Digital Health Intervention for People Experiencing Homelessness

Interim Evaluation Report

Prepared by the Center for Community Health and Evaluation and MedPOINT Management Services

Funded by the California Healthcare Foundation

November 22, 2023

Executive Summary

Background

This report presents the preliminary findings of an independent evaluation of Samaritan, a digital health intervention designed to assist people experiencing homelessness (PEH) in gaining the social and financial support they need to reach their goals. California Healthcare Foundation (CHCF), in collaboration with Healthcare LA (HCLA), an Independent Practice Association (IPA), and California Hospital Medical Center (CHMC), supported the implementation of the Samaritan program as a pilot in seven health centers in the Los Angeles area.

The Center for Community Health and Evaluation (CCHE) and MedPOINT Management (MPM) are evaluating this pilot program using a mixed-methods approach.

Methods

The goals of the Samaritan pilot evaluation are to understand the contribution of the Samaritan program to members' health behavior change, experience, outcomes (e.g., housing goals, chronic condition management), and the effect on healthcare utilization (e.g., emergency department, primary care utilization). During the evaluation design, key leaders emphasized a desire for the evaluation to help them understand Samaritan's overall reach and its impact on healthcare utilization, cost, and no-show rates. They also wanted to understand the impact on the participating health centers in terms of staff experience and workflows. Finally, they wanted to understand the potential for Samaritan to be sustained, which the evaluation results would inform.

Key Findings

Ten preliminary key findings emerged from the data:

1. Health centers need leadership, buy-in, ample startup time, and designated staff to launch Samaritan successfully to support the increased workload.
2. Strict eligibility requirements tied to health plans and hospital capitation have been a significant barrier for potential users.
3. Care manager involvement is a primary component of successful implementation. Care managers got a morale boost from seeing members connect to care. This boost often offsets the additional capacity strain of administering and integrating another program.
4. Samaritan currently integrates better into health centers with existing care manager support. Acute care hospital setting integration is currently challenging.
5. Leaders, care managers, and most members cite financial support from Samaritan as the most significant benefit for members.
6. Words of encouragement from Good Samaritans are meaningful and motivating for members. Community support differentiates Samaritan from other similar programs.
7. The ability for members to customize their goals, action steps, and spending decisions enhances their self-efficacy and sets Samaritan apart from other programs.
8. Overall, preliminary data suggests that Samaritan members may be using the Emergency Department less often than they did before joining.

9. High-level, preliminary partner data show potential decreases in costs of care for Samaritan members.
10. Patients rated their experience participating in the Samaritan program highly.

Summary

The early findings of this interim report show some clear benefits of the Samaritan program for members: financial support, reduced social isolation, and better connections to healthcare. Healthcare leaders are also experiencing reductions in costs associated with emergency department utilization. As Samaritan considers expansion, leaders, care managers, and members offer many suggestions, including expanding eligibility criteria for enrollment, allocating plenty of implementation resources ahead of time, carefully considering whether the hospital setting is viable, and maintaining the care manager relationship.

Background

This report presents the preliminary findings of an independent evaluation of Samaritan, a digital health intervention designed to assist people experiencing homelessness (PEH) in gaining the social and financial support they need to reach their goals. Samaritan is a platform where community members can donate money and send encouraging messages to PEH enrolled in the program. Samaritan members can access financial and social support to help them meet their needs and earn bonuses by taking action toward their social determinants of health (SDoH) goals. The Samaritan program could be considered a type of contingency management intervention. This intervention type is predicated on motivational incentives to help people perform positive behaviors to achieve their goals, such as meeting with a care manager and attending preventative healthcare appointments.

California Healthcare Foundation (CHCF), in collaboration with Healthcare LA (HCLA), an Independent Practice Association (IPA), and California Hospital Medical Center (CHMC), supported the implementation of the Samaritan program as a pilot in seven health centers in the Los Angeles area. In June 2023, one study identified 75,518 and 46,260 people living unsheltered in Los Angeles County and the City of Los Angeles, respectively[1], comprising 30% of the nation's unsheltered population[2]. These seven health centers serve a substantial number of people experiencing homelessness or at risk of becoming homeless.

In some health centers, the implementation of Samaritan's pilot program could leverage work that the health centers were doing through the state of California's Medicaid Transformation effort. This endeavor included the Enhanced Care Management (ECM) and Community Supports programs, part of CalAIM, to improve care coordination and provide community supports to address members' social needs.

Methods

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CCHE and MPM used a mixed-methods approach, combining qualitative data analysis from interviews with quantitative analysis of data from the health plan claims data and data collected directly through the Samaritan platform. The 10-month evaluation implementation phase goes from April 1, 2023, to February 29, 2024. The results in this interim evaluation report are for April 1, 2023, to November 15, 2023.

The evaluation team developed a plan including evaluation questions (Appendix A, Table 3), measures, and data collection methods (Appendix A, Table 4). The evaluation findings are based on data collected through:

- Interviews with participating health centers and other stakeholders (see Appendix A, Table 5)
- Interviews with a sample of Samaritan members (i.e., patients)
- Data from MedPOINT Management on healthcare utilization and outcomes
- Data from Samaritan's platform on engagement, goals, and social and financial incentives.

Appendix A, Table 6 includes additional demographic and chronic condition data. For the interim report, these demographics provide context for the patient population. In the final analysis, the evaluation team will use this demographic data to help gauge the characteristics of members engaging with Samaritan and whether those characteristics increase engagement and improve outcomes. The team also performed a literature review to scan for peer-reviewed information for guidance on evaluating contingency management programs to inform the evaluation design (see Appendix B).

Evaluation Findings

This section describes results from the evaluation, derived from qualitative and quantitative analyses of each data source and triangulation across data sources. This interim report only covers available data from April 1, 2023, to November 15, 2022. The evaluation team plans additional data collection and analyses for the final report as more data becomes available. The evaluation team organized this section around ten key findings that span the pilot implementation of Samaritan in L.A. County.

The following **key findings** emerged from data analysis:

1. Health centers need leadership, buy-in, ample startup time, and designated staff to launch Samaritan successfully to support the increased workload.

The seven health centers that chose to participate in Samaritan were typically introduced through a presentation, approached by other physicians, or asked by their leadership (like HCLA) to launch the program. They were provided training and demonstrations by Samaritan staff and offered weekly check-in calls on enrolling patients with whom they already have a relationship. Using a list of eligible patients provided by a data partner, 40 care managers contacted eligible patients to explain the program and see if they were interested in receiving additional financial and social support for reaching their goals.

