

*NEW COST DATA EMERGES IN CALIFORNIA ON ENDING RANDOM  
RICOCHETING OF FREQUENT USERS OF HEALTH SERVICES THROUGH  
HOUSING*



Corporation for Supportive Housing

*OAKLAND, CALIFORNIA.* Final evaluation data from the Frequent Users of Health Services Initiative, has demonstrated new integrated strategies and systemic results from identifying and intervening with housing and services in the frequent use of emergency room and inpatient services for a cohort of primarily uninsured and needy individuals, nearly half of whom were homeless.

Nearly half (45%) of the frequent user clients were homeless, and among these, more than a third were placed in permanent housing, with 54% placed in shelters, board and care homes, or other similar settings. For homeless participants who accessed housing, ER charges dropped 32% (from over \$800,000 pre-enrollment to \$553,000 post-enrollment) versus 2% for unhoused persons (about \$1.5 million pre-enrollment and post-enrollment), and inpatient charges dropped 27% (from \$5.15 million to \$3.7 million) versus an increase of 49% for unhoused individuals (from \$2.8 million to \$4.26 million).

For all homeless and non-homeless participants across all program sites, there was a 30% decrease in ER visits and a 17% decrease in ER costs, as well as a 14% decrease in inpatient admissions and an 8% decrease in inpatient costs, pre and post participation.

In Atlantic City this week for the New Jersey Governor's Housing Conference, Council Director Mangano paid a visit to the local emergency room, continuing his commitment to make such visits to key stakeholders in the health care sector. On his visit, he was told by local nurses and physicians that frequent users locally arrive 70% of the time by ambulance, with an average cost per visit of \$1,000. The same individuals visit over and over again, including multiple times daily, using as one practitioner reported, beds that others need.

The Frequent Users Initiative was a five-year, \$10 million project jointly funded by The California Endowment and the California HealthCare Foundation and based at the Corporation for Supportive Housing in Oakland. The goal of the Initiative was to promote the development and implementation of innovative, integrated models to address the comprehensive health and social service needs of frequent users of emergency departments and replace it with ongoing, coordinated, and multidisciplinary care provided in more appropriate settings. Funding supported planning grants, implementation grants, technical assistance for all grantees, and outcome evaluation of both the planning and implementation grants.

Through a competitive request for proposals (RFP) process, the Initiative funded six one-year planning grants and six three-year implementation grants—one awarded in 2003 and renewed for an additional year in 2006, and five awarded in a second round of funding in 2004. Taking part in planning and/or implementation were the Counties of Alameda, Los Angeles, Orange, Sacramento, Santa Clara, Santa Cruz, Sonoma, and Tulare.

According to the final report compiled by the Lewin Group, overall, the programs yielded statistically significant reductions in emergency department (ED) utilization (30%) and hospital charges (17%) in the first year of enrollment. Based on analyses of a subset of individuals for whom two years of data were available, ED utilization and charges decreased by an even greater magnitude in the second year after enrollment. Emergency department visits decreased by 35 percent in the first year of the program for this subset of individuals, and by year two, utilization decreased by more than 60 percent from the pre- enrollment period.

Support of hospital administration and program buy- in and support from a larger hospital organization - such as a Hospital Council - served to develop a collective solution for the frequent user population that was able to lower barriers and competition. The business case for investment in relied on sufficient evidence of impact across multiple systems. A consistent, systematic data collection strategy with the hospital and other partner organizations allowed the program to track data over time that could be used to leverage additional funding and establish the business case for intensive case management for this hard-to-serve population.

Development of a countywide database linking hospital, primary care clinic and mental health service, and drug and alcohol treatment utilization enhanced data sharing capabilities and care coordination across medical and social service systems. Among other key findings was the importance of electronic "flagging" systems that provided an automated mechanism for hospital staff to identify patients who met program eligibility for timely referral and co-location of the program at the hospital ER, providing referrals in "real time." Program penetration at multiple hospitals across the county minimized missing frequent users and clients who visited multiple hospitals throughout the region could be identified more easily.

Individual recruitment and engagement was enhanced with small incentives, such as grocery vouchers, phone cards to maintain appointments and communicate with staff, bus passes, food boxes, and program "wallet cards" so clients could easily contact program staff. [Read more . . .](#)