



Frequent Users of Public Services:

Ending the institutional circuit

Changing systems to change lives

About the Corporation for Supportive Housing

The Corporation for Supportive Housing (CSH) is a national non-profit organization and community development financial institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information about CSH, please visit www.csh.org. If you have questions or comments regarding this document, or would like to request copies of Frequent User Forum materials, please contact CSH at info@csh.org.

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Introduction to the Report – About the National Forum

Across the country, public and private agencies are partnering to develop, implement, and evaluate innovative cross-system strategies to improve the quality of life and reduce public costs among persons whose complex, unmet needs result in “frequent use” of emergency health, shelter, and correctional services. These programs identify and target the small group of individuals whose overlapping health and mental health issues place them at high risk of repeated, expensive, and avoidable engagement with corrections and crisis care systems.

In recognition of these efforts, the Corporation for Supportive Housing (CSH) assembled a diverse group of leaders from the health, corrections, and housing fields for a *National Frequent Users Forum* in Chicago, Illinois, on October 16, 2008.¹ The Forum provided the first opportunity for practitioners, policy leaders, and researchers to share practices, emerging evidence and lessons learned in their work with “frequent users.” Over 60 experts from 25 communities strategized on how to support innovative models of care and work for the systems change needed to take successful pilot programs “to scale” and to integrate proven strategies into mainstream practice.

The National Frequent Users Forum brought together key leaders – in healthcare, mental health, substance abuse, corrections, homeless prevention, and law enforcement – to discuss the commonalities and differences among frequent users of these systems. Researchers sat down with program staff who talked with policymakers who consulted with funders. Topics included how frequent users are identified, building relationships among institutional (hospitals, jails, prisons) and community-based partners, creating mutual responsibility when people cross multiple systems, approaches and interventions for active users of drugs and alcohol, and many other issues.

CSH’s goals in convening this first Frequent Users Forum were to achieve the following:

- Facilitate connections among persons engaged in work with frequent users in different systems and different communities;
- Identify common themes and differences in programs;
- Learn from each other about ‘what’s out there’ in the rapidly growing area of frequent user interventions and the mounting evidence of their effectiveness; and
- Strategize on how best to demonstrate to policy makers the needs of frequent users and the opportunity that targeted interventions present to improve lives while making better use of increasingly scarce public resources.

While local concerns and opportunities have shaped pilot interventions and determined the particular target population and approach, results from these programs show significant savings across a range of public services.

The Frequent Users Forum produced a number of defining moments as participants recognized commonalities as well as important distinctions in their work within different systems. The meeting was successful in stimulating a broad-based exchange of experience and strategies for improving both practice and policy, and beginning to build a database of programs for continued idea exchange and collaboration.

In addition to learning that a small group of people with complex unmet needs have a significant role in driving escalating health, emergency service, and correctional system costs. We also learned that much of this cost is avoidable through more appropriate models of care that result in better individual and systemic outcomes. Increasingly sophisticated administrative data analyses enable communities and systems to identify and target

¹ CSH thanks the Robert Wood Johnson Foundation and Funders Together for their generous support of the National Frequent Users Forum. Funders Together is a national network of foundations and corporations supporting strategic and effective grant making to end homelessness.

frequent users for new approaches to care. In this work, housing status is increasingly recognized as a significant determinate of outcomes and costs, and supportive housing interventions have been demonstrated to be a core service element for reducing avoidable utilization of more costly emergency and institutional care. In fact, the most innovative and effective of these programs are cross-system strategies. Unfortunately, existing eligibility barriers and perverse systemic incentives impede innovation.

This report summarizes major themes that emerged from the Forum, including an overview of ongoing initiatives and their results, and suggested strategies for sustaining, expanding, and replicating effective solutions for frequent users. The report also includes a “scan of practice” with key facts and contact information on the frequent user initiatives represented at the Forum. Lastly, the report outlines exciting new developments since the Forum, including recently released research findings from the growing body of evidence supporting targeted interventions designed specifically to address avoidable use of correctional and crisis care services.

The experiences and evidence shared at the Forum show that confining the pursuit of better outcomes and budget savings to any one sphere of policy has limitations. Frequent users of health services and correctional systems affect a range of public systems that involve multiple government agencies, direct service providers, and funding streams. Because policymakers seeking to reduce the cost of caring for complex beneficiaries of any one of these systems do not control the policies that ultimately affect spending for all systems, comprehensive solutions will require broad-based approaches that consider the full range of public services. It is also critical to take what we have learned through pilot frequent user programs--often launched with one-time funding and philanthropic support--and embed these lessons in mainstream systems so that effective program models can be sustained, expanded, and replicated. This will require leadership, vision, and coordination across multiple state and local agencies.

For more information on the National Frequent Users Forum and related initiatives, please contact info@csh.org.

Chapter 1: Why Focus on Frequent Users?

The need is large and the cost is high

Increasingly sophisticated data collection systems and analyses provide new methods for identifying frequent users of healthcare, correctional, and emergency systems; to show the ripple effect of avoidable public service use across systems, and to target interventions to those most in need and most likely to benefit. Meanwhile, the poor outcomes and significant public costs associated with avoidable use of public services by frequent users represent both a serious problem for public and private systems of care, and an enormous opportunity to improve the lives of frequent users while making better use of public resources. At this time of unprecedented budget crises and health care cost trends, insufficient resources are available to serve these and other vulnerable community members, making the pursuit of cost-effective measures to improve health and public safety outcomes critical. Frequent users also highlight opportunities to bridge gaps in fragmented service systems to make these systems work better for everyone.

For these and other reasons, public awareness of and interest in the frequent user phenomenon is growing as well. In a 2006 *New Yorker* magazine article, “Million Dollar Murray,” Malcolm Gladwell described a homeless veteran with chronic substance use issues who racked up a million dollars in public costs through repeated jail stays, emergency room visits, and use of medical detoxification services. (Gladwell, 2006). A 2008 *Wall Street Journal* article described preliminary results from the Chicago Housing for Health Partnership (CHHP), a demonstration project targeting chronically ill homeless singles upon discharge from the hospital, as offering “fresh evidence that efforts to move the homeless into permanent housing quickly can improve their lives and save taxpayer money.” (*Homeless study looks at ‘Housing First’: Shifting policies to get chronically ill in homes may save lives, money*, Wall Street Journal, March 6, 2008).

Forum participants articulated a number of reasons why a focus on “frequent users” or “high utilizers” is critically needed, including:

- Poor client outcomes;
- Unmet client needs;
- Overburdened public systems;
- The need to control costs; and
- Growing recognition of shared responsibility for individual and community outcomes.

“Types” of Frequent Users – And Types of Systems Impacted

The Frequent Users Forum brought together practitioners and researchers from a range of frequent user programs, including interventions targeting one or more of the following populations:

- *Frequent users of emergency and inpatient health care.* Most communities experience a small number of individuals who repeatedly and excessively utilize hospital emergency department (ED) and inpatient services as their primary source of medical care. Excellent programs around the country demonstrate effective outcomes from working with frequent users of hospital emergency rooms, ambulances, and/or inpatient care. (Hall, 2008).
- *High-cost, high-need Medicaid beneficiaries.* Five percent of Medicaid beneficiaries drive up to 50% of total Medicaid spending. (Center for Health Care Strategies, 2008). Frequent ED or hospital use often results in poor health outcomes, diminished quality of life, and unnecessary costs, which hamper the ability of states to pursue coverage expansions and other priorities. As states look for ways to ease budget pressures, it is important that the complex needs of these beneficiaries are better understood.
- *Frequent involvement with correctional systems.* Research in communities across the country identified groups of individuals who cycle repeatedly and frequently in and out of local and state correctional settings, and are clients of homeless services and other public systems. Many of these individuals cycle between

homelessness, hospitalization, incarceration, parole/probation, the shelter system, and technical violation on parole/probation, repeating this cycle before and after incarceration. One study found that 11% of people returning from New York State prisons to New York City become homeless with the first few months after leaving prison; of this group, about a third return to prison within two years. The risk of return to prison is significantly higher for those who are homeless and/or mentally ill. (Metraux and Culhane, 2004).

Likewise, the Georgia Department of Corrections found that, with each move after release from prison, a person's likelihood of re-arrest increased by 25%. (Meredith, et al., 2003).

- *Frequent use of emergency alcohol and drug treatment services.* Individuals with chronic, hard-to-treat alcohol and other drug (AOD) disorders remain a vexing challenge. As with other chronic conditions, a small proportion of clients absorb a disproportionate share of treatment dollars. Often these clients cycle through crisis episodes with bouts of high-cost acute care followed by poorly coordinated continuing care. As frequent primary payers, state and county agencies not only are concerned with inefficient spending for AOD treatment, but are also impacted by financing multiple crisis services for these individuals.

These “types” of frequent use are overlapping. Yet, while initiatives may target frequent users of just one public system or are designed to address the overlapping use of two or more systems, such as shelters and jail – once programs enroll the targeted population they invariably find that they are serving frequent users of other systems as well. Indeed, a growing number of communities are using administrative data to identify frequent users of multiple systems.

Treatment failures: Chronically ill and disabled community members are getting the most expensive care yet experiencing the worst outcomes, including extraordinarily high rates of mortality and morbidity. The astonishing mortality rate documented among street homeless persons rivals many cancers and chronic diseases. Since January 2000, the Street Team of the Boston Health Care for the Homeless Program (BHCHP) has prospectively followed a cohort of 119 “rough sleepers” – about half of Boston’s chronic homeless population at that time. This cohort consists of individuals over age 17 who had been living at least six consecutive months on Boston’s streets and who suffered from co-occurring medical, mental health, and substance abuse issues. Most had been homeless for over a decade, with a range from two to 50 years on the streets. The demographics mirrored the population of Boston – the median age at enrollment was in the mid-40s and over 80% had medical insurance through Medicaid, Medicare, or MassHealth at the time of enrollment. At the end of the eight-year period 2000 to 2008, the following data emerged: 46 (39%) of 119 people experiencing long-term homelessness had died; another nine (8%) were living in nursing homes with permanent disabilities; 48 (40%) had been housed; two were incarcerated; four were living in shelters; and seven remained on Boston’s streets. The program has lost only three individuals to follow-up.

“The mortality rate among chronically homeless persons is among the highest of any subgroup in the United States. We are simply failing to treat this fatal chronic condition.”

- Jim O’Connell, MD, Boston Health Care for the Homeless

The most common causes of death among people experiencing street homelessness followed by BHCHP have been often preventable: cancer (22%), cirrhosis (22%), drug overdose (9%), trauma (9%), HIV/AIDS (7%), coronary artery disease (7%), and emphysema (7%). One person died of hypothermia and one of hyperthermia. The Massachusetts Department of Medical Assistance found an aggregate of 18,384 ED visits by this cohort of 119 persons during the five-year period from 1999 through 2003. BHCHP is still investigating the number and charges for hospital admissions, mental health and substance abuse care, ambulance and emergency medical services, and police and corrections utilization.

A recent study also documented the relatively high risk of death of inmates in their first two weeks out of prison. The death rate among 30,000 recently released prisoners in Washington State was 13 times the rate among the general population, primarily due to drug overdose, heart disease, homicide, and suicide. (Binswanger, et al., 2007).

The inability to meet client needs: Service systems are recognizing the complexity of needs presented by this core group of users and acknowledging that a more effective intervention requires collaboration with other systems. Emergency rooms, inpatient care, detox, and correctional facilities have become the “providers of last resort” for many persons with complex needs who lack the housing and stability necessary to connect to more appropriate systems of care. As age and vulnerability increase, long-term care facilities become providers of last resort.

Research has shown that many large jail systems, such as those in Los Angeles, Chicago and New York, have become the primary providers of mental health care in their jurisdictions. (Freudenberg, 2006; Fox, et al., 2001). Kathleen Coughlin of the New York City Department of Corrections noted at the Forum that Rikers Island Jail admits 30,000 men and women each year, many of whom have untreated mental health issues and chronic illnesses. Indeed, each year, U.S. jails process an estimated 12 million admissions and releases. Substance addiction, job and housing instability, mental illness, and a host of health problems are part of the day-to-day realities for a significant share of this population. Given that more than 80% of inmates are incarcerated for less than one month, jails have little time or capacity to address these deep-rooted and often overlapping issues. (Solomon, et al., 2008).

“Jail is the one crisis care center where people are not turned away. People come to jail every day, and we never tell them we have no room.”

- Kathleen Coughlin, New York City Department of Corrections

Likewise, state Medicaid programs are seeking more effective ways to address the multiple needs of their highest-need, highest-cost patients who frequently have an array of problems, often a combination of disabling mental illness and a chronic physical illness (such as diabetes or cardiovascular disease). Many also suffer from problems associated with substance use, housing instability, and other barriers to care. Most experience multiple hospitalizations during a year, as well as significant amounts of emergency room use, ambulatory care, home care, and pharmaceuticals. Annual Medicaid costs for these patients often exceed \$100,000, yet analyses often reveal suboptimal patterns of service utilization. Following discharge from inpatient treatment, patients are often not linked with ambulatory treatment in the community; ambulatory care is often fragmented, with little or no coordination between primary and behavioral treatment; coordination between primary care and specialty care, as well as among chronic illness specialists, is inadequate; and the health care system is not well equipped to address behavioral issues that prevent patients from complying with treatment. (United Hospital Fund, Medicaid Institute, 2009).

Overburdened public systems: Avoidable overuse of emergency medical and public safety services also degrades these services for other members of the community. Data show that frequent users’ multiple visits account for disproportionate costs and time for EDs, increase anxiety in waiting rooms and among ED staff, and drain state and county health care resources. A relatively small number of individuals can have a large impact on a community’s safety net. The Frequent Users of Health Services Initiative (FUHSI), a pilot program in six counties, addressed avoidable ED use among patients with complex, unmet needs not effectively dealt with in acute care settings. FUHSI evaluation results revealed the following: a small number of patients drive

disproportionate use of EDs; identified frequent users made an average of 10.3 ED visits annually, with average annual charges of \$11,388 per patient; that frequent users experienced an average 6.3 inpatient days each, with average annual charges of \$46,826 per patient; and that this episodic, hospital-based care doesn't effectively meet the multiple, complex needs of these patients. The FUHSI pilot projects were successful in creating a more responsive system of care that proactively addresses patients' need and produces better health outcomes while freeing up ED resources for acute medical crises.

The need to control costs: Increasing evidence shows that a small percentage of patients have a significant role in driving rapidly rising costs in publicly funded health and behavioral health care systems, and that correctional facilities are increasingly required to shoulder the responsibility and the costs of complex health and mental health needs.

"We have been willing to pay a high price to be able to judge persons who are failing, but when law enforcement ends up as the default social services system, that is a bad result."

- Officer Patrick O'Bryan, City of Reno Police Department (who was featured in Malcom Gladwell's NY Times article, "Million Dollar Murray")

Forum participants agreed there has never been a more important time to make the arguments that really "stick" for many policymakers – the financial benefits of frequent user initiatives. Both the focus on escalating health care costs and the worsening federal, state and local fiscal crises create an urgent need to use existing resources more effectively.

Like health care costs in general, Medicaid expenses are growing faster than wages or other economic measures, exerting enormous pressure on federal, state, and many local budgets, which each share a portion of the cost burden. (National Governors Association, 2008). According to the Medicaid Institute of the United Hospital Fund, costs associated with enrollees in New York's Medicaid program vary significantly. In New York State, 21% of Medicaid beneficiaries with complex health care and social service needs incur 76% of the \$47 billion in annual costs of the program. Indeed, data show that as few as three percent of Medicaid enrollees may drive as much as 30% of Medicaid spending. (United Hospital Fund, Medicaid Institute, 2008).

Moreover, frequent users of one crisis service are usually frequent users of multiple public systems. Between 2002 and 2006, the 266 persons identified as meeting the criteria for the Hennepin County, Minnesota Frequent Users of Jail and Shelter Program accounted for 68,566 nights in county jail, shelter or detox facilities. Just 60 of these persons accounted for half the nights in jail or shelter. Over 90% received health or eligibility supports from Hennepin County Human Services and Public Health Department. Almost 80% received behavioral health care, and 80% had a criminal history that included livability and property crimes.

Recognition of shared responsibility: Individual treatment failures, rising costs, and a growing body of research provide ample evidence of the failure of existing, fragmented systems of care to meet the needs of persons with complex medical and behavioral health issues who repeatedly cycle through our communities' shelter, correctional and emergency health care systems. Forum participants noted, however, there is growing acknowledgement across systems of shared responsibility and of the opportunities for mutual benefit from better outcomes for individuals and systems. The recognition that frequent users impact multiple public systems provides the impetus for integrated, cross-system approaches.

Forum participants agreed that key challenges in addressing issues of frequent use include identifying prolonged patterns of public system crisis care use, communicating the systems gaps and failures that contribute to these patterns to decision makers, and building the systems of care to change the trajectory for individuals and their communities toward stability and improved outcomes. Forum participants observed that in many communities there is recognition the “wellness infrastructure is broken,” but that decision makers and staff have difficulty within any one system to identify the problems within their own “siloes” sector. Forum participants noted coordinated service delivery of housing, addiction and health treatment, and re-entry from prison and jail becomes complicated by intergovernmental systems that have assigned city, county, and state responsibility for various criminal justice and social service functions.

Participants agreed that collecting and analyzing data across systems, and using the data to raise awareness with both individual-system leaders and higher-level officials responsible for community-wide outcomes are critical. Communities that have made progress toward collective responsibility for outcomes frequent users have employed data sharing agreements to identify overlapping caseloads and engage in cross-agency strategic planning and goal setting to define local barriers to appropriate care, as well as assess resources. These communities work across areas of expertise to answer questions, such as who are we targeting; what does this target population need most: when and how do we deliver the interventions; and how do we assess and evaluate outcomes to gauge progress and to maintain support for the intervention. Such cross-agency strategies formalize roles and responsibilities and track outcomes as “diagnostic tools” to evaluate approaches.

In the past, jail administrators could plead ignorance of the multiple needs of persons who cycle in and out of jail or take the position that these needs fell outside the correctional system’s mandate of “care, custody and control.” Yet chronic offenders – almost by definition – are now known to the criminal justice and human service systems. Most jurisdictions have the capacity to identify their chronic offenders through data matching across systems, creating an opportunity to intervene (Solomon, et al., 2008). The emergence of re-entry councils that include both correctional and social service agencies has led to more effective cross-system strategies to reduce recidivism by addressing underlying causes. One example – the New York City Frequent User Service Enhancement Initiative emerged through an ongoing Department of Corrections and Department of Homeless Services collaboration to improve discharge-planning services in City jails.

Results to date: Improved outcomes at reduced public cost

A growing body of research shows that targeted interventions, which employ cross-system strategies, including care coordination, and “non-medical” supports such as housing, can interrupt patterns of repeated rounds of institutional and emergency care, thereby improving individual lives and making better use of limited public resources. These findings provide empirical evidence to substantiate the experiences of frequent user programs and their participants.

Results from the *Chicago Housing for Health Partnership* (CHHP) show that offering housing and case management to homeless adults with chronic illnesses creates stability and dramatically reduces hospital days and emergency room visits. CHHP is an integrated system of housing and supports for individuals with chronic medical illnesses who are homeless upon discharge from hospitalization. An 18-month randomized control trial compared hospitalizations, hospital days, and ED visits among housed participants and a comparison group of chronically ill homeless persons who continued to receive “usual care” – a piecemeal system of emergency shelters, family, and recovery programs.

Results were recently reported in the *Journal of the American Medical Association*. (Sadowski, et al., 2009). At 18 months, 66% of the intervention group reported stable housing compared to only 13% of the “usual care” group. Controlling for a range of individual and service variables, housed participants had 29% fewer hospitalizations, 29% fewer hospital days, and 24% fewer ED visits than their “usual care” counterparts. As the authors note, for every 100 chronically ill homeless persons offered the intervention, this translates annually into 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer ED visits. For the one-third of study

participants living with HIV/AIDS, housed participants also experienced significantly better health outcomes than those who continued in “usual care.” (Buchanan, et al., 2009). Still to come are a comparison of nursing home days used by the two groups and a full cost-benefit analysis that takes into account the cost of the intervention. However, preliminary results indicate a 50% reduction in nursing home days among housed participants (Sadowski, 2009), and that the reductions in avoidable health care utilization translated into annual savings of at least \$900,000 for the 200 housed participants after taking into account the cost of the supportive housing (*Wall Street Journal*, March 6, 2008).

The California HealthCare Foundation and The California Endowment created *the Frequent Users of Health Services Initiative* (FUHSI) in 2002. FUHSI included six pilot programs that provided or connected frequent users to medical and behavioral health care, transportation, housing, and benefits. Pilot programs were located in Alameda, Los Angeles, Sacramento, Santa Clara, Santa Cruz, and Tulare Counties. Ultimately, the Initiative aimed to relieve pressure on overburdened systems and to promote more effective use of resources. Documented by The Lewin Group, evaluation results summarized in the chart below show that a multi-disciplinary coordinated care approach can reduce ED visits and costs while improving the stability and quality of life for patients.

FUHSI Interventions Reduce Expensive Hospital Charges

| | One Year Pre-Enrollment | One Year in Program | Two Years in Program | % Change Over Two Years |
|--------------------------------------|-------------------------|---------------------|----------------------|-------------------------|
| Average Emergency Department Visits | 10.3 | 6.7 | 4 | 61%* |
| Average Emergency Department Charges | \$11,388 | \$8,191 | \$4,697 | 59%* |
| Average Inpatient Admits | 1.5 | 1.2 | 0.5 | 64%* |
| Average Inpatient Days | 6.3 | 6.5 | 2.4 | 62%* |
| Average Inpatient Charges | \$46,826 | \$40,270 | \$14,684 | 69%* |

* Statistically significant

One of the FUHSI sites, Project Connect in Santa Cruz, also documented declines in ambulance use (55%), jail bookings (51%), and jail days (37%) among enrolled participants.

The highlights above are just a few of the findings of this extensive evaluation. For the full findings and information on data sources, methods, and limitations, see *Frequent Users of Health Services Initiative: Final Evaluation Report* at www.frequenthealthusers.org.

