MEETING THE NEEDS OF FREQUENT USERS:
Building Blocks for Success

This toolkit from the Frequent Users of Health Services Initiative (the *Initiative)* was created to share the lessons of a multi-year, multiple-site project which addressed the challenges and barriers facing frequent users of emergency departments. Whether you are a service provider, hospital administrator, government employee, or advocate, these building blocks can help guide your efforts to create a more rational and cost-effective system of care that addresses the multiple and complex needs of frequent users.

A joint initiative of The California Endowment and California HealthCare Foundation.

The Initiative is based at the Corporation for Supportive Housing.

The following building blocks offer ideas, strategies, tools, and tips to help you meet the needs of frequent users in your community. They also highlight some of the solutions implemented by established programs when faced with challenges.

BUILDING BLOCK #1
Practical Strategies for
Outreach and Engagement

BUILDING BLOCK #3
Linking Housing to Services
for Better Outcomes

BUILDING BLOCK #2
Collaboration and Integration
for Systems Change

BUILDING BLOCK #4
Funding Strategies for
Frequent User Programs

THESE BUILDING BLOCKS CAN HELP LAY THE FOUNDATION OR BUILD UPON ONGOING EFFORTS IN YOUR COMMUNITY TO:

- Use promising practices to address frequent users' needs, while reducing emergency department visits and costs

- Access scarce resources needed for frequent users, including mental health services, benefits advocacy, housing, respite care, and substance abuse treatment

- Work to improve health outcomes, financial stability, and quality of life for frequent users

- Bring together stakeholders from across service areas to address communitywide issues with communitywide solutions

- Create an alternative approach to decrease costly hospital emergency departments visits, and to lessen frequent users' impact on other community resources

Meeting the needs of frequent users is a rational solution to using scarce community resources more effectively. Because frequent users are often uninsured and do not have primary care physicians or medical homes, they tend to rely on hospital emergency departments for episodic or crisis care. Frequent users' hospital visits can account for disproportionate costs and time for emergency departments, contribute to emergency department overcrowding, and drain state and county health care resources. Furthermore, emergency departments are not designed to meet the psychosocial needs of frequent users and do not have the capacity to assist them with housing, drug treatment, and mental health care. Replacing a costly and ineffective cycle of use with ongoing, coordinated, and multi-disciplinary care provided in the appropriate settings is a more rational approach to providing services for frequent users.

Frequent user programs have an evidence base for reducing costs and improving outcomes. Local and state budget shortfalls mean that communities everywhere must look for smarter ways to use limited resources and still provide the quality services people need. Evaluation results from the *Initiative* programs show that coordinated, multi-disciplinary care for frequent users can reduce emergency department visits and costs, while improving the stability and quality of life for patients. Frequent user programs are proven to be successful in helping this population access needed benefits and resources such as SSI, Medi-Cal, and federal housing support. In the long run, these programs have the potential to reap significant cost savings through reductions in health care costs.

Helping frequent users access the services and resources they need is the right thing to do. Most frequent users who cycle in and out of hospital emergency departments have complex underlying issues that contribute to this pattern. They may struggle with chronic and acute medical conditions, such as diabetes or cellulitis. Some suffer from mental illness or are in need of substance abuse treatment. About half of all frequent users are homeless. Many are chronically homeless; that is, they have been continually homeless for over a year. Most frequent users have some combination of these conditions. In one way or another, frequent users have slipped through the cracks of our fragmented care systems and are not able to access the services they need to manage their conditions and stabilize their lives. Quite simply, frequent users need help navigating complex systems to access the services they need, including housing and medical, mental, and substance abuse treatment.

Additional Resources

FREQUENT USERS OF HEALTH SERVICES INITIATIVE — Summary Report
FREQUENT USERS OF HEALTH SERVICES INITIATIVE — Final Evaluation Report

For more information about the Frequent Users of Health Services Initiative and other materials, please visit www.frequenthealthusers.org.

BUILDING BLOCK NO.1

Practical Strategies for Outreach and Engagement

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With the commitment to serve frequent users in your community comes the challenge to systematically identify, locate, and engage them. Many frequent users have multiple, complex needs. Some are homeless or lack a stable address, making them difficult to find. Others may have mental health disorders, which can require psychiatric intervention. Many frequent users have been let down by systems of care and are distrustful or fearful to try something new. Often frequent users will visit hospital emergency departments because they struggle with navigating through the health care system and are either uninsured or lack a primary care physician.

Finding and connecting services and support to people who have slipped through the cracks can be a difficult endeavor, but there are strategies that work. The *Initiative* frequent user programs have developed successful techniques with participating partners (such as hospitals, community health clinics, and local shelters) to identify, locate, and engage frequent users.

Key Tips for Outreach and Engagement

· Collaboration and communication with hospital staff and community service providers is crucial to effectively identifying, locating, and engaging frequent users and understanding their most critical needs.

· Having a suite of strategies, resources, and incentives to draw from is necessary for engagement.

· Meeting frequent users "where they are" and helping with their immediate needs is an important start to establishing a trusting relationship.

Identifying Frequent Users

The first step to engagement is to establish a practical strategy for identifying frequent users in hospital emergency departments or other community partner sites. Successful methods of identifying frequent users of emergency departments include:

HOSPITAL FREQUENT USER LISTS

In order to identify frequent users in your community, you may need to manually review emergency department lists from multiple hospitals, looking for patients who meet the eligibility criteria your frequent user program has defined.   While this methodology can be time-consuming because it requires cross-referencing lists from multiple hospitals and matching names, it does allow you to identify frequent users who migrate across several hospitals in a community.

Hospitals can either provide these lists, or provide direct access to their emergency department records so you can run a report that identifies frequent users based on your threshold criteria. If you do not have ongoing access to the hospital database, it is important after your initial search to have the hospital provide monthly (or weekly, if possible) updated lists of frequent user visits.

