

SUMMARY REPORT OF EVALUATION FINDINGS

A Dollars and Sense Strategy to Reducing Frequent Use of Hospital Services

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

The Initiative is based at the Corporation for
Supportive Housing.



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



About the Frequent Users of Health Services Initiative

The Frequent Users of Health Services Initiative (the *Initiative*) was a six-year, \$10 million joint project of The California Endowment and the California HealthCare Foundation, with a program office housed at the Corporation for Supportive Housing, a national nonprofit organization that helps communities create permanent housing with services to prevent and end homelessness. The program office supported the grantees, oversaw the *Initiative's* direction, and provided technical assistance. The *Initiative* was designed to promote the development of innovative, integrated approaches to address the comprehensive health and social service needs of frequent users of emergency departments, and decrease avoidable emergency department visits and hospital stays. Ultimately, the *Initiative* aimed to relieve pressure on overburdened systems and promote more effective use of resources.

WHO ARE FREQUENT USERS?

For the purposes of the *Initiative*, frequent users were defined as a small group of individuals who frequently use emergency departments and who have complex, unmet needs not effectively addressed in high-cost acute care settings. These individuals face barriers in accessing medical care, housing, mental health care, and substance abuse treatment, contributing to their frequent emergency department visits.

Initiative funding supported a program office for six years that financed six one-year planning grants and six three-year implementation grants for pilot programs, provided technical assistance to grantees, and paid for an external process and outcome evaluation of the planning and implementation grants. The Lewin Group, a health care policy research and management consulting firm, conducted the external process and outcome evaluation. The Lewin Group presented their extensive findings from the outcome evaluation in *Frequent Users of Health Services Initiative: Final Evaluation Report*. Those findings are highlighted here in the *Summary Report*.

COUNTIES AWARDED GRANTS

County	2003 Planning Grant	2004-2007 Implementation Pilot Grant
Alameda**	X	X
Los Angeles		X
Orange	X	
Sacramento	X	X
Santa Clara**	X	X
Santa Cruz*		X
Sonoma	X	
Tulare	X	X

*Santa Cruz was awarded an implementation grant in 2003 that was renewed for an additional year in 2006.

**Alameda and Santa Clara were awarded implementation grants in 2004 that were renewed for an additional six months in 2007.

The pilot programs, created through implementation grants, developed interventions to address the range of needs specific to frequent users in their hospitals and communities. While the programs shared many features, no two were exactly alike. The models employed varied from intensive case management provided by licensed clinical staff to less intensive peer and paraprofessional staff-driven interventions. Despite variations in their models, all of the pilot programs worked to respond to the immediate and long-term needs of clients, addressing both their medical and non-medical problems. They aimed to improve coordination of acute, primary, and preventive care and social services among providers.

*The Initiative's ability to connect clients to support services and care in lower-cost community-based settings resulted in significant hospital utilization reductions. The interventions of the pilot programs led to a **61 percent decrease** in emergency department visits and a **62 percent decrease** in inpatient days over two years of client participation.*

THE IMPACT OF FREQUENT USERS

Hospital emergency departments are a community resource, and the only health care resource that, by law, must serve everyone, regardless of a patient's ability to pay.¹ Increasingly, emergency departments are used instead of primary care by insured patients who either lack a medical home or have difficulty accessing their primary care provider.²

Providing emergency department and inpatient hospital services can be extremely expensive. Frequent users' hospital visits account for disproportionate costs and time for emergency departments, drain state and county health care resources, and increase stress on emergency department staff. Furthermore, emergency departments are not designed to meet the psychosocial needs of frequent users and do not have the capacity to assist them with housing, substance abuse treatment, and mental health care. For many frequent users, more appropriate care 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 emergency department 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.

“The Initiative is a case management model of care for people who frequent the emergency department in the hospital in order to provide them with services in the community at a lower cost.”

