

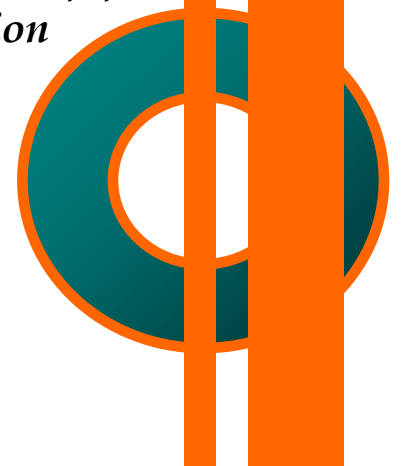
*Frequent User Programs:*

*How Services Are Provided to People  
Who Frequently Use Emergency  
Departments in California*

*Prepared by  
The Corporation for Supportive Housing*

*On Behalf of  
The California Health Care Foundation*

*August 2010*



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## Introduction

Studies document that a small cohort of individuals account for a disproportionate share of acute medical care use. Among this cohort, people who frequently use emergency departments for avoidable reasons (“frequent users”) consume significant resources, but have poor health outcomes.<sup>1</sup> The Frequent Users of Health Services Initiative (“the Initiative”), funded jointly by the California Health Care Foundation and The California Endowment, created six programs in 2002 that targeted and provided services to frequent users to improve health outcomes and test delivery system models.

Initiative programs, in geographically diverse regions, used different strategies to reduce emergency department use among frequent users. As indicated in the Lewin Group’s Final Evaluation of the Initiative, programs that provided intensive interventions to frequent users were successful in improving the health of the enrollees. Frequent user participants not only decreased their emergency department visits, they also significantly reduced hospital charges while lowering their hospital admissions and the number of days they spent in the hospital.<sup>2</sup> Four of the six programs are still in existence, despite the end of grant funding in 2008.

Before the Initiative began testing approaches to serving frequent users throughout the state, staff at San Francisco General Hospital (“SFGH”) had been providing intensive case management to frequent users of their emergency department since 1995 (though the services are provided through the Psychiatry Department, the program serves individuals with medical emergencies). In 2000, the SFGH Emergency Department Case Management program released a report that indicated intensive interventions resulted in hospital savings.<sup>3</sup> Researchers conducted a follow-up randomized control group study and confirmed that frequent users who receive intensive services decrease emergency department use. Study authors concluded the costs of the program were no more expensive than costs avoided from enrollees’ reductions in emergency department visits.<sup>4</sup>

Partly due to results from programs like these, frequent users have garnered increased interest in recent years. In April 2009, an Associated Press article reported that nine Medicaid beneficiaries accounted for 2,700 visits to the emergency department in Austin, Texas, resulting in costs to taxpayers of \$3 million.<sup>5</sup> The story was reported across the media outlets and followed a

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<sup>1</sup> Baker, D., et. al. “Regular Source of Ambulatory Care and Medical Care Utilization by Patients Presenting to a Public Hospital Emergency Department. *JAMA*. 1994; 271: 1909-12; Mandelberg, J.H., et. al. “Epidemiologic Analysis of an Urban, Public Emergency Department’s Frequent Users.” *Acad. Emerg. Med.* June 2000; 7(6): 647-46; Kushel, MB, et. al. “Emergency Department Use Among the Homeless and Marginally Housed: Results from a Community-Based Study.” *Am. J. Public Health*. 2002; 92(5): 778-784.

<sup>2</sup> Linkins, K., et. al. *Frequent Users of Health Services Initiative: Final Evaluation Report*. Aug. 2008. [www.csh.org/fuhsi](http://www.csh.org/fuhsi).

<sup>3</sup> Based on costs pre-enrollment versus post-enrollment in the program, the study reported that, for every \$1 spent on the program, the hospital received \$1.44 in savings. Okin, RL, et. al. “The Effects of Clinical Case Management on Hospital Service Use Among ED Frequent Users.” *Am. J. Emerg. Med.* 2000; 18(5): 603-08.

<sup>4</sup> Shumway M, Boccellari A, O’Brien K, et al. “Cost-effectiveness of Clinical Case Management for ED Frequent Users: Results of a Randomized Trial.” *Am J Emerg Med.* 2008;26:155-164.

<sup>5</sup> “Nine Patients Account for Nearly 2,700 Texas ER Visits.” *Associated Press*. Apr. 2, 2009 (reported in *Dallas Morning News* and *National Public Radio*, among other news outlets).

Washington State Medicaid program report that 200 Medicaid beneficiaries averaged 45 visits to the emergency department a year, for a total of 9,000 emergency department visits.<sup>6</sup>

These statistics contributed to a discussion about the population during debate over the Patient Protection and Affordable Care Act (“Health Reform”), even prompting President Obama to mention frequent users before a Joint Session of Congress.<sup>7</sup> The Annals of Emergency Medicine, in response, conducted a literature review after passage of Health Reform that called into question assumptions about frequent users, stating that frequent users, though not homogenous, generally seek emergency department care for serious medical conditions rather than for frivolous reasons, and are typically publicly insured. The research review also reported that programs providing intensive case management services yield the most effective outcomes.<sup>8</sup>

In the wake of increased awareness of frequent users, and the costs incurred as a result of their poor health outcomes on California’s hospitals and public health care systems, counties and hospitals throughout California have been developing community-based case management models to serve frequent users.<sup>9</sup> Programs exist in both urban and rural communities and in public and private hospitals. Like the Initiative programs, no two existing frequent user programs are identical in program design, though almost all provide intensive case management services, and all are intended to reduce emergency department visits and inpatient stays, to control hospital costs, to reduce readmissions, and to improve health outcomes.

To survey these programs, the California Health Care Foundation engaged the services of the Corporation for Supportive Housing (“CSH”) to draft a report regarding existing frequent user programs in California. CSH identified 12 existing frequent user programs throughout the state, and some programs described are replicated in multiple hospitals or across multiple sites. One program in San Mateo County recently ended due to budget cuts; nevertheless, the program is detailed in this report as a model that may be reinstated in better economic times. In drafting this report, CSH interviewed program directors and reviewed reports regarding program outcomes. The report includes a comparison of program approaches, a description of each program by county, and an overview of observations from program directors. Finally, the report identifies best practices and challenges of developing future frequent user programs.

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<sup>6</sup> Mancuso, D., et. al. “Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness.” *Washington State Department of Social and Health Services, Research and Data Analysis Division*. June 2004; Report No. 11.119fs.

<sup>7</sup> Arnst C. “McCain Health-Care Proposal.” *Business Week*. April 29, 2008. Available at: [http://www.businessweek.com/bwdaily/dnflash/content/apr2008/db20080429\\_854428.htm](http://www.businessweek.com/bwdaily/dnflash/content/apr2008/db20080429_854428.htm); Obama, B. “Remarks by the President to a Joint Session of Congress on Health Care, Sept. 9, 2009; US Capitol, Washington, DC. Available at: [http://www.whitehouse.gov/the\\_press\\_office/Remarks-by-the-President-to-a-Joint-Session-of-Congresson-Health-Care](http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congresson-Health-Care).

<sup>8</sup> Though the report indicated that programs that target frequent users have “mixed results,” the report authors acknowledged that programs providing intensive case management yield consistent improved outcomes. LaCalle, E., Rabin, E. “Frequent Users of Emergency Departments: The Myths, the Data, and the Policy Implications.” *Annals of Emergency Med.* Vol. 56; No. 1; 42-48. July 2010.

<sup>9</sup> Data from the Department of Health Care Services provided to Senate President pro tem Darrell Steinberg in 2008 revealed that over 28,000 Medi-Cal beneficiaries visit the emergency department at least five times a year for two or more chronic conditions.

## Summary & Comparison of Programs

Program Name	Criteria for "Frequent User"	Multi-disciplinary Team	Staffing	Benefits Advocacy	Housing For Homeless Clients	Case Manager Staff-to-Client Ratio	Funding	Program Began	Costs Per Client per Year
Project RESPECT (Alameda County)	10 ED visits w/in 12 months, or 4 ED visits each year for 2 consecutive years	On the team: .15 Nurse practitioner  Physician consultation  .05 Psychiatrist	Also on team: .5 Licensed Clinical Social Worker  2 Case Managers  .15 Benefits Advocate  .20 Program Manager	Provided through partnership with Homeless Action Center	Shelter Plus Care housing vouchers	1:20	Hospitals (Alta Bates, Summit Medical Center, Highland), Alameda Health Care Services Agency	2004	Average of \$5,250, including costs of clinical services
Community Connections (Fresno County)	9 ED visits w/in 12 months, or 6 visits w/in 6 months	Monthly consultations w/physicians (for clients w/chronic diseases)	On team: 1 Program Coordinator  2 Outreach Specialists	Assist uninsured clients to obtain Medi-Cal and County Insurance	Connected 3 clients to shelter services; In process of obtaining 5-10 Shelter Plus Care Vouchers	1:20	Hospital (Community Regional Medical Center)	Sept. 2009	No data yet available

Program Name	Criteria for "Frequent User"	Multi-disciplinary Team	Staffing	Benefits Advocacy	Housing For Homeless Clients	Case Manager Staff-to-Client Ratio	Funding	Program Began	Costs Per Client per Year
Kern Medical Center Care Transitions & Coordination Program (Kern County)	4 ED visits w/in 12 months, 2 admissions and 1 ED visit w/in 12 months, or 3 admissions w/in 12 months	Connects clients to primary care (initially included clinical staff on team, but no clinical staff currently)	On team: 2 Care Managers  1 Project Manager	Initially engaged legal services agency to provide benefits advocacy, but no longer partnering w/agency	No	1:30 to 1:35	Kern County Coverage Initiative	2008	Data unavailable
Project 50 (Los Angeles County)	3 ED visits w/in 3 months, or mix of 3 ED visits and/or hospitalizations w/in 12 months	On the team: .5 Psychiatrist  1 Nurse Practitioner  1 Licensed Vocational Nurse  1 Medical Assistant	Also on team: 2 LCSWs  1 MSW  1 Outreach Worker  2 Case Managers	Yes	All clients placed in permanent supportive housing	1:20	Los Angeles County  FQHC Provides Some Services	2007	Report will be released Spring 2011 regarding costs.

