Frequent Users of Health Services:

A Priceless Opportunity for Change

By

Elinor Hall, MPH

Health Policy and Management Consulting

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I. Executive Summary

Most communities experience a small number of individuals who repeatedly and excessively utilize hospital emergency department (ED) and inpatient services as their primary source of medical care. Their problems tend to be complex, often including chronic illness, substance abuse, mental illness and homelessness. While small in number, these “frequent users” generate an inordinately large share of medical care costs and utilize scarce hospital resources for conditions that could have been prevented or more appropriately treated in other community settings. Frequent users contribute to emergency department overcrowding and to higher health care costs for everyone.

Research and demonstration projects conducted by hospitals, community organizations and local governments now confirm that frequent users can be helped in a more effective manner through intensive “hands-on” case management, a service that can lead them to appropriate primary medical care, housing and other community-based services. The result is not only an improvement in their health and lives, but more appropriate (and cost-effective) utilization of healthcare resources for the entire community.

Case management services are not expensive or technologically complicated. They start with the development of a caring relationship between the frequent user and a case manager, a dedicated individual with the ability to “defragment” the health system and address the patient’s multiple, interwoven health and psycho-social conditions. As this paper documents, frequent users who receive these services markedly decrease their use of ambulance, emergency department and hospital inpatient services and they show statistically and clinically significant improvements in chronic medical conditions (including mental illness) and reductions in homelessness and drug and alcohol use. Many frequent users also show reductions in utilization of other public services including short-term shelter days, criminal justice services and general assistance payments.

Meeting the needs of frequent users does not involve the expansion of government services to a new previously un-served population: these patients typically are already beneficiaries of the “system.” They receive expensive, publicly-financed services including medical care through Medicaid, disproportionate share payments to hospitals, and other state-funded medical care programs, mental health and addiction services, police and corrections, food and shelter services, general assistance (in states that have it), and state-funded veterans’ services in states that offer them. Meeting the real needs of frequent users does not necessarily mean additional expenditures; frequent user programs demonstrate dramatic cost offsets and can literally pay for themselves.

Identifying and addressing the needs of frequent users should be a component of achieving broader health policy goals. Expansion of health insurance coverage must include appropriate services for frequent users; merely providing a new payer for dysfunctional utilization would be a hollow achievement. Quality improvement programs must help the health system address the real needs of frequent users if they are to provide the right services in the most appropriate setting. Meeting the needs of frequent users will help to reduce health disparities, relieve overburdened emergency rooms, create livable cities and respond to special populations such as veterans. Addressing the needs of frequent users offers the opportunity to improve the health of vulnerable individuals and simultaneously improve the health care system. Health policy and management leaders at every level can benefit from understanding this population and the programs that work with them effectively.
Numerous studies have confirmed the existence of a small group of adults who use acute care services in an ineffective and disproportionate manner. Behind these neutral words is a powerful reality. For example:

- Washington State’s Medicaid program identified 198 adults (less than 1 percent of the 130,000 aged, blind and disabled enrollees) who made 9,000 emergency room visits in 2002, an average of 45 visits per member. These frequent users incurred 19 percent of all expenditures made on behalf of this category of individuals enrolled in Medicaid.¹

- The Boston Health Care for the Homeless program tracked 119 chronically homeless patients for five years. During this time 40 individuals (34 percent) in this group died or moved into nursing homes; the increasingly smaller group still utilized 18,834 emergency room visits – an annual average of 32 visits per original member for the five year period. Significantly, those individuals who were able to obtain housing during the time period reduced their annual health care costs to $6,056 compared to $28,436 for those still living on the street.²

There is a growing recognition that a small percentage of the population utilizes disproportionately large amounts of health care in any one year. In 2002, 5 percent of the population accounted for nearly half (49%) of all civilian, non-institutionalized health care expenditures, while the lower 50 percent of spenders accounted for only 3 percent of total costs. In the Medicaid program the elderly and disabled constitute around 25 percent of all enrollees but account for about 70 percent of Medicaid spending. People with disabilities accounted for 43 percent and the elderly for 26 percent.³ In 2003, 5 percent of California Medicaid patients utilized 60 percent of fee-for-service expenditures.⁴ Predictably the most costly conditions were heart conditions, trauma, cancer, mental disorders and pulmonary conditions.⁵

Emergency department services are also utilized unevenly. On average, there are 42 ED visits per year for every 100 Americans (or one ED visit per person every 2.5 years). Medicaid beneficiaries visit the ED at higher rates than any other category of patient (82 visits per 100 people), a rate that is higher than that of the uninsured and Medicare.⁶

Efforts to contain health care costs, improve quality, and assure access must be structured to manage the reality of disproportionate utilization by small groups. Many researchers, payers and providers are working on this issue. This paper contributes to that effort by focusing on a particular sub-group of high utilizers: the frequent users of emergency and acute services who also have contributing psycho-social issues.

Frequent users of acute services who are the focus of this presentation are characterized by interwoven health and psycho-social problems:

- They are often low-income Medicaid beneficiaries or are uninsured.

II. Frequent Users of Acute Services

<table>
<thead>
<tr>
<th>Number of ED visits per 100 persons</th>
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</thead>
<tbody>
<tr>
<td>Medicare</td>
</tr>
<tr>
<td>48</td>
</tr>
</tbody>
</table>

NOTES: Error bars are 95% confidence intervals. The denominator for each rate is the population total for each type of insurance obtained from the 2006 Nation Health Interview Survey. More than one source of payment may be recorded per visit. SCHIP is State Children’s Health Insurance Program.

SOURCE: CDC/NCHS, National Hospital Ambulatory Medical Care Survey.
• They are often disabled and/or have poorly managed, chronic health conditions including diabetes, asthma, HIV, heart disease, kidney disease, etc.

• They have complex, co-occurring health conditions, such as mental illness, substance abuse, prior trauma, domestic violence involvement and cognitive deficits that interfere with access to and appropriate use of health services.

• They are unstably housed, homeless for extended periods of time, or have repeated episodes of homelessness.

An on-line video of Tom, and slide shows of other Initiative clients, are posted on the Corporation for Supportive Housing’s web site. Another in-depth profile of a homeless frequent user and the successful efforts to help him find shelter, get dialysis and recover his health, appeared in the Washington Post in 2007.

One California physician who works with frequent users, compared them to someone trying to juggle, “Most people can juggle one ball (say, diabetes) or even two (add unemployment), but trying to juggle a third ball (depression) and a fourth (homelessness) results in all the balls hitting the ground.” Frequent users give up and stop trying to manage their health and their lives.