*Monique Zmuda, Deputy
Controller, City and County of San Francisco*

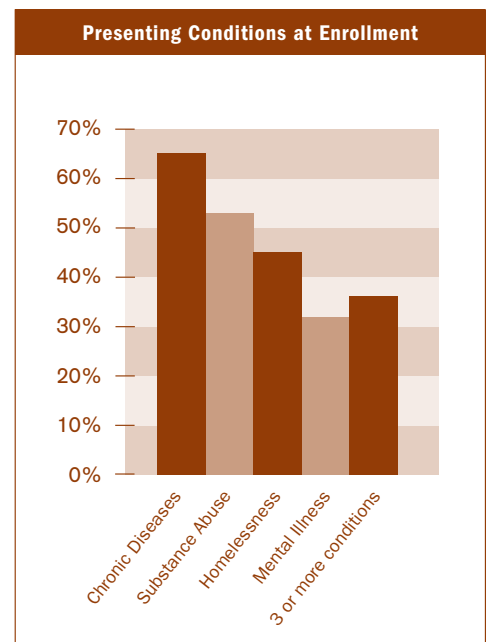
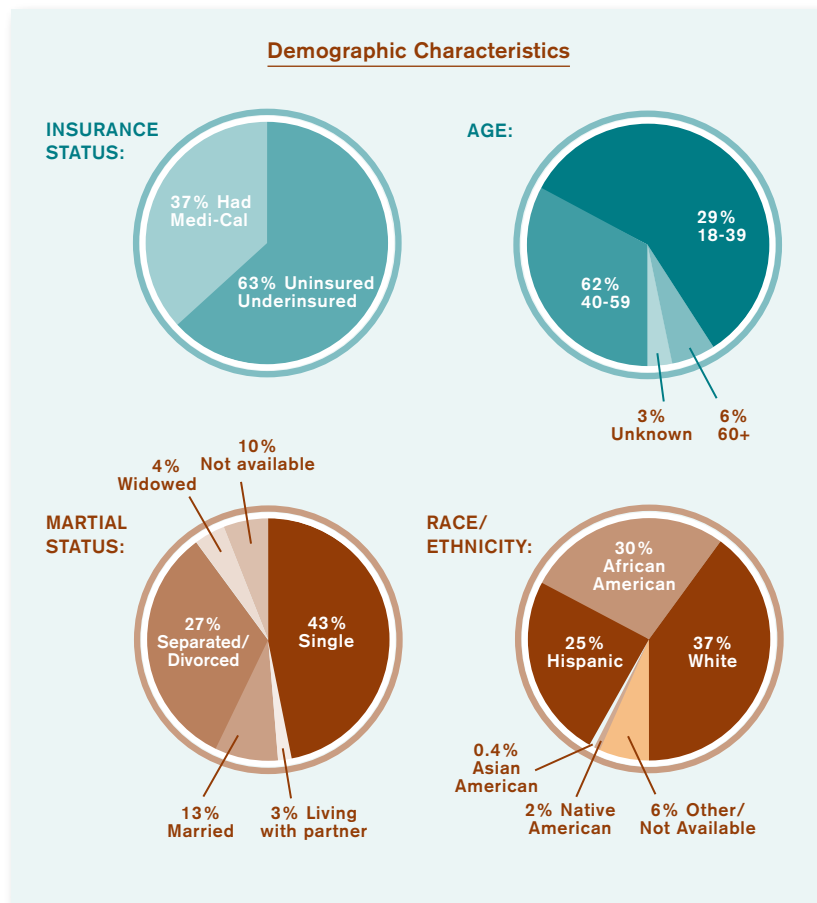
¹ The Federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals that accept payment from the Department of Health and Human Services, Centers for Medicare and Medicaid Services to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay. EMTALA applies to virtually all hospitals in the United States.

² McConville, Shannon, & Lee, Helen. Emergency Department Care in California: Who Uses it and Why? California Counts: Population Trends and Profiles. Vol. 1, No. 1; August 2008.