Program Name	Criteria for "Frequent User"	Multi-disciplinary Team	Staffing	Benefits Advocacy	Housing For Homeless Clients	Case Manager Staff-to-Client Ratio	Funding	Program Began	Costs Per Client per Year
Care Transitions & Coordination Program (Los Angeles County)	LAC+USC: 2 ED visits w/in 12 months Kaiser Sunset: 3 or more ED visits Long Beach Memorial: Hospital staff referrals Hollywood Presbyterian: 2 or more ED visits or hospital admissions or diagnosis of congestive heart failure	Medical Director on team Coordination of care w/health care professionals	Also on team: 1 Program Admin. LAC+USC: 3 Care Managers Kaiser Sunset: 2 Care Managers Long Beach and Hollywood: 2 Care Managers	None	Linkage to shelter and transitional housing	1:30 to 1:35	LAC+USC: Initially through UniHealth Foundation grant, then through Board of Sups. grant Kaiser Sunset: Foundation grant Long Beach and Hollywood: Hospitals (Long Beach Memorial, Hollywood Presbyterian)	LAC+USC: Dec. 2004 Kaiser Sunset: Dec. 2008 Long Beach: Oct. 2008 Hollywood: April 2010	Approx. \$1,800

Program Name	Criteria for "Frequent User"	Multi-disciplinary Team	Staffing	Benefits Advocacy	Housing For Homeless Clients	Case Manager Staff-to-Client Ratio	Funding	Program Began	Costs Per Client per Year
Triage, Transport, and Treatment (T3) Program (Sacramento County)	Criteria based on history and background of client	Clinical services offered through FQHC	On team: 1 LCSW  5 Case Managers  1 Program Director	Yes, by case managers	Connects clients to transitional and permanent supportive housing programs & provides services in supportive housing	1:20 to 1:25	Sutter Medical Center, Sacramento  Some behavioral health services billable to Medi-Cal	2007	Varies
Serial Inebriate Program (San Diego County)	5 or more visits to reception center or ED for public intoxication	Drug and alcohol abuse treatment	1 Police Officer	No	All clients placed in six-month group residential housing	NA	City and County of San Diego	2000	Exact costs unknown, but cost of whole program is \$200,000 per year.



Program Name	Criteria for "Frequent User"	Multi-disciplinary Team	Staffing	Benefits Advocacy	Housing For Homeless Clients	Case Manager Staff-to-Client Ratio	Funding	Program Began	Costs Per Client per Year
Emergency Department Case Management Program (San Francisco)	5 ED visits w/in 12 months	On team: .90 Nurse Practitioner  .50 Primary Care Physician  .25 Psychiatrist	Also on team: 5 Case Managers  1 Supervisor  1 Program Coordinator  1 Admin. Assistant	Link clients to benefits advocacy through partnership with County's Disability Evaluation Consultation Unit	Short-term vouchers for SROs  Shelter Plus Care Vouchers	1:13 to 1:15	County Department of Public Health	1995	Data unavailable
New Directions (Santa Clara County)	8 or more ED visits w/in 12 months, County residency	On team: .125 Psychiatrist  .125 Medical Director	Also on team: 7 MSW-Level Social Work Case Managers  1 LCSW Case Manager Supervisor	Recent partnership w/community benefits advocates	25 HUD vouchers, obtaining additional vouchers (22 additional vouchers for respite clients)	1:25	Hospitals (Santa Clara Valley, Good Samaritan, O'Connor, El Camino)  Respite grant foundation funding	2002	\$6,000 (including costs of clinical services)

Program Name	Criteria for "Frequent User"	Multi-disciplinary Team	Staffing	Benefits Advocacy	Housing For Homeless Clients	Case Manager Staff-to-Client Ratio	Funding	Program Began	Costs Per Client per Year
Project Connect (Santa Cruz County)	<p>CCAH: 10 ED visits w/in 6 months, or 20 w/in 12 months</p> <p>Dominican: 10 ED visits w/in 6 months, or 8 w/in 12 months</p> <p>Generally, also have psycho-social condition</p>	<p>On team: .50 Public Health Nurse</p> <p>.20 Nurse Practitioners</p>	<p>Also on team: Project Director</p> <p>.6 LCSW Case Manager Supervisor</p> <p>1 Case Manager</p> <p>1-2 MSW Interns (housing support)</p>	Benefits Advocate Working for Homeless Person's Health Project	Shelter Plus Care Vouchers	1:20	<p>Santa Cruz County</p> <p>Central Coast Alliance (Medi-Cal Managed Care)</p>	2004	Current costs unknown; CCAH members incur costs of \$4,428
Frequent User Program (Solano County)	3 ED visits w/in 1 month	None	1 Case Manager	Through Case Manager	None	1:10	Solano County	October 2008	\$16,000, including hospital costs

Program Name	Criteria for "Frequent User"	Multi-disciplinary Team	Staffing	Benefits Advocacy	Housing For Homeless Clients	Case Manager Staff-to-Client Ratio	Funding	Program Began	Costs Per Client per Year
The Bridge (Tulare County)	8 or more ED visits w/in 12 months or 5 or more ED visits w/in 6 months	Regular discussions w/treating physicians	On team: 1 Project Director  4 Case Managers  Hiring 1 Outreach Specialist	For uninsured patients admitted to hospital, case managers now offer assistance in proving eligibility for insurance	Shelter Plus Care Vouchers	1:25 to 1:30	Kaweah Delta Hospital	2004	\$1,682

Program Name	Criteria for "Frequent User"	Multi-disciplinary Team	Staffing	Benefits Advocacy	Housing For Homeless Clients	Case Manager Staff-to-Client Ratio	Funding	Program Began	Costs Per Client per Year
HOME Team (San Mateo County) (funding ended June 2010)	7 ED visits w/in 12 months, County residency, uninsured or under-insured status	On team: Public Health Nurse	Also on team: 1 Social Work Supervisor  1 Social Worker  1 Community Worker	Through HOME Team staff	Shelter and permanent housing vouchers	No data	San Mateo County Agencies: Aging and Adult Services, Alcohol and Other Drug Services, Health Foundation, Human Services Agency, STARS Award  Medi-Cal Targeted Case Management  Silicon Valley Community Foundation	2007	No data

## *Program Descriptions*

### *Alameda County: Project RESPECT*

#### **Program Description:**

Project RESPECT was initially funded through a grant from the Frequent Users of Health Services Initiative. Though grant funding ended in 2008, the program was able to secure funding through hospital partners and Alameda County.

The program offers a community-based multidisciplinary approach to serving insured and uninsured frequent users, providing intensive case management and medical and behavioral health services to enrollees. Case management and clinical staff meet regularly about specific frequent user enrollees. Many of the enrollees suffer from very serious medical conditions, as well as serious mental illness and substance abuse disorders. Over the years, referrals from emergency department staff have included more gravely ill participants.

The program has strong partnerships with community services, which facilitates the “whatever it takes” approach that Project RESPECT offers. The program provides benefits advocacy services to clients who have no regular source of income to obtain Supplemental Security Income (SSI) and Medi-Cal. In turn, benefits advocacy allows the County and LifeLong Medical Care to back bill Medi-Cal for medical services and giving clients an income. The SSI income allows clients who are homeless to secure permanent housing more easily. The program also partners with the County’s Continuum of Care program to acquire housing vouchers for homeless clients with disabilities. Because of the program’s strong commitment to creating and maintaining partnerships, the program has gained community acceptance.

#### **Partners:**

- LifeLong Medical Care, a Federally-Qualified Health Center providing primary and behavioral health care services;
- Alameda Health Consortium, an association of community health centers;
- Alameda County Shelter Plus Care, which funds tenant-based and project-based supportive housing vouchers for people who are disabled and homeless;
- Homeless Action Center, offering legal assistance and representation to clients applying for entitlement programs, like Supplemental Security Income (SSI) and Medi-Cal; and
- Alameda County Behavioral Health Care Services.

#### **Hospitals:**

- Highland Hospital (Alameda County Medical Center);
- Alta Bates Hospital; and
- Summit Medical Center.

#### **Funding Sources:**

- Contracts with hospitals and
- Alameda Health Care Services Agency (through June 2011).

**Staffing:**

- .50 Licensed Clinical Social Worker;
- 2 Paraprofessional Case Managers;
- .15 Benefits Advocate;
- .15 Nurse Practitioner;
- .05 Psychiatrist;
- Consulting Physician; and
- .20 Program Manager.

**Method of Identifying Frequent Users:**

- Emergency department staff identifies patients meeting the criteria of 10 or more emergency department visits per year or four or more visits in two consecutive years and place identified patients on “hot lists” for referral.
- The program is currently exploring the use of a web-based case management tool to identify frequent users and share information with team members, potentially operational in September 2010.

**Outreach and Engagement of Frequent Users:**

- The case managers find clients wherever the client is residing (in shelters, vehicles, or on the streets, in the case of homeless clients), if the case manager cannot get to the emergency department in time to speak with a potential client.
- Case managers engage clients in the services by meeting client needs, either for housing vouchers, transportation, food, etc. The program uses gift cards on occasion as an incentive for potential participants to engage in services offered.

**Services Provided:**

- Primary care;
- Mental health care;
- Substance abuse counseling;
- Referral for substance abuse treatment services;
- Case management;
- Skills training;
- Medication monitoring/management;
- Shelter Plus Care housing vouchers; and
- Benefits advocacy.

**Average Time in Program:**

10 months

**Case Management Staff-to-Client Ratio:**

1:20

**Program Costs/Client:**

Program costs currently average \$5,000 to \$5,500 per year, including clinical services, behavioral health care (if the client is uninsured), case management, and benefits advocacy.

**Outcomes:**

The program has not continued to track outcomes systematically since the Final Evaluation of the Frequent Users of Health Services Initiative report was released in August 2008. At that time, the Lewin Group reported the following outcomes:

- 40% of homeless clients connected to permanent housing;
- 88% of clients without income approved for SSI;
- 57% of clients connected to a primary care physician;
- 73% of clients with mental illness receiving mental health treatment; and
- Clients' decrease by 63% emergency department visits.

