GREATER SAN GABRIEL VALLEY COMMUNITY HEALTH SNAPSHOT 2022

Brought to you by:

San Gabriel Valley Hospital Collaborative

Published: March 31, 2023

ACKNOWLEDGMENTS

Many thanks to our funders - UniHealth Foundation, United Way of Greater Los Angeles, Well Being Trust, and our hospital partners - for supporting the Greater San Gabriel Valley Hospital Collaborative.

Hospital Collaborative Members:

Nonprofit Hospitals
- City of Hope National Medical Center
- Emanate Health
- Huntington Hospital
- Kaiser Permanente Baldwin Park Medical Center
- USC Arcadia Hospital
- Pomona Valley Hospital Medical Center

Local Health Departments
- Pasadena Public Health Department
- Los Angeles County Department of Public Health

Convening and Technical Assistance
- Health Consortium of Greater San Gabriel Valley
- Center for Nonprofit Management

BACKGROUND

The Greater San Gabriel Valley (SGV) Hospital Collaborative is an initiative facilitated by the Health Consortium of Greater San Gabriel Valley (Health Consortium). The mission of the Health Consortium is to strengthen the health care safety net and optimize seamless access to high quality physical, behavioral and social health services in the Greater SGV. Beginning in 2018, the Health Consortium, in partnership with the UniHealth Foundation, convened the Hospital Collaborative, including six nonprofit hospitals in Service Planning Area 3 (SPA 3) of Los Angeles County along with LA County Department of Public Health, Pasadena Public Health Department and Center for Nonprofit Management. The purpose of the Hospital Collaborative was to not only streamline and share community data stemming from each hospital's Community Health Needs Assessment (CHNA), but also to develop a joint strategy to address priority health needs identified across each hospital's respective CHNA that more broadly impacted the whole region. This partnership is now in its fifth year.

Greater SGV Hospital Collaborative Partners

City of Hope Medical Center

Emanate Heath

Huntington Hospital, an affiliate of Cedars Sinai

Kaiser Permanente Baldwin Park

Pomona Valley Hospital Medical Center

USC Arcadia Hospital

Los Angeles County Department of Public Health

Pasadena Public Health Department

Center for Nonprofit Management

Every three years, nonprofit hospitals throughout the United States conduct CHNAs to develop a deeper understanding of the health care needs of the residents of their service areas. The CHNA process involves collecting and analyzing both primary data (from interviews, focus groups and listening sessions) and secondary data (from large public datasets like the US Census and local and regional public health departments). CHNAs provide insight into the magnitude and severity of disease and predictive factors, as well as an understanding of the social, economic, cultural and environmental factors that influence health behaviors and health outcomes.

This hospital collaboration is innovative with respect to the size and diversity of the joint service areas of participating hospitals, and the breadth of key stakeholders engaged. This snapshot report draws from the CHNAs conducted by each hospital partner, including comparable priority issue areas across hospitals and reflections from community stakeholders in the SPA 3 region. Specifically, the report provides (1) a high-level overview of data that describes the area's population; (2) five key priority issue areas in the Greater SGV, including: Behavioral and Mental Health, Health Care Affordability and Accessibility, Housing and Homelessness, Economic and Food Insecurity, and Chronic Conditions; and (3) a profile of cooperative projects already in motion to address priority needs as a result of this collaboration.

For more detailed information about these priority issues as well as specific health topics by category including disease rates, behavioral and mental health indicators, maternal and child health and health concerns of specific populations (i.e. the aging population), please refer to the Greater San Gabriel Valley Hospital Collaborative website, where you can find links to each of the participating hospitals' complete CHNA:

www.publichealth.lacounty.gov/chs/SPA3/SGVhospitalcollaborative.htm.

HOW YOU CAN USE THIS REPORT

This report combines public health indicators with the perspectives of residents and service providers on issues affecting quality of life and health in the Greater San Gabriel Valley. Specifically, this report includes select demographic and public health indicators; brief summaries of priority health needs; insights into the connections between economic, social, political, cultural and geographic factors and quality of life in the San Gabriel Valley; and a profile of current programs developed to address some of these needs --- the Food for All SGV program to address food insecurity and the SPA 3 Patient Navigation program to address homelessness and housing. Furthermore, community recommendations for improving health and wellbeing for residents is considered. This report can be used to complement nonprofit program grant writing, and to direct and anchor collaborative public health program development.