ELECTRONIC FLAGGING SYSTEMS

Electronic alert or flagging systems are another way to identify frequent users in hospital emergency departments. Electronic flagging provides an automated mechanism — usually a pop-up screen — to inform hospital staff that the patient is eligible for a frequent user program. This short-cut can reduce reliance on the hospital to provide lists of frequent users by providing real-time referral to the program. For example, when a frequent user visits the Santa Clara Valley Medical Center emergency department, a pop-up window appears on the intake computer screen, notifying emergency department staff to contact New Directions and displaying the program contact information. Ideally the electronic flagging system should be automated to generate an email or fax notification to program staff when a patient becomes eligible for program enrollment.

PROVIDER AND STAFF REFERRALS

Emergency department physicians, social workers, nurses, and other service providers should be encouraged to make referrals, as they are often the first to become aware of a patient's multiple visits. Once your frequent user program is established and has gained credibility with emergency department staff, direct referrals allow your program to target high-risk frequent users and eliminate the need to review lists. While some frequent user programs use referrals to supplement other identification methods, other programs, such as The Bridge in Tulare County, rely on referrals as their primary means of identifying frequent users.

Accepting referrals is an important way to strengthen communication and build relationships with emergency department physicians and staff and other service providers, because it lets your partners know that you are there to provide support for their patients. At Highland Hospital in Alameda County, fax forms for referrals are made readily available in the MD charting room, and posters with program information are posted to help emergency department staff alert Project RESPECT of presenting frequent users. Referrals can come from service providers outside of the hospital as well. In Tulare County, The Bridge has received referrals from the county mental health department and even from a Single Residency Occupancy hotel manager who is familiar with the program. Santa Cruz County's frequent user program, Project Connect, receives referrals from community clinics and ambulances. By coordinating with service providers and staff from different agencies to compare frequent users, you may find overlap with jails, ambulances, and community clinics. By targeting those frequent users who are also frequent users of other publicly funded services, your program can further reduce costs.

CHALLENGES TO IDENTIFYING FREQUENT USERS

- Different hospitals may not be able provide data in the same format, requiring extra time and coordination to manage lists or databases.

- Routine identification of frequent users by hospital emergency departments or other service providers requires consistent communication with ED staff and hospital administrators.

- Hospital lists must be re-checked constantly if they are not consistently updated, as the status of a frequent user may change.

- High staff turnover at hospitals means ED staff will need to be re-educated on the value of serving frequent users, and on the important role ED staff play in identifying and referring frequent user patients.

- Patients referred by providers or staff may not always be frequent users, but do show risk factors of becoming a frequent user, or are disruptive in the ED.

Locating Frequent Users

Once you have identified frequent users in your community, the next step is to find them. Locating frequent users requires identifying and going to the places where they tend to be.

AT THE HOSPITAL

Contact information for frequent users provided by hospitals is often incorrect because hospital intake procedures do not note housing status. By virtue of being homeless, some patients may not be able to provide the hospital with a residential addresses or an alternative address, such as a shelter, family member home, or former home. Because of this inaccuracy, it is best to try to meet potential clients at the hospital, as they can be hard to find otherwise. Having a designated space for your program in the emergency department is ideal, because it provides an opportunity to meet frequent users either before or after a visit. If that is not an option, it is important to visit the emergency department several times a week. In Alameda County, Project RESPECT staff are available at the emergency department five days a week, either in-house or on call, and when staff are in-house, they wear t-shirts that identify the program to patients. Project Connect staff in Santa Cruz County carry a pager or cell phone, so that hospital staff are able to call them on weekends or after hours and let them know when a frequent user is presenting. Attending inpatient discharge meetings with hospital social workers and patients is another way to locate frequent users in the hospital.

IN THE COMMUNITY

As meeting frequent users in the emergency department is not always possible, it is important to develop other strategies to find and meet frequent users. Often potential clients who are the most difficult to engage are the hardest to find, particularly homeless and mentally ill frequent users. It is important to have a network of referral systems within community-based-organizations whose staff know these patients. Collaborating with other organizations that serve these populations can increase opportunities to locate them. Talking to people who know or live near a client is another successful mechanism for locating a frequent user. It is important to create not only a network of organizations, but also a network of community members. Finally, cold calls and mailings telling identified frequent users about the program — coupled with an incentive, such as the promise of a gift card — can be an effective strategy to locate and eventually engage frequent users.

Engaging Frequent Users

Client outreach, enrollment, and engagement can be an enormous challenge for a frequent user program. Due to frequent users' complex needs, not every potential client you approach will enroll in your program at first contact, requiring multiple engagement attempts. The following strategies may improve your outreach efforts to engage frequent users.

EXAMINING CASE HISTORIES

Before meeting a potential client, it is important to look at the case history to help you develop a strategy for your engagement approach. Indicators of homelessness, alcohol and substance abuse, chronic illness, domestic violence, and mental health disorders will help staff understand how a client should be approached and what their needs might be. Also, these indicators can give you an idea of whether or not a client might be successful in the program.

Some populations can be easier to engage than others. For example, your program may not have the resources to successfully serve a frequent user who seeks out pain medication. Potential clients who are domestic violence victims may be apprehensive about talking on the phone, and may require you to meet them in person, away from the home. In Santa Cruz County, Project Connect found that many homeless frequent users are actually easier to engage because of the project's collaboration with local homeless programs.

> "As hospital staff, we try to look at why patients are visiting the emergency department. We try to learn as much as possible, because we need to know what we are dealing with. Are there mental health issues or domestic violence issues at home?"
>
> *John Tyndal*
> Program Coordinator
> The Bridge/Kaweah Delta Health Care District

ESTABLISHING TRUST

Establishing a trusting relationship with a client is probably the most integral element of engagement. Case managers and outreach workers should try to meet frequent users in person and have face-to-face interaction to create an opportunity to make a connection. Having bilingual staff who can communicate directly with potential clients is an asset. Sometimes it can be difficult to fully engage a patient in the ED, especially if they are in pain, intoxicated, or are medicated. Even so, the ED is still a good place for initial contact with a potential client, and provides an opportunity to give them program information.