The program showed a 16% increase in inpatient admissions for clients in their first year of receiving Project RESPECT services. Yet, the level of severity of several of the Project RESPECT clients skewed these results, as these highly-vulnerable clients began receiving long-overdue hospital care after enrolling in the Program during the first year. Program clients who were not lost to follow-up or death in the first year actually reduced their accrued hospital charges by 18%.

**Number of Clients Served to Date:**

Approximately 150-200 clients served since the program began.

**Program Began:**

2004

**Contact:**

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## ***Fresno County: Community Connections***

### **Program Description:**

Community Connections is a hospital-based program of Community Regional Medical Center, providing community-based intensive case management and outreach services, and connecting clients to primary, mental health, and substance abuse treatment. It began serving clients in September 2009. The program coordinator modeled the program design from the Frequent Users of Health Services Initiative programs in Tulare, Santa Clara, and Santa Cruz Counties. Program staff participate in interdisciplinary meetings that may include medical and mental health providers to discuss specific needs of individual clients and determine how to meet those needs.

The program has collaborated with several community entities, including Fresno County Department of Behavioral Health, to refer clients for mental health care. Clients have been referred to substance abuse treatment within and outside the county. Though the majority of clients the program has served are Medi-Cal beneficiaries, the program assists uninsured clients to obtain SSI, Medi-Cal, and public assistance.

### **Collaboration:**

- Fresno County Department of Behavioral Health;
- Community Regional Medical Center Ambulatory Clinic, Case Management, Emergency Department, Asthma Clinic, and Diabetes Clinic;
- Clinica Sierra Vista;
- Poverello House;
- Holy Cross Clinic;
- Faith-based community; and
- Community Based Organizations, including Adult Protective Services and In-Home Supportive Services.

### **Hospital:**

Community Regional Medical Center

### **Funding Source:**

Community Regional Medical Center

### **Staffing:**

- 1 MSW Program Coordinator (working on obtaining license) and
- 2 Outreach Specialists.

### **Method of Identifying Frequent Users:**

The hospital identified patients who met the criteria of nine or more emergency department visits within 12 months or six or more visits within six months based on hospital data. Program staff assess and enroll clients based on this list.

### **Outreach and Engagement of Frequent Users:**

- If a potential client appears on the identified list of patients, the Emergency Department Social Worker will refer the potential client to program staff to facilitate an introduction



with the patient. Otherwise, program staff contact potential clients at home or in the community. A nurse practitioner working at a partner shelter also contacts program staff if a potential client appears at the shelter.

- The program occasionally uses incentives to engage clients in program services, such as gas cards, grocery gift cards, and retail store gift cards.

**Services Provided:**

- Outreach and engagement;
- Linkage to primary care physicians in community clinics;
- Assistance with establishing a medical home;
- Advocacy with health care providers;
- Obtainment of behavioral and health care appointments;
- Assistance in coordinating care;
- Attendance at appointments with clients;
- Linkage of uninsured clients to Medi-Cal and County Coverage Initiative program;
- Provision of taxi vouchers and bus passes or tokens for clients to attend appointments;
- Completion of home visits for supportive counseling;
- Assistance with scheduling and follow-up of appointments;
- Assistance with obtaining identification;
- Linkage to substance abuse and mental health services;
- Linkage to social services and supports (SSI, general relief, food stamps);
- Linkage to financial services; and
- Linkage to shelter and housing

**Average Time in Program:**

Too early in the program's history to obtain accurate data.

**Case Manager Staff-to-Client Ratio:**

Approximately 1:20.

**Average Costs Per Client:**

Too early in the program's history to obtain accurate data.

**Outcomes** (in the process of pre- and post- data collection):

- Linked three people to shelter services;
- Connected multiple clients with severe mental illness to county mental health services;
- Brokered residential substance abuse treatment in Los Angeles and Washington State;
- Reduced emergency department visits among clients;
- Obtained primary care and specialty care services for clients, including dental services for one client with severe dental needs; and
- Provided food assistance to clients through church donations.

**Number of Clients Served to Date:**

73 people total, with an active enrollment of 51 clients (others lost to follow-up or death).

**Program Began:**

September 2009

**Contact:**

Caine Christensen, Program Coordinator

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## ***Kern County: Care Management Program (now called Care Transitions & Coordination)***

### **Program Description:**

Through a contract with Kern Medical Center, COPE Health Solutions, a not-for-profit health service provider, offers care management to people who frequently visit Kern Medical Center's emergency department (ED) or who have frequent admissions to the hospital. The program is funded through the Kern County Coverage Initiative—the Coverage Initiative is a program in 10 counties statewide intended to provide medical homes to people who are uninsured. Since the Coverage Initiative funds the program, all of the clients of the program are uninsured.

The Coverage Initiative program in Kern County helps clients navigate the health care system and attempts to eliminate barriers to receiving primary care. Because of its partnerships with health care providers, it connects clients to one of 14 community clinics within the client's neighborhood and eliminates barriers county residents often face, such as long travel times and difficulties accessing appointments for primary care. The program provides clients with a care manager who helps clients coordinate appointments and access social and medical resources as well.

### **Partners:**

- National Health Services, a Federally-Qualified Health Center that provides medical and behavioral health care (10 clinic sites);
- Community Action Partnership of Kern Family Health Center, part of a community action agency that offers employment training and provides food assistance (one clinic site); and
- Kern Medical Center outpatient clinics (3 clinics at 2 sites).

### **Hospital:**

Kern Medical Center

### **Funding Sources:**

Kern County Coverage Initiative.

### **Staffing:**

- 2 trained Paraprofessional Care Managers with prior experience in the health care field or case work;
- 1 Project Manager; and
- 1 Medical Director, who oversees the program.

### **Method of Identifying Frequent Users:**

The County provides care managers with lists of enrolled Coverage Initiative clients who have visited the emergency department at least four times within one year, who have two hospital admissions with an emergency department visit over a year, or who have had three or more hospital admissions over the course of a year. The hospital updates this list monthly.

### **Outreach and Engagement of Frequent Users:**

Staff contact potential clients at the time of hospitalization, by phone, or in homeless shelters.

**Services Provided:**

- Accompaniment to health care appointments as an advocate for care;
- Help in managing medications;
- Obtainment of appointments with primary care physicians (otherwise difficult to access);
- Assistance in navigating the health care system;
- Visitation of clients in their homes to provide services if the client is unable to obtain transportation or physically unable to travel to the medical center;
- Assistance in accessing social services existing in the community, including helping clients with applications for Food Stamps and Housing Choice vouchers;
- Assistance in obtaining food baskets from local entities as needed;
- Connection with free legal assistance if needed;
- Linkage to emergency shelter and transitional housing; and
- Provision of bus tokens to help clients get to and from medical appointments.

**Average Time in Program:**

Six to 12 months (attempting to transition clients after six months in program, but average time in the program is longer).

**Case Manager Staff-to-Client Ratio:**

1:30 to 1:35

**Average Costs Per Client:**

No data available (part of entire Coverage Initiative budget).

**Outcomes:**

- A pre/post study showed a decrease of 50% in emergency department visits among clients and over a 50% decrease in inpatient admissions.
- When evaluating data using a comparison group, a UCLA evaluator found a 32% decrease in emergency department visits compared to a control group with similar characteristics.
- Data showed a decrease in inpatient visits, although not significant. However, data showed that the most admissions were unavoidable.

**Number of Clients Served to Date:**

131

**Program Began:**

2008

**Contact:**

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## *Los Angeles County: Care Transitions & Coordination Programs*

### **Program Description:**

COPE Health Solutions manages programs in Long Beach and Hollywood that target people who frequently use the emergency departments at Long Beach Memorial Medical Center (“LBMHC”) and Hollywood Presbyterian Medical Center (“HPMC”). Care managers who have experience working in community health centers comprise the staff. Due to frequent in-person contact with the care managers, clients and care managers develop a trusting relationship that enables clients to learn to coordinate their care and access appropriate care.

COPE previously managed a program from December 2004 to June 2010 that targeted frequent users of the Los Angeles County-University of California (“LAC+USC”) Medical Center. The LAC+USC program initially targeted frequent users, and eventually became part of a broader program, the Camino de Salud Network (“CDSN”), that continues to work toward expanding care coordination for underserved populations. CDSN evolved into a network of 12 community clinics, LAC+USC HealthCare Network, two private hospitals, and the Keck School of Medicine at USC, to improve continuity of care and access to specialty care. The program that targets frequent users continues, but the care managers who previously worked under the management of COPE now work directly under the three LAC+USC Healthcare Network comprehensive health centers where these care managers are stationed. The program also includes care management services for patients with cancer being discharged from the LAC+USC palliative care unit.

COPE previously managed a Care Management Program for the Kaiser Permanente Los Angeles Medical Center (also known as Kaiser Sunset) funded by Kaiser Community Benefit for a one year program in 2008. The hospital was frequented by a large number of homeless individuals and care managers helped discharged patients access recuperative care services and transitional housing. They also provided information and facilitated in-services for Kaiser Sunset staff regarding available services in the area for homeless people.

### **Partners:**

- Los Angeles County Department of Mental Health in Hollywood;
- Exodus, Inc., a contractor for the Los Angeles County Department of Mental Health, which provided mental health services to frequent users of LAC+USC Hospital;
- LAC+USC Healthcare Network Comprehensive Health Centers;
- Community Clinics in Long Beach and Hollywood; and
- A transportation agency that provides bus tokens to allow clients to get to and from medical appointments.

### **Hospitals:**

- Long Beach Memorial Medical Center;
- Hollywood Presbyterian Medical Center;
- Formerly LAC+USC Medical Center; and
- Formerly Kaiser Permanente Los Angeles Medical Center (Kaiser Sunset).

### **Funding Sources:**

- Programs in Long Beach and Hollywood are funded directly by the hospitals;
- The former LAC+USC program was funded initially through UniHealth from 2004-2008. Funding continued through a grant from the Los Angeles County Board of Supervisors, Supervisor Gloria Molina, from 2008-2010; and
- Kaiser Permanente Community Benefit Grant for Care Transitions and Coordination at Kaiser Sunset.

