



Case Study

Frequent Users Systems Engagement (FUSE):

Local Perspective and Statewide Impact in Montana

Project Overview

Brief Background/Project History

Often the Frequent Users Systems Engagement (FUSE) approach is developed in a single community for a single program. In Montana, FUSE developed statewide across seven different communities. While these communities have much in common, each has its own diverse set of characteristics from geography and population,

to partnerships and capacity. Montana offers an interesting case study in the statewide approach to FUSE. As a large state with a small population, Montana communities are far apart and somewhat disconnected; thus, the FUSE communities there have developed strong community networks and realistic plans to implement FUSE using local strengths. A takeaway for other, smaller and rural communities is this: ***FUSE. Is. Possible.*** In any size community, with any amount of resources the goal of FUSE is to better connect existing resources, possibly create new resources, and build a network of partners and coalition with the political will to make FUSE a reality, from scratch if needed!

With the generous support from the Montana Healthcare Foundation (MHCF), these communities were selected to advance a Frequent Users Systems Engagement (FUSE) project to those engaged in multiple systems, such as housing and homelessness, health, and justice-involvement to permanent supportive housing. Corporation for Supportive Housing (CSH) was selected by MHCF to assist communities plan and implement their FUSE projects over the course of two years. This includes gathering stakeholders, data support, coaching, and working with each community to overcome barriers.

These Montana communities are both intrepid and creative and are made stronger by the interesting application of a statewide approach.

Glossary and Common Acronyms

1. **Coordinated Entry Systems (CES)**¹ – A community-wide strategy to align resources, assess individuals by their need, assign appropriate services, and house persons in a prioritized and streamlined way.
2. **Continuum of Care (CoC)**² – U.S. Department of Housing and Urban Development (HUD)'s geographic unit designation for communities. While often aligned with a single county, there are many examples of sub-county CoCs, as well as multi-county and statewide CoCs.
3. **Notice of Funding Opportunity (NOFO), formerly NOFA**³ – A competitive funding stream offered through the HUD CoC program. Communities must evaluate all CoC-funded projects and prioritize them for funding locally.
4. **Youth Homeless Demonstration Program (YHDP)**⁴ – A competitive funding stream offered through HUD as a pilot program to specifically establish and sustain programs directed toward youth homelessness.
5. **Homeless Management Information Systems (HMIS)**⁵ – A database solution required by HUD for all CoCs to maintain. HMIS implementation may support a single CoC or multiple CoCs. HMIS should capture data⁶ on the majority of all homeless services provided in a CoC, such as personal identifiers, demographics, services provided, service histories, and housing outcomes.
6. **Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)** – An assessment form used in a number of CoCs that collect information about an individual or household in addition to the HMIS standard questions to determine severe risk of, among other things, mortality if unsheltered. Responses are used to create a composite 'score,' where generally the higher the score the deeper the service intervention should be. Scores are often used in communities to determine PSH housing priority in CES where a score of 8-9+ is considered high need.
7. **Montana Department of Public Health and Human Services (DPHHS)**⁷ – Independent department of the state of Montana with oversight of public health and Medicaid program implementation, as well as the MPATH project.
8. **Montana's Program for Automating and Transforming Healthcare (MPATH)** – A project through Montana DPHHS to streamline healthcare services and analytics through strategic, statewide data collection and data matching.
9. **Patient Aligned Care Team (PACT)**⁸ – A service model emerging from Veteran homeless services. Combines specialized support teams across health and housing services to provide whole-person, wrap-around care to persons. Communication and coordination of care is done at a team level, rather than one-on-one with the participant.

