking too long, not accessible). The LAHSA portal is being underused by hospital partners, as reflected in the comparison of MyOrg and LAFH data and also as noted in the interview with the Patient Navigator.

2. Referrals Not Connected to Services. Despite efforts by the Patient Navigator to respond quickly after receiving a referral, the patient would at times already be discharged. Of the 57 MyOrg referrals during the program period, 30 made it into the LAFH case note system. If the Patient Navigator was as effective at responding to HMIS referrals as non-HMIS referrals, this would indicate that 48% of referrals were discharged without contact information before they could be assessed for services. Thus, despite the Patient Navigator's noted responsiveness to the hospitals, many referrals were likely made too late for the hospital to make a warm handoff to LAFH (a pattern that was noted in the interview with the Patient Navigator).

   90% of the patients to whom the Patient Navigator provided or attempted to provide services were spoken to before discharge. The estimated 49 referrals that did not appear in LAFH data are likely people who were discharged without contact information before they could be assessed for services.

Collaboration & Partnership

Collaboration and partnership among stakeholders, especially between hospitals and the program, had some specific challenges. Engagement with hospitals and communication between partners were crucial elements of this program. Interviewees all noted lack of communication or interest from hospitals, and the available quantitative data indicates that hospital participation increased initially but then declined over time. In SPA 3, hospitals were more connected through their regional consortium and had an established network and priorities in supporting the area regionally. In SPA 2, the hospitals did not have a shared structure for regional collaboration, leading to lower buy-in and commitment to the program.

The program may have benefited from more planning around the goals and objectives of the collaboration prior to implementing a pilot project. One of the program's greatest successes of the program was its ability to connect people to housing, though this outcome was significantly influenced by the level of hospital involvement. There was a clear disparity in success based on how engaged the hospitals were. Advocacy efforts played a role in improving client placements,

but there was a lengthy learning curve to understand how the hospital system operated and how to integrate the program effectively within it.

Hospitals should be given reasonable expectations about this program's capabilities and should be encouraged to make referrals early. The data seems to suggest that hospitals were waiting until discharge to make contact, and this led to the Patient Navigator being unable to meet with all participants before they were discharged. In contrast, the majority of participants in this program appear to have met with the Patient Navigator before they had a discharge date.

Additional challenges to engagement may be attributable to hospital staff burnout, their existing workload, and a lack of hospitals willing to partner due to insufficient information and overwhelmed teams. Delays in referrals for older patients, and the loss of contact with discharged patients without phones, added complexity to the program's success. Some additional training in using the HMIS portal may have improved efficiency with referrals, but only if closer coordination was possible between LAFH and the hospitals.

