



# Policy Scan: Care Provision Challenges

## Final Working Draft

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## **Executive Summary**

Frequent users of health services (FUHS) have been defined by the Frequent Users of Health Services Initiative (*Initiative*) as clients who have serious health and psychosocial conditions and use health services in ways that do not result in positive health outcomes, while expending a disproportionate amount of available health care resources.<sup>1</sup> The California Endowment and California Health Care Foundation (*Foundation Partners*) are co-funding the Frequent Users of Health Services Initiative to improve the quality of care for FUHS.

This is one of several policy papers that will assist the *Initiative* in developing and advancing a policy agenda to improve the systems and policies that currently create barriers to effectively caring for FUHS. The focus here is on the current system's response to caring for FUHS, new models of care that have developed and the challenges and questions that remain as barriers to meeting the complex needs of FUHS.

## ***Current System of Care***

The current system of care has largely failed in its ability to adequately respond to the needs of FUHS. Traditional rigid divisions between physical health, mental health and substance abuse treatment systems impair the ability to address the needs of FUHS in a coordinated manner. FUHS often lack resources such as a stable home, source of food and a caregiver that could allow for healthcare to be delivered outside of traditional institutional settings (i.e., hospitals). While the current system has emphasized the shifting of healthcare to the outpatient setting, FUHS have not benefited from this shift because the additional resources they need are often not integrated into their overall management or is done so in a fragmented way. Their fragmentation in care is exacerbated by the separate funding streams that support medical and non-medical care delivery and facility licensing requirements that restrict the types and extent of care delivery wherein licensed clinical and non-clinical support teams can provide services in a single setting.

The independent training of providers within disciplines of care (i.e., medical, mental health, substance abuse) prevent adequate cross-systems training and further limit the potential to truly respond to the complex needs of FUHS. Even when providers attempt to work together, the limitations in their ability to share clinical data across systems due to legal mandates such as the Health Insurance Portability and Accountability Act (HIPAA) and medical record confidentiality requirements are barriers that limit coordinated, comprehensive care strategies.

### ***New Models of Care***

The challenge for programs designed to address the needs of FUHS is to create more responsive models of care that will serve all of a person's complex medical and psychosocial problems. New, responsive, model programs have followed different strategies; some have aimed to decrease reliance on acute care while others have targeted the needs of individual person's risk of becoming FUHS. In the first category, programs such as respite care, a soft-tissue infection outpatient surgical center, and an alcohol sobering center shift the locus of care outside traditional healthcare settings and simultaneously provide wrap-around (social and housing) services. These programs offer alternatives to institutional care for acute illnesses and offer an "open door" to critical services, such as substance abuse treatment. In the second category of new programs such as intensive case management, and supportive housing, decrease reliance on acute healthcare is achieved by proactively addressing the non-healthcare needs of clients and working to coordinate care across disparate systems. These successful programs overcome many of the barriers that FUHS face in their interactions with the healthcare system and provide insights on how barriers to care might be addressed to respond to this high risk population.

### ***Care Provision Challenges***

There are many barriers that not only impair the care of FUHS, but also threaten the stability of programs directed towards FUHS. The limitations of data sharing due to medical record confidentiality requirements and HIPAA privacy regulations, as outlined for the current system of care remain a challenge for new programs. Data management systems in many local counties and community programs are often not sophisticated enough to allow the kind of analysis and data tracking necessary between programs. Ability to track and document

successful outcomes are critical to ongoing programmatic funding and program expansion or replication.

Many barriers to care and program stability are also attributable to a funding and regulatory system that lack the flexibility to support programs whose range of services fall outside the scope of traditional healthcare. Difficulties often arise in obtaining steady funding because of restrictions in obtaining MediCal reimbursement for multidisciplinary activities labeled as “non-medical benefits”. Another critical barrier related to funding is the difficulty many FUHS face in qualifying for MediCal, both because many patients suffer from multiple disorders, but lack a diagnosis that qualifies them for MediCal, and because the onerous requirements of applying for MediCal make obtaining insurance difficult or less desirable, even for those who are eligible.

Other challenges to creating effective programs for FUHS include lack of provider cross-training, differences in diagnostic criteria for treatment eligibility between systems of care, and the inability to respond to complex patient needs at a central point of care. Collectively these barriers hamper the quality of care that can be offered to frequent user patients because they impose limitations to comprehensive care that could be rendered at one time.

### ***Policy Implications***

Each of these challenges to caring for FUHS must be addressed, but changes cannot happen by responding to each challenge in isolation. Because many problems stem from the compartmentalization of funding and regulatory mechanisms across different health care agencies, advances will require cooperation between agencies in order to allow blending of funding streams and flexibility in programmatic regulations. As an example, MediCal reimbursement, an important revenue stream for programs serving vulnerable populations, is not typically available for many of the types of programs that could respond to FUHS (many innovative program models provide a range of services that are not MediCal covered benefits). Extending the scope of MediCal covered services may be difficult in the current fiscal environment, but may be necessary to avoid costly hospitalizations among the frequent user population. Similarly, because the unique needs of FUHS require programs that offer services

in non-traditional health care settings with a mix of clinical and non-clinical services (by licensed and unlicensed clinical personnel), such as in respite care and sobering centers, licensing (facility and personnel) regulations will need to be modified to accommodate these types of innovations.

## ***Conclusions***

To improve care for FUHS, there will need to be changes in health care financing, provider training strategies, and licensing of facilities (and possibly provider licensing requirements), as well as improvements in communication and data sharing capabilities between disciplines. The segregation of systems of care have led to an inefficient system which is poorly suited to serve persons whose needs cross existing categorical funding and licensing. The breadth of needs of FUHS requires an array of services and skills not ideally coordinated in the mainstream healthcare system. Success is attainable, but will require significant flexibility and innovation.

The *Initiative* remains challenged to consider the following questions as it moves forward to formulate a policy agenda to address the quality of care for FUHS patients:

1. Are there other lessons from successes in the mainstream system that should be adapted for FUHS?
2. What are the most effective ways to apply lessons learned from the programmatic successes of caring for FUHS in non-traditional health care settings?
3. What are the critical elements for replication of successful programs?
4. What are effective incentives (or regulations and training paradigms) to insure that providers have the appropriate skills to care for FUHS?
5. Is there a way to eliminate or reduce the artificial segregation of care that has evolved between mental health and physical health care services that make care for frequent user patients more difficult?
6. How can barriers to shared information across systems of care be minimized?

7. What are the best strategies to overcome funding barriers in the current fiscal environment?

Attempting to answer these questions, themselves, will require a dedicated group of health care leaders across many disciplines working with legislators and local and community stakeholders. Simply initiating the discussion will be a critical inroad to informing policymakers and stakeholders about the challenges posed by frequent user patients and their extensive utilization of scarce resources and health care dollars.

## I. Introduction

This paper is one in a series of policy and research papers developed as part of the Frequent Users of Health Services Initiative (*the Initiative*) to identify and advance a policy agenda that can create changes in health care delivery, policy and financing to improve the quality of care for frequent user patients. Funded by the California Endowment and the California Health Care Foundation (*Foundation Partners*), the *Initiative* aims to improve the care and reduce inappropriate utilization of health and related services by uninsured “frequent users.” The *Initiative* defines frequent users of health services (FUHS) as those clients who have serious health and psychosocial conditions and use health services in ways that do not result in positive health outcomes, while expending a disproportionate amount of available health care resources.<sup>1</sup>

### What is the risk profile of a FUHS?

An examination of the risk factors for becoming a FUHS (**Appendix I**) provides a basis for understanding the current systems, policies and programmatic barriers to caring for this high-risk population and provides possible insights into appropriate responses to their needs. Medical, psychiatric, and psychosocial factors including homelessness<sup>2-4</sup>, substance use<sup>5</sup>, and criminal justice system involvement (as victim and perpetrator)<sup>6, 7</sup> place persons at high risk of becoming a FUHS. In general, chronic medical and psychiatric problems create the need for ongoing, coordinated health care and effective self-care. When coupled with psychosocial problems, such as lack of medical insurance, homelessness, substance abuse and criminal justice system involvement, exacerbations of underlying medical and psychiatric illnesses occur and lead to recidivist use of high cost health services (ED use and inpatient hospitalizations). It is increasingly evident that these individuals would benefit from receiving continuous care that is coordinated with social and support services. Often this care needs to take place outside of traditional healthcare settings.<sup>1</sup> In the absence of a system of care responsive to all of their complex needs, FUHS have continued to falter in the current health care system.

