Frequent Users of Public Services:

Ending the institutional circuit

Changing systems to change lives

CSH
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The Problem: *People and Systems in Crisis*

In nearly every community across the United States today, a small set of individuals are caught in a tragic spiral of involvement in crisis services—services provided at enormous expense to the public but achieving few or no positive gains for individuals. Treatment failures, rising costs, and a growing body of research provide ample evidence of the failure of existing, fragmented systems of care to meet the needs of persons with complex medical and behavioral health issues who repeatedly cycle through our communities' shelter, correctional, and emergency health care systems.

These persons—often referred to as "frequent users" or "high utilizers" of public services—face the double jeopardy of having complex health and behavioral health problems but having no coordinated systems of care. This dynamic—coupled with a lack of stable housing—forces them through a revolving door of multiple, costly crisis and institutional settings such as emergency rooms, inpatient care, detox facilities, long-term care facilities, and correctional facilities. The clear alternative is a more appropriate, more humane, and less expensive approach to integrated care that includes housing.

People and Systems Impacted

These individuals' personal crises become public crises as their frequent and persistent utilization of encounters drive up public spending (in such areas as Medicaid, corrections, and homeless services) and contribute to overcrowded jails and overburdened emergency departments. Moreover, these increased expenses do not result in positive health, housing, or community safety outcomes. Issues communities and systems face include:

- **Frequent use of emergency and inpatient primary and behavioral health care.** Most communities experience a small number of individuals who repeatedly and excessively utilize hospital emergency department and inpatient services as their primary source of medical care.
- **High-cost, high-need Medicaid recipients.** Five percent of Medicaid beneficiaries drive up to 50 percent of total Medicaid spending. (Center for Health Care Strategies, 2008). The care this small population receives is often inappropriate acute care, resulting in poor health outcomes, diminished quality of life, and unnecessary costs which hamper the ability of states to pursue coverage expansions and other priorities.
- **Frequent involvement with correctional systems.** Research in communities across the country has identified groups of individuals who cycle repeatedly and frequently in and out of local correctional settings, and are "customers" of homeless services and other public systems. Another group of individuals experience a cycle that includes prison, release on parole supervision, homelessness, hospitalization, technical violation, and re-incarceration.

One study found that 11 percent of people returning from New York State prisons to New York City become homeless with the first few months after leaving prison; of this group, about a third return to prison within two years. The risk of return to prison is significantly higher for those who are homeless and mentally ill. (Metraux and Culhane, 2004)

Reasons to Focus on Frequent Use

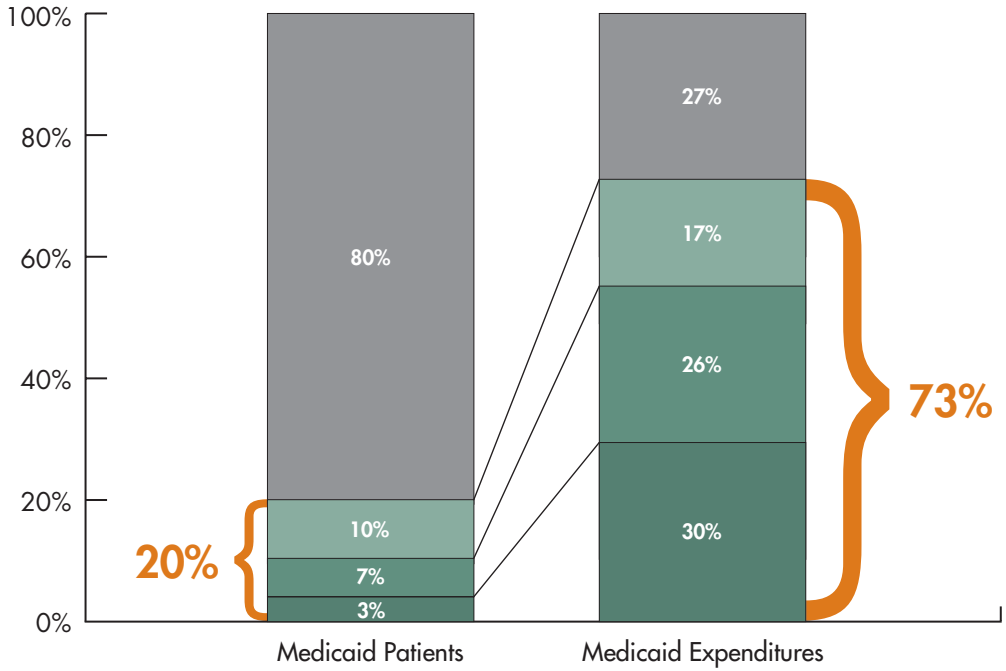
Research and operational experts agree, these are the reasons why a focus on "frequent users" or "high utilizers" is critically needed, including:

- Poor outcomes
- Unmet needs
- Overburdened public systems
- The need to control costs
- Growing recognition of shared responsibility for individual and community outcomes

As illustrated in the chart below, 20 percent of Medicaid beneficiaries in New York State with very complex health care and social service needs incur 73 percent of $3 billion in annual costs of the program. Indeed, data show that as few as three percent of Medicaid beneficiaries may drive as much as 30 percent of Medicaid spending. While not all people in this study represent frequent users, many—71 percent of the 92 percent admitted—had multiple hospitalizations. (United Hospital Fund, Medicaid Institute, 2004)

Increasingly, service systems are recognizing the complexity of needs presented by this core group of users of public systems and acknowledging that more effective interventions require collaboration with other systems. At times of unprecedented budget crises and ever-rising health care costs, communities must address issues surrounding frequent, avoidable use of crisis care in order to be able to dedicate available resources to serve a broader number of vulnerable community members.

High Cost Utilizers of the New York State Medicaid Program



The Solution: *Promising Outcomes and Opportunities to Change*

The recognition that frequent users impact multiple public systems provides the impetus for integrated, cross-system approaches that include housing as a stabilizing factor. Increasingly sophisticated data collection systems and analyses provide new opportunities to identify frequent users of healthcare, correctional, and emergency systems; show the ripple effect of avoidable public service use across systems; and target interventions to those most in need and most likely to benefit. While initiatives may target frequent users of just one public system or are designed to address the overlapping use of two or more systems—such as shelters and jail—once programs enroll the targeted population they invariably find that they are serving frequent users of other systems as well.

Further, a growing body of research has demonstrated that targeted interventions employing cross-system strategies—including care coordination and housing—can interrupt patterns of repeated rounds of institutional and emergency care, thereby improving individual lives and making better use of limited public resources. As described in this section, these research findings provide empirical evidence to substantiate the anecdotal experiences of programs providing interventions for such frequent users—and of those individuals themselves.

Each of these initiatives has implemented a variety of system and practice innovations that can be replicated in other communities, including:

- Data analysis to identify high-cost frequent users and target services
- Predictive modeling to target care management services
- Vulnerability assessments to identify individuals at greatest risk
- Medical respite care to reduce hospital stays and readmissions
- Integrated services by multidisciplinary teams
- Linkages between hospital or jail and community providers to support "in-reach" and care coordination
- Chronic care management instead of episodic acute care
- Ongoing partnerships among agencies and direct service providers with shared goals for shared consumers
- Housing as a stabilizing factor to enhance or enable service effectiveness

Reducing Crises, Improving Outcomes

One example, the ***Chicago Housing for Health Partnership*** (CHHP), shows that offering housing and case management to homeless adults with chronic illnesses creates housing and health stability and dramatically reduces hospital days and emergency room visits. An 18-month randomized control trial compared hospitalizations, hospital days, and emergency department visits among housed participants and a comparison group of chronically ill homeless persons who continued to receive "usual care"—a piecemeal system of emergency shelters, family, and recovery programs. Results were recently reported in the *Journal of the American Medical Association*. (Sadowski et al., 2009)

At 18 months, 66 percent of the intervention group reported stable housing compared to only 13 percent of the "usual care" group. Controlling for a range of individual and service variables, housed participants experienced 29 percent fewer hospitalizations, 29 percent fewer hospital days, and 24 percent fewer emergency department visits than their "usual care" counterparts.