INTRODUCTION

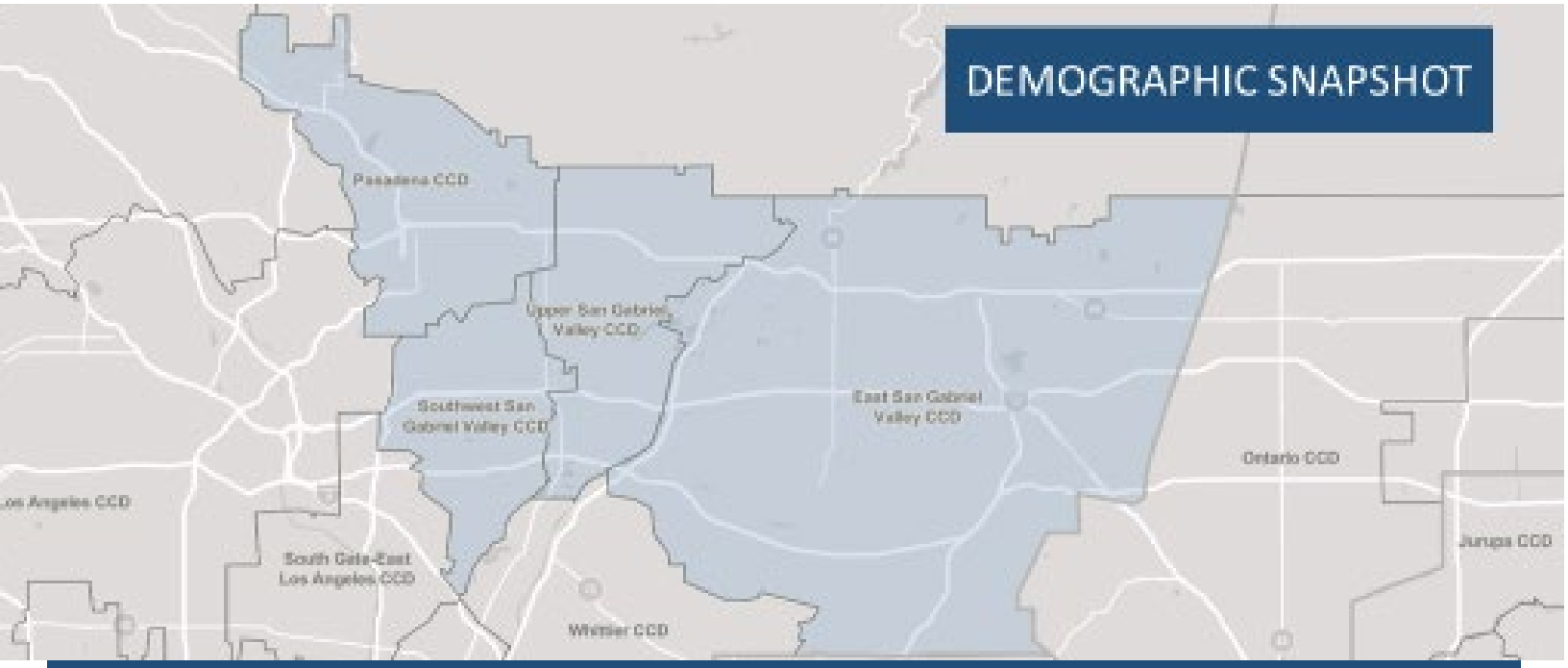
The Greater San Gabriel Valley is home to 1,857,067 residents (nearly one-fifth the population of Los Angeles County) and spans approximately 400 square miles. The geographic boundaries of the Greater San Gabriel Valley are aligned with those of Service Planning Area 3—a planning area that includes 28 cities and 16 unincorporated areas. Communities range widely in population size, from the City of Industry (264 residents) to Pomona (151,713 residents) with highest proportional increases seen in Pomona (9.5%) and Pasadena (8.2%).[i]

Beyond size and population, the Greater San Gabriel Valley is one of the most racially and ethnically diverse regions of the United States. Approximately 46% of the region's population is Hispanic/Latino, 30.2% is Asian, 17.7% is White, 2.9% is African-American, and less than 1% is either American Indian/Alaska Native (0.2%), Native Hawaiian/Pacific Islander (0.1%) and other (0.4%).The diverse racial and ethnic groups who call the Valley home are unevenly distributed in pockets of high density—an artifact of a long history of housing policies, immigration and migration in the region. The region is also linguistically heterogeneous—nearly two-thirds of La Puente and South El Monte households speak Spanish at home. Over half of households within the cities of Rosemead, Rowland Heights, San Gabriel, Monterey Park (53.9%) and Temple City (51.6%) speak an Asian or Pacific Islander language at home. Meanwhile, Altadena, Bradbury and Pasadena have the highest percentage of households speaking some other Indo-European Language.[ii]

> *"San Gabriel Valley is a tale of two cities, with pockets of wealth and pockets of poverty."*

This report aims to echo key themes that emerged from the primary and secondary data collection efforts of multiple community health needs assessments conducted in the San Gabriel Valley by hospitals in this collaborative. Looking at the current health trends through an equity lens reveals that the geographic size of the Valley—coupled with the cultural, racial, and socioeconomic diversity and heterogeneity—make providing responsive health care services that equally meet the needs of all residents an important priority. Additionally, understanding how current economic and social trends, along with reports on the added complexities of structural racism, impact access to healthy and long lives for vulnerable groups is an important step in developing and evolving public health initiatives, systems and institutions. Furthermore, the snapshot points to the enormity of need that necessitates community-wide attention and support.

