Frequent Users Systems Engagement (FUSE): A Detroit Model

Identifying and Addressing the Need in Detroit

Wednesday, September 12th
2012 Regional Supportive Housing Conference
Overview

• About CSH
• The Basics of Supportive Housing
• Core Elements of FUSE and Scope
• Detroit FUSE
• Next Steps & Discussion
CSH is a national non-profit organization that helps communities create permanent housing with services to prevent and end homelessness.

Since 1991, CSH has been advancing its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing.
CSH’s Geographic Reach and Organization

- “Field” offices in 14 localities:
  - Rhode Island
  - Connecticut
  - New York
  - New Jersey
  - District of Columbia
  - Ohio
  - Illinois
  - Indiana
  - Minnesota
  - Texas
  - Michigan
  - Northern California
  - Los Angeles
  - San Diego

- CSH also provides targeted assistance to other communities and states through our Consulting Group

National Programs:
- Federal Policy
- Project Development and Finance
- Communications
- Innovations and Research
Accomplishments

Since inception in 1991, CSH has:

• Raised over $221 million from foundations, corporations, and government contracts to expand supportive housing nationwide.

• Leveraged $6.15 billion in federal, state, and local public and private sector financing.

• Committed over $200 million in targeted technical assistance, loans and grants to support the creation of 35,000 units of affordable and supportive housing.

• The units in operation have ended homelessness for at least 26,000 adults and children.
What is Supportive Housing?
Supportive housing is permanent, affordable housing combined with a range of supportive services that help people with special needs live stable and independent lives.
Essential Features

- **Housing**
  - **Permanent**: Not time limited, not transitional.
  - **Affordable**: To very low income people.
  - **Independent**: Tenant holds lease with normal rights and responsibilities.

- **Services**
  - **Flexible**: Responsive to tenants’ needs.
  - **Voluntary**: Participation not condition of tenancy.
The Issue:
Costly and Inefficient Utilization of Hospital and other Crisis Systems
The Institutional Circuit of Homelessness and Crisis

- High utilization of crisis services in one public system is often part of a larger “institutional circuit”

- Institutional circuit pattern:
  - Indicates complex, co-occurring social, health and behavioral health problems.
  - Reflects failure of mainstream systems of care to adequately address needs.
  - Demands more comprehensive intervention encompassing housing, intensive case management, and access to responsive health care.
In many communities, there exists a subset of individuals who consume a disproportionate amount of health services with no improvements to health outcomes.

Billings’ (2006) analysis of NYC Medicaid claims data found that:

- 20% of adult disabled patients subject to mandatory managed care account for 73% of costs.
- 3% of patients accounting for 30% of all costs for adult disabled patients.
High Utilizers of Health Services with Poor Health Outcomes

- California Initiative found that each frequent user averaged $58,000 a year in hospital charges ($13,000 related to ED visits, $45,000 related to inpatient days)
- A San Francisco General Hospital study found that total hospital costs per frequent user averaged $23,000 per year
- A study of chronically homeless inebriates by the University of California, San Diego Medical Center found that 15 individuals averaged $100,000 each in medical charges

"Million Dollar Murray" Phenomenon

The Cost of Homelessness vs. Housing
Source: Corporation for Supportive Housing

- Supportive Housing (average): $15,275
- City Shelter: $19,863
- City Jail Cell: $60,068
- State Prison Cell: $27,010
- City Hospital Bed: $432,525
- Psychiatric Hospital Bed: $170,455
- Supportive Housing at CG: $11,497
Thousands of people with chronic health conditions cycle in and out of crisis systems of care and homelessness - at great public expense and with limited positive human outcomes.