The California HealthCare Foundation and The California Endowment created the *Frequent Users of Health Services Initiative* (FUHSI) in 2002, administered by the Corporation for Supportive Housing. FUHSI included six California pilot programs that provided or connected frequent users to medical and mental health care, substance abuse treatment, transportation, housing, and benefits. Documented by The Lewin Group, evaluation results summarized in the chart to the right illustrates that a multi-disciplinary coordinated care approach can reduce emergency department visits and hospital admissions and stays while improving the stability and quality of life for patients. These interventions also reduce charges significantly.

Additionally, connecting homeless frequent users to permanent housing made significant differences in their ability to reduce inpatient and emergency department charges. In fact, inpatient days and charges decreased by 27 percent for permanently housed clients, but for those who remained homeless, inpatient days grew by 26 percent and inpatient charges increased by 49 percent. Additionally, those who became connected to permanent housing in the first year of enrollment saw a 32 percent decrease in emergency department charges, compared to just a 2 percent decrease charges for those clients who remained homeless.

FUHSI Interventions Reduce Expensive Hospital Charges

	One Year Pre-Enrollment	One Year in Program	Two Years in Program	% Change Over Two Years
Average Emergency Department Visits	10.3	6.7	4	↓ 61%*
Average Emergency Department Charges	$11,388	$8,191	$4,697	↓ 59%*
Average Inpatient Admits	1.5	1.2	0.5	↓ 64%*
Average Inpatient Days	6.3	6.5	2.4	↓ 62%*
Average Inpatient Charges	$46,826	$40,270	$14,684	↓ 69%*

* Statistically significant

The Solution: *Continued...*

The New York City Departments of Correction (DOC) and Homeless Services (DHS), with assistance from the Department of Health and Mental Hygiene (DOHMH) and the New York City Housing Authority (NYCHA), are implementing the Frequent Users Service Enhancement (FUSE) Initiative in collaboration with community-based housing and service providers. This ground-breaking structured demonstration initiative has placed 100 individuals into permanent supportive housing in an attempt to break their institutional circuit between jail, shelter, emergency health, and other public systems. Although early in the initiative, preliminary findings show promising results.

FUSE Reduces Public Systems Utilization

A preliminary outcomes assessment, completed in 2008 by the John Jay College Center for Research and Evaluation, was conducted using a quasi-experimental design with a matched comparison group. Days spent in jail and shelter before and after placement into supportive housing were compared for the subset of clients who were placed into housing at least one year ago (n=86), and a comparison group of individuals matched to this subset (n=102). From this analysis, the group who received FUSE housing and services had a 92 percent reduction in the number of days spent in shelter, whereas the comparison group only decreased their shelter use by 71 percent over the year following placement. With regard to DOC involvement, the group who received the FUSE intervention also reduced the number of jails days spent by 53 percent, whereas the comparison group decreased their jail use by 20 percent. The matched comparison group's results provide a reasonable assurance that the FUSE is having a positive impact.

A cost-effectiveness analysis of FUSE can be performed by using the per diem costs concluded by Dr. Dennis Culhane and colleagues in their authoritative 2002 study: $129 per day for incarceration in a city jail and $68 per client per day for municipal shelter. People placed through FUSE supportive housing reduced systems utilization of jail and shelter by $7,231 in the first year of housing, $3,586 from reduced jail days, and $3,645 from shelter. However, probably only a portion of this offset is due to FUSE. Using a difference in differences methodology to isolate the effect attributable to FUSE in light of the comparison group's performance in the year after housing, more conservative cost offsets can be derived. This method shows a $2,953 adjusted annual cost offset, $2,224 in jail utilization and $729 in shelter. Given this more modest projection the FUSE program shows the potential to break even after approximately two years and generate public savings in the third if it were taken to scale.