DEMOGRAPHIC SNAPSHOT

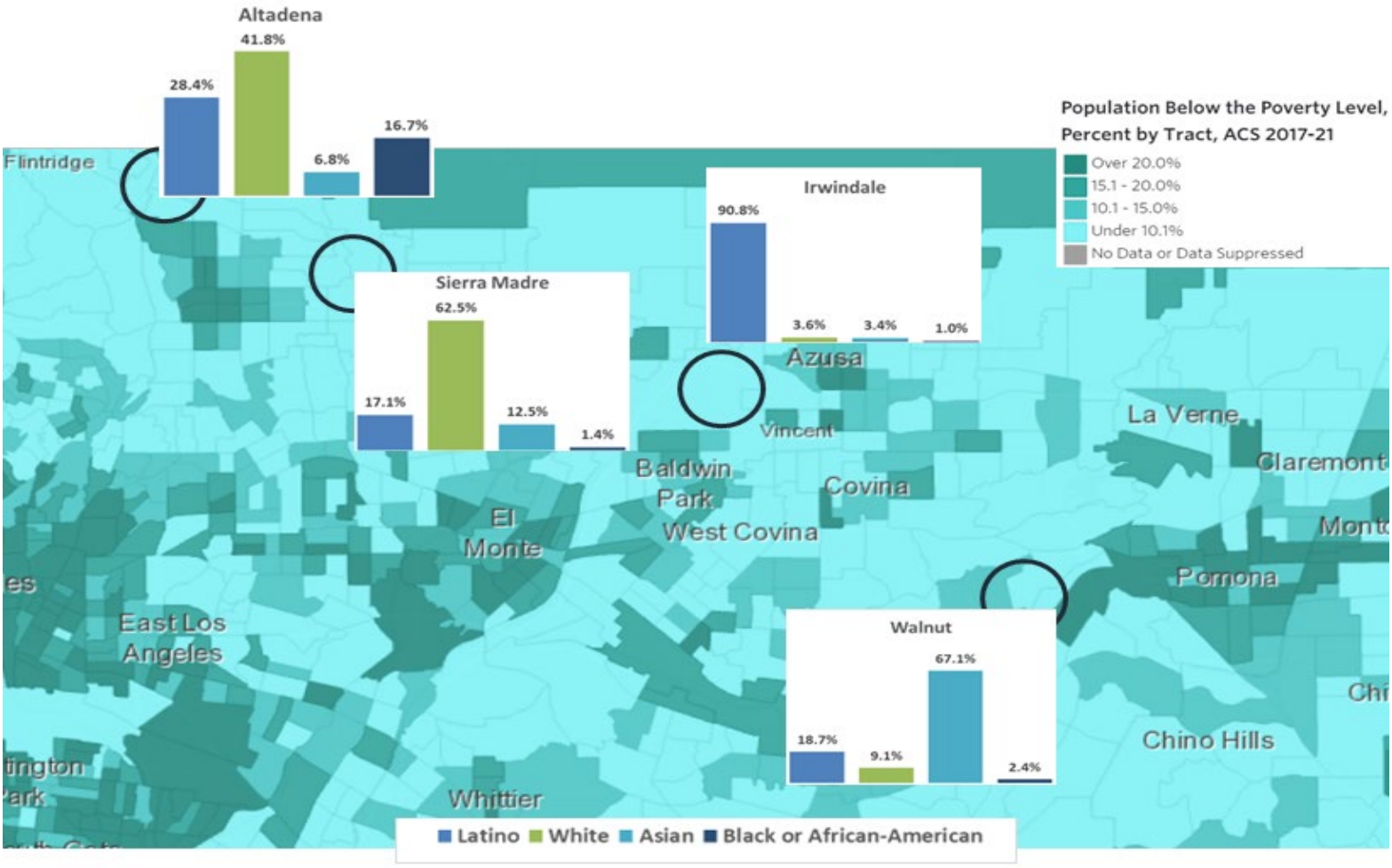


Community Profile[iii]	Pasadena	Upper SGV	SW SGV	East SGV	LA County
Hispanic/Latino	26.4%	43.4%	40.2%	**54.6%**	48.0%
White	**39.4%**	15.2%	6.5%	16.0%	25.6%
Black/African American	7.1%	1.8%	0.9%	2.8%	**7.6%**
American Indian/Alaska Native	0.1%	0.1%	0.1%	**0.2%**	**0.2%**
Asian	21.6%	36.9%	**50.4%**	23.7%	14.7%
Native Hawaiian/Pacific Islander	0.1%	0.0%	0.1%	0.1%	**0.2%**
Other Race	**0.6%**	0.4%	0.3%	0.4%	**0.6%**

- Hispanic or Latino is the largest segment of the population in all of Greater San Gabriel Valley, except in Pasadena region, where the White population exceeds all other sub-populations.
- Fewer Black or African Americans live in Greater San Gabriel Valley than in the rest of the county though the Pasadena region is on par with the Los Angeles County rate.
- The proportion of Asian population is higher in all areas of the Greater San Gabriel Valley, with Upper and Southwest San Gabriel Valley regions recoding rates two to three times higher than the Los Angeles County rate.

Population: Seniors 65+	16.8%	15.8%	**18.4%**	15.3%	14.6%
Population: Under 18	20.4%	**21.9%**	18.8%	21.3%	21.1%
Foreign Born	28.9%	42.4%	**48.6%**	34.5%	33.3%
Language at Home: Not English	42.2%	66.7%	**73.0%**	58.7%	55.3%
Marital Status: Never Married	35.6%	37.8%	37.3%	38.2%	**43.0%**
Average family size	3.29	3.67	3.53	**3.77**	3.51

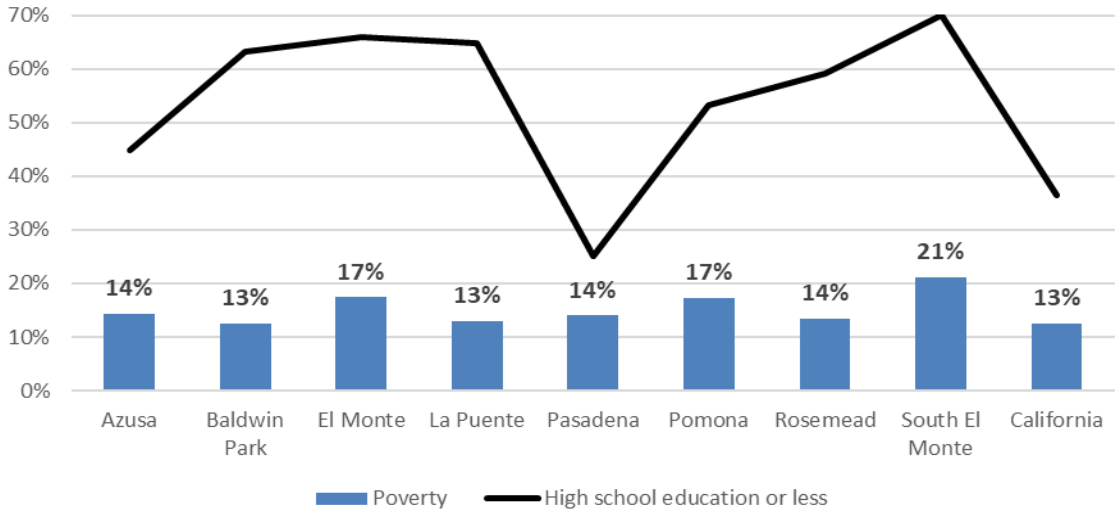
- Greater San Gabriel Valley has larger proportion of residents who are seniors than Los Angeles County.
- Southwest San Gabriel Valley caters to a greater proportion of senior residents than its neighboring regions or the county and has the smallest proportion of residents 18 and under.
- The Southwest and Upper San Gabriel regions have proportionately more residents who are foreign born and speak a language other than English in their household.



