Implementation and evaluation of a pilot patient navigator program for individuals experiencing homelessness lasting 2-to-4 weeks in duration

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Background

- In 2020, there were **4.471 persons experiencing homelessness in Dallas**.[1]
- People experiencing homeless are disproportionately affected by chronic diseases, physical and mental illness, high risks of morbidity, premature death, and face barriers to accessing care.[2]
- A novel student-led **Standardized Care System (SCS)** is being developed to connect persons experiencing homelessness to **community resources** and services **specific to each patient's individualized needs.**

Purpose

- Implement a **4-week pilot program** to measure achievability, efficacy, and inform future larger-scale program implementation.
- **Primary Outcomes:**
  - **Number of client-navigator encounters**
  - **Completion of objectives**

Acknowledgements

- Union Gospel Mission Dallas
- UT Southwestern Department of Family Medicine

Methods

- A team of two student navigators working with one client at Union Gospel Mission Shelter to accomplish **1 health-based objective over the course of 2-to-4 weeks** (fig.1).
- Talk with client and identify client's objective and create **SMART goals** (specific, measurable, achievable, resource-based, and time-bound) outlining what specific steps are needed to complete the client's objective.
- As the client creates and completes his SMART goal, the student-navigator's involvement slowly tapers off to encourage **client independence, self-sufficiency, and confidence building in forming and accomplishing goals** so that they are able to continue addressing their needs and utilizing community resources when they are no long meeting with the student-navigators.
- Each client defined goal aligned with the Centers for Disease Control and Prevention's **Healthy People 2030 campaign** addressing social determinants of health[3].

Results in Progress

- As of 03/26/2021, the team has documented **7.5 total direct client-navigator hours** over a course of 4 weeks, in addition to **email communication with the client** and **finding community resources** (Table 1).

Client Defined Goals	# of SMART Goals Set and Achieved	Healthy People 2030 Objective[3]
Substance Use Treatment	1	"Increase the proportion of people with a substance use disorder who got treatment in the past year - SU-01"
Setting up Eye and PCP Appointment	1	"Increase the proportion of adults who get recommended evidence-based preventative health care – AHS-08" "Increase the proportion of adults who have had a comprehensive eye exam in last 2 years – V-02"
Obtaining Social Security Benefits	1	"Reduce the proportion of people living in poverty – SDOH-01"

Table 1. Client objectives corresponding with Healthy People 2030

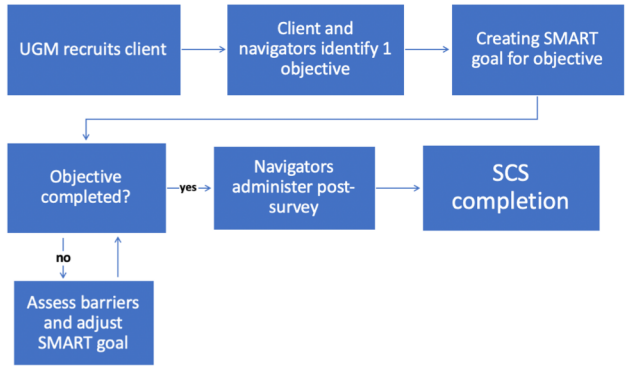

Fig 1. SCS 4-week structure

Conclusion

- The SCS pilot demonstrates the program's ability to **link clients to community resources for short term goals** through the creation of SMART goals.
- This pilot SCS is the starting point for a sustainable community contribution to improve local social and health equity for people experiencing homelessness.

References

1. MDHA, 2020. State of Homelessness Address. Dallas, TX.
2. Omerov, P. et al. (2020) Homeless persons' experiences of health- and social care: A systematic integrative review. *Health & social care in the community*. [Online] 28 (1), 1–11.
3. Browse objectives - Healthy People 2030. (n.d.). Retrieved April 18, 2021, from https://health.gov/healthypeople/objectives-and-data/browse-objectives