PROFILE OF FREQUENT USERS AT ENROLLMENT

All of the pilot programs included a threshold number of emergency department visits in their eligibility criteria, which ranged from four to ten visits in one year. In addition to the threshold number of emergency department visits, some pilot programs required clients to meet psychosocial criteria, 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, age 40 to 59. Notably, only 16 percent of all participants were married or living with a partner at enrollment. In general, frequent users experience chronic physical conditions, mental illness, substance abuse disorders, or homelessness, and most have some combination of these conditions. Of the patients enrolled in *Initiative* programs, two-thirds had untreated chronic physical diagnoses, such as diabetes, cardiovascular disease, cirrhosis, respiratory conditions, seizures, Hepatitis C, HIV, or chronic pain. More than half suffered from substance abuse disorders, and about a third were diagnosed with mental illness. Almost half of frequent users who participated in the *Initiative* pilot programs were homeless. More than a third had three or more of these risk factors. Many of the frequent users in the *Initiative* pilot programs also lacked the familial or social supports necessary to stabilize their health. Although 37 percent were insured by Medi-Cal at enrollment, the remaining 63 percent were underinsured or uninsured.



Highlights of the Initiative Evaluation Results

The goal of the *Final Evaluation Report* was to examine the impact of the pilot programs in three primary areas: 1) individual-level outcomes; 2) emergency department and inpatient hospital utilization and costs; and 3) changes to organizational and community systems of care. The following highlights the top-line 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.

Before and After: Hospital Emergency Department and Inpatient Utilization Charges

RESULTS AFTER ONE YEAR

The *Initiative* pilot programs were successful in decreasing frequent users' emergency department and inpatient visits and the associated charges in these areas after one year of program enrollment.³ Overall, emergency department visits dropped by 30 percent and charges fell by 17 percent. Inpatient admissions decreased by 14 percent and charges by 8 percent.

These reductions are striking, especially when taking into consideration that they are tempered by the impact of a small group of "outlier" clients whose catastrophic illnesses or escalating chronic disease required continued and sometimes prolonged inpatient care. Notably, after one year of enrollment, 15 percent of clients accounted for nearly 85 percent of the total inpatient charges. Despite the skewed effects of these clients on overall utilization and charge trends, the pilot programs were still able to reduce emergency department and inpatient use and charges, while serving these often very sick "super frequent users."

One Year in Program	% Change Over One Year
ED Visits	↓30%*
ED Charges	↓17%*
Inpatient Admits	↓14%*
Inpatient Days	↓2%
Inpatient Charges	↓8%*

*Indicates statistically significant

RESULTS AFTER TWO YEARS

For frequent users who were enrolled and tracked for two years, the magnitude of change in emergency department and inpatient utilization and charges was even greater. The following table presents the average emergency department and inpatient visits and charges, as well as the average number of inpatient days per client after receiving one and two years of services from the pilot programs.

Two Years in Program	One Year Pre-Enrollment	One Year in Program	Two Years in Program	% Change Over Two Years
Average ED Visits	10.3	6.7	4	↓61%*
Average ED 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%*

*Indicates statistically significant

³ For the full findings of the *Final Evaluation Report* and information on data sources, methods, and limitations, see *Frequent Users of Health Services Initiative: Final Evaluation Report* at www.frequenthealthusers.org.

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.

RESULTS FOR FREQUENT USERS WITH MEDI-CAL AT ENROLLMENT

A large number of frequent users, 37 percent, were Medi-Cal beneficiaries upon enrollment in the pilot programs. Clients with Medi-Cal at enrollment with two years of data decreased both emergency department and inpatient utilization. After two years in a program, these clients decreased their emergency department visits by 60 percent and reduced their emergency department charges by 55 percent. Inpatient utilization and charge reductions were even greater, with a 67 percent decrease in inpatient admissions, a 69 percent decrease in inpatient days, and an 80 percent decrease in inpatient charges.