> "The whole process of outreach and engagement is about establishing a trusting relationship. The listening part is incredibly important."
>
> *Brenda Goldstein, MPH*
> Supportive Housing Program Director
> LifeLong Medical Care

When establishing a relationship with a potential client, instead of trying to address the reason they are visiting the emergency room right off the bat, it is better to assist with an immediate need or a pressing priority, such as helping the client get an ID card, find housing, or access transportation. Doing so will establish trust and show that you are there to help.

KEY TIPS FOR ENGAGEMENT

- Identify a client's most pressing need, and if possible, help them resolve this first.
- Be respectful, nonjudgmental, and non-threatening.
- Remember to listen.
- Don't give up; be persistent and consistent.
- Always be available.
- Follow through and deliver on promises.
- Don't overpromise.

OFFERING INCENTIVES

Being able to offer incentives to help with immediate and long-term needs can help you build relationships with frequent users. Incentives used by frequent user programs include:

- Gift cards
- Transportation
- Clothing
- Food
- Hygiene kits
- Offering assistance with insurance, benefits, medication, and housing

> "We try to have a range of resources to offer people – from the small things like tents, sleeping bags, or grocery store cards, to the really big things like access to housing and benefits. These have all worked to motivate and engage people. It's about having a long list of resources to offer. You have to walk the walk and you have to deliver."
>
> *Christine Sippl, MPH* Senior Health Services Manager Santa Cruz County Health Services Agency

CHALLENGES TO ENGAGEMENT

- Frequent users will often cancel or not show up for appointments.
- Family members of potential clients who are the payee for their benefits may hinder participation, fearing disruption of benefits they control.
- Clients may not always be able to identify what services they need.
- Needed services, such as housing, may not be available.

BUILDING BLOCK NO.2

Collaboration and Integration for Systems Change

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The complex needs of frequent users and the scarcity of available resources they need — such as medical respite care, sobering centers, and supportive housing — can make accessing appropriate care for this population extremely difficult. Meanwhile, state and local health and human services budgets are tightening, and there is a growing need for new resources to serve frequent users and other populations.

Given these constraints, how have frequent user programs been able to access the services they need to serve their clients? Working together with stakeholders, policymakers, and service providers in a coalition or collaborative can enhance your ability to access new resources for frequent users and similar populations. Collaboration can also increase the visibility of your efforts and highlight the need to serve frequent users. Most importantly, working with multiple stakeholders provides an opportunity to integrate parallel efforts and create a foundation for systems change.

WHAT IS SYSTEMS CHANGE?

In the case of serving frequent users, systems change is defined as an alteration in the policies and procedures of individual organizations, or between organizations, that improve service systems for this population. The improvement can come about by increasing access to existing services, adapting services to make them more appropriate for this population, or creating new services. Most importantly, systems change requires people to contribute to the institutionalization of a new approach by consistently changing habits and implementing new ways to improve services through the use of resources, authority, technology, and ideas.

Examples of systems change can include adjustments in eligibility requirements, benefits, and provider hours of operation; co-location of services; establishment of referral arrangements; and the sharing of information across multiple agencies, programs, and providers. It can also mean identifying service gaps and adding new services where needed, such as medical respite care, sobering centers, and supportive housing, or integrating existing programs.

MEDICAL RESPITE CARE

Hospitals in California are now required to create discharge plans for patients who no longer need acute care hospitalization but are well enough to be discharged with appropriate follow-up care. When a patient is homeless, this presents a dilemma. Providing medical respite care, also called recuperative care, is one solution to ensuring that homeless frequent users and other fragile populations receive the care they need to fully heal after being discharged from the hospital.

Medical respite care provides sub-acute, post-operative, and recuperative care in a setting that is an alternative to costly acute care hospitalization. It can be structured to serve populations with varying needs and can be provided in a variety of settings, from rooms in shelters to free-standing facilities. Some medical respite care programs serve ambulatory patients with a low level of need who have the ability to care for themselves, while others provide hospice care to individuals in their final phase of a terminal illness. Medical respite care can be the product of single-agency or of collaborative efforts.

SOBERING CENTERS

Some homeless patients who frequent hospital emergency departments are under the influence of alcohol or drugs. They may not always have a medical need, but do need a safe place to sober up and access other needed services. Most traditional homeless shelters will not admit clients who are under the influence of alcohol or other drugs due to liability issues and not being equipped to handle the special demands of this population. By providing a safe and secure place to recover, sobering centers address the problem of severe and ongoing public intoxication. Usually in operation 24 hours a day, seven days a week, sobering centers are overseen by trained personnel and are often a point of entry to other community services, including treatment, mental health services, housing, and more intensive case management. Sobering centers are also an alternative to avoidable emergency department use and jail stays for non-criminal offenses.

HOUSING

For frequent users who are homeless, it can be nearly impossible to change patterns of emergency department use without being able to address their temporary and permanent housing needs. Despite a great need for both temporary and permanent stable housing coupled with supportive services, these important resources for frequent users are limited in most communities. Ideally, a frequent user program should be able to provide permanent housing with access to supportive services using a Housing First approach.[1] The *Initiative* frequent user programs that were able to provide supportive, permanent housing found that case managers and care coordinators were better able to engage frequent users in other services and routines essential in stabilizing their health outcomes. In many communities, there is a lack of temporary housing slots and shelter beds, which can limit a program's ability to meet frequent users' immediate housing needs.

"When all of the agencies came together, everyone talked about what resources were being used and who was using them. The frequent user population rose to the top of the list for the jails and hospitals. Out of that planning project came the frequent user project, respite care, and detox center."

Brenda Goldstein, MPH, Supportive Housing Program Director, LifeLong Medical Care

[1]Housing First is both a philosophy and a methodology for reducing homelessness. For more information about Housing FIrst, please visit BeyondShelter.org. To read about successful Housing First programs, visit the Corporation for Supportive Housing Website at www.csh.org.