## **Purpose and Methods**

The purpose of this paper is two-fold. First, to discuss the barriers to care that are commonly experienced by FUHS, focusing on the programmatic, systemic and policy barriers in California. Second, to provide an overview of the current attempts to address the needs of frequent user patients, comparing and contrasting new efforts with the current system of care. As a reference, we briefly summarize the populations that make up FUHS and discuss why these populations appear to be at risk for becoming frequent users (**Appendix I**). Materials used in the development of this paper include background work provided by the *Initiative* (the Environmental Scan and Best Practices Documents)<sup>i</sup>; the published medical literature; and discussions with experts and individuals in some of the programs reviewed.

## **II. Responding to the Needs of Frequent Users of Health Services: The Current System of Care**

### ***Overview***

Because frequent users often have a multitude of problems that do not fall within one diagnostic category (i.e. mental health, substance use and physical health problems), they are often poorly served by the existing health care system. Currently, the physical and mental health care and substance abuse treatment systems function in parallel. They have separate systems to train practitioners, parallel organizational cultures, and parallel funding streams. Many of the challenges encountered in effectively caring for FUHS are directly attributable to the challenges of caring for persons whose problems do not fit into one clinical category. Below, we outline some of the care provision challenges that hamper care under the current system.

### ***Care Provision Challenges***

Some of the difficulties in attending to the needs of FUHS stem from poor communication between providers working in different disciplines. Different systems caring for the same patient often do not communicate. This lack of communication can be attributed partly to the

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<sup>i</sup> Greiff D, Wulsin L, Ahmed R. *Improving Care for Uninsured High Utilizers in Public and Other Health Delivery Systems – Environmental Scan / Background Research*. Draft Report, December 22, 2000. Debbie Greiff Consulting and Insure the Uninsured Project. Bristol K, Greiff D, (Welch M, Mangiante L, Alesandrini N, Editors). *Review of Best Practices*, Frequent Users of Health Services Initiative, Fall 2002.

lack of shared records. In general, few public systems of care have the ability to share computerized records across physical health, mental health and substance abuse treatment systems. This is partly attributable to a lack of shared technology, but it is also a reflection of confidentiality requirements that are exacerbated by new legislative requirements of the Health Insurance Portability and Accountability Act (HIPAA).<sup>8</sup> The privacy notification and other requirements of HIPAA themselves are onerous and have been subject to varying degrees of interpretation even within systems of care. The result is providers who already do not communicate are now afraid to share information for fear of legal and financial penalties.

Lack of communication, however, goes beyond not sharing records. The physical, mental health and substance abuse treatment systems have not historically shared organizational cultures or training systems. Practitioners in these separate systems have different training backgrounds, philosophies, levels of expertise, and positions on the hierarchy. Lack of trust and shared languages hamper communication between them. Similarly, practitioners are rarely cross-trained often limiting services that programs can offer to persons who have multiple disorders. For instance, traditionally mental health and substance abuse treatment programs lack staff with medical training for physical health problems and thus, can not care for persons with complex medical conditions. While the challenge of caring for persons with co-occurring mental health and substance abuse disorders is increasingly recognized, no current movement is underway to foster joint training to providers early in their training. Attempts have been made to co-locate services at the point of service delivery but few have systematically addressed the systems and policies sustaining parallel treatment approaches, training or data sharing capabilities.

Different treatment philosophies also challenges provision of care to FUHS; in the case of substance abuse, this problem is particularly acute. There is a lack of consensus on the proper way to treat persons with chronic substance abuse. Some practitioners subscribe to the harm reduction philosophy which is a set of strategies to reduce the negative consequences of drug use by accepting that some drug users will not be able to stop using. Harm reduction does not demand abstinence from drug use rather it aims to reduce the negative effects of substance abuse.<sup>9</sup> There is disagreement within the substance abuse

treatment community around the role of harm reduction. There is further disagreement within the mental health community, where many have insisted on abstinence from drugs or alcohol prior to entering mental health treatment. Consequently, providers may find themselves with directives to use one philosophy of care, while not necessarily embracing that approach. Patients are often caught in the middle of these treatment approach debates.

The care of persons with co-occurring mental health and substance abuse disorders is further challenged by restrictions on which diagnoses qualify one for mental health treatment. Because MediCal pays for mental health services primarily through “carve-outs”; under a carve-out, the mental health care of a patient is a benefit obtained only through the mental health system (while non-mental health care is a benefit under the medical system). Within the mental health system, the benefits are structured such that there are restrictions on diagnostic criteria that determine whether or not services are covered. Under the “carve-out” system priority is also given to patients who are likely to be the costliest patients for the mental health system: those with serious mental illness who have had long-term psychiatric hospitalizations. While FUHS are often costly for the system as a whole, through their use of medical and psychiatric services, they may not be the most prioritized in the mental health system because they may not carry a qualifying mental health diagnosis. Accordingly, many patients in need of mental health care, may not be eligible for services within the carve-out system. The end result is a fragmentation of care to FUHS clients or inadequate care for mental health conditions.

Many FUHS are not insured by MediCal (some are not because of lack of qualifying diagnoses, as noted above). Other FUHS are not insured by MediCal because their illness is deemed to be primarily attributable to substance abuse; a diagnosis of substance abuse alone does not qualify one for Supplemental Security Income / State Supplemental Payment (SSI/SSP) and thus, MediCal benefits. Other patients lack MediCal coverage because they are “casualties of complexity,”<sup>10</sup> unable to navigate the complicated bureaucratic requirements for Medi-Cal enrollment.

Funding continues to be a major ongoing barrier to effectively respond to the needs of FUHS particularly for programs that cut across disciplines. Current debate on how best to sustain

existing programs in the face of declining Federal, State and local funding (See companion paper, Kelch D., *Frequent Users of Health Services: The Legislative Environment*) raise many questions for providers and systems caring for FUHS about how basic programs will continue, much less special programs for high-risk groups. Most programs targeted to special needs groups begin with seed funding from philanthropic groups (e.g. Foundations); however, once program goals are met this funding often can't pay for ongoing services. Additionally, Federal, State and local funding infrastructures are usually set up to fund programs for persons with a single health problem. It is difficult to blend funding and programs are often forced to compete with one another for scarce funding

Although many challenges exist with the current system of care, promising opportunity is possible within a local community or county, where a single governing entity can oversee programs across disciplines and move funding between programs allowing for easier blending of funds and integration of services. For example, recently, some counties have integrated substance abuse and mental health divisions to create a single, behavioral health care division to be more responsive to patient like FUHS. Adoption of such a strategy is not necessarily uniformly embraced by the mental and medical systems as a whole, but may offer a promising response to the challenge of caring for FUHS.

### ***Policy Implications***

Policy changes may help to overcome these barriers to care for FUHS. While it would be difficult to mandate changes in all provider trainings to encourage cross-disciplinary training, there may be ways to encourage diversification within training programs to improve skill mix. Also, many successful programs for FUHS use paraprofessionals and "peer staff" working under supervision of clinical personnel. These providers may be particularly well-suited to provide culturally competent and accessible services, but their services are not always reimbursable under MediCal. Policies allowing for reimbursement for those services rendered by paraprofessionals and "peer" staff working under licensed clinical staff should be developed or expanded as appropriate.

