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The Complex Chronically III: Addressing the Needs of Frequent Patients and Inappropriate Emergency Room Use

by *Melissa Jones, Esq., Health Policy Analyst*

Over the past few years, Redwood Coast hospital and health and human services workers have observed an influx of hospital patients, between the age of 45-60, with complex chronic illnesses who are frequently utilizing the emergency room (ER) and pose significant discharge challenges.

These complex chronically ill patients may suffer from many of the following: substance abuse and behavioral issues, inadequate social and financial support systems, lack of a stable home environment and the need for long term placement. The region's current long term care delivery system is not able to accommodate them even though their functional status has deteriorated to the level they can no longer provide for themselves.

There are very few resources and very little rural based research for communities on this issue. However, urban areas have been struggling with this problem and can offer some best practices. The urban programs discussed here could be modified or adopted to suit our rural region's needs.

There are three ways communities are addressing the needs of these complex chronically ill patients.

First, some have adopted an integrated care model specifically for this population. Integrated care models primarily focus on the coordination of medical,

behavioral, social, and when needed, housing services.

Second, some have successfully adopted "Housing First" or supportive housing programs. The Corporation for Supportive Housing is a national non-profit organization that helps cities and communities address their homeless population through supportive housing and other services. They offer some basic policy and advocacy tools for community organizing and raising awareness of the issue.¹

Third, some states have adopted and received grants for "ER Diversion" programs. ER Diversion programs aim to reduce inappropriate frequent use of Emergency Room services. A few of these ER Diversion programs are in rural communities.

Frequent Users of Health Services Initiative and Integrated Care

The Frequent Users of Health Services Initiative is funded by the California Endowment and the California Health Care Foundation. This initiative supports integrated care models in several communities: Santa Clara (New Directions), Santa Cruz (Project Connect), Alameda (Project RESPECT), Los Angeles (Improving Access to Care), Sacramento (The Care Connection), and Tulare (The Bridge). All of these communities are in urban areas.

One example of a successful program is in Santa Clara County. The County conducted a pilot study of patients that frequently use the ER and tested different strategies for decreasing ER use. Out of that study, a program called “New Directions” was formed. The target patients frequently utilized the ER and often had psychosocial issues, chronic conditions, or mental health problems. Some of the patients lacked stable housing. New Directions consists of three parts: intensive case management, interdisciplinary and inter-agency case conferences and linkage to primary care to ensure continuity of care. The case manager assesses the patient’s needs and enrolls them in the New Directions program. A plan is established by the case worker with patient participation and input.² Case managers help the patient find and obtain specialized care and social services or other benefits.

“Housing First” in San Francisco

The Santa Clara study described above identified housing as a central concern, and New Directions employs a Housing First model when a person is homeless. Housing First models have saved over \$18,000 annually in health and social services costs.³ 85% of participants remain housed and a majority experience decreased mental health symptoms.^{3,4} Housing First embraces the concept that to successfully avoid homelessness, housing aid must be the first service offered. Typically Housing First plans integrate medical and behavioral care into the solution for a coordinated and comprehensive system of care.

There are two types of Housing First sites: scattered site and fixed site. Scattered site is more appropriate for individuals that can remain fairly independent and do not need on-site services and daily care. Fixed housing has on-site case management staff and other services.³ The type of model will be dependent on (a) how vulnerable the individual is, and (b) how independent the individual is.⁵

San Francisco has two models for integrating housing, medical, behavioral, and mental health care. They are based in the Housing First concept.⁶

According to San Francisco’s ten year homeless plan: “Direct Access to Housing (DAH) has 360 units of permanent supportive housing in five single room occupancy hotels and 33 units in a licensed residential

care facility. The units have private baths and shared cooking facilities; three meals daily are prepared for the residents. DAH acquires the building through “master leasing,” which has the added benefit of renovating buildings in troubled neighborhoods.

All six DAH sites have between three and five on-site case managers as well as a site director. Case managers assist residents to access and maintain health benefits, provide substance use, mental health, life skills and family counseling, assist in accessing medical and behavioral health (mental illness and substance abuse) treatment, assist with accessing food and clothes, and interface with property management in preventing evictions. All six sites have access to a roving behavioral health team, which can place residents off-site in mental health or substance abuse programs when appropriate. All sites have access to medical care.”⁷

Community Housing Partnership (CHP) owns and operates housing for formerly homeless individuals and families. CHP develops and operates permanent housing for formerly homeless people with on-site support services (including housing retention, case management and counseling, crisis intervention, family and senior services, community building), job training, leadership development and employment opportunities.

As a preventive measure, San Francisco’s most recent homeless plan includes strategies for identifying individuals in jails and foster youth programs that will need behavioral or mental health help. The city hopes to address the needs of these populations before they are released by setting them up with services and resources prior to their integration back into the community.