These frequent users are well-known to local hospitals: their charts are thick; they have a personal relationship with the physicians and staff and often with the homeless shelter and law enforcement. Many are uninsured; even if they are eligible for publicly-sponsored coverage they can’t or won’t complete the applications and maintain enrollment. Medicaid and other payers don’t know these patients personally but if they review comprehensive utilization and claims data, and ask the right questions, they can identify them.

Despite their disproportionately high utilization of expensive hospital services, most frequent users are not receiving effective treatment. Emergency departments provide episodic, high-intensity care, designed to respond to acute injuries and illnesses. ED physicians lack access to full medical records and do not typically monitor and manage chronic diseases. Most hospitals are not able to arrange for the ambulatory care services and social supports that frequent users need, including primary care, substance abuse treatment, mental health outpatient services, permanent housing, benefits advocacy, transportation, etc.

While hospitals may attempt to refer frequent user patients to community or publicly-operated primary care clinics, barriers to care still exist. Primary care clinics often have long waits for a new routine appointment; most do not offer specialty care, imaging or pharmacy on-site; and many clinics require co-pays. Even when frequent users seek out primary care, busy providers find it difficult to address their many complex issues in a short medical care appointment.

Meet Tom, a Frequent User of Acute Services

• Tom is a 56 Caucasian male who has lived in his community for years.

• When younger he held a variety of jobs and traveled the world.

• He was his mother’s caregiver; after she died, his alcoholism progressed.

• Homeless for over 10 years, he lived under the front porch of a kind attorney.

• He had uncontrolled diabetes, chronic pain and mental illness.

• In the year prior to enrollment in a Frequent Users of Health Services Initiative program, he had 11 ED visits, 14 ambulance transports and spent 50 days in the hospital.
III. Local Programs That Work

There are excellent programs around the country demonstrating effective models for working with frequent users of a range of acute services.\textsuperscript{9} Many of these projects are not focused on users of medical care \textit{per se}. Their target population may be high users of emergency homeless shelters, mental health services, sobering centers, or the criminal justice system. Inevitably some of these high utilizers are also frequent users of acute hospital services, though the populations do not completely overlap.

In recent years, a number of research and demonstration projects specifically designed to assist frequent users of acute hospital services have been implemented. In summary, these model programs demonstrate that frequent users who receive intensive case management services and are able to access a mix of community-based services are able to reduce their utilization of expensive, acute hospital care. Equally exciting are the client outcomes: participants show improvements in health status and reductions in homelessness and problem use of alcohol and drugs. Three selected community level demonstration projects addressing frequent users of hospital services are described in detail below.

\textbf{San Francisco General Hospital}

The San Francisco General Hospital, led by the Department of Psychiatry, has been working to serve frequent users for many years and has published a number of peer reviewed articles on the topic.\textsuperscript{10} The Hospital found that homeless patients comprised 24 percent of its emergency room users and 19 percent of all inpatients. Many of these homeless patients fit the profile of “frequent users” with multiple medical and psycho-social conditions.\textsuperscript{11} In April 2007, SF General Hospital, in conjunction with the University of California at San Francisco reported on an evaluation of a two-year research and demonstration project for frequent users.\textsuperscript{12} The Hospital identified 252 frequent users from its records and encouraged those who met study criteria to participate in the program. Approximately two-thirds (n=167) of the participants were randomly assigned to receive intensive multi-disciplinary case management services while the remaining 85 were provided with the usual level of care. About half of the participants had 5 to 11 emergency room visits in the prior year with the other half recording 12 or more visits; all had psycho-social problems. The patient profile of the study participants showed:

- An average of 14 unique diagnoses per person with a range of 1 to 70 unique diagnoses per person;
- Approximately a quarter of the clients had a mental disorder diagnosis (22%);
- Over half had documented alcohol problems (57%);
- A very high level of clients were homeless or unstably housed (81%); and
- About two-thirds were uninsured (67%).

\textbf{SF General Hospital Study Outcomes}

- Case managed patients had statistically and clinically significant reductions in homelessness, problem alcohol use, lack of health insurance and lack of social security income support.
- Emergency department utilization declined by 40 percent in case managed patients (for both high and lower users) compared to the control group patients.
- Case managed patients had fewer medical inpatient admissions, but the decrease was not statistically significant.
Outcomes of the two year study were dramatic, showing health improvements and reductions in emergency room use.

The cost of the case management program, which was paid for by the hospital, was fully offset by the costs avoided in the ED. Many program participants went from being uninsured to having Medicaid coverage, thus improving the hospital’s reimbursement. However, these new revenues were not considered in the evaluation which focused on the cost of care. It is likely other government programs benefited as well, including the criminal justice system and programs that work with the homeless and veterans. The Medicaid program saw a shift in how it supported these patients: rather than paying for them through the Disproportionate Share Hospital (DSH) program covering the uninsured, they gained enrolled beneficiaries whose health outcomes improved as a result of receiving appropriate care.

**The Frequent Users of Health Services Initiative**

The Frequent Users of Health Services Initiative (the Initiative) was a 5 year demonstration project funded by The California Endowment and the California HealthCare Foundation administered by the Corporation for Supportive Housing (CSH). The Initiative funded six California communities (rural, urban and suburban) to develop innovative approaches to reducing emergency department visits by frequent users. Five of the sites focused on comprehensive case management; one offered a brief peer counselor intervention. Three projects were hospital-based, three were community-based, including a county health department and a multi-site FQHC Clinic. All sites had collaborative advisory groups.

Clients rolled in the Initiative program had the following characteristics:

- An average of 8.9 ED visits in the prior year and $13,000 in hospital charges;
- An average of 1.3 hospital admissions (5.8 days) in the prior year with charges of $45,000;
- 66 percent had untreated chronic medical conditions, the most common being diabetes, cardiovascular disease, chronic pain, liver disease, asthma, seizures, and HIV;
- Over half (58%) had substance abuse issues including alcohol and drugs; drugs by prevalence included methamphetamines, crack/cocaine, heroin, prescription drugs;
- 36 percent had mental illness (Axis I and II diagnoses);
- 47 percent were homeless at enrollment.

Thirty-six percent of enrollees had 3 or more conditions, (namely, chronic medical problems, homelessness, substance abuse or a mental health diagnosis). This indicates the complex and challenging nature of their conditions.

Intermediate outcomes showed reduced homelessness and increased insurance coverage for clients enrolled at least a year.