**Staffing:**

- LAC+USC program has 3 Care Managers (Bachelor of Arts degrees, experience in social work);
- Kaiser Sunset program had 2 Care Managers;
- Long Beach and Hollywood programs each have 2 Care Managers;
- 1 Program Administrator; and
- Oversight by a medical director.

**Method of Identifying Frequent Users:**

Enrollment for all programs is based on the needs identified by the participating hospitals.

**LAC+USC Program:**

Enrollers stationed in the hospitals identify patients who meet the COPE criteria of two emergency department visits within 12 months (previously required five emergency department and/or inpatient visits within a 12 month period, but relaxed criteria in order to engage more individuals and reach out to patients who are at risk for severe frequent users and become difficult to engage).

**Kaiser Sunset Program:**

Care managers identified patients who had three or more emergency department or inpatient visits through hospital census reports. An enroller was also stationed in the emergency department to assist with enrollment.

**Long Beach Memorial Medical Center Program:**

Criteria are not based on utilization history but rather on referrals from LBMMC hospital staff. Hospital case managers and discharge planners identify patients who would benefit from care management services. Patients include Medicare, Medi-Cal, and uninsured patients.

**Hollywood Presbyterian Medical Center Program:**

Eligibility is based on two or more admissions or emergency department visits to HPMC, or at least one admission for a diagnosis of congestive heart failure within the last 12 months. A care coordinator is stationed in the emergency department during busy emergency department times and assigns or re-directs patients to medical homes in the area, as well as provides basic education about primary care. The care coordinator works with community clinics in the area to facilitate appointments for patients. If patients are in need of more intensive services, the care coordinator enrolls the patient into the Care Management Program.

**Outreach and Engagement of Frequent Users:**

Care managers attempt to engage clients while the client is still in the hospital, but also do home visits and street outreach for homeless clients.

**Services Provided:**

- Attendance at appointments with clients;
- Help in accessing primary care;
- Linkage of clients with mental illness to community-based mental health treatment, through formal relationships with Exodus, Inc., and the County Department of Mental Health (for Hollywood Presbyterian frequent users);
- Connection to substance abuse treatment, including referral to methadone maintenance programs and sober living facilities;
- Assistance in accessing social services existing in the community, including helping clients with applications for Food Stamps and Housing Choice vouchers;
- Linkage to emergency shelter and transitional housing; and
- Provision of bus tokens to help clients get to and from medical appointments.

**Average Time in Program:**

Approximately six months to one year.

**Case Manager Staff-to-Client Ratio:**

1:30 or 1:35

**Average Costs Per Client:**

Approximately \$1,800

**Outcomes:**

- Long Beach (formal evaluation of the program is still pending):
  - Primary care compliance nearly 80% for clients enrolled; and
  - 61 clients have graduated from the program.

**Number of Clients Served to Date:**

- For the four years of the LAC+USC program, the staff served over 390 clients.
- Long Beach program has served 179 clients to date.

**Program Began:**

- LAC+USC program: December 2004 – June 30, 2010
- Kaiser Sunset program: from December 2008-January 2009.
- Long Beach Memorial Medical Center program: began in October 2008; and
- Hollywood Presbyterian program: began in April 2010.

**Contact:**

Reema Shah, Manager, Care Transitions & Coordination, COPE Health Solutions

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## ***Los Angeles County: Project 50***

### **Program Description:**

Project 50 is part of the Los Angeles County Homeless Prevention Initiative, approved by the Board of Supervisors in 2007 to create a demonstration project targeting the 50 most chronically homeless people in Skid Row. The program was designed to provide direct access to housing and integrated supportive services on site to the 50 homeless people living on the streets of Skid Row who were the most vulnerable to early mortality.

Dr. Jim O’Connell (Boston Health Care for the Homeless) conducted research in Boston regarding vulnerability to early mortality among homeless people, finding that certain indices reflect risk of early mortality, including, among other risk factors, frequent use of hospital emergency departments and frequent hospital admissions. (Other risk factors included HIV/AIDS, cirrhosis, age of 60 or older, end-stage renal disease, a history of frostbite, and co-occurring psychiatric, substance abuse, and chronic medical conditions.) Since this research, communities across the country have devised indices of vulnerability. Indices consistently include frequent use of emergency departments and hospitals as a primary indicator of vulnerability. The Downtown Emergency Services Center in Seattle, for example, created a functional assessment that includes frequent use of hospital acute care services.

Project 50 identified the 50 most vulnerable individuals based on strategies used by Common Ground in New York. Common Ground conducted a campaign to identify the most vulnerable homeless people using Common Ground’s “vulnerability index” based on Dr. O’Connell’s research. Project 50 is an example of how community-based organizations have developed and used vulnerability indices. Almost 45% of people identified as “most vulnerable” for Project 50 are frequent users. Vulnerability indices Common Ground used in San Fernando Valley, Hollywood, and Long Beach yielded similar findings. Common Ground has begun a “100,000 Homes” campaign to use the index to identify people who are most vulnerable to early mortality and spur community investment to provide housing and services to these individuals in cities across the country, many of which are in California.

Project 50 created multiple partnerships to provide individuals with access to housing and intensive services. The three most key partners are Los Angeles County, Skid Row Housing Trust (which provides housing to the participants), and JWCH Clinic (which provides health care and other services to clients). Project 50 uses many of the same tools frequent user programs employ to engage and stabilize frequent users, relying on service provision through the Integrated Supportive Services Team, including intensive community-based case management and access to primary and behavioral health care. Clients of Project 50 have, to date, been seriously ill, with several participants dying due to preexisting medical conditions, and almost all participants continuing to receive services after three years of the program’s existence. The County extended the program to 74 individuals in mid-2010. Similar models have been implemented across the County, with over 400 units in the pipeline as of the date of this report.

### **Partners:**

Project 50 involves 24 county and non-profit partners. These include the following organizations:



- Los Angeles County Department of Public Health;
- Los Angeles County Department of Mental Health;
- Los Angeles County Board of Supervisors;
- Los Angeles County Chief Executive's Office;
- Los Angeles County Sheriff's Department;
- Los Angeles County Probation Department;
- Housing Authority of the City of Los Angeles;
- Los Angeles Homeless Services Authority;
- Los Angeles Mayor's Office;
- Los Angeles Police Department;
- Didi Hirsch Clinic;
- Skid Row Housing Trust, which provides housing affordable to chronically homeless individuals, without a limit on length of stay;
- JWCH Institute, Inc., a Federally-Qualified Health Center that provides clinical services to participants, currently at a housing site created by Skid Row Housing Trust;
- Volunteers of America;
- Los Angeles Public Defender;
- Public Counsel;
- Los Angeles City Attorney's Office;
- United States Department of Veterans Affairs;
- County of Los Angeles Community Development Commission;
- Common Ground, which conducted and scored the Vulnerability Index for people sleeping on the streets of Skid Row;
- Los Angeles County Substance Abuse Prevention Control;
- University of Southern California Dental School; and
- University of Southern California Pharmacy School.

**Hospitals:**

- Los Angeles County+USC Center and
- Harbor-UCLA Medical Center

**Funding Sources:**

- Los Angeles County Homeless Prevention Initiative funds;
- JWCH funds some services (an enhanced Medicaid reimbursement rate allows the FQHC to provide these services).

**Staffing:**

- .5 Psychiatrist;
- 1 Nurse Practitioner;;
- 2 LCSWs;
- 1 MSW;
- 1 Licensed Vocational Nurse;
- 1 Medical Assistant;
- 1 Outreach Worker; and

- 2 Case Managers.

**Method of Identifying Most Vulnerable:**

- The Vulnerability Index, which scored people living on the streets in Downtown Los Angeles according to greatest vulnerability to mortality, required volunteers conducting the survey to ask survey respondents a battery of questions that included their age, their length of time on the streets, their health history, and other items. Included in these questions, the respondents were asked how many times he/she has visited the emergency department in the three months prior to the survey and how many times he/she has been hospitalized over the year prior to the survey. The Common Ground database calculated a vulnerability score based on the responses to the battery of questions, partly based on whether that individual has been to the emergency department at least three times within the past month, or has had a mix of at least three emergency department visits and/or hospitalizations within the last year.
- Volunteers obtained each survey respondent’s personal information. Most participants authorized the survey takers to take a photograph to help Project 50 staff identify potential participants in the program at a later date.

**Outreach and Engagement of Frequent Users:**

If a survey respondent ranked within the “top 50 people most vulnerable,” Project 50 staff searched for the individual to offer permanent housing. Almost all Project 50 clients were frequent users of emergency services. Once housed, the participants were offered wrap-around services on a voluntary basis, with significant case manager engagement.

**Services Provided:**

- Direct placement into permanent supportive housing;
- Benefits advocacy (making this project sustainable for the County);
- Primary care;
- Mental health care;
- Substance abuse counseling;
- Referral to substance abuse residential treatment;
- Transportation assistance;
- Money management;
- “Wrap around” case management to coordinate care, conduct skills training, and meet client needs, with case managers working on the first floor of the supportive housing development housing Project 50 clients; and
- Social networking.
- All services are offered on site.

**Average Time in Program:**

84% of participants are still housed after two and a half years.

**Case Manager Staff-to-Client Ratio:**

1:20

**Average Costs Per Client:**

A cost analysis will be completed in the Spring.

**Outcomes:**

- 76% successfully applied for and are receiving SSI;
- 98% of participants are now receiving benefits to which they are entitled, with approximately 70% on SSI;
- 67% recognize an increase in benefit since enrollment;
- 45% of participants reported to be in good or significantly improved physical health since receiving program services;
- 95% of participants are participating in mental health treatment;
- 83% of participants report substance abuse, 80% of whom are participating with substance abuse treatment;
- 100% of participants are participating in physical health treatment;
- 60% of participants have received mental health services, with 75% of these participants reported to be in good or significantly improved mental health;
- Significantly fewer visits to the emergency department and days inpatient among participants, with only 12 participants visiting the emergency department and only 19 participants being admitted to the hospital over the term of the program; and
- All clients placed in permanent housing, with a 84% retention rate after over two years (clients were originally placed in various supportive housing apartments throughout the Skid Row area, but most were relocated to the newly-opened Cobb apartments in April 2010).<sup>10</sup>

**Number of Clients Served to Date:**

67 total clients.