“Not only do frequent user programs decrease expensive hospital visits in the short-term, in the long run, they can prevent this population from becoming permanently disabled and in need of more intensive and expensive care.”

- Carole Chamberlain, Program Officer for The California Endowment (a FUHSI funder)

The New York City Departments of Correction (DOC) and Homeless Services (DHS), with assistance from the Department of Health and Mental Hygiene (DOHMH) and the New York City Housing Authority (NYCHA), are implementing the *Frequent Users Service Enhancement Initiative* (FUSE) in collaboration with community-based housing and service providers. This groundbreaking structured demonstration initiative has placed 100 individuals into permanent supportive housing in an attempt to break their institutional cycle between jail, shelter, emergency health, and other public systems. The John Jay College Research and Evaluation Center conducted an initial evaluation of the program utilizing a quasi-experimental design with a comparison group generated through propensity score matching. Although early, preliminary findings show promising results. Days spent in jail and shelter before and after placement into supportive housing were compared for the subset of clients who were placed into housing at least one year ago (n=86), and a comparison group of individuals matched to this subset (n=102). From this analysis, the group who received FUSE housing and services had a 92% reduction in the number of days spent in shelter, whereas the comparison group only decreased their shelter use by 71% over the year following placement. With regard to DOC involvement, the group who received the FUSE intervention also reduced the number of jail days spent by 53%, whereas the comparison group decreased their jail use by 20%. The matched comparison group's results provide a reasonable assurance that the FUSE is having a positive impact.

In Seattle, the Downtown Emergency Service Center's (DESC) *1811 Eastlake* project is a Housing First program with on-site services targeting homeless men and women with chronic alcohol addiction who are frequent users of crisis and emergency healthcare services. Nearly half of the residents have a co-occurring mental illness and almost all have other chronic and disabling health conditions. Sobriety is not required as a condition of tenancy and residents are encouraged, but not required, to participate in chemical dependency and mental health treatment. An evaluation conducted by the Addictive Behaviors Research Center of the University of Washington reported outcomes of the 1811 Eastlake project on public use and costs for 95 housed participants compared with 39 wait-list control participants enrolled between November 2005 and March 2007. Findings reported in the April issue of the *Journal of the American Medical Association* show that 1811 Eastlake saved taxpayers more than \$4 million dollars over the first year of operation: median costs in the year prior to being housed of \$4,066 per person per month in publicly funded services (such as jail, detox center use, hospital-based medical services, alcohol and drug programs, and emergency medical services), dropped to \$958 after 12 months in housing. During the first six months, even after considering the cost of administering housing for the 95 residents in this Housing First program, the study reported an average cost-savings of 53%—nearly \$2,500 per month per person—in health and social services, compared to the costs of the wait-list control group of 39 homeless people. Moreover, alcohol use by Housing First participants dropped by about one-third, with use decreasing over time while housed. (Larimer, et al., 2009).

The San Francisco Department of Public Health's (SFDPH) *Direct Access to Housing* (DAH) program is also a "low threshold" program that accepts single adults into permanent housing directly from the streets, shelter, acute hospital, or long-term care facilities, regardless of active substance abuse disorders, serious mental health conditions, and/or complex medical problems. DAH was developed specifically to reverse the trajectory of "high-utilizers" of public health system through the provision of supportive housing. Established in 1998, DAH now provides permanent housing with on-site supportive services for approximately 1,100 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. The main goal of the DAH program is to provide housing to a group of people that have rarely, if ever, maintained stable housing as adults. Since opening the first DAH site in 1998, almost two-thirds of the residents have remained housed in the DAH program. Of the remaining one-third, half moved to other permanent housing. Only four percent of residents were evicted from the housing facilities. Due to the severity of medical illnesses among the population housed in DAH, four percent of DAH residents have died.

Overall, DAH residents used a considerable amount of health care services prior to entering DAH housing. After placement, there was little change in outpatient visits in part because on-site case managers encourage residents to maintain primary care appointments. On the other hand, published results show that acute medical care reduced significantly after housing when compared to the two years prior to housing placement, with a 58% reduction in ED visits and a 57% reduction in inpatient episodes. About one-sixth of residents had exacerbations of their mental illness leading to psychiatric hospitalization both before and after tenancy; however, the number of days per hospitalization decreased significantly after being housed. (Kessel, et al., 2006).

“Without access to stable residential environments, the trajectory for chronically homeless individuals is invariably up the ‘acuity ladder’ causing further damage and isolation to the individual and driving health care costs through the roof.”

- Josh Bamberger, MD, San Francisco Department of Public Health, Direct Access to Housing

The New York City Department of Health and Mental Hygiene’s (DOHMH) *Managed Addiction Treatment Services* (MATS) program is a voluntary strengths-based intensive case management program for “high-users of alcohol and other drug (AOD) treatment services” (defined as annual per patient costs to Medicaid \geq \$30,000 for AOD treatment services). The MATS program is sponsored by the DOHMH and the City’s Human Resources Administration (HRA), and is funded primarily by the New York State Office of Alcoholism & Substance Abuse Services (OASAS). Three vendors contracted to provide intensive case management services, which are offered to eligible individuals in coordination with HRA. Individuals applying for entitlements or attending a re-certification meeting at HRA—and who are subject to AOD treatment under the requirements of 1996 federal welfare reform—are asked if they are interested in receiving intensive case management. If so, the individual signs a release to HRA to allow the caseworker to check the client’s Medicaid history for AOD treatment services. If the individual falls into the “high-user” category (as defined above), they are offered MATS services and referred to the appropriate vendor. Initiated in 2007, the NYC MATS program has reached its maximum enrollment of 736 participants. A preliminary Medicaid cost analysis for the initial 820 persons enrolled in MATS shows an average length of stay in the program of over five months. During this period, participants avoided costs of \$10.4 million in AOD treatment services use. Projected annualized savings in AOD treatment services are approximately \$26 million, versus the annual costs of MATS of \$4.4 million.

Finally, the San Diego Police Department-initiated *Serial Inebriate Program* (SIP) offers housing and treatment in lieu of custody to persons convicted on a criminal charge of public drunkenness or disorderly conduct. The University of California-San Diego Department of Emergency Medicine and the Institute for Public Health at San Diego State University conducted a retrospective review of health care utilization records (EMS, ED, and inpatient) of 529 homeless chronic inebriates identified through two public hospitals from January 2000 through December 2003. Treatment through the SIP was offered to 268 of these individuals and 155 (55%) accepted. Use of EMS, ED, and inpatient services declined by 50% for clients who chose treatment, resulting in total medical charges avoided of almost \$74,000 a month for the group of 155 persons who accepted the intervention, consisting of estimated decreases in total monthly average charges for the group of \$5,662 (EMS), \$12,006 (ED), and \$55,684 (inpatient). There was no change in use of services for individuals who refused treatment. (Dunford, et al., 2006).

As these evaluations show, pilot programs are employing a range of strategies and approaches successfully to address the frequent user phenomenon in the health services, correctional, drug treatment and other sectors – and working across systems of care to meet the actual needs of participants. Frequent User Forum participants identified a number of commonalities. The next three sections outline some lessons learned.

Who are frequent users? Different target populations – similar profiles

One of the most significant defining moments for Forum participants was the realization that frequent users of emergency health, behavioral health, and correctional services report the same patterns of overlapping personal vulnerabilities, including:

- Chronic illness;
- Substance use issues;
- Homelessness; and
- Mental illness.

Vulnerability assessments conducted by frequent user initiatives also reveal similar patterns of social exclusion, including:

- Extreme poverty;
- Lack of family/social contacts;
- Histories of victimization; and
- Minority race and ethnicity.

Frequent users identified by any single system are often frequent users of multiple crisis systems; and regardless of which system(s) people are using, the vulnerabilities and systems failures that contribute to the pattern are similar. For these vulnerable persons, emergency and correctional systems often become de facto housing, health and mental health care systems. Indeed, Forum participants observed that frequent users are subject to “the luck of the draw” when “falling into” a specific system at any point in time.

Some communities are using administrative data to identify overlap among frequent users of public systems. In New York City, administrative data matches have revealed a 30% overlap of persons with frequent admissions to the public shelter and jail systems (FUSE); in Seattle and in Santa Cruz County, California, data matches showed that frequent users of EDs and sobering centers were also frequently in jail (1811 Eastlake and FUHSI, respectively).

The *Scan of Practice* attached to this report as Appendix B includes details of the criteria and methods employed by each program represented at the Forum to target frequent users for tailored interventions (see the section in each profile entitled *Targeting the Population*), as well as the demographics of program participants (see *Program Participants*). For example, eligibility for FUSE is determined through a quarterly data match between the New York City Departments of Corrections and Homeless Services to identify people with a minimum of four jail and four shelter stays over the last five years. This replenishing list of approximately 850-1,100 individuals is then cross-referenced with the current jail and shelter census to locate potential FUSE participants. Indeed, the New York City Administrative Code now mandates the identification of frequent users of these city services. Jail frequent users are often homeless, have high rates of substance abuse and serious mental illness, and are often repeatedly arrested for low-level misdemeanors, violations and “quality of life” offenses.

The chart below describes participants from a sample of the frequent user programs represented at the Forum.

| Program | Target Population | Participant Demographics | | | |
|---|--|--------------------------|-----------------|------------------------|-------------------------|
| | | Homeless | Chronic Illness | Substance Use Disorder | Mental Health Diagnosis |
| Chicago Housing for Health Partnership (CHHP) | Chronically Ill Homeless People | 100% | 100% | 86% | 46% |
| 1811 Eastlake, Downtown Emergency Service Center (DESC) | Chronically Homeless Adults with Severe Alcohol Problems | 100% | Most | 100% | 44% |
| Frequent Users of Health Services Initiative (FUHSI) | Frequent Users of ED Service | 45% | 65% | 53% | 32% |
| Frequent User Service Enhancement (FUSE) Initiative | Frequent Users of Jail & Shelter | 100% | NR | NR | 30% - 50% |
| New York State Chronic Illness Demonstration Project | Medicaid Recipients with Chronic Illness & Special Needs | NR | 76% | 73% | 69% |
| New York City Managed Addiction Treatment Services (MATS) | High Cost Users of Alcohol and Other Drug Treatment | 82% | 38% | 100% | 27% |
| NR = Not Reported | | | | | |

The Chicago Housing for Health Partnership (CHHP) identifies chronically ill homeless people as they discharge from partner hospitals. Homeless adults that are hospitalized at one of the three partner hospitals are eligible to receive CHHP services if they are homeless (no source of stable housing for at least one month prior to hospitalization) and have at least one chronic medical condition that normally increases morbidity and mortality. A group of 407 CHHP participants followed for 18 months had high rates of long-term substance abuse, mental illness, and medical issues such as HIV/AIDS (34%) and hypertension (33%), as well as a number of other chronic medical illnesses such as diabetes and cancer.

King County identifies residents of the Downtown Emergency Service Center's (DESC) 1811 Eastlake project in Seattle using data from King County's public hospital (Harborview Medical Center). The average resident at 1811 Eastlake reported being homeless 31 of the 36 months prior to moving in. Residents studied in a recently published evaluation were found to spend 9,043 bed nights in DESC shelters, an average of 103 nights each. The group was overwhelmingly disabled with chronic health conditions, many resulting from a lifetime of alcohol addiction: 44% had co-occurring severe mental illnesses; 61% had hepatitis or other liver disease; 42% had seizure disorder; 23% had heart disease. Their average annual income of was just \$4,160 (or \$346 a month).

FUHSI identified frequent users as "a small group of individuals with complex, unmet needs. These individuals face barriers in accessing housing and medical, mental health, and substance use treatment, all of which contribute to frequent emergency department visits." (Lewin Group, 2008). All of the FUHSI pilot programs included a threshold number of ED visits in their eligibility criteria, which ranged from four to ten visits in one year. In addition to the threshold number of ED visits, some pilot programs targeted services to people meeting psychosocial criteria associated with frequent use, such as mental illness, homelessness, or a history of substance use. Based on data collected across the pilot programs, the dominant profile of a frequent user is a non-white male, aged 40 to 59 years. Notably, only 16% of all participants were married or living with a partner at enrollment.

Forum participants agreed that one challenging question is how to connect to frequent users and recruit them for targeted interventions. All are desperately poor; they lack social and human capital; and it is often difficult to separate cause and effect among issues such as housing loss, mental health problems and chronic illness.

Chapter 2: What is Working?

Varied approaches, shared goals

The frequent user initiatives represented at the Forum employ a range of intervention strategies – from large-scale government health and addiction care management systems, to direct placement in community-based supportive housing. Programs also evaluate success using a variety of measures, including changes in ED admissions, inpatient stays medical costs, incarceration, shelter stays, and crisis drug treatment admissions; as well as measures of stability and improved quality of life. The programs vary in scale, programmatic focus, types of partnerships, and service provision. Yet programs express shared goals: to change the trajectory for individuals caught in cycles of institutional care; to reduce avoidable emergency and correctional services use; and to redirect some or all of the savings realized to sustain funding for effective frequent user interventions that produce better outcomes.

The *Scan of Practice* attached as Appendix B to this report includes detailed program descriptions of the frequent user interventions represented at the Forum. While the programs included in the Scan demonstrate a wide array of practices, program directors identified several core components of effective service strategies:

- Outreach and assertive engagement with targeted participants to establish trust and overcome barriers resulting from isolation and symptoms of mental health and/or substance use problems;
- In-reach into institutions (either corrections or institutions of care) to begin building relationships between “inside” and “outside” care providers;
- A concentrated “dose” of individual support in the period after initial engagement;
- Access to affordable and supportive housing, including individualized help getting and keeping housing and housing subsidies;
- Connection to a range of services (e.g., primary care, mental health, drug and alcohol treatment, transportation);
- Integrated care for medical, mental health, and substance use conditions and coordination of care among providers;
- Practical, sustained support to meet basic needs and respond to individual preferences and goals;
- Trauma-informed services that restore hope; and
- Harm reduction and enhanced motivation to change harmful/risky behaviors.

Experience to date also shows that successful interventions require stable funding, cross-system relationships, strong provider networks, ongoing coordination, and the flexibility necessary to identify and respond to participant emergencies. Ideally, these efforts lead to an integration of systems, in which any door leads to access to services that address needs.

ONGOING PRACTICE CHALLENGE

Participant Engagement:

Initiatives report that the most vulnerable persons are also the hardest to engage. Programs must earn the trust of the target population by demonstrating their success to participants, so that consumers can “vouch” for the program, and program implementation must allow time for this word of mouth peer outreach and/or other engagement processes essential to the uptake of effective programs.

Learning laboratories

The Rethinking Care Program, developed by the Center for Health Care Strategies (CHCS), will serve as a national Medicaid “learning laboratory” by helping stakeholders develop better approaches to identify and manage care for “high-opportunity” patients. This four-year initiative is supported by multiple funders including the Aetna Foundation, Robert Wood Johnson Foundation (RWJF), and Kaiser Permanente Community Benefit (KP), with local support from regional foundations. Current Medicaid-led pilots are underway in Colorado (targeting the top 20% highest-cost, highest-risk adults with chronic conditions in the state), New York (using a predictive algorithm to identify patients at greatest risk for unnecessary hospitalization), Pennsylvania (targeting individuals with serious mental illness and physical health co-morbidities), and Washington State (targeting adults with mental illness and/or chemical dependency and physical health co-morbidities). Each of these initiatives will include rigorous external evaluation, which will contribute to the growing evidence base on clinical solutions for serving beneficiaries with serious, co-morbid conditions.

As part of FUHSI, six pilot programs developed tailored models and interventions to address the range of presenting conditions of frequent users in their hospitals and communities. The models varied from intensive case management provided by licensed clinical staff to less intensive peer and paraprofessional staff-driven interventions. Program interventions varied but several key components contributed to successful outcomes and changes to the community health care system: case management, incentives for engagement, and transportation assistance.

CSH is working with researchers from the Urban Institute and Columbia University’s Center on Homelessness Prevention Studies (CHPS) to evaluate the impact of affordable housing with services for people with chronic behavioral health challenges and significant criminal justice and shelter-use histories in three different places: New York City, Chicago, and the state of Ohio. These three studies will help determine whether supportive housing interrupts the cycle of homelessness and incarceration for the frequent user population. In addition to measuring cost effectiveness and the impact of supportive housing on housing stability and recidivism, researchers at CHPS (who are conducting the study in New York) will track physical and mental health outcomes. These studies will help us better understand the patterns of service use and institutional involvement for this group.

Varied approaches to motivating change

The approaches frequent user programs employ to motivate participants with complex needs to change range from coercive strategies (such as suspended criminal sanctions conditioned upon program uptake and compliance) to recovery-oriented housing and services to low threshold, low demand “harm reduction” interventions to “palliative care” (such as the administration of alcohol) for persons who are unable to end substance use. All of these approaches acknowledge individual responsibility, but seek to institute systems-level goals and expectations.

Each of the three initiatives described below employs a different approach to engaging and serving homeless frequent users with chronic mental, physical and/or substance use problems:

ONGOING PRACTICE CHALLENGE

Tracking Outcomes Over Time:

Pilot programs report that implementation of a new initiative takes at least a year, and that ideally participants should be engaged in a program for at least two years before outcomes are evaluated. FUHSI initiative programs, for example, saw much more dramatic declines in emergency room use and inpatient days after two years than at the one year mark, in part, due to participants’ need for significant care to stabilize chronically ill frequent users.

- The San Diego Serial Inebriate Program (SIP) employs a coercive strategy, working with the San Diego Police Department to convict chronic inebriates on criminal charges of public drunkenness or disorderly conduct, then to offer six months of treatment in lieu of custody, housing participants in small groups with case management, and employing negative reporting. Initiated in 2001 by the San Diego Police Department to assist a group of homeless individuals stuck in a “revolving door” between jail, EDs, and the city’s sobering center, the goal is to provide patients who have exhausted traditional therapeutic options with a sober living alternative while reducing their adverse community impact. The Serial Inebriate Program aligns the judicial system with treatment to create the incentive for individuals’ participation in an outpatient recovery program.
- In comparison, the San Francisco Department of Public Health’s Direct Access to Housing (DAH) program employs a low-threshold, harm reduction approach. Established in 1998, the DAH program has provided permanent housing with on-site supportive services for approximately 1,100 formerly homeless adults (through 2008), most of whom have concurrent mental health, substance use, and chronic medical conditions. All residents in the DAH facilities have tenant rights and all services offered to residents are voluntary. On-site support service staff actively engage residents and attempt to assist individuals in making choices that reduce their physical, psychiatric or social harm. Over time, as residents develop trust in the on-site staff, the resident is able to work with the staff to develop and adhere to an individualized treatment plan. For residents that are unable or unwilling to accept offered services and/or to reduce harmful behavior, staff members continue to engage residents in dialogue and continue to offer services.
- Central City Concern’s Housing Rapid Response (HRR) and Recuperation Care Program (RCP) initiatives for frequent users are recovery-oriented programs that employ a Housing First strategy to serve single adults in the Portland, Oregon metro area who are impacted by homelessness, poverty, and addictions. The HRR program provides low barrier and alcohol and drug free housing to persons with long histories of homelessness due to chemical dependency, mental illness, physical disabilities, chronic medical conditions and/or a criminal justice involvement. The RCP provides post-hospitalization housing and healthcare services for low-income and homeless patients who have received medical care but need continuing attention in order to effectively convalesce. Both programs help at-risk individuals stabilize in housing and access Central City Concern’s established network of primary and behavioral healthcare and addictions treatment. The approach is to meet vulnerable clients where they are and help them facilitate positive change at their own rate, with the goal of achieving and maintaining recovery from addiction.

The importance of housing

Forum participants agreed that perhaps the most important element in successful programs is access to safe, affordable, appropriate housing. Housing provides the essential baseline for accessing the health care and supportive services necessary for the appropriate management of chronic illness, mental illness, re-entry from prison and jail, substance use, and other complex health and social issues. Some of the frequent user initiatives included in the *Scan of Practice* are specifically targeted to homeless persons; others identify housing instability as a key determinant of poor outcomes. Affordable housing integrated with service supports ensure that people with long histories of homelessness who face persistent obstacles, such as a serious mental illness, a substance use disorder, or a chronic medical problem such as HIV/AIDS will maintain their housing and obtain health stability. Supportive housing has repeatedly been demonstrated to both end homelessness and reduce systems involvement and costs. (Culhane, et al, 2002; Larimer, 2009; Sadowski, 2009). The program results outlined in this report add to the growing body of evidence that housing reduces chaotic use of expensive emergency health and homeless services, decreases recidivism, and improves health care access and outcomes, all while helping government avoid unproductive spending.

Housing increases the impact of multidisciplinary care

FUHSI results clearly show that getting and maintaining housing increases the impact of multidisciplinary care. Approximately half of all frequent users served by FUHSI were homeless at enrollment, and many were chronically homeless. Patients with housing were much more likely to experience health stability than patients who were precariously housed or homeless. Among homeless frequent users enrolled in the FUHSI programs, 12% were connected to permanent housing through U.S. Department of Housing & Urban Development Housing Choice Vouchers, and 69% were placed in shelters, board and care homes, or other similar sites. Connecting homeless frequent users to permanent housing made significant differences in a frequent user's ability to reduce ED visits and charges. Those who became connected to permanent housing in the first year of enrollment saw a 34% decrease in ED visits and a 32% decrease in ED charges, compared to just a 12% decrease in visits and a 2% decrease charges for those clients who remained homeless or in less stable housing. In a comparison of inpatient use among homeless clients who became permanently housed and those who did not, both groups showed similar reductions in the number of inpatient admissions after one year of multidisciplinary services. However, examination of inpatient length of stays and charges shows striking differences in outcomes. Inpatient days and charges decreased by 27% for permanently housed clients, but for those who remained homeless, inpatient days *grew* by 26% and inpatient charges *increased* by 49%.

ONGOING PRACTICE CHALLENGE

Housing Barriers:

For homeless/unstably housed frequent users, programs cite access to housing units and subsidies as the most powerful draw for potential participants. Program directors cited the limited availability of supportive housing as one of the greatest barriers to improving client outcomes. There is a need for specialized housing that has lower barriers to entry, and strategies to improve access to existing housing. For example, to facilitate housing for FUSE participants leaving jail, the New York City Departments of Corrections and Homeless Services worked with the local public housing authority to secure a "criminal justice waiver" to allow access to public housing (linked to support services) for program participants with non-violent and drug-related convictions.