<table>
<thead>
<tr>
<th>All Initiative Projects Client Connections</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless at Enrollment</td>
<td>271</td>
<td>47%</td>
</tr>
<tr>
<td>Homeless Connected to Any Housing</td>
<td>188</td>
<td>69%</td>
</tr>
<tr>
<td>Homeless Connected to Permanent housing</td>
<td>89</td>
<td>33%</td>
</tr>
<tr>
<td>Clients Already on Medi-Cal</td>
<td>215</td>
<td>37%</td>
</tr>
<tr>
<td># Medi-Cal Applications Submitted, # Approved</td>
<td>109, 60</td>
<td>55% approved</td>
</tr>
<tr>
<td># SSI/SSDI Applications submitted, # Approved</td>
<td>176, 61</td>
<td>35% approved</td>
</tr>
<tr>
<td>Qualified for County indigent care coverage</td>
<td>191</td>
<td>33% qualified</td>
</tr>
</tbody>
</table>
The extensive evaluation conducted by Lewin Consulting has been posted to the FUHSI website at www.frequenthealthusers.org, and to the CSH website at www.csh.org. Because this demonstration project did not have a control group, Lewin Consulting utilized various statistical techniques to determine that its data measured the results of the program not just the impact of regression to the mean. Data on pre- and post-enrollment use of hospital services at the Initiative sites after one and two years of enrollment are shown below. Patients showed greater reductions in acute care use in the second year after enrollment than in the first year.

While hospital charges have a limited relationship to actual costs and were not adjusted for annual rate increases, they are helpful to compare the intensity of services provided during ED visits and hospital days over time. Compared to utilization in the year prior to enrollment, total ED visits decreased 35 percent during the first year of program participation and 61 percent during the second year of participation. Inpatient admissions decreased 17 percent in the first year. While inpatient days increased slightly, inpatient charges were down 14 percent, suggesting patients were less emergent. In the second year inpatient admissions were 64 percent less and inpatient days were 62 percent less; charges decreased 69 percent. Hospital inpatient and ED charges together were $10.3 million less during year two of participation than they were during the year prior to enrollment. Costs for physician services in both the emergency room and inpatient settings were not tracked but they should show a commensurate decrease. Santa Cruz County’s Initiative project also documented a 33 percent reduction in ambulance transports and a 47 percent reduction in jail bookings.

As an outcome of the Initiative demonstration project, Senator Darrell Steinberg sponsored SB 1738 directing Medi-Cal (California’s Medicaid program) to

<table>
<thead>
<tr>
<th>ED Visits and Charges for One Year Before and One and Two Years After Enrollment</th>
<th>Pre-Enrollment</th>
<th>One Year Post Enrollment</th>
<th>Two Years Post Enrollment</th>
<th>Pre-Year 2 Post Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of ED visits</td>
<td>2,471</td>
<td>1,608</td>
<td>965</td>
<td>61% decrease</td>
</tr>
<tr>
<td>Mean ED visits</td>
<td>10.3</td>
<td>6.7</td>
<td>4.0</td>
<td>61% decrease*</td>
</tr>
<tr>
<td>Sum of ED Charges</td>
<td>$2,744,612</td>
<td>$1,974,034</td>
<td>$1,132,118</td>
<td>59% decrease</td>
</tr>
<tr>
<td>Mean ED Charges</td>
<td>$11,388</td>
<td>$8,191</td>
<td>$4,697</td>
<td>59% decrease*</td>
</tr>
</tbody>
</table>

*Statistically significant. Statistical tests were run only for difference between means, not sums. (N=241)

<table>
<thead>
<tr>
<th>Inpatient Admissions and Charges One Year Before and One and Two Years After Program Enrollment</th>
<th>Pre-Enrollment</th>
<th>One Year Post Enrollment</th>
<th>Two Years Post Enrollment</th>
<th>Pre-Year 2 Post Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of Inpatient Admits</td>
<td>352</td>
<td>292</td>
<td>125</td>
<td>64% decrease</td>
</tr>
<tr>
<td>Mean Inpatient Admits</td>
<td>1.5</td>
<td>1.21</td>
<td>.52</td>
<td>64% decrease*</td>
</tr>
<tr>
<td>Sum of Inpatient Days</td>
<td>1,528</td>
<td>1,568</td>
<td>579</td>
<td>62% decrease</td>
</tr>
<tr>
<td>Mean Inpatient Days</td>
<td>6.3</td>
<td>6.51</td>
<td>2.4</td>
<td>62% decrease*</td>
</tr>
<tr>
<td>Sum Inpatient Charges</td>
<td>$11,285,258</td>
<td>$9,705,218</td>
<td>$3,538,952</td>
<td>69% decrease</td>
</tr>
<tr>
<td>Mean Inpatient Charges</td>
<td>$46,826</td>
<td>$40,270</td>
<td>$14,684</td>
<td>69% decrease*</td>
</tr>
</tbody>
</table>

*Statistically significant. Statistical tests were run only for difference between means, not sums. (N=241)
create a pilot case management program for 2,500 frequent users. In spite of the State’s formidable budget deficits, the bill passed the Assembly and Senate based on the compelling need for a better, more efficient way of caring for these patients. The bill must be signed by the Governor, and the pilot program must be approved for federal Medicaid matching funds, before it will be implemented.

**Seattle Programs: Begin at Home and 1811 Eastlake**

In 1980 members of the Plymouth Congregational Church in downtown Seattle founded the Plymouth Housing Group (PHG) to focus on the needs of homeless people sleeping on the church steps. PHG started the Begin at Home project in 2003. It now has 20 dedicated housing units for homeless “high utilizers” of emergency room, medical respite and sobering center services. The initial 20 individuals accepted in the program as tenants had expenses of at least $10,000 each at the County’s public hospital (Harborview Medical Center) and/or at least 60 visits to the local sobering center in the prior year. The participants were predominately white males with an average age of 50. Participants had been homeless an average of 40.9 months and had 4.2 medical conditions on average.

The project provided case management, mental health, chemical dependency and primary health care services through an integrated, multi-disciplinary team. After one year, 85 percent (17) of the 20 enrollees were still in housing and participating in the program. Two tenants had died while one individual was evicted. The pre-post program evaluation identified significant reductions in health care utilization, including an 88 percent decrease in hospital admissions and a 74 percent decrease in ED visits. Since participants had numerous long-term chronic conditions and averaged more than three years of homelessness, a case can be made that regression toward the mean is not the sole cause of these dramatic utilization changes. PHG calculated that the overall acute care service cost avoidance was approximately $1.5 million during the first year, far exceeding the $372,000 annual cost of the program.

Seattle is now in the second year of a larger project (“1811 Eastlake”) for 75 frequent users of public services. Multiple funding partners purchased and remodeled a building (located at 1811 Eastlake) and are collaborating to provide case management, mental health, substance abuse and primary care services. The Robert Wood Johnson Foundation funded an independent three year evaluation that will be conducted by the University of Washington's Addictive Behaviors Research Center.