**Program Began:**

2007, with first person being housed in 2008.

**Contact:**

Elizabeth Boyce, Homeless Coordinator, Chief Executive Office  
[eboyce@ceo.lacounty.org](mailto:eboyce@ceo.lacounty.org)

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<sup>10</sup> Los Angeles County Chief Executive Office. *Los Angeles County Homeless Prevention Initiative Status Report: FY 2009-10, January-March, Third Quarter Status Report*. July 16, 2010.

## ***Sacramento County: The Effort's Triage, Transport, and Treatment Program (T3)***

### **Program Description:**

T3 provides intensive, wrap-around services to people who frequently use the emergency department for reasons better addressed through primary care. The program partners with Sutter Medical Center Sacramento and offers a holistic approach to identifying barriers to appropriate care and providing whatever the client needs to remove those barriers. T3 staff engage clients in creating three-tiered individualized care plans to address clients' medical, behavioral health, and case management needs.

T3 is a program of The Effort, a Federally-Qualified Health Center. It therefore relies on the multidisciplinary clinical services The Effort's clinics provide. Some of the clinical and case management services are provided in a satellite clinic at Martin Luther King, Jr., Village, a permanent supportive housing site where 50 of T3's clients live at any given time. The T3 program has become a natural partner for future supportive housing projects in Sacramento, thereby allowing three additional permanent supportive housing projects totaling over 200 apartments to come to fruition.

### **Partners:**

- Sacramento Self-Help Housing, which The Effort pays to provide transitional housing with health monitors on site to T3 clients (the clients' transitional housing status allows them to secure housing vouchers once permanent housing is found); and
- Mercy Housing California, which has developed the MLK Village complex, where T3 clients who have experienced chronic homelessness live (paid for by vouchers backed by The Effort's T3 case management team).

### **Hospital:**

Sutter Medical Center Sacramento

### **Funding Sources:**

- Sutter Medical Center Sacramento, paying for intensive case management of T3 clients, with some limited medical visits until T3 clients are eligible for benefits (where possible).
- As an FQHC with extensive behavioral health services, The Effort is able to provide considerable billable services and offer a healthcare home to T3 clients. Onsite satellite clinic services are offered in the permanent supportive housing locations.

### **Staffing:**

- 1 LCSW;
- 5 Case Managers (with varying degrees of formal education, including case managers with Associate's degrees, Bachelor's degrees, and Master's degrees); and
- 1 Program Manager (with a Master's degree in counseling).

### **Method of Identifying Frequent Users:**

Sutter Medical Center Sacramento is able to identify patients who meet criteria the T3 program developed (the criteria take into account a potential client's medical history, as well as emergency department visit history). The decision-making algorithm is built into the hospital's

practice management system. When a potential client meets the criteria of the algorithm, the T3 program is paged automatically. Additionally, emergency department staff often refer frequent users to the T3 program after obtaining client consent for referral. Hospital staff have good relationships with T3 case managers, who go to the emergency department at least twice every day. Emergency department staff will often attempt to engage potential T3 clients, then page case managers when a potential client expresses interest in the program.

### **Outreach and Engagement of Frequent Users:**

Case managers attempt to engage potential clients still in the emergency department. If the case manager does not reach a client before the client is discharged, emergency department staff will refer clients to an orange binder T3 leaves behind, where they can find contact information for T3, with bus passes to reach one of The Effort's clinics.

### **Services Provided:**

- Primary care;
- Mental health care;
- Substance abuse care;
- Wrap-around case management services;
- Assistance obtaining financial entitlements, such as SSI and county relief;
- Help acquiring identification;
- Assistance in clearing legal issues, such as outstanding tickets;
- Transportation to allow clients to get to and from appointments; and
- Connection to emergency, transitional, and permanent housing.

### **Average Time in Program:**

T3 does not impose a cut-off period for clients who have been in the program for a significant period. Some clients, particularly those living in supportive housing for whom T3 provides supportive services, have received services from the program since the program began.

### **Case Manager Staff-to-Client Ratio:**

The maximum case manager to client ratio is 1:25, and is typically less than 1:20, approximating ratios similar to services offered via richly funded with Mental Health Services Act monies.

### **Average Costs Per Client:**

The costs per client per year vary depending on client utilization.

### **Outcomes:**

After being enrolled in the program for 12 months, clients experience--

- A 54% reduction in use of Emergency Department (65% reduction for clients engaged in program for more than 6 months);
- A 35% reduction in inpatient days;
- 70% of clients who are chronically homeless being housed; and
- 80% clients reducing substance use significantly.

### **Number of Clients Served to Date:**

Over 200. Currently, T3 is serving 110 clients.

**Program Began:**

2007

**Contact:**

Amber Salazar, Program Manager for T3, SST, ICP, and ICP-Plus, The Effort

[ASalazar@theeffort.org](mailto:ASalazar@theeffort.org)

(916) 709-4650

## ***San Diego County: Serial Inebriate Program***

### **Program Description:**

James Dunford, M.D., is an emergency physician at the University of California, San Diego, Medical Center and City of San Diego EMS Medical Director. He worked closely with the San Diego Police Department to implement the Serial Inebriate Program (SIP) after documenting the costs of frequent users who were chronically homeless alcoholics. During an 18-month period from 1997-98, Dr. Dunford calculated that 15 individuals incurred costs of \$1.5 million in ambulance, emergency department and in-hospital care visiting two ER's a total of 417 times. He further noted poor health outcomes resulting from these 417 visits, finding that all of these patients had been caught in a cycle of emergency detox, jail, and hospital use.

Counter to other frequent user programs in California, the SIP program provides coercive incentives to engage clients. It provides housing and services to potential clients in lieu of a jail sentence after police have repeatedly arrested the potential client for public intoxication. The coercive approach has generated some controversy among disability rights organizations, though the California Supreme Court rejected a legal challenge to the program. SIP reported successful outcomes in a study published in 2006.<sup>11</sup>

### **Partners:**

- San Diego Police Department;
- San Diego Medical Services, the City paramedic provider;
- Mental Health Systems, Inc., the provider of alcohol and drug treatment to SIP clients;
- San Diego County Sheriff's Department;
- San Diego County Alcohol and Drug Services;
- San Diego City Attorney's Office;
- Office of the Public Defender;
- Volunteers of America, who staff the Inebriate Reception Center;
- Superior Courts; and
- St. Vincent De Paul Village, the new "medical home" for all SIP clients;

### **Hospital:**

University of California, San Diego Medical Center

### **Funding Sources:**

- From 2001-03, SIP received funding from County Alcohol and Tobacco settlement awards.
- Since 2003, SIP has received \$80,000 per year from the City of San Diego for housing provided to SIP clients..
- Since 2003, SIP has received \$120,000 per year from the County of San Diego for treatment services provided to SIP clients.

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<sup>11</sup> Dunford, J., Castillo, E., Chan, T., et. al. "Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources." *Annals Emerg Med.* Vol. 47, No. 4; 328-36. Apr. 2006.

**Staffing:**

- 2 Police Officers (1 sergeant, 1 patrol officer);
- 1 Mental Health provider; and
- .5 FTE County case worker.

**Method of Identifying Frequent Users:**

- Police officers and emergency medical services staff pick up individuals publicly intoxicated and determine whether the individual is medically stable and ambulatory. If so, the individual is transported to an inebriate reception center for assessment. If not, the individual is transported to emergency departments for treatment.
- After accumulating five transports to the inebriate reception center within 30 days, the individual is considered “chronic” and is transported to jail, awaiting arraignment.
- Judges provide an option to chronic inebriates of increasing jail sentences for each court appearance or a six-month SIP treatment program (those with a history of violent criminal activity, arson, or child abuse are excluded).
- If a potential SIP client accepts treatment, the SIP officer transports the client to St. Vincent de Paul Medical Clinic to obtain any necessary medications and then is transported to group residential treatment.
- After residency in the group treatment site, the client receives additional supportive services through St. Vincent De Paul and other outpatient clinics.

**Outreach and Engagement of Frequent Users:**

San Diego police arrest individuals on a charge of public intoxication. In lieu of custody, courts offer potential clients treatment in the SIP program. SIP provides case management and temporary housing. If potential clients reject treatment, the offender is sentenced to a jail term. After repeating this cycle, the jail sentence increases each time the potential client rejects SIP treatment up to a maximum of 180 days. A 2006 study of the program reported that, the longer the jail sentence provided to potential SIP clients, the more likely individuals accepted treatment

**Services Provided:**

- Group residential mental health and substance abuse treatment; and
- Referral to outpatient community clinics upon discharge from six months of treatment.

**Average Time in Program:**

Six months of treatment while in group residential settings.

**Staff-to-Client Ratio:**

No reliable data, since the program includes two police officers dedicated to the program, multiple officers of the court, and housing and treatment staff.

**Average Costs Per Client:**

No reliable data; however, the program costs the City and County approximately \$200,000 per year.

**Outcomes:**

- Decreased emergency department visits among SIP clients by 50%; and



- Decreased emergency department, emergency medical service, and hospital inpatient charges by 50%.<sup>12</sup>

**Number of Clients Served to Date:**

No reliable data.

**Program Began:**

January 2000

**Contact:**

James Dunford, M.D., City of San Diego EMS Medical Director

[JDunford@ucsd.edu](mailto:JDunford@ucsd.edu)

(619) 533-4359

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<sup>12</sup> Dunford, J., Castillo, E., Chan, T., et. al. "Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources." *Annals Emerg Med.* Vol. 47, No. 4; 328-36. Apr. 2006.

## ***San Francisco: Emergency Department Case Management Program***

### **Program Description:**

One of the first programs to serve people who frequently visit the emergency department, the San Francisco General Hospital Emergency Department Case Management program operates through the Department of Psychiatry, but targets frequent users with medical needs to explore the interface between behavioral health and medical conditions. The program helps clients navigate the health care system and provides a “whatever it takes,” harm reduction approach to serving the population. Program staff engage clients by asking clients what they need. Based on the response, the program staff attempts to meet those needs. Through these efforts, the client forms a trusting relationship with program staff and eventually works to improve health outcomes and decrease dependence on the emergency department.