Two Years in Program Medi-Cal at Enrollment	One Year Pre-Enrollment	One Year in Program	Two Years in Program	% Change Over Two Years
Average ED Visits	12.6	7.8	5.1	↓60%*
Average ED Charges	\$12,650	\$8,470	\$5,673	↓55%*
Average Inpatient Admits	1.8	1.5	.6	↓67%*
Average Inpatient Days	8.5	7.4	2.6	↓69%*
Average Inpatient Charges	\$61,533	\$40,982	\$12,195	↓80%*

*Indicates statistically significant

Other Achievements

All of the *Initiative* pilot programs endeavored to redirect care from emergency departments to lower-cost community-based settings. The programs assisted frequent users with navigating multiple systems — primary, mental health, substance abuse, and social services systems of care. Through a multidisciplinary team approach, which often included a physician and/or licensed clinical social worker, a case manager, and a benefits advocate, the programs were able to significantly reduce emergency department and hospital inpatient use. In addition to these hospital reductions, the pilot programs also connected frequent users with housing and other non-clinical services, such as transportation and legal advocacy. With these supports, clients were better able to attend appointments, manage prescriptions, and ultimately stabilize their health.

“By developing interventions that more effectively coordinate and serve frequent users, you are also freeing up those resources – financial and physical – to better serve other people.”

Barbara Masters, Public Policy Director,
The California Endowment

CONNECTION TO PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES

Successful connection to primary care and behavioral health services varied across the pilot programs and was influenced by the availability of services in each community, as well as the level of clinic participation and program partnerships with providers and stakeholders. Despite the challenge of accessing clinical services for frequent users, the pilot programs were able to connect most clients to primary care. Sixty-one percent of clients were connected to a community clinic, and 31 percent were assigned a primary care provider. Additionally, 15 percent were connected to specialty medical care. For those frequent users with mental health issues at enrollment, 42 percent were connected to mental health services.

CONNECTION TO HOUSING

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*. Furthermore, evidence suggests that patients with housing are much more likely to experience health stability than patients who are precariously housed or homeless.⁴ Among homeless frequent users enrolled in the programs, 12 percent were connected to permanent housing through HUD housing vouchers, and 69 percent were placed in shelters, board and care homes, or other similar sites.⁵

Connecting homeless frequent users to permanent housing made significant differences in a frequent user's ability to reduce emergency department visits and charges. Those who became connected to permanent housing in the first year of enrollment saw a 34 percent decrease in emergency department visits and a 32 percent decrease in emergency department charges, compared to just a 12 percent decrease in visits and a 2 percent 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, an examination of inpatient length of stay and charges shows striking differences in outcomes. Inpatient days and charges decreased by 27 percent for permanently housed clients, but for those who remained homeless, inpatient days grew by 26 percent and inpatient charges increased by 49 percent. Disparities between clients connected to permanent housing and those who remained homeless were likely the result of discharge planning. State law now requires hospital emergency departments to create a discharge plan for homeless patients.⁶ Hospital stays for homeless patients may be longer than stays for patients with housing, due to prior attention surrounding hospital discharge policies, as well as hospital staff concern for patients' health.

“Homeless people have higher rates of chronic health problems than the general or poverty populations. This takes the form of higher rates of illnesses such as high blood pressure, heart disease, diabetes, lung disease, and HIV disease. This is reflected in the fact that one-third of homeless people note that their health is fair or poor in comparison with about 10% of the overall population who report that they have fair or poor health.”