Healthcare leaders' **advice to those interested in implementing Samaritan is to allocate resources to start up and implementation. That includes organizing the right people, teams, workflow, and systems to support implementation duties and regular responsibilities.**

Challenges with implementing in health centers

Key leaders and care managers experienced conflicting **pace and understanding** challenges throughout implementation. Some leaders felt rushed through implementing Samaritan, since learning a new system takes time, and there was not always enough decision time, buy-in, or time to thoroughly explain things to their health center teams. However, other leaders noted a slower-than-expected program rollout in some health centers because of staffing, communication, and eligibility challenges. A few key leaders were frustrated by messy data and reporting and thought Samaritan implementation would benefit from a data person in the clinic or an outside partner. One person suggested starting with a small pilot at their clinic and building from there. Some care managers cited their lack of **understanding** of the program, and others wished for more organizational leadership support (resources, guidance). Both leaders and care managers suggested Samaritan consider creating a set of **predefined action step** "recipes" for care managers to start with, starting simply and becoming more complex over time. Some health centers had started creating these on their own already.

> *"We had to learn at the start who the right people were who needed to be involved at different stages. Didn't train 10 health centers right away. We had to figure out data analytics and working this into their patient flow, documentation, internal systems, E.H.R, care management. It takes communication between local leadership conversation and health centers."* -Key leader

After implementation at health centers, the most cited reflection by health center partners concerned competing job duties and **staff capacity to complete enrollment tasks**. A key leader explained, "*Health centers have been really challenged with workforce shortages; some lost care team staff and weren't able to implement, had to get whole new set of people, or didn't have bandwidth to support more responsibilities. It's been difficult coming out of COVID*." One health center is not spreading the use of Samaritan outside their care managers because they have found it hard to integrate into their workflow.

Successful components of health center implementation

Health center partners tried **integrating Samaritan into their existing systems** to reduce the burden on care managers of implementing a new program. As one care manager commented, *"We are designing a workflow so that it becomes a tool helpful for care managers with current work rather than a burden as in additional work to do."* Key leaders recommended that others ensure **dedicated staff and systems** are ready for the extra duties required at the beginning of the program. This support worked well at one clinic, whose care manager shared: "*When staff needed support, we acknowledged the current workload and allocated certain care managers to assist for Samaritan specifically. Or we decreased the current workload so there could be a balance to absorb the demands of Samaritan."* Care managers also appreciated support from their health center leadership, which included piloting the integration of Samaritan into their workflow, leveraging the ECM program, and providing a guide for using incentives.

Samaritan has also **enhanced collaboration** among organizations participating in the pilot. Key leaders and care managers positively reported utilizing partners with the health system, case manager groups, and MPM to engage as many patients as possible and address capacity and workflow challenges Key leaders and care managers had various views on the quality of communication across partners.

All health center partners appreciated Samaritan's **technical assistance**. Care managers felt that Samaritan provided much support and training. At launch, it worked well to hold initial education meetings and spread the word through providers as they saw the impact. One care manager whom Samaritan trained was able to train their colleagues. Additionally, Samaritan pamphlets made for members are helping to clarify the details of the program at some health centers. Care managers also reported appreciating Samaritan's help in solving problems around gift cards and support around eligibility determinations and I.T. issues.

2. Strict eligibility requirements tied to health plans and hospital capitation have been a significant barrier for potential users.

Health centers rely on a data partner to provide an eligibility list of patients capitated to the hospital or a health plan. Capitation is a contracted agreement for payments to a facility that are fixed and pre-arranged. CHMC receives payments per patient enrolled in the health center or per capita. From the list of eligible patients, care managers can reach out to patients to invite them to participate in Samaritan. Member word of mouth sometimes spreads to other patients who inquire about the program but may not be eligible.

Many key leaders mentioned limited eligibility criteria (through specified health plans only) as a challenge of the partnership. Most care managers reported that Samaritan members are a **small percentage of their caseload** because of the strict eligibility criteria, limiting who can benefit from the program. It also requires a different care management workflow for those patients than others, making it more challenging to integrate Samaritan into standard work. As one care manager said, *"We need a way to integrate this into workflow better, so any unhoused patient would have access to services. Now, because of IPA collaboration, we are targeting those patients. We aren't providing this resource to all those who need it."*

Many key leaders and care managers emphasized that **more patients could benefit from Samaritan** through expanded eligibility criteria in future stages. Because the pilot is focused on members of HCLA (one IPA in L.A. County), this program is not available to all patients who could benefit from it. Another key leader explained, *"There are definitely some organizations [not currently participating] that would LIKE access to Samaritan, especially in south L.A. Some of these already have care managers that set goals…having these goals paired with assistance would be great."*

"What I find challenging is that some patients have a significant financial need but unfortunately they don't meet the current Samaritan criteria and thus are ineligible. I have a significant caseload of patients who fall under healthcare plans that are not contracted with Samaritan, but I would really love if they were."
-Care manager

When asked what was missing from Samaritan that would make it more seamless the most significant request was **information sharing for medical records systems and for eligibility purposes**. Healthcare leaders wished Samaritan was integrated into electronic health record systems to check eligibility or view data across health centers and hospitals (substance use, mental health screening, SDOH markers, claims, etc.). One care manager shared that it takes time to check with a data partner or external data system if someone is eligible, which can cause a **delay in enrollment**. Another health center reported that the web-based enrollment aspect burdened their care managers. Leaders stated that such integration would also be helpful for prevention strategies, especially with older adults who comprise most Samaritan members at some health centers. As mentioned in the previous finding, identifying a data person to help with reporting and eligibility tasks could smooth implementation across sites.

3. *Care manager involvement is a primary component of successful implementation. Care managers got a morale boost from seeing members connect to care. This boost often offsets the additional capacity strain of administering and integrating another program.*

Member interviews emphasized that active care management is essential for Samaritan to work. Most member engagement happens with care managers during a visit or over the phone to continue accessing funds and creating and achieving program Action Steps.

What is going well with care manager involvement

Care managers provided insights into many benefits of using Samaritan. They reported that it is unique in that it is **easy for them to use** and **meets member needs quickly** in terms of providing resources in an efficient and customized way. One care manager reported gaining **extra insights into holistic member journeys** using the Samaritan program. Care managers reported that meeting immediate needs and building rapport with members increases job satisfaction. Care managers reported that scheduling regular check-ins with members and external partners helped with implementation and engagement. One key leader agreed that they have observed the Samaritan program being a morale boost for the care managers at their health clinic because it shows them that the organization is bringing in programs that make a difference.