Housing First, low-threshold housing works for homeless frequent users

The results reported here also point to the importance of low-threshold “Housing First” strategies that immediately place or stabilize homeless frequent users in appropriate stable housing. This is a paradigm change for some communities and providers, but makes sense given that we know that the disabling health problems and social factors that lead to repeated use of emergency services can best be addressed once a person is housed, and many frequent users have been unable to get or keep housing without the availability of housing first options.

Housing alone is not sufficient; participants also need case management, substance abuse treatment, employment training, or other supports. However, once in housing, participants can be linked to the “wrap around” services that best meet their immediate and long-term supportive service needs. The fundamental shift is that services are flexible and may change over time; housing is permanent. A central premise of Housing First is the acknowledgment that people will typically remain homeless if access to housing is contingent upon completing treatment or programs as a prerequisite. 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. Frequent user programs report that offering supportive, permanent housing with a Housing First approach is the most effective strategy to engage a homeless client fully with physical health conditions or substance abuse and mental health disorders. For many persons, simply being housed reduces stress and symptoms related to mental health or substance abuse disorders. The interventions described in this report show that accessing permanent housing can also reduce frequent visits to the hospital ED, as well as hospital charges.

Once stable, some frequent users will benefit most from recovery-supported housing. For other persons, a “harm reduction” approach is more successful, in which housing programs do not require sobriety. The housing strategy employed must be coordinated with the service strategy, and it is important for communities to offer a range of housing options for frequent users and other homeless persons. Whatever the program approach, the key to success is that providers have the flexibility and strategies in place to continue to engage and re-engage individuals who are unwilling or unable to achieve or maintain sobriety and to do “whatever it takes” to help them achieve housing stability. Successful programs reported they train staff to treat relapse as a learning opportunity rather than a failure.

Other system and practice innovations

Data analysis to identify high-cost frequent users and target services. Initiatives increasingly employ sophisticated administrative data analyses and data integration to spot frequent involvement with health, corrections, drug treatment, and/or multiple systems in order to identify individuals that might benefit from a frequent user intervention.

Some programs use low-tech outreach approaches to identify potential program participants. Some initiatives, however, are employing innovative electronic alerts or “flags” to find potential participants. Electronic flagging provides an automated mechanism – usually a pop-up screen – to inform staff of a hospital, shelter, jail, or other system that a person seeking services is eligible for a frequent user program. Several of the FUHSI programs use electronic flagging to obtain real-time referrals from hospital ED’s. Ideally, the electronic flagging system is automated to generate an email or fax notification to program staff when a potential participant becomes eligible for program enrollment, and the flagging system collects data shared among multiple systems or among partner hospitals or jails.

Predictive modeling to target care management services. Another databased strategy for targeting services is the use of predictive models to identify persons at highest risk of poor health outcomes and avoidable, high-cost service use. Some state or local systems administrators examine administrative and/or reimbursement data to identify risk factors, establish eligibility criteria for a targeted intervention, and identify potential participants. (See CHCS, 2008). The New York State Chronic Illness Demonstration Project, a three-year initiative that pay Medicaid providers a monthly care coordination fee to assess and coordinate the care of participants, utilizes a predictive algorithm to target patients at high risk for medical, substance abuse, or psychiatric hospitalization. Programs that are considering using predictive modeling on a state or regional basis according to claims data may make finding these individuals difficult for programs that must provide services to these individuals, particularly if the program has few ties to the community. Even community-based programs may encounter significantly greater expense in locating these individuals than programs relying on local hospital or ED referral.

Vulnerability assessments to identify individuals at greatest risk. Individual health assessments also enable providers to target services to persons at highest risk of mortality, morbidity, and/or avoidable involvement with emergency and institutional services. Homeless outreach and health care providers use the “Vulnerability Index” to assess fragility of health and risk of mortality. Developed by Dr. Jim O’Connell of Boston’s Healthcare for the Homeless project, and adapted by Common Ground for implementation in several communities, volunteers and staff conduct surveys of homeless people to capture health and social vulnerabilities and identify persons with the most severe health risks. The Index prioritizes the population for housing and other supports based on risk of mortality. (NAEH, 2008).

ONGOING PRACTICE CHALLENGE

Data Collection and Analysis:

Creative data sharing arrangements are needed that meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other individual protections while facilitating access to the data needed to identify, target, and track participants, and to evaluate impact on multiple public systems. Standardized and comprehensive data collection tools to gather information on health outcomes and utilization and to collect data in a manner that facilitates meta-analyses and comparison of outcomes across programs is important to examine the impact of supportive housing and other frequent user interventions on mortality, quality of life, management of chronic illnesses, and transmission of infectious disease.

Medical respite care to reduce hospital stays and readmissions. Both the CHHP program in Chicago and the Central City Concern Recuperation Care Program (RCP) in Portland place homeless and unstably housed persons directly into supportive housing upon discharge from inpatient hospital stays. These programs provide post-hospitalization healthcare services for low-income and homeless patients who have received medical care but need continuing attention to recover. The programs demonstrated that respite care enables formerly homeless, chronically ill participants to stabilize their lives, improve health outcomes, and reduce costly re-admission to inpatient care.

Multidisciplinary team health delivery systems. Programs employ case conferencing among providers addressing medical, mental health, and harmful substance use problems to coordinate and improve care. Several FUSHI project teams targeting frequent users of California hospital EDs included housing providers, benefits advocates, case managers, and primary and behavioral health care providers. These teams hold regular multidisciplinary case conferences to coordinate care. The Boston Health Care for the Homeless Street Outreach team offers both primary and specialty medical care, and includes a psychiatrist and a clinical social worker, making it possible to develop a seamless integration of medical and behavioral health care directly on the streets. Portland Central City Concern's established framework of housing, medical, behavioral health treatment, and case management services, enables the organization to provide culturally appropriate, multidisciplinary, integrated services for the frequent users it serves.

Collaboration between jails and community providers. The New York City Discharge Planning Collaboration is an example of a "re-entry council" developed to improve outcomes for frequent users of shelter and jail. Staffed by the City's DOC and DHS, the collaboration brings together government agencies and non-profit providers, advocates, researchers, and foundations – more than 60 organizations – to reduce recidivism and homelessness among people in NYC shelters and jails. Initiatives include the Frequent User Service Enhancements (FUSE) and other systemic and process-oriented ways of increasing access of community-based services providers to inmates.

Obtaining benefits is critical. Initiatives enable institutional partners to break away from the traditional "fix them and get them out" attitude to focus on creating a stabilizing environment. Stability becomes the goal, rather than discharge. A key component of individual sustainability is connection to benefits. To provide frequent users with stable, reliable access to health care and to enable participants greater access to housing through income stability, helping participants obtain Supplemental Security Income (SSI), which includes Medicaid, was one essential strategy of several FUHSI projects. At the time of enrollment, 63% of frequent users across all programs were either uninsured or underinsured. For these clients, 80% were connected to either county indigent health coverage (64%) or Medi-Cal (16%). For those patients who did not have SSI upon enrollment, benefits advocates, who were project partners, deemed 20% of clients eligible and helped participants apply for SSI. At the time of the evaluation, Social Security Administration granted more than half of those applications; many others were waiting for decisions.

Tools for replicating success

An excellent resource on lessons learned and successful strategies is the FUHSI toolkit, [*Meeting the Needs of Frequent Users: Building Blocks for Success*](#). The FUHSI Toolkit is a valuable asset for communities attempting to replicate the successes of the Initiative pilots.

Chapter 3: Translating Experience into Policy

Changing systems to change lives

Frequent user interventions are achieving consistent and impressive results in a wide range of communities, systems, and target populations. The initiatives profiled in this report provide concrete examples of how targeted, interdisciplinary approaches, especially those that incorporate supportive housing, can break a costly cycle, and how government can work across silos and with the private and non-profit sectors to solve complex problems. Given the promising outcomes, the next question is how to take these approaches to scale to meet the needs of the full subset of individuals who are experiencing institutional cycles of homelessness, incarceration, and public service use.

Successful strategies have identified the barriers to transformation of frequent users – both individual and systemic – and employed community-wide planning and implementation to create shared responsibility to solve these problems. Programs work by providing a set of interventions and supports that help people take responsibility for their behavior, while also making the systems changes necessary in order to provide people better opportunities for change. Effective interventions focus simultaneously on changing both individuals and systems.

Taking these strategies “to scale” will require elevating awareness and developing a sense of “collective accountability” within each community. The combination of outcomes data from rigorous evaluation, local service and cost data, and compelling personal stories has been found to be persuasive to policy audiences. The critical next step is disseminating this message across public sectors to a broad audience of public and private health, mental health, drug treatment, homeless service, law enforcement and corrections executives, and policy makers including state and local budget directors and other officials responsible for fiscal management. Managers at every level in health, behavioral health, corrections, and crisis services stand to benefit from a better understanding of the frequent users of their services and of the potential impact of programs designed to serve these persons more effectively. Moreover, although frequent users may be most vulnerable to system shortcomings, improvements made to address barriers to care will likely benefit other users who have complex needs or similar vulnerabilities.

Forum participants noted that solving the quality of care and cost challenges presented by frequent users of crisis and correctional services will require not only continued local innovation, but also national attention and support. Efforts to improve outcomes and reduce waste will encounter challenges, such as the high costs of initial investment, unintended administrative complexities. Successful strategies must therefore integrate the administrative, operational, and clinical components of care, and proceed by identifying goals, changing systemic incentives, and making specific process improvements.

Finally, Forum participants agreed that we must work toward both immediate and longer term, aspirational policy goals. Frequent user initiatives have already achieved significant policy changes in their communities: e.g., removing barriers to housing; targeting services to the most vulnerable; expanding the capacity of service systems to deliver integrated medical and behavioral health care; and changing state and local reimbursement mechanisms and funding priorities. Pilot project findings must also be used to support broader goals, including adoption of state policy initiatives to improve Medicaid reimbursement for case management and

ONGOING PRACTICE CHALLENGE

Restrictive Eligibility Criteria:

Lack of coordinated funding streams and restrictive eligibility criteria complicate interventions and can be a further barrier to engagement of participants. Cross-system coordination and planning can simplify eligibility determinations and streamline recruitment.

multidisciplinary care strategies, replication of successful frequent user and supportive housing strategies, and expansion or improved access to income support and health coverage through SSI or other benefits programs.

Paying for what makes sense: Financing multidisciplinary care and housing

Forum participants agreed the most significant policy challenge in bringing successful frequent user pilots to scale is the current financing structure for public services. Effective strategies require coordinated investments in housing and services, yet separate public payers impede the development of comprehensive, cost-effective systems of care.

The programs represented at the Frequent Users Forum are creating an empirical evidence base that “non-medical” interventions – especially housing – may be more effective to improving outcomes and reducing costs than medical interventions, and that structural supports may be more successful in reducing recidivism and harmful substance use than coercive strategies. Yet structural interventions (housing, case management; incentives for treatment compliance) are rarely reimbursable under Medicaid and typically not incentivized in publicly funded programs to address recidivism, chronic drug and alcohol use, or even homelessness.

Frequent user initiatives highlight the extraordinary public costs fragmented systems generate. Yet, costs and savings often occur in different systems of care, and/or at different levels of government (federal, state, and local). The current paradigm pits medical care, behavioral health care, corrections, housing, and support services against each other in the competition for scarce resources. We must be careful, therefore, not to make the case that these interventions are merited only where cost savings can be demonstrated, since it can be difficult to capture and “value” such cost savings in the context of a budget process. Moreover, for some frequent users, who are seriously ill, providing access to appropriate medical care (which may include surgery or specialty care) may be associated with higher costs in the short run.

“For some frequent users with serious, untreated medical problems, providing appropriate health care may cost more, especially in the short term, but the standard for delivering appropriate and quality health care for other Americans who are seriously ill or at the end of their lives isn’t, ‘Is it cheaper?’ but rather, ‘Is it effective and appropriate?’”

- Jennifer Ho, Hearth Connection

Even where costs and savings occur within the same system, obtaining and sustaining the public investment required for new approaches to care is difficult. As stated above, the current cost of the New York City MATS program for chronic substance users suggests actual cost savings (in AOD treatment services use *alone*) of approximately \$21.6 million dollars annually when taking into account the program costs of \$4.4 million. Yet, plans to expand the program were aborted due to the City’s current fiscal crisis.

Frequent user programs have wide-ranging benefits resulting from their multi-disciplinary, collaborative approach, yet they can be difficult to fund for that same reason. Many reimbursement streams are categorical — they have their own complex rules on eligibility, coverage, and reimbursement. These funding streams often only serve a specific population and do not cover multi-disciplinary approaches.

Several of the frequent user initiatives featured in this report are employing innovative new funding strategies to change system incentives and/or encourage cross-system investments. One example is the New York State Chronic Illness Demonstration Project, which will operate for three years; it will have risk and shared savings arrangements in years two and three to incentivize cost-savings and compliance with quality controls. Thirty% of the monthly coordination fee will be at risk on a per enrollee basis should costs exceed those for a control

group and projects will be eligible to participate in distribution of 50% of shared savings if annual expenses are below 85% of control group expenditures. Most of the FUHSI programs continue today using other sources of funding (e.g., Medicaid billing, contributions from relevant agencies, case rates paid by hospitals for case management of their frequent users). The Santa Cruz County FUHSI, Project Connect, was able to secure funding from the County general fund by demonstrating their ability to lower jail and ambulance costs, generating additional sources of county savings.

Private philanthropy has also played a key role in driving innovation, funding pilot interventions to demonstrate effectiveness and to produce the data necessary to support government investment in new service strategies. Forum participants described such privately funded pilot programs as important “learning laboratories” that have produced data and experience to inform both practice and system change.

However, taking necessary innovation to scale will require comprehensive reform in public funding mechanisms. At the federal level, we must:

- Streamline Medicaid eligibility based on income instead of complex categorical eligibility, covering everyone below federal poverty level;
- Provide targeted federal grants for coordinated care;
- Modify payment systems to finance integrated services by multidisciplinary teams for people with complex medical and behavioral health problems, such as using Medicaid waiver authority, demonstration programs, and/or optional benefits to encourage states and providers to collaborate to improve care and control costs;
- Adjust Medicaid eligibility requirements to allow for the suspension of coverage rather than termination during short jail stays;
- Encourage partnerships among federal agencies that “touch” frequent users (Departments of Justice, Health and Human Services, Housing and Urban Development; etc.);
- Add housing stability as an outcome for the full range of agencies that receive funding to serve homeless persons, regardless of the service provided;
- Encourage local participation by hospitals, corrections and other systems affected by frequent users to participate in forums convened to develop collaborative solutions to the human and financial burdens brought on by systemic gaps and breakdowns.

NOTE: The first of these recommendations will be accomplished via Healthcare Reform Legislation. At the time of publishing this report (January 2009), both the House and Senate have made sweeping gains, but must reconcile their respective legislation in Conference Committee.

Relationships: the key to effective interventions and change

Forum participants repeatedly pointed to the key role of relationships in the development, implementation, evaluation, and dissemination of information regarding frequent user initiatives. Relationships provide the opportunity to demonstrate to institutions, practitioners, and policymakers how each can benefit in the success of programs. Relationships with thought leaders can lead to the public support and pressure necessary to direct attention to the needs of frequent users. “Commissioner to commissioner” relationships facilitate cross-system strategies and relationships, and lay the foundation for culture change necessary within institutions. Data sharing relationships are critical to remove barriers to program implementation and evaluation. Effective institutional in-reach and tracking depends upon the establishment and maintenance of middle-level and grassroots networks, in addition to high-level cross-system relationships. Finally, peer-to-peer communications are critical to establishing the credibility necessary for program “uptake” by the persons programs hope to serve.

The high-level cooperation of multiple agencies and systems is needed to overcome the bureaucratic and funding obstacles that perpetuate the “revolving door” experienced by frequent users. Doing what has to be

done at the scale required will require coordination of housing programs, homeless services, criminal justice, health care, child welfare, employment, and other programs. To engage these systems requires speaking their language and the language of those who control their budgets. It may not be about homelessness, reentry, chronic illness or mental health, per se, but about encounters, patient days, recidivism, and cost-effectiveness.

Forum participants stressed the importance of paying attention to the self-interest of partners. The CHHP hospitals would not have participated if the project had not paid hospital staff to implement the program. They also noted the need to be aware of the very different incentives and pressures of program partners. State Medicaid or corrections directors and the elected officials who control their budgets will only invest in frequent user initiatives if they see it as in their interest to do so.

Successful initiatives also cited the need for high-level leadership within institutions to address cultural barriers. Establishing broad stakeholder buy-in can be difficult because of perceptions about frequent users (e.g., that they are unemployed, homeless, or substance abusers). Frequent user strategies will only work if the culture of the institution supports the end goals. No program will be successful without available and willing staff members to facilitate access to services. For example, in the paramilitary correctional structure, the sheriff or commissioner, along with wardens and other top jail officials, need to clearly, consistently, and frequently remind staff why the program is a priority and link this mission to promotion and performance evaluations.

Active coordination among public systems and between institutional settings and community-based providers is required to achieve these systems changes. Meeting with agency CEOs and CFOs early on will help programs understand each partner's vision for the program and determine their specific roles in achieving that vision. CHHP program directors met regularly to discuss implementation issues and to keep directors updated, while a coordinator convened social workers and case managers. Buy-in and relationship building is essential among high-level officials, as well as between mid-level and grassroots staff who help sustain programs when administrations change. Nurturing these relationships involves sharing program results to demonstrate how partners gain-share in relationships.

"To sustain an initiative over the long term, you must broadly share data on its effectiveness to make it politically impossible to shut the program down."

- Arturo Bendixon, AIDS Foundation of Chicago

Since the Frequent Users Forum

Evidence of the effectiveness and cost-utility of frequent user initiatives has continued to build rapidly in the months since the October 2008 Frequent Users Forum. Summarized below are just some of the dramatic new developments reported in the research literature, in program evaluations and reports, and in the public discourse.

Emerging policy initiatives

The growing body of evidence on the unmet needs of frequent users and the impact of targeted interventions is giving rise to proposed policy changes and initiatives. Outlined below are just some examples of ongoing systems-level work.

- A Corporation for Supportive Housing working paper, *Health Care Reform: Solutions That Make Sense*, outlines proposed health care delivery and financing changes needed as part of comprehensive Health Reform. (CSH, 2009). The working paper cites evidence of low levels of Medicaid eligibility and enrollment among homeless persons with disabilities or serious chronic health conditions, and describes existing barriers to providing the coordinated, multidisciplinary care necessary to meet their complex health and behavioral health needs. Recommendations include access to Medicaid for every American living below poverty level, community-based health services linked to housing, adaptation of current payment systems to finance community health services models that integrate medical and behavioral health care, and federal support for state efforts to provide innovative care management strategies and medical home program models.
- In order for Medicaid to be an effective financing mechanism, the federal Department of Health and Human Services' Center for Medicare and Medicaid Services (CMS) will need to review Medicaid eligibility, benefits, and reimbursement for the frequent user population and the comprehensive services they require. Health care reform legislation recently passed by both the House and Senate would streamline and expand Medicaid eligibility, making many more frequent users eligible for coverage. Health reform legislation (now pending in Congress) contains several provisions that may expand opportunities for CMS, states, and local partners to implement innovative programs and financing mechanisms that integrate medical and behavioral health care and reduce avoidable hospitalizations and emergency medical services
- Legislation has been introduced to create a federal Coordinated Care Medicaid demonstration program. The Medicaid demonstration that would be authorized by the REDUCE ACT (S. 1761) would allow up to 10 states to target comprehensive services to people with complex medical and behavioral health conditions who have been or are likely to be frequent users of emergency health care (in EDs, ambulance or emergency medical services, detoxification, and emergency mental health services). Communities would need to coordinate across their health care system and provide team-oriented services. In this proposal, states would receive 100% federal financial participation for the first and second years of the program and 75% for each of the following three years. The REDUCE Act allows for services outside the state's plan to be included in the application, allows states to implement the program in all or part of the state and requires a rigorous evaluation to drive future policy. If it passes, states will need to implement the program and base initiatives on evidence-based practice such as that included in this report. For more information and updates on the status of this proposal, follow this [link](#).

- A recent report from the Medicaid Institute at United Hospital Fund, *Rethinking Service Delivery for High-Cost Medicaid Patients*, concludes that changes in health care financing and reimbursement will be necessary in order to improve outcomes and reduce spending for high-cost Medicaid beneficiaries with multiple and substantial needs. (United Hospital Fund, 2009). The report provides an overview of the United Hospital Fund's Medicaid High-Cost Care Initiative, which was launched in 2005 to stimulate new practices and policies to improve care for and reduce Medicaid spending on these high-cost Medicaid beneficiaries. The Initiative involved analytic work (identifying patients, assessing patterns of service use, developing strategic options), program collaboration (awarding targeted grants to health care providers, who conducted surveys and developed pilot interventions), and policy work (examining Medicaid reimbursement, considering what policy changes are needed). Among the successes, patients in the New York City Bellevue Hospital pilot recorded dramatic reductions in ED visits (67%) and inpatient admissions (45%). A critical feature of the Initiative was that it discussed the need for strategies that identify and provide services that address social barriers to care. The report identified stable supportive housing as a tool for reducing frequent hospitalizations. However, the report identifies substantial barriers to service delivery innovation that is sustainable, scalable and replicable, noting that Medicaid's high-cost patients are extremely complex, health care delivery systems are under financial stress, the framework for paying providers is counterproductive, and hospitals have strong incentives to preserve the status quo. Given these constraints, the report calls for sustained and collaborative leadership among state officials, health care providers, and independent analysts who are committed to fiscally sound solutions that improve patient health outcomes.