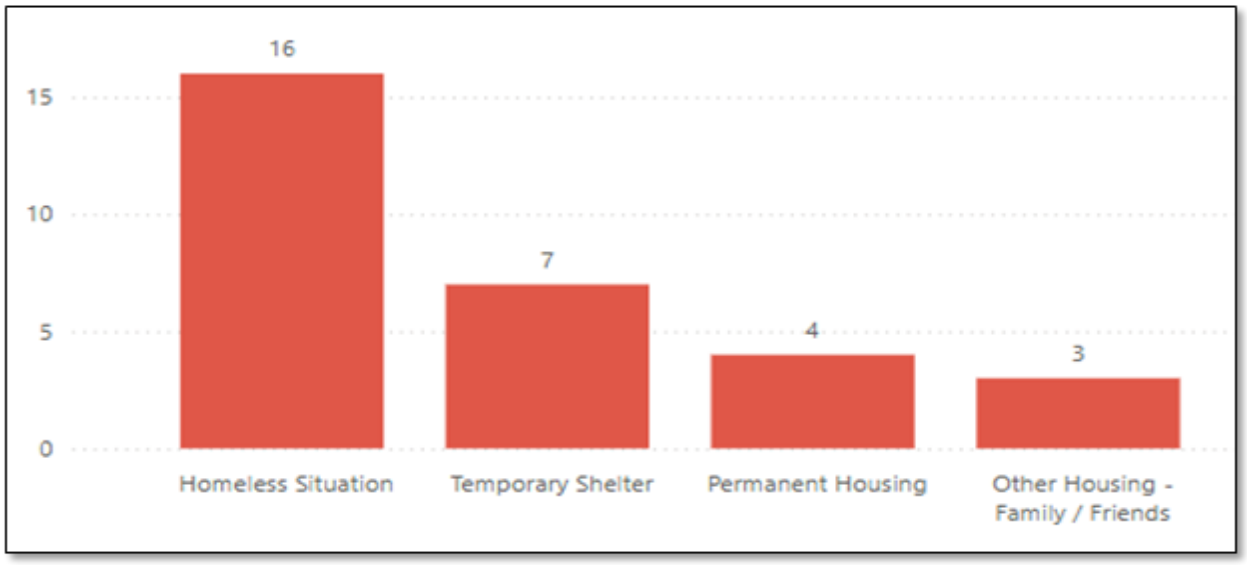
Program Impact

This section describes the measurable impact of the program on its participants, such as the housing outcomes of the patients and the referrals they received to other services.

Housing Outcomes

The Patient Navigation program missed the goal of placing 40% of participants (or a total of 20 of them) in <u>permanent</u> housing. Only 4 received permanent housing. But of the 37 participants, 19 cases were matched to interim housing at least one time. These are not mutually exclusive, meaning that a patient may have been counted twice if they received both interim housing and permanent housing. However, the analyses in Figures 8-10 count each participant one time.