Strategies for Collaboration and Integration

Over the course of the *Initiative*, frequent user programs in Alameda, Santa Cruz, and Santa Clara counties advanced their capacity to access new resources and effect systems change by focusing primarily on expanding and strengthening partnerships and collaborations within their counties. The following are examples of successful working groups, collaboratives, and coalitions that these frequent user programs have either established or joined:

> "It's important to be as visible as you can in the community and participate in community meetings. It pays off. Provide service where you can, because it creates a lot more collaboration and effectuates system change."
>
> *Sherry Holm, LCSW*
> Project Manager, Hospital Council of Northern and Central California

COLLABORATION IN THE PROGRAM PLANNING PROCESS

By enlisting multiple stakeholders together with high-level administrators, agency directors, and policymakers in the planning process for your frequent user program, you will create a valuable network that will ultimately help future endeavors, in addition to assisting frequent users in the short term. In the planning year of Santa Clara County's frequent user program, New Directions, project leaders brought in high-level department heads not only for advice and suggestions, but also to inform them of the project's goals. New Directions found that having an inclusive summit meeting and brainstorming session increased visibility, established support, and created ongoing connections that proved indispensable in accessing new resources for frequent users.

"FIX-IT" COMMITTEES AND CASE CONFERENCING

These reoccurring meetings to address specific client needs should include your program partners, as well as any other relevant stakeholders that may be able to help find solutions to issues that arise for your clients. In Santa Cruz County, Project Connect improves the coordination and delivery of services by holding monthly "Fix-It" meetings that include direct service staff, as well as agency heads who have the authority to make decisions affecting county services. The committee addresses problems, establishes new systems of referral, creates access to services, and coordinates services. Furthermore, regular input from Project Connect's interdisciplinary service team to key decision makers allows Project Connect to address systemic barriers and gaps in service capacity — sometimes immediately.

PARTNERSHIPS FOR INTEGRATED CARE

Working together with local organizations and service providers can help streamline services, improve engagement, and help ensure better outcomes, which ultimately can increase funding and access to services. For example, Project RESPECT's partnership with the Homeless Action Center (HAC), a benefits advocacy organization that connects eligible frequent users to SSI and Medi-Cal, has opened several doors for Project RESPECT. HAC's success in connecting clients to SSI and Medi-Cal was so great that the Alameda County Department of Social Services contracted with Project RESPECT to help them move their clients from GA to SSI, and allowed the Alameda County Medical Center to bill retroactively for $1.1 million in charges for uncompensated care for previously uninsured clients.

COUNTYWIDE PLANS TO END HOMELESSNESS

Project RESPECT, New Directions, and Project Connect all joined their County 10-Year Plan to End Homelessness[2] to increase their presence and effectiveness. With staff holding key positions on committees, they directly communicated with local administrators and policymakers, including agency directors and county supervisors, making adequate supportive housing for the frequent user population a policy goal for all three counties.

For New Directions, working with the countywide plan helped the program access Shelter Plus Care vouchers, a U.S. Department of Housing and Urban Development (HUD) grant, and a position on the Blue Ribbon Commission on Ending Homelessness. As a key member of the Blue Ribbon Commission on Ending Homelessness, New Directions was charged with developing an appropriate discharge planning process for homeless patients in all hospitals in the county, and with identifying the resources needed to make the plan successful. In this way, New Directions was able to successfully push for a medical respite care program, and was able to build recognition of the importance of and need for intensive case management for multiple high-risk populations.

HUD PLANNING GROUPS

As a homeless service agency, Project Connect has been an active member of the Santa Cruz County HUD Planning Group. In order to secure homeless housing funding, HUD requires Planning Groups to address discharge planning for homeless people from hospitals, jails, and treatment programs in their annual applications. Project Connect serves locally to meet the requirement to ensure adequate discharge planning from hospitals, and in this way strengthens the annual funding

[2] *Across the nation and throughout California, numerous states and counties have implemented 10- or 15-year plans to end homelessness to address needed resources for chronically homeless populations and create strategies to end homelessness. These plans generally establish an intra-agency task force with multiple stakeholders to establish concrete objectives to reduce homelessness. For more information about the Alameda County 10-Year Plan to End Homelessness, visit www.everyonehome.org. For more information about the Santa Clara County 10-Year Plan to End Homelessness and the Santa Clara County Blue Ribbon Commission on Ending Homelessness and Solving the Affordable Housing Crisis, go to www.collabscc.org.*

application to HUD for all organizations involved. As a partner in the Planning Group, Project Connect used project data and their collaboration with the jail and court systems to help successfully apply for funding for 33 new units of HUD-funded rental housing for chronically homeless adults addicted to alcohol. This success in gaining additional HUD homeless housing funding also helped to increase the amount of annual homeless funding the county is eligible to receive through HUD McKinney-Vento Continuum of Care funding. Now, every time Project Connect partners with others to develop a new homeless housing project, a specific portion of units are prioritized for frequent users.

MULTIPLE STAKEHOLDER COALITIONS

In Santa Clara County, community and county hospitals joined for the first time around a patient population rather than around provider training issues by forming the Silicon Valley Health Coalition (SVHC). Members of SVHC include New Directions; area hospitals; the county departments of Mental Health, Alcohol & Drug Services, Social Services, and Public Health; two community housing agencies; Catholic Charities; community clinics; transportation agencies; and Healthcare for the Homeless programs. Responding to identified service needs of this population, New Directions and SVHC have been involved in systems changes in Santa Clara County that streamline service access for frequent users, including an expedited process for obtaining food stamps, an expedited electronic SSI application process, free bus transportation passes for homeless clients, and planning for a respite care program for homeless patients discharged from hospitals or emergency departments.