King County used data from the Harborview Medical Center, the Dutch Schisler Sobering Center and the County’s mental health services, detox facility and jails to identify the 200 most expensive consumers of publicly funded services. The Downtown Emergency Services Center, the lead agency in managing the facility, started at the top of the list and sought out and extended invitations to the most expensive frequent users to become residents of the new building.

Of the 79 people initially contacted, only four turned down the opportunity to live in the building, disproving the myth that this population is “homeless by choice.” Ninety three percent of participants were men with an average age of 48. Each had long-term histories of homelessness and many years of chronic alcoholism. In addition, nearly half of the residents had a co-occurring severe mental illness and almost all had other chronic and disabling health conditions including hepatitis or other liver disease (61%), seizures (42%) and heart disease (23%).

A September 2007 New York Times article profiled two of the initial residents of 1811 Eastlake, bringing these statistics to life.

<table>
<thead>
<tr>
<th>“Begin at Home” Health Care Utilization Reductions</th>
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<tbody>
<tr>
<td>Service</td>
</tr>
<tr>
<td>Hospital Admissions</td>
</tr>
<tr>
<td>ED Visits</td>
</tr>
</tbody>
</table>

(N=20)
Residents of the building pay 30 percent of their income as rent. They are allowed to drink but must abide by a code of conduct within the building and out in the neighborhood. Fifteen project staff members work on-site with at least one staff member available 24-hours a day. On-site services include meals, mental health and chemical dependency treatment, primary health care (delivered by a nurse practitioner and medical residents from Harborview Hospital), medication monitoring and a support group for military veterans.

The final evaluation will be based on two years of service delivery (through March of 2008) and will be available by December of 2008. Data from the project’s first year of services is posted on the Downtown Emergency Services Center web site and appears to be promising. Sobering Center admissions decreased 87 percent from an average of 92 admissions per resident in the year prior to move-in, to 12 admissions per year per resident post move-in. Medicaid charges for residents declined 41 percent ($1.4 million) from Harborview Medical Center alone.

The impact of the project on the larger community was also dramatic. The Downtown Seattle Association reported a 48 percent reduction in alcohol related incidents and the number of calls for the King County Sobering Unit van dropped by 21 percent.

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</tr>
</thead>
<tbody>
<tr>
<td>Medical Expenses**</td>
<td>77</td>
<td>$3,507,717</td>
<td>$2,071,709</td>
<td>-41%</td>
<td>$621,086</td>
<td>$2,071,709</td>
<td>-41%</td>
</tr>
<tr>
<td>EMS Paramedic Interventions</td>
<td>63</td>
<td>634</td>
<td>10</td>
<td>526</td>
<td>8</td>
<td>$762,085</td>
<td>-19%</td>
</tr>
<tr>
<td>County Jail Bookings</td>
<td>74</td>
<td>190</td>
<td>3</td>
<td>105</td>
<td>1</td>
<td>$37,474</td>
<td>-45%</td>
</tr>
<tr>
<td>County Jail Days</td>
<td>74</td>
<td>2,312</td>
<td>31</td>
<td>1,343</td>
<td>18</td>
<td>$238,529</td>
<td>-42%</td>
</tr>
<tr>
<td>Sobering Center Admissions</td>
<td>70</td>
<td>6,432</td>
<td>92</td>
<td>837</td>
<td>12</td>
<td>$916,560</td>
<td>-87%</td>
</tr>
<tr>
<td>Detox Visits</td>
<td>50</td>
<td>82</td>
<td>2</td>
<td>93</td>
<td>2</td>
<td>$13,733</td>
<td>+13%</td>
</tr>
<tr>
<td>DESC Shelter Night Stays</td>
<td>59</td>
<td>1,870</td>
<td>32</td>
<td>156</td>
<td>3</td>
<td>$44,338</td>
<td>-92%</td>
</tr>
</tbody>
</table>

*Includes utilization and costs of those people who moved out. **Based on charges submitted to Medicaid. Visits to Harborview Medical Center alone decreased 32%, from 1,152 to 787 (an average drop of five visits [16 to 11] per resident).
IV. Lessons Learned from Effective Programs

It is difficult for any one component of the health care or social service system to successfully intervene with frequent users. These patients need all system components to work together smoothly and require intensive personal support to stabilize their lives, their health and their use of medical care services. Successful frequent user programs are able to accomplish the following tasks:

DEVELOP PARTNERSHIPS: Successful frequent user programs develop partnerships with local health and social service leaders and front-line workers. Having diverse, committed partners allowed Initiative grantees to elevate awareness and understanding of the needs of frequent users across the county, increase the local capacity for housing the homeless, improve access to mental health and substance abuse treatment, improve communication and care coordination among hospital and primary care providers, streamline processes for securing SSI benefits, food stamps, and MediCal coverage and develop a sense of “collective accountability” for frequent users that led to cross-system approaches to issues beyond ED use such as discharge planning, respite care and pain management. In many programs the supporting partners contribute project funding and/or in-kind services.

IDENTIFY FREQUENT USERS: Frequent user programs must develop criteria and systems for identifying eligible patients. Criteria are often based on the number of ED visits over a year or more combined with the presence of other psycho-social problems. The most comprehensive sources of data come from payers such as managed care plans and State Medicaid programs; however these will not include information on uninsured patients. Information from a single hospital will identify some frequent users but will miss “ED roamers” and services provided outside that hospital. Ideally frequent user programs will get referrals from all hospitals in the community and from other public coverage programs; but this is optimal, not required.

ENGAGE FREQUENT USERS: Many frequent users are homeless or unstably housed and are difficult to locate once they leave the emergency room. Even when case managers have an office in the emergency room, many frequent user visits do not occur during office hours. Case managers must be able to work nights and weekends and must be comfortable visiting homeless shelters, single room occupancy hotels, and campsites. Frequent users often have large unpaid bills at the hospital and a history of trouble with authorities; they may be suspicious of a new case manager. The case manager, who may be a social worker, mental health specialist, nurse, or community outreach specialist, must assertively engage the client and spend time building a trusting relationship. Small incentives such as bus passes, grocery certificates, and phone cards help recruit new clients and encourage them to keep appointments with case managers.

COLLABORATE WITH EMERGENCY DEPARTMENTS: Hospital and community-sponsored programs for frequent users must coordinate with ED providers to change the pattern of care delivered. Securing sustained ED participation is hampered by the episodic, emergency nature of ED care, concerns about patient privacy/HIPAA requirements and high ED staff turnover. Even projects sponsored by hospitals must work to educate and secure the involvement of frontline ED staff. Fortunately, EDs benefit directly from frequent user projects and can be highly motivated to participate.