Figure 8: Cumulative Placement Outcomes by Number of Patients

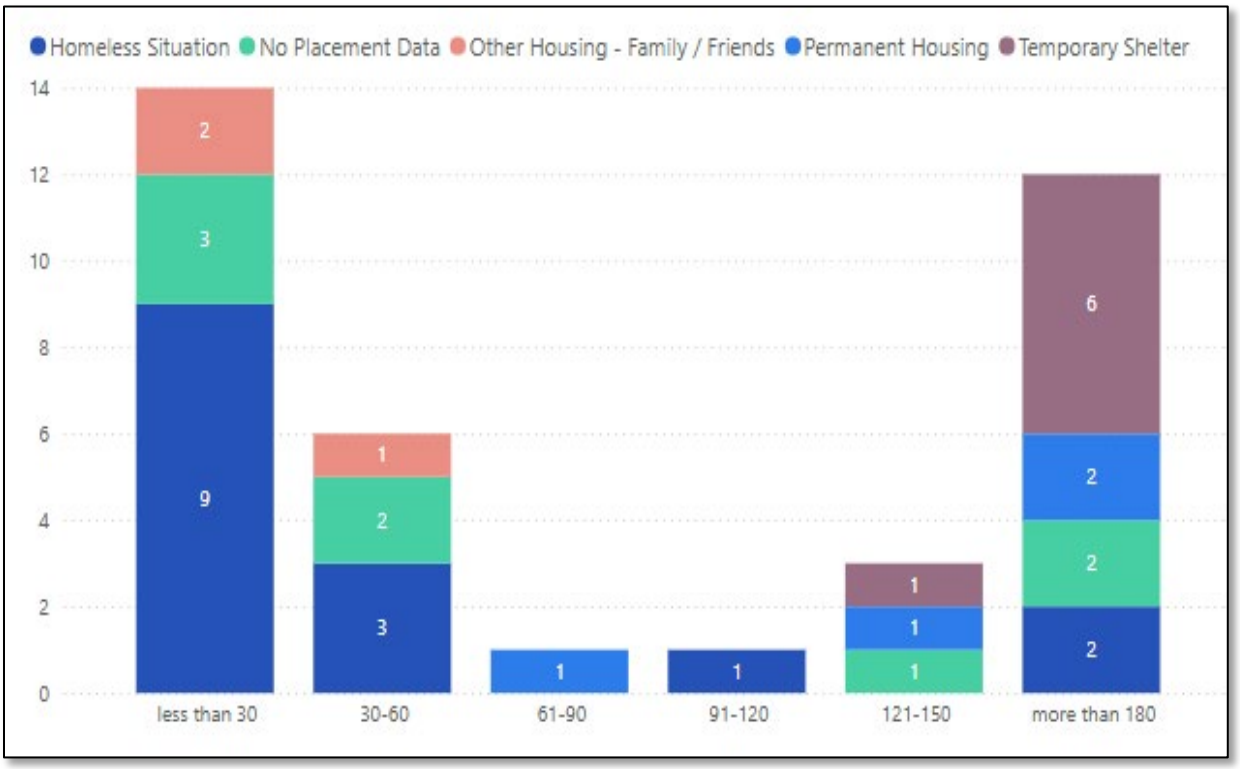


Before housing outcomes can be analyzed in detail, it is important to note how placements were defined. Placements were identified by LAFH on a case-by-case basis at the conclusion of a patient's participation or of the program. The housing/shelter categories are self-explanatory. "Homeless Situation" is defined by LAFH as "the participant is presumed to be homeless when they exited the program either because they were confirmed homeless at the time of exit or their exit destination/situation is unknown." Also, LAFH identified placement categories for only 30 of the 37 patients who received services, indicating that some of the outcomes were unknown or unclear. These categories are described in Figure 8 on the previous page.

Of the patients who were placed in permanent housing, one did so with the help of family and friends, according to the case notes. This person did not receive any services after they were matched for interim housing, and they were only in the program for 65 days. Participants who were placed in permanent housing had also 1.75 interim housing placements on average (2 on average, not counting the participant who was housed with the help of family/friends). In contrast, patients who were placed but did not end up in permanent housing had few placements on average (either 1.4 or 1.1, depending on whether an outlier is counted). This analysis indicates that patients often have multiple interim housing placements before they are placed in permanent housing.

Program length-of-stay appeared to have the strongest connection with the above placement categories. As indicated in Figure 9, the longer the program length of stay (at least 121 days), the greater the likelihood of some "better" placements.

Figure 9: Program Length of Stay, Color-Coded by Placement



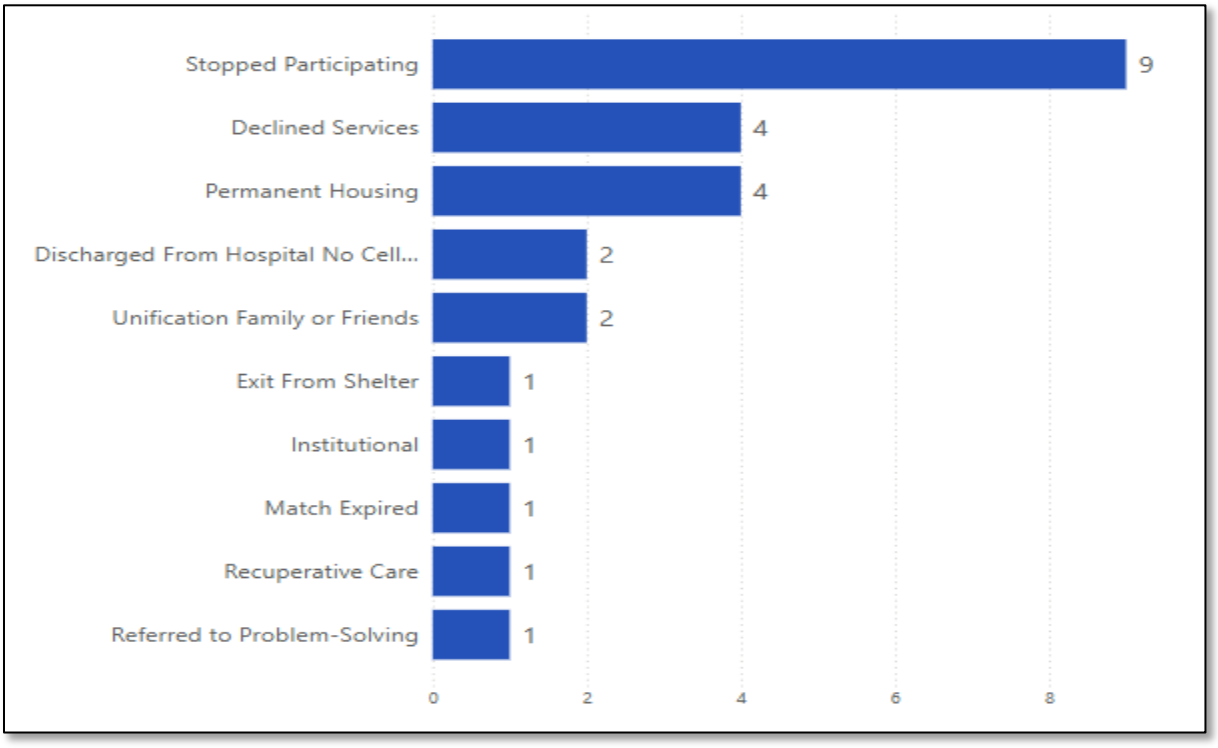
Among the participants who ended up in permanent housing, 2 participated in the program for more than 180 days and another for 121-150 days. Nearly all participants who were in temporary housing by the end of the program participated for more than 180 days (and the other 1 participated 121-150 days). This should not be surprising because intakes for the program declined over time, so the participants who were in Temporary Housing in the end would have been in the program longest.