Dr. Margot Kushel, Associate Professor of Medicine in Residence, UCSF/San Francisco General Hospital

One Year in Program Connected vs. Not Connected	Connected % Change Over 1 Year	Not Connected % Change Over 1 Year
Average ED Visits	↓34%*	↓12%*
Average ED Charges	↓33%*	↓2%*
Average Inpatient Admits	↓27%*	↓23%*
Average Inpatient Days	↓27%*	+26%*
Average Inpatient Charges	↓27%*	+49%*

*Indicates statistically significant

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 percent of frequent users across all programs were either uninsured or underinsured. For these uninsured or underinsured clients, 80 percent were connected to either county indigent health coverage (64%) or Medi-Cal (16%). For those patients who did not have SSI upon enrollment, 20 percent 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.

⁴ Burt, Martha, PhD, & Martinez, Tia, JD, "Impact of Permanent Supportive Housing on the Use of Acute Care Health Services by Homeless Adults." *Psychiatric Services*, Vol. 57, No. 7. July 2006.

⁵ Only pilot programs in Alameda, Santa Clara, and Santa Cruz counties were able to offer clients permanent housing with vouchers.

⁶ In 2006, California passed legislation, AB 2745 (Jones), requiring hospitals to have written discharge plans, including a plan for appropriate post-hospital care, for homeless patients.

Project RESPECT, Alameda County

A community-based model with intensive case management services that include care coordination and service delivery. A multidisciplinary team meets through regular case conferences. Benefits advocacy plays a major role in the team. Clinical team members provide medical care.

Key Characteristics:

- Average number of months in program: 10
- Access to HUD permanent housing vouchers
- Case management in supportive housing settings
- Presence at multiple hospitals
- Direct access to a psychiatrist
- Partners with the HealthCare for the Homeless Program

Partners:

- Highland Hospital
- Lifelong Medical Care
- Homeless Action Center
- Alameda County Medical Center
- Alameda County Behavioral Health Care Services
- Alameda Health Consortium
- Alta Bates Hospital

Project Improving Access to Care (PIAC), Los Angeles County (San Fernando Valley)

A community-based model with case management services that include care coordination and linkage to services. Also has a professional case management staff and benefits advocacy.

Key Characteristics:

- Average number of months in program: 4
- Staff co-located within ED
- Diverse and bilingual staff
- Availability of primary care at the lead organization

Partners:

- Tarzana Treatment Centers
- Valley Care Community Consortium
- Olive View-UCLA Medical Center
- Los Angeles County Department of Health Services
- Los Angeles County Department of Public Social Services
- Neighborhood Legal Services
- Northeast Valley Health Corporation
- Meet Each Need with Dignity
- L.A. Family Housing, Chrysalis, Inc.

New Directions, Santa Clara County

A hospital-based model with case management services that include care coordination and linkage to services, professional case management staff, and a multidisciplinary team that meets through weekly case conferences.

Key Characteristics:

- Average number of months in program: 11
- Assigns clients to primary care provider
- Access to HUD permanent housing vouchers
- Case management to clients in supportive housing programs
- Presence at multiple hospitals
- Provides services at medical respite program
- Partners with HealthCare for the Homeless Program

Partners:

- Hospital Council of Northern and Central California
- Santa Clara Valley Medical Center
- O'Connor Hospital
- St. Louise Regional Hospital
- Silicon Valley Health Coalition

Project Connect, Santa Cruz County

A community-based model with case management services that include care coordination and direct service delivery, a multidisciplinary team, and benefits advocacy. Clinical team members provide medical care to participants.

Key Characteristics:

- Average number of months in program: 16
- Data sharing with Sheriff's Department and ambulance provider
- Team members provide (and bill for) direct medical and case management services
- Access to HUD permanent housing vouchers
- Case management in supportive housing settings
- Presence at multiple hospitals
- Co-located with HealthCare for the Homeless Program

Partners:

- Dominican Hospital of Santa Cruz
- Watsonville Community Hospital
- Santa Cruz County Health Improvement Partnership Council and Safety Net Coalition
- Central Coast Alliance for Health

The Care Connection, Sacramento County

A hospital-based program with peer based intervention and a short-term model that provides linkage to services and system navigation skills.