Issues of data sharing have been complicated by requirements under HIPAA; there remains a great need to reduce barriers to information sharing between medical, psychiatric and substance abuse providers. This would be important not only at the level of caring for the individual client, but also for those trying to track utilization of high risk groups. Because it is so difficult to track and share information on clients across systems of care, it is difficult to recognize when interventions in one system impact care utilization in others. Many data systems in local county public health and community-based groups are also not sophisticated enough to allow the type of data tracking and systems analysis necessary. Often communities and local agencies lack the resources to upgrade their data systems, so regulations like HIPAA are seen as unfunded mandates that compete for limited resources.

Policy changes may also be necessary in regulations determining eligibility for MediCal, mental health care services. The current mental health, managed-care carve out could go a long way in providing needed services for persons who are FUHS with substance abuse disorders by recognizing substance abuse related disorders as a legitimate disabling mental health condition which qualifies one for services within mental health managed MediCal,. Alternatively, a broader inclusion of reimbursement for substance abuse and mental health services within MediCal's medical benefits structure could also be helpful. Such policy changes would provide a single funding stream to reduce fragmentation of care, and would reduce the difficulty providers often face in trying to meet client needs across bureaucracies.

### **III. Responding to the Needs of Frequent Users of Health Services: New Models of Care**

#### ***Overview***

Many of programs that have evolved to care for FUHS parallel interventions that have been made in the mainstream system. For example, as health care has shifted to the outpatient setting, hospital stays have been shortened by the use of extensive home-based interventions, such as home nursing and infusion centers. Surgical hospitalizations have been averted through the use of outpatient surgery centers. Many hospital Emergency Departments (ED) have developed "fast tracks" or mid-level practitioner staffed wards for the rapid treatment and discharge of patients with routine health problems presenting to the ED without true

“emergencies.” The first set of programs discussed here (respite care, a soft tissue infection outpatient surgery clinic and sobering centers) borrow from these principles of shifting healthcare to less costly settings and adapted them to FUHS populations to reduce the use of expensive health care resources. These interventions differ from the mainstream system of care by increasing the scope of services available to attend to the needs of FUHS. These services include providing short-term housing for those being discharged from hospitals, and providing extensive substance abuse counseling and case management services.

Programs that focus on specific populations at risk for frequent utilization (intensive case management, supportive housing, dual mental health and substance abuse treatment centers for persons with co-occurring disorders) reflect the recent trend towards multidisciplinary care for those with chronic illnesses. “Disease management” programs have gained favor in recent years; in disease management, a multidisciplinary team, with a clinician acting as care manager, delivers comprehensive care to persons with chronic illness. While the treatment team includes physicians, nurses, mental health professionals, dieticians and other clinicians, each client has a case manager, usually a Registered Nurse (RN), to assist him or her navigate the complexities of the health care system. The disease management approach explicitly recognizes the value of multidisciplinary teams to respond to all of a client’s needs. This multidisciplinary model of care may be ideally suited for the complex FUHS patient.

Programs for FUHS bear similarities to disease management programs, but have a few distinct features. Successful programs for FUHS must also include an array of services not seen in mainstream disease management programs, such as housing or substance abuse treatment. While programs in the current system are focused on lowering costs by avoiding costly acute care and providing equal or better quality, the programs for FUHS provide high quality and less costly alternatives to hospitalization and they provide an “open door” through which FUHS can access a multitude of other services: substance abuse and mental health treatment, housing, and benefit entitlement counseling. Oftentimes, providing such wrap-around services means identifying untreated and under-treated conditions that may actually lead to increased use of healthcare services. However, the increased use is justified if it leads to appropriate and more

responsive care, and breaks the recidivist cycle of care often seen among frequent user patients.

Below, successful programs that have attempted to respond to the needs of FUHS are described and the care provision challenges and policy implications of the programs' challenges and successes are discussed.

### ***Programs designed to decrease the need for acute care services***

The three program-types discussed (medical respite care, soft-tissue wound care clinic and sobering centers) attempt to decrease frequent utilization by providing alternatives to acute care (emergency department visits and inpatient hospitalizations). Each program sees the provision of alternative care as only part of its mission; each program type integrates services to address the psychosocial co-morbidities found in these populations and uses its time with clients as an opportunity to engage the client in long-term, coordinated care. Each program sees itself not only as an alternative to costly hospitalization and ED use, but also as a “front-door” through which difficult-to-engage persons can access the health, substance abuse treatment and housing systems of care. Importantly, each program recognizes that the needs of FUHS differ from those of other health consumers. These programs provide services that may not be needed by other clients, but without them, FUHS are trapped in a cycle of continued ED use and hospitalization and ultimately poorer health outcomes.

#### **i. Medical Respite Care**

Respite care is recuperative or convalescent services for homeless persons who do not require hospitalization but who are too ill to be on the streets or in shelters. Models of respite care vary; all have some form of short-term housing with different levels of medical care available on site. Respite care can be provided in a free-standing medical facility or in shelter beds set aside for persons for whom are ill.

One of the most established free-standing medical respite centers is McInnis House, a program of the Boston Health Care for the Homeless program. McInnis currently has 72 beds serving men and women and an additional 18 beds at Betty Snead House (a separate site for

women). Both accept referrals from hospitals, homeless health care clinics and homeless shelters. The respite homes are independent facilities and staffed round-the-clock by licensed clinical staff, offering both recuperative and skilled nursing care for homeless persons without other options. Respite programs provide an important opportunity to stabilize and engage patients who are otherwise difficult to engage into treatment. McInnis and Snead House integrate a variety of services into respite care including mental health assessment and counseling, psychiatric care, physical therapy, benefits enrollment and discharge planning and referrals to supportive housing.

San Francisco's two respite care programs, both operated by the Department of Public Health are funded through county health departmental general funds. One program, based at North of Market Service Center, consists of beds at a group shelter. Medical respite clients stay throughout the day (as opposed to non-respite clients who must leave shelters during the day). Registered nursing (RN) oversight and meals are provided. Intake is coordinated through a RN; referrals come from patients discharged from hospitals and from non-hospital-based and homeless service providers for patients who are too ill to be on the street but do not meet criteria for hospitalization. Average length of stay is approximately two weeks; these services are for acute needs and are not equipped to successfully transition patients towards permanent solutions.

The San Francisco Department of Public Health (SFDPH) also runs a medical respite at the Windsor Hotel, a SFDPH funded supportive housing residence. The Windsor's target population is chronically homeless persons with multiple medical co-morbidities. The Windsor consists of 60 long-term supportive housing beds and 26 short-term respite beds. The Windsor is staffed by 2 RNs, a part-time physician, psychiatric social worker and health workers. Respite clients are referred by health care workers and homeless service providers. Average length of stay in the respite unit is 6 weeks. Because clients who meet criteria for a skilled nursing facility (SNF) have other options in San Francisco (which has a large public skilled nursing facility), care at the Windsor Hotel's respite program, unlike that of Barbara McGinnis House, is focused on those who have medical need but do not meet criteria for SNF level of care. But, the enhanced services available at the Windsor (as compared to the North of

Market Respite) and increased length of stay make it more conducive for intensive work on engaging patients in treatment and attempting to find housing. The availability of a public skilled nursing facility in San Francisco obviates the need for respite to care for those who meet criteria for a stay at a SNF; other municipalities in California which do not have a SNF facility equipped to take those who are uninsured may benefit from a program which has the array of services offered at McGinnis House. Respite care explicitly recognizes that homeless patients have special needs that are unmet in the current system that has shifted a larger burden of healthcare delivery to the outpatient setting. By recreating many of the services that the mainstream system presumes patients have (access to a home where a visiting nurse could check on them, access to food and a caregiver to provide basic needs), respite can allow homeless patients' care to be safely shifted to the outpatient setting. Without respite care, that shift is impossible, and homeless persons with chronic (or acute) health problems are more likely to be hospitalized and have extended stays (often months, as opposed to weeks). In addition, recognizing that respite meets patients at crisis points, most programs have attempted to integrate access to other services, such as substance abuse treatment, into the care plan, thus providing an "open door" to recovery.