Growing public awareness of the frequent user phenomenon

Recent news articles point to growing public awareness of the complex needs of frequent users of emergency services, the high costs associated with ineffective responses, and the success of targeted interventions. A November 2008 *Washington Post* column called on the Mayor of Washington, D.C., to reconsider proposed cuts to the District's successful Housing First program for homeless adults, comparing the cost of the program--about \$67 a day per person for supportive housing--to hospital charges for a day in the ED (\$3,085) or a mental hospital (\$435), or the costs of jail (\$105). (*Homes for the Homeless, Bargains for Everyone*, The Washington Post, November 20, 2008). Other recent news articles cite the success of frequent user interventions highlighted in this report, including Boston's Health Care for the Homeless Program (*In Boston, House Calls for the Homeless*, New York Time, November 11, 2008), the 1811 Eastlake program (*Study: Seattle Housing for Alcoholics Saves Money*, Associated Press, March 31, 2009).

As explained in a recent Boston Globe editorial supporting the Massachusetts Home and Healthy for Good program, "Intuition would suggest that getting chronically homeless people into permanent living quarters will improve their well-being and save money spent on institutional care, whether it be hospitalizations, shelters, detox facilities, or jails. However, in tight budget times, intuition is not good enough. ... Proponents of the housing-first policy always knew it was compassionate. Now they can prove it's a bargain." (Boston Globe Editorial, March 29, 2009).

Policy recommendations – The change we need, and how we get there

We know that interventions targeted to "frequent users" of expensive public services present a unique opportunity to improve the lives of individuals and communities. Directing public dollars towards solutions that work better, cost less, and mitigate costly, avoidable emergency and institutional responses is an effective remedy for the systems that see frequent users and the users themselves. This kind of systems change requires effort on several fronts and at different levels: we must elevate awareness, establish new collaborations, improve access to mental health and substance abuse treatment, streamline processes for securing entitlements and health coverage, and develop a sense of "collective accountability" within our communities.

Use Data to Identify Frequent Users, their Patterns of Utilization, and Outcomes

- Employ government and publicly funded institutions to gather and analyze administrative data to identify frequent users of health and emergency services, frequent involvement with corrections, and the overlap of these populations.
- Identify and predict patterns of utilization, and target individuals who are caught in these cycles of institutionalization who are discharged into homelessness or unstable situations that compromise health of vulnerable populations.
- Use administrative data analysis to create a care system that is more effective and efficient.
- Track health care outcomes among persons at highest risk due to chronic health, behavioral health and psychosocial factors, hold public systems accountable for these outcomes, and use these outcomes as a measure of the impact of supportive housing.

Leverage Existing Data by Expanding Dissemination Points

- Use the Frequent User Forum materials to convene local or regional forums to discuss opportunities for collaboration. These regional efforts can cultivate greater political will.
- Cultivate national, state, and local leadership by using local programs and evidence to support broader systems change, while simultaneously using the national policy discussion to influence local decision-making.
- Disseminate data at a broad range of venues targeted to leaders in health care, health care finance, corrections, housing, mental health care, substance use treatment, and other impacted systems.
- Continue to demonstrate the importance of supportive housing to the success other social policy sectors and initiatives, making the business case that housing is critical to health reform, economic development and infrastructure, jobs, and ending the costly cycle of homelessness, recidivism and institutionalization.
- Educate leaders within these systems so that the issue is discussed in gatherings of corrections systems, emergency room providers, drug treatment providers, and other impacted systems.
- Identify key public figures (such as judges interested in alternatives to incarceration) to lead public opinion.
- Make a convincing case to the public that this is a problem that can be solved. This can influence public officials to take action. To disseminate information to the public, assemble the information and make connections with the media, the business community, and other forums to show the public what works and how it can be accomplished.

Engage in Strategic Cross–Agency Systems Change Planning

- Bring together siloed funding streams and service providers competing for limited public funds, and encourage cross-system collaborations that can identify and address barriers to effective and efficient care.
- Prioritize system-wide outcomes and cost-savings and use interagency planning bodies to identify systemic barriers to innovation.
- Create financing mechanisms that allow the systems that fund hospitals, jails, and prisons to pay for and connect vulnerable populations to supportive housing and wrap-around services to stop the cycle of frequent use and inappropriate discharge.
- Promote cross-agency strategic planning, goal setting, and funding, and provide incentives to create permanent supportive housing targeted specifically at high-utilizers of public services.
- Take the lessons learned from pilot programs and embed the strategies and interventions in mainstream systems.

Remove Barriers to Effective Interventions

- Provide community-based health services linked to housing--which allow homeless people with serious medical and behavioral healthcare needs to live in the community--as an integral part of comprehensive health care reform.
- Evaluate and address barriers to innovation, such as categorical eligibility requirements and funding streams, clean and sober requirements, public housing biases against people with a history of incarceration, and other obstacles to appropriate housing and care for frequent users.

Engage the Full Range of Systems that Experience the Frequent User Dilemma

- Jails, prisons, and community corrections agencies
- Publicly financed health care systems, including Medicaid and indigent care
- Veteran's administrations
- Hospitals
- Mental health systems
- Substance abuse systems
- Community-based housing and service providers
- U.S. Department of Housing & Urban Development, the U.S. Department of Health and Human Services, the U.S. Justice Department, and other federal agencies

Engage the Full Range of Stakeholders

- Hospital administrators and health system leaders
- Police chiefs, judges, sheriffs, and leaders in state corrections agencies
- Finance officials in health care and criminal justice agencies, and state and local government budget officials
- Governing board members of health care and related agencies
- Funding decision makers and other elected officials (council members, state legislators, etc.)
- Direct service providers, including doctors, psychiatrists, parole and probation officers, and other health care workers and case managers responsible for implementation of policy change
- Managed care organizations
- Consumers and family members
- Other community leaders with a stake in the solution

Finance the Solutions

- Direct mainstream resources, such as Medicaid, mental health and substance abuse block grants, criminal justice funding, child welfare, employment program funds, and rehabilitation programs, toward evidence-based solutions that work to reduce frequent avoidable use of public systems.
- Expand access to Medicaid to every American living below the poverty level and broaden reimbursable activities to include care coordination and other services provided beyond clinic walls.
- Adapt current payment systems to finance community health services teams that integrate care for medical and behavioral health conditions, providing a "person-centered health care home" linked to housing.
- Provide federal government support for state efforts to provide innovative care management strategies targeting high-cost people with complex medical and behavioral health conditions.

A Guide for Sectors

What philanthropy can do:

- Provide funding and technical assistance to enable providers to build successful data collection tools and strategies.
- Provide the venture capital and investments in provider capacity so that organizations can successfully build and operate supportive housing or other programs targeting frequent users.
- Identify communities that are “ready to proceed” with combined frequent user initiatives that cross corrections, shelters, and medical services, and focus resources to move those efforts forward.
- Help bridge gaps between systems by convening stakeholders and public sector systems to educate and break down silos between systems.

What government can do:

- Work together with providers and researchers to develop models and instruments to facilitate sharing of medical utilization data with appropriate safeguards for privacy – including Medicaid claims data.
- Develop the capacity to use administrative data matching to identify frequent users.
- Provide technical assistance to address perceived and actual legal barriers to data sharing.
- Reach across agencies to enhance funding streams and programs.
- Benchmark and set outcomes, provide incentives for agencies to work together across sectors, monitor results, and adjust funding accordingly.

What researchers can do:

- Continue and refine work to evaluate the impact of care coordination and housing on health, education, income security, community development, corrections, and other sectors.
- Compare the social and economic benefits of providing improved housing options with the cost of providing the housing, using cost models and analyses sufficient to convince government and providers that the tools discussed at the Forum are cost-neutral or even result in cost savings.
- Develop, document, and disseminate successful data collection tools and strategies.
- Work toward the development of standardized core data set for collection across sites and agencies to facilitate comparisons and meta-analyses of program outcomes.
- Expand research and evaluation to measure mortality and other health outcomes.

What providers/practitioners can do:

- Convene forums or processes to continue conversation about reaching outliers (persons hardest to reach due to serious and persistent mental health issues and harmful drug use).
- Create a full range of supportive housing options within each community (low threshold, harm reduction, and alcohol and drug free).
- Facilitate cross-site collaboration and evaluation to strengthen the evidence base that can be used for advocacy.
- Define specific health outcome goals and partner with researchers to develop measurements of these outcomes.

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Appendix A: Frequent User Forum Participants

| NAME | | TITLE/AGENCY | LOCATION |
|----------|-------------------|--|-------------------|
| Angela | Aidala | Columbia University Center for Homelessness Prevention Studies | New York, NY |
| Jacquie | Anderson | CSH | Oakland, CA |
| Sue | Augustus | CSH | Chicago, IL |
| Peggy | Bailey | National Alliance to End Homelessness | Washington, DC |
| Josh | Bamberger, MD | City of San Francisco, Department of Public Health | San Francisco, CA |
| Mikkel | Beckman | St. Stephen's Human Services | Minneapolis, MN |
| Arturo | Bendixon | AIDS Foundation of Chicago | Chicago, IL |
| Gwen | Bibb | Kaweah Delta District Hospital | Visalia, CA |
| Karen | Carpenter-Palumbo | Commissioner, New York State Office of Alcoholism and Substance Abuse Services | Albany, NY |
| Richard | Cho | CSH | Hartford, CT |
| Kathleen | Coughlin | New York City Department of Correction | New York, NY |
| Deb | DeSantis | CSH | New York, NY |
| Liz | Drapa | CSH | Chicago, IL |
| James | Dunford, MD | City of San Diego, Medical Emergency Programs | San Diego, CA |
| Jan | Eldred | California Health Care Foundation | Oakland, CA |
| John | Fallon | CSH | Chicago, IL |
| Charlene | Flaherty | CSH | Scottsdale, AZ |
| Jocelyn | Fontaine | Urban Institute | Washington, DC |
| Linda | Frisman | University of Connecticut | Storrs, CT |
| Barbara | Geller | Connecticut Department of Mental Health and Addiction Services | Hartford, CT |
| Brenda | Goldstein | Lifelong Medical Care | Berkeley, CA |
| Laura | Grund | New York City Department of Health and Mental Hygiene | New York, NY |
| Eli | Hall | Consultant | Portland, OR |
| Richard | Harris | Mental Health and Addictions, State of Oregon | Portland, OR |
| Jennifer | Hawkins | Common Ground | New York, NY |
| Daliah | Heller | New York City Department of Health and Mental Hygiene | New York, NY |
| Jennifer | Ho | Hearth Connection | St. Paul, MN |
| Sherry | Holm | New Directions, Santa Clara County and Santa Clara Hospital Council | San Jose, CA |
| Stacy | January | Bexar County Probate Court | San Antonio, TX |
| Brad | Kaeter | Hennepin County Criminal Justice | Minneapolis, MN |

| NAME | | TITLE/AGENCY | LOCATION |
|-----------|----------------|--|-------------------|
| Cheryl | Kennedy-Perez | Massachusetts Department of Public Health/Bureau of Substance Abuse Services | Boston, MA |
| Elizabeth | Lee | Michael Reese Health Trust | Chicago, IL |
| Alice | Lind | Center for Health Care Strategies | Lawrenceville, NJ |
| Karen | Linkins | Lewin Group | Scottsdale, AZ |
| Diane | Louard-Michel | CSH | New York, NY |
| Heather | Lyons | CSH | Portland, OR |
| Lisa | Mangiante | Frequent Users of Health Services Initiative | Alameda, CA |
| Fran | Martin | CSH | Hartford, CT |
| Natalie | Matthews | Connecticut Coalition to End Homelessness | Hartford, CT |
| Nancy | McGraw | CSH | New York, NY |
| Andy | McMahon | CSH | Minneapolis, MN |
| Angelique | Miller | AIDS Foundation of Chicago | Chicago, IL |
| Mari | Moen | CSH | Minneapolis, MN |
| Joan | Montbach | Palladia, Inc. | New York, NY |
| Ryan | Moser | CSH | New York, NY |
| Jim | O'Connell, MD | Boston Healthcare for the Homeless | Boston, MA |
| Patrick | O'Bryan | Reno Police Department | Reno, NV |
| Maureen | O'Malley-Moore | Santa Clara County, Board of Supervisors | San Jose, CA |
| Sharon | Rapport | CSH | Oakland, CA |
| Debbie | Reznick | Polk Bros Foundation | Chicago, IL |
| Brenda | Rosen | Common Ground | New York, NY |
| Laura | Sadowski, MD | Cook County Hospital | Chicago, IL |
| Amber | Salazar | The Effort | Sacramento CA |
| Ginny | Schubert | Schubert Botein Policy Associates | New York, NY |
| Christine | Sippl | Santa Cruz County Health Services Agency | Santa Cruz, CA |
| Stephen | Somers | Center for Health Care Strategies | Lawrenceville, NJ |
| Connie | Tempel | CSH | New York, NY |
| John | Tyndal | Kaweah Delta District Hospital | Visalia, CA |
| Richard | Van Horn | Mental Health America of Los Angeles | Long Beach CA |
| Katrina | VanValkenburgh | CSH | Chicago, IL |
| Carol | Wilkins | CSH | Oakland, CA |
| Carol | Zierman | Heading Home Ramsey (10 Year Plan) | St. Paul, MN |

Appendix B: Scan of Practice

Set out in this appendix are a) system impacts of each program represented at the forum, b) contact/web information for each program, and c) detailed program descriptions for the broad sample of frequent user interventions represented at the Frequent Users Forum. While this group of programs provides a good overview that is illustrative of programs operating around the country, please note this Scan of Practice is not exhaustive or to fully representative all activity under way.

Systems impacts – interventions represented at the Frequent Users Forum

| Program Name | Community Served | Targeted Population | Connection to Publicly Funded Health Benefits | Public Health Care Reimbursement (Medicaid/Medicare) | Connection to Primary Care (medical home) | Emergency Department Visits | Hospital Admits | Arrests | Jail Admits | Shelter Admits | Inpatient Mental Health Admits | Outpatient Mental Health Care | Sobering Center (detox) Admits | Alcohol & Substance Use Treatment | Morbidity and Mortality | Housing |
|--|------------------|--|---|--|---|-----------------------------|-----------------|---------|-------------|----------------|--------------------------------|-------------------------------|--------------------------------|-----------------------------------|-------------------------|---------|
| Boston Health Care for Homeless Street Outreach Team | Boston, MA | Chronically Ill Street Homeless* | | X | X | X** | X*** | X | X*** † | X | X | X | | X | X | X |
| Center for Health Care Strategies | National | Highest-Need, Highest-Cost Medicaid Beneficiaries | | X | | | | | | | | | | | | |
| Central City Concern Housing Rapid Response | Portland, OR | Chronically Homeless Adults* | | | | | | X | | | | | | X | | X**** |
| Central City Concern Recuperation Care Program | Portland, OR | Low-Income & Homeless Adults Upon Hospital Discharge | | | X | X | X | | | | | | | X | X | X |
| Chicago Housing for Health Partnership | Chicago, IL | Chronically Ill Homeless People | X | X | | X | X*** | | | | X | | | | X | X**** |

| Program Name | Community Served | Targeted Population | Connection to Publicly Funded Health Benefits | Public Health Care Reimbursement (Medicaid/Medicare) | Connection to Primary Care (medical home) | Emergency Department Visits | Hospital Admits | Arrests | Jail Admits | Shelter Admits | Inpatient Mental Health Admits | Outpatient Mental Health Care | Sobering Center (detox) Admits | Alcohol & Substance Use Treatment | Morbidity and Mortality | Housing |
|--|--------------------------------------|---|---|--|---|-----------------------------|-----------------|---------|-------------|----------------|--------------------------------|-------------------------------|--------------------------------|-----------------------------------|-------------------------|---------|
| Direct Access to Housing | San Francisco, CA | Homeless Adults with Mental Health, Substance Use and Chronic Medical Conditions* | X | X | X | X | X*** | | | | X | X | | X | X | X**** |
| Downtown Emergency Service Center (DESC) - 1811 Eastlake | Seattle, WA | Chronically Homeless Adults with Severe Alcohol Problems* | | X | | X** | X*** | | X*** | X*** | X | | X | X | | X**** |
| EssentialCare Medical Care Management Program | Massachusetts | MassHealth Managed Care Participants with Complex Issues | | X | X | X | X*** | | | | X | X | | | | |
| Frequent Users of Health Services Initiative (FUSHI) | Six California Counties | Frequent Users of ED Service | X | X | X | X | X*** | X | X*** | | | | | | | X |
| Frequent Users of Jail and Shelter Pilot | Bridgeport, New Haven & Hartford, CT | Frequent User of Jail & Shelter | | | | | | X | X*** | X*** | X | X | X | X | | X**** |
| Frequent Users of Jail and Mental Health | Cook County, Illinois | Frequent Users of Jail & Mental Health Services | | X | | X** | | X | X***† | X*** | X | X | X | X | | X**** |
| Frequent Users of Jail and Shelter Program | Hennepin County, MN | Frequent User of Jail & Shelter | X | | | | | X | X*** | X*** | | | X | | | X**** |

| Program Name | Community Served | Targeted Population | Connection to Publicly Funded Health Benefits | Public Health Care Reimbursement (Medicaid/Medicare) | Connection to Primary Care (medical home) | Emergency Department Visits | Hospital Admits | Arrests | Jail Admits | Shelter Admits | Inpatient Mental Health Admits | Outpatient Mental Health Care | Sobering Center (detox) Admits | Alcohol & Substance Use Treatment | Morbidity and Mortality | Housing |
|--|------------------|--|---|--|---|-----------------------------|-----------------|---------|-------------|----------------|--------------------------------|-------------------------------|--------------------------------|-----------------------------------|-------------------------|---------|
| Frequent Users of Jail and Shelter Initiative | New York City | Frequent User of Jail & Shelter | | | | | | X | X*** | X*** | | | | | | X**** |
| New York State Chronic Illness Demonstration Project | New York State | Medicaid Recipients with Chronic Illness & Special Needs | | X | X | X** | X*** | | | | X | X | X | X | X | |
| New York State CASA NIDA Funded Disease Management Study | New York State | High Cost Users of Alcohol and Other Drug Treatment Services | | X | X | X** | X*** | X | X† | | X | X | X | X | | |
| New York City Managed Addiction Treatment Services | New York City | High Cost Users of Alcohol and Other Drug Treatment Services | | X | | | | | | X | | | X | X | | X |
| Serial Inebriate Program (SIP) | San Diego, CA | Chronic Homeless Inebriates* | | X | | X** | X*** | | X*** | | X | | X | X | | |

*These programs specifically target chronically homeless persons.

**In addition to medical emergency department visits, these programs track emergency medical service (EMS) paramedic interventions.

***In addition to hospital, psychiatric, jail and/or shelter admissions, these programs examine length of stay in these institutional settings.

****In addition to housing placement, these programs examine length of stay in housing.

†These programs also track prison admissions.

List of programs and initiatives represented at the Frequent User Forum

Boston Health Care for Homeless Street Outreach Team

Chronically Ill Street Homeless – Boston, Massachusetts

Center for Health Care Strategies

Highest-Need, Highest-Cost Medicaid Beneficiaries – National Initiative

Central City Concern Housing Rapid Response

Chronically Homeless Adults – Old Town Neighborhood of Portland, Oregon

Central City Concern Recuperation Care Program

Low-Income & Homeless Adults Upon Hospital Discharge – Portland, Oregon

Chicago Housing for Health Partnership

Chronically Ill Homeless People Upon Hospital Discharge – Chicago, Illinois

Direct Access to Housing

Homeless Adults with Mental Health, Substance Use and Chronic Medical Conditions – San Francisco, California

Downtown Emergency Service Center (DESC) 1811 Eastlake

Chronically Homeless Adults with Severe Alcohol Problems – Seattle, Washington

EssentialCare Medical Care Management Program

MassHealth Managed Care Participants with Complex Issues – State of Massachusetts

Frequent Users of Health Services Initiative (FUHSI)

Frequent Users of Emergency Department Services – Six California Counties

Corporation for Supportive Housing Frequent Users of Jail and Shelter Evaluation (FUSE) – Returning Home Initiative

Mail to: info@csh.org

Connecticut Frequent Users of Jail and Shelter Pilot

Frequent User of Jail & Shelter – Bridgeport, New Haven & Hartford, Connecticut

Mail to: info@csh.org

Cook County Frequent Users of Jail and Mental Health

Frequent Users of Jail & Mental Health Services – Cook County, Illinois

Hennepin County Frequent Users of Jail and Shelter Program

Frequent User of Jail & Shelter – Hennepin County, Minnesota

NYC Frequent Users of Jail and Shelter Initiative

Frequent User of Jail & Shelter – New York City

New York State Chronic Illness Demonstration Project

Medicaid Recipients with Chronic Illness & Special Needs – New York State

New York State CASA NIDA Funded Disease Management Study

High Cost Users of Alcohol and Other Drug Treatment Services – New York State

New York City Managed Addiction Treatment Services (MATS)

High Cost Users of Alcohol and Other Drug Treatment Services – New York City

Serial Inebriate Program (SIP)

Chronic Homeless Inebriates – San Diego, California

Boston Health Care for Homeless Street Outreach Team *Chronically Ill Street Homeless – Boston, Massachusetts*

Health care for chronically homeless street folks is a challenge, and despite high visibility and considerable publicity in the press, virtually nothing is known about the street folks who inhabit the interstices of our inner cities. In January 2000, the Street Team of the Boston Health Care for the Homeless Program (BHCHP) decided to prospectively follow a cohort of about half of Boston's street population--119 "rough sleepers"--were enrolled.

Targeting the Population:

The members of BHCHP's Street Team walk the streets of the city, seeking out the men and women who live in alleys and under bridges. Their goal is to offer care to these homeless people who cannot tolerate homeless shelters or mainstream clinics and hospitals. Rough sleepers face unusually severe health risks. They suffer from exposure to the extremes of heat and cold; complex and chronic medical illnesses; and frequent exposure to violence. Many suffer from persistent mental illness and substance abuse.

Program Participants:

The cohort of 119 rough sleepers followed since 2000 consists of individuals over age 17 that have been living at least six consecutive months on Boston's streets and who also suffer from co-occurring medical, mental health, and substance abuse issues. Most have been homeless for over a decade, with a range from two to 50 years on the streets. The demographics mirror the population of Boston: the median age at enrollment was in the mid-40s and over 80% had medical insurance through Medicaid, Medicare, or MassHealth at the time of enrollment.