Enabling access to supportive housing for this group of people will improve life outcomes for the tenants, more efficiently utilize public resources, and likely create cost avoidance in crisis systems like hospitals and shelter.
Core Elements of FUSE

- Data Analysis and Matching
- Systems Engagement Plan & Inter-agency Collaboration
- Supportive Housing
- Provider Identification/Capacity Building
- Specialized Services
- Outcome Measures
• New York City FUSE

As of February 2011, the initiative had placed 150 frequent users of jails and shelters in Permanent Supportive Housing to reduce their utilization of these systems

Preliminary Findings:
- 91% retention rate over the first year
- 92% reduction in days spent in shelters
- 53% reduction in jail usage
Local hospitals and service providers collaborated in the development and implementation of more responsive systems of care to address unmet needs, produce better outcomes, and reduce unnecessary use of emergency services.

A five year, $10 million demonstration project in six sites in California with over 1000 individuals enrolled across the six sites.

- Alameda County – Project RESPECT
- Los Angeles County – Project Improving Access to Care
- Sacramento County – The Care Connection
- Santa Clara County – New Directions
- Santa Cruz County – Project Connect
- Tulare County – The Bridge
## Outcomes: Hospital Utilization & Charges

### Frequent Users of Health Services Initiative (CA)

<table>
<thead>
<tr>
<th></th>
<th>1 Year PRE</th>
<th>2 Years POST</th>
<th>% DIFFERENCE</th>
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<tbody>
<tr>
<td><strong>ED Visits (Mean)</strong></td>
<td>10.9</td>
<td>4.5</td>
<td>59% decrease</td>
</tr>
<tr>
<td><strong>ED Charges</strong></td>
<td>$2,093,247</td>
<td>$952,770</td>
<td>55% decrease</td>
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<tr>
<td><strong>Inpatient Admissions</strong></td>
<td>283</td>
<td>82</td>
<td>69% decrease</td>
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<tr>
<td><strong>Cumulative Inpatient Days</strong></td>
<td>1,266</td>
<td>365</td>
<td>71% decrease</td>
</tr>
<tr>
<td><strong>Inpatient Admission Charges</strong></td>
<td>$9,905,168</td>
<td>$2,824,710</td>
<td>72% decrease</td>
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</table>
With Social Innovation Fund grant, CSH is now leading a 5-year national effort to pilot and test supportive housing linked to health care for high utilizers of crisis

- Grantmaking – $1.4 million in annual grants to teams of organizations in four communities
- Technical Assistance – One-on-one technical assistance and national Learning Collaborative
- Evaluation – Rigorous multi-site evaluation to measure the impact of these models on recipients’ health and housing stability, and Medicaid and other public costs

Expected Results:
- Health and housing stability for 500 high-need, high-cost individuals with chronic conditions
- Replicable approaches for linking affordable housing with care management and health care
- Compelling evidence of the model’s impact on housing, health, and public costs
- A policy blueprint for aligning mainstream housing resources and health payment systems (Medicaid) to scale models
Meeting the Needs of Homeless Individuals with Serious Medical Concerns
Portland, OR – Central City Concern’s Recuperative Care Program

• Supportive and transitional housing for homeless patients of area hospitals.
• CCC offers beds (through housing) and a medical home with its FQHC clinic.
• Includes direct hospital investment.
• 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 stable housing.
Seattle, WA
Plymouth on Stewart

- 87 units – 40 PSH.

- 20 specifically for health services
  - 14 units for high utilizers of Medical Respite/emergency room services.
  - 6 for high utilizers of the Sobering Center/chemical dependency services.

- Service partner is Health Care for the Homeless – FQHC clinic.
The 100,000 Homes Campaign and the Detroit FUSE Initiative
100,000 Homes Campaign: Detroit

- National campaign
  
  [http://100khomes.org/](http://100khomes.org/)

  Goal is to house 100,000 of the nation’s most vulnerable homeless individuals by 2013.

- Community partnership to identify and house our community’s most vulnerable.

- MPRO and NSO were two partners.
**MPRO & NSO**

**MPRO** – Michigan’s Quality Improvement Organization. *Improving quality, safety and efficiency across the healthcare continuum.*

- MPRO is a national health care quality improvement organization that works within all healthcare settings.
- MPRO’s mission is to improve quality, safety and efficiency across the healthcare continuum.
- MPRO has lead an initiate to prevent avoidable re-hospitalizations across Michigan.