There have been few evaluations of the effectiveness of respite facilities' ability to decrease length of hospital stay. In 1996, a Veterans Administration Medical Center (VAMC) opened up a short stay hospital hotel, "hoptel", on the grounds of the VAMC complex at an estimated cost of \$22 per day. Lengths of stay in the hoptel averaged 3 days and ranged from one day to two weeks. A study after two years of operation found that, for homeless persons using the hoptel, lengths of hospital stay were nearly identical to those of non-homeless veterans after correcting for DRG.<sup>11</sup> A study of respite care in Chicago found that those discharged to respite care needed 60% fewer hospitalization days (3.3 respite vs 8.2 hospital days) in the year following respite than those who were eligible for respite but not assigned secondary to space limitations.<sup>12</sup> Such decrease in length of stays likely translate to reduced overall costs given that inpatient hospital stays are likely to be more costly than the lower level of care offered in an outpatient, respite care model. Further studies to validate this assumption are needed.

## ii. Integrated Soft Tissue Infection Service (ISIS)

Recognizing that soft tissue infections secondary to injection drug use was the largest single cause of non-psychiatric hospital admissions at San Francisco General Hospital (SFGH), the hospital created a specialized outpatient clinic to treat soft tissue infections, the integrated soft tissue infection services (ISIS). The goals of ISIS were to decrease the need for costly hospitalizations among injection drug users (IDU) and to decrease the use of the ED visits, operating rooms and inpatient hospitalizations for the management of soft tissue infection. Additionally, by co-locating substance abuse and social services at the clinic, planners hoped to take advantage of the “open door” that is created when IDU patients present episodically in their attempts to gain entry into drug treatment.

### Description of program

The ISIS clinic includes outpatient surgical management of infections, with coordinated substance abuse treatment and referral and social services. Located on a hospital ward, the clinic is staffed by academic faculty surgeons, three RN's, a substance abuse counselor, a social worker, and an administrative support person. A pain management specialist, pharmacist, and infectious disease specialist are available for consultation as needed. The clinic is open every day on a walk-in, first come, first-served basis. Patients requiring surgical intervention are treated on-site under local anesthesia. All patients with wounds are provided follow-up appointment with an adjacent clinic where dressing changes are performed. Patients are offered on-site substance abuse counseling and referrals to methadone detoxification (21 day treatment) or maintenance treatment as needed.

An analysis of the first year's operation of the clinic found that there were 3,365 patient visits and 2,255 surgical procedures. Only 6% of patients required hospital admission. Only 9% of IDU clients refused referral to substance abuse counseling; 42% were enrolled either in methadone detoxification or maintenance programs directly from ISIS clinic. Eighty-six (86%) of clients reported their satisfaction as excellent or very good.<sup>13</sup> In the year after the clinic opened, use of the operating room for soft tissue infections decreased by 70%; admissions to

the surgical service for soft tissue infections decreased by 47%; ED use for soft tissue infection patients decreased by 34% and inpatient bed use (for soft tissue infections) decreased by 33%. Calculating the cost-savings in reductions in ED usage, OR time and hospital admissions, minus the expenses for operating the clinic (\$550,000) resulted in an estimated cost reduction of \$8,765,200.

### iii. Alcohol Treatment Diversion Units

Chronic public inebriates, or “CPIs,” are at high risk for being frequent users of health services. In San Francisco in the late 1990s, the policies regarding the disposition of public inebriates was changed so that persons found to be intoxicated were brought to the ED. Intoxicated individuals rapidly became a large proportion of patients visiting all San Francisco emergency departments, contributing to the FUHS population. Emergency Medical Services (EMS) estimates that 50-100 CPIs account for 5% of all EMS calls in San Francisco.

Inebriated patients make-up 21% of all ED patients in San Francisco; the average length of ED stay for an inebriated patient is substantially longer than other patients.<sup>14</sup> There are an estimated 10,000 ED visits a year by intoxicated persons; each costs an estimated \$1500 per visit for an uncomplicated visit. Two-thirds are brought in by ambulance; the other third are “walk-ins.” Less than 20% of these visits result in hospital admission. These FUHS contribute greatly to the current crisis of ambulance diversion. Ambulance diversion is a policy concern statewide. When EDs go on diversion, emergency transport time rise, as ambulances are not able to bring patients to the nearest ED. Private hospitals may take on higher numbers of unsponsored patients, as public facilities may be on divert and unable to accept patients that would normally be brought to them. Finally, patient continuity is affected, as patients whose caregivers are at a hospital that is diverting patients are cared for by new providers who are less familiar with their chronic care needs.

It is estimated that 75% of CPIs brought to EDs could be successfully triaged to intermediate care facilities. These intermediate care facilities, such as sobering centers, are designed to be safe places for persons who are intoxicated, but not otherwise needing medical treatment, to “sleep off” their intoxication and become engaged in services necessary for recovery. Other

states have successfully started sobering centers, including Seattle, Washington, Portland Oregon and Phoenix, Arizona. In California, San Diego has established a similar facility.

Sobering centers that comprehensively include alcohol recovery services with access to comprehensive medical and support services could go further in being more responsive to FUHS who are also CPIs. In San Francisco, increasing concern about the high rates of ambulance diversion and rising ED costs, drove the formation of a group to investigate the opening of a sobering center; the result is a 28-bed center slated to open in June 2003. The program will be sited at an existing detoxification center: this decision offered numerous benefits, including that the treatment facility was already licensed to provide such care. Private hospitals offered \$400, 000 to the program; the Department of Public Health budgeted another \$400,000. The sobering center will be open 24 hours a day, 7 days a week,. There are multiple ways to access the center, including through “vans” staffed by Emergency Medical Technicians (EMTs) to transport clients to the centers and referrals from the ED. Vans are dispatched through the 911 system or find persons through neighborhood surveillance. The centers are staffed by licensed and unlicensed staff trained to give care, substance abuse counselors and case managers. Nurses perform initial assessments; medically stable clients are given a safe place to “sleep” off their intoxication, offered food, a shower and substance abuse counseling and case management. If the client is interested, he or she can be directly admitted to an alcohol treatment facility. Case managers can work to engage clients over time. The program does not offer coercive treatment, but rather hope that over time, clients can be engaged in alcohol treatment, housing and other services. It is estimated that each client visit will cost approximately \$100.

There have been no formal evaluations of sobering centers, although there have been evaluations of important markers of success. Portland’s rate of recidivism has dropped from 90% in the early years of the program to 20% now; Phoenix’s rate is 30%. The Seattle program notes a rate of 6% of sobering center clients who require transport to the ED; they report no deaths in 4 years of operation. Phoenix reports 2 deaths in five years and Portland reports 4 deaths in 20 years of operation.

### ***Program addressing frequent user patient subtypes***

While the first set of programs intervened at the point of contact by shifting the site of care, these programs aim to decrease the need for care or to reorganize care that is better suited to respond to the specific needs of FUHS, or those at risk of becoming FUHS. These programs, largely focused on chronically homeless, frequent users of the ED and the severely mentally ill and those with co-occurring psychiatric and substance abuse disorders, attempt to provide wrap around services to high-risk persons. By reorganizing care around the needs of FUHS, they aim to decrease excess health service utilization and to improve care and outcomes. And, like the programs designed to decrease acute care needs, these programs extend the role of service providers beyond that of the mainstream healthcare system, through use of counselors and clinical staff who are skilled in housing benefit determination and other entitlement services.

#### **i. Supportive Housing**

Supportive housing is a strategy by which housing services are integrated with health and social services for chronically homeless persons. Populations targeted for supportive housing, including homeless persons with mental illness, substance abuse, major medical illness and criminal justice system involvement are often the same populations identified as frequent users.