During the past eight years, 46 (39%) of the 119 street folks followed by the BHCHP Street Team have died, while another nine (8%) are now living in nursing homes with permanent disabilities. Forty-eight (40%) have been housed, with two incarcerated, four now living in shelters, and seven remain on Boston's streets. BHCHP has lost only three individuals to follow-up. This astonishing mortality rate rivals many cancers and chronic diseases. The most common causes of death have been medical and often entirely preventable: cancer (22%), cirrhosis (22%), drug overdose (9%), trauma (9%), HIV/AIDS (7%), coronary artery disease (7%), and emphysema (7%). Only one person died of hypothermia and one of hyperthermia.

Key Features and Innovations:

The philosophy of the BHCHP Street Team has been to maintain a quiet and consistent presence on the streets, seizing every opportunity for coffee, conversation, and support in order to earn trust and foster an enduring relationship between doctor/nurse and patient. A critical principle is that primary and even specialty care can be provided directly on the streets as well as in BHCHP's shelter and hospital clinics. This multidisciplinary medical and mental health team combs the streets each day, works on an outreach van during the nights, conducts a weekly street clinic at Massachusetts General Hospital, and cares for rough sleepers admitted to BHCHP's 104-bed respite care program. This model of care respects the vicissitudes of life on the streets and seeks to make health care accessible, available and continuous in places familiar and comfortable for each individual: on park benches, in alleyways, and under bridges. This integration of direct care on the streets and in shelters within the mainstream health care provided by Boston's academic medical centers has been a bedrock foundation of BHCHP's service delivery model.

Initiative Partners:

The BHCHP Street Team provides intensive care to rough sleepers by:

- Operating a special "Street Clinic" at Massachusetts General Hospital to provide health services to patients who have forged bonds with Street Team providers;
- Offering health care by a BHCHP physician on the Pine Street Inn Overnight Rescue Van; and
- Providing a medical presence for the daytime street outreach teams run by local homeless shelters.

Since 2002, a psychiatrist and a clinical social worker from Massachusetts Mental Health Center have become full members of the Street Team. Their efforts have made it possible to develop a seamless integration of medical and behavioral health care directly on the streets.

Demonstrating Success:

The Street Team now provides integrated primary care and mental health services for over 500 individuals.

The Massachusetts Department of Medical Assistance found an aggregate of 18,384 ED visits by the cohort of 119 persons followed during the five-year period from 1999 through 2003. BHCHP is still investigating the number and charges for hospital admissions, mental health and substance abuse care, ambulance and emergency medical services, and police and corrections utilization.

Lessons Learned:

Over 130 BHCHP Street Team clients have been housed through new programs during the past two years and the team has continued to provide the medical and mental health support for those who have been housed. Home visits are now a key component of the care model and the role of BHCHP and other health care for the homeless programs is evolving in response to the critical need for supportive services for housed persons who have experienced long periods of homelessness.

For more information, go to:

<http://www.bhchp.org>

Center for Health Care Strategies

Rethinking Care for Medicaid's Highest-Need, Highest-Cost Populations – National Initiative

Approximately five percent of Medicaid beneficiaries drive up to 50% of total spending in states across the country. More than 80% of these high-cost beneficiaries have three or more chronic conditions, and up to 60% have five or more; yet, the majority of these patients receive fragmented and uncoordinated care often leading to unnecessary and costly hospitalizations and institutionalizations. Rethinking the way States care for Medicaid's highest-need, highest-cost beneficiaries presents a compelling opportunity to improve care and control costs. The Rethinking Care Program was developed by the Center for Health Care Strategies (CHCS) to serve as a national "learning laboratory" to design and test better approaches to care for high-opportunity beneficiaries. The four-year initiative is linking State pilot demonstrations with a national learning network committed to advancing Medicaid's capacity to serve these beneficiaries.

Targeting the Population:

Using health risk assessment, claims data, and predictive models, *Rethinking Care Program* initiatives prioritize the top 5-20% highest-need, highest-cost Medicaid beneficiaries among multi-morbid persons with disabilities, including those with severe and persistent mental illness. Currently, Medicaid-led pilot programs are underway in Colorado (targeting the state's top 20% highest-cost, highest-risk adults with chronic conditions); New York (using a predictive algorithm to identify patients at greatest risk for unnecessary hospitalization); Pennsylvania (targeting individuals with serious mental illness and physical health co-morbidities); and Washington State (targeting adults with mental illness and/or chemical dependency and physical health co-morbidities).

Program Participants:

- Colorado Medicaid is working with two health plans--Colorado Access and Kaiser Permanente--to provide enhanced care management to the state's highest-cost, highest-risk adults with multiple chronic conditions. Approximately 2,000 beneficiaries have enrolled in the Colorado Access pilot since its launch in June 2008, and Kaiser Permanente was slated to begin enrollment in spring 2009.
- New York Medicaid is implementing seven regional demonstration pilots that will test an interdisciplinary model of care to improve health care quality, ensure appropriate use of services, improve clinical outcomes, and reduce the cost of care for beneficiaries with medically complex conditions. The pilots will be based in New York City, Long Island (Nassau County), Capital District Region (Albany County), Western Region (Erie County), and Westchester County.
- Pennsylvania's Medical Assistance program will integrate physical and behavioral health services for adults with serious mental illness and physical health co-morbidities within two regional pilot projects. The pilots will pair a physical health managed care organization (MCO) with their respective county behavioral health MCO. The pilots will each enroll up to 3,500 beneficiaries.
- Washington Medicaid will provide intensive care management and care coordination for adults with chronic physical needs and mental illness or substance abuse issues. King County Care Partners--a partnership of King County Aging and Disability Services, Harborview Medical Center, and four community health center networks--is coordinating the initial Seattle area pilot for approximately 500 fee-for-service beneficiaries. Enrollment began in February 2009. A second Washington State pilot will explore working with select community mental health centers to identify patients who need assistance managing chronic medical conditions.

Key Features and Innovations:

Integrated Care Collaboratives: Through the *Rethinking Care Program*, CHCS is working with state-led multi-stakeholder collaboratives to design and test the new care management interventions described above for their

highest-need, highest-cost beneficiaries. The goal is to promote strategies to better care for the top 5-20% of Medicaid beneficiaries whose care needs account for a significant portion of Medicaid expenditures. State pilot projects are designed to: 1) identify patients who are most likely to benefit from enhanced care management; 2) develop tailored care management interventions; and 3) rigorously measure quality and cost outcomes. Pilots are currently underway in four states.

National Learning Network: Solving the quality and cost conundrum for high-opportunity Medicaid beneficiaries requires regional innovation and national attention. The *Rethinking Care Program* is convening a national network of leading health care and policy experts to build consensus on rapid cycle testing of new models and tools to develop the evidence base in terms of both quality and costs. These national experts are working with CHCS to analyze the policy and administrative barriers to innovation and identify ways to realign financing to support quality improvement.

Initiative Partners:

In addition to CHCS, the *Rethinking Care Program* involves multiple local and national stakeholders, including Medicaid agencies, health plans, provider systems, consumer groups, health services researchers, and evaluation partners (e.g., MDRC, Mathematica Policy Research, universities). The four-year initiative is supported by multiple funders, including the Aetna Foundation, Robert Wood Johnson Foundation, and Kaiser Permanente Community Benefit, with local support from the New York State Health Foundation, and the Colorado Health Foundation.

Demonstrating Success:

Rigorous external evaluation of the *Rethinking Care Program* pilots will determine which interventions work best for which subsets of patients and whether those interventions are cost effective. These findings will contribute significantly to the emerging evidence-base on clinical and cost-effective solutions for serving beneficiaries with serious, co-morbid conditions. Lessons will be widely disseminated.

Anticipated Lessons:

Most high-need, high-cost Medicaid beneficiaries have multiple chronic conditions and generally do not receive appropriate integrated care within fragmented fee-for-service care. This often results in poor health outcomes, diminished quality of life, and unnecessary costs, which hamper the ability of states to pursue coverage expansions and other priorities. As states look for ways to ease budget pressures, it is important that the complex needs of these beneficiaries are better understood. The lessons from the *Rethinking Care Program* will help Medicaid stakeholders, as well as other purchasers, especially Medicare, the Veterans Administration, and employers with aging workforces, design more responsive programs for these patients to both improve their care and control spending.

For more information, go to:

http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=676169

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Central City Concern Housing Rapid Response *Chronically Homeless Adults – Old Town Neighborhood of Portland, Oregon*

Central City Concern (CCC) is a 501(c)(3) nonprofit agency serving single adults and families in the Portland (OR) metro area who are impacted by homelessness, poverty and addictions. Founded in 1979, the agency has developed a comprehensive continuum of affordable housing options integrated with direct social services including healthcare, recovery, and employment. CCC's Housing Rapid Response (HRR) is an award-winning program providing rental assistance and basic support services for chronically homeless adults, helping them transition from life on the streets into self-sufficiency. Such individuals tend to use a disproportionate amount of public resources, especially from repeated incarceration, as well as other forms of emergency services such as uncompensated healthcare. To best meet the needs of this vulnerable population, and to reduce their reliance on public resources, HRR helps these at-risk individuals stabilize in housing and access primary and behavioral healthcare and addictions treatment.

Targeting the Population:

Those served by HRR have been homeless for long periods of time (in many cases, close to a decade), and may be experiencing mental health and/or medical concerns, substance abuse and have a significant history of participating in various lower level crimes that generally affect neighborhood livability. These individuals are identified and referred into the program by the Service Coordination Team which is comprised of members of various community partners including, but not limited to, Portland Police Bureau, Portland Business Alliance (the downtown Chamber of Commerce), residential and outpatient alcohol and drug treatment providers, and mental health service providers.

Program Participants:

Participants' long histories of homelessness are due to a variety of interrelated issues such as chemical dependency, mental illness, physical disabilities, chronic medical conditions and a history of involvement with the criminal justice system.

Key Features and Innovations:

HRR utilizes relevant best practices to meet these vulnerable clients where they are, helping them facilitate positive changes at their own rate. Participants referred into the program by the Service Coordination Team are assessed for appropriate services which may include transitional housing, inpatient, or outpatient addictions treatment and mental health services. The overall goal for participants is to attain permanent housing and become self-sufficient. Once housed, HRR case managers and staff (including alcohol and drug counselors and peer mentors) leverage CCC's established framework of treatment and support options to provide culturally appropriate, multidisciplinary, integrated services. This approach contributes to immediate stability across multiple life domains, allowing HRR clients – with continued support from HRR staff – to focus on long term issues such as maintaining recovery, maximizing health, accessing entitled benefits, and pursuing employment.

Initiative Partners:

HRR is supported by a number of local stakeholders including the City of Portland (Police Bureau, Office of Neighborhood Involvement, Bureau of Housing and Community Development) and the Portland Business Alliance. The approach is also earning local recognition as well – in 2006 HRR was awarded the prestigious Gilman Award for Exemplary Achievement by the Community Development Network, honoring extraordinary innovation and positive community impact.

Demonstrating Success

Current data show that 90 HRR clients have been permanently housed since inception. At any time, up to 20 clients are stabilized in Alcohol and Drug Free Community transitional housing and 35 in low barrier transitional housing. HRR operates on a "stages of change" model, with clients able to move between different kinds of housing depending on their readiness to address addiction issues. Participants in the HRR program also have

the opportunity to participate in inpatient and/or outpatient drug and alcohol treatment through other Service Coordination Team providers. Because of the outreach and engagement services and case management by the HRR team, frequent offenders who might otherwise be engaged in the community justice system are off the streets, stabilized in housing (or working towards housing) and accessing supportive services such as primary and behavioral healthcare, outpatient and residential chemical dependency treatment, employment services, benefits acquisition, and intensive case management. Data related to police involvement show a 59% decrease in client arrests after HRR involvement. Clearly, the program is successfully engaging and supporting some of the hardest to serve members of the community in a humane, cost-effective manner.

Lessons Learned:

HRR is operated by CCC's Community Engagement Program (CEP), a multidisciplinary case management program that provides housing, intervention, and healthcare services to chronically homeless adults. CEP's substantial experience and successes in engaging these hard to serve clients is well documented – a recent outside evaluation found that CEP generates a savings to the community of over \$12 million annually in reduced hospitalizations and jail time, or \$15,006 per person per year. Leveraged from this proven approach, HRR is also having a significant positive impact, providing effective support and services to those in need, reducing strain on public resources, and enhancing livability and public safety issues in downtown Portland.

For more information, go to:

<http://www.centralcityconcern.org/hrr.htm>

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Central City Concern Recuperative Care Program *Housing Low-Income & Homeless Adults Upon Hospital Discharge – Portland, Oregon*

Central City Concern (CCC) is a 501(c)(3) nonprofit agency serving single adults and families in the Portland metro area who are impacted by homelessness, poverty and addictions. Founded in 1979, the agency has developed a comprehensive continuum of affordable housing options integrated with direct social services including healthcare, recovery and employment. CCC created the Recuperative Care Program (RCP) in 2005 to enable patients to go home from the hospital to CCC housing with staff to care for them.

Targeting the Population:

Operating under CCC's Old Town Clinic, the RCP provides post-hospitalization healthcare services for low-income and homeless patients who have received medical care but need continuing attention in order to effectively recover. RCP staff works closely with Portland area hospitals and CareOregon to identify patients in need of respite care

Program Participants:

RCP participants are referred directly from local hospitals and after an initial screening are transported to designated RCP "beds" in CCC housing.

Key Features and Innovations:

Once placed in the RCP, participants receive:

- Intensive case management;
- Access to continuing healthcare at the Old Town Clinic;
- Access to alcohol and drug treatment through CCC (detox and outpatient);
- Safe, stable transitional housing;
- Client monitoring;
- Food boxes;
- Assistance making and keeping appointments with agency and non-agency healthcare providers (including transportation); and
- Discharge planning including follow up monitoring, ongoing case management and assistance securing transitional/permanent housing (either operated by CCC, or in the community).

RCP case managers check on patients daily, take them to follow-up appointments and ensure that they eat regularly and safely take their medications. If patients exhibit the need for additional medical care – from basic needs to addiction and/or mental health concerns – RCP connects them to Old Town Clinic's array of services. RCP patients also learn how best to use the healthcare system. The staff teaches them to use their primary care home rather than the local ED. Once patients stabilize, they can focus on rebuilding their lives with CCC specialists there to help them get supportive housing, food stamps, skills training, work and other resources to become self-sufficient.

Initiative Partners:

- Providence Health Systems
 - Portland Medical Center
 - St. Vincent's Hospital
- Legacy Health Systems
 - Emanuel Hospital
 - Good Samaritan Hospital
 - Mt. Hood Medical Center
- Oregon Health and Sciences University
- CareOregon
- Kaiser Sunnyside Hospital

Corporation for Supportive Housing
Frequent Users of Public Services

- Portland Adventist Medical Center
- City of Portland, Bureau of Housing

Demonstrating Success:

Since its inception in 2005, the RCP has:

- Served more than 540 people;
- Had a successful discharge rate (full recovery and completion of care) of 76%; and
- Discharged 77% of all participants to housing: permanent, transitional, with family/friends or other stable housing.

Lessons learned:

The Recuperative Care Program not only improves the health of at-risk patients by reducing unnecessary recidivism and discharging people onto the street, but it also improves the efficiency of hospitals. Quality recuperative care reduces the frequency of return visits to an emergency room, significantly lowering hospitals' costs and saving critical resources to meet other needs.

For more information, go to:

<http://www.centralcityconcern.org/rcp.htm>

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Chicago Housing for Health Partnership *Chronically Ill Homeless People Upon Hospital Discharge – Chicago, Illinois*

In 2002, a multi-disciplinary group of health care, respite care, and housing providers in Chicago came together to serve homeless individuals with chronic medical health conditions. The Chicago Housing for Health Partnership (CHHP) is a “hospital-to-housing” effort that identifies chronically ill homeless individuals at hospitals, moves them to permanent supportive housing, and provides them with intensive case management services so that they can maintain their health and secure long-term housing stability. The program addresses the fact that one of every three inpatients (32.4%) at Chicago’s Cook County Hospital was homeless or at high risk for homelessness during a study period in 2006.

During an 18-month research phase, CHHP researchers – the Collaborative Research Unit of Stroger Hospital, Cook County Bureau of Health – used a randomized control trial design to study the number of hospital, emergency room, and nursing home visits incurred by two groups: individuals who received CHHP supportive housing, compared to those who received “usual care,” a piecemeal system of emergency shelters, family, and recovery programs. The information was used to track health outcomes and assess how much in avoidable medical expenses could be saved through stable housing and increased access to primary care, rather than ongoing reliance on costly hospital visits and nursing home stays. A sub-study of the 25% of CHHP participants living with HIV/AIDS also compared health outcomes between those who were by through the CHHP program and those who continued with “usual care.”

Targeting the Population:

Chronic medically ill homeless adults that are hospitalized at one of three partner hospitals are eligible to receive CHHP services if they are:

1. Homeless – with no source of stable housing for the last 30 days; and
2. Have a chronic medical condition – with a diagnosis of at least one condition that normally increases the morbidity and mortality among homeless individuals or in the general population: HIV/AIDS infection; renal disease; liver disease; history of arrhythmia; congestive heart failure; cancer; coronary artery disease; severe asthma; chronic obstructive pulmonary disease (emphysema); cerebrovascular disease (stroke); seizure disorders; diabetes; and/or sickle cell anemia.

Program Participants:

The CHHP research study followed 405 chronically ill homeless persons over an 18-month period following discharge from Chicago hospitals. Participants had high rates of long-term substance abuse (86%), mental illness (46%), and medical issues such as HIV/AIDS (36%) and hypertension (33%), as well as a number of other chronic medical illnesses such as diabetes and cancer. The median duration of homelessness among study participants was 30 months and 60% reported drug use within the last month.

Key Features and Innovations:

The CHHP intervention, developed by the project consortium of hospitals, respite care centers, and housing agencies, has three integrated components:

- Expedited hospital discharge – participants receive hospital discharge planning from an on-site intervention social worker, including plans for discharge to respite care facility for transitional care between hospitalization and permanent housing.
- Housing First – placement in permanent, stable housing.
- Specialized Case Management Services – delivered through a Systems Integration Team (SIT), composed of case managers from the partner hospitals, respite programs and housing providers.

In this Housing First model, the chronically ill homeless are placed or stabilized in appropriate stable housing first. The CHHP consortium explains that this is a paradigm of change but makes sense given that we know that the underlying causes of homelessness can best be addressed once a person is housed. They note that

research is showing that providing services in a permanent housing setting leads to better outcomes and is less expensive than the cost of habitual shelter stays and the emergency medical services often required by the chronically ill homeless. This does not mean participants do not need case management, substance abuse treatment, employment training or other supports. It means that they are linked to these “wrap around” services that best meet their immediate and long-term supportive service needs. The fundamental shift is that services are transitional; housing is permanent.

In the summer of 2007, CHHP evolved from a demonstration project to a permanent citywide collaboration between 15 healthcare, housing, and social service agencies. Led by the AIDS Foundation of Chicago, CHHP currently provides 180 permanent housing subsidies for homeless individuals who are discharged from three area hospitals.

Initiative Partners:

Project Partners 2003 – 2007:

Stroger Hospital Medical Center
Mount Sinai Hospital Medical Center
VA Great Lakes Health Care System
AIDSCARE
Christian Community Health Center
Chicago Christian Industrial League
Chicago House
Deborah’s Place
Featherfist
Franciscan Outreach Association
Heartland Human Care Services
Housing Opportunities for Women
Interfaith House
Mercy Supportive Housing
Lawson YMCA
Vital Bridges
AIDS Foundation of Chicago

Funders:

HUD: Supportive Housing Program / Housing Opportunities for Persons With AIDS
Michael Reese Health Trust
AIDS Foundation of Chicago
Baxter International Foundation
Chicago Community Trust
Grant Healthcare Foundation
Polk Bros Foundation
Prince Charitable Trusts
Field Foundation
Siragusa Foundation

Demonstrating Success:

An 18-month randomized controlled trial compared hospitalizations, hospital days, ED visits, and nursing home stays among 201 chronically ill homeless persons in the intervention group and 204 members of the “usual care” comparison group. Results were recently reported in the *Journal of the American Medical Association*. (Sadowski, et al., 2009). Also recently published are the results of an HIV sub-study of health outcomes among the 36% of CHHP demonstration project participants living with HIV/AIDS (Buchanan, et al., 2009). Still to come are final results of a comparison of nursing home days used by the two study groups, as well as a cost-benefit analysis comparing health care savings to the cost of the CHHP housing intervention.

Impact on health care utilization: Despite high rates of mental illness, substance use, and other factors thought to an individual’s ability to remain stably housed, at 18 months 66% of the intervention group reported stable housing compared to only 13% of the “usual care” group. This stability translated into significant reductions in avoidable emergency and inpatient health services. Controlling for a range of individual and service variables, housed participants had 29% fewer hospitalizations, 29% fewer hospital days, and 24% fewer ED visits than their “usual care” counterparts. As the authors note, for every 100 chronically ill homeless persons offered the intervention, the expected benefits over a one-year period would include 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer ED visits. (Sadowski, et al., 2009).

Impact on HIV health outcomes: Among CHHP study participants living with HIV/AIDS, housed participants also experienced significantly better health outcomes than those who continued in “usual care.” A sub-study examined the impact of housing on HIV disease progression. After twelve months, 55% of HIV-positive participants who received a CHHP housing placement were alive and had “intact immunity,” compared to only 34% of the HIV-positive participants randomly assigned to “usual care,” and members of the intervention group were almost twice as likely at 12 months to have an undetectable viral load (40%) as those who did not receive housing (21%). (Buchanan, et al., 2009).

Impact on nursing home days: CHHP researchers became aware during the course of the study of the potential significance of nursing home costs among study participants. Preliminary results show that 23% of participants had a nursing home stay during the 18-month study period, and that almost half of these (48%) were short-term, temporary stays. A full analysis of nursing home costs among CHHP participants is still ongoing but preliminary results indicate that housed participants used only half the number nursing home days as their usual care counterparts.