ER Diversion Programs⁸

ER Diversion (ERD) programs address the needs of the complex chronically ill population by preventing or deterring them from using the ER inappropriately in the first place. ERD programs address the needs of the complex chronically ill regardless of their housing situation.

Illinois recently implemented an ERD that was funded through a federal grant from the Department of Health and Human Services Centers for Medicare

and Medicaid. The program collaborates with a Federally Qualified Health Center, community mental health center, and a hospital.

The goal of the program is to establish an integrated system of care that addresses the chronic needs of the community, thus reducing unnecessary hospital admissions. Another goal of the program is educate patients about when to seek care in an emergency setting. One of the hurdles that the Illinois program is experiencing is when a person arrives at the ER, hospital staff will often see and admit them to comply with the federal Emergency Medical Treatment and Active Labor Act. The program is currently working on establishing a referral process and education about appropriate treatment as part of discharge planning.

The program also established a “living room” setting near the hospital for individuals with behavioral health problems. The area is furnished like a home, but is staffed with trained clinicians that focus on short term recovery issues. The clinicians provide the patient with care and inform them about alternative resources. It is the hope that this “first contact” will deter future inappropriate ER use.

South Dakota has a rural community that uses a telehealth based project funded by the same federal grant as Illinois. This project allows people to receive urgent care through a telehealth consult with a provider in a nearby urban community. The clinic will be staffed with a nurse to facilitate care.

Humboldt County’s Current Status

Humboldt County has some current projects in place that could be broadened to address the needs of the complex chronically ill populations.

The county is working on its 10-year homeless plan and drafting action steps. One of the sub-committees is focused on discharge planning and will include representatives from medical, law enforcement, and mental health. This may be helpful in addressing the issue of the complex chronically ill that are homeless.

The main strategy in reducing the homeless population is based on supportive housing similar to the programs described above. Department of Mental Health Services funded a project for the homeless population with mental health issues. The county is

currently looking for a developer to either renovate an old building or build a new one for the main housing component of the project.

Additionally Arcata House, an organization dedicated to securing housing for the homeless and disabled, has an “Apartments First!” program which has been quite successful. Through Apartments First! Arcata House works with landlords and apartment complexes to help individuals find affordable housing. Apartments First! provides case management for clients. The case manager arranges and monitors appointments with social and medical services, provides transportation and helps clients to obtain short and long term life goals. Arcata House indicated that if they had more funding, it may be possible to expand the Apartments First! program to include the complex chronically ill population.

Conclusion

A broad and comprehensive system of care that coordinates housing, behavioral, mental, social, and medical resources has been an extremely effective method in other communities and could benefit the region. With adaptation, there are proven models available to help the complex chronically ill population who frequently use the ER for their care.

About the Author

Melissa R. Jones, Esq. is the Health Policy Analyst at the California Center for Rural Policy, Humboldt State University. She completed her bachelor’s degree in Sociology from Sonoma State University, and her Juris Doctorate from Lewis and Clark Law School in Portland, Oregon. While at Lewis and Clark, she focused on health care and policy issues from a legal standpoint. In addition to her JD, she obtained a certificate in Public Interest Law. She is a member of the California State Bar.

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Endnotes

1. Also, the (CSH) is advocating for a change in the newest Medi-Cal waiver to address the needs of frequent users. Corporation for Supportive Housing. Frequent Users of Emergency Departments: Addressing the Needs of Vulnerable Population in a Medicaid Waiver. http://www.csh.org/_data/global/images/MediCalWhitePaper--Final.pdf. Published July 2009. Accessed January 24, 2010.
2. Frequent Users of Health Services Initiative. Project New Directions: on Track for Positive Changes in Santa Clara County. <http://documents.csh.org/documents/fui/NewsletterWinter05.pdf>. Published Winter 2005. Accessed January 24, 2010.
3. Ending Community Homelessness Coalition. Solutions for Homeless Chronic Alcoholics in Austin. <http://www.caction.org/homeless/documents/SolutionsHomelessChronicAlcoholicsAustin.pdf>. Published September 2009. Accessed January 28, 2010.
4. Corporation for Supportive Housing. Supportive Housing Works to End Homelessness. <http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=344&nodeID=81>. Accessed January 24, 2010.
5. Austin TX planned on doing a community assessment using 3 tools: a vulnerability assessment tool was based on a Seattle, WA model, a vulnerability index, and a self-sufficiency index from the Arizona Dept. of Housing.
6. Other major cities using Housing First: Seattle, Chicago, Ottawa, and San Jose.
7. San Francisco Ten Year Planning Council. The San Francisco Plan to Abolish Chronic Homelessness. <http://www.ich.gov/slocal/plans/sanfrancisco.pdf>. 2004. Accessed January 28, 2010.
8. Washington Association of Community and Migrant Health Centers. Medicaid Emergency Room Diversion Grant Summaries. <http://wacmhc.org/documents/ER%20Diversion%20Project%20Descriptions%20by%20State.pdf>. 2008. Accessed January 24, 2010.



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