In Alameda County, Project RESPECT partners increased the visibility of the program by participating in countywide discussions regarding the Coverage Initiative (ACE program).[3] Alameda County is using Coverage Initiative funds not only to increase access for the uninsured to the existing system of care, but also to redesign the health care delivery system. As a partner in the planning process, Project RESPECT was able to integrate into Alameda County's Coverage Initiative the key concepts that have been successful in Project RESPECT — a medical home model, case management, and integrated care teams.

[3]*California's Health Care Coverage Initiative is an effort to expand health care coverage for eligible low-income, uninsured individuals in ten select counties. For more information, please visit www.dhcs.ca.gov/services/Pages/CoverageInitiative.aspx.*

BUILDING BLOCK NO.3
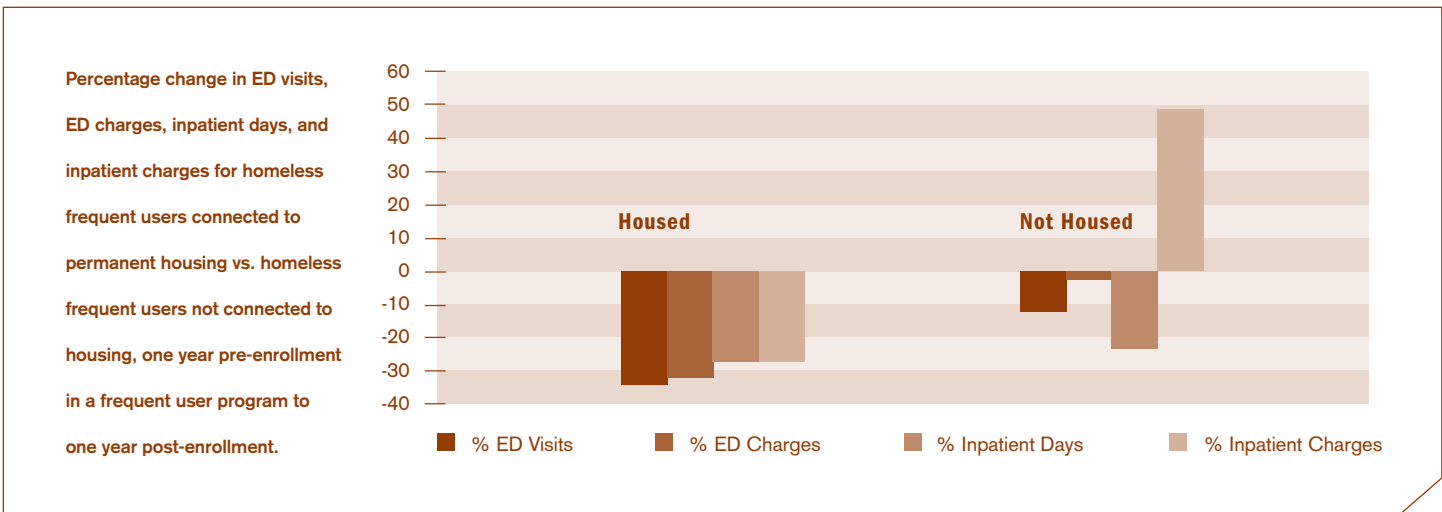
Linking Housing to Services for Better Outcomes

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The importance of helping homeless frequent users access housing linked with supportive services (supportive housing) cannot be understated. Approximately half of all frequent users served by the *Initiative* were homeless at enrollment, and many were chronically homeless. Homeless people are often very sick and have multiple chronic diseases. Furthermore, being homeless makes it is especially difficult for frequent users to stabilize their health and manage other conditions. They have no reliable place to store medications and medical supplies, and prescriptions are often stolen. It is also difficult for homeless people to keep wounds clean due to a lack of sterile and stable environment, and it is almost impossible for them to get the rest needed to fully heal.

For many frequent user programs, offering supportive, permanent housing with a Housing First[1] approach is the most effective strategy to fully engage a homeless client with physical health conditions or substance abuse and mental health disorders. A central premise of Housing First is the acknowledgment that people will typically remain homeless if they are required to enter and complete treatment or programs as a prerequisite to accessing independent housing. Housing First asserts that homeless clients are more receptive to interventions and social services support after they are in their own housing, rather than while they are living in temporary shelter, transitional facilities, or on the streets. For many, being housed reduces stress and symptoms related to mental health or substance abuse disorders. Accessing permanent housing can also reduce frequent visits to the hospital emergency department, as well as hospital charges. Homeless frequent users served by the *Initiative* decreased their ED visits by 34% after being permanently housed, compared to a 12% reduction in ED visits for those not connected with permanent housing.

Percentage change in ED visits, ED charges, inpatient days, and inpatient charges for homeless frequent users connected to permanent housing vs. homeless frequent users not connected to housing, one year pre-enrollment in a frequent user program to one year post-enrollment.

[1] Housing First is both a philosophy and a methodology for reducing homelessness. For more general information about Housing First, please visit BeyondShelter.org. To read more about successful Housing First programs, visit the Corporation for Supportive Housing Website at www.csh.org.

While housing stability can be instrumental in fostering behavior changes for homeless frequent users, it can also take a long time to put in place. In general, there is a lack of available or existing supportive housing in most communities. This housing gap can present a major challenge in serving frequent users. Often, it is the frequent user program that must find ways to access housing and either provide or link the client to the supportive services they need after they are housed. Working with local housing efforts and collaboratives, such as a countywide plan to end homelessness, can greatly assist your efforts to secure more housing resources for frequent users.

Why Frequent Users Need Supportive Housing

· For homeless frequent users who need assistance with medical and/or psychosocial issues, supportive housing is often the only successful approach to end homelessness.

· Safe and permanent housing can give clients the stability they need to organize their lives and their health.

· With housing, case managers can meet clients in their residence to more easily assist them with their needs.

Definition of Supportive Housing[2]

Generally, supportive housing includes the following elements:

· The unit is available to a person who is homeless, or at risk of homelessness, and has multiple barriers to employment and housing stability, which might include mental illness, chemical dependency, and/or other disabling or chronic health conditions.