Cost-benefit analysis: Also, still to come is a full cost-benefit analysis that will compare the cost of the CHHP intervention to health care savings. Preliminary results published in a March 2008 *Wall Street Journal* article indicate that the reductions in avoidable health care utilization translated into annual savings of at least \$900,000 for the 200 housed participants, after subtracting the annual \$12,000 expense per participant of providing the CHHP supportive housing intervention.

Lessons Learned:

- Regular, coordinated meetings of program partners are key to the success of the partnership. Program directors meet regularly to discuss implementation issues and share information on what was happening in their programs. A coordinator also regularly convenes social workers and case managers for training, to discuss practice issues, and to coordinate the care of shared clients.
- Sustainability depends in part upon who pays for the coordinator to keep the relationships working – the CHHP coordinator is funded as a support service position through a HUD grant.
- It is also a key to sustainability to have high level, middle level, and grassroots networks in place, as well as cross-system relationships, since change at the top level of governmental partners is inevitable.
- Data on the success of the program has been the most important factor in making it politically difficult or impossible to shut the program down.
- Equally important is showing institutions their self-interest in the success of programs. CHHP hospitals would not have participated if CHHP had not been able to pay for staff in these agencies.
- Given the multiple challenges faced by participants, it is critical to offer clients the option to move between collaborating housing providers and among participating sites.

For more information, go to:

<http://www.aidschicago.org/care/chhp.php>

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Direct Access to Housing

Homeless Adults with Mental Health, Substance Use, and Chronic Medical Conditions – San Francisco, California

Established in 1998, the San Francisco Department of Public Health's (SFDPH) Direct Access to Housing (DAH) program provides permanent housing with on-site supportive services for approximately 1,100 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions. SFDPH, with a budget of over \$ 1 billion annually, operates a large public hospital, a large publicly funded skilled nursing facility (1,200 beds), 26 primary care and mental health clinics, and contracts for a broad array of services through community-based providers. Finding appropriate housing for individuals who have few family or community connections is a major challenge for staff of these public or community-based organizations. Without access to a stable residential environment, the trajectory for chronically homeless individuals is invariably up the "acuity ladder" causing further damage and isolation to the individual and driving health care costs through the roof. The DAH program was developed in an attempt to reverse this trajectory through the provision of supportive housing directly targeted toward "high-utilizers" of public health system. DAH is a "low threshold" program that accepts single adults into permanent housing directly from the streets, shelter, acute hospital or long-term care facilities. Residents are accepted into the program with active substance abuse disorders, serious mental health conditions, and/or complex medical problems.

Targeting the Population:

Residents are specifically referred to the DAH program if they are high users of the public health system and have on-going substance abuse, mental illness and/or medical problems. Residents do not need to be recipients of SSI or general assistance. Building staff work to "screen in" prospective tenant rather than looking for reasons to deny housing. Many of the individuals housed in the DAH program have been unable or unwilling to maintain permanent housing for any extended period of time in their adult lives. Persons who are gravely disabled and/or have a skilled nursing need cannot be accommodated in DAH housing. Access to DAH is through a centralized intake process where potential residents are prioritized based on severity of illness. As different buildings within DAH have different staffing patterns, the intake team matches the needs of each individual referred with the appropriate level of service. As new buildings are developed, the DAH intake team reaches out to specific agencies that serve individuals in the greatest need of housing resources. The first DAH facilities were designed to house people directly from the streets and therefore a large percentage of the units are controlled by agencies such as Healthcare for the Homeless and other outreach teams that serve people who are street based or staying in emergency shelters. More recently, residents have come from medical and psychiatric institutions that serve a high percentage of homeless patients.

Program Participants:

The DAH Program's targeted population--chronically disabled homeless adults with histories of severe, persistent mental and emotional disorders--typically has trouble sustaining connections to public support agencies and consequently is unable to maintain stable treatment or housing arrangements. Many not only have histories of hospitalization, but also of institutionalization, substance abuse, poor medication compliance, and difficulty in living independently and participating in structured activities. Undocumented immigrants are also admitted. Participation in treatment and services is encouraged but not required.

Key Features and Innovations:

The DAH program provides 1,100 units of permanent supportive housing in nine Single Room Occupancy (SRO) hotels, five newly developed properties, and one licensed residential care facility ("board and care"). In most of the buildings, including SROs or apartment buildings, people live independently in their own units but have support services on site as well as 24 hour desk clerks. One building is a residential care facility with a higher level of support on site and shared rooms. Additionally, the DAH Program has secured blocks of specific units in several buildings owned and operated by non-profit providers. In these instances, the DAH program pays for the subsidies and some support services but does not provide support services and property management funding for the entire building. The DAH buildings range in size from 33 to 106 units. A majority

of the units have private baths and shared cooking facilities. At the residential care facility, three meals per day are prepared for the residents. For the renovated SRO sites, SFDPH acquires sites for the DAH program through a practice known as “master leasing.” The main benefits of this approach include the ability to rapidly bring units on-line and the reliance on private capital for the upfront renovation costs. In addition, the renovated buildings combined with on-site services stabilize properties that have often been problematic for the surrounding neighborhood.

The key components of SFDPH’s housing strategy for renovated SROs include:

1. Identifying privately-owned buildings that are vacant or nearly vacant where the building’s owners are interested in entering into a long-term lease with SFDPH. These are triple net leases with the owner retaining responsibility only for large capital improvements.
2. Negotiating improvements to the residential and common areas of the building prior to executing the lease. It is the owner’s responsibility to deliver the building with improvements completed and in compliance with all health and safety codes. Improvements typically include build-out of supportive service and property management offices, community meeting rooms, community kitchens, and additional bathrooms. All rooms are fully furnished prior to occupancy.
3. SFDPH contracts with one or more organizations to provide on-site support services and property management. Most buildings include a collaborative of two or more entities.

All fifteen sites have between three and seven on-site case managers as well as a site director. Most of the case managers are bachelor’s level social workers though some have advanced social work degrees. Site directors are generally master’s level, licensed social workers or registered nurses. Case managers assist residents to access and maintain benefits, provide one-on-one substance use, mental health, life skills and family counseling, assist in accessing medical and behavioral health (mental illness and substance abuse) treatment, assist with accessing food and clothes, and interface with property management to assist in preventing eviction.

All sites have access to medical care. Most residents have primary care providers at one of the public health clinics or at the Housing and Urban Health Clinic (HUHC). At the recuperative care facility there is around the clock nursing services. Four sites have five-day-a-week nursing services and a dedicated mid-level practitioner to assist with urgent care and access to primary care. The sites with nurses can offer residents directly observed therapy for psychiatric and medications five days a week. The other sites have access to an on-call nurse practitioner for urgent care home visits. All residents of the DAH buildings can use the primary care and psychiatric care services at the HUHC. The HUHC provides services five days a week and is available to all residents by appointment and drop-in for both mental health and medical care. At all sites, staff meet monthly with the medical director for the DAH program to assist with medical treatment plans and to strategize on how to access appropriate medical and psychiatric care in the community.

Initiative Partners:

DAH master leases buildings from private owners, as well as secures blocks of units in buildings owned and operated by non-profit housing providers. SFDPH contracts with one or more organizations to provide on-site support services and property management. Most buildings include a collaborative of two or more entities. The SFDPH Housing and Urban Health Clinic (HUHC) is the medical partner.

Funding:

Funding for the DAH program comes predominantly from the city general fund. Other revenue sources used by the health department to support the program include state money targeted toward homeless mentally ill persons, Ryan White Care Funds, Substance Abuse and Mental Health Services Administration, and reimbursement through the Federally Qualified Health Center system for a portion of the medical and mental health related expenses. Approximately 80% of DAH residents receive Supplemental Security Income and Medi-Cal (California’s Medicaid system) benefits. DAH also receives revenue from tenant rent. Residents pay between thirty and fifty% of their income (depending on building) toward rent. Total cost to provide permanent

housing and support services in DAH buildings (excluding the one licensed residential care facility) is approximately \$1,500 per month/per resident. The average rent received from a resident is \$350 per month, thereby requiring a \$1,150 per month subsidy from governmental sources.

Demonstrating Success:

The main goal of the DAH program is to provide housing to a group of people that have rarely, if ever, maintained stable housing as adults. Since opening the first DAH site in 1998, almost two-thirds of the residents have remained housed in the DAH program. Of the remaining one-third of the residents who moved out of the program, half moved to other permanent housing. Only 4% of residents were evicted from the housing facilities. Evictions usually resulted from repeated non-payment of rent (despite mandatory third party rent payment services), violence or threats to staff or residents, or destruction of property.

Given that the health department funds DAH, an important outcome measure is health care utilization before and after placement in the program. Overall, DAH residents use a considerable amount of health care services prior to entering the DAH facility. Each DAH resident averaged 12 visits to outpatient medical services in the year prior to placement in the facility. After placement, there is little change in outpatient visits, in part because on-site case managers encourage residents to maintain primary care appointments. However, there are significant reductions in residents' use of emergency and inpatient medical services following placement. In the most recent building evaluated, the median reduction in annual health care costs to Medi-Cal per resident was \$20,000, as compared to costs in the year prior to moving in.

About one-sixth of residents had exacerbations of their mental illness leading to psychiatric hospitalization, both before and after placement in the program. However, the number of days per hospitalization decreased significantly after placement. This is not surprising as discharge from psychiatric hospitalization is often delayed due to lack of available appropriate community based housing. The DAH program routinely holds a resident's permanent housing unit during a period of acute exacerbation of their mental illness.

Lessons Learned:

The Direct Access to Housing Program (DAH) emerged from a City-sponsored planning process in San Francisco that brought together consumers, providers, and local policy makers to address the critical need for safe, affordable housing for people with mental illness, particularly those exiting institutions in the mental health, substance abuse, and criminal justice systems. DAH is an initiative of the Housing and Urban Health (HUH) unit within the Community Programs Division of the San Francisco Department of Public Health (SFDPH). HUH funds and controls access to housing units that are master leased from private owners and infused with supportive services and professional property management.

All residents in the DAH facilities have tenant rights and all services offered to residents are voluntary. On-site support service staff actively engages residents and attempt to assist individuals in making choices that reduce their physical, psychiatric or social harm. Over time, as residents develop trust in the on-site staff, the resident is able to work with the staff to develop and adhere to an individualized treatment plan. For residents that are unable or unwilling to accept offered services and/or to reduce harmful behavior, staff continues to regularly engage residents in dialogue and continue to offer services. A considerable amount of staff meeting time and supervision is spent supporting staff to maintain empathy and engagement with residents despite some resident's poor choices and outcomes.

For more information, go to:

<http://www.sfdph.org/dph/files/reports/StudiesData/Homeless/HomelessSvcsRpt1022004AppendC.pdf>

See also: Kessell, E.R., Bhatia, R., Bamberger, J.D., Kushel, M.B. (2006). Public Health Utilization in a Cohort of Homeless Adult Applicants to a Supportive Housing Program. *Journal of Urban Health*, 83: 860-873.

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Downtown Emergency Service Center (DESC) 1811 Eastlake *Chronically Homeless Adults with Severe Alcohol Problems – Seattle, Washington*

The Downtown Emergency Service Center (DESC) is a non-profit organization working to end the homelessness of vulnerable people, particularly those living with serious mental or addictive illnesses. DESC opened the 1811 Eastlake project in December 2005. 1811 Eastlake, located just north of Seattle's downtown core, is a Housing First program with on-site services for 75 formerly homeless men and women living with chronic alcohol addiction who are frequent users of crisis and emergency healthcare services. Nearly half of the residents have a co-occurring mental illness and almost all have other chronic and disabling health conditions. Chemical dependency treatment and mental healthcare are provided onsite. Residents are encouraged, but not required, to participate in treatment, nor is sobriety required as a condition of tenancy. DESC partnered with the Addictive Behaviors Research Center at the University of Washington to rigorously evaluate the effectiveness of 1811 Eastlake. The recently-completed three-year study was funded by the Robert Wood Johnson Foundation.

Targeting the Population:

DESC partnered with county officials to deliberately seek out the most expensive consumers of taxpayer-funded crisis services, including Harborview Medical Center, the Dutch Shisler Sobering Support Center, and the County's detox facility and jails. Through DESC staff outreach at the Sobering Center, in shelters, and other places eligible individuals were contacted and offered tenancy in the project. Only four of the initial 79 people contacted turned down the offer of housing at 1811 Eastlake, disproving widely held beliefs that "some homeless people don't want housing."

Program Participants:

Among residents during the first 12 months of operation of 1811 Eastlake:

- 94% were men (far higher than the 71% served in other DESC permanent housing) and the average age was 48 years (on par with other DESC housing).
- The average resident reported being homeless 31 of the 36 months prior to moving in. In total, residents of 1811 Eastlake spent 9,043 bednights in DESC shelters, an average of 103 nights each.
- The group was overwhelmingly disabled with chronic health conditions, many resulting from a lifetime of alcohol addiction. Forty-four percent had co-occurring severe mental illnesses, 61% had hepatitis or other liver disease, 42% had seizure disorder, and 23% had heart disease.
- The average annual income of residents was \$4,160 (or \$346 a month).
- The one-year retention rate was 66%. Seven people died in the first year, including one who died after moving out. Of those who moved out, 16 returned to homelessness, two moved to long-term treatment, one to a nursing home, and one to other supportive housing.

Key Features and Innovations:

1811 Eastlake aims to improve the lives of its residents through reduced alcohol consumption, better health care, and increased stability. It seeks to reduce residents' use of the community's crisis response system, reduce public nuisances and encourage residents to undertake, and follow through with alcohol treatment.

DESC is the only provider in the Seattle area to have converted all of its housing stock to Housing First practice. As the name suggests, Housing First practice dispenses with decades of trying either to reward people with housing for achieving some pre-determined clinical goal or trying to predict who is "ready" for housing. Instead, Housing First is simply a practice that gets people into housing, because it is a basic human right, and it makes more sense to try helping someone with a major mental illness, addiction, or developmental or other disability once the chaos of living on the streets has been eliminated.

Residents at 1811 Eastlake have no treatment requirements but on-site case managers work to engage residents about substance use and life goals. Residents benefit from 24-hour, seven day a week on-site supportive services including:

- State-licensed mental health and chemical dependency treatment.
- On-site health care services.
- Daily meals and weekly outings to food banks.
- Case management and payee services.
- Medication monitoring.
- Weekly community building activities.

Initiative Partners:

Public funders:

City of Seattle

King County

Federal Home Loan Bank, Seattle

U.S. Department of Housing and Urban Development

Washington State Housing Finance Commission

State of Washington, Department of Community, Trade and Economic Development

Friends and supporters:

The Downtown Seattle Association

Enterprise Community Investment

The Enterprise Foundation

Graham and Dunn PC

The Hanley Foundation

HomeStreet Bank

Impact Capital

The Robert Wood Johnson Foundation

Seattle City Council

Seattle Housing Authority

University of Washington, Addictive Behaviors Research Center

Demonstrating Success

An evaluation conducted by the Addictive Behaviors Research Center of the University of Washington evaluated outcomes of the 1811 Eastlake project on public use and costs for 95 housed participants (with drinking permitted) compared with 39 wait-list control participants enrolled between November 2005 and March 2007, and secondarily evaluated changes in reported alcohol use for housed participants and the effects of housing duration on service use.

Researchers collected administrative data from the King County Mental Health Chemical Abuse and Dependency Services Division, Washington Department of Social and Health Services, Harborview Medical Center (HMC), King County Correctional Facility, Public Health–Seattle & King County, and Downtown Emergency Service Center. With participants' written consent, specific itemized data were obtained, including days in jail and number of jail bookings; sobering center visits; HMC ED, inpatient, and outpatient contacts (date of service, length of stay for patient services, and billing amounts); emergency medical service (EMS) calls and transports; use of the Downtown Emergency Service Center shelter; and publicly funded medical detoxification and inpatient drug/alcohol treatment. Claims submitted to Medicaid were also obtained.

Major findings reported in the April 2009 issue of the *Journal of the American Medical Association (JAMA, Vol. 301 No. 13)* included:

- DESC's 1811 Eastlake saved taxpayers more than \$4 million dollars over the first year of operation. Average (mean) annual costs per person while homeless the year before moving in were \$86,062. By comparison, it cost \$13,440 per person per year to administer the housing program.
- Median costs for the research participants in the year prior to being housed were \$4,066 per person per month in publicly funded services such as jail, detox center use, hospital-based medical services, alcohol and drug programs and emergency medical services. The monthly median costs dropped to \$1,492 and \$958 after six and 12 months in housing, respectively.
- During the first six months, even after considering the cost of administering housing for the 95 residents in this Housing First program, the study reported an average cost-savings of 53% – nearly \$2,500 per month/per person in health and social services, compared to the costs of the wait-list control group of 39 homeless people.
- Alcohol use by Housing First participants decreased by about one-third. The median number of drinks for participants dropped steadily from 15.7 per day prior to move-in to 14, 12.5 and 10.6 per day at 6, 9 and 12 months in housing.

Lessons Learned:

DESC has known for years through their experience working with highly vulnerable individuals that when they eliminate the chaos of homelessness from a person's life, social and clinical stabilization occur more readily and are more long-lasting. This study confirmed this is true for the residents of 1811 Eastlake. The lesson for policymakers and practitioners alike is that for this subset of the homeless population, providing housing and on-site services without requirements of abstinence or treatment is significantly more cost-effective than allowing them to remain homeless.

As noted by the authors of the recent JAMA article: "Findings from a rigorous evaluation of the 1811 Eastlake support the basic premise of Housing First: providing housing to individuals who remain actively addicted to alcohol, without conditions such as abstinence or treatment attendance, can reduce the public burden associated with overuse of crisis services and reduce alcohol consumption. Findings suggest that permanent, rather than temporary, housing may be necessary to fully realize these cost savings, because benefits continued to accrue the longer the individuals were housing."

For more information, go to:

<http://www.desc.org/1811.html>

See also: Larimer, M.E., Malone, D.K., Garner, M.D., et al. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *JAMA*, 301(13): 1349-1357.

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EssentialCare Medical Care Management Program

MassHealth Managed Care Participants with Complex Issues – State of Massachusetts

MassHealth is a public health insurance program for low- to medium-income residents of Massachusetts. The national health insurance program called Medicaid and the State Children's Health Insurance Plan (SCHIP) are combined in one program in Massachusetts called MassHealth. The EssentialCare (EC) Medical Care Management program was developed by the Massachusetts Behavioral Health Partnership (MBHP) in collaboration with MassHealth's Primary Care Clinician (PCC) managed care plan for individuals who require the highest levels of care because of complex medical conditions. The goal of the program is to increase access to all healthcare services, to integrate care, and to improve the health status of these individuals.

Targeting the Population:

Participants must be MassHealth PCC Plan Members that have Essential-type coverage and who meet medical criteria. Specifically, EssentialCare Medical Care Management is offered to members with:

- Conditions that require complicated treatment plans.
- Difficulty managing their physical illness.
- Frequent routine or primary care at hospital EDs.
- Difficulty keeping appointments for medical and/or behavioral health service.
- Difficulty staying compliant with their physical or behavioral health medication regimens.
- An "at high risk" rating through predictive modeling software.

Program Participants:

Many individuals who qualify for the program have complex conditions that may include mental illness, substance abuse, as well as chronic illnesses. Since its inception in 2003, the program has served approximately 4,000 members, averaging approximately 450 to 500 members on any given day.

Key Features and Innovations:

Program staff include a Boston-based director and regionally based field clinical care managers. These care managers, RNs, or medical social workers have extensive care management experience in primary/community care settings serving high-risk populations. They are available to meet the member in convenient locations, such as a PCC office, the member's home, a specialist's office, or hospital ED.

Each member is assigned a field care manager who meets with the member in diverse locations, such as a PCC or specialist's office, the Member's home, or at the hospital ED waiting room. Care managers work with the member, their PCC, and other providers to develop an individual care plan that focuses on improving the member's well-being and coordinates covered services.

The plan proposes ways to improve the member's well-being and to ensure continuity of care within the community. Field care managers also identify and refer members to appropriate community resources. They help inform the member about his or her illnesses, monitor medical compliance, assist with transportation issues, coordinate care between providers, and offer the member encouragement and emotional support.

Initiative Partners:

MassHealth is a Massachusetts state program that is overseen by the Executive Office of Health and Human Services. The Federal government pays half of the cost of MassHealth and the state government pays most of the rest.

Demonstrating Success

In a 2005, researchers at the Center for Health Policy Research (CHPR) at the University of Massachusetts

Medical School found the following benefits for members enrolled in EC:

- The rate of office visits declined from an average of 12.1 visits per year prior to enrollment to 7.7 visits per year after enrollment.
- Emergency room visits declined from an average of 1.8 visits per year to 1.1 visit per year.
- Inpatient hospitalization declined from one out of four people having such visits before enrollment to one out of ten after enrollment.
- Those enrolled in EC had significantly fewer gaps in medication refills – four gaps compared to ten gaps before EssentialCare enrollment.
- The average medical costs for participants were reduced by 19% for each member, from \$798 to \$648, a reduction of \$150 per member/per month.

Lessons Learned:

- The Essential Care program under the management of MBHP and the PCC Plan contains all major elements of a successful care management program, as defined by a recent large-scale analysis of best practices in care management.
- The EC program promotes a culture of “providing the right care at the right time” to avoid medical or social crises.
- Care managers have a mission of improving care and obtaining appropriate services for their clients.
- Care managers respond quickly to changing client circumstances.
- The Essential Care program responds flexibly to care manager recommendations.

For more information, go to:

<http://www.masspartnership.com/>

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Frequent Users of Health Services Initiative (FUHSI) *Frequent Users of Emergency Department Services – Six California Counties*

Across California, many hospital EDs are treating individuals who visit hospitals multiple times a year, often because of complex physical, mental, and social needs. Known as "frequent users," these individuals often experience chronic illness, mental health, and substance abuse disorders, and homelessness. Launched in 2002, the Frequent Users of Health Services Initiative (the Initiative) was a six-year joint project of The California Endowment and the California HealthCare Foundation, with program direction and technical assistance provided by the Corporation for Supportive Housing. The Initiative included six pilot programs designed to test new models of care for "frequent users" of hospital EDs. Through grant making and intensive programming, the Initiative focused on building a more responsive system of care to decrease frequent users' avoidable ED visits and hospital stays. The Foundations created the Initiative to encourage innovative, integrated approaches to serving frequent users and to stimulate the development of a cost-effective, comprehensive, coordinated delivery system for health and social services. The Initiative supported innovative approaches that address clients' multiple needs through data sharing, multidisciplinary care, adoption of best practices, and effective engagement of patients in the most appropriate setting. Ultimately, the Initiative aimed to relieve pressure on overburdened systems and promote more effective use of resources.