There are numerous examples of supportive housing programs in California. One model program is the San Francisco Direct Access to Housing (or DAH) programs. DAH is operated by the San Francisco Department of Public Health, with the explicit recognition that supportive housing is a health intervention for homeless persons with multiple co-morbidities. It is funded primarily through SFDPH general funds, although clients contribute a proportion of their entitlement income towards their rent and MediCal pays for some services. Direct Access to Housing currently houses 421 formerly homeless persons in six different sites at Single Room Occupancy hotels (SROs). The DAH program identifies formerly run-down SRO hotels; the SFDPH then signs a guaranteed 10-year lease with the property owner who agrees to rehabilitate the building according to SFDPH specifications and guarantees to set aside space for support services. Services vary between sites; all sites have 24 hour property

management services, some food and medical services. On-site services range from bachelor-level case management to around the clock nursing. One site has an on-site clinic with five-day-a-week nursing care and one-day-a-week urgent and primary care. Staff are employed by local community based organizations or are employed by the Health Department's Healthcare for the Homeless Clinic. All sites subscribe to the "harm reduction" model where abstinence is not a requirement for housing. Consistent with the harm reduction model, none require urine drug tests for residents. Thus, many clients in DAH programs are active substance users at entry: the program attempts to engage persons in treatment, when they are ready for it.

Only one of the sites is a licensed facility; it serves persons with severe mental illness who have formerly been in locked facilities. By providing a supportive environment, this program has allowed clients to live in a significantly less restrictive setting and regain their independence. It does so at a substantial cost savings, compared with being in a locked facility. As a licensed facility, it has more restrictions, however, than the other supportive housing programs. In the other, unlicensed facilities, all residents have tenant rights; they can be evicted only if there are significant behavioral disruptions. This relationship is in keeping with the goals of supportive housing, which strives to allow clients to live independently.

Preliminary data suggests that supportive housing is a promising option for improving outcomes and decreasing high utilization in medically and psychiatrically complicated frequent users of health services. Data on the efficacy of supportive housing programs in limiting high utilization are limited, although process measures, such as increased length of time housed are encouraging. A study conducted in New York City found that, for chronically homeless mentally ill persons, that the costs of supportive housing were largely offset by decrements in the cost of public services such as long-term psychiatric hospitalization, jail and prison time, and hospitalization.<sup>15</sup> Other studies have found that approximately 75% of persons placed in supportive housing have remained housed for at least a year.<sup>16</sup> Studies have found decreases in use of ED and hospitalization services among those placed in supportive housing, although these studies were not controlled. These studies found that clients who engaged in substance abuse and mental health treatment decreased their utilization of the ED and hospital for

physical health burdens. Even though their acute care use had not been explicitly for drug use or mental illness, by treating these, other acute care use was lessened.<sup>17</sup> The services offered at these sites were often “non-medical” in origin. By providing stable housing and engaging clients in case management and substance abuse treatment, reliance on acute health care was lessened.

## ii. Case Management

Case management is a system whereby a professional (or paraprofessional) assumes responsibility for the coordination of care for a client. Models of case management vary widely, differing in training of case managers, scope of practice and time spent with clients. Some case management programs are “medical case management” whereby the case manager is a health care professional (usually an RN) who provides assistance, often oriented towards persons suffering from a particular disease entity: i.e. diabetes case management. Others are brokered case management or care management, whereby the case manager, often a social worker or paraprofessional works to guide the client towards an array of services offered by others.

County Medical Service Program (CMSP) have used a care management approach in their demonstration projects (see Insert) to address the needs of county indigent care patients, many of whom are also frequent user patients. Faced with dramatic funding reductions and rising costs for the care of indigent patients, the CMSP has initiated a series of demonstration projects to improve care management, reduce costs and improve health outcomes for program clients. The CMSP generally operates as an “old-Style” fee-for-service program very similar to the MediCal fee-for-service program with little utilization management. Two current projects are summarized below.

**Innovations in Care Management:  
The County Medical Service Programs (CMSP) experiments**

*Solano County* – CMSP grant to implement the following: 1) Chronic disease management program offering early intervention, outreach, education and care coordination for CMSP clients diagnosed with asthma, hypertension, and diabetes; and, 2) Organization and expanded delivery of outpatient mental health services for CMSP clients with mild to moderate symptoms through the county’s mental health delivery system.

*Sonoma County* – CMSP grant to implement the following: 1) Incorporation of approximately 4,700 CMSP clients into the organized health care system in Solano County that serves MediCal clients; and, 2) Organization and expanded delivery of outpatient mental health services for CMSP clients in the county through the county’s mental health delivery system, with a focus on clients with dual mental health/substance abuse diagnoses.

These projects have important implications for the *Initiative*, since CMSP clients have similar demographic characteristics and often only enroll in CMSP at the point of seeking expensive medical care and treatment. The projects are designed to intervene with supportive services using a care management strategy to avoid more costly emergency and inpatient service usage.

*Source:* County Medical Services Program.  
Excerpt by Kelch, D. *From: the Overview of Strategic Plan Implementation Grant Program*  
[www.cmsspcounties.org](http://www.cmsspcounties.org).

iii. Assertive Community Treatment

Another care management strategy is intensive case management, whereby the case manager takes a proactive role to engage the client in services; an example of intensive case management is Assertive Case Management (ACT). Assertive community treatment is a comprehensive community-based model for delivering treatment, support, and rehabilitation services for people with severe mental illness.<sup>18, 19</sup> ACT was started 30 years ago in response to the finding that persons with severe mental illness discharged from inpatient treatment experienced rapid readmissions. ACT is a model of service delivery in which a team of professionals assumes direct responsibility for providing services needed by the consumer, for as long as they are needed. Services provided under ACT include assistance with daily living skills (transportation, shopping), work opportunities, entitlements, health promotion, medication support, housing, financial management, and counseling. It is sometimes referred to as a “hospital without walls” wherein many of the attributes of inpatient psychiatric hospitalization (daily rounds with the patient, weekly staff meeting, medication monitoring) are continued in the outpatient setting.

There are a variety of principles that define ACT. These include: services targeted to severely mentally ill; direct provision of services (not brokered); team approach; small staff to consumer

ratio (approximately 1 to 10); interventions happen in the community, not in clinics or hospital settings; treatment and services are individualized; services are available 24 hours a day, 7 days a week and are not time-limited. ACT and modified ACT programs with their unlimited access, and intense client engagement strategies may be the model of care most suited to address the multiple, complex needs of FUHS patient.

In 1994, Alameda county found that 500 clients, representing 4% of all clients served, used 38% of publicly funded mental health resources.<sup>20</sup> Each had costs of approximately \$40,000 or more in two of the previous three years. In an effort to reduce utilization, Alameda County initiated a fixed dollar capitation ACT model program to serve 100 persons in this group. The program, called STRIDES (Steps Toward Reaching Independence, Dignity and Success) is profiled in the *Initiative's Best Practices Guide*.<sup>21</sup> The STRIDES program was able to produce cost savings, of approximately \$12,000 a year for each client in the first year and \$8,000 in the last. Over the four years. The county's costs were \$2,338, 490 less for STRIDES clients than for the comparison ones.<sup>20</sup>

Whereas ACT programs are explicitly for those with severe persistent mental illness, the principles of ACT have been successfully adapted towards other FUHS populations, with some changes. In 1995, the Psychiatry Department at San Francisco General Hospital founded the Emergency Department Frequent User Program. This program, described in depth in the *Initiative's Best Practices Document*<sup>21</sup> is an example of intensive case management, using many principles gleaned from ACT to target high users of the ED.

#### iv. Integrated Treatment for Co-occurring Mental Illness and Substance Abuse Disorders

In 1995, the Governor directed the California Department of Mental Health (DMH) and the Department of Alcohol and Drug Programs (ADP) to work together to develop integrated treatment for persons with co-occurring disorders. The two departments organized the Dual Diagnosis Task Force (DDTF) to support the development of and promote access to effective programs for persons with co-occurring disorders.