· The tenant ideally pays no more than 30 percent of his or her household income toward rent and utilities, and never pays more than 50 percent of income toward such housing expenses.

· The tenant has a lease or similar form of occupancy agreement with no limit on length of tenancy, as long as the terms and conditions of the lease or agreement are met.

· The unit's operations are managed through an effective partnership among representatives of the project owner and/or sponsor, the property management agent, the supportive services providers, the relevant public agencies, and the tenants.

[2]Definition of Supportive Housing provided by the Corporation for Supportive Housing at www.csh.org.

- The tenant household has easy, facilitated access to a flexible and comprehensive array of supportive services designed to assist the tenants to achieve and sustain housing stability.

- Service providers proactively seek to engage the tenant in on-site and community-based supportive services, but participation in such supportive services is not a condition of ongoing tenancy.

- Service and property management strategies include effective, coordinated approaches for addressing issues resulting from substance use, relapse, and mental health crises, with a focus on fostering housing stability.

Frequent User Supportive Housing Success Stories*

Project RESPECT in Alameda County

One of Project RESPECT's homeless clients, Charles, has stayed successfully housed for almost two years. Once housed, Charles was able to engage in mental health services and has begun to take medication for his mental illness. Since then, he has stopped visiting the emergency department. Charles now has a part-time job helping his landlord with projects, is engaged with a community mental health provider for counseling, and receives housing case management and primary care from LifeLong Medical Care.

New Directions in Santa Clara County

When he enrolled in New Directions, Michael had been living in a friend's shed and drinking about a quart of alcohol of per day. He came to the program with significant physical issues, including back and shoulder pain, and a history of gastrointestinal problems, including bleeding, which caused him to visit the ED frequently. With the help of New Directions, he was approved for SSI and was able to access housing. While Michael understood that his housing was not dependent on sobriety, with the support of New Directions he also began to understand that he could not function well while drinking, and he agreed to go into detox. Since then, Michael has maintained his home with some help from In Home Supportive Services, and he is returning to his work as an artist. Although Michael does have relapses with alcohol, he checks himself into detox as needed, and he now attends AA meetings regularly. Michael has been enrolled in the program for two years.

Client names have been changed to protect their privacy.

Challenges to Accessing Housing for Frequent Users

· Clean and sober requirements prevent many frequent users from qualifying.

· Many temporary housing facilities require potential clients to participate in religious activities.

· The housing application process for frequent users can be time consuming and confusing.

· Frequent users need a monthly subsidy, such as SSI, to pay for most housing.

Strategies for Accessing Housing Resources

JOINING COUNTYWIDE PLANS AND COALITIONS TO END HOMELESSNESS

Project RESPECT, New Directions and Project Connect all joined their County 10-Year Plan to End Homelessness[3] with great success. With staff holding key positions on committees, they directly communicated with local administrators and policy makers, including agency directors and county supervisors, making adequate supportive housing for the frequent user population a policy goal for all three counties. For New Directions, working with the countywide plan helped the program access Shelter Plus Care vouchers, a HUD grant, and a position on The Blue Ribbon Commission on Ending Homelessness.

LINKING TO HOUSING ORGANIZATIONS IN THE COMMUNITY

In Alameda County, Project RESPECT has worked with the City of Berkeley Mental Health Division and the Alameda County Housing and Community Development Agency to make housing resources available for frequent users. Project Connect partners in Santa Cruz County include the Santa Cruz County Homeless Persons Health Project and a network of homeless service and supportive housing providers. Being closely aligned to homeless service providers has allowed Project Connect to build up its supportive housing resources and successfully serve the homeless frequent user population.

"Every community does have a Housing Collaborative — it's just a matter whether the frequent user program can be involved. Like everything else, you make relationships, and sometimes you push your way in. The Shelter Plus Care housing opportunities came out of the participation in the Collaborative, the HUD grant, and our position on the Blue Ribbon Commission. Many relationships and visibility came out of that collaboration."

Sherry Holm, LCSW
Project Manager Hospital Council of Northern and Central California

[3]Across the nation and throughout California, numerous states and counties have implemented 10- or 15-year plans to end homelessness to address needed resources for chronically homeless populations and create strategies to end homelessness. These plans generally establish an intra-agency task force with multiple stakeholders to establish concrete objectives to reduce homelessness. For more information about the Alameda County 10-Year Plan to End Homelessness, visit www.everyonehome.org. For more information about the Santa Clara County 10-Year Plan to End Homelessness and the Santa Clara County Blue Ribbon Commission on Ending Homelessness and Solving the Affordable Housing Crisis, go to www.collabscc.org.

WORKING WITH HOSPITALS TO ADDRESS DISCHARGE PLANS FOR HOMELESS PATIENTS

State law now requires hospital emergency departments to have a discharge plan for homeless patients.[4] This means that hospitals are in need of available housing resources and effective models for discharging homeless patients. In Santa Clara County, New Directions joined other stakeholders to work with local hospitals to implement a medical respite program and provide shelter for homeless patients to recuperate. Working with area hospitals to address the need for housing or respite care for discharged homeless patients can help increase the overall awareness of the necessity of more housing resources for frequent users.

Housing Options for Frequent User Programs

Depending on the housing resources available in your community, there may be a variety of housing options to offer frequent users, from licensed board and care to independent living in an apartment. For some communities, only limited options may be available, such as a bed in a temporary shelter or a room in a hotel. While the *Initiative* recommends securing non-shared housing that allows clients to live independently as tenants, this housing option may not always be available for frequent users in your community. The following are a variety of housing options that have been utilized by *Initiative* frequent user programs:

TEMPORARY SHELTER

Many temporary housing facilities require individuals to be clean and sober, or require them to participate in religious activities. Furthermore, shelters are only a short-term solution to homelessness. However, shelters are often the only housing resource available when a frequent user is discharged from a hospital, and shelters can help stabilize a client as you look for more permanent housing options. One option for frequent user programs is to buy and reserve shelter beds for their clients in advance, to ensure that there are always shelter beds available to frequent users.