Targeting the Population:

Frequent users are a small group of people with serious health conditions who also have psychosocial risk factors, including mental health disorders, substance abuse and homelessness, and account for disproportionate costs and time for EDs. These frequent users average:

- 10.3 ED visits each annually, with average annual charges of \$11,388 per patient;
- 1.5 hospital admissions annually; and
- 6.3 inpatient days each, with average annual charges of \$46,826 per patient.

All of the pilot programs included a threshold number of ED visits in their eligibility criteria, which ranged from four to ten visits in one year. In addition to the threshold number of ED visits, some pilot programs required clients to meet psychosocial criteria, such as mental illness, homelessness, or a history of substance use.

Initiative pilot program employed varied methods and strategies to target and engage program participants, including:

- Electronic "flagging system" in EDs for automated referral process.
- Co-location of program staff within the ED for "real time" access.
- Program access to housing vouchers for permanent housing.
- Ongoing case management by program staff for housed clients.
- Program penetration/presence at multiple hospitals across a county.
- Diverse and bilingual program staff.
- Use of incentives to enhance recruitment (phone cards, grocery vouchers, etc.).
- Transportation assistance (bus passes, taxi vouchers, home visits).
- Staff accompanying/attending client appointments.

Program Participants:

Based on data collected across the pilot programs, the dominant profile of a frequent user is a non-white male, age 40 to 59. Notably, only 16% of all participants were married or living with a partner at enrollment. The profile of the population enrolled in these programs varies from site to site, but in aggregate, people identified as frequent users possess the following characteristics:

- 65% have unmanaged chronic illness – most commonly diabetes, cardiovascular disease, chronic pain, cirrhosis and other liver disease, asthma and other respiratory conditions, seizures, Hepatitis C, and/or HIV;
- 53% have an alcohol or substance use disorder;
- 45% are homeless; and

- 32% have mental illness.

About one third (36%) of frequent users have three or more conditions (some combination of mental illness, substance use, homelessness and medical conditions), and 32% have two.

Key Features and Innovations:

The goal of the Initiative was to create a more responsive system of care that proactively addresses patient needs; produces better outcomes; and frees up ED resources for acute medical crises. The Initiative was designed to develop new models to better serve frequent users, replacing a costly and ineffective cycle with ongoing, coordinated, and multi-disciplinary care provided in more appropriate settings.

At the heart of the Initiative are the demonstration projects that test new models of care for frequent users throughout California. In 2003 and 2004, the Initiative selected six communities in California for three-year programs to test different approaches for addressing the needs of frequent users:

- Alameda County – through Alameda Health Consortium;
- Los Angeles County – through Tarzana Treatment Centers (San Fernando Valley);
- Sacramento County – through UC Davis Health System;
- Santa Clara County – through Hospital Council of Northern and Central California;
- Santa Cruz County – through Santa Cruz County Health Services Agency; and
- Tulare County – through Kaweah Delta Hospital Foundation.

Urban and rural sites were selected to identify frequent users, implement new models of care coordination, and determine best practices for both reducing avoidable use of EDs and increasing the quality of life for frequent users. The Initiative projects brought together multiple service providers and streamlined care for this high-risk population. The six pilot programs developed tailored models and interventions to address the range of presenting conditions of frequent users in their hospitals and communities. The models varied from intensive case management provided by licensed clinical staff to less intensive peer and paraprofessional staff-driven interventions. Due to variations in models and types of services provided, staff composition, and the complexity of clients, program costs also varied. Based on estimates, the average cost of Initiative program services was \$4,325 per client annually. Actual program costs across the pilots ranged from \$2,805 to \$5,845 per client annually.

Program interventions varied, but several key components contributed to successful outcomes and changes to the community health care system. Every program employed core elements of case management, incentives for engagement, and transportation assistance.

Initiative models included:

- Six programs in six counties representing partnerships of hospitals, health/human service, housing, behavioral health, criminal justice.
- Five intensive case management, one brief peer intervention.
- Three hospital-based, three community-based.
- Various team compositions ranging from peer counselors and paraprofessionals to multidisciplinary teams – one with social workers and nurses and the ability to bill for direct services.

Key elements of frequent users case management included:

- Connecting patients to both medical and non-medical services (e.g., primary care, mental health, drug and alcohol treatment, housing, transportation).
- Intensive individual support, especially initially.
- Coordination of care.
- Effective linkages between case managers and ED personnel.

Initiative Partners:

Both foundations provided oversight to the Initiative Program Office which supported the grantees, oversaw the Initiative's direction, and provided technical assistance. The Initiative Program Office was part of the California program of the Corporation for Supportive Housing (CSH), a national nonprofit organization that works to prevent and end homelessness.

In collaboration with the Initiative Program Office, an Initiative Advisory Committee of California and national, public and private, thought leaders, clinicians and healthcare administrators, provided strategic guidance on key program elements, review of applicants' proposals, and assistance with developing and advancing the Initiative's policy agenda.

Demonstrating Success

The Lewin Group, a health care policy research and management consulting firm, conducted an external process and outcome evaluation of the Initiative.

Results from the Initiative programs have shown that a multi-disciplinary, coordinated care approach can reduce ED visits and costs, while improving the stability and quality of life for patients.

- 68% of uninsured and eligible clients were approved for Medi-Cal;
- 64% of those uninsured and ineligible for Medi-Cal were linked to county indigent health care programs;
- 61% were connected to a community clinic and 31% were assigned a primary care provider;
- 53% of eligible clients were approved for SSI;
- 42% with mental health issues at enrollment were connected to services;
- 34% of clients were connected to permanent housing; and
- 20% with substance use issues were connected to services.

One of the sites, Project Connect in Santa Cruz, also has data illustrating utilization across multiple systems. Results show that enrolled clients had declines in ambulance use (55%), jail bookings (51%) and jail days (37%).

Lessons Learned:

The significance of housing status. At enrollment, nearly half of all program participants were homeless. Given the prevalence of homelessness among frequent users and an increasing awareness on the part of pilot program staff that housing is a critical factor in addressing the health concerns of this population, connecting clients to housing became a major focus of the Initiative. Among homeless frequent users enrolled in the programs, 12% were connected to permanent housing through HUD Housing Choice Vouchers, and 69% were placed in shelters, board and care homes, or other similar sites. Connecting homeless frequent users to permanent housing made significant differences in a frequent user's ability to reduce ED visits and charges. Those who became connected to permanent housing in the first year of enrollment saw a 34% decrease in ED visits and a 32% decrease in ED charges, compared to just a 12% decrease in visits and a two percent decrease in charges for those clients who remained homeless or in less stable housing. In a comparison of inpatient use among homeless clients who became permanently housed and those who did not, both groups showed similar reductions in the number of inpatient admissions after one year of multidisciplinary services. However, an examination of inpatient length of stay and charges shows striking differences in outcomes. Inpatient days and charges decreased by 27% for permanently housed clients, but for those who remained homeless, inpatient days grew by 26% and inpatient charges increased by 49%.

Individual sustainability = connection to benefits. Connection to health coverage and income security through SSI was also an essential strategy for providing frequent users with stable, reliable access to health care and housing. At the time of enrollment, 63% of frequent users across all programs were either uninsured or underinsured. For these uninsured or underinsured clients, 80% were connected to either county indigent health coverage (64%) or Medi-Cal (16%). For those patients who did not have Supplemental Security Income (SSI)

upon enrollment, 20% of clients were deemed eligible and applied for SSI. Slightly more than half of those applications were approved. The rates of SSI-eligible frequent users who submitted applications varied across the pilot programs. Those with more active benefits advocacy components had greater rates of application submission and approval.

Length of time in the program is a significant factor. The Initiative pilot programs were successful in decreasing frequent users' ED and inpatient visits and the associated charges in these areas after one year of program enrollment. Overall, ED visits dropped by 30% and charges fell by 17%. Inpatient admissions decreased by 14% and charges by eight percent. These results are especially impressive after taking into account the "super frequent users" who accounted for 85% of inpatient charges. For frequent users who were enrolled and tracked for two years, the magnitude of change in ED and inpatient utilization and charges was even greater. By the end of the second year of participation, these frequent users showed considerable decreases in inpatient admissions, days, and charges. The evaluation revealed modest reductions in inpatient admissions and charges and a slight increase in inpatient days in the first year of enrollment. These trends suggest that the initial increase in inpatient days was due in part to clients accessing appropriate primary care through which medical treatment needs, such as surgery, were identified and scheduled. Once clients' health conditions stabilized through these interventions, the need for hospitalization decreased. In addition, during the first year of enrollment, many of these clients were connected to insurance, mental health and substance abuse treatment, housing, and income benefits, which also may have assisted in their overall stabilization.

Lessons Learned:

Hospital EDs are a community resource and the only health care resource that, by law, must serve everyone regardless of a patient's ability to pay. Increasingly, EDs are also used as primary care by insured patients who either lack a medical home or have difficulty accessing their primary care provider. Providing ED and inpatient hospital services can be extremely expensive. Frequent users' hospital visits account for disproportionate costs and time for EDs, drain state and county health care resources, and increase stress on ED staff. Furthermore, EDs are not designed to meet the psychosocial needs of frequent users and do not have the capacity to assist them with housing, substance abuse treatment, and mental health care. For many frequent users, care that is more appropriate can often be provided effectively earlier in less intensive community-based settings. A primary goal of the Initiative was to identify frequent users so they could be redirected to more appropriate settings that could respond to their needs in a more successful, rational, and cost-effective way.

From the inception of the Initiative, there was interest in demonstrating impact on more than just individual patterns of ED and inpatient utilization. Because frequent users slip 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, a central goal was to stimulate the development of a coordinated system of care that would bridge gaps in services, address the underlying needs of frequent users, and promote effective use of health care resources. The findings from the evaluation provide hospitals, service providers, government agencies, and policymakers with evidence of identified strategies that can facilitate an end to inefficient, costly, and avoidable use of acute health services, while improving the stability, health, and quality of life for frequent users.

Translating Experience Into Policy:

Concrete policy initiatives flowing from the FUHSI pilot projects include both local accomplishments and statewide proposals.

The primary local accomplishment is that most of the Initiative programs have become self-sustaining and continue today using other sources of funding (e.g., Medi-Cal billing, contributions from relevant agencies, and case rates paid by hospitals for case management of their frequent users).

Initiative findings are also being used as support for the broader adoption of case management and multidisciplinary care strategies, for frequent user programs and supportive housing, and for increased focus on benefits programs. These efforts include two California initiatives – one to redirect Medi-Cal resources through

the federal waiver process and the other to expand Medi-Cal eligibility as a cost-containment strategy. More information is available in the following CSH policy papers:

- *Frequent Users of Emergency Departments: Addressing the Needs of a Vulnerable Population in a Revised Medi-Cal Waiver*, CSH, 2009.
<http://www.csh.org/data/global/images/MediCalWhitePaperFINAL.pdf>
California is now engaged in a debate about how a revised Medicaid 1115 waiver should be structured. The Administration and the Legislature support a comprehensive waiver that would attract greater federal resources, preserve the health care safety net, improve health outcomes, and expand coverage. A comprehensive waiver also provides a unique opportunity to the State to transform care for frequent users of emergency rooms and other populations with similar vulnerabilities. Through this white paper, CSH promotes the successes of the Frequent Users of Health Services Initiative as well as advocates for a comprehensive waiver that allows for reimbursement for non-medical services, such as case management, transportation, vocational services, and linkage to permanent housing, through community-based providers that are integrated and flexible, that offer services in a range of settings, and that coordinate care for patients who experience difficulties accessing appropriate treatment.
- *Preventing Long-Term Healthcare Costs by Revising Medi-Cal Eligibility*, CSH, 2006.
<http://documents.csh.org/documents/fui/Eligibility.pdf>
Initiative findings show that many individuals who frequently use ED and inpatient hospital services are uninsured and have multiple needs. Only people who are disabled, age 65 or older, pregnant, or have dependent children are eligible for Medi-Cal. Frequent users who are uninsured and lack access to a regular source of medical care are at risk of becoming permanently disabled and in need of expensive long-term care. Extending Medi-Cal eligibility to the small population of ED frequent users could reduce the avoidable use of emergency rooms, decrease the demand on county resources, improve health outcomes for frequent users, and potentially decrease long-term Medi-Cal costs.

For more information, go to <http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=4224&nodeID=83>

See also:

Summary Report of Evaluation Findings: A Dollars and Sense Strategy to Reducing Frequent Use of Hospital Services, Corporation for Supportive Housing, October 2008

<http://documents.csh.org/documents/fui/FUHSISummaryReportFINAL.pdf>

Frequent Users of Health Services Initiative: Final Evaluation Report, *Prepared by the Lewin Group (www.lewin.com) for the California Endowment and the California HealthCare Foundation, August 2008*

<http://documents.csh.org/documents/fui/FUHSIEvaluationReportFINAL.pdf>

Toolkit: Meeting the Needs of Frequent Users: Building Blocks for Success, Corporation for Supportive Housing, January 2009

<http://www.csh.org/index.cfm?fuseaction=page.viewPage&pageID=4251&nodeID=83>

This Toolkit from the Frequent Users of Health Services Initiative (the Initiative) was created to share lessons from a multi-year, multiple-site project that addressed the challenges and barriers facing frequent users of EDs. 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 multiple and complex needs frequent users experience.

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Corporation for Supportive Housing Returning Home Initiative (FUSE Projects)

The Corporation for Supportive Housing's national Returning Home Initiative aims to end the repeated cycles of incarceration and homelessness experienced by thousands of people by placing them in supportive housing upon reentry from prison or jail. Every year in America, 650,000 people are released from prisons and over seven million individuals are released from jail. Among these individuals re-entering the mainstream populations there is a high prevalence of mental illness and other chronic health conditions. Three out of four have a substance abuse problem and more often than not, they are returning to already impoverished communities. CSH launched the Returning Home Initiative in the spring of 2006 with a \$6 million investment from the Robert Wood Johnson Foundation (RWJF) and additional support from the Conrad N. Hilton Foundation, the JEHT Foundation, and the Open Society Institute. RWJF invested an additional \$4 million in June 2009.

A central component of the Returning Home Initiative is the Frequent Users Service Enhancements (FUSE) program model that targets homeless persons with histories of frequent involvement with jails, shelters, mental health services, and other correctional and crisis systems. The FUSE approach integrates the efforts of housing, human service, corrections, and other public systems, and includes a combination of in-reach services and engagement, intensive support services upon release, and linkages to long-term housing and supports. FUSE initiatives are currently underway in New York City, Cook County (IL), Hennepin County (MN), with additional initiatives being designed in Connecticut, Washington, DC, and other jurisdictions.

Targeting the Population:

The Returning Home FUSE initiatives target people with histories of repeated homelessness and incarceration – and in some cases diagnosed mental illness – who are returning from prison or jail to the community. Collaborative data matching across public systems is used to identify and define the group of eligible persons, and then to locate these persons for program outreach or “in-reach.” For example, eligibility for the New York City FUSE program is determined through a quarterly data match between the City's Departments of Correction and Homeless Services to identify people with a minimum of four jail and four shelter stays over the last five years. This replenishing list of approximately 850 to 1,100 individuals is then cross-referenced with the current jail and shelter census to locate potential participants. The Cook County FUSE program includes data from hospitals and the state mental health system in the matching process as well, in order to target services to frequent users of shelter and jail who have also been diagnosed with a serious mental illness.

Program Participants:

The FUSE initiatives serve the small but significant group of persons in their communities who have experienced recent, repeated stays in both shelter and jail, many of whom also have extensive histories of homelessness, chronic health conditions, and substance use and/or mental health problem that make them more likely to experience recurring health crises and a cycle of inappropriate and costly incarceration and crisis care. Among New York City FUSE program participants: 100% are homeless; 30 to 50% have mental health problems; 25 to 40% have been diagnosed with a serious mental illness; and most were arrested for “quality of life” crimes. A 2007 Hennepin County (MN) data match found 266 persons who met the criteria for the planned FUSE program: these 266 persons accounted for 68,566 nights in county jail, shelter or detox during a four-year period; just 60 of these persons accounted for half of the nights in jail or shelter; almost 80% had a behavioral health case open at some point; and 80% had a criminal history that included livability and property crimes.

Key Features and Innovations:

The CSH Returning Home Initiative currently provides guidance and support for four FUSE pilot projects at varying stages of implementation:

- The New York City Frequent User Service Enhancement Initiative provides 201 units of supportive

housing (100 existing units and 101 in lease-up) for people leaving jail who have a minimum of four jail stays and four shelter stays over the last five years;

- The Connecticut Frequent Users of Jail and Shelter Pilot will have a 30-unit capacity to place single adults with at least four jail stays and four shelter stays over the last five years in supportive housing across three Connecticut cities – Bridgeport, New Haven, and Hartford;
- The Cook County (IL) Frequent Users of Jail and Mental Health Services Initiative is providing 120 on-going rental subsidies, with intensive wrap-around services from community mental health services, targeted to the approximately 10,000 people annually with serious mental illness who cycle between homelessness and incarceration in Cook County Jail; and
- The Hennepin County (MN) Frequent Users of Jail and Shelter Program is targeting 50 units of supportive housing to people who have experienced long-term homelessness, have been booked into the Hennepin County Jail or Adult Corrections Facility at least four times in the last five years, are currently on probation, and have little or no income.

The FUSE program models vary based on the population served and the local political, bureaucratic, and budgetary context but each program is designed to break the cycle of repeated homelessness and incarceration by providing affordable housing coupled with support services. All programs share the following key elements:

- Dedicated housing resources – including tenant-based rental subsidies, dedicated supportive housing units, set-aside units in larger supportive housing buildings, or a combination of these types of housing, often provided in collaboration with one or more local housing authorities and human service agencies and administered by non-profit housing providers. In New York City, for example, FUSE program housing resources include sponsor-based Housing Choice Vouchers provided by the New York City Housing Authority and set-aside units in supportive housing buildings funded by the City's Departments of Homeless Services and Health and Mental Hygiene, administered by eight community-based housing and service providers.
- Enhanced services and in-reach – intensive support services during the critical time period from recruitment through stabilization in housing, typically funded through a one-time payment in flexible service funding per tenant. During Round I of the New York City FUSE program, service enhancement funding of \$6,500 per unit was provided by the JEHT Foundation; Round II service enhancements will be provided by the NYC Departments of Correction and Homeless Services, with additional funding from CSH.
- Connection to a range of ongoing services – to link FUSE participants to sustainable, comprehensive medical and mental health services and other support services to ensure housing stability. In Cook County, each program participant will be assigned to one of four community-based mental health providers for initial and ongoing care.
- Public-private collaboration – to target participants, secure needed resources, provide ongoing services, and evaluate outcomes. Each of the FUSE pilot initiatives is funded with a blend of federal, state, local and private philanthropic resources, and program development and oversight includes non-profit housing and service providers, government representatives, evaluators, and CSH.
- Local innovation – to overcome barriers and create opportunities. The New York City Housing Authority granted the FUSE program a criminal justice waiver for “sponsor-based” vouchers that are linked with stabilization and support services that promote public safety and tenant success.

Initiative Partners

Private funding for the Returning Home Initiative has included the Robert Wood Johnson Foundation, the Conrad N. Hilton Foundation, the JEHT Foundation, the Open Society Institute and the Langeloth Foundation. Each of the FUSE pilot programs has also involved broad-based partnerships with public agencies, non-profit providers of housing and services, and local philanthropy. In addition to CSH, current partners include:

- New York City FUSE: New York City's Departments of Correction, Homeless Services, Health and Mental Hygiene, and Housing Preservation and Development; Human Resources Administration; New

York City Housing Authority; eight non-profit housing and service providers; Columbia Center for Homelessness Prevention Studies, and the John Jay College Research and Evaluation Center.

- Connecticut FUSE: Connecticut's Departments of Corrections and Mental Health and Addiction Services; Court Support Services Division; and Office of Policy Management; the Connecticut Coalition to End Homelessness; and non-profit supportive housing providers.
- Cook County (IL) FUSE: the Cook County Sheriff's Office; Chicago Low Income Trust Fund; City of Chicago Department of Housing; Cermak Health Services; Illinois Division of Mental Health; National Institute of Justice; and community service and mental health providers.
- Hennepin County (MN) FUSE: Hennepin County's Departments of Community Corrections, Human Services, and Public Health; Heading Home Hennepin (Hennepin County's 10 Year Plan to End Homelessness); and St. Stephens Human Services.

Demonstrating Success

The New York City program was the first FUSE initiative implemented and has been operating long enough to produce concrete results. The first round of New York City FUSE with 100 supportive housing units has been extremely successful in helping people maintain housing and avoid returns to homelessness. Provider housing data shows that NYC FUSE has a 91% housing retention rate for the first year following placement, and 85% housing retention for all placements ranging up to 34 months in duration.

A preliminary outcomes assessment conducted by the John Jay College Center for Research and Evaluation examined days spent in jail and shelter before and after placement into supportive housing for New York City FUSE clients and a matched comparison group. The group who received FUSE housing and services had a 92% reduction in the number of days spent in shelter, whereas the comparison group only decreased their shelter use by 71% over the year. Likewise, jail days were reduced by 53% for the group who received the FUSE intervention, while compared to only a 20% reduction in jail days for the comparison group. FUSE participants showed significantly increased resilience, extended time in the community, and a reduced rate of cycling between the City's Departments of Correction and Homeless Services. Cost-effectiveness analyses based on these data show a cost offsets to those systems of at least \$2,953 per person, per year – indicating the potential for the program to break even and generate public savings if taken to scale. Columbia University is currently conducting a rigorous evaluation of the initiative that will examine the impact and cost-effectiveness of the intervention.

