Implementation and evaluation of pilot program providing patient navigation to individuals experiencing homelessness

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Background

- In 2019, there were **3,722 persons experiencing homelessness in Dallas**.
- Homelessness is associated with increased morbidity, premature mortality, and significant barriers to accessing care.
- A novel student-led **Patient Navigator Program (PNP)** is in development to connect persons experiencing homelessness to **community resources** and services **specific to each patient's individualized needs.**
  - Navigators are graduate students in Medical and Health Professions Schools.

Purpose

- Implement a **15-week pilot program** to demonstrate feasibility, evaluate efficacy, and provide recommendations for large-scale program implementation.
- **Primary Outcomes:**
  - **Number of client-navigator encounters**
  - **Number of SMART goals per objective**
  - **Completion of objectives**
- Secondary Outcomes:
  - Client feedback and self-efficacy as measured through pre- and post-survey.

Methods

- A team of four student navigators working with one client and their family at Union Gospel Mission Shelter to accomplish **6 health-based objectives over the course of 15 weeks**.
- Pre-survey identified client's 6 highest priority needs, each classified under one of **11 PNP-standardized categories**.
- Each objective is broken down into **weekly step-wise SMART goals** (specific, measurable, achievable, resource-based, and time-bound) to enhance patient self-efficacy.

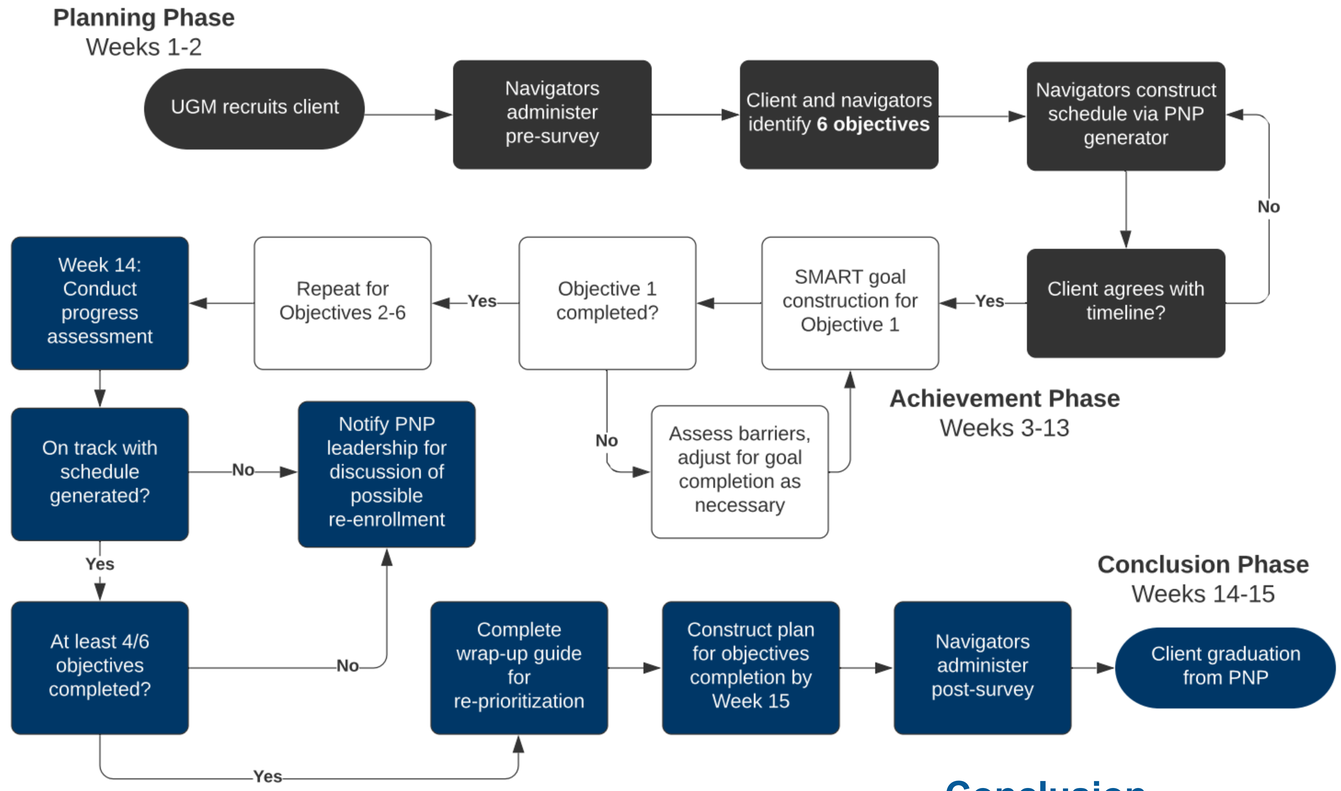

Figure 1. 15-Week PNP Cycle

Results in Progress

- As of 10/10/20, the team has documented **10 total direct client-navigator encounters** over a course of 10 weeks, in addition to **weekly electronic communication and community resource management**.
- Of note: Prior to PNP engagement, client reports three unsuccessful attempts to apply for healthcare financial assistance. This objective was completed Week 6 of the PNP cycle, and they will be linked into primary care for the first time in "many years."
- Post-survey has not been completed and survey results have not been analyzed at this time.

Objective	Standardized Category	# SMART Goals	Completed?
Healthcare financial assistance	Cost of care	4	Yes – Week 6
Legal problem	Trauma	4	No – resource nonexistent
GED preparation	Social determinant of health	2	Yes – Week 4
ID reinstatement	Administrative	5	Not yet
Linkage into dental care	Access to specialty care	1	Not yet
Cost of childcare	Social determinant of health	N/A	Not yet

Table 1. Client objectives and progress at Week 10

Conclusion

- The PNP pilot is the beginning of a **sustainable community impact** in improving health outcomes among individuals experiencing homelessness in Dallas.
- **Next steps**: Large-scale implementation, pairing 8 navigator teams with one client per 15-week cycle, with 3 cycles planned in 2021, for a total of 24 clients graduating in PNP's inaugural year.

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