SUPPORT A CHANGE PROCESS: Effective case managers build a trusting relationship with their clients and work in partnership to meet clients’ expressed needs and wishes. Perhaps the frequent user wants relief from pain, a personal doctor or a safer living situation. Developing a plan, working on the plan and achieving the goals that clients have for themselves begins to reduce ED use. Receiving a psychiatric evaluation and mental health treatment,
entering detox and/or substance abuse treatment and agreeing to restrict drug seeking behavior are important “next steps” for many clients. Benefits advocacy contributes to the process by helping the uninsured qualify for health coverage and providing a source of income through SSI, GA or work.

**PROVIDE HOUSING:** Stable housing is tremendously important to changing the life circumstances and utilization patterns of frequent users. It is difficult to maintain a healthy lifestyle or manage a chronic disease while living on the streets. Homeless patients have no place to safely store medications or blood sugar monitors; they can’t keep their wounds clean; they are subject to violence and injury. Lack of suitable housing also undermines mental health and substance abuse treatment progress. Programs that have strong connections to permanent “low demand housing” are much more effective than programs that work with emergency shelters.

Low-income housing is a difficult resource to access; most public programs have long waiting lists and federal requirements do not allow individuals with prior drug convictions to be accepted. Many sites require clients to be “clean and sober” before they can receive housing. Each of the frequent user programs profiled, attempts to provide supportive housing early in their engagement with frequent users. The San Francisco City-County Health Department manages its own apartments and Single Room Occupancy buildings for use by individuals with health care needs and disabilities.

**ACCESS COMMUNITY-BASED SERVICES:** A successful frequent user program must be able to provide a range of community-based services either through its own resources and/or though advocacy and coordination with providers. Needed services include primary and specialty physician care and outpatient mental health and substance abuse services. Developed in response to federal and state legislation, many locally operated health and social services program exist in “silos,” with their own service criteria, application processes, waiting lists, payment requirements, etc. For example, public mental health programs may only serve patients with persistent and serious mental illness. Many frequent users do not qualify for these programs although they have diagnoses that hamper their recovery and stability. Some alcohol and drug detox programs only admit insured patients; the uninsured are referred to emergency rooms.

Many successful frequent user programs have mental health, substance abuse and primary care providers on their case management teams. This allows them to provide some services directly rather than trying to broker access to care in overcrowded systems.

In addition to the systemic barriers to services, frequent users face practical access problems. They may have low-literacy skills and need help filling out forms, securing government identification documents or gathering their medical records. Transportation to the ED is easy: call 9-1-1. Transportation to community-based programs needs to be facilitated with taxi vouchers, bus passes, even rides from the case manager. Not surprisingly, many frequent users have “failed relationships” with the community resources they need and they require advocacy to reconnect with these services.
Frequent users are the “canaries” in the US health care system coal mine. They are particularly vulnerable to system shortcomings due to their lack of resources and the complexity of their lives and health conditions. Frequent users, along with other health care consumers, would benefit from state and federal initiatives that:

- Provide universal health insurance coverage or in the interim, make Medicaid available to all low-income people through a simplified enrollment process. With few exceptions, low-income adults only qualify for Medicaid if they are aged, blind or disabled or have custody of a child. These “categorical” eligibility requirements mean that many single adults, childless couples or older workers will not receive Medicaid regardless of how little income they have.

- Increase the availability of primary care providers; these family medicine specialists to improve patient outcomes by providing prevention and education and coordinating referrals and care.25

- Create unified medical records that enable providers to coordinate services provided in multiple settings and to improve quality for complex cases.

- Increase access to mental health and substance abuse services; integrate these services more closely with physical medicine.

- Increase coordination and integration among health care services and social services particularly low-income supportive housing.

The success of many national policy issues and the integrity of numerous state/federal programs will be affected by how we respond to the needs of frequent users. For example:

- The National Interagency Council on Ending Homelessness has set a goal of ending homeless in the United States.26 Fifty-three states and territories have established their own Interagency Homelessness Councils and adopted plans to end homelessness. The success of these plans depends on addressing the needs of the chronically homeless, including and especially, frequent users of acute health services whose stability in housing is impacted by their health conditions.

- Medicare and Medicaid will be greatly challenged by the “silver tsunami” of aging baby boomers. Reducing disability among adults prior to age 65 will reduce the use of expensive publicly-financed nursing home care in the future.

- The federal government, and ultimately states, cities and communities, have a role in the health and well-being of veterans. Currently many frequent users are Gulf War veterans. We can anticipate that some proportion of the Iraq war veterans now struggling to get care for complex medical conditions and mental health issues will become frequent users.

- There is national concern about overburdened hospital emergency departments. The Institute of Medicine’s 2006 report Hospital–Based Emergency Care: At the Breaking Point, stated: “ED overcrowding is a nationwide phenomenon, affecting rural and urban areas alike. In one study, 91 percent of EDs responding to a national survey reported overcrowding as a problem; almost 40 percent reported that overcrowding occurred daily.”27 Redirecting frequent users to community-based services will help address this problem.

- Governments at all levels are interested in creating vital, livable cities; helping frequent users to stabilize their lives improves the urban environment and frees-up law enforcement resources to address more serious issues.
Frequent users of acute services are not the responsibility of any one state or federal program. Approaching the issue solely as a Medicaid problem could exclude many frequent users who are initially uninsured. Approaching the issue solely as a housing problem will exclude some frequent users who are not homeless and will focus on many homeless patients who are not frequent users. Mental health and substance abuse programs have similar limitations as lead agencies. On the other hand, creating a new bureaucracy to address the fragmented nature of our health and social service systems would be an ironic, and likely self-defeating, approach.

Instead, different disciplines and service sectors must collaborate in order to serve frequent users; shelter and housing programs, health coverage programs, substance abuse and mental health services, primary, hospitals, veterans’ services, poverty and criminal justice programs should all play a role. Leadership from the highest levels of government can speed recognition of the issues and remove barriers to change.

State Governments have numerous opportunities to provide leadership on the issue of frequent users. Increasing awareness of the issue is a good place to start. States could create a standard definition of frequent users and identify their numbers and their associated public sector and health care costs. States and their local partners manage many of the health and social service programs that frequent users need and are in a good position to address this issue. Executive branch leaders could convene impacted agencies and develop plans to better serve frequent users of health services. These plans could include changes to existing services to make them more accessible to frequent users as well as the creation of new programs of intensive case management and care coordination.