All of the clients in the program are medically fragile and the vast majority are homeless, but some are high-end emergency department users, while others are less dependent on emergency department care, allowing the program to serve a range of clients in distress. In the first few years of the program, the program did not include any clinical staff. Within three years, however, program administrators decided to add a nurse practitioner and physician to the program’s team to respond to clients’ urgent care needs without clients having to visit the emergency department. As a result, the program has evolved to a multidisciplinary team model.

### **Partners:**

- San Francisco Department of Public Health’s Direct Access to Housing Program;
- San Francisco Housing Authority’s Shelter Plus Care Program;
- Community clinics;
- San Francisco’s Department of Human Services’ Disability Evaluation Consultation Unit, which offers benefits advocacy services to assist clients obtain SSI and Medi-Cal benefits;
- San Francisco First, a homeless outreach team; and
- HOME, a homeless outreach medical team, which works with the program on a paramedic response pilot program.

### **Hospital:**

San Francisco General Hospital, in contract with the University of California, San Francisco.

### **Funding Source:**

San Francisco County Department of Public Health contracts with the University of California, San Francisco.

### **Staffing:**

- 5 Case Managers (all with Master of Social Work degrees);
- 1 Case Manager Supervisor (primarily handling referrals, with small case load of clients);
- 1 Program Coordinator (also has small case load of clients);
- .90 Nurse Practitioner;
- .50 Primary Care Physician;
- .25 Psychiatrist (in process of hiring); and
- 1 Administrative Assistant.

**Method of Identifying Frequent Users:**

The program receives referrals of clients who meet criteria of five or more visits within 12 months—initially, program targeted people of 12 or more visits—through the following:

- Hospital emergency department staff (primary source of referrals);
- Hospital inpatient staff;
- Other hospital staff; and
- Paramedics (through pilot program of homeless outreach medical team).

**Outreach and Engagement of Frequent Users:**

The program staff work in the hospital and often engage clients before discharge. Program staff engage clients by asking what the client needs or wants, then attempting to fulfill the concrete needs of the client (i.e., providing food, bus tokens or cab vouchers, short-term housing, or personal hygiene items). Providing discharging patients with a short-term voucher for a single room occupancy hotel allows the patient to recover before returning to the streets and allows the staff to locate the client.

**Services Provided:**

- Assistance in obtaining benefits to which the client is entitled (SSI, Medi-Cal, County assistance, etc.);
- Connection to temporary shelter and permanent housing;
- Help with managing money;
- Mental health and substance abuse treatment;
- Linkage to primary care;
- A trusting relationship with a case manager; and
- Skill building (i.e., showing clients how to shop for food, how to manage frustration while waiting for appointments, etc.).

**Average Time in Program:**

Two years. A small group of participants continue to receive services beyond two years, but program is in the process of developing a timeframe for graduating clients.

**Case Manager Staff-to-Client Ratio:**

1:13 to 1:15

**Average Costs Per Client:**

Data unavailable.

**Outcomes:**

- Clients have decreased emergency department use by 50-75%, depending on length of services (according to a 24-month randomized trial, using a control group);<sup>13</sup>
- Housed 70-75% of homeless clients (most clients of program are homeless);
- Linkage of all clients to primary and mental health care;

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<sup>13</sup> Shumway M, Boccillari A, O'Brien K, et al. "Cost-effectiveness of Clinical Case Management for ED Frequent Users: Results of a Randomized Trial." *Am J Emerg Med.* 2008;26:155-164.

- Teaching clients to use substances more safely; and
- Successful connection to benefits.

**Number of Clients Served to Date:**

Data not available.

**Program Began:**

1995

**Contact:**

Kathy O'Brien, Emergency Department Case Management Program Coordinator

Kathy.O'Brien@sfdph.org

(415) 206-5071

## ***Santa Clara County: New Directions***

### **Program Description:**

New Directions was the only frequent users program created before the Frequent Users of Health Services Initiative began that received an Initiative grant. The program employs a multidisciplinary approach with a commitment to intensive “whatever it takes” case management. The program’s partnerships enable it to garner strong and visible community support. The program employs a four-tiered approach to serving clients, allowing clients to graduate to less intensive services over time as clients become more stable. The case management staff have case conferences every week with clinical staff to discuss the individual needs of clients. The program also provides services to patients of the County’s medical respite program that provides medical care to 15 homeless patients being discharged from the hospital.

A connection with the Hospital Council has enabled the program to increase awareness of the needs of frequent users among hospitals, not only in the County, but throughout the South Bay Area. The program currently operates through four hospitals in Santa Clara County and the Program Director continually looks for opportunities to expand.

### **Partners:**

- Hospital Council of Northern and Central California and Healthcare Foundation;
- Santa Clara County Housing Authority;
- Santa Clara County Blue Ribbon Commission to End Homelessness;
- Destination: Home;
- Emergency Housing Consortium; and
- Valley Homeless Healthcare Program.

### **Hospitals:**

- Santa Clara Valley Hospital;
- Good Samaritan Hospital;
- El Camino Hospital (established since the Initiative ended);
- O’Connor Hospital; and
- Though a previous partnership with Regional Medical Center ended, program staff are again connecting with the Hospital in hopes of re-establishing the former relationship.

### **Funding Sources:**

- 4 Hospitals;
- Medical respite care grants:
  - Pacific Care Foundation
  - Kaiser Community Benefit Fund
  - Valley Medical Center Foundation
  - Recent contract with the U.S. Department of Veterans Affairs that will fund respite care beds and three months of New Directions case management services.

### **Staffing:**

- 7 MSW-level Social Work Case Managers (working on obtaining licenses);
- 1 LCSW Case Manager Supervisor;

- .125 Psychiatrist; and
- .125 Medical Director.

**Method of Identifying Frequent Users:**

Emergency department staff initially flagged clients who meet the New Directions criteria of eight or more emergency department visits within 12 months and residency within Santa Clara County. Staff are now transitioning away from the flagging system, even though the system was effective, and toward contacting New Directions case managers directly.

**Outreach and Engagement of Frequent Users:**

Case managers are located in the four hospitals and connect with clients (when possible) while the clients are still in the hospital. Case managers also seek potential clients wherever the client is residing.

**Services Provided:**

- Assignment to a primary care physician;
- Connection to mental health and substance abuse treatment;
- Advocacy on behalf of clients with health care professionals;
- Case conferencing every week with health care clinicians;
- Help with managing medications;
- Education regarding health care;
- Connection for homeless clients to permanent housing (initially, received 25 HUD vouchers with an additional 22 vouchers are available for Medical Respite patients, and in the process becoming a part of a Direct Referral process for Housing Choice (Section 8) vouchers from the local housing authority);
- Provision of transportation to clients to get to and from appointments; and
- Recently, through a pilot program with a community organization, advocacy on behalf of clients to obtain benefits to which the clients are entitled.

**Average Time in Program:**

11 months

**Case Manager Staff-to-Client Ratio:**

1:25

**Average Costs Per Client:**

\$6,000 per client, per year, including costs of clinical care.

**Outcomes:**

- All clients connected to primary care physician;
- 53% of clients connected to specialty care;
- 40% of clients abusing substances connected to substance abuse treatment;
- 22% decrease in client emergency department visits after one year of program services;
- 14% decrease in client inpatient admissions after one year; and
- 25% decrease in the number of days clients spent in the hospital after one year.

**Number of Clients Served to Date:**

>250

**Program Began:**

2002.

**Contact:**

Sherry Holm, Program Director, New Directions

[Sherry.Holm@hhs.sccgov.org](mailto:Sherry.Holm@hhs.sccgov.org)

(408) 655-8187

## ***Santa Cruz County: Project Connect***

### **Program Description:**

Project Connect is one of the grantees of the Frequent Users of Health Services Initiative. It is operated through the County Health Services' Agency Homeless Person's Health Project, and has a strong community-based multidisciplinary team approach to addressing the needs of frequent users, providing intensive case management, as well as access to licensed health care professionals, a Federally-Qualified Health Center (County-based Health care for the Homeless Clinic Program), and a benefits advocate on the Homeless Person's Health Project team. Like other Initiative grantees, Project Connect has adopted a stepped-down approach in services intensity.

Unlike other frequent user programs, Project Connect maintains enrollment of at least 20 clients at any point in time who are members of the Central California Alliance for Health (CCAH), the multi-county-organized health system that provides managed care to Medi-Cal beneficiaries. The program has sustained this relationship by continually making a case for the cost-effectiveness of program services. Staff of Project Connect and the Alliance meet monthly to review lists of potential clients and discuss strategies for engaging these clients.

The program has also been very successful in engaging clients in services and in keeping clients engaged, partly because the program works across county systems and can provide clients access to a large array of services and can effectively track changes in client service utilization. In fact, the program shares data across multiple systems of care: hospitals, primary care clinics, mental health and substance abuse treatment providers, emergency medical services, and the sheriff's department. This cross-system collaboration not only supports the services provided to frequent users, it also has allowed the program to demonstrate successes in reducing non-hospital public services, such as reductions in jail time among enrollees.

The Santa Cruz County Health Improvement Partnership (HIP) and the Safety Net Clinic Coalition (SNCC) continue to serve as the project's guiding community coalition. Project Connect is supported as one of three projects identified in HIP's IHI Triple AIM portfolio of projects focused on improving transitions from hospital to primary health care homes.

Project Connect has recently been required to reduce staffing allocations due to County budget cuts. Though the program has received increased Alliance funds, County funds that previously supported the program to enroll uninsured frequent user clients have been significantly reduced. The program continues to provide housing-linked supportive services, case management and money management services to clients who were previously Project Connect clients, both those with Medi-Cal and those who remain uninsured

### **Partners:**

- Central California Alliance for Health;
- The Health Improvement Partnership of Santa Cruz County
- Santa Cruz County Sheriff's Department; and
- Santa Cruz Emergency Medical Services.



**Hospitals:**

- Watsonville Community Hospital; and
- Dominican Hospital

**Funding Sources:**

- Santa Cruz County; and
- Central California Alliance for Health, the County's managed care organization for Medi-Cal beneficiaries.