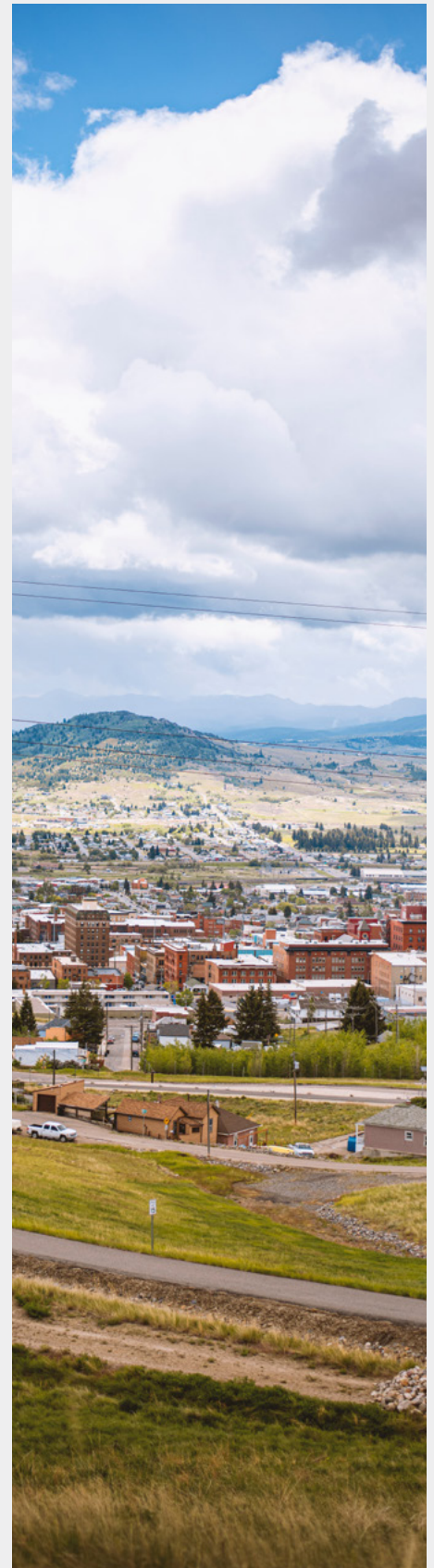


Photo of Butte, Montana by Steven Cordes on Unsplash.

Community Summary

Figure 1.

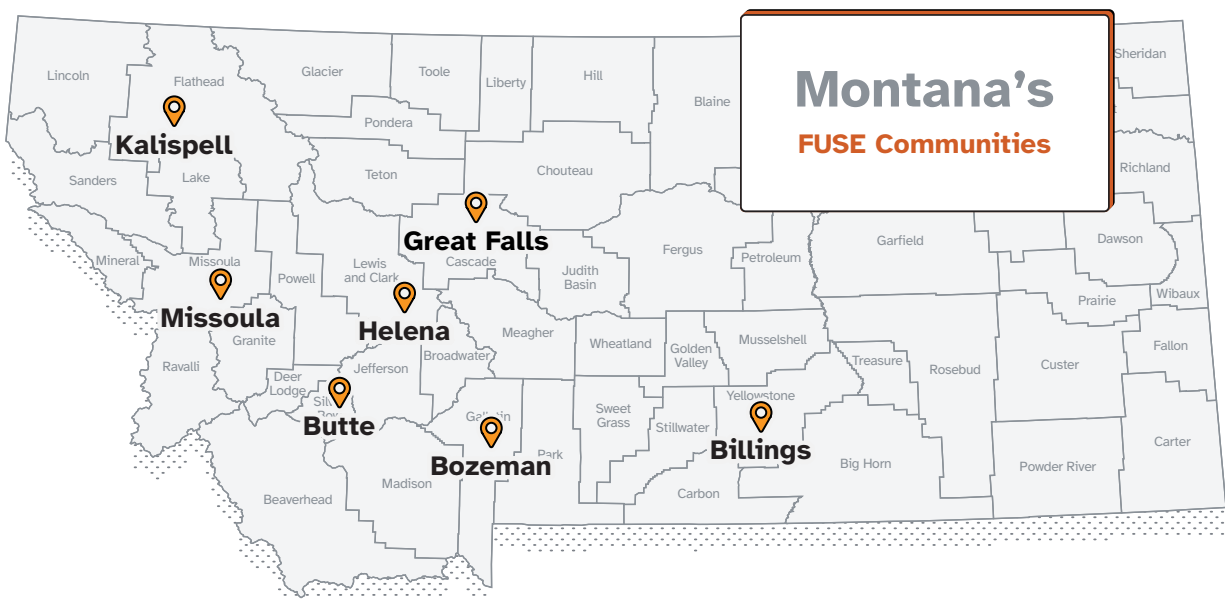


Table 1. FUSE Communities

Name	Year Started	Units	Prioritization Criteria	Data Sources & Matching	Primary Coordinator
Billings	2020	TBD	Still in development; pending match and review of results	DPHHS MPATH	United Way of Yellowstone County
Bozeman	2019	19	Individuals who have appeared in the VI-SPDAT or appeared at the warming center (seeking services and are experiencing homelessness); four or more visits to the emergency room (ER) and 3 or more jail visits starting June 2018	HMIS and Warming Center, Gallatin Detention Center, Bozeman Health and Big Sky Medical Center; Manual matching	HRDC (Human Resource Development Council) — Health Housing Initiative
Butte	2018	25	Still in development; reevaluating with changes to Coordinated Entry Systems (CES) prioritization due to COVID	Action Inc., Butte Police, Butte Detention Center, St. James Hospital; By-Name List, signed participant Release of Information (ROIs)	Action Inc.