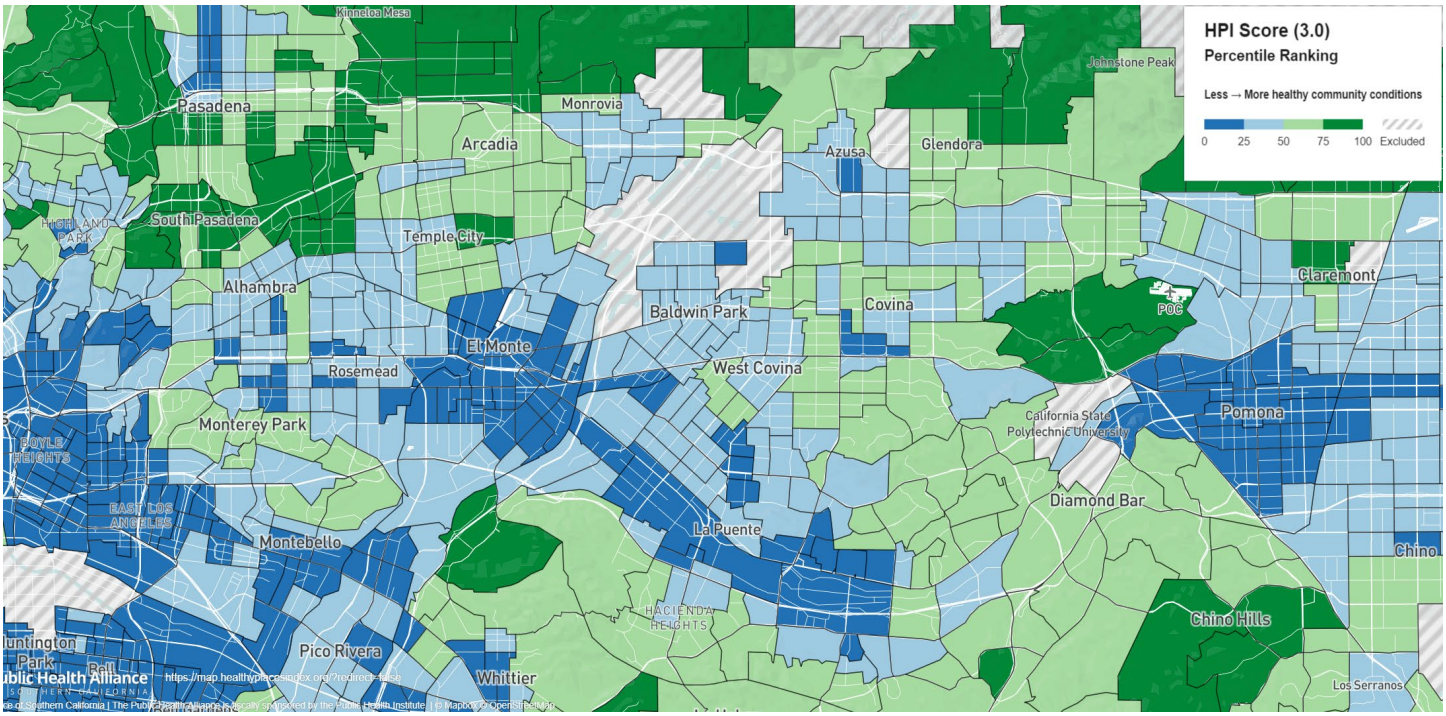
Poverty Level by Ethnicity in Select Cities of Service Planning Area 3[iv]

Racial/ethnic sub-populations vary and are highly concentrated in specific geographic "pockets" throughout the Valleys. For example, 21.1% of the population lives below 100% FPL in South El Monte, while only 6.2% do in Sierra Madre. This is indicative of the challenges of building a coordinated service delivery system that is culturally and linguistically responsive and available in the communities where needed.[2]

Baldwin Park, El Monte, La Puente, Pomona, Rosemead, South El Monte, and parts of Pasadena have high concentrations of residents with low income and low levels of educational attainment. These are the communities most vulnerable to economic, housing, and food insecurity, factors that can lead to higher-than-average morbidity and mortality rates.



Healthy Places Index[v]



The California Healthy Places Index, developed by the Public Health Alliance of Southern California, is used to identify community conditions that impact life expectancy, and to help policymakers have a tool to address structural health inequities. "High need" areas are indicated by the darker blue shading. The scores are based on a composite of 25 community indicators, such as education and access to healthcare, that are weighted to maximize a single score associated with life expectancy at birth. The HPI applies a positive frame focusing on assets a community has they can build on, rather than what is lacking.

Health disparities (shaded in dark blue with a lower HPI score--less healthy community conditions) are present in various San Gabriel Valley Communities including Pasadena, Boyle Heights, Montebello, El Monte, South El Monte, La Puente, Whittier, Azusa, South Covina and Pomona.