**Neighborhood Service Organization (NSO)** was established in 1955 as a private non-profit human service agency.

- NSO’s mission is to be “always within reach” for Metro Detroit’s most vulnerable citizens.
- NSO runs Tumaini Center, a walk-in center open 24/7, and provides permanent supportive housing for individuals who are homeless and disabled.
- NSO recently opened the Bell Building, a 155 unit PSH project for single individuals with disabilities. This project is the largest of its kind in Detroit.
281 individuals counted/ 211 surveys completed
107 (51%) vulnerable with high mortality risk

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<tr>
<th>Risk indicator</th>
<th>Average From All Sites</th>
<th>Detroit</th>
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<tbody>
<tr>
<td>Sample Size</td>
<td>8575</td>
<td>211</td>
</tr>
<tr>
<td>Tri-morbid</td>
<td>54%</td>
<td>51%</td>
</tr>
<tr>
<td>3x ER or Hospital last year</td>
<td>34%</td>
<td>66%*</td>
</tr>
<tr>
<td>3x ER last 3 months</td>
<td>25%</td>
<td>43%*</td>
</tr>
<tr>
<td>&gt; 60 years old</td>
<td>20%</td>
<td>13%</td>
</tr>
<tr>
<td>HIV+/AIDS</td>
<td>6%</td>
<td>7%</td>
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<tr>
<td>Liver Disease</td>
<td>19%</td>
<td>10%</td>
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<tr>
<td>Kidney Disease</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Cold/Wet Weather Injury</td>
<td>15%</td>
<td>21%*</td>
</tr>
<tr>
<td>% vulnerable</td>
<td>42%</td>
<td>51%*</td>
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* indicates higher than national average
FUSE Requires Cross-System Collaboration

- In September of 2010, the Detroit Initiative began with a Hospital Summit, which brought together providers from all the hospital systems toward a common goal, reducing cost and improving the quality of service for “frequent users”.

- Prior to the initial Workgroup Meeting in November of 2010, stakeholders were recruited from other systems of care, including mental health, criminal justice and community health.
Partnership: Building a Collaborative

Partners In the Detroit FUSE Initiative

- Detroit Medical Center
- Michigan Department of Community Health
- Michigan Department of Human Services
- Advantage Health Care
- The City of Detroit Health Department
- Gateway Community Health
- CareLink Network
- Wayne County Community Mental Health
- Adult Well-Being Services
- Veteran’s Administration
- US Department of Housing and Urban Development (HUD)

- Detroit Wayne County Community Mental Health Agency
- Michigan State Housing Development Authority
- Wayne County Community Corrections
- Wayne State Physician Group
- Greater Detroit Area Health Council
- St. John Health System
- Voices of Detroit Initiative (VODI)
- Homeless Action Network of Detroit
- Community Living Services
With a Workgroup in place and meeting monthly, the initiative moved forward. With a homeless population hovering near 20,000 and limited resources, we had to be strategic with our focus, so put together a definition of a “frequent user”

Requirements for Participants:
- Homeless (Per HUD McKinney Vento Act definition)
- A Minimum of 6 Emergency Room Visits Annually
- OR
- A Minimum of 3 Hospital Admissions/Readmissions Annually
- AND
- Severe and Persistent Mental illness

AND
One or More of the Following Medical Conditions:
- Dialysis
- Wheelchair User
- Oxygen Needs
- Substance Abuse
- TBI/Organic Brain Disease
- Persons with a PICC-Line
- HIV/AIDS

OR
- 3+ Chronic Health Conditions
The Detroit FUSE Project has taken a two-pronged approach to the project through the establishment of a Case Analysis Subcommittee, which works concurrently with the Steering Committee:

- **Steering Committee**—Attended by stakeholders from participating agencies; uses de-identified data to examine the systems cost for frequent users, as well as demographics on these individuals.