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Name	Year Started	Units	Prioritization Criteria	Data Sources & Matching	Primary Coordinator
Great Falls	2018	6	High VI-SPDAT score (6+), ER visits, address listed as a shelter or general delivery	HMIS, Alluvion Health, St. Vincent De Paul, Family Promise, Indian Family Health Clinic; list of lists approach; manual matching	YWCA
Helena	2019	TBD	TBD	HMIS, Medicaid, Family Promise, St. Peter's Health; leveraging DPHHS' MPATH warehouse and matching process	United Way of Lewis and Clark County
Kalispell	2018	9	Currently using CES highest scoring/top ten, high utilizers of health care and hospital system, dynamic prioritization determined through new cross-sector partners and data matching.	HMIS; list of lists approach; CES case conferencing; Excel/ manual matching	Community Action Partnership of Northwest Montana
Missoula	2018	42	10 emergency department (ED) visits within a year look back, experiencing homelessness and interaction with 2 of the 6 systems (St. Patrick's Hospital, Community Medical Center, Police, Jail, HMIS or Poverello Center)	Top 50 users from partners; list of lists approach; Excel matching	Partnership Health Center

Health Center Highlight

All seven communities view including local health centers and healthcare providers in the FUSE planning and eventual implementation as an important priority. Though involved at different stages and for different and multiple roles, all communities have healthcare and health center partners and allies in building FUSE.

Figure 2:
Health Center Roles in FUSE



Summary of Health Center Roles in Montana

Health centers can take on a number of roles in a FUSE project. While health centers can be a full data sharing partner or FUSE project manager from the outset of FUSE planning, they also may be on-boarded later in the planning or implementation stage. Health centers can play a critical role in supporting FUSE participants' housing and health outcomes through their everyday services that support many distinct patient populations.

It is sometimes the case that health centers are a supportive service connection or referral network partner to FUSE, with no real difference in the relationship to any other system partners. Over time, as FUSE is built up and details worked out, health centers may feel more comfortable with the landscape to become an eventual data source or matcher, given certain technical and privacy capabilities.

For example, **Bozeman Health**⁹, a regional healthcare network operating several facilities, took on much of the early data organization work. They provided legal support and guidance to develop a data sharing agreement, which allows partners to share data (including identifiers) with the project coordinator at **HRDC**¹⁰, a housing partner and coordinated entry lead in Bozeman. The coordinator may then conduct the matches and use data to analyze the FUSE population and their needs. Locally, HRDC has been a critical partner and has a broad reach in the community across several social service areas, including long-standing relationship with healthcare and health centers.



Key Features and Innovations

Table 2. Key Features and Innovations by FUSE Community

Name	Challenges	Opportunities	Innovations
Billings	<ul style="list-style-type: none"> + Select the most impactful data elements to tell the story + Build data matching and sharing capacity and data culture + Coordinate new and existing funding locally 	<ul style="list-style-type: none"> + Established working groups to take on specific aspects of FUSE + Wide range of data availability and willing data sharing partners 	<ul style="list-style-type: none"> + Engagement with health system partners to inventory which organizations report into DPHHS
Bozeman	<ul style="list-style-type: none"> + Need additional data sharing infrastructure/partners + Engage with local government at a deeper level + Land availability/affordability for development 	<ul style="list-style-type: none"> + Foundational data/list to work from, adjust, and grow + Engaged with FUSE implementation work previously and housed frequent users + Multipronged approach to funding and sustaining services 	<ul style="list-style-type: none"> + Signed Release of Information (ROIs) from participants to share data among partners + Leveraging existing resources and working with CES/Public Housing Authorities + Relationship with local emergency department and sharing data on frequent user housing statuses
Butte	<ul style="list-style-type: none"> + Sustainable funding for supportive services + Behavioral health (BH) service coordination + Integrated/automated data sharing and matching process 	<ul style="list-style-type: none"> + Foundational data/list to work from, adjust, and grow + Engaged with FUSE implementation work previously and housed frequent users + Multipronged approach to funding and sustaining services 	<ul style="list-style-type: none"> + Signed Release of Information (ROIs) from participants to share data among partners + Leveraging existing resources and working with CES/Public Housing Authorities + Relationship with local emergency department and sharing data on frequent user housing statuses