Challenges with care management duties and Samaritan

The relationship between the care manager and the member is sometimes fragile. If there is a **staff transition** with the care manager or a **change in phone access** for the member, the relationship can break down. Without the care manager's help as an intermediary to **explain the** benefits or speak a member's native **language**, some members could not participate independently. Members reportedly can be confused about how Samaritan works, sometimes worried that there is a catch to the financial piece. One care manager shared that it works well to **engage members' families** to support them using

the app, observing that they can continue to provide support after the member graduates from the Samaritan program. This finding is like one from our literature review that noted relatives being influential in patients' success in staying housed.

4. *Samaritan currently integrates better into health centers with existing care manager support. Acute care hospital setting integration is currently challenging.*

PEH in California have high rates of acute and emergent health service utilization.[3] Leaders explained how they tried implementing Samaritan in the acute care hospital setting. The staff made enrollment attempts in the emergency department, hoping to connect patients with the greatest immediate needs with support through Samaritan. However, challenges spurred leadership to shift the implementation strategy within the pilot to partnering health centers with regular contact with patients and existing care management structures.

The initial implementation of Samaritan in the Emergency Department setting was an unexpected challenge.

When asked to describe the challenges of the partnership or program, leaders described consistent barriers in the initial goal of implementing in the hospital setting. **Technical issues** (e.g., signup connectivity, patient continuity, access) with both phones and patients interfered with success, as did **physical space and workflow constraints**. Leaders also noted **resource capacity** (e.g., staff capacity). These limits and space constraints delayed the pilot startup for some or made them feel rushed (not enough decision, buy-in, or training time).

> *"There are some learnings in terms of understanding the complicated environment in LA county, how Samaritan fits into the greater healthcare landscape and who pays for it at the end of the day. Unless there is dramatic improvement shown, not sure it makes sense to have hospitals participate."* -Key leader

Some healthcare leaders commented that the emergency setting has not worked for Samaritan implementation yet, but it is a good idea. One key leader shared, "*It would have been great if they could have been enrolled in the E.R., but the current systems made it unworkable. The hospital needs a system to identify eligible patients; E.R. staff wanted to do it but didn't have the resources to do so [perform real-time eligibility checks].*"

The shift from hospital implementation to the health center setting could offer better long-term patient engagement potential.

Key leaders and care managers agreed that the hospital setting might not be conducive to establishing long-term relationships with patients, which was beneficial to support their engagement with Samaritan. A key leader admitted: *"The group picked is hard to pin down; they often hospital hop."* Successfully engaging members in Samaritan largely **depends on patient follow-through and choosing an appropriate enrollment setting**. Many members engaged in the program reported having an established relationship with their health center. For one member, their trust in their health center transferred to Samaritan: *"I've been with the clinic for over 20 years. That is where my home is. It changes it, knowing the clinic trusts them [Samaritan], I can trust them too."*

Thinking carefully about what PEH subpopulations and settings are most ready to benefit from Samaritan will help set members and the program on a path of success.

Working to connect to hard-to-reach patients is one of the potential benefits of Samaritan. However, one center struggled similarly as the hospital did in terms of priority population. A key leader shared how their health center **overestimated the benefit Samaritan could have with a population of patients who had the highest needs**. Patients who are disconnected from care and lack a care manager to guide them may struggle to participate. A care manager stated*: "Success would be if the patient population selection could be a better match to requirements of Samaritan."* These findings align with a recent California homelessness report recommended expanding targeted homelessness prevention services and providing support that matches the behavioral health needs of the population to reap the most benefits.[4]

> *"Without a relationship in place, the health center ends up expending a lot of resource for very small return. There is a value to concentrating on those patients that are highest users and bringing them back into regular care. Patients need a relationship with the health center."*
>
> *-Key leader*

Similar to focusing on the right populations, key leaders advised that future Samaritan rollouts should **select environments or settings with most the potential for success**, such as health centers with minimal staff turnover and resources to devote to Samaritan. A leader described how one of the clinics that really could have benefitted chose not to participate due to having "*too much on their plate, with ECM they couldn't add another thing, there was no bandwidth*." Similarly, staff from a clinic that did not enroll any patients foresaw others being successful "*because staff was more stable, seasoned, and knowledgeable in doing their job*." A care manager also advised "*being mindful of where and which team the Samaritan program is placed in."* A key leader summed up this advice*: "Leaders truly have to understand complexities within the systems they are trying to use. Even if it's a great value, they have to accept that certain organizations cannot support it, and move on."*

5. Leaders, care managers, and most members cite financial support from Samaritan as the most significant benefit for members.

Members access funds by working with their care manager to decide on action steps to help them work towards their chosen goals and then complete them. The care manager releases funds to a debit-type card for use anywhere that accepts debit cards. There are no restrictions on how members may use the funds. Members with a smartphone to access their Samaritan app can see their account details.

> *"Samaritan has made things a little bit easier and kind of helped the patient get to where I would like to see them faster, since they have the financial incentive…it already goes with my work, just flows into it. It's not really extra time consuming."* *-Care manager*

When asked what made Samaritan stand out compared to other contingency management (incentive) programs, a few leaders questioned Samaritan's uniqueness if its primary feature is offering financial incentives since lots of other programs can do that. However, most leaders agreed that its **community aspect** of providing financial support sets Samaritan apart. Additional financial uniqueness included using e-funds that are quick and easy to use and linked to member goals; web-based enrollment and tracking gives care managers insights into each member's overall journey; and Samaritan gives members more options for spending funds where they wish.

Appreciation for flexible spending connected to goals

Key leaders and care managers reflected that the financial incentives that Samaritan offers are filling a need and are a significant benefit for members. Leaders acknowledged that while other programs offer financial incentives, Samaritan's ability to **direct community donations** to individuals and provide **e-funds connected with goals** is unique. One key leader strongly suggested that Samaritan build in restrained use of funds so they do not become a "band-aid" for members, meaning they risk lacking self-efficacy upon graduation from the program.