Additionally, all 3 participants who were placed with family/friends participated for 60 days or fewer, indicating that participants who could be placed with friends/family were able to do so more quickly. Finally, 80% of patients who ended up in a "homeless situation" as their placement participated for 60 days or fewer (12 of 15), indicating a relationship between success in the program and length of time in the program. Please note that this relationship could go in either or both directions – (a) leaving early could have caused less-committed participants to have less success in the program or (b) having less success in the program could have caused frustrated participants to leave early.

Program Exits

Patient attrition, between those who stop participating and those who decline service, is high. Figure 10 presents the description of the final case outcome for each patient at time of exit, though exit data was not available for 11 patients. 9 enrolled participants stopped the program and 4 declined services.

Figure 10: Exit Outcomes by Number of Patients



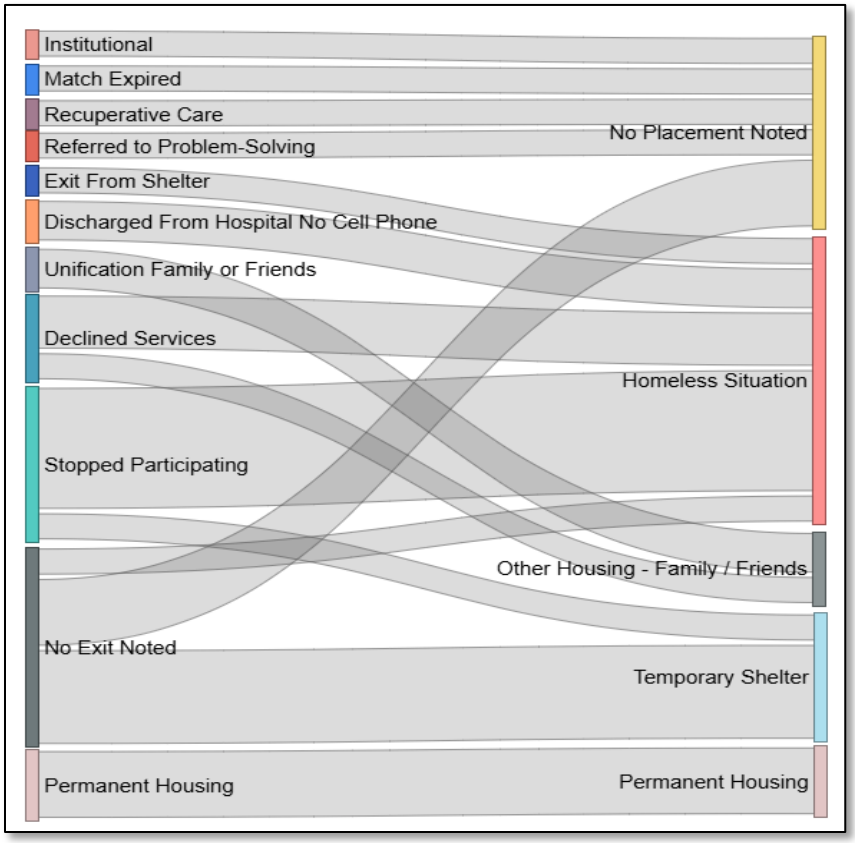
To calculate, an "exit note" in the case note system allowed to identify and describe program exits. However, because the start and end of services were based on the earliest and latest case