Table 2. Key Features and Innovations by FUSE Community

Name	Challenges	Opportunities	Innovations
Great Falls	<ul style="list-style-type: none"> + Funding and resource opportunities to build housing stock and services + Data privacy and paperwork to obtain health data routinely + Integrated data matching/sharing process 	<ul style="list-style-type: none"> + Engaged group of partners from health and law enforcement + Cross-matched data set to analyze on prioritization criteria and FUSE population 	<ul style="list-style-type: none"> + Leveraging existing resources and working with CES/PHAs + Using health data to explore costs of services + Working with local government to champion project
Helena	<ul style="list-style-type: none"> + Re-establishing prioritization criteria from one-time match data results + Obtaining person-level data to use for housing matches + Low vacancy rate in community affecting voucher expirations and renewals 	<ul style="list-style-type: none"> + Access to data sets through DPHHS warehouse + Data sharing infrastructure and framework established + Very engaged, interdisciplinary project team 	<ul style="list-style-type: none"> + Leveraging State resources to fill pivotal data sharing and matching role + Using data from multiple sources to analyze FUSE population, develop prioritization criteria, to include COVID lessons learned and challenges
Kalispell	<ul style="list-style-type: none"> + Consolidating data from multiple sources/systems + Data sharing infrastructure + Alignment with cross-sector partners amid COVID response 	<ul style="list-style-type: none"> + Thorough planning phase, with keen insight on where to focus and improve project + Housing resources in community's back pocket from CoC NOFA/YHDP + Pairing housing subsidy with services partners (e.g. PACT) to support FUSE identified population 	<ul style="list-style-type: none"> + Local champion recruitment to assist in networking and cross sector partnerships + Hospitals and County health system partners exploring serving as access points for FUSE/CES
Missoula	<ul style="list-style-type: none"> + Dedicated and durable supportive services funding streams + Comprehensive behavioral health services + Data sharing framework which allows for person-level sharing 	<ul style="list-style-type: none"> + Funding and development opportunities with local PHA and County government + Data-driven prioritization criteria based on Boise model and local experiences 	<ul style="list-style-type: none"> + Focus on racial equity and inclusiveness of experience and perspective in partner and project groups + Leveraging resources from local city and county governments for housing development

Figure 3: FUSE Workgroups



Leadership/Core Group



Data Group



Cross-Systems Planning/
Community Group



Funding Group (Planned)

Approach

Partnerships and Roles

In Billings, the community engaged in numerous conversations with partners to identify the kinds of data that would prove useful in establishing prioritization criteria and tell a story about systems use. Meeting organizations where they were at in terms of what they were willing to share, data were collected, sorted, and matched to analyze system use and lay the groundwork for more detailed data sharing processes.

Two communities, Billings and Kalispell, focused on creating FUSE workgroups in Figure 3, a common practice for many communities after the initial feasibility assessment and first round of partnership engagement. These workgroups focused on one aspect of FUSE project development. Workgroups manage the week-to-week activities and free up time for the project management group to manage the long-term strategic milestones of FUSE.

Data Collection and Matching

INITIAL MATCHING APPROACHES WITH “LISTS OF LISTS”

The FUSE project in Missoula is comprehensive, inclusive, and data-informed. It has some challenges in data infrastructure and matching being more manual and focused on the administration rather than analysis of the list. The coordinators have pulled together a group of partners reflective of the community, from health, housing, and justice to local and tribal governments.

Using a “list of lists” approach, partners provide top 50 users, and those lists are manually reviewed. Partners sign memorandum of understanding (MOUs) and share de-identified information, though there is interest in leveraging a state-level solution. The community criteria incorporate emergency rooms (ER) visits, homeless status, and experience with the justice and other healthcare systems. It did use the VI-SPDAT and one point, but phased it out after observing that those who would be prioritized for FUSE were not rising to the top of the CES list (a common occurrence in many FUSE communities).

Similarly, in Kalispell the local coordinated entry process, HMIS, and a “list of lists” approach have been the prime ways of collecting and analyzing data for frequent use. List of lists entails different stakeholder groups contributing lists of their own top users to a single table (either a literal table or virtually) and matching across these lists. For example, a hospital might contribute the top 50 users of emergency rooms and a jail might select the top 50 most frequently incarcerated individuals. A match across two or more of the lists is placed on a joint list and prioritized accordingly.

The health system in Kalispell is anchored by two area hospitals, which are also exploring viability of serving as front doors to the homeless system’s CES and offer a wealth of information and expertise. As with other communities, the challenge is successfully navigating data privacy and legal agreements. Other partners, such as probation and libraries are at the table, and some are exploring using CES and Homeless Management Information System (HMIS) agreements as the conduit to exchange and share data. Kalispell is actively linking their available units and seeking pairing Patient Aligned Care Team (PACT) services to those identified. While they currently use a manual matching process, to better maximize resources, they are keen on advancing a more automated data sharing methodology through the statewide data inventory process and Department of Health and Human Services (DPHHS).