COVID-19 & ITS IMPACT

In the three years since the first public health orders resulting from the COVID-19 pandemic in March, 2020, over 3.5 million actual cases in Los Angeles County, and over 700,000 actual cases in San Bernardino County, were reported.[vi] Findings on the impact of COVID-19 include:

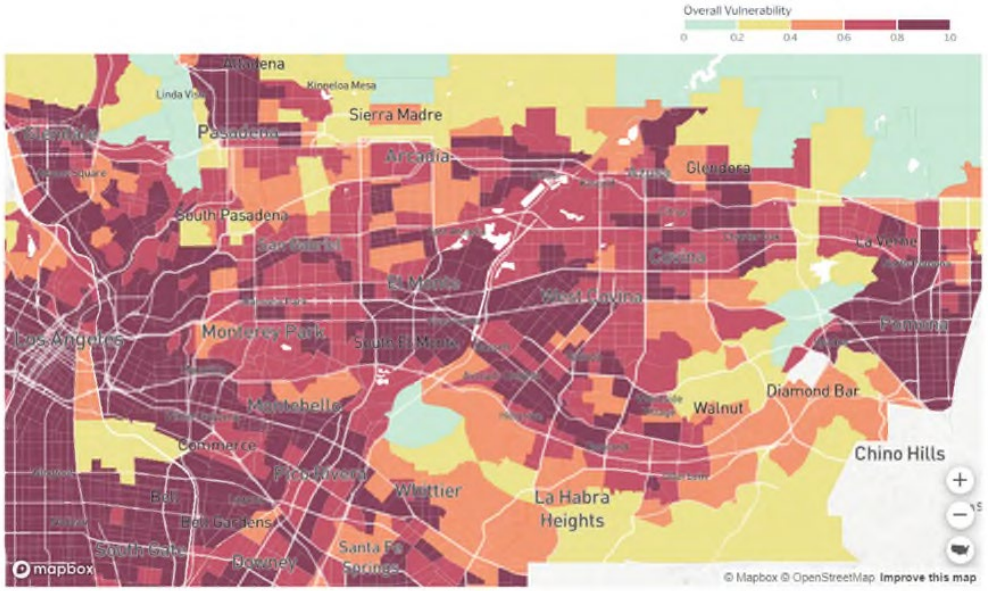
> *The physical impact [of COVID quarantines] is yet to be determined, but the mental health impact is very apparent*.

- Employers, nonprofit leaders, healthcare organizations, and community members expressed frustration with changing work environments and increased stress. Over 8% of San Gabriel Valley residents experienced difficulty paying for basic necessities and/or rent or mortgage. Many more lost their jobs (16%) or had reduced hours or income (24%), rates much higher than the rest of California (13.2% and 23.8% respectively).[vii]

College students & teenagers were disproportionately impacted due to COVID-19

- San Gabriel Valley residents highlighted how the cumulative effect of quarantines resulted in declining mental health, feelings of isolation and a disconnect from systems and support, mental and physical exhaustion, general burnout, labor shortages, and educational gaps.
- Vulnerable members of the San Gabriel Valley, such as seniors, students, the unhoused, medical professionals, people with chronic diseases, and people struggling with financial instability, were disproportionately affected, highlighting the inequity between communities.
- Community members expressed concerns over losing friends and family members, rampant misinformation relating to COVID, as well as the long-term health impacts.
- Sharing information on changing COVID information was particularly challenging for healthcare workers.
- Increased access to telehealth was a "silver lining" of the COVID-19 pandemic for many service providers.

The COVID-19 Community Vulnerability Index (CCVI) overlays indicators of social vulnerability, such as socioeconomic status or language barriers, with indicators of vulnerability unique to the COVID-19 pandemic, such as access to health care and comorbidities among the population. Darker areas indicate greater vulnerability. The map shows that many communities in SPA 3 had high vulnerability because of COVID-19.[viii]



PRIORITY HEALTH NEEDS

The following section describes the priority health needs that emerged from the Community Health Needs Assessments of the Greater San Gabriel Valley Hospital Collaborative partners.

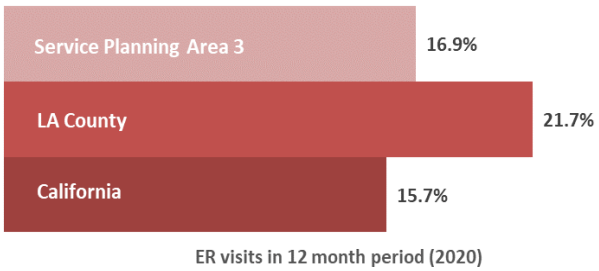
Access to Healthcare

The COVID-19 pandemic worsened existing barriers to care such as long wait times, costs, public health disinformation, and access to specialists, which increased the mistrust that many communities have with the health system.

- Barriers to care are impacted by many factors including misinformation and distrust, shortages in medical care professionals, long wait times and delays in appointments, difficulties prioritizing check-ups and appointments due to unpaid time away from work, hesitancy because of COVID, and challenges with insurance coverage. People with less education and/or lower income are less likely to seek any type of care which contributes to poor health outcomes.
- Insurance systems can be difficult to navigate. Without insurance or lack of coverage through their employer, many individuals rely on the emergency room or urgent care which increases costs for the hospital and individual.
- Rates among low-income communities for vision and dental coverage are extremely low, and health care costs, even with health insurance, are prohibitively high.
- Even with access to health insurance, structural and institutional barriers continue to persist for some residents such as implicit bias against the poor, seniors, people of color and LGBTQ individuals, lack of culturally appropriate doctors and services, and lack of access to primary care. These barriers contribute to a delay in care.

Community Recommendations

- Prioritize relationship building with communities to become trusted sources of information.
- Develop health care services that are rooted in cultural values and traditions.
- Reduce wait times for accessing care.
- Expand telehealth services coupled with technology training on how to access these services.
- Increase pipeline of medical care professionals.



People who do not have health insurance are less likely to have primary care physicians, which is key to preventive care.

Residents between the ages of 18 and 64 in the service area were less likely to have a consistent source of care than younger residents, ages 0 to 17.

Mental Health and Behavioral Health

The COVID-19 pandemic severely impacted the mental health of all communities. Increased isolation and economic uncertainty have highlighted the need for greater access to mental health and behavioral health services.