notes for each patient, not every patient had complete exit data. For example, if a patient stopped returning calls, they might not have a clear exit recorded in the data. To address this, the LAFH data team coded each participant who exited the program based on whether they had a recorded "exit" note or did not participate for more than 3 months (i.e., stopped participating through inaction or avoidance). To further refine this list, LAFH identified the specific patient identification numbers for patients who should not be considered as having exited.

To better understand the placement and exit data, the two types of outcomes were compared through a special type of link analysis called a Sankey diagram (see Figure 11).[9] This diagram displays the categories for each outcome type (exits on the left; related placement outcomes on the right) and links the two outcome types to show the patients they have in common.

Based on this analysis, people who stopped participating ended up in a homeless situation and the people who declined services ended up either in a homeless situation or with friends/relatives.

Figure 11: Relationship Between Exits (left) and Placement Outcomes (right) for Patients



[9] A Sankey diagram is a type of flow diagram that visually represents the flow of quantities between different categories. The key feature of a Sankey diagram is that the width of the arrows or flows is proportional to the quantity of the flow, making it easy to see the distribution and relationships between different elements.

Referrals to Mental Health and Other Programs

The program revealed few referrals or little focus on mental health issues, as originally intended. Because of the noted link between mental health issues and homelessness from the SPA 3 pilot, this program sought to increase referrals to mental health services. I

A thorough search of the case notes was completed for the term “mental health” and for other text strings indicating mental health issues such as anxiety and depression. The only relevant entries indicate that the Patient Navigator helped two participants with transportation to mental health appointments and asked for shelter staff to do a wellness check on a participant who was exhibiting emotional distress.

Beyond a focus on mental health, case note data was also reviewed for indications of referrals to other programs. These text string searches included “sent referral,” “referral has been made,” “put a referral,” “interim housing referral,” “IH referral” (but not “referrals”), “rental assistance,” “resources to get a,” and referrals to Helping Hands Senior Foundation. The analysis identified 19 referrals to outside organizations for 14 patients. There were 1.4 referrals to other programs on average per patient who had at least one referral, 0.5 referrals on average for all patients served. Additionally, 23 of 37 of patients (62%) received no such referrals.

Experience of program participants

Overall, interviewed patients expressed a very positive experience about the program with the overwhelming majority expressing “feeling good” about the positive changes in their lives. Nine participants shared their personal journeys while in the program. Among them, 5 identified as male, 3 as female and 1 as transgender. Participants self-reported their age: 2 were in their seventies, 2 in their sixties, four in their fifties and one declined to state. Participants defined their community very broadly as either San Fernando Valley or a specific city in the region (i.e. Van Nuys), often specifying where they have family or were raised. Three defined their community outside of Service Planning Area 2.

Program participants shared personal accounts of their experiences with homelessness, which were marked by significant hardship. Prior to joining the program, many had spent time living in tents or on the streets, while others had sought temporary shelter. Several mentioned the added challenges of dealing with chronic illnesses or experiencing a critical health crisis, which often played a role in their homelessness. These stories reveal the multifaceted nature of their struggles, underscoring how health issues can intersect with and exacerbate housing instability.

Overall, participants felt that the program had a profound impact on their lives, offering critical support and resources that helped many move from instability toward greater stability. While challenges remain, particularly around systemic delays and health concerns, participants were optimistic about their continued progress, with many focused on securing permanent housing, employment, and better health in the year ahead.

Motivations for participation: Participants expressed what drove them to participate in the program, with the primary motivation being the desire for support and access to essential resources. A key theme that emerged was the pivotal role hospital social workers and liaisons

played in helping participants navigate their circumstances and connect with the LAFH patient navigator. For instance, one participant recounted, “The hospital social worker contacted the hospital liaison at LAFH for a shelter bed. The hospital liaison referred me to the patient navigator”, highlighting the importance of such support in stabilizing participants’ immediate needs.