While frequent users do not fall squarely into any State agency’s portfolio, Medicaid has a particular stake in assuring that frequent users are treated appropriately. Although many frequent users are uninsured, many others have Medicaid. For example, California’s Medicaid program (Medi-Cal) recently identified 28,000 adult beneficiaries who had 5 or more ED visits in 2007 and who met other criteria for being a frequent user. Even when frequent users are uninsured, Medicaid programs help to finance their care indirectly through Disproportionate Share Hospital payments made to public hospitals and clinics. Often cities and counties help to finance services for the uninsured through their safety net health care systems. The next section of this document explores the role of Medicaid in addressing the needs of frequent users.
VI. Medicaid Funded Services for Frequent Users

Many state Medicaid programs are focusing on the needs of high utilizers; in order to control Medicaid costs, they must intervene with the small group of patients that drive expenditures. Most of the high cost patients are among the Aged, Blind and Disabled or SSI enrollees. Although many states have implemented managed care programs that cover children and families, disabled adults and seniors are not usually required to enroll. In an attempt to coordinate care, prevent health crises and deliver the right service in the right environment, states are experimenting with a variety of mechanisms including targeted case management, primary care case management, medical case management and various types of demonstration and pilot programs secured under waivers. The Center for Health Care Strategies has analyzed efforts by states to create care management strategies that steer a middle course between capitated managed care plans and the fee-for-service model. The efforts of three states (Maine, New York and Washington) seem particularly relevant to the needs of frequent users and are profiled in this section.

Maine

MaineCare, has begun providing a special benefit to heavy utilizers of Medicaid services, particularly those with unstable chronic conditions and a history of ED and inpatient use. Maine determined that during a recent 12 month period, 1 percent of Medicaid patients (2,253 members) incurred 32 percent of program costs, 5 percent of patients incurred 61 percent of costs and 10 percent were responsible for 74 percent of costs. The lowest utilizing half of all enrollees accounted for only 2.37 percent of program resources.

In response, Maine created a new Medicaid Care Management benefit and in October 2007 entered into a two-year contract with Schaller Anderson Medical Administrators, Inc (since acquired by Aetna) to provide services to eligible beneficiaries statewide. The contract contains performance goals but the company is not at-risk for the outcomes. The State expects net savings of $55 million (total funds) in the Medicaid budget over the two-year term of the contract.

The Care Management benefit offers many of the services provided through managed care without the complexities and controversies of capitated managed care plans. Services under this benefit include:

- Establishment of a medical home;
- Integration of physical and behavioral health;
- Coordination with existing care management programs;

Distribution of Medicaid Costs by Percent of MaineCare Enrollees

<table>
<thead>
<tr>
<th>% OF ENROLLEES</th>
<th>% OF MEDICAID COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>50%</td>
<td>80%</td>
</tr>
</tbody>
</table>
• Education on high-risk behavior and emergency room use;
• Disease management/education;
• Concurrent review of hospital care; focus on one day admissions, readmissions; and
• Discharge planning for chronically ill and high-risk members including a face-to-face meeting with members and families prior to discharge.

Maine's Care Management benefit will undoubtedly assist many beneficiaries in utilizing services more appropriately, but it may or may not meet the needs of frequent users with complex psychosocial problems. The program was structured to enroll patients after they returned a mail-in health questionnaire and many services are delivered via telephone. Many frequent users do not have a stable address or telephone number and are difficult to engage via these traditional disease management approaches.

States that create programs intended to serve heavy utilizers of acute services may want to stratify their programs and create a special option for the types of frequent users described in this document. These frequent user program should include lower caseloads with in-person services, a mechanism to improve access to behavioral health, primary care and housing and funding for other “wrap around services” that facilitate client stability such as money management, transportation and benefits advocacy. Ideally frequent users will be screened into these programs initially, rather than being required to “fail” with traditional services first. New York Medicaid offers an example of a new program that was specifically designed to serve this target population.

New York

New York is one of three states working with the Center for Health Care Strategies as a pilot demonstration site for the Rethinking Care Project. Funded by RWJ and other major national foundations, Rethinking Care will “serve as a national Medicaid ‘learning laboratory’ to design and test better approaches to care for these high-opportunity beneficiaries.” New York State is working to design and implement a new Medicaid “Chronic Illness Demonstration Project” for frequent users. In 2006, legislation directed the Department of Health (DOH) to develop a demonstration project to test models of care and reimbursement after determining that, “Medicaid beneficiaries with multiple co-morbidities are among the most medically complicated and most costly, accounting for 20 percent of all Medicaid beneficiaries but seventy-five percent of all Medicaid costs. Because these individuals require services across multiple delivery systems, licensed by multiple agencies, their care is often fragmented, uncoordinated and at times duplicative.”

DOH worked with CMS to design a capitated Primary Care Case Management (PCCM) program for this population and issued an RFP in early 2008 to select contractors by region. DOH will identify beneficiaries eligible to voluntarily enroll in the demonstration project using an algorithm (developed at NYU and tested at Bellevue Hospital) that predicts which patients are most likely to experience an inpatient admission(s) in the coming year based on prior utilization, diagnoses, etc. The Demonstration Project will serve beneficiaries “with mental health and/or chemical dependency [who] have at least one chronic medical condition, with a majority having multiple medical conditions.” The target population is further characterized as lacking a medical home and access to primary care along with high use of emergency room and frequent hospitalizations. The Chronic Illness Demonstration Project will have a control group and will be formally evaluated.

The Legislature appropriated $10 million of state funds annually with the expectation that most of the services provided would draw down federal Medicaid matching funds. Core services that must be provided by contractors include: comprehensive health assessments and care plans; care coordination, provider engagement strategies, patient self management/activation interventions and caregiver/family support and involvement. The contractors, who are locally-based, will be expected to contribute significant resources toward linkage to housing.

New York Medicaid has experienced disappointing outcomes from a more traditional disease management program. The Care Management Demonstration (CMD) which started in 2006,
has had difficulty enrolling the target population and did not demonstrate the anticipated changes in medical care utilization. The DOH expects to publish an evaluation of that project in the fall of 2008 to refocus it through stratification of the target population and services offered.

Washington

Washington State is also leading the way in learning how to meet the needs of high-utilizing Medicaid patients. In 2002 it started a traditional disease management program with a statewide commercial vendor and a number of smaller regional programs. Again these programs experienced difficulty in engaging patients who had complex issues, particularly mental health, homelessness and/or substance abuse and outcomes were inconclusive. A new Care Management program is being developed that will in Seattle to be operated by a local non-profit in Seattle to provide intensive hands on care for the highest utilizing patients. This project is part of the Center for Health Strategies effort and will be expanded to a second site and will be evaluated.