> *"The money is supposed to go toward your goals, say for instance I found a school for an updated nursing assistant license. Now, I can do a course but it's $4,000. I don't have that. You can take that money on your card to put it toward that goal, or a bill, food, whatever." -Member*

Among the six members interviewed so far, most agreed that the financial benefits motivated them to sign up for Samaritan and were helpful and flexible. Members explained that to receive funds on their card, they must ask their care manager to transfer the funds. Members varied in how much they count on the funds to cover their monthly bills or see them as a backup account to cover "extras." One housed member said, *"It works, but sometimes I forget it's on there. It's like a backup for me. Don't get me wrong, it helps, everybody needs extra. It's helpful going out to eat and stuff. It's a blessing."*

Logistical challenges and potential enhancements

Several members commented that they had to learn how the card works and that the technology was challenging (e.g., signing up, accessing funds, losing the card, tracking action steps). Members described having to call their case manager to ask them to transfer funds to the card before they could access the funds, sometimes now knowing how much money they had to spend. Additionally, not all members could physically go to the health center to pick up the card.

Key leaders were aware of these issues and that members need to pick up the physical card before using it; they suggested Samaritan consider new technical ways to get money to members. One member suggested that donors can choose to identify themselves when they donate. This deanonymizing would be helpful because the member might already be conversing with them and want to thank them. Another member suggested that Samaritan offer education on budgeting and that stores give discounts for Samaritan card holders.

6. Words of encouragement from Good Samaritans are meaningful and motivating for members. Community support differentiates Samaritan from other similar programs.

Words of encouragement are a unique feature of Samaritan that allows community strangers, donors or "Good Samaritans" who sign up for the platform to send anonymous messages to individual members (in addition to or instead of financial support). Messages are received by members who have phone access as text notifications, and they can reply as they wish. Members described receiving words like "*I believe in you*" and "*keep moving forward*" and "*don't give up on yourself*."

Key leaders, care managers, and members agreed that the words of encouragement feature of Samaritan is unique and impactful for both members and the community. Literature review findings suggest that even small social interactions with strangers can increase patient happiness and reduce social isolation.

Telling members' stories

All members found receiving words of encouragement to be very supportive. For many, these **meant even more than financial support**. Many members talked about being isolated and not having a social support system and that the messages really helped them feel they were not alone and had people looking out for them. As one member said, *"The first one I got at 7 am and it made my day, I didn't expect it. This was the most important, it helps me not get discouraged and move forward. Everyone sends beautiful messages, that they believe in me, and I should keep moving forward, that God is with me- pushes me to keep fighting."*

> *"For every human being, most people want to tell you their story if you are listening non judgmentally. When you are desperate, you want people to know you are, but also why."*
> *-Member*

Some members say they experience a mix of people sending messages, while a few have **developed meaningful relationships** with "regulars." When members have the technological access to get the messages directly through text, they enjoy responding: *"The encouragement is something I look forward to and sometimes helps me get through my day. Makes me feel encouraged and that I am not alone, used to think nobody cares what I am going through, now I don't have to ball up everything inside. I tell them how much I appreciate them sending a note and encouraging me."* One member started a newsletter for eight Good Samaritans she met through the program, since she desired to move past general anonymous greetings to share her own story and get to know theirs. In contrast, one care manager explained disinterest in this aspect*: "I am not using words of encouragement. It's a great resource, but it's additive for me. I talk to my patients all the time."*

Involving the community

Community participation as part of Samaritan's social incentives was cited as a distinguishing factor of the program by healthcare leadership. The ability for **strangers to engage with members** through personalized messages, even minimally, creates respect and value for patients who often feel overlooked. As one key leader noted, *"The fact that Samaritan includes community members is really important because it helps community education surrounding vulnerable populations. It creates community."* Another key leader agreed that writing notes of encouragement can positively impact the community that writes them. A key leader emphasized that the **respect** and value that Samaritan shows to the members has a big impact.

> *"There is so much inequity for unhoused patients, we tend to overlook them. By not only providing financial benefits but messages of encouragement it really makes Samaritan special compared to other interventions. It's not just about financial incentives, but also about creating respect and value for this population. It underscores that perspective as a way to engage differently."* *-Key leader*

At times, community responses can feel impersonal. To support more opportunities for connection, one more senior member wished they could hear a recorded message of encouragement and send a thank you message that way. Another, who described a time when Samaritan wanted to offer a financial incentive to community members to send words of encouragement, felt negatively about the resulting messages (which included many clichés). One respondent wondered if the community (donors) could connect members to resources (through an organizational tab or forum post) as they engage with them.

7. *The ability for members to customize their goals, action steps, and spending decisions enhances their self-efficacy and sets Samaritan apart from other programs.*

When asked if Samaritan was filling a gap in the healthcare system, key leaders described Samaritan as helping health centers address members' social needs. One unique feature of Samaritan is for members and care managers to work together and identify customized needs and goals. As members complete their own goals, care managers load financial incentives onto their Samaritan card. Like a debit card, members can decide how and where to spend those funds.

Perceived motivation to reach SDoH goals

Key leaders and care managers viewed Samaritan as meeting members' needs by providing customized support. They agreed that Samaritan **motivates members to move towards their goals**. Leaders commented that members' self-efficacy is built by building confidence around budgeting, planning, leading communications with Good Samaritans, and check-in routines with their care manager. Care managers described more members keeping appointments more regularly. Members recounted taking action steps related to making doctor or therapist appointments and connecting to new medical or housing resources. One member is working towards a Certified Nursing Assistant degree and said Samaritan is motivating them and helping financially.

Care managers commented that some members entered the program already very engaged and were naturally engaged with Samaritan. Care managers had varied experiences identifying action steps; one said it would be helpful to have a formula of action steps to follow with a member, while another said they would like action steps to be more tailored and complex over time. One care manager also received a request from a member to be able to update their own stories in the app.

8. *Overall, preliminary data suggests that Samaritan members may be using the Emergency Department less often than they did before joining.*

Key leaders listed decreased emergency room use as one of the top outcomes they hope for *and* that they are seeing in preliminary data. Key leaders also discussed seeing an increase in members engaging in preventive care. Key leaders and care managers think members are experiencing better health outcomes because of Samaritan. One member commented that after being informed about Samaritan, they joined the health center as a new patient.