In addition to practical resources, many participants expressed a strong motivation to improve their lives. They spoke about the personal growth and positive changes they had experienced since joining the program. Statements like, "I feel good about the positive changes in my life" and "I think the program was very helpful" reflect a renewed sense of improvement and optimism.

Program Benefits: The Patient Navigation program played an essential role in addressing immediate housing needs and offering broader support. Several participants emphasized how the program helped them secure shelter, whether temporarily or more permanently. In one instance, a participant mentioned, “I like the program. It helped me get shelter after my hospital stay. I lost my shelter bed because I got incarcerated and the patient navigator was able to help me get back into the shelter again.”

Beyond shelter, the program provided vital assistance with other resources. Participants noted how the program helped them with transportation to medical appointments, obtaining important documents like Social Security cards and birth certificates, and providing clothing and other necessities. One participant stated, “I got into a shelter, and I have all my documents, and I started attending my mental health appointments”. Another individual shared that getting "off the streets" had been a huge accomplishment, and they were now focused on securing permanent housing and employment.

Emotional support was another valuable benefit, with many participants highlighting the regular contact with their Patient Navigator as an essential component in their journey toward stability. Participants spoke about how meaningful it was to have someone to rely on—whether a patient navigator, program staff, or family—during their vulnerable moments. One participant even noted that the patient navigator was "the only real help" they had received while homeless. As noted by another participant, “The program helped me have someone to talk to when I was admitted to the hospital a few times and keep me connected with the shelter so I could have a bed when discharged I also received clothing and shoes while in the program”.

Some participants also felt that they were making progress toward having more stability, moving forward in various aspects of life, including securing housing, accessing healthcare, and managing mental health challenges. “I feel good” was reported by 8 of 9 interviewed patients about the changes happening in their life as a result of the program.

Upon reflecting on the patients’ experience, the patient navigator also highlighted the following key successes for the program:

- Shelter and Housing Progress in terms of shelter stability, housing vouchers, and approved housing applications.

- Documentation and Preparation- A common focus is on participants becoming "document ready," which includes obtaining essential documents and completing applications for housing, SSDI, and other services.
- Health and Wellness focus including attending regular medical appointments, such as mental health check-ups and doctor visits

Program challenges: Though the program was generally perceived as highly helpful, participants also noted a few challenges. One common issue was frustration with systemic delays and gaps in resources. Some participants mentioned the long wait times for housing assistance or difficulties accessing services due to their undocumented status. These frustrations underscore the need for more timely and accessible resources in the support systems for unhoused individuals.

Additionally, participants continued to face persistent health issues, both physical and mental. While the program helped many access more consistent healthcare, health challenges remained a significant barrier for some. Reconnecting with family also emerged as a goal for a few participants, with the hope that their involvement in the program could aid in re-establishing these vital connections.

Patients' Aspirations: Looking ahead, many participants expressed a strong desire for stable housing. The goal for most is to secure permanent housing and escape the instability of the shelter system. Employment and financial stability were also prominent aspirations, with several participants hoping to secure jobs or improve their financial situation through benefits such as SSDI. Additionally, health and personal well-being were perceived hopes for the future. Participants aimed to improve their physical and mental health, with a particular focus on maintaining sobriety and continuing recovery.

Cost Effectiveness

Because focused services to high-utilizer patients experiencing homelessness could conceivably reduce costs and save time for hospital staff, the program set out to measure these outcomes if possible.

Before discussing results, it is first necessary to reiterate the limitations of the data:

1. The HMIS data obtained for this report did not list all hospital visit dates for each patient. Though this report makes use of linking LAFH case note data to MyOrg data by unique dates of birth, this process only captures referrals and does not record all hospital visits by homeless patients.

2. HCAI cost data and hospital usage data were not available for 2024 at the time this report was written. Conceivably, the evaluation team could have measured data about homeless patients in 2024 and measure any reductions from 2023 numbers, but this data was not available.