From a public policy perspective, the Justice Policy Center of the Urban Institute is evaluating the systems change impact of the Returning Home Initiative in New York City, Chicago/Cook County, and Los Angeles to assess progress made increasing collaboration across public agencies and the integration of funding and policy to better serve the target population. In addition, the Urban Institute is conducting two separate evaluations (in the state of Ohio, and Chicago/Cook County, I). These studies focus on measuring the impact of several issues, including: 1) recidivism rates; 2) reductions in homelessness/decrease shelter use; and 3) reductions in the costs associated with multiple service use across the criminal justice, housing/homelessness services, and mental health services systems.

The Urban Institute is also conducting site visits to New York City, Los Angeles, and Chicago/Cook County to explore how various agencies in these three large urban centers have collaborated to increase access to permanent supportive housing for persons with extensive histories of correctional involvement and shelter use.

Lessons Learned:

By providing housing and services that are often difficult to access upon release, supportive housing can stabilize a population whose untreated chronic health, mental health, and substance-use issues would otherwise frequently lead to homelessness, relapse, and recidivism. The FUSE initiatives have already learned a lot about targeting, engaging, and supporting the target populations, as well as about strategies and options for attracting investment by corrections and other public systems. These lessons include:

- Higher than expected administrative burdens, increasing the amount of time needed for program implementation.
- The importance of strong inter-agency commitment, high-level access, and long-term involvement, as well as frequent and regular progress meetings with all project partners.
- Recruitment is complicated by lack of trust in service providers and repeated engagement is often necessary. This requires a shift in provider practice from passive tenant selection to active recruitment; persistent “in-reach” and a “burst” of supports upon release are keys to successful placement.
- Participants’ complex involvements in multiple systems and services also create barriers to eligibility and placement.
- Implementation and evaluation design and approval delays impact the evaluation timeframe and policy discussions; program process benchmarks and implementation progress are not persuasive to policy audiences, who want to see results.

Expected long-term outcomes of Returning Home include: increased collaboration across agencies; better understanding and identification of persons needing targeted services; evidence that supportive housing reduces recidivism; examples of reinvestment of criminal justice system resources in supportive housing; development of more supportive housing champions within the criminal justice system; and creation of more supportive housing for people exiting prisons and jails.

For more information, go to:

<http://intranet.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=4196&stopRedirect=1>

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New York State Chronic Illness Demonstration Project *Medicaid Recipients with Chronic Illness & Special Needs – New York State*

In New York State, 21% of Medicaid beneficiaries incur 76% of the \$47 billion in annual costs of the program. These high cost patients generally fall into six special needs categories: chronically ill, HIV/AIDS, long term care, alcohol/drug users, chronically mentally ill, and mental retardation/developmental disabilities. The State is implementing and evaluating a range of strategies to improve outcomes and contain costs, such as increased ambulatory care payments based on disease burden and complexity of care and enhanced payments for evening and weekend hours. The New York State Chronic Illness Demonstration Project is a \$60 million, three-year initiative that will award five grants to providers in the form of a monthly care coordination fee to assess and coordinate the care of participants.

Targeting the Population:

The demonstration project utilizes a predictive algorithm developed by Professor John Billings from New York University Wagner School targeting patients at high risk (est. 70%) for medical, substance abuse, or psychiatric hospitalization in the next 12 months.

Program Participants:

Eligible patients have had largely uninterrupted Medicaid eligibility but have limited engagement and coordination of care, despite significant consumption of health care resources.

They have significant medical needs:

- 76% have a chronic disease.
- 52% have multiple chronic diseases.
- 69% have a history of mental illness.
- 73% have a history of substance use.
- 54% have a history of mental illness and substance use.

They are not well connected to the health care delivery system:

- 24% have not had a primary/specialty care visit in the prior 12 months.
- 65% have had an emergency room visit in the prior 12 months.

Their average cost to Medicaid in the prior 12 months was \$37,500:

- \$21,000 in hospital costs.
- \$600 in primary/specialty care costs.
- \$2,300 in ambulatory behavioral health costs.
- \$6,500 in medication costs.
- \$1,700 in personal/home care costs.
- \$5,400 in other costs.

Their cost in the next 12 months is expected to be \$46,000 without intervention:

- \$27,000 in hospital costs.
- \$500 in primary/specialty care costs.
- \$3,200 in ambulatory behavioral health costs.
- \$7,300 in drug costs.
- \$2,000 in personal/home care costs.
- \$6,000 in other costs.

Key Features and Innovations:

The Chronic Illness Demonstration Project has awarded funds to geographically diverse providers in the form of a monthly care coordination fee to assess and coordinate the care of participants. Participation in these regional demonstration programs is voluntary for Medicaid-eligible New Yorkers.

Each project is required to have an integrated network of providers to assure facilitated access to medical, mental health, and substance abuse services for participants and collaboration with community-based social

service providers. Projects will provide participants with comprehensive care coordination and work toward improving patient self-management and caregiver/family involvement. Projects must also have provider engagement strategies to assure disenfranchised patients are appropriately served. Each project will have a randomly assigned or other form of control group to assist in the evaluation of cost containment and utilization. Projects will operate for three years and have risk and shared savings arrangements in years two and three.

Each project will have a randomly assigned or other form of control group to assist in the evaluation of cost containment and health care utilization; each will also include a rigorous outside evaluation to incentivize compliance with quality and reporting requirements and health care costs as compared to similarly risk scored control group members.

- Risk Sharing: Thirty% of the monthly coordination fee (MCCF) will be at risk on a per enrollee basis – 10% for quality and reporting requirements and 20% if annual care expenses plus the MCCF exceeds the cost of similarly risk scored control group members); and
- Shared Savings: Projects that meet Quality Reporting Requirements will be eligible to participate in distribution of 50% of shared savings (from a \$6 million fixed pool) if annual care expenses plus the MCCF are below 85% of control group expenditures.

Initiative Partners:

In January 2009, the New York State Department of Health (DOH) announced the creation of regional demonstration projects to address the complex health care needs and social barriers to care for chronically ill Medicaid beneficiaries (http://www.nyhealth.gov/press/releases/2009/2009-01-05_medicaid.htm). The following entities will operate a regional demonstration project (an award in Westchester County is expected to be announced later):

- Metropolitan Region – New York City:
 - New York Health and Hospitals Corporation: serving Brooklyn, Manhattan, and Queens.
 - Institute For Community Living, Inc.: serving Brooklyn and Manhattan.
 - UnitedHealthcare of New York Inc.: serving the Bronx and Queens.
- Long Island Region:
 - Federation Employment and Guidance Services: serving Nassau County.
- Capital District Region:
 - Whitney M. Young Jr. Health Center Inc.: serving Albany, Rensselaer, and Schenectady Counties.
- Western Region – Buffalo:
 - UB Family Medicine, Inc.: serving Erie County.

Demonstrating Success:

The New York State Department of Health will evaluate the efficiency and effectiveness of the health care provided under these programs. Evaluation will include five components: impact on service utilization; impact on cost expenditures; impact on quality/clinical outcomes; assessment of interventions and implementation; and assessment of replicability. Development, implementation, and evaluation of this project are supported by the Center for Health Care Strategies (CHCS), a nonprofit health policy resource center based in New Jersey, and Professor John Billings of New York University. The selected regional entities under this competitive procurement will participate in a learning collaborative led by DOH and CHCS in which best practices from other states and from national research will be shared to enhance the performance of the demonstrations.

Translating Experience into Policy:

New York State legislation passed in 2007 authorized the program to establish geographically diverse chronic illness demonstration projects for Medicaid fee-for-service beneficiaries. Awardees are part of the three-year demonstration that seeks to improve health outcomes and identify cost savings to the Medicaid system. The program will include additional funding to support attainment of quality and cost-containment goals. The overarching goal of these demonstrations is to establish innovative, quality-driven interdisciplinary models of

care designed to improve health care quality, ensure appropriate use of services, improve clinical outcomes and reduce the cost of care for Medicaid beneficiaries with medically complex conditions.

For more information, go to:

<http://www.health.state.ny.us/funding/rfp/0801031003/>

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New York State CASA NIDA Funded Disease Management Study *High Cost Users of Alcohol and Other Drug Treatment Services – New York State*

Individuals with chronic, hard-to-treat alcohol and other drug (AOD) disorders remain a vexing challenge for state governments. As with other chronic diseases, a small proportion of clients absorb a disproportionate share of treatment dollars. Often these clients cycle through crisis episodes with bouts of high-cost acute care followed by poorly coordinated continuing care. As the primary payers, state and county agencies not only are concerned with inefficient spending for AOD treatment but also must contend with supporting multiple crisis services for these individuals. Recently states have been turning to disease management programs (DMP) to control Medicaid costs of caring for chronic illnesses. Despite their enormous promise, relatively few rigorous evaluations of DMPs have been conducted. Thus, important questions remain about whether the DMP strategy will improve care and reduce costs. New York State's Office of Alcoholism and Substance Abuse Services (OASAS) is conducting a three-year, \$25 million Managed Addiction Treatment Services (MATS) demonstration pilot that provides grants to 23 counties to provide case management services to high-cost utilizers of AOD treatment. OASAS's MATS program is the first DMP for substance abuse initiated at a state level.

The National Institute on Drug Abuse (NIDA) is providing the National Center on Addiction and Substance Abuse at Columbia University (CASA) with a grant over five years (2007 – 2012) to develop and test new chronic disease management approaches to addictions. The grant, which was developed by Jon Morgenstern and Charlie Neighbors, will improve upon the OASAS MATS program, with the CASA team providing technical assistance and coaching on strategies for improving care that derive from science (e.g., evidence-based practices) and business strategies (e.g., Continuous Quality Improvement teams). CASA will evaluate the MATS program in two New York counties--Nassau and Albany--to see if the concept saves money and improves outcomes.

Targeting the Population:

The MATS initiative is designed to improve the delivery of health care and other related services to Medicaid recipients requiring treatment for chemical dependence. MATS is focused on intensive case management services to voluntarily participating high cost Medicaid-eligible recipients of chemical dependence services.

Program Participants:

Client characteristics and outcomes will be collected from extensive administrative records. With support from OASAS and the counties, the CASA team will analyze administrative data to address the primary and secondary questions of the study. Additionally, the CASA team will be interviewing key stakeholders to document and summarize key lessons learned about the practical implications of implementing a disease management intervention for chronic addiction.

Key Features and Innovations:

In early 2006, OASAS began implementing the MATS initiative an intensive case management initiative, in various localities throughout the state of New York. MATS is a voluntary program with the goal of helping patients access necessary chemical dependence and other health (e.g., mental health and medical) and support (e.g., food stamps, housing) services through intensive case management. Either the county mental hygiene agency or their case management provider operates MATS programs. Each MATS client is assigned a case manager to help the client coordinate chemical dependence treatment services and learn about and get other necessary services offered by the local department of social services.

CASA will capitalize on this demonstration to mount and rigorously test an innovative disease management intervention for chronic addiction (DM-CA). The DM-CA will be a system level intervention with a framework drawn from recent innovations in health care encapsulated in the Chronic Care Model. DM-CA will be designed to improve monitoring and coordination of care in order to avert crisis events (e.g., inpatient detox) and help engage clients in stabilizing outpatient services, thereby reducing health care costs.

In partnership with national experts in chronic disease care, continuous quality improvement (CQI), and evidence based practice in AOD treatment, the CASA team will work with OASAS and the two New York counties to develop the DM-CA. The intervention will consist of: 1) use of CQI to improve the county/case management teams' ability to achieve the goals of the MATS program; 2) technical assistance on integration of evidence based practices; and 3) use of available data to provide real-time performance feedback to counties. A Learning Collaborative will be chartered for two years that will allow for formalized exchange between Albany and Nassau Counties to foster cross-pollination of ideas as well as speed the dissemination of lessons learned.

Initiative Partners:

The MATS program is carried out at the city and county level through a partnership between the local mental hygiene agency and the local department of social services. County mental hygiene agencies and OASAS fund MATS programs.

Demonstrating Success:

CASA's primary questions with this project include:

- Does DM-CA decrease the number of high-cost, crises days, including medically managed detoxification, inpatient rehabilitation, ED visits, hospitalization for psychiatric destabilization, and medical hospital stays?
- Does DM-CA increase connection to more-stable outpatient care?
- Recent CDC guidelines recommend HIV testing and counseling for all high-risk groups, including substance dependent individuals. Does DM-CA increase rates of HIV testing?
- Does DM-CA reduce Medicaid expenditures?

OASAS also have a set of additional questions that will examine as the data allow:

- Does DM-CA reduce criminal justice events?
- Do client outcomes as examined in the primary questions endure through a second year of follow-up?
- How does the performance of DM-CA implemented in Albany and Nassau Counties compare to case management delivered in the other 20 counties taking part in the MATS initiative?
- What does it cost to deliver DM-CA?

Lessons Learned:

Research has consistently shown that untreated addiction results in significant costs to the health care, criminal justice, and welfare systems, as well as in the workplace. Persons with addictive disease appropriately identified and treated for their addiction problems demonstrate significant reductions in the use of health care resources; decreased involvement with the criminal justice system; reduced reliance on and use of public welfare resources (including cash assistance and foster care and child protective services); and increased ability to retain employment and to function positively in the workplace. Therefore, the goal of MATS is to assure effective and appropriate access to needed treatment services and positive treatment outcomes for recipients of chemical dependence services, combined with enhanced cost-effectiveness in the State's Medicaid program.

CASA anticipates the following products from this endeavor:

- A rigorous scientific evaluation of the effectiveness of a disease management intervention for chronic addiction (DM-CA).
- A state-of-the-art economic study of savings associated with DM-CA that cannot be attributed to factors unrelated to DM-CA (e.g., regression to the mean).
- A benchmarking study of MATS case management outcomes across the state.
- A description of model practices that would be integral to an evidenced-based disease management program for addictions.

For more information, go to:

<http://www.casacolumbia.org/absolutenm/templates/PressReleases.aspx?articleid=505&zoneid=65>

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New York City Managed Addiction Treatment Services (MATS) *High Cost Users of Alcohol and Other Drug Treatment Services – New York City*

More than 4,200 NYC Medicaid recipients fall in the category of “high-users of alcohol and other drug (AOD) treatment services,” currently defined as annual per patient costs to Medicaid equal to or greater than \$30,000 for AOD treatment services. The New York City Managed Addiction Treatment Services (MATS) program, operated by the New York City Department of Health and Mental Hygiene (DOHMH) is voluntary strengths-based intensive case management to high-users of AOD treatment services.

Targeting the Population:

Individuals applying for entitlements or attending a re-certification meeting at New York City’s Human Resources Administration (HRA), and who are subject to AOD treatment under the requirements of 1996 federal welfare reform, are asked if they are interested in receiving intensive case management. If an individual is interested, s/he signs a release to HRA to allow the caseworker to check the client’s Medicaid history for AOD treatment services. If the individual falls into the “high-user” category (\geq \$30,000 in annual Medicaid AOD treatment costs), they are offered MATS services and referred to the appropriate vendor (borough-specific).

Program Participants:

DOHMH MATS participant data through October 2008 (cumulative enrollment 1,616 participants) provides the following population and services snapshot:

- Co-occurring mental health diagnoses: 27%
- Co-occurring physical health diagnoses: 38%
- Homeless upon enrollment: 82%
- Referred for housing: 35%
- Homeless participants housed: 12%

Key Features and Innovations:

Three vendors are contracted to provide intensive case management services, which are offered to eligible individuals in coordination with the HRA:

1. To support, extend, and optimize treatment engagement and retention for this population;
2. To address and resolve other social/health needs with wraparound services (homelessness prevention, domestic violence services, vocational, employment assistance); and
3. Consequently, to reduce their risk of repeat admissions for detoxification and other crisis services (and so also reduce associated Medicaid costs).

Initiative Partners:

The NYC MATS program is sponsored by the DOHMH and the HRA. It is funded primarily by the New York State Office of Alcoholism & Substance Abuse Services (OASAS), with some local funding from DOHMH and HRA.

Demonstrating Success

Initiated in 2007, the NYC MATS current maximum enrollment of 736 has been achieved and maintained. Participant data through October 2008 (cumulative enrollment 1,616 participants) shows:

- Initial AOD treatment engagement: 78%
- Of initial, AOD treatment retention at 30 days: 62%
- Of initial, AOD treatment retention at 90 days: 42%
- MATS caseload retained from enrollment: 88%

The current cost of MATS service delivery is approximately \$4.4 million annually. A preliminary Medicaid cost analysis for the initial 820 NYC MATS participants enrolled (4/07 thru 3/08) with New York City MATS average

length of stay of 5.23 months, suggests actual cost savings (in AOD treatment services use *only*) of approximately \$10.4 million. Projected annualized savings are approximately \$26 million dollars.

Translating Experience Into Policy:

Despite demonstrated cost savings, planned MATS initiative expansion to incrementally increase caseload over FY 2008 and FY 2009 has been aborted due to the New York City and State fiscal crises. At best, the current program will be maintained as part of an ongoing State/City partnership.

For more information, go to:

<http://www.nyc.gov/html/doh/html/dmh/dmh-mats.shtml>

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Serial Inebriate Program (SIP) *Chronic Homeless Inebriates – San Diego, California*

In January 2000, the San Diego Police Department (SDPD) initiated a pilot Serial Inebriate Program (SIP) to assist an estimated 300 chronic homeless inebriates stuck in a “revolving door” between jail, EDs, and the downtown Volunteers of America (VOA) inebriate reception (sobering) center (IRC). Early success allowed this program to expand citywide as a partnership linking law enforcement, the fire department, emergency medical services, hospitals, the public defender, the city attorney, the superior court, VOA, the business community, treatment providers, and county alcohol and drug services. The goal of SIP is to provide patients who have exhausted traditional therapeutic options with a sober living alternative while reducing their adverse community impact. SIP aligns the judicial system with treatment to create incentive for individuals’ participation in an outpatient recovery program tailored to their needs.

Targeting the Population:

SIP targets chronically homeless persons who are frequent users of jail, emergency health services, and crisis alcohol treatment services. SIP offers housing and treatment in lieu of custody to persons convicted on a misdemeanor criminal charge of public drunkenness.

Program Participants:

A retrospective review of SIP participants during the four-year period 2000-2003 revealed the following demographics:

- Age > 50 (73%).
- Male (92%).
- Caucasian (75%).

Key Features and Innovations:

Law enforcement is responsible for providing all individuals determined to be publicly intoxicated with a safe sobering environment. Individuals who lack other means of safe shelter are transported to the IRC where they receive supervision and monitoring by VOA staff until sober. Such individuals are encouraged to enter the VOA recovery program but many decline and promptly resume drinking. However, if an individual is transported to the IRC five times within 30 days, VOA staff rejects the individual and police transport to jail. California considers public intoxication as a misdemeanor that can (under certain circumstances) result in incarceration for up to 180 days. The California 4th District Court of Appeals determined that the state may incarcerate repeatedly intoxicated individuals because it has a legitimate need to control public drunkenness when such behavior creates a safety hazard. The court concluded that state law does not punish the mere condition of being a homeless chronic alcoholic but rather the associated conduct that poses a public safety risk.

The San Diego Serial Inebriate Program employs a coercive strategy for highly recidivist individuals. Judges convict on the charge of public drunkenness (Penal code Section 647(f)) and then offer the option of completing a six-month outpatient treatment program in lieu of custody. Should individuals choose treatment, they are screened for eligibility (exclusions include significant histories of violence, arson, etc). If determined eligible, they are transported by a police officer to their new “medical home,” the downtown St. Vincent de Paul Medical Clinic. After receiving necessary outpatient medications, they are transported to living facilities where clients are housed together in small groups, receive case management and attend daily recovery programs. Should a client walk away from treatment he is reported to the court and rearrested. SIP clients often reject the court’s initial offer of treatment, but progressive convictions bring longer sentences (30, 60, 90, 120, 150, 179 days) and the acceptance rate rises linearly to over 60%.

Initiative Partners:

- San Diego Police Department
- San Diego EMS

- Mental Health Systems, Inc. (lead treatment provider)
- San Diego Sheriff's Department
- San Diego County Alcohol and Drug Services
- San Diego City Attorney
- Office of the Public Defender
- Superior Courts
- St. Vincent de Paul Village

Demonstrating Success:

The University of California, San Diego Department of Emergency Medicine and the Institute for Public Health at San Diego State University conducted a retrospective review of health care utilization records (EMS, ED, and inpatient) for 529 SIP clients identified during the period January 2000 through December 2003.

Over this four-year period 308 of 529 (58%) individuals were transported by EMS 2,335 times; 409 of 529 (77%) individuals amassed 3,318 ED visits, and 217 of 529 (41%) individuals required 652 admissions, resulting in 3,361 inpatient days. Health care charges totaled \$17.7 million (EMS, \$1.3 million; ED, \$2.5 million; and inpatient \$13.9 million). Treatment was offered to 268 individuals, and 156 (58%) accepted. For the 156 clients who chose treatment the use of EMS, ED, and in-patient (IP) services declined collectively by 50%, resulting in an estimated decrease in total monthly average charges of \$5,662 (EMS), \$12,006 (ED), and \$55,684 (IP). There was no change in use of services for the 112 individuals who refused the treatment program. There was a significant trend toward acceptance of treatment as jail sentences lengthened: 0 to 30 days (20% acceptance) vs. > 150 days (63% acceptance), ($p < 0.001$).

Translating Experience into Policy:

San Diego SIP was initiated in 2000 with funding from monies tied to the San Diego County alcohol and tobacco settlement. Retrospective review of emergency medical transport, ED visits, hospital admissions, and inpatient length of stay during the period 2000 – 2003 showed medical savings of almost \$74,000 a month for clients who accepted the intervention. Based upon these results, SIP has been subsequently funded by the city and county since 2003. Many communities have now expressed interest in developing programs similar to San Diego SIP including Santa Cruz, San Jose, Sacramento, Las Vegas, Seattle, San Francisco, San Bernardino, San Antonio, Reno, and North Carolina.

For more information, go to:

<http://www.sandiegosisp.org/>

See also:

Dunford, J.V., Vilke, G.M., Chan, T.C., Castillo, E.M., Lindsay, S. (2006). Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources. *Annals of Emergency Medicine*, 47: 328-336.

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