Key Characteristics:

- Average number of months in program: 5
- Peer-to-peer support
- Integrated and supported within the ED
- Staff are co-located within ED
- Dedicated housing specialist

Partners:

- UC Davis Medical Center
- Harm Reduction Services
- Mexican American Alcoholism Program
- Transitional Living and Community Support
- The Salvation Army

The Bridge, Tulare County

A hospital-based model with case management services that include care coordination and linkage to services by paraprofessional staff.

Key Characteristics:

- Average number of months in program: 10
- Presence in multiple hospitals
- Co-located within ED
- Diverse and bilingual staff
- Clients are linked to community clinic for primary care
- Developed shared database to track client ED and clinic use across multiple sites
- Financial flexibility with paraprofessional model

Partners:

- Kaweah Delta Health Care District
- Tulare District Health Care Systems
- Sierra View District Hospital
- Family Health Care Network
- Tulare Community Health Clinic
- Tulare County Health and Human Services Agency
- Health and Mental Health Clinics

How Did the Programs Work?

PROGRAM COSTS

The six pilot programs developed tailored models and interventions to address the range of presenting conditions of frequent users in their hospitals and communities. As noted, 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, programs costs also varied. Based on estimates from the Corporation for Supportive Housing, 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.

PROGRAM SERVICES AND STRATEGIES

Project RESPECT
 PIAC
 The Care Connection
 New Directions
 Project Connect
 The Bridge

Outreach and Client Engagement Strategies						
Electronic “flagging system” in ED for automated referral process		X	X	X		X
Program staff are co-located within the emergency department for “real time” access		X	X			X
Program has access to vouchers for permanent housing	X			X	X	
Program staff provide ongoing case management for housed clients	X			X	X	
Program has penetration/presence at multiple hospitals across the county	X			X	X	X
Program staff is diverse and bilingual		X			X	X
Uses incentives to enhance recruitment (phone cards, grocery vouchers, etc.)	X	X	X	X	X	X
Transportation assistance is provided (bus passes, taxi vouchers, home visits)	X	X	X	X	X	X
Staff accompany/attend client appointments	X	X	X	X	X	X
Team Composition and Service Delivery						
Multidisciplinary provider team directly bill for direct physical and mental health svcs.	X			X	X	
Staff or partner provides benefits advocacy for clients	X	X		X		
Peers are part of the team and are integrated into hospital collaboration			X			
Case conferences with a multidisciplinary provider group are held regularly	X			X	X	X
Program has direct access to a psychiatrist	X			X		
Program partnership with HealthCare for the Homeless program	X			X	X	
Transitions clients over time to less intensive services through tiered levels of case management to balance caseloads	X	X		X	X	X
Partnerships and Collaborations						
Collaborates with multiple hospitals across the county and can track clients’ utilization throughout the community	X			X	X	X
Program has strong support from hospital administration, including a shared vision and recognition of the value of the program	X		X	X		X
Hospital partners communicate and collaborate on other issues beyond frequent ED use/support case management function of FUHSI program (pay/patient)	X			X	X	X
Program has a strong physician champion or program champion in the community	X			X	X	
Program has strong partnerships with MH, housing, primary care, SA, and legal services to enhance client access to needed services	X			X	X	
Systems Change Focus						
Collaborative has moved beyond operations to address broader policy/systems issues	X			X	X	
Collaborative partners take collective responsibility in resolving frequent user issue	X			X	X	
Addresses pain management through appropriate training and protocols for frequent users with issues related to pain control	X			X	X	X
Data Collection and Evaluation						
Has process in place to track data elements across multiple systems (hospital charge/ costs, primary care, MH, SA, EMS, jail bookings)				X		
Countywide database links hospital, primary care, and MH service utilization						X

Promising Practices

The collective experiences of the *Initiative* pilot programs, including the successes and challenges, generated significant lessons in the areas of program planning, staff composition, client engagement, service delivery, partnership development, and data collection and evaluation. The following are highlights of these lessons learned. Further exploration of the promising practices and lessons learned from the *Initiative* pilot programs can be found in the *Initiative* toolkit, *Meeting the Needs of Frequent Users: Building Blocks for Success* at www.frequenthelthusers.org.