Despite limited data available, there are some indications of potential cost savings that could be attributed to this program. The best approach for measuring any potential change in re-hospitalization involved measuring time between hospital visits observed by the Patient

Navigator. If patient navigation helped older adults experiencing homelessness to have better health outcomes and/or stop using emergency rooms for non-medical problems, the data should show more time between hospital visits as participants continued in the program. This evaluation presents this data in two variables:

1. Time to First Admission. This variable is defined as the number of days between (a) when a participant started receiving services and (b) when that participant was noted as being readmitted into a hospital. For example, if a participant started receiving services on a Monday and then was readmitted to a hospital that Friday, this difference would be 4 days for that participant.

2. Time from Last Admission. This variable is defined as the number of days between (a) the last time a participant was admitted to a hospital and (b) the last day that participant is noted as receiving services. For example, if a participant's last hospital visit in the data was on a Monday and then they stopped receiving services (or the program ended) on Friday, this difference would be 4 days for that participant.

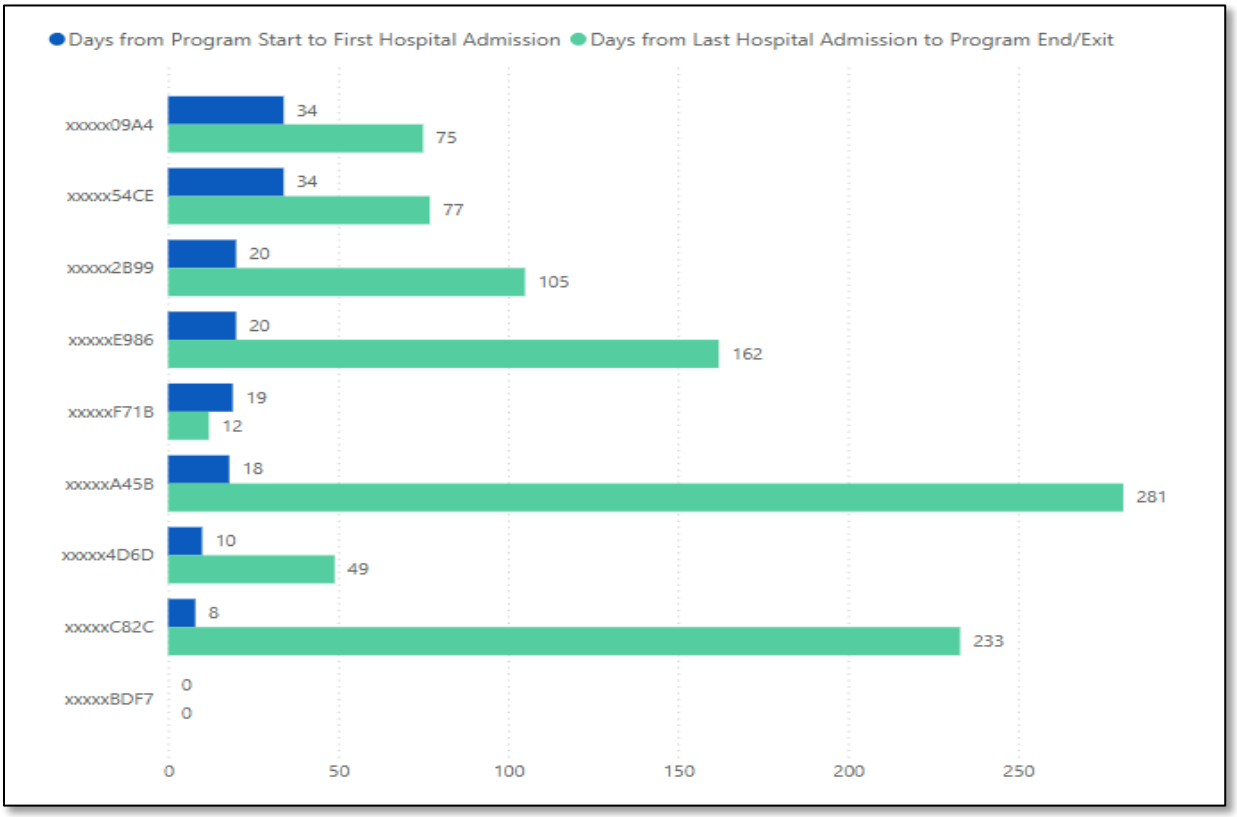
3. Analysis. If participating in the program would tend to reduce the tendency of participants to visit hospitals, we would expect to see shorter time from the beginning of the program to the first hospital visit (indicating more frequent admissions at the beginning of the program) and longer time from the last hospital visit to the end of the program (indicating less frequent admissions after participating for a time). The below analysis compares these two time differences to estimate change in frequency of hospital visits associated with the program.