TRANSITIONAL HOUSING PROGRAMS

Transitional housing programs assist people who are ready to move beyond emergency shelter into a more independent living situation. This living option can allow frequent users to develop the stability, confidence, and coping skills needed to sustain independent, permanent housing.

[4]*The Federal Emergency Medical Treatment and Active Labor Act (EMTALA), also known as COBRA or the Patient Anti-Dumping Law was passed in 1986, in part to combat patient dumping. More recently, in 2006, California passed legislation, AB 2745 (Jones), requiring hospitals to have written discharge plans including a plan for appropriate post-hospital care for homeless patients. In 2007, the City of Los Angeles passed an ordinance making it a misdemeanor for hospitals or their agents to transport patients without written consent.*

SOBER LIVING ENVIRONMENTS/HOUSES

Sober living environments (SLE) or houses provide an alcohol- and drug-free environment for individuals who are attempting to establish or maintain sobriety. SLEs can be affiliated with treatment programs or linked to aftercare programs. In these managed homes, a client typically has a room and shares living space with other individuals who all support one another in their sobriety. SLEs are particularly helpful for people who have had success in a residential treatment program, but need a transitional home with structure to support their sobriety before returning home.

SHELTER PLUS CARE VOUCHERS

The federal HUD Shelter Plus Care Program (S+C) is administered through local county agencies and provides rental assistance for hard-to-serve homeless persons with disabilities who are connected to supportive services funded from sources outside the program. S+C is a program designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities, primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and chronic illness. The program offers a variety of housing choices, including tenant-based rental assistance, sponsor-based rental assistance, project-based rental assistance, and Section 8 or SRO housing. S+C allows for a range of supportive services funded by other sources, in response to the needs of the hard-to-reach homeless population with disabilities.

SUPPORTIVE HOUSING PROGRAMS

HUD Supportive Housing Programs can help homeless frequent users live as independently as possible, achieve residential stability, increase their skill level or income, and obtain greater self-determination.

SRO PROGRAMS

HUD SRO Programs can provide rental assistance for homeless people connected to Single Residency Occupancy (SRO) housing. SRO housing contains units for single-person occupancy and may include individual or shared bathrooms and kitchens. Rental assistance for homeless individuals is provided to the SRO owner for 10 years provided that they rehabilitate the housing.

HOTELS AND APARTMENTS

Frequent users can be housed in hotels and apartments with funding from S+C vouchers, Section 8 rental assistance, and through financial assistance such as SSI.

LICENSED BOARD AND CARE

These non-medical, community-based facilities can provide at least two meals a day and routine protective oversight to residents. While licensed board and care does not offer independent living for frequent users, some clients may prefer the additional support licensed board and care offers.

SKILLED NURSING FACILITIES

These medical facilities provide services that cannot be dispensed in assisted living or board and care homes. Typically these services involve managing complex and potentially serious medical problems. For some frequent users, skilled nursing facilities may be the most appropriate housing option available.

BUILDING BLOCK NO.4

Funding Strategies for Frequent User Programs

FREQUENT USERS *of*
HEALTH SERVICES
INITIATIVE

*Promoting new ways to provide health and social services
to benefit individuals and communities*

www.frequenthealthusers.org

While frequent user programs have wide-ranging benefits resulting from their multi-disciplinary, collaborative approach, they can be difficult to fund for that same reason. Many reimbursement streams are categorical — they have their own complex rules on who is eligible to receive assistance, what services are covered, and how providers are reimbursed. These funding streams often only serve a specific population and do not cover multi-disciplinary approaches. In addition, for a variety of reasons, funding sources such as hospitals, counties, and service providers, often cannot assume all of the costs of frequent user programs.

Strategies to Secure Funding

Although there is no single fool-proof approach to securing funding for programs serving the frequent user population, there are strategies that can help your efforts. The following are several strategies used by the *Initiative* frequent user programs that have helped them move from foundation funding to self-sustainability.

Meeting with hospital CEOs and CFOs early on in the start of your program will help you understand their vision for the program and determine their specific goals. For example, some hospital leadership may be interested in reducing uncompensated care, while others may focus on reducing emergency department wait times. Keeping hospital CEOs and CFOs aware of the program — through newsletters, meetings, or monthly reports that show what services are being provided, the number of frequent users being served, the number of frequent users who are eligible, and trends highlighting emergency department admission and inpatient day reductions — will let them know that serving frequent users can benefit the hospital.

Providing case-by-case data and feedback for emergency department providers is also very important in achieving hospital buy-in of your program. Frequent users' repeat visits for issues that are not effectively addressed in the emergency department, such as mental health and substance abuse disorders, can frustrate emergency department staff and physicians who are working with limited resources. They know that the care frequent users receive in the emergency department doesn't really address frequent users' underlying issues. Attending monthly emergency department staff meetings to provide updates on specific clients lets providers and staff know which clients are no longer visiting the ED.

**USING THE POWER
OF DATA**

The ability to consistently track data to show reductions in emergency department and inpatient use and costs is imperative to securing and sustaining funding for your program. Having anecdotal stories of your program's success is important, but is not enough to convince funding sources, such as hospitals and county agencies, to invest in your program. By gathering solid data on the frequent users you are serving that shows their impact on hospitals before and after enrolling in the program, you will be better

> "When we started our project, we met with the CEOs of each hospital and introduced ourselves and talked about the project. We asked them, 'What is it that you want to know from us? What is it that would like to see?' From that we sent out a monthly report with the services we provided, the number of patients enrolled, and the number of recruitment attempts."
>
> *John Tyndal*
> Program Coordinator
> The Bridge/Kaweah Delta Health
> Care District

> "A frequent user project can only attract funding if it tracks the change it's able to make. You have to have reliable data or else no one will ever believe your anecdotal information. These repeat visits are a terrible use of funds because hospital care is expensive. So if you can make the case, they will listen."
>
> *Christine Sippl, MPH*
> Senior Health Services Manager
> Santa Cruz County Health Services Agency

equipped to present your case effectively to potential funding sources. Also, if your program is helping frequent users qualify for benefits such as SSI and Medi-Cal, tracking the money that can be recovered through retroactive reimbursement for those patients can be an incentive for service providers and hospitals to support your program.