**Staffing:**

- Project Director;
- .60 LCSW Case Manager Supervisor;
- 1.0 Case Manager;
- .50 Public Health Nurse; and
- .20 Nurse Practitioners
- 1.0- 2.0 MSW Interns (housing support)

**Method of Identifying Frequent Users:**

Using the criteria of at least 10 emergency department visits within the most recent six months or 20 visits in the most recent 12 months, CCAH generates a monthly list of frequent emergency department users who are CCAH members. In addition, Dominican Hospital generates a quarterly list of frequent users with a minimum of 10 emergency department visits in six months or eight visits in 12 months for the project. As a rule, those selected for outreach and engagement also have at least one co-occurring mental health or substance abuse disorder, homelessness or other significant psychosocial issue. Emergency department case managers at both hospitals also refer, via fax, phone, or e-mail, "hot" clients to Project Connect staff and staff do weekly rounds at each hospital. Using clients identified through all sources, the staff meets monthly to select individuals to be outreached for potential enrollment, with approval from CCAH for clients who are their members.

**Outreach and Engagement of Frequent Users:**

Project Connect staff locate potential clients wherever the clients live, even if on the streets or in a car (the majority of Project Connect clients are homeless upon enrollment).

**Services Provided:**

- Face-to-face and telephonic care coordination;
- Direct provision of primary and behavioral health care including onsite pharmacy services and care coordination for care provided through County and community clinics
- Attendance at clients' appointments;
- Transportation to and from appointments;
- Benefits advocacy services; and
- Connection to housing through 3 HUD homeless housing programs operated by HPHP
- Supportive services linked to housing
- Money management services

**Average Time in Program:**

16 months

**Case Manager Staff-to-Client Ratio:**

1:20 (based on case manager FTE of 1.5)

**Average Costs Per Client:**

Current average cost per year per client unknown; CCAH member case management reimbursed at \$369 per enrolled active member per month for up to 18<sup>th</sup> months as needed. A 12-month intervention would be reimbursed at \$4,428.

**Outcomes:**

According to a June 2010 evaluation of Project Connect for Central Coast Alliance members, Project Connect clients achieved the following results over a 12-month period:

- A 40% reduction in emergency department visits;
- A 13% decrease in days spent in the hospital (even though the number of hospital admissions increased to address critical care needs of clients in the first year of program services);
- A 7% decrease in ambulance transports; and
- A 56% increase in visits to primary care physicians.

Previous outcomes from the 2008 Final Evaluation of the Initiative showed—

- 21% of clients who were homeless at enrollment were connected to permanent housing through HUD vouchers;
- 95% of uninsured clients were approved for SSI and Medi-Cal;
- Clients decreased emergency departments by 63% over one year of enrollment; and
- Clients reduced inpatient admissions by 34% and days spent inpatient by 18%.

**Number of Clients Served:**

Project Connect currently serves about 33 clients.

**Program Began:**

2004.

**Contact:**

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## ***Solano County: Frequent User Program***

### **Program Description:**

Solano County funds a small program with one case manager that provides intensive services to frequent users. The case manager recently left the program, so the County is in the process of hiring her replacement. The previous case manager engaged in significant face-to-face interactions with the clients, and acted as a strong advocate on behalf of clients' access to services. The County intends to employ the same strategy with a new case manager.

### **Partners:**

- La Clinica Community Clinic;
- Community Drug Rehabilitation Center; and
- Community Board and Care Home.

### **Hospitals:**

- Sutter Solano Medical Center;
- NorthBay Medical Center;
- VacaValley Hospital; and
- Kaiser Hospital Vallejo.

### **Funding Sources:**

Solano County.

### **Staffing:**

1 Case Manager (paraprofessional).

### **Method of Identifying Frequent Users:**

Using the criteria of three emergency department visits in one month, the hospitals participating in the program contact the case manager when an individual who meets the frequent user criteria is in the emergency department.

### **Outreach and Engagement of Frequent Users:**

The case manager searches for potential clients wherever the clients live. The vast majority of the clients are homeless, so the case manager is often required to meet clients on the streets or under freeway overpasses.

### **Services Provided:**

- Linkage to primary care physicians;
- Assistance with applications for Medi-Cal and SSI;
- Transportation to help clients get to and from appointments;
- Advocacy on behalf of clients to access medical and behavioral health care and among health care providers; and
- Connection to short- and long-term shelter.

### **Average Time in Program:**

Three to four months, on average, with discharge to permanent housing, residential treatment, connection to family, or other forms of ongoing care.

**Case Manager Staff-to-Client Ratio:**

1:10

**Average Costs Per Client:**

\$16,000, including hospital, emergency department, medical, and behavioral health care.

**Outcomes:**

Since the inception of the program, the vast majority of clients voluntarily admitted themselves into residential treatment or were connected to long-term case management services offered by a community shelter. Several clients returned home to family.

**Number of Clients Served to Date:**

43 clients were served in 2009.

**Program Began:**

October 2008.

**Contact:**

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## *Tulare County: The Bridge*

### **Program Description:**

One of the Frequent Users of Health Services Initiative grantees, The Bridge has been able to continue providing case management services through ongoing hospital funding from Kaweah Delta Hospital (though the other two district hospitals in Tulare County no longer participate in the program). The Bridge, like other frequent user programs, provides intensive case management services to frequent users, linking clients to primary and behavioral health care and offering whatever assistance clients need to coordinate and access appropriate care. The program tiers intensity of services according to client need and upon graduation of client from one level of services to another.

Since the end of the Initiative grant, The Bridge is now accessing permanent housing assistance through the federal homeless assistance grants program, has gained a new partner in a community shelter, and has taken on a new role in assisting uninsured patients admitted to the hospital to gain insurance. The hospital has also implemented a data system that allows physicians, nurses, and hospital social workers to communicate with The Bridge's case managers electronically.

### **Partners:**

- Family Health Care Network;
- Tulare Community Health Clinic;
- Tulare County Health and Human Services Agency;
- Health and Mental Health Clinics;
- Tulare County Continuum of Care, which is providing Shelter Plus Care vouchers to The Bridge's homeless clients (three of The Bridge's clients, in fact, were the first to receive the Continuum of Care's first-ever Shelter Plus Care vouchers);
- Visalia Rescue Mission, a community shelter, whose staff contacts The Bridge staff when a potential client stays at the shelter, allows The Bridge clients to stay later during the day in the shelter to facilitate meetings with The Bridge case managers, and permits The Bridge clients to stay longer in the shelter until the client is able to obtain permanent housing.

### **Hospital:**

Kaweah Delta Hospital

### **Funding Sources:**

Kaweah Delta Hospital.

Within the last year, The Bridge began working with the hospital's financial counselors to obtain needed documents to verify eligibility for Medi-Cal or county indigent care insurance for uninsured patients admitted to the hospital. The hospital previously hired an agency to obtain this information, but was losing money in paying for these services, as the private agency charged 25% of the hospital's back-due public insurance payments. The Bridge case managers are now receiving, on average, five referrals for this service per week, and staff providing these services have saved the hospital over \$250,000, which is more than \$50,000 than the cost of The Bridge program.

**Staffing:**

- 1 Project Director;
- 4 Case Managers (paraprofessional); and
- In the process of hiring 1 Outreach Specialist.

**Method of Identifying Frequent Users:**

- Forty percent of The Bridge's financial counseling services (described above) clients meet The Bridge's criteria of eight or more emergency department visits within a year or five or more visits within six months. As a result, The Bridge now receives referrals from the hospital's financial counseling service.
- The Bridge continues to receive referrals from the emergency department's flagging system that allows physicians to identify frequent users meeting The Bridge's criteria.
- The Bridge staff, as employees of Kaweah Delta Hospital, are able to access the hospital's databases, as well as specific instructions physicians, hospital social workers, and nurses leave for The Bridge staff.

**Outreach and Engagement of Frequent Users:**

- The Bridge's case managers have office space at the hospital and attempt to meet with potential clients before discharge;
- If unable to speak to clients in the emergency department, The Bridge staff will search for clients in other locations (i.e., shelters, on the streets, at a client's home, etc.); and
- The Bridge staff offer potential clients incentives to engage in services, such as bus passes and grocery vouchers.

**Services Provided:**

- Case management services to provide clients with skills training, help clients coordinate their care, and assist clients to address their medical and behavioral health needs;
- Linkage to primary and behavioral health care through community clinics;
- Transportation assistance to help clients get to and from appointments;
- Connection to permanent housing through Shelter Plus Care vouchers for homeless clients with disabilities;
- Case conferencing with clients' clinicians; and
- Assistance in obtaining documentation and providing information necessary to verify eligibility for insurance.

**Average Time in Program:**

10 months.

**Case Manager Staff-to-Client Ratio:**

1:25 to 1:30.

**Average Costs Per Client:**

\$1,682 per client, per year.

**Outcomes:**

The Bridge does not currently track specific outcomes for clients. However, according to the 2008 Lewin Group report, The Bridge was able to achieve the following outcomes:

- 66% of clients referred to a community clinic for primary care;
- A 50% decrease in emergency department visits among clients one year post enrollment in the program;
- An 8% decrease in inpatient admissions one year post enrollment; and
- An 11% decrease in inpatient charges one year post enrollment.

**Number of Clients Served to Date:**

- Since Initiative grant ended, The Bridge has provided intensive case management services to 68 individuals; and
- Staff have assisted approximately 300 hospital patients obtain documentation necessary to prove eligibility for insurance.

**Program Began:**

2004

**Contact:**

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*San Mateo County: Healthier Outcomes Through Multidisciplinary Engagement (HOME) Team (defunded as of June 2010)*

**Program Description:**

To address the multiple barriers of frequent users (including homelessness, poverty, mental illness, substance abuse, and chronic medical conditions), HOME Team interventions sought to redirect care from the emergency department to lower-cost community-based settings by: 1) assisting frequent users to navigate and access available and more appropriate types and levels of services (primary care, county/community mental health, and substance abuse treatment); 2) decreasing psychosocial problems such as homelessness, substance abuse, lack of health insurance, and lack of income that may contribute to excess hospital utilization; and 3) improving coordination of acute, primary, and preventive care among service providers and settings.