> *It is a challenge to find a therapist within your network or a therapist that is the right gender or ethnic and cultural background. Also, the cost of services can be prohibitive.*

- Barriers to accessing mental and behavioral health services are primarily driven by a limited availability of facilities and services, stigmatization of support, a lack of culturally responsive services, and general cost of care. In many communities, including among African Americans, Latinos, and LGBTQ+, social stigma surrounding mental health persists.
- Anxiety, depression, and suicide ideation are on the rise due to the COVID-19 pandemic, particularly among Black and Hispanic Americans.
- The linguistic, cultural, and racial diversity of the Greater San Gabriel Valley indicates a need for mental and behavioral health care services that is responsive to patterns of mental and behavioral health care utilization that vary across communities and subpopulations.
- Needs assessment participants uplifted anxiety and depression stemming from rising costs in housing, COVID, general cost of living, negative effects of social media, and education.
- Young people increasingly experience bullying, harassment, and familial abuse. Children and youth who experience stress are more likely to have poorer mental and physical health.

Community Recommendations

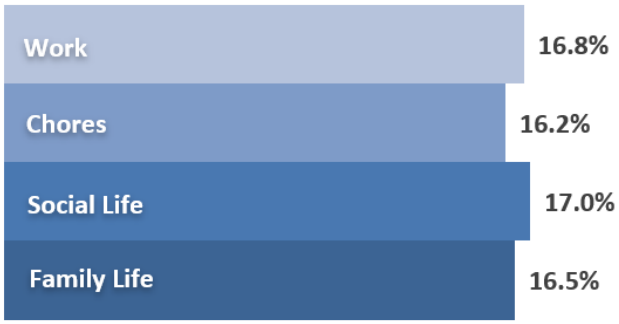
- Increase access to mental health services, particularly rapid adoption of digital platforms for behavioral health services.
- Increase culturally appropriate outreach to dispel myths around mental health and bridge trust between health systems and communities.
- Find opportunities to increase investments to de-stigmatize, improve awareness of mental health and behavioral health, and establish trust with populations in need.

In Service Planning Area 3[ix]:

A portion of adults experienced an increase in interpersonal conflict (14.1%) or in snapping and yelling in their household during COVID (12.4%)

38% of adults reported accessing a mental health professional in a one-year period.

31% of teens experienced chronic sadness or hopelessness and felt they needed help for emotional or mental health problems (feeling sad, anxious, or nervous) in a prior 12-month period.



Type of adult impairment in 12 month period (2 year estimate 2019-20)

Chronic Conditions

Chronic conditions are particularly challenging because of the complex nature of underlying causes, and the influence of economic and social factors on management and treatment of chronic diseases.

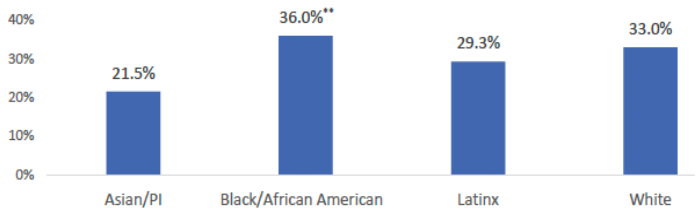
> *Stress is a factor in all these chronic diseases, and, for everyone, stress is elevated due to the pandemic.*

- Challenges of managing chronic conditions have been amplified as a result of the pandemic. Chronic diseases (including high blood pressure, diabetes, and other heart problems) are complicated at least in part because of neglected access to care and problems associated with continuing to manage these conditions.
- Economic insecurity and heavy workloads persist as barriers for many to attaining healthy diets, access to needed medications, physical activity, and leisure time with friends and family – factors that prevent chronic illness and support the management of chronic illness.
- Elevated levels of stress, lack of access to care in low-income communities and financial instability exacerbate prioritization and management of chronic diseases.
- Housing insecurity and homelessness function as barriers to the management of chronic illness and contribute to risk for chronic illness. Unhoused individuals have difficulties accessing care for chronic conditions.
- Food insecurity contributes to poor diets and increased prevalence of chronic conditions.

Two-fifths of adults in LA County 65 years and older (40.7%) were overweight, and adults between 50 and 59 years of age had the highest obesity rate (27.7%).[x]

More than one in five adults, ages 65 and over, were identified as diabetic in Los Angeles County[xi]

As the 7th leading cause of death in the U.S., diabetes rate has increased across all counties in Southern California, with the highest increase reported in SPA 3, at a rate of 13.3% compared to a state rate of 10.9%.[xii]



High Blood Pressure by Ethnicity in SPA 3 (2019-20)[xiii]

SPA 3 residents show higher levels of hypertension (27.4%) and borderline hypertension (8.3%) diagnoses than residents in Los Angeles County (26.2% and 8.2% respectively)[xiv]

Cancer Rates, age adjusted, per 100,000 persons in Los Angeles County[xv]

	Latino	White	Asian/PI	Black	All
Incidents	309.9	437.3	296.3	408	373.5
Mortality	120.1	148	110.3	185.2	136.9
Mortality Ratio	39%	34%	37%	45%	37%

In Los Angeles County, the ratio of incidents to mortality for all cancer types is highest for African Americans

Housing Insecurity

Housing insecurity and homelessness are at crisis levels in Los Angeles County, with the Greater San Gabriel Valley also deeply impacted. In 2022, the number of unhoused in Los Angeles County has risen to 69,144. In SPA 3, the rate of unhoused has increased by 2%. Most persons experiencing homelessness are chronically unhoused, single adult individuals (82%) over 25; 14% are families, and 58% are male. Latino/ Hispanic communities are the most susceptible to homelessness.

> *"There is not enough low-income housing or housing with affordable rents. The areas that are being gentrified are pushing people out of their housing, and people are being displaced out of their communities."*

- Lower wages act as a major barrier to health care and increased housing insecurity. Wages cannot keep pace with rising living and housing costs. In many SPA 3 communities, rental and mortgage costs exceed the national average.
- Housing insecurity has significant downstream health impacts and other safety concerns on residents. The increased costs of living and limited housing supply for lower to middle income residents take a toll on families to have stable housing in their own communities. Even for employed residents, affordable housing is challenging and taxing. Finding available resources can be especially difficult for those who are undocumented.
- Some residents and families co-share housing, often doubling up or tripling up, to split costs of living. Overcrowded housing conditions are more severe in areas with higher proportion of people of color.