PROGRAM PLANNING AND IMPLEMENTATION

Programs met challenges in developing and establishing their programs, strengthening and solidifying partnerships, raising awareness among stakeholders, and demonstrating program accomplishments and systems change results over a short period. However, by creating partnerships and collaborating with stakeholders early in the planning and implementation phases, *Initiative* programs were able to raise the visibility and awareness of their efforts and gain further buy-in from hospitals, county agencies, and community-based service providers.

STAFFING

An important lesson of the *Initiative* programs was the need to hire staff experienced in working with a deeply complex population with multiple medical and psychosocial needs. The programs implemented flexible schedules to enhance their availability to referrals from emergency departments. Accessibility of program staff to emergency department providers ultimately helped to promote hospital buy-in and enhanced partnership with the programs.

CLIENT ENGAGEMENT

Use of incentives such as food boxes, transportation assistance, benefits advocacy, and housing vouchers greatly enhanced client engagement and program participation in the *Initiative* pilot programs. The evaluation found that the primary reasons for client disenrollment included program completion/graduation (29%), loss to follow-up (19%), failure of client to participate (16%), and death (15%).

Programs reported that clients who were medically fragile, specifically those with mobility and/or ambulation problems, were more motivated to engage in the programs. Despite having access to needed services, because of their compromised health status, this population may not experience significant health improvements. However, participation in the programs often increased quality of life and enabled some clients to decrease their use of acute and costly services.

SERVICE DELIVERY

In general, the pilot programs incorporated a cross-system, multidisciplinary approach using a variety of interventions to address the complex needs of frequent users. Notably, the programs' ability to connect uninsured clients to needed insurance and other benefits presented opportunities to gain local support, since an approved application for SSI benefits often results in a hospital's ability to back-bill Medi-Cal for care provided to the patient since their SSI application date. Doing so enabled one hospital participating in Project RESPECT in Alameda County to retroactively bill for uninsured patients and reduce costs associated with uncompensated care.

“Although the *Initiative* focused on frequent users, it has implications for other pieces of the system where there are similar problems. The *Initiative* is about how to meet the needs of people, while spending resources responsibly and with accountability.”

*Margaret Laws, Director,
Innovations for the Underserved,
California HealthCare Foundation*

CONNECTION TO HOUSING

Another key lesson learned by the *Initiative* pilot programs was the importance of permanent housing to achieving health stability, as noted above. The lack of housing options for homeless frequent users often hindered progress that the other services, such as mental health services, substance abuse treatment, and medication stabilization, would have produced with the availability of stable permanent housing.

COLLABORATION/PARTNERSHIP DEVELOPMENT

Sustaining hospital (especially emergency department) commitment and buy-in was challenging for many of the *Initiative* pilot programs. High turnover and rotation of emergency department staff affected the continuity of program understanding and hindered the referral process. The programs found that having consistent staff presence in the emergency department was helpful to bridge organizational cultures, to provide opportunities to train new emergency department staff, and to reinforce existing relationships. Community hospital participation was motivated in part by the potential to decrease inpatient admissions and lengths of stay among uninsured patients.

Establishing broad stakeholder buy-in was sometimes difficult because of perceptions about frequent users (e.g., that they are unemployed, homeless, or substance abusers). By taking a prevention approach and by serving frequent users at the end stages of their illnesses, the pilot programs were able to enhance buy-in with some stakeholder groups.