In 1995, the State of California put out an Request For Proposal to fund 4 demonstration projects, using SAMSHA funds. The four selected projects were located in Merced County, Contra Costa County, San Diego and Santa Cruz. The counties in which the projects are located have continued to fund the project after project completion in 2001. The four projects differed substantially in approach. The Contra Costa Project used an ACT approach. The team spent much of their time out in the community (at client homes, public meeting areas, and homeless encampments). The project provided services on site but also linked clients to existing community services. The Merced project, in rural Merced County, provided substance abuse and mental health services on-site. After recognizing the difficulty that clients had in accessing services, the program acquired a van to provide transportation. In San Diego, program staff included mental health and substance abuse counselors as well as psychiatric residents from University of California San Diego and worked at a single site.. The Santa Cruz project served 68 clients. It was a 90-day residential treatment project located in Watsonville. Most of the staff was substance abuse treatment staff trained in co-occurring disorders; the only mental health staff was a part-time psychiatrist who was available for weekly visits with clients.

All sites conducted evaluations. Results were mixed. Most sites found statistically significant improvement in clients' psychiatric functioning and substance abuse, although findings were not universal. In three of the four sites, costs for physical health care went up with treatment. This was viewed by many as a positive result, reflecting the attainment of care for unmet needs. Costs for mental health treatment and substance abuse treatment increased at all sites, reflecting the attainment of mental health treatment for previously unmet needs. Costs for criminal justice system involvement seemed to decrease after enrollment at all sites.

### ***Care Provision Challenges***

The new models of care reviewed here address some of the challenges inherent in caring for FUHS. Finding that FUHS' needs were not being adequately met within existing healthcare structures, these programs adapted by either shifting the site of care outside the traditional healthcare settings and or providing an array of services responsive to the individual client's need. In so doing, they responded to many of the barriers to caring for FUHS under the

current system. Many of the barriers to responding to the needs of FUHS follow from the difficulties of designing systems of care that cross disciplinary boundaries and that require services outside of the traditional healthcare settings. These barriers include segregated funding, fixed facility licensing requirements, lack of cross-disciplinary training of provider staff, artificial segregation of care and care entitlement programs, and controversies about treatment modalities.

### Funding

A major barrier to meeting the needs of FUHS is funding. While FUHS are costly to care for in the existing system, it is difficult to free resources to create systems responsive to their needs. Funding streams are designated based on traditional disciplinary segmentation: mental health, substance abuse, and physical health. This not only makes obtaining funding for interdisciplinary projects difficult, but it can create disincentives to programs whose primary beneficial effects are outside of its funding sphere. For example, programs that are funded through the mental health system may realize cost-savings in the physical health sphere by decreasing the need for ED visits for physical health problems; however, these savings do not accrue to the sector that is paying for the program. Obtaining start-up funding for new programs can be difficult: most programs reviewed here initially relied on general funds, which are the least restrictive, but may be difficult to sustain.

Although many programs may lead to eventual cost-savings, these savings do not necessarily accrue to those who made the initial investment. It can be difficult to translate cost savings on paper into real savings: money may not be extractable from the system. In the case of the ISIS program, the changes initially resulted in loss of funding for the surgical service, because billings to the service decreased by reductions in operating room services and hospital stays. Also, while there were decreased costs for caring for persons with soft tissue infections, these costs were difficult to extract. One way to extract costs is to close hospital beds or operating rooms and release staff; this is often not desirable or politically feasible. Another way to extract cost is to replace patients who do not have insurance with those that do. Because there is a surfeit of unmet needs in the public healthcare sector, it is often not possible to replace uncompensated care with compensated care. Rather, other uninsured patients often use the

services. Thus, while costs may not be extractable, these programs may allow unmet needs to be met. This was the case with ISIS; while patients reported improved quality of care and had increased access to substance abuse services, costs were not extracted, but services were made available to other patients.

In the STRIDES program, by contrast, 20 beds were “shut” to patients from Alameda County and the hospital contracted out with other counties to use the bed, thus generating a source of revenue and “extracting” the costs of the program.

### Licensing

Another care provision challenge that affected all the programs was facility licensing. Currently, licensing structures for health care facilities, substance abuse treatment units and residential care facilities exist in isolation from one-another, under the auspices of different state agencies, without an overarching framework. This structure is ill-suited to address the needs of programs that don't fit comfortably into a previously existing facility licensing category. This affects programs that address co-occurring disorders, where it is not clear whether they should be licensed as substance abuse treatment programs or mental health care programs. It also affects programs that try to extend the array of services offered. In the case of supportive housing, there was initially some pressure to license supportive housing programs that care for persons with disabilities as residential care facilities. But this would be antithetical to the purposes of the intervention: supportive housing does not serve the same purpose as a board and care facility and strives to provide independent living and a transition to further independence. To meet the goals of a residential care facility would require changes that would deter that purpose. Specific legislation was necessary in California to exempt supportive housing programs from the requirement to be licensed as a Board and Care facility. Other programs have sought to find the right auspices under which to be licensed, often having to make alterations in the model of care delivery and clinical and non-clinical personnel in order to fit into an existing facility licensing category.

### Training of Staff

The fragmentation in care of FUHS is not only a result of segregated funding and facility licensing, but also in provider staff training. Health care practitioners are rarely cross-trained across disciplines. Also, clinicians rarely acquire the skill set necessary to engage and manage hard to reach clients whose lives are often chaotic. Most of the programs featured in this paper were staffed by persons working within teams that were able to offer physical health, mental health and substance abuse treatment, as well as other services. But the lack of cross-training across disciplines complicates this task. In addition, many of these programs' success are attributable in part to the use of paraprofessionals and "peer" staff. These unlicensed and, in some cases, untraditional, care providers help bridge gaps between providers and client and are essential for providing accessible and culturally appropriate care. Supervised by licensed clinical staff, these providers serve an important purpose of outreach, engagement and establishing trust. However, issues of required licensed staff for facility licensing and lack of reimbursement for their services within existing funding streams complicate and limit their use.

### Artificial Segregation of Care and Care Strategies

Because the availability of all types of health and mental health services is often limited by lack of funding, prioritizing who should receive these services is problematic. There are legitimate differences in philosophies as to who should be targeted for some type of services: those who are most likely to "succeed" versus those whose problems are most severe. Differences exist as to whether persons who are actively abusing substances, for instance, should be entered into care in an effort to engage them in treatment and reduce the negative consequences of their use (harm reduction), or whether programs should require participants to be clean and sober with the assumption that this would lead to a more successful outcome. Similarly, the segregation between systems of care (mental health, physical health and substance abuse treatment) is a barrier towards treating patients who require services in more than one system, which is the typical case for almost all FUHS.

### Lack of Shared Data Systems

There is lack of effective sharing of information across systems of care and inadequate data systems infrastructure. This hampers clinical practice, but also hampers the ability to track success across disciplines. Program success is often judged by their ability to decrease one type of service use (hospitalizations, mental health care visits) but successes that cross those barriers go unaccounted for and thus, unrecognized. Without the explicit recognition that multiple systems (criminal justice use, physical health ED and hospitalizations, mental health care, substance abuse) of care are impacted by new models of care for FUHS, it will be difficult to track achievement and to make accurate assessments as to which patients are most likely to benefit from programs. Many programs noted that their inability to know how their program had impacted other systems of care, particularly when evidence suggested that their program was effective in decreasing use of other services, but they were unable to access data necessary to prove that.

### Controversies

As with any innovations, not everyone agrees with the changes. Many of the new model programs, because they expand the role of care providers and spectrum of services that programs offer, are open for criticism. Some worry that programs that provide medical services outside of traditional healthcare settings, such as sobering centers, may compromise patient safety. Others, such as intensive case management, particularly ACT, have been criticized as paternalistic and coercive. Other controversies arise over issues of “ownership” of programs and patients. For programs to be successful, different stakeholders need to be able to relinquish ownership issues and work together. In the successful programs, this happened, although it rarely happened without a strong leader who was able to convince the stakeholders to let go of their “ownership.”