Community Recommendations

- Improve housing protections through eviction moratoriums, information sharing of tenant rights, and prevention/safety net strategies.
- Increase affordable housing options and expand access to income eligible benefits.
- Address the stigma around "homelessness" and the shame felt in losing a home and increase political and community will to address the shortfall in affordable housing.
- Improve support systems for families and residents "at-risk" of homelessness by providing targeted employment and housing supports, particularly for transitional age youth, foster youth, undocumented immigrants and seniors.
- Increase mental health providers and mental health resources at transitional housing.
- Connect hospital systems regionally to better support families and residents, particularly those at risk of being unhoused.

Unhoused Sub-Population	SPA 3				Los Angeles County			
	2015	2019	2020	2022	2015	2019	2020	2022
Chronically Unhoused	32%	28%	39%	33%	34%	28%	36%	41%
Substance Abuse	24%	13%	33%	21%	25%	13%	24%	26%
Mental Illness	20%	24%	28%	21%	30%	23%	22%	25%
Veterans	8%	6%	4%	6%	10%	7%	6%	2%
HIV/AIDS	1%	1%	2%	2%	0%	2%	2%	2%
Domestic Violence Experience	19%	35%	29%	41%	1%	5%	29%	8%

Longitudinal rates of unhoused sub-populations in San Gabriel Valley/SPA 3[xvi]

Food Insecurity

A household is food insecure under one of two conditions, a reduction in the quality, variety, or desirability of diet with little to no indication of reduced food intake (low food security) or multiple indications of disrupted eating patterns and reduced food intake (very low food security) according to the US Department of Agriculture.

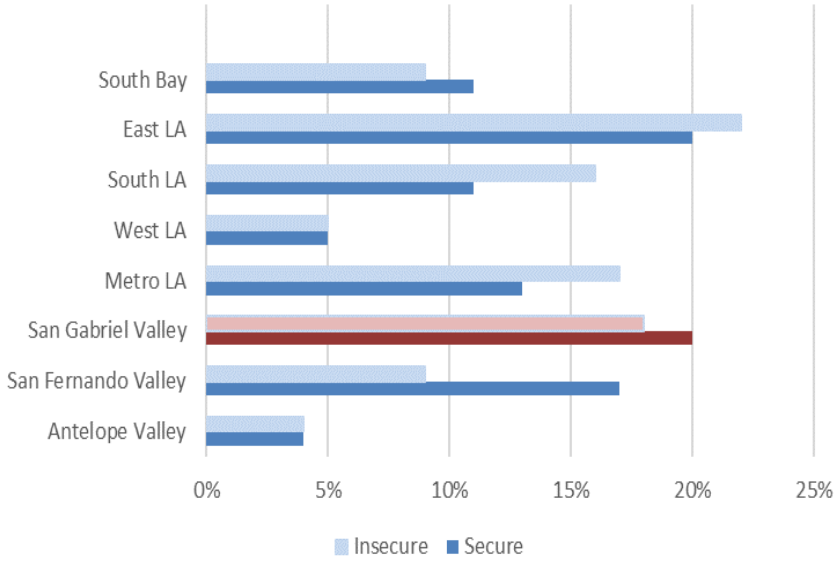
> *If you do not have enough money to put food on the table and make the rent, you don't prioritize health.*

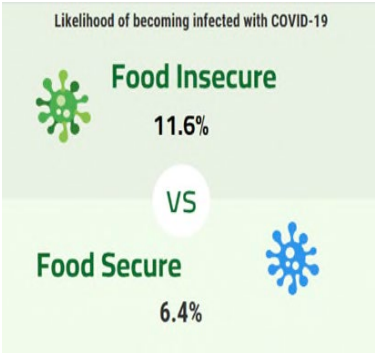
- Access to healthy food options has been difficult particularly in low-income communities, where there are not enough grocery stores but more cheap fast food options. In SPA 3, 30% of adults living 200% below the federal poverty level reported not being able to afford food.
- Over the past 10 years, food insecurity has increased in every county in California, and COVID-19 deepened food insecurity issues further for low-income communities who were already suffering from limited access to healthy food.
- Food insecurity for children in low-income communities affects academic development and increases chances of depression.
- Food giveaways were less accessible to seniors.
- Many nonprofits pivoted during COVID from their core program to meet a growing need for food security as many residents experienced food insecurity for the first time.

Community Recommendations

- Improve food distribution infrastructure, particularly the number of food pantries and supermarkets in food insecure communities.
- Work with local corner stores to offer affordable healthy food.
- Simplify the process for accessing CalFresh and other government benefits providing support to families.

L.A. County Population with Food Insecurity During COVID-19[xvii]





The San Gabriel Valley had the 2nd highest population in Southern California with food insecurity during COVID-19

A Call to Action

With the effects of the COVID-19 pandemic still looming throughout Los Angeles County, many communities in the Greater San Gabriel Valley (SGV), particularly our most vulnerable residents, have yet to recover and still continue to experience economic, social, cultural, political and environmental barriers that impact access to resources and greatly impede their health and wellbeing, putting further stress on already stretched public and social service systems. Lower income residents, in particular, are impacted by economic and housing security and are challenged to afford basic needs foundational to health, such as safe, affordable housing, access to healthy food, and health care.

This moment requires vigilance and presents an opportunity to tackle persistent challenges that have exacerbated the need for support and services in our most vulnerable communities. The mission of the Health Consortium of Greater SGV, an initiative of the Health Consortium of SGV, is to strengthen the health care safety net and optimize seamless access to high quality physical and behavioral health services in the Greater San Gabriel Valley (SGV).