TAILOR MESSAGING TO MAKE YOUR CASE

When making the case to hospital administrators to support your frequent user program, use your program data to show how serving frequent users can reduce emergency department and inpatient costs for the hospital. Note that your program may be able to provide a funding source for uninsured or indigent patients by helping them access benefits such as Medi-Cal or county indigent health care, and can help reduce the volume of unpaid emergency department visits.

> "We have a really busy emergency department, so reducing volume is a good thing from a hospital perspective, and particularly reducing the volume of low or poor payers."
>
> *Gwendolyn Bibb*
> Project Director
> The Bridge/Kaweah Delta Health Care District

When making the case to a managed care program to fund these services for their frequent users, focus on how frequent user programs can reduce emergency department and inpatient visits, and can ultimately decrease expensive payments to the hospital, particularly for hospital inpatient stays. It is important to present information and statistics that show how linking frequent users to primary care, housing, mental, and substance abuse treatment can help improve health outcomes in the long-term.

DIVERSIFY FUNDING SOURCES

While having multiple funding sources for your program can be difficult to track and manage, finding one funding source to cover all of the services and resources frequent users need, as well as administrative costs, is unrealistic. Also, if one funding stream dries up, having multiple funding options to fall back on can help make your program less vulnerable. Since different funding streams may reimburse different services, diversification can also give you the ability to offer an expanded array of services.

SECURE ONGOING FUNDING STREAMS

Finding and securing ongoing funding streams (as opposed to short-term grants or contracts) will provide your program with financial security and can lessen your time spent securing funding, reduce staff turnover, and help your program provide consistent levels of service.

Funding Options for Frequent User Programs

FEDERALLY QUALIFIED HEALTH CENTERS

If your frequent user program partners with a federally qualified health center (FQHC), your clients who are Medicaid/Medi-Cal and Medicare beneficiaries can access FQHC health services, including the services of licensed clinical social workers and professional medical services. The FQHC can then bill for these services at enhanced reimbursement rates, reducing overall health care costs for your program. Services are covered when provided to a beneficiary at the FQHC, the beneficiary's place of residence, or elsewhere (e.g., at a temporary shelter or homeless encampment). FQHCs also provide health services to the uninsured, using federal grant revenue to cover these patients.

MEDICAID / MEDI-CAL PROGRAMS

Two other Medicaid/Medi-Cal programs, Medi-Cal Administrative Activities (MAA)[1] and Targeted Case Management (TCM)[2], also provide reimbursement for activities necessary to frequent user programs, such as case management services and helping clients access benefits. However, in California, local governments must match federal TCM funds for the cost of services, and state funds are not available. Since not all local governments provide TCM funding, this option is not available in all counties.

ESTABLISHING CASE RATES

Establishing a case rate per patient with area hospitals or your county managed care program can provide an effective ongoing funding stream to serve frequent users. In Santa Clara County, New Directions uses an annual case rate per patient with the hospitals they serve based on a minimum of five patients, although they recommend a minimum of 25 patients to make the case rate more cost-effective.

OTHER COUNTY FUNDING SOURCES

Other county funding resources may be available, provided that your program can demonstrate a direct benefit to the county. In Santa Cruz County, Project Connect was able to secure funding from the County General Fund by showing how they were able to lower jail and ambulance use and create savings for the county. In Alameda County, Project RESPECT's partnership with the Homeless Action Center to provide benefits advocacy services and help people get off of general assistance and onto

[1]Medi-Cal Administrative Activities (MAA) includes administrative activities necessary for the proper and efficient administration of the Medi-cal program, including outreach to bring in Medi-Cal beneficiaries or high-risk clients and providing information about Medi-Cal; assisting clients to access services covered by Medi-Cal; facilitating the Medi-Cal application; non-emergency transportation for Medi-Cal beneficiaries; program development; and other activities. For more information, visit www.dhcs.ca.gov/provgovpart/Pages/CMAA.aspx.

[2]Targeted Case Management (TCM) consists of case management services that assist Medi-Cal eligible individuals within six specific targeted populations to gain access to needed medical, social, educational, and other services. For more information, visit www.dhcs.ca.gov/provgovpart/Pages/TCM.aspx.

SSI was so successful that the county Department of Social Services contracted with the program to provide benefits advocacy for other general assistance recipients. In addition, programs should explore collaborating with county mental health departments to serve frequent users in programs funded by the Mental Health Services Act (MHSA).[3]

IN KIND SUPPORT

Aside from funding streams, in kind support is another important strategy to provide essential services for your frequent user program. In kind support can include the use of hospital or nonprofit space; hospital and nonprofit staff resources (administrative activities, meetings, etc.); housing, drug and alcohol services; transportation; and other services.

Funding Challenges

- Some funding streams may only provide reimbursement for a small subset of the population you are serving.

- Finding ways to provide needed services that comply with reimbursement requirements can be difficult, particularly with Medi-Cal.

- Many programs do not have adequate capacity to raise funds and apply for grants.

- Tracking activities and billing requirements can be cumbersome and time-consuming for some funding streams.

- High turnover of hospital personnel can make it difficult to keep staff and administrators informed about the project.

- County agencies have limited budgets.

[3]*The passage of Proposition 63 (now known as the Mental Health Services Act) in November 2004 provided increased funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition-age youth, adults, older adults. and families. The Act addresses a broad continuum of prevention, early intervention, and service needs, and the necessary infrastructure, technology, and training elements that will effectively support this system. For more information, visit www.dmh.ca.gov/Prop_63/MHSA.*