Figure 4: Common Threads for Success



LEVERAGING STATEWIDE DATA CAPACITY

Helena, Montana's capital, is where many of the State's departments are situated, which places it in a distinctive position with FUSE implementation. Stakeholders in Helena have played a role testing certain strategies and innovations, particularly in data collection and sharing.

As a prime example, the mutually beneficial relationship with the DPHHS has led to an innovation in data matching, where data may be sent to DPHHS for matching and sent back to the community to use to analyze results. Though data is anonymous, the community is looking for ways to share identifiers long-term for use in prioritizing and matching individuals to FUSE and ultimately housing and services.

DPHHS' enterprise data warehouse, part of their Montana Program for Automating and Transforming Healthcare (MPATH) is the main driver of this potentially transformative innovation for not only Helena, but the other FUSE communities as well. Leveraging DPHHS infrastructure, expertise, and data savvy has saved Helena many hours of effort and could be scaled to the other communities as well, potentially offering access to data sets individual communities have struggled obtaining consistently.

Common Threads for Success

Planning for Implementation — Next Steps

IDENTIFY A PROJECT MANAGER (PM)

- + Recognize a person or small group of people as the project manager(s)
- + Negotiate goals and objectives for PM; ensure to the extent possible FUSE is the primary aspect of their job, rather than extra
- + Identifying this role creates accountability for community and PM

RECRUIT A PROJECT CHAMPION

- + Project champion is spokesperson, driver, cheerleader, and optimist
- + Potential candidates are political leaders, government officials and law enforcement, philanthropic leaders, or stellar volunteers
- + Project asset to move project forward, make connections and network, fund raise and communicate, and bust barriers

LEVERAGING STATE EXPERTISE AND CAPACITY FOR DATA SHARING AND MATCHING

- + DPHHS has expressed a willingness to assist FUSE communities with data sharing and matching through their MPATH data warehouse project
- + CSH has initiated and is facilitating conversations between DPHHS, FUSE communities, and potential data sharing partners
- + This is viewed as a long-term recommendation to ease the administrative burden on communities matching lists over the course of months to years

HOUSING AND SERVICES FUNDING COORDINATION

- + Public Housing Authorities in some, but not all communities play a major role in fueling housing resources; PHAs adopting set asides or a homeless preference could be used as model for others across Montana
- + Behavioral health (BH) services were an identified need in most every community; more or different engagement is needed to draw major BH partners to the table in FUSE communities
- + Strengthen relationships with local health centers for data sharing and as a connection point and resource for FUSE participants
- + As projects progress, Medicaid funding may be used to fill service gaps, or free up more flexible funding to meet other needs

Additional Resources

- + [Building and Launching Tiny Homes as Permanent Supportive Housing \(urban.org\)](#)¹¹
- + [FUSE - CSH](#)¹²
- + [Investing in Supportive Housing - Montana Healthcare Foundation \(mthcf.org\)](#)¹³
- + [Grantee Spotlight: Missoula's Supportive Housing Project - Montana Healthcare Foundation \(mthcf.org\)](#)¹⁴
- + [Reducing Homelessness, Associated Health Care Costs \(mt.gov\)](#)¹⁵

Endnotes

- 1 <https://files.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>
- 2 <https://www.hudexchange.info/programs/coc/>
- 3 https://www.hud.gov/program_offices/comm_planning/coc/competition
- 4 <https://www.hudexchange.info/programs/yhdp/>
- 5 <https://www.hudexchange.info/programs/hmis/>
- 6 <https://www.hudexchange.info/news/hud-releases-fy-2022-hmis-data-standards/>
- 7 <https://dphhs.mt.gov/AboutUs/index>
- 8 <https://www.patientcare.va.gov/primarycare/PACT.asp>
- 9 <https://www.bozemanhealth.org/>
- 10 <https://thehrdc.org/>
- 11 <https://www.urban.org/sites/default/files/publication/105263/building-and-launching-tiny-homes-as-permanent-supportive-housing.pdf>
- 12 <https://www.csh.org/fuse/>
- 13 <https://mthcf.org/news/investing-in-supportive-housing/>
- 14 <https://mthcf.org/news/missoula-supportive-housing-project/>
- 15 <https://dphhs.mt.gov/News/2019/06/reducinghomelessness>



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This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$550,000 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.