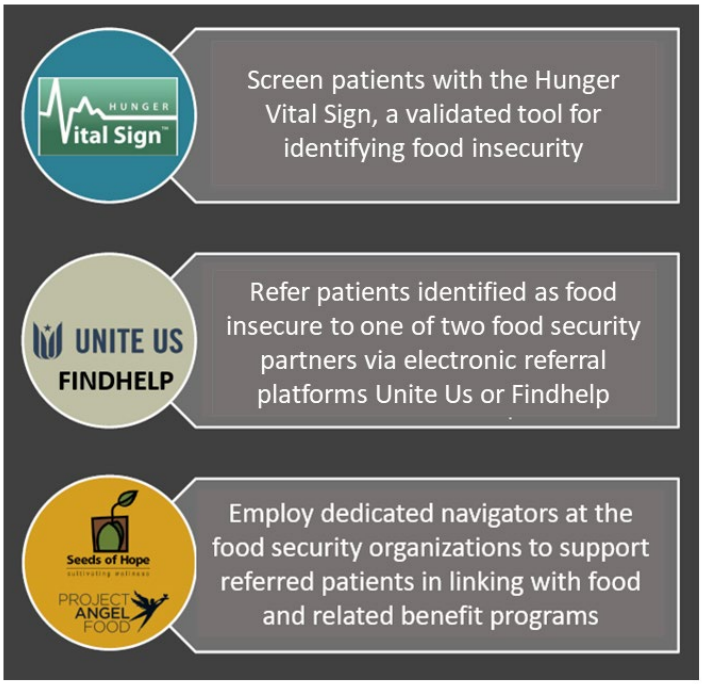
The SGV Hospital Collaborative has been engaging for the past several years in finding ways to leverage information collected through their collective Community Health Needs Assessments (CHNAs) to develop coordinated strategies in addressing areas of need. The pages that follow provide examples of the Hospital Collaborative's initiatives already underway in both food security, through the Food for All SGV program, and homelessness, through the SPA 3 Patient Navigation program. The Collaborative is also exploring opportunities to expand recuperative care in the Greater San Gabriel Valley.

This report, in addition to the detailed public health data contained in the Community Health Needs Assessments published by each of the Greater San Gabriel Valley Hospital Collaborative partners, will continue to inform the work of the Health Consortium as well as the Hospital Collaborative. The SGV Hospital Collaborative and Health Consortium of Greater SGV invite your participation in a collective effort to improve health access and outcomes in our communities by using innovative approaches for coordination and collaboration among our community members and leaders across sectors and industries.

Food for All – San Gabriel Valley Initiative

Hospitals are increasingly taking responsibility for addressing social determinants that impact the health of residents. This initiative addresses food insecurity documented in research studies to be linked to higher risk for poor health outcomes associated with chronic disease, hunger, depression, and increased healthcare costs.

The 2-year pilot program provides a regional approach to address food insecurity among economically and medically vulnerable hospital patients at five area nonprofit hospitals within the Greater San Gabriel Valley-- Huntington Hospital, USC Arcadia Hospital, City of Hope, Kaiser Permanente Baldwin Park and Emanate Health.



Program components include:

- Food screening and tracking: Each hospital incorporates a food screening protocol as part of the admission or discharge process using a screening tool. Referrals are tracked in one of two referral platforms in use by the hospitals.

Food partnerships: Eligible patients are linked to Seeds of Hope for emergency food services or Project Angel Food for medically tailored meals. Navigators at these two organizations build relationships with patients and link them to food and other related benefits.

Throughout the two years of the program, the initiative will:

(1) Build and test program infrastructure and workflows to support implementation among hospital partners;
(2) Institute a data and referral management system to facilitate data collection and successful referrals;
(3) Provide emergency food to 1,200 people and 12,500 medically tailored meals to address food insecurity identified among participating hospital patients; and
(4) Develop a plan for sustaining hospital commitments to addressing food insecurity and advancing the regional approach. Hospitals will explore various ways to sustain food security resource by institutionalizing internal policies addressing food security, aligning with potential reimbursement opportunities, and securing ongoing financial contributions to the food partners.

SPA 3 Patient Navigation Initiative[xviii]

Efforts to coordinate between the homeless services and healthcare systems are vital in improving both health and housing outcomes for people experiencing homelessness. The Patient Navigation pilot program was developed and spearheaded by United Way of Greater Los Angeles's Home for Good Initiative which unifies the SGV region around a bold vision of ending homelessness in L.A. County.

> *"If we don't get them right at that moment where they are willing to get help, then we lose the opportunity. Patient Navigators help support that patient and provide service or resources that same day.*

In its first year, the program was designed to support post-discharge care coordination and case management for 100 people experiencing homelessness who were "high-utilizers" of hospital emergency services in the San Gabriel Valley/SPA 3 area of Los Angeles County. The program is centered around 5 hospital partners from the SGV Hospital Collaborative that refer patients to Union Station Homeless Services (USHS) who provides the post-discharge support to patients. Hospital partners include Emanate Health, Huntington Hospital, Kaiser Permanente Baldwin Park, USC Arcadia and Pomona Valley. Patient navigators were embedded within partnering hospital teams and workflows to:

1. Conference and problem solve referred cases.
2. Integrate and coordinate effectively available resources.
3. Facilitate a process of healthy recovery for participants.
4. Connect target patients to shelter/housing placements, primary care services, public benefits, and more.

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

Hospital and homeless service partners successfully co-designed, planned, and implemented the 18-month project. The evaluation has captured the perceived impact of the program on participants and project partners, the effectiveness of implementation, health and housing outcomes for patients served, and the cost effectiveness for hospitals including reducing emergency department/inpatient readmittance for high utilizers of hospital services experiencing homelessness.

The project is now in its second phase of implementation focused on patients ages 50 and over.

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