Some of Washington’s urgency regarding the frequent user population stems from a high profile study that was published in 2004 by the Washington Department of Social and Health Services (DSHS). This study (also cited in Section II) indicated that 7,000 Medicaid enrollees averaged more than 11 ED visits each during 2002.\(^3\) Representing 5 percent of the aged, blind and disabled Medicaid enrollees\(^5\) they accounted for 38 percent of ED costs for that population. One hundred ninety-eight “super frequent users” in this group visited the ED over 31 times each in that year, averaging 45 visits per person or 9,000 visits as a group. Based on diagnoses found in claims data, 56 percent of these ‘super frequent users’ had both a mental health and an alcohol or drug related diagnosis. An additional 23 percent had only a mental illness disorder and 11 percent had only a substance abuse diagnosis. Only 10 percent had no indication of substance abuse or mental illness as documented in the Medicaid records. Ninety-nine percent of the ‘super frequent users’ received prescriptions for pain, with an average of 42 prescriptions per patient during the year. In comparison, 27 percent of Medicaid enrollees without an ED visit received a pain prescription during the year. The study led to a number of changes in the Medicaid program including a special program to flag patients who were “doctor shopping” and require prior approval for their services.

Washington also demonstrated a very innovative approach to meeting the real needs of higher utilizing patients by expanding access to substance abuse treatment services for Medicaid and General Assistance clients.\(^6\) Washington had previously documented that Medicaid patients with untreated substance abuse had higher medical care costs than patients who had received treatment and that cost saving occurred after receipt of treatment and continued over time.\(^7\) \(^8\) Washington matched the names of the super frequent users with patients in its mental health and substance abuse treatment data bases and determined that two out of three patients with a mental health diagnosis had received some level of mental health services during the year but only one out of six patients with a substance abuse disorder had received treatment for that condition.

The State Legislature authorized and funded the Drug and Substance Abuse Treatment expansion program to increase access to services for adults on Medicaid and General Assistance and for youth on Medicaid. The new expenditures were funded by assumed savings (or cost offsets) in the projected budget for medical care and nursing home care for adult treatment recipients.\(^9\) Realization of the projected savings was dependent on which patients entered treatment. If high-utilizing patients took advantage of the new benefit, more savings would be realized than if very low-utilizers entered treatment.

DSHS published an evaluation of the Substance Abuse Expansion program in November 2007.\(^4\)\(^0\) Savings in expenditures per member, per month, actually exceeded the budgeted savings in every category as shown in the table on page 19.

Although savings per beneficiary exceeded projections, start-up of the treatment expansion benefit was slower than anticipated and fewer clients received treatment than expected. Because treatment expansion funds were committed and spent independently of the services actually delivered, the expansion did not cover its costs during the first years of the program and the budget for the expansion was reduced (but not eliminated).
The substance abuse treatment expansion services were directed at enrollees with “disproportionate costs,” though not specifically the small group of frequent users described in this paper. The frequent users described in this paper are unlikely to enter traditional treatment programs without additional supports. They may be medicating the misery of homelessness or mental illness with drugs and alcohol. They have undoubtedly “failed many treatment programs” in the past and may have given up the desire or hope to change. States wishing to impact the frequent user population should consider combining treatment expansion with an intensive case management program that would help the complex, expensive frequent user group to take advantage of this benefit.

<table>
<thead>
<tr>
<th>Medicaid Service and Beneficiary Type</th>
<th>Budgeted Savings per Treated Member per Month</th>
<th>Actual Savings per Treated Member per Month</th>
<th>% Actual Savings to Projected Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Care Savings for Disabled Beneficiaries Receiving Substance Abuse Treatment</td>
<td>$199</td>
<td>$287</td>
<td>142%</td>
</tr>
<tr>
<td>Nursing Home Savings, Per Member, Per Month for Disabled Beneficiaries</td>
<td>$58</td>
<td>$137</td>
<td>233%</td>
</tr>
<tr>
<td>General Assistance Patients, All Services</td>
<td>$117</td>
<td>$149</td>
<td>127%</td>
</tr>
</tbody>
</table>
VII. Increasing Access to Coverage for Frequent Users

Many frequent users have very low-incomes and no health insurance. A lack of coverage is a prime reason that frequent users go to hospital emergency departments for care, the only component of our health care system required by law to serve the uninsured. Preventing avoidable ED visits and inpatient stays and reorienting frequent users to community-based services is easier if frequent users have health coverage that pays for needed medical care.

Frequent users have two main problems securing Medicaid or other publicly-financed health coverage: they are eligible but can’t get through the complex application and disability certification process or they are not eligible because they are not sufficiently poor or disabled to qualify. As described in this section, state actions can impact both of these barriers.

The National Health Care for the Homeless Council published a helpful document, “Casualties of Complexity: Why Eligible Homeless People are Not enrolled in Medicaid,” that identifies the numerous policy and administrative obstacles that result in eligible, homeless/disabled individuals being uninsured. For example, homeless patients routinely do not receive redetermination notices and have difficulty providing the required documents and third-party contact information. States have the ability to streamline eligibility requirements and application processes as long as they conform to federal standards. Instead of requiring quarterly, face-to-face re-determination of eligibility, states can determine eligibility annually and waive face-to-face interviews. Instead of requiring beneficiaries to re-submit notarized copies of documents such as birth certificates, drivers licenses, and marriage records for each recertification, states can require only documentation of income and other information that has changed. States can waive asset requirements and establish timelines for prompt processing of completed applications. More comprehensively, States can develop automated eligibility and enrollment systems which have great potential to improve the quality and cost of public coverage enrollment systems.

States also have the option of providing Medicaid Administrative funds for community-based outreach and enrollment assistance. These funds can be targeted geographically and to serve specific groups of people including homeless individuals and others facing enrollment obstacles. This type of benefits advocacy can make an enormous difference: San Francisco General Hospital documented that 50 percent of uninsured emergency room frequent users could qualify for Medi-Cal with the support of benefits advocates. Thanks to its investments in benefits advocacy, the hospital is able to bill for many services that would have otherwise been “bad debts” or charged off to the limited Disproportionate Share Hospital payment pool.