> *"I told my care manager about my hypertension and anxiety and she said be calm, you can see the Dr. You don't have to go to the hospital. I'd be going 2-3 times a day, calling paramedics, feeling crazy. She helped me get appointments, see specialists, she was helping me so much I just stopped going to the hospital. It took a while for me to calm down. Now I sit and say a prayer, go outside take a walk. I don't get all upset when I go to the Dr. no more. She's a calm girl, I like her."*
> *-Member*

Utilization data

In a review of the number of visits by place of service, the evaluation team found that the number of visits to the emergency room for care decreased in **HCLA by 22.8%** and in **CHMC by 28.2%** (Figures 1 and 2) from before to after Samaritan program enrollment. Utilization data from each location may be for the same member's visits but different domains of the visit, as allowable, for billing purposes. Before enrollment refers to available data for the members from the place of service and center or hospital for six months prior to enrollment. After enrollment refers to available data for the members for the six months after enrollment. All data is for members engaged in the Samaritan program for the six months before and after, not termed or disenrolled from the program.

Figure 1:Number of visits by place of service, before and after enrollment, HCLA claims

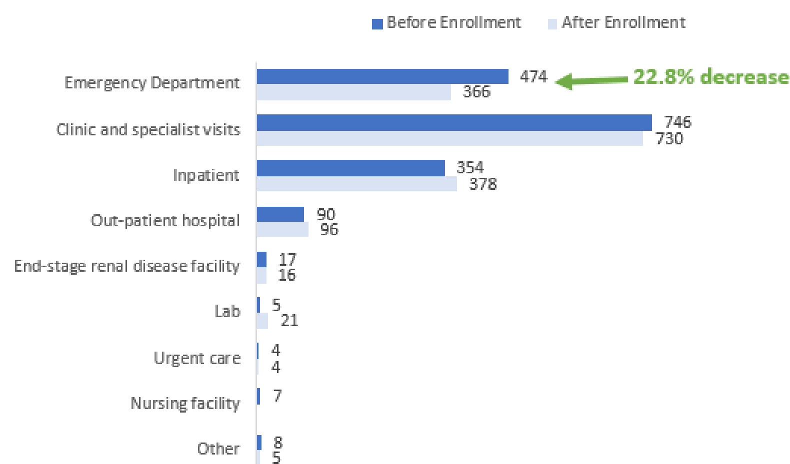
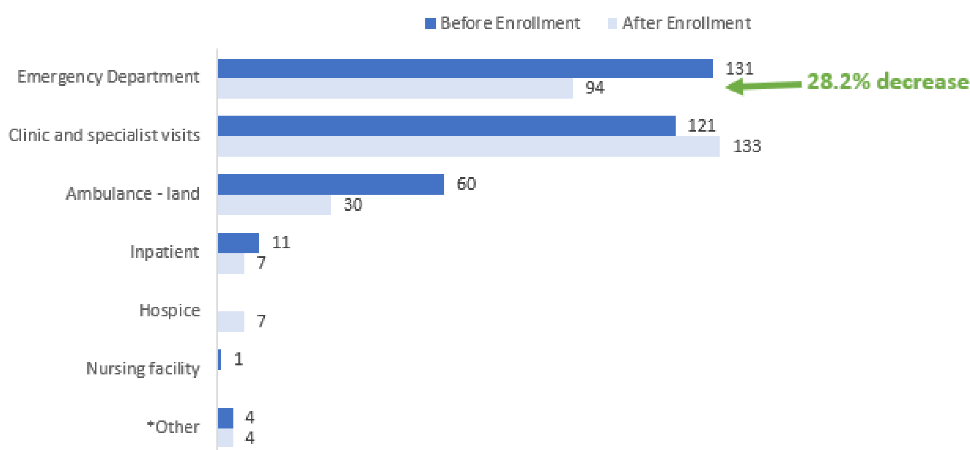


Figure 2: Number of visits by place of service, before and after enrollment, CHMC data



The overall count of claims and services decreased from before enrollment to after enrollment. HCLA's count of claims went from 1,705 to 1,617 before and after, respectively. The HCLA services count decreased from 3,350 to 3,193 before and after, respectively. In CHMC, the increase in clinic and specialty visits could indicate that preventative care services were occurring more often (Table 1).

Many visits in the Clinic and specialty visit category were for more preventative-type services, such as those provided by podiatry, ophthalmology, cardiology, neurology, and nephrology. In HCLA, the number of clinic and specialty visits decreased slightly from before enrollment to after enrollment, but the data shows the types of visits also shifted to less emergency-like services (Table 2).

Table 1: CHMC specialty services, before and after enrollment

Specialty	Before		After	
	Count of Claims	Total Cost	Count of Claims	Total Cost
HOSPITAL	131	$30,822.59	94	$35,844.81
DURABLE MEDICAL EQUIPMENT	81	$8,567.24	72	$7,231.74
HOME HEALTH AGENCY	37	$6,930.00	55	$6,846.60
AMBULANCE	54	$8,127.18	30	$5,498.03
AMBULATORY SURGERY CENTER	4	$6,952.45	4	$4,606.86
AUDIOLOGY			2	$3,101.27
HEMATOLOGY/ONCOLOGY	2	$1,112.72	4	$978.84
TRANSPORTATION	6	$2,083.10		
ONCOLOGY	1	$324.06		

Table 2: HCLA specialty services, before and after enrollment

Specialty	Before		After	
	Count of Claims	Total Cost	Count of Claims	Total Cost
RETINAL OPHTHAL...	109	$31,330.81	98	$26,437.66
DIALYSIS	6	$26,656.00	6	$23,392.00
RADIOLOGY	256	$23,469.47	225	$17,611.41
EMERGENCY MEDIC...	215	$19,670.02	155	$15,431.34
HOSPITALIST	45	$15,980.66	30	$11,846.98
PODIATRY	61	$8,310.06	68	$13,151.88
OPHTHALMOLOGY	48	$8,484.14	47	$11,790.10
CARDIOLOGY	86	$7,453.27	86	$9,938.91
PHYSICAL THERAPY	78	$6,578.00	73	$5,204.41
NEUROLOGY	17	$3,957.95	25	$6,991.74
NEPHROLOGY	37	$4,529.32	82	$6,282.12
HAND SURGERY	41	$8,430.43	20	$1,864.83
DURABLE MEDICAL ...	34	$6,231.49	23	$3,208.75
HOSPITAL	27	$5,002.09	37	$4,042.56
SURGICAL ONCOLO...	4	$583.64	7	$7,100.47
ORTHOPAEDIC SUR...	26	$4,276.71	16	$3,205.56
PAIN MANAGEMENT	22	$2,157.66	38	$4,455.06
INTERVENTIONAL C...	17	$1,180.70	32	$4,539.06

CHMC's overall visit count went from 328 to 275 before and after, respectively. CHMC's services count went from 1,555 to 1,146 before and after enrollment, respectively. Ambulance services decreased after enrollment, and clinic and specialty visits increased after enrollment. Ambulance services are often related to emergency care.