Tracking hospital visits by participants involved using the Patient Navigator's case notes (i.e., LAFH data) to identify hospital admissions. These case notes define admissions as "PN-Admitted to Hospital" or "PN- Participant Admitted To Hospital." It is reasonable to assume that the Patient Navigator would be aware of and able to track most of these visits while patients were in the program for several reasons. First, participants were obligated to report hospital visits to maintain their temporary housing. Second, hospital staff contacted the Patient Navigator on several occasions to report that a patient had been admitted to the hospital. Third, the Patient Navigator regularly checked in with patients to find out about health issues and hospital visits even if not right away. Though only 8 of the 37 patients have one or more hospital admissions documented in the data, the analysis only requires that these patients report all or most of their hospital admissions.

Time since the last hospital admission was 6 times longer on average than time to first admission, indicating that participants had greater time between hospital admissions after participating in patient navigation. In looking at whether reported hospital admissions declined for patients over time, the data shows that the average amount of time from starting participation with the program to the first self-reported hospital visit (i.e., Time to First Admission) is 18 days. In contrast, the average amount of time from the last self-reported hospital visit to ending participation with the program (i.e., Time from Last Admission) is 110 days. To check whether this was different than other case note types, the analysis excluded hospital admissions and also intake case note types (because they tend to occur in the

beginning) and ran similar averages across all these other case note types. Under this comparative analysis, each earliest case note was, on average, 76 days after beginning participation and each latest case note was, on average, 105 days prior to ending participation per category per patient. Thus, the average time after the last hospital admission was 6 times greater than the average time to the first hospital admission, while the same comparison was only 1.4 times greater for all the other non-intake case note types. This is illustrated in Figure 12, which lists the anonymized patient identification number for each patient on the left and presents the number of days to the first hospital visit (blue) and from the last hospital visit to the end of the program or participation (green) each as the lengths of the bars.

Figure 12: Time to First Admission vs. Time from Last Admission



Notably, MyOrg data could potentially use referral data as a proxy for how often they are visiting hospitals. There are several problems with this approach. One is that the average distinct date of birth appears 0.27 times per year in the MyOrg data, and we have a limited amount of post-treatment data given that the program recently ended at the time of this writing. Another potentially more important issue is that referrals may more accurately indicate how interested a person is in treatment rather than how often a person is being admitted to a hospital. This later interpretation is supported in the data. Across all MyOrg data dating back to 2020, the 37 people who participated in services in this program had 44 referrals (1.2 referrals per patient); whereas, the 17 people who were invited to participate and did not participate in services had 14 referrals (0.8 referrals per patient).

Appendix A: List of LAFH Services

PN- Appointments
PN- Assessment
PN- Contact Number Changed
PN- Documents
PN- Documents ID, Social Security, Income
PN- Donations
PN- Employment
PN- Gift Card
PN- Income
PN- Intake
PN- Legal Support
PN- Matched Interim Housing
PN- Permanent Housing
PN- Referral helping hands senior foundation
PN- Transportation
PN- VI-SPDAT (which is an assessment tool for homelessness services)
PN- VOD (which stands for “Verification of Disability”)
PN-Transportation
PN- Housing
PN- Walk In Assessment
PN- Unification Family or Friends
PN- Voucher Application
PN- Social Services
PN- Engagement
PN- Hospital Visit
PN- Wellness Check

**Note: the above list contains corrections and excludes duplicates. These edits did not affect the analysis.