The model of working with clients was based on a strength-based approach, motivational interviewing, and harm reduction. Each of these methods focused on making change at the client's own pace. HOME Team recognized that the need for assertive case management for clients with multiple needs should be guided by the client's immediate need and his/her hopes and dreams, in the expectation that this approach would result in behavioral change.

**Partners:**

- San Mateo's shelter network;
- The Salvation Army;
- The faith-based community;
- San Mateo County Behavioral Health and Recovery Services;
- Health Care for the Homeless; and
- County clinics.

**Hospitals:**

- Stanford Hospital;
- Seton Medical Center; and
- Mills Hospital.

**Funding Sources:**

- San Mateo County Aging and Adult Services;
- San Mateo County Alcohol and Other Drug Services;
- San Mateo County Health Foundation;
- San Mateo County Human Services Agency;
- San Mateo County STARS Award;
- Medi-Cal Targeted Case Management; and
- Silicon Valley Community Foundation

**Staffing:**

- 1 Social Work Supervisor;
- 1 Public Health Nurse, RN, PHN, MPA;



- 1 Social Worker, BSW; and
- 1 Community Worker.

**Method of Identifying Frequent Users:**

Using the criteria of seven emergency department visits within 12 months, County residency, and lack of insurance or underinsured status, the emergency department identified frequent users using an electronic flagging system. Potential clients were also identified through staff referral and case manager access to the emergency department database.

**Outreach and Engagement of Frequent Users:**

A supervisor assigned a case manager who would conduct all screening of potential clients for each day. While case managers screened potential clients in the emergency department, they conducted a longer intake assessment of clients in a private office to ensure client privacy.

**Services Provided:**

The program provided a range of direct and supportive services, including the following:

- Individualized assessment and care planning;
- Coordination of care conferences consistent with the “medical home” model, which included a client’s primary care provider, mental health therapist, HOME Team case manager, substance abuse counselor, medical specialist, and often the client and his/her family members;
- Assistance in securing health care and income benefits (e.g., County indigent health coverage, MediCal, SSI/SSDI, GA, etc.);
- Linkage and referral to primary care, mental health, and substance abuse treatment services;
- Scheduling and accompaniment of clients to medical and social service appointments;
- Crisis management and resolution;
- Coordination of communication between hospital emergency department staff and primary care or social service providers;
- Education and support of clients’ efforts to build money management, self-care, and chronic disease management skills;
- Assistance with housing, including shelter vouchers and subsidized housing;
- Assistance with basic needs, including food vouchers, bus tokens, and clothing vouchers;
- Advocacy for system changes to improve care for clients with complex needs; and
- Membership on working steering committees to address systemic collaboration and improvement, including the San Mateo County Change Agent, San Mateo County Medical Center’s meetings to address patient access, Healthcare for the Homeless meetings, etc.

**Average Time in Program:**

10 months.

Discharge of frequent users was dependent on client’s needs, using a step-down approach:

Tier I: Highly intensive case management during a crisis period, requiring very frequent, possibly daily contact.

Tier II: Moderately intensive case management during an intervention period, requiring less frequent contact that may require weekly to biweekly contact.

Tier III: Least intensive case management during a stabilization period, requiring monthly contact.

**Case Manager Staff-to-Client Ratio:**

1:20

**Average Costs Per Client:**

While the program maintained information regarding staffing, it did not calculate costs of the medical and behavioral health care services.

**Outcomes:**

- Improved client engagement in care;
- Improved client health status and functioning; and
- Strengthened safety net.

**Number of Clients Served:**

144

**Program Began:**

2007

**Contact:**

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## *Promising Plans for Frequent User Programs*

### *San Diego County*

The United Way of San Diego (UWSD) is piloting a “Project 25” Frequent User Initiative in San Diego that will coalesce a broad array of supports designed to reduce acute care use by frequent users with long-term histories of homelessness. Project 25 is designed to provide more appropriate supports for people experiencing chronic homelessness with complex health and behavioral health issues, including permanent supportive housing, using a housing first model, along with intensive case management. Project 25 will document the costs of service use for all participants, and will include a data and evaluation component that analyzes outcomes.

Project 25 is based on a strong partnership between the United Way of San Diego, the County of San Diego, and the San Diego Housing Commission. The United Way is currently developing a Request for Proposals which is expected to offer funding of up to \$500,000 per year, for three years, for a total investment of \$1.5 million. In addition, through partnership with County Health and Human Services’ Full Service Partnership (FSP), participants will receive case management and mental health services. The San Diego Housing Commission will provide housing subsidies for up to 25 eligible participants, ensuring that housing is affordable to all clients enrolled in the initiative.

The United Way expects to release the RFP in late August or early September 2010, with project start-up by the end of the year.

### *Mendocino County*

A group of Mendocino County organizations, referred to as the “Mustard Seed Coalition,” which includes the Ukiah Valley Medical Center President/Chief Executive Officer and several of his staff, other health care providers, the County Mental Health Services Act Homeless Coordinator, the Sheriff’s Department, and multiple county agencies and community-based organizations, began discussions in 2009 to plan for a frequent users program. The efforts resulted in a planning grant from the County Medical Services Program for a project targeting people who use jail, AIDS/Hepatitis C, shelter, and emergency department hospital services.

The Mustard Seed Coalition is currently determining appropriate criteria for eligibility for program services that will reduce jail recidivism and frequent emergency department use. It is also currently working to secure permission to share data across systems, to include obtaining releases that allow program staff to review data of other county systems.

## Conclusions

As this report documents, most frequent user programs are still young, started in the last one to fifteen years. Despite the relatively early stages of development of many of these programs, the programs can already teach us a great deal about the population and what works to improve health outcomes and decrease hospital use. Program design and population targeting varied considerably from program to program, some programs intentionally targeting people who are very ill and vulnerable to early mortality, while others attempt to target a mix of clients with varying degrees of illness. Yet, program directors reported the following experiences in common about the population and the key ingredients for a successful program:

- *Frequent users have serious medical conditions:* Consistent with the Lewin Group’s Final Evaluation of the Frequent Users of Health Services Initiative, all program directors interviewed confirmed that people who use the emergency department frequently are doing so to treat serious conditions that are most often emergencies, contrary to popular perception that frequent users make emergency department visits for minor problems that do not rise to the level of an emergency. Common conditions reported included cellulitis, congestive heart failure, diabetes, cirrhosis and other liver diseases, respiratory conditions, and musculoskeletal pain—frequent users are in the emergency department for serious conditions and they usually suffer from a complex array of impairments and psychosocial barriers to care. San Mateo’s HOME Team, for example, reported that 90% of their clients suffered from chronic diseases, the most common including cardiovascular diseases, chronic pain, HIV, cirrhosis, and diabetes, and that most were homeless. The “avoidable” nature of the emergency department visit is that the seriousness of the clients’ conditions could have potentially been avoided through more coordinated and appropriate treatment.
- *Frequent users often have never been diagnosed with a serious mental illness:* Many frequent users suffer from mental illness, but their illness is either not severe enough to qualify for county mental health services or has never been diagnosed with a specific impairment. In those circumstances, frequent users’ mental illness complicates and overlays their ability to care for their complex needs.
- *Frequent users are often on Medi-Cal:* Two programs serve exclusively uninsured individuals, but all of the other program directors reported a significant population of Medi-Cal beneficiaries who are frequent users.
- *Intensive case management is a key to success:* All of the programs employ intensive case management with a low staff-to-client ratio, frequent face-to-face contact, and regular communication with clients’ clinicians. Most programs use a tiered approach that decreases the intensity of interventions over time, as clients stabilize. Program directors repeatedly cited a passionate dedicated staff creating trusting relationships with clients as critical to program success. Indeed, building this trust between case manager and client is essential in overcoming client lack of trust of “the system,” given clients’ prior experiences attempting to access care.

- Medical respite programs are often connected to frequent user programs: Programs in Alameda, Santa Clara, Sacramento, and Los Angeles Counties also operate or partner with medical respite programs that serve homeless patients being discharged from the hospital. The services are compatible to both programs. Additionally, program directors have indicated considerable cross-over between the populations. Program directors have also reported sizeable overlap in populations who are frequently arrested (often for quality of life crimes) and who frequently use shelter services.
- Many frequent users are homeless: Though two or three of the programs serve fewer than 20% of clients who are homeless, the majority of the programs serve a significant number of homeless people who are frequent users. In fact, program directors or staff often stated that homeless people make up at least 50% of their clients, and are often the vast majority of their clients. Many more clients are unstably housed. Conversely, chronically homeless people are often frequent users; as reported earlier, frequent use of the emergency department and frequent admissions to the hospital are considered risk factors for early mortality among people living on the streets. Program directors whose programs offer permanent housing vouchers to homeless clients stated housing was one of the most, if not the most, critical element to the success of their program, not only in decreasing emergency department and inpatient use, but in improving the health outcomes of their clients. The Lewin Group's Final Evaluation report of the Initiative is consistent with this observation.<sup>14</sup>
- The Health Information Portability and Accountability Act (HIPAA) is not a barrier to serving the population or partnering with hospitals: Contrary to fears expressed about creating frequent user programs, all program directors interviewed for this survey stated that HIPAA has not prevented data sharing between the programs and hospitals with which they are partnering. Program staff are often hospital employees. Other programs have business agreements with hospitals that allow information sharing. One program that created cross-systems collaborations suffered some resistance among county agencies to share information, but other program directors reported an ability to share information among county employees working for frequent user programs and county employees working in other agencies. Regardless of the manner in which the programs comply with HIPAA, program directors confirmed that they have not experienced difficulties obtaining client releases.

The trend toward creating frequent user programs in communities across California will most likely continue into the next decade, particularly with the passage of Health Reform, which will ensure all indigent adults have access to Medicaid by 2014. Clearly, the biggest barrier to creating these programs is corralling the funding necessary to serve the population. The programs included in this report not only provide models for addressing the needs of this program, but also for what works to ease the burdens on our Medicaid programs.

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<sup>14</sup> Linkins, K., et. al. *Frequent Users of Health Services Initiative: Final Evaluation Report*. Aug. 2008. [www.csh.org/fuhsi](http://www.csh.org/fuhsi).

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