9. High-level, preliminary partner data show potential decreases in costs of care for Samaritan members.

Some key leaders commented that they believed Samaritan has provided financial benefits to the IPA and health centers.

Utilization data

In a review of the cost data by place of service, the evaluation team found that **emergency room costs decreased by $6,759 and $37,909 in HCLA and CHMC**, respectively (Figures 3 and 4). HCLA also had inpatient and outpatient services decrease in overall costs. The CHMC data set showed increases in the costs of clinic and specialty visits. While some specialty costs increased, it should be noted that some

patients could access needed specialty services after enrollment, such as hearing aids and surgical services they may not have been accessing.

CHMC saw notable reductions in ambulance costs (data not shown), although the overall emergency department costs were higher despite less volume. This cost differential was due to higher costs for patients going to different emergency department locations after enrollment. Inpatient costs for CHMC saw a large decrease of 43.75% or $37,909.38 after Samaritan enrollment, signaling facility-associated cost savings.

Figure 3: Total costs by place of service, before and after enrollment, HCLA claims data

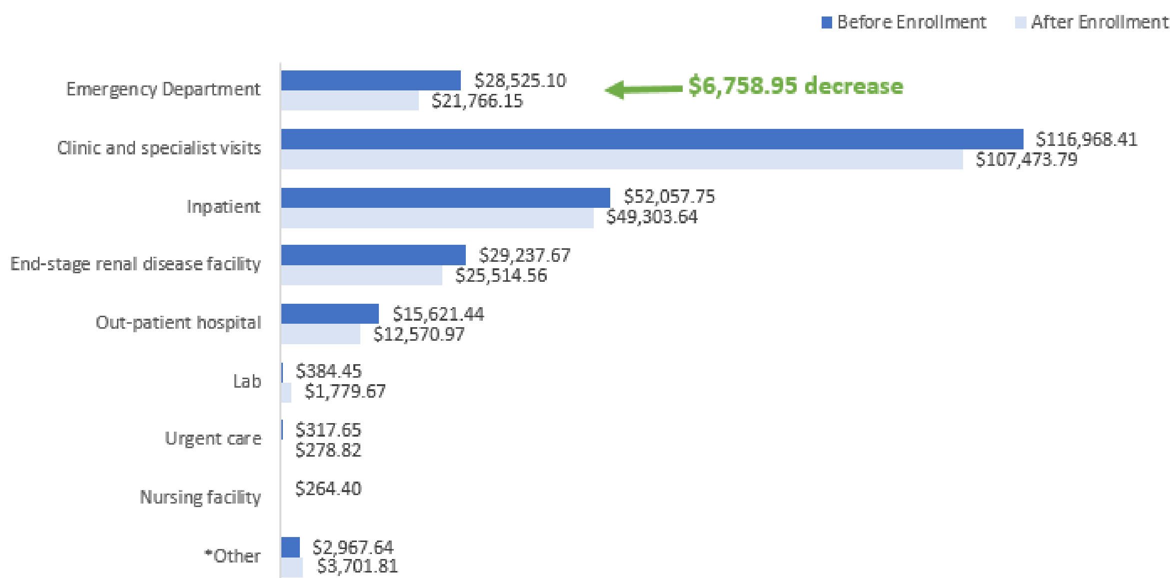
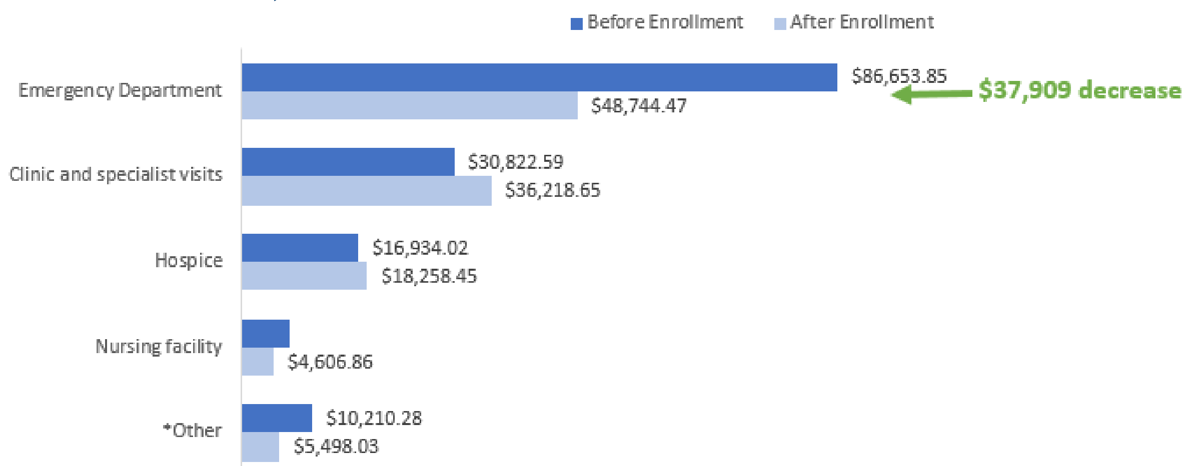


Figure 4:Total costs by place of service, before and after enrollment, CHMC claims data



*Note: For Figures 3 and 4, the Other category specialties are listed in Appendix C.

Based on the domains claimed for each visit, the HCLA Average Cost per Member data before enrollment was $2,368.70 and decreased to $2,246.48 after Samaritan enrollment. The average cost per member was reduced by $122.22, or 5.2%.
Based on the domains claimed for each visit, the CHMC Average Cost per Member before enrollment decreased from $3,029.12 to $2,639.13 after Samaritan enrollment. This decrease was an average cost-per-member reduction of $389.99, or 12.9%.

Overall, this data appears to show that membership with the Samaritan program brought down clinical care costs overall. Some specialty costs increased (such as podiatry, ophthalmology, cardiology, neurology, and nephrology) the overall costs of services per member. However, members were accessing needed services after Samaritan enrollment, which can be seen as preventive and beneficial to their long-term health outcomes. Over time, these services may not be needed as much. For example, colonoscopies can be more expensive than some general services but are only needed every five to ten years. Although some cost savings appear modest when combined with prevention services, they could signal a **considerable financial difference** when scaled.