FUSE Cost Avoidance Relative to Comparison Group

	DOC		DHS	
	FUSE	Comp	FUSE	Comp
Average Days Pre	52.8	45.0	58.2	26.6
Average Days Post	25.0	36.0	4.6	7.0
Average Days Avoided	27.8	9.0	53.6	19.6
% Days Avoided	53%	20%	92%	74%
% Reduction Attributable to FUSE	33%		18%	
Days Reduced Attributable to FUSE	17.2		10.7	
Per Diem Jail/Shelter Cost from NY—NY Cost Study (Culhane, 2002)	$129		$68	
Annual Cost Offset Per Person	$3,586		$3,645	
Adjusted Annual Cost Offset Per Person	$2,224		$729	
Annual DOC & DHS Cost Offset Per Person	$7,231			
Adjusted Annual DOC & DHS Cost Offset Per Person	$2,953			

The Change Still Needed: *Recommendations for Policy and Funding*

Interventions targeted to "frequent users" of expensive public services present a unique opportunity to improve the lives of individuals and to support healthier communities. Directing public dollars toward solutions that work better, cost less, and mitigate expensive, avoidable emergency and institutional responses is an effective remedy for frequent users—as well as the systems that treat or incarcerate such individuals. This kind of systems change requires effort on several fronts and at different levels: elevating awareness, establishing new collaborations, improving access to mental health and substance abuse treatment, streamlining processes for securing entitlements and health coverage, tying services to housing, and developing a sense of "collective accountability" within our communities are all necessary to achieve systems reform.

How We Get There

Confining the pursuit of better outcomes and budget savings to any one sphere of policy has limitations. Frequent users of health services and correctional systems affect a range of public systems that involve multiple government agencies, direct service providers, and funding streams. Stakeholders across systems and sectors have important roles to play in achieving solutions:

Government can work with providers and researchers to better understand the dynamic of frequent users, help share data to move the solutions forward, reach across other departments and agencies, and provide incentives for non-profits and service providers to work across sectors.

Philanthropy can lead by investing in change, infusing venture capital to build provider capacity, and bridging gaps between systems by acting as conveners.

Researchers can refine and expand existing work on frequent user studies, and develop, document, and disseminate successful data collection tools and strategies.

Providers and practitioners can focus housing and services efforts on frequent users in partnership with impacted systems, participate in discussions about best practices on housing the "hardest to house," and create the full range of housing options including harm reduction and alcohol and drug free communities.

Because policymakers seeking to reduce the cost of caring for complex beneficiaries of any one of these systems do not control the policies that ultimately affect spending for all systems, comprehensive solutions require broad-based approaches that consider the full range of public services. It is also critical to build upon lessons learned through pilot frequent user programs—often launched with one-time funding and philanthropic support—and embed these lessons in mainstream systems so that effective program models can be sustained, expanded, and replicated. This requires leadership, vision, and coordination across multiple state and local agencies.

Important steps toward systems change and improved outcomes include:

- Recognizing collective accountability for outcomes
- Using data to identify frequent users, their patterns of use, and outcomes
- Engaging in strategic cross–agency systems change planning
- Removing barriers to effective interventions
- Financing the solutions

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About the Corporation for Supportive Housing

The Corporation for Supportive Housing (CSH) is a national non-profit organization and community development financial institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information about CSH, please visit **www.csh.org**.

Information in this document was compiled after CSH assembled a diverse group of leaders from the health, corrections, and housing fields for a National Frequent Users Forum in Chicago, Illinois, on October 16, 2008. The Forum provided the first opportunity for practitioners, policy leaders, and researchers to share practices, emerging evidence and lessons learned. Information in this report represents the best thinking of over 60 experts from 25 communities in fields as diverse as public safety and Medicaid administration to hospital districts and probate courts. More information about additional research, other successful initiatives, and details in implementing policy change are available in the full report at **www.csh.org**.

CSH thanks the Robert Wood Johnson Foundation and Funders Together for their generous support of the National Frequent Users Forum.

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