PROGRAM EVALUATION

For the *Initiative* pilot programs, program evaluation enhanced the program's ability to shape the program. Information gleaned from program evaluation in its earliest stages, as well as a consistent data collection plan, helped to inform the programs' evolution. The pilot programs found that sharing preliminary results with staff and partner agencies was an important strategy in strengthening relationships and partnerships. Preliminary positive results provided an impetus to continue these relationships and partnerships.

Conclusion

Overall, the six pilot programs funded through the *Initiative* reduced avoidable use of emergency department services, decreased inpatient hospital utilization, and connected clients to housing, income benefits, health insurance, and a primary care home. The pilot programs diverged in achieving systems change goals in their counties, but all gained considerable understanding of the roots of systems change, as well as methods of overcoming barriers. Many of the pilot programs achieved sustainability by developing strategies to secure funding for their programs and continue serving frequent users without philanthropic support.

Local and state budget shortfalls compel communities to seek smarter ways to use limited resources, while providing the quality health care people require. Evaluation results from the *Initiative* programs show that coordinated, multidisciplinary care for frequent users with psychosocial barriers can reduce emergency department visits and hospital stays and costs, while improving patient health and quality of life. Frequent user programs succeeded in helping this population to access needed benefits and resources, such as primary and mental health care, SSI, Medi-Cal, and federal housing support. Moreover, frequent user programs are often cost-neutral, as they redirect clients from high-cost acute care to less costly and more responsive community-based care.

FOR MORE INFORMATION

The Corporation for Supportive Housing will continue to promote the best practices identified by the *Initiative's* frequent user programs, and to explore policy opportunities created by the *Initiative's* evaluation findings. For more information about Corporation for Supportive Housing policy efforts, visit www.csh.org.

For more information about the *Initiative*, visit www.frequenthealthusers.org.

The following additional *Initiative* reports and materials are available at www.frequenthealthusers.org:

The Frequent Users of Health Services Initiative: Final Evaluation Report

Meeting the Needs of Frequent Users: Building Blocks for Success

Frequent Users of Health Services: Barriers to Care

Policy Barriers and the Impact of Categorical Programs

The Case for Case Management

How Medi-Cal Can Finance Effective Interventions to Reduce Avoidable Emergency Department Use

ADDITIONAL RESOURCES

AB 2034 Program Experiences in Housing Homeless People with Serious Mental Illness

Corporation for Supportive Housing, www.csh.org, December 2005

Adapting Your Practice: General Recommendations for the Care of Homeless Patients

Health Care for the Homeless Clinicians' Network, www.nhchc.org, 2004

Characteristics of Frequent Emergency Department Users

Kaiser Family Foundation, www.kff.org, October 2007

Characteristics and Interventions for People who Experience Long-Term Homelessness

2007 National Symposium on Homelessness Research, aspe.hhs.gov, February 2007

Community-Wide Strategies for Preventing Homelessness: Recent Evidence

Urban Institute, www.urban.org, June 2007

Costs of Serving Homeless Individuals in Nine Cities

The Partnership to End Long-Term Homelessness, www.rwjf.org, November 2004

The Impact of Community Health Centers & Community-Affiliated Health Plans on Emergency Room Use

National Association of Community Health Centers, www.nachc.com, April 2007

Leveraging Medicaid: A Guide to Using Medicaid Financing in Supportive Housing

Corporation for Supportive Housing, www.csh.org, July 2008

Urgent Matters: An initiative to improve hospital flow and reduce emergency department crowding

www.urgentmatters.org

ACKNOWLEDGEMENTS

The *Initiative* was a collaborative effort guided by an oversight group and an advisory committee and managed by a program office. The programs funded by the *Initiative* were partnerships among public and private agencies, service providers, and stakeholder organizations.

PILOT PROGRAMS

Project RESPECT (located in Alameda County)
Project Improving Access to Care (located in Los Angeles County)
Care Connection (located in Sacramento County)
New Directions (located in Santa Clara County)
Project Connect (located in Santa Cruz County)
The Bridge (located in Tulare County)

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

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