10. Patients rated their experience participating in the Samaritan program highly.

Among the capitated CHMC patients eligible for Samaritan, 200 members enrolled during this pilot period. Preliminary results from the first six member interviews revealed consistent satisfaction and appreciation of the program. All members interviewed gave Samaritan a rating of 10 out of 10. One said, *"It's a nice program. It's encouraging, helps you mentally and physically."*

Members gave overall positive feedback about their **care managers** as well. They reported receiving help with referrals, enjoying the supportive relationship, and help remembering things. They said having someone check in on them felt good, which was a new experience for some. As one member shared, *"The care manager told me they're going to give me reminders for my appointments and medications, nobody ever does that for me before. It is amazing. I did need some appointments I couldn't get for myself; she makes sure I get it done."*

> *"I first thought Samaritan was scary and unbelievable, like is this really happening? Really what it's supposed to be? It was something new so I didn't know how to grasp it. They told me they're going to give me reminders for my appointments and medications, nobody ever does that for me before. It is amazing."*
>
> *-Member*

Members also mentioned reasons for **disengagement**: needing to focus on other life responsibilities (like employment); being concerned they would have to repay the money, or not clearly understanding the program's benefits, and not being in a habit of connecting to a care manager or center before Samaritan. Patients with these circumstances struggled more to engage long-term.

Interim Evaluation Summary

The early findings of this interim report show some clear benefits of the Samaritan program for participants. **Financially**, Samaritan provides for tangible financial needs, uniquely identified by each participant, that keep cars running, lights on, or food accessible. Even if the causes of homelessness are multifaceted, PEH in California believes financial support could have prevented it.[5] Similarly, we heard agreement from interviewees that financial incentives are the most beneficial aspect of the Samaritan program. **Socially**, Samaritan reduces patient social isolation through enhanced care manager relationships and community donor support. Making sure all participants know about the messages of encouragement ensures that all have an opportunity to participate. Finally, it is connecting patients to **healthcare** in more cost-effective ways.

Several considerations arise as the program weighs expansion across various healthcare settings in the country. One is to work with health plans to expand **eligibility criteria** so more patients can participate. Another is to think through what population, **setting,** and logistics allow for the most conducive and successful implementation and for the health center to allocate **resources** for its implementation to ensure a successful launch. Whether prioritizing an acute or ambulatory care setting, maintaining the **care manager's** point of connection has been critical for ongoing member engagement during this pilot. Samaritan's technical assistance was perceived as valuable and can continue to serve as a resource.

Next Steps

These interim results can be shared with evaluation participants with the disclaimer that more data is coming. Over the coming months, CCHE will conduct a second round of interviews with key leaders, care managers, and members to gain additional insights into these findings and possibly elevate new ones for the final report. We will do a more comprehensive analysis of quantitative data available from partners to enhance these findings and test for statistical significance. We will also incorporate data from a comparison group like Samaritan patients but not participating to see what differences might be attributed to the Samaritan program. The final report is expected in April 2024.

Appendix A: Evaluation Methods

The interim report details qualitative and quantitative findings from April 1, 2023, until November 15, 2023.

The evaluation contains two components:

1) **Qualitative analysis** through interviews with key leaders, care managers, and members discussing program implementation, member engagement and impact, staff experience, and workflow integration.

2) **Quantitative analysis** with MedPOINT with data about patient/member engagement with Samaritan, E.D. utilization, cost, and chronic condition management. Members included in this analysis had the following criteria:

- Enrolled in Samaritan from April 15, 2022, to February 15, 2023.
- Eligible for six months pre-Samaritan enrollment
- Eligible for six months post-Samaritan enrollment
- Capitated to CHMC
- Not termed or disenrolled from the Samaritan program

The tables below detail evaluation questions, each data collection method, what each method entailed, who participated, and how the data were analyzed. After analyzing each data source, we looked at results across methods to triangulate data and identify key findings. While some key findings rely more heavily on a single data source, the evaluation team derived all from a mixed-methods, thematic analysis.

Table 3: Evaluation Questions

Topic	Questions
1. Healthcare system implementation/ integration:	*How has Samaritan been integrated/ implemented into participating center/hospital care management workflows? What have been the facilitators and barriers? How are these compared across different centers? How does the app support existing care management efforts?*
2. Care manager experience:	*What are the care managers/health center experience with care management combined with Samaritan and/or compared with other programs?*
3. Member experience:	*What is the member's experience in participating with the platform? Has participating with Samaritan as a member improved their confidence, self-efficacy, and social connections?*
4. Platform engagement/ utilization:	*To what extent are patients and care managers engaging with Samaritan? To what extent does Samaritan facilitate improved member involvement in care management?*
5. SDOH outcomes:	*What is the impact of Samaritan on social needs and financial support?*

6. Healthcare system outcomes:	*What is the impact of Samaritan on PC/ED utilization, cost, and management of chronic conditions? Which care gaps are being closed? Does Samaritan facilitate more appropriate health services utilization (decreasing E.D. use/increasing preventative care)?*

Table 4: Methods and Analysis Description

Type	Description and Analysis
Qualitative data: interviews	*Key leader and care manager interviews will be conducted at two points in time. The first round took place in August 2023, and the second round will be completed in early Spring 2024 to expand further on any findings or questions that emerged from the interim report. The first group of interviews (X key leaders, X Care Managers) provided qualitative data on the implementation and integration of Samaritan into healthcare settings, and its perceived impacts at the organizational, care manager and member levels.* *Interviews were generally conducted with one participant at a time (occasionally a small group up to four) and whom were familiar with Samaritan. The interview protocol asked about a variety of topics related to Samaritan implementation, integration and early experiences:* • *Initial expectations and attempts of the program* • *Implementation and integration facilitators and barriers* • *Perceived experiences for healthcare organizations, care managers, and members* • *Advice for others interested in implementing the program* *The first six individual member interviews (of 30 rolling) were also conducted in October to enhance the interim report and inform the final report. After completing an informed consent, members were contacted by their care managers to schedule an interview time.* ***Analysis:*** *Interviews were digitally recorded and transcribed. CCHE conducted a thematic analysis of the transcripts. Codes were developed a priori, based on the interview protocol, and empirically, based on emergent themes.*
Cost data	*HCLA claims were from the Integrated Physician's Association (IPA), and claims under CHMC came from them directly.* *MedPoint Management submitted this claims data for the following cost metrics for 104 members before enrollment and 100 members six months after enrollment.* • *Cost of care savings for the program overall (CHMC + HCLA)* • *Cost of care savings for HCLA and what specialty costs changed*