- **Case Analysis Team**—Evaluates the cases of individuals to determine system overlap, determine eligibility and complete referral for the FUSE services.
The Challenges of Moving a FUSE Project Forward:

- We learned hospital systems often have significant privacy policies that are more restrictive than HIPPA, which meant that we were unable to utilize a Business Associate Agreement.

- We determined that the only way to move forward with the project was to have hospitals serve as the recruitment site. In this way hospitals could identify their frequent users based on the criteria the workgroup put together, and ask them to participate in the project when they presented in their ER.

- Institutional Review Boards: In order to conduct research, your evaluation may have to go through an IRB process. Most likely, the hospitals who are serving as referral sources will also have to conduct an internal IRB. Moving through the various IRB applications will be time consuming.
The Challenges of Moving a FUSE Project Forward (Continued):

• Timing—trying to align all the resources for this project is challenging. You have to consider housing subsidies, staffing, the Institutional Review Board process, etc. Hurry up and wait would be the best way to describe it.

• Make sure you have access to housing before project launch. If you don’t have vouchers set aside for those identified as FUSE eligible, you may find it very difficult to remain engaged with them.

• We faced many setbacks that delayed forward movement on the project, but those involved have worked together to find solutions. However, we are two years into the project and are just now about to begin providing housing and services to clients.
FUSE Service Model

- Individuals who meet frequent user criteria are referred from the hospital to Neighborhood Service Organization (NSO), our service partner in the project.
- Individuals are assessed to determine they qualify for the project, and if so, complete the consent to participate in the project and the assessment tools.
- Individuals are randomly assigned to the intervention or control group. Individuals assigned to the intervention group will receive PSH and services focused on coordinating care to reduce ER visits and coordinate health care needs including mental health and primary care. Staffing consists of a Project Coordinator, a RN and a Peer Support Specialist.
Wayne State University School of Social Work is our evaluation partner.

Evaluation is two-fold:

1. Examining utilization for both the control and intervention group for one year pre-enrollment and two years post. This information is provided by the hospitals and the community mental health agency.

2. Tracking quality of life indicators through assessment tools for both the control and intervention group. Tools assess physical and mental health, substance use, housing stability and motivation to change behavior related to health.
Detroit FUSE Next Steps

- Project Start: estimated project start date is 10/1/12. NSO will have access to 25 units of Shelter Plus Care specific to this project beginning on 10/1.

- Moving from the ramp up to the launch phase will be challenging, lots of partners on board.

- Linkage to primary care from a participating local FQHC clinic.

- Continue to engage workgroup to address issues as they arise.

- Work across the state to educate policymakers and politicians on the business case to serving frequent users who are homeless.
Lessons Learned

- Do your research. It is best to have a good understanding of where the system cracks are if you want to fix them.

- Build on accomplishments from other FUSE Initiatives across the country—don’t be afraid to ask for advice from those whose initiative is up and running.

- Be creative in how you approach the project. Navigating the information sharing can be difficult but working closely with your partners while being flexible can make a world of difference.

- Don’t rush into it. In order for the project to be effective, you need to address it with a thoughtful, multisystem approach.
Replicating the Model
A Framework for Action

- Develop an inter-agency collaboration with partners from health care, housing, and behavioral health to develop shared goals.

- Assess opportunities and conduct administrative match to identify the target population.

- Design a supportive housing intervention.

- Identify public and philanthropic resources to target for investment.
Potential Roles for Hospitals

- Assist with data match and analysis
- Key partner in inter-agency collaboration providing leadership, public and political support
- Resource Re-Investment
- Direct role in service provision
- Outcomes/performance measurement
What are hospital or criminal justice systems currently doing in your area to address the needs of persons who are homeless and frequent users of emergency and/or jail services?

What did you learn from this presentation that may help you to address the needs of frequent users in your community?
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