### Housing and Transportation

Across all programs, the need for stable housing for FUHS was repeatedly mentioned as essential. Lack of housing is a critical barrier to improving care and decreasing acute care for FUHS. There are numerous barriers to adequate housing, including lack of funding and difficulty with finding sites for low-income housing. However difficult, the attainment of housing

for clients is crucial to the success of programs targeting FUHS, and for client stability. Though not discussed here, a related issue to housing is transportation. Transportation to care is an important barrier especially in rural and suburban areas which lack public transportation systems thus limiting client access to necessary services and necessitates that new models of care are properly located within communities or housing services.

### ***Policy Issues***

The barriers describe above bring suggest a host of related policy issues: while some barriers may not be amenable to changes in policy, others are. In this section, we will outline some of the possible areas for further policy development.

### Funding

One of the primary policy issues facing those designing services for FUHS is funding. As discussed, the segmentation of funding has multiple negative consequences for the initiation and sustainability of programs that address the needs of FUHS. Policy changes, such as financing made available for services for co-occurring disorders, have allowed some programs to start. But other changes could make these innovations more stable.

Some programs, such as some supportive housing programs, are able to receive partial MediCal reimbursement for their services, but funding is not systematic.<sup>22</sup> These issues are illustrative: the policy recommendations have implications not only for the funding of supportive housing, but also the changes may assist other programs. There are different strategies to obtain MediCal funding for supportive housing. These include partnering with a Federally Qualified Health Center (FQHC) to provide health services. Services that would normally be reimbursable by MediCal, including clinical services delivered by physicians or mid-level providers or social work services delivered by licensed clinical social workers, are reimbursable for supportive housing programs that partner with FQHC, for clients who have MediCal. Supportive housing providers who are also mental health providers can bill for their services under the MediCal mental health carve-out. Finally, some supportive housing services are reimbursable under the MediCal rehabilitation option. Services that are intended to restore

skills that clients need to live independently may also be reimbursable. These strategies may be applicable to other services for FUHS.

While this funding provides some core funding for supportive housing, it is not systematic. Many supportive housing clients (and FUHS) do not qualify for MediCal. This is true for many FUHS and is attributable both to the limited definitions of medical necessity standards for benefit eligibility which exclude substance abuse related disorders and to the bureaucratic challenges to applying for and renewing MediCal. Administrative requirements require patients to frequently renew their MediCal to prove that they meet criteria at different points: this further complicates the ability for FUHS to be insured and creates a system whereby persons are transiently and unpredictably insured.

Additionally, many of the services offered by supportive housing are not reimbursable, including services offered by providers who do not qualify under MediCal. It is important that MediCal reimbursement be made available for the full range of services necessary, particularly those of clinical case management, whose work includes engaging clients in care. Not all supportive housing programs have been able to negotiate partnerships with FQHC or mental health care providers. Some recommendations that follow to improve the stability of MediCal funding for supportive housing include: decreasing barriers to enrollment in MediCal, modifying the definitions of covered services to include services that are necessary for FUHS to regain independence and reduce use of acute care services, covering services provided by paraprofessionals supervised by licensed clinical staff and services provided in an array of settings (including those outside traditional healthcare facilities), providing technical assistance to providers of services for FUHS to assist with meeting administrative procedures for billing, and providing incentives to FQHC to partner with programs that provide services to FUHS.<sup>22</sup> Other strategies for funding include engaging with other interested parties to acquire funds and seeking to blend funding from multiple funding streams.

An example of engaging other interested parties is seen in both respite care and sobering centers, both of which have, in some areas, received funding from private hospitals that recognized that these services could reduce their liability for caring for unsponsored patients

and thus reduce their costs. In San Francisco, private hospitals provided some of the start-up money for sobering centers, in the hope that decreased numbers of ED patients could reduce their uncompensated care both by having fewer CPIs cared for in their hospital, and by decreasing diversion rates at the public hospital. Recognizing the stakeholders who stand to gain from these programs and providing incentives for them to partner financially is a successful strategy.

Some providers have successfully blended funding from multiple funding streams to fund their innovative strategies. Policy changes that facilitate this will go a long ways towards providing stable funding for innovative programs for FUHS. The programs for co-occurring disorders are examples of where a policy decision was made to blend funding at the level of the agency offering the funding: this dramatically facilitated the initiation of these programs.

#### Licensing of facilities

As mentioned in the barriers section, many programs are constrained by requirements for licensing; programs that cross disciplinary boundaries or provide a range of services outside the usual spectrum generally lack a specific licensing agency or facility licensing category. As licensing agencies operate in isolation from one-another without an overarching framework, programs are forced to choose a category: healthcare facility, substance abuse treatment facility or mental health care facility and adapt to fit within an existing structure. There are opportunities for licensing agencies to create more flexible categories that would accommodate the range of services necessary to provide effective care. This includes creating licensing categories for services that are provided outside the spectrum of “usual” health services for non frequent user patients, including the provision of services in non-traditional settings provided by non-traditional providers. While licensing is important for obtaining funding and insuring quality of care, it is crucial that licensing requirements are not excessively burdensome and do not require programs to alter effective services in order to meet requirements.

### Training and Licensing of Staff

Because the skill set needed to engage and manage FUHS are different from those ordinarily necessary to provide traditional health care, it is important that funding streams and licensing requirements assist staff in acquiring this skill set. Policy changes could include those that would provide funding for cross-training itself, provide incentives for the acquisition of the skill set, and that would encourage the use of unlicensed, paraprofessionals and “peer” staff through changes in reimbursement. While it may be difficult to change policies to ensure that service providers are cross-trained in different disciplines, there may be ways to encourage such training, through modifications within licensing requirements so as to recognize such training emphasis.

### Data sharing

Current policies affecting the handling of patient information about substance abuse treatment and mental health, coupled with requirements under HIPAA may serve to reinforce the divisions that exist between different modes of treatment. Within the confines of HIPAA, changes that could ease the restrictions on sharing relevant patient information (maintaining the restrictions of confidentiality) by clinicians involved in the patients care would assist in decreasing barriers to care. Doing so may also help change the limitations in how knowledge of patient outcomes in all disciplines can assist in establishing the evaluation of programs’ effectiveness.

### Housing

Adequate housing is essential to improving health and decreasing unnecessary use among FUHS. It is important that policymakers recognize the integral role that stable housing plays in the success of these programs. The success of supportive housing programs has demonstrated that it is possible to maintain housing in formerly chronically homeless individuals. While a discussion of housing policy is beyond the scope of this paper, it is important to recognize that for the population of frequent user patients, housing must be thought of as integral to the spectrum of services provided.

## IV. Conclusion

There are many challenges facing the provision of care for FUHS, but as new models of care have demonstrated, with appropriate flexibility and innovation, success is possible. The replication of these efforts will require reconfiguring current funding and facility and provider licensing restrictions in order to allow their ongoing success, while removing the systems and policy barriers that foster these restrictions. Providing effective services for FUHS will require many changes, including a loosening of the historical divisions between physical health, mental health and substance abuse treatment programs, a willingness to extend the scope of services provided as “health care” to include housing and case management and more, and the flexibility to move the site of care to FUHS outside of traditional settings. While these changes will be difficult, the need to provide high quality and responsive care to frequent users of health services demands it.

## V. Questions for Consideration

The *Initiative* remains challenged to consider the following questions as it moves forward to formulate a policy agenda to address the quality of care for FUHS patients:

1. Are there other lessons from successes in the mainstream system that should be adapted for FUHS?
2. What are the most effective ways to apply lessons learned from the programmatic successes of caring for FUHS in non-traditional health care settings?
3. What are the critical elements for replication of successful programs?
4. What are effective incentives (or regulations and training paradigms) to insure that providers have the appropriate skills to care for FUHS?
5. Is there a way to eliminate or reduce the artificial segregation of care that has evolved between mental health and physical health care services that make care for frequent user patients more difficult?
6. How can barriers to shared information across systems of care be minimized?
7. What are the best strategies to overcome funding barriers in the current fiscal environment?