Type	Description and Analysis
	• *Cost of care savings for CHMC and what specialty costs changed* *Analysis:* *CCHE reviewed data, conducted basic validation checks to identify quality issues, and worked with teams to revise erroneous values. Data were excluded when there were data quality concerns. Member data was also excluded in members termed or no long a part of the the Samaritan program.*
PC/ED utilization data	*MedPoint Management submitted data for utilization at CHMC Facilities before and after Samaritan enrollment.* *Descriptive statistics were used in this report.* *CCHE reviewed data and conducted basic validation checks to identify quality issues and worked with teams to revise erroneous values as needed. Data were excluded when there were data quality concerns, such as claim redundancies.*

Table 5: Participating organizations and interviewees

The first round of interviews incorporated in this report includes 15 key leaders, seven care managers and six members distributed among the following health centers:

HEALTH PARTNER	KEY LEADERS	CARE MANAGERS (CTP)	MEMBERS
HCLA/CHMC	x		
Samaritan	x		
CommonSpirit	x		
Southside Coalition (ECM)	x		
MedPoint Management	x		
St. Johns Community Health	x	x	
To Help Everyone (THE.)	x	x	x
Eisner	x	x	x
Venice Family Clinic (VFC)	x	x	
JWCH	x		
UMMA			x

Table 6: Member demographic information
Enrolled April 15, 2022, to February 15, 2023

Median age	**50 years**	
Average age	47.8 years	
Age range	3 - 82 years	
Sex at birth	Male	24.1 %
	Female	75.9 %
Health centers	St Johns Community Health	74
	Eisner	25
	THE Clinic, Inc	6
	University Muslim Medical Assoc Inc	2
	Venice Family Clinic	1
Chronic conditions identified	Diabetic member	46
	Member already identified with multiple readmissions (high utilizers)	7
	Alcohol and drug abuse	3
	Cancer/Oncology	3
	End-Stage Renal Disease status	3
	Homeless	2
	Transplant evaluation	2
	Other	19
Top 10 Zip Codes	90044	11
	90047	10
	90037	8
	90059	6
	90001	5
	90003	5

	90011	5
	90043	5
	90007	3
	90018	3

Appendix B: Literature Review

The incentive intervention style Samaritan employs is called contingency management (CM). Most contingency management studies have concentrated on reducing substance use and do not offer relevant comparisons for this program. CCHE conducted a literature review looking for studies published on programs similar to Samaritan, which facilitates the transfer of money and words of support from strangers to people experiencing homelessness (PEH). While none were found, there have been **several studies on other health-promoting technological interventions** that communicated mixed results. For example:

- *Access:* Studies of PEH's interactions with technology revealed that although most PEH have access to phones, practical implications such as expensive upkeep, loss of phones, and low digital competency among older individuals pose challenges.
- *Trust:* There is a significant lack of trust among PEH when it comes to sharing personal information through technology.[6] However, a systematic review of ehealth interventions revealed that participants generally found them to be convenient, informative, and valuable. [7]
- *Clinical outcomes*: A study on the effects of a phone intervention on PEH demonstrated feasibility and high rates of satisfaction, although there was no significant change in clinical outcomes.[8]

One component of the Samaritan platform is the **ability for strangers to send messages of support to members**. While no studies specifically focus on the social support of strangers for PEH, related studies offer insights about the benefits of social connections. For example:

- *Happiness*: Interacting with strangers can be a positive form of social connection, as most interactions with strangers are generally positive and beneficial.[9] Engaging in minimal positive social interactions with strangers has been associated with increased happiness and subjective wellbeing, promoting feelings of social connection and appreciation.[10]
- *Health:* Social isolation leads to increased morbidity and mortality, increasing the risk of suicide, premature death, and various health conditions, including Type 2 diabetes and respiratory illnesses.[11] A systematic review of 29 studies indicated that the lack of social support and limited social networks contribute to, or are associated with, the chronicity of homelessness. A study involving 544 PEH revealed that perceived financial, emotional, and instrumental support were all associated with better health outcomes and a lower likelihood of victimization.[12]
- *Housing:* Individuals with strong social ties are 64% less likely to experience homelessness. One study found that ties to relatives were the most important in reducing homelessness, followed by participation in religious services and ties to friends.[13] Without ties, social isolation persists even after PEH attains housing.[14]

Another component of Samaritan is **financial support provided to members when they complete action steps**. Studies have primarily focused on PEH completing pro-social and health-promoting goals. For example:

- *Adherence*: Two studies examining the provision of financial incentives to encourage smoking cessation among PEH found short-term benefits but no evidence for longer-term cessation.[15] Similarly, a study providing incentives for participation in case management services found no difference in outcomes at the six-month mark.[16]

- *Follow-up*: In a randomized controlled trial (RCT) focusing on T.B. treatment in PEH, the percentage of individuals who completed treatment was similar between the incentive and non-incentive groups. However, those who received incentives required less follow-up to complete treatment.[17]

While a systematic review of 29 studies suggested that financial incentives hold promise for various health outcomes among PEH, conflicting findings and adverse consequences were also reported.[18]

Appendix C: Other places of services

Ambulance - Air/Water

[Ambulatory Surg Center

Assisted Living Facility

Birthing Center

"Community Mental Health Center.

'Comprehensive Inpat Rehab

(Comprehensive Outpat Rehab

'Custodial Care Facility

'Group Home

Homeless Shelter

Indian Health Service Free Sta

Indian Health Service Provider

Intermed Care - Mental Retard.

[Mass Immunization Center

(Military Treatment Facility

(Mobile Unit

Non-Res Treatment Fac

Non-Residential Opioid Treatment Facility

(Off Campus-Outpatient Hospital

(Other Unlisted Facility

'Outpatient Hospital

Pharmacy

Prison/ Correctional Facility

Psych Facility Partial Hosp.

Psych Residential Trmt Center

[Residential Subst. Abuse Trmt

[Rural Health Clinic

'School Based Site,

'State/Local Public Health

'Temporary Lodging

'Tribal 638 Free Standing Facil

'Tribal 638 Provider Based Fact

"Walk-In Retail Health Clinic

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