Expanding Health Insurance Coverage

Supporting enrollment of eligible clients is important, but not all frequent users qualify for Medicaid. One of the fundamental barriers for frequent users is the categorical nature of Medicaid. The federal government requires states to cover low-income seniors, pregnant women and children and people who are determined disability through the SSI (Supplemental Security Income) process. Most states also optionally cover low-income, custodial parents. No matter how low their income, most adults ages 19-64, without custody of children, are not eligible for Medicaid coverage unless they meet SSI criteria for permanent disability. Many frequent users do not qualify because drug or alcohol dependency by itself is not considered a disability by Social Security and with proper treatment and support they can recover. Without Medicaid, they can’t get access to treatment. Moreover, many have underlying conditions that won’t be cured in the absence of substance abuse but this is difficult to document.
There appears to be renewed interest at the state and national levels in covering the uninsured. As of August 2008, three states had enacted comprehensive health coverage reforms and another 14 were considering similar action.\textsuperscript{4,5} The great majority of health coverage extension plans involve expanding Medicaid to cover people with higher incomes and/or to cover people who are not categorically qualified as aged, blind or disabled. In 2007 Massachusetts implemented major health coverage reform (Chapter 58) that provides fully subsidized coverage for individuals with incomes up to 150 percent of FPL (individuals up to 300 percent of poverty can enroll but must pay some portion of the premiums). Maine and Oregon have long had federal waivers extending Medicaid benefits to low-income adults who are not parents and who do not meet SSI disability criteria. During 2008, the California Legislature considered AB 671 (Beall) that would extend Medicaid coverage to low income frequent users. Frequent Users were defined as "individuals who have undergone emergency department treatment on five or more occasions in the past twelve months, or eight or more occasions in the past twenty-four months, and who have two or more of the following risk factors: chronic disease diagnosis, mental illness diagnosis, homelessness, substance abuse, and a history of not adhering to prescribed treatments."\textsuperscript{46} The bill did not pass, but it is nonetheless an interesting example of one way to provide coverage to a very needy population that is impacting public costs in many systems.

Programs that extend coverage to the uninsured should specifically address the needs of frequent users. Doing so will help contain costs and maintain public support. It would be a missed opportunity if these bold efforts merely provided a source of reimbursement for continued dysfunctional use of acute health care services by frequent users.

**Other Federal Options**

Even without expanding insurance coverage, Congress could increase access to medical care for frequent users by expanding existing grant programs. The Bureau of Primary Health Care currently funds care for low-income, uninsured patients at Community Health Centers and through the Health Care for the Homeless program. The federal government could increase services for frequent users through these two programs by: 1) providing grant augmentations for Community Health Centers to develop special programs for uninsured frequent users; 2) providing grants for new Community Health Centers and Homeless Health Care program start-up; 3) educating grantees about the needs of frequent users and best practices for serving them; 4) recognizing frequent user programs as a basis for increasing a Federally Qualified Health Center’s Medicaid rates to cover the full cost of these programs.

The provision of funding for low-income housing, especially housing that includes medical and social services, is a vital role for the federal government. Effective frequent user programs are logical and necessary partners to supportive housing projects for adults with disabilities. Some homeless services programs have done an excellent job of working with frequent users.
VIII. Conclusion

All sectors of society have an interest in assuring that frequent users receive effective care and appropriate interventions. Serving frequent users does not mean extending government services to a new group that has not been previously served. Frequent users are already receiving expensive publicly-funded (though poorly coordinated, and often misdirected) services. Addressing the needs of frequent users involves reprogramming existing resources to achieve the goals of health, recovery and stability.

As a society we cannot afford to provide expensive emergency department, ambulance and inpatient services for conditions that could be prevented or more appropriately treated in community settings.

And we cannot afford to ignore the needs of low-income patients who have multiple chronic conditions until such time as they become completely disabled and require skilled nursing home care at public expense. Moreover we must not turn an institutional blind eye to the needs of people whose chronic physical and mental health conditions result in poverty, homelessness, disability and early death.

Provision of intensive case management, along with access to primary care, supportive housing, substance abuse treatment and mental health services can make a dramatic difference in the lives of frequent users. Providing these services to patients who need them is a win/win proposition: the medical care system, the patients, the community and the payers all benefit. Failure to meet the real needs of frequent users is costly in every way; the provision of appropriate community-based care, housing and case management is priceless.
ENDNOTES


9. The Interagency Council on Homelessness lists innovative programs on its web site at www.ich.gov/innovations/index.html Programs addressing chronic homelessness have relevance to work with frequent users.


11. Kushner, Margot, et al., Emergency Department Use Among the Homeless and Marginally Housed: Results from a Community Based Study.” Am J. Public Health, 2002


13. The Corporation for Supportive Housing is a non-profit agency that provides technical assistance and advocacy for low-income housing for special populations www.csh.org

14. www.csh.org/fuhsi


17. “Regression toward the mean is the phenomenon whereby members of a population with extreme values on a given measure for one observation will, for purely statistical reasons, probably give less extreme measurements on other occasions when they are observed.” http://en.wikipedia.org/wiki/Regression_toward_the_mean.

18. Savings would be 5-10% greater if adjusted for inflation in hospital charges over time

19. www.leginfo.ca.gov/cgi-bin/postquery?bill_number=sb_173&sess=CUR&house=B&author=steinberg

20. www.plymouthhousing.org
Funders included the City of Seattle Housing Levy, King County, the State Housing Trust Fund, LIHTC, HUD, Federal Home Loan Bank, the State Substance Abuse Treatment


Selecting patients based on a longer period of high service utilization eliminates frequent users who are likely to reduce service use without intervention (namely regress to the mean)


Private communication from the State Department of HealthCare Services to Senator Darrell Steinberg dated August 11, 2008. In addition to having 5 or more ED visits, the beneficiaries had to have at least two of three conditions including a chronic physical condition, a mental disorder or a substance abuse disorder. 11,805 beneficiaries had all three conditions.

“The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care services for low-income populations and people with chronic illnesses and disabilities. We work directly with states and federal agencies, health plans, and providers to develop innovative programs that better serve people with complex and high-cost health care needs.” www.chcs.org


New York Social Services Law, section 364-1, Chronic Illness Demonstration Projects

New York State Chronic Illness Demonstration Project RFP, pg8 viewed at www.health.state.ny.us/funding/rfp/0801031003/0801031003.pdf

www.health.state.ny.us/funding/rfp/0411121215


Does not include patients who have both Medicare and Medicaid coverage since Medicare is responsible for most of the payments for these “dually eligible” enrollees

Georgia, North Carolina and Pennsylvania have also expanded substance abuse services for Medicaid enrollees

Kohlenberg, L, Mancuso, D, and Nordlund, D, “Chemical Dependency Treatment for Disabled, Blind and Aged Clients: Alternative Health and Nursing Home Cost Offset Models,” Washington State Department of Social and Health Services, Research and Data Analysis Division, http://publications.rda.dshs.wa.gov/1124/


Federal law, (EMTALA) requires emergency departments to screen and stabilize every patient who presents, regardless of their ability to pay


www.kff.org/uninsured/kcmu_statehealthreform.cfm

www.leginfo.ca.gov/cgi-bin/postquery?bill_number=ab_671&sess=CUR&house=B&author=beall
Supported by an unrestricted educational grant from the National Pharmaceutical Council.