Attempting to answer these questions, themselves, will require a dedicated group of health care leaders across many disciplines working with legislators and local and community stakeholders. Simply initiating the discussion will be a critical inroad to informing policymakers and stakeholders about the challenges posed by frequent user patients and their extensive utilization of scarce resources and health care dollars.

## **Appendix I. Risk Factors for Becoming a Frequent User of Health Services**

In order to design a system that is responsive to the needs of FUHS, it is important to understand the causes that lead people to become FUHS. Risk factors such as homelessness, mental illness, substance abuse and involvement with the criminal justice system and lack of medical insurance act in concert: there is a great deal of overlap between them and people who have more than one of the risk factors are at high risk of becoming FUHS. By understanding the complex way that these risk factor interact, we are better positioned to understand the barriers and potential solutions to improve care for FUHS.

### ***Homeless persons***

Homelessness is an important risk factor for FUHS. Homelessness is often the end result of extreme poverty interacting with other FUHS risk factors. Without the stability that housing brings, it is difficult to address other FUHS risk factors.

There is a large amount of evidence to support that homeless persons are at high risk of becoming FUHS. Research suggests that homeless persons are more likely to have had an Emergency Department (ED) visit<sup>23-27</sup> or inpatient hospitalization in the past year than non homeless persons<sup>28-30</sup>, more likely to have repeated ED visits<sup>2, 3, 31, 32</sup> or hospitalizations, and more likely to have extended length of stay<sup>33 11</sup>. While a substantially higher percentage of homeless persons report any use of the ED in the prior year than the general population, it is a small percentage of frequent users that account for the majority of ED use by the homeless population.<sup>2</sup> In the general ED population, homeless persons are more likely to be frequent users than non-homeless persons.<sup>3</sup> Thus, while homelessness is an important risk factor for FUHS, not all homeless persons become FUHS. FUHS appears to result from homelessness in combination with other vulnerabilities, such as mental illness, substance abuse and criminal justice system involvement.

### ***Persons with mental illness***

Mental illness is a risk factor for FUHS. Like homelessness, not all persons with mental illness become FUHS. While persons with chronic persistent mental illness are the most likely to become frequent users of the mental health system, those with co-occurring disorders (mental illness and substance abuse disorders) and those who are homeless may be at highest risk of becoming frequent users of physical health services. Mental illness is associated with high user of both the ED<sup>34</sup> and inpatient medical services<sup>35</sup>; chronic mental illness is a risk factor for both increased mental health and physical health utilization. Among persons with mental illness, those with co-occurring substance abuse disorders are most likely to be high users.<sup>36</sup> It is estimated that 29% of Americans with mental illness have a concomitant substance abuse disorder: 22% with an alcohol disorder and 15% with a non-alcohol drug abuse disorder.<sup>37</sup> Those with mental disorders in the prison population had the highest rates of co-morbid addictive disorder.<sup>37</sup> Among persons with a psychiatric hospitalization, those who were homeless had higher rates of ED and hospitalization services than those who were not.<sup>38</sup> Among psychiatric ED users, those who are homeless are more likely to be high users than those who are not.<sup>39</sup> Among all persons with mental illness, it is a small proportion that uses the majority of the services. In one California county with a million persons, 500 clients (4% of those served in a given year) accounted for 38% of all publicly funded mental health services.<sup>20</sup>

### ***Substance Use Disorders***

Substance abuse is associated with high rates of morbidity and mortality and increased health care utilization,<sup>25, 40-43</sup> particularly of the ED<sup>25, 34, 44-47</sup> and inpatient hospitalizations.<sup>48, 49 50</sup> The health care utilization patterns of persons with substance abuse are driven both by direct effects of alcohol and illicit drugs (infectious complications, overdoses, liver disease) and by indirect effects (increased injuries from violence) and from poor access to non-ED based ambulatory care. As a result of their reliance on acute health care, drug users' health care costs are substantially higher than matched non-drug users.<sup>49</sup> Co-morbid substance abuse is a major risk factor for re-hospitalization and frequent hospitalization in patients with severe mental illness.<sup>36, 51, 52</sup>

### ***Alcohol Use Disorders***

Persons with alcohol use disorders are at high risk of being FUHS. Persons with alcohol use disorders are susceptible to not only numerous medical complications of alcohol, but are also at high risk for injuries. It is estimated that alcohol related complaints account for 10-12% of all ED visits nationwide and approximately 25% of all ambulance transports in urban areas.

Persons with severe alcohol abuse disorders who, by dint of their alcohol use disorder have lost access to employment, housing, and family and community contacts may find themselves homeless and drinking in public. Sometimes referred to as chronic public inebriates, or “CPIs,” these individuals are at particularly high risk for being FUHS. Because they consume alcohol in public, they are often found by emergency service providers (police, ambulances) intoxicated with alterations in level of consciousness. Standard procedure in many cities is to bring such persons to the ED for assessment.

### ***Co-Occurring Disorders***

While chronic medical conditions, mental illness, and substance abuse each work to place persons at risk of becoming FUHS, those with multiple risk factors are at the highest risk. According to the 1999 Surgeon General’s Report on Mental Health, 41-65% of persons with a lifetime substance abuse disorder also have a lifetime history of mental illness and 51% of those with a lifetime mental health disorder have a lifetime history of a substance abuse disorder.<sup>53</sup> Having co-occurring disorders<sup>i</sup> complicates treatment for both; individuals with co-occurring disorders report more difficulty seeking and receiving treatment for either. In addition, persons with co-occurring disorders appear to be at higher risk of developing medical complications, becoming homeless and of having involvement in the criminal justice system than those without.<sup>54</sup>

### ***Persons with Criminal Justice System Involvement***

Prior incarceration may be a risk factor for high utilization of the health care system. There is significant overlap between criminal justice system involvement, mental illness, substance abuse and homelessness. It is estimated that between 3 and 16 percent of the jail and prison populations suffer from severe mental health and substance abuse disorders.<sup>54</sup> People with mental illnesses have an estimated 64% greater chance of being arrested for committing the

same offense as someone without a mental illness.<sup>54</sup> In general, persons who are incarcerated have had little contact with the ambulatory health care system, despite significant disease burden, including high rates of infectious disease (HIV infection, hepatitis, sexually transmitted diseases, tuberculosis), high rates of mental illness, and high rates of substance abuse.<sup>6, 7</sup> Incarcerated persons have higher rates of use of inpatient psychiatric hospitalization than non-incarcerated persons.<sup>55</sup> While the justice system has become the “default providers of care”<sup>54</sup> for persons with co-occurring disorders, most jails and prisons lack coordinated services for treatment these disorders simultaneously.

### ***Lack of insurance or underinsurance***

Lack of insurance has many repercussions for the care of FUHS. While it makes funding FUHS programs more difficult, because of lack of reimbursement for services, it also contributes to FUHS by impeding FUHS ability to get their basic healthcare needs met. Many persons beset with mental illness, substance abuse disorders, homelessness or criminal justice system involvement is either medically uninsured or “underinsured” (using publicly funded entitlement insurance programs.) Their lack of adequate insurance decreases access to the mainstream health care system and leaves them dependent on the publicly funded “safety-net” health care system, including public hospitals and affiliated clinics and Federally Qualified Community Clinics and the publicly funded mental health care system.

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<sup>i</sup> Co-morbid mental illness and substance abuse disorders are sometimes called "dual diagnosis" or "co-morbid disorders." In this report, we will use the language adopted by the Substance Abuse and Mental Health Services Administration and refer to them as "co-occurring disorders."