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## Responding to Chronic Homelessness Project Profile

Focus on: **Prevention: Discharge Planning**  
Focus on: **Integration of Health Related Services**

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New Directions  
(Hospital Council of Northern and Central California)  
Santa Clara County

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### **Activity Description**

*Why:* In 2003, approximately 400 frequent user patients<sup>1</sup>, many of whom were “chronically homeless,” made almost 4,900 visits to the five emergency departments, which together treat 85 percent of the frequent user patients in the county. Many of these patients have complex psychosocial issues in conjunction with medical conditions and, in addition, they are often economically disadvantaged. During a pilot study of frequent user patients that began in 2002, the planning committee of New Directions found that many study participants had a history of mental illness or alcohol and other substance abuse, while 30 percent had co-occurring mental illness and substance abuse disorders. Sixty-two percent lacked stable housing, 51 percent had incomes of less than \$500 per month, and 23 percent were on probation or parole.

*What:* New Directions is a product of the pilot study, which initiated community case management for frequent user patients. Strategies were tested and refined during the pilot, with the result being an intervention composed of three core parts: intensive case management, interdisciplinary and inter-agency case conference and linkage to primary care and continuity of physician.

*Partners:* County, City, Hospitals and Nonprofit Agencies:

- Santa Clara Valley Medical Center
- San Jose Medical Center
- Saint Louise Regional Hospital
- Regional Medical Center of San Jose
- O’Connor Hospital
- Santa Clara County Department of Alcohol and Drug Services
- Santa Clara County Department of Public Health
- Santa Clara County Social Services Agency
- Santa Clara County Department of Mental Health
- Santa Clara County Office of Affordable Housing
- Community Health Partnership
- Catholic Charities
- Corporation for Supportive Housing

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<sup>1</sup> A frequent user patient has made eight or more emergency department visits in the prior 12 months to one or more of the hospitals participating in the project.

- EHC LifeBuilders
- Gardner Family Health Network
- InnVision
- San Jose Police Department
- Santa Clara Family Health Plan
- Valley Homeless Health Care Program
- Valley Transportation Authority

*Significant Program Design Features:*

**Component 1: Intensive Case Management**

- Assertive case management model (build trust, flexible client-specific supports, 'whatever it takes')
- Focuses on helping clients achieve stability in key areas (for example, medical, behavioral, housing, food)
- Establishes the case manager as a continuous point of contact and support
- Emphasizes gradual transition to increased independent self-care and employment.
- Low case loads
- Provides:
  - Assistance with furnishing and moving into apartments
  - Assistance and advocacy in maintaining good tenant-landlord relationships
  - Assistance with budgeting and other life skills
  - Access to financial assistance and health insurance
  - Assistance and advocacy obtaining mainstream benefits, including SSI, GA, Food Stamps, Medicare and MediCal.
  - Assistance in accessing employment and training services
  - Assistance with accessing and using transportation
  - Group programs in decreasing stress & anxiety, increasing coping mechanisms, managing money, and other topics as needed

**Component 2: Interdisciplinary and Inter-agency Case Conferencing**

- Multidisciplinary team that includes members from the Mental Health Department, Alcohol and Drug Services, and Primary Medical Care
- Enables coordination of care across providers and facilitates timely access to needed services at the right location
- Team members assist in reviewing cases and finding solutions and options for clients with difficult issues.
- Team makes recommendations for changes in systems that create barriers to services for this population.
- New Directions also works with a community collaborative formed specifically for the New Directions program, including members from Public Health, Mental Health, Alcohol and Drug Services, hospitals in the community, several housing organizations, transportation systems, community health clinics, primary health care providers, and community based support organizations. All of these members provide services needed by this population, and all members have actively participated in working with New Directions on issues and barriers to services for this population.

### **Component 3: Linkage to primary care and continuity of physician.**

- Access to primary and specialty medical care with a specific primary care physician assigned
- Advocacy to move through barriers to service and health care access
- Assistance in accessing medical care including escorting participants to medical appointments and providing follow-up after appointments
- Assistance in filling prescriptions and being compliant with taking prescribed medication
- Assistance in accessing mental health and substance abuse programs

*A note on housing:* New Directions soon recognized that lack of permanent housing is the biggest barrier to success for this population. Even when the client is motivated, it is extremely difficult without stable housing to make improvements in chronic health conditions, mental illness, or substance abuse. Therefore the project formed a partnership with a local homeless housing provider to develop permanent supportive housing, using a Housing First model, to provide permanent units for New Directions' clients.

### **Funding Sources**

- Frequent Users Initiative Program, a joint initiative of The California Endowment and the California HealthCare Foundation
- Applicant for HUD Continuum of Care-SHP Funds (with housing provider to provide permanent, supportive housing)
- In-kind and/or cash resources from each partner

### **Outcomes**

Initial results from the pilot study show:

- 31 percent reduction in emergency department visits
- 53 percent decrease in inpatient hospital days for clients
- After just one year of enrollment, the cost of ED, inpatient, and outpatient clinic services provided to clients declined by almost half.
- This reduction was even greater for clients who completed two years of enrollment.
- Hospital inpatient days declined after nine months of case management for one group of clients for whom data are available.

### **Places Where Similar Work is Underway**

- Santa Cruz County—Santa Cruz County Health Services Agency (Project Connect)
- Alameda County—Alameda Health Consortium (Project RESPECT)
- Los Angeles County (San Fernando Valley)—Tarzana Treatment Centers (Project Improving Access to Care)
- Sacramento County—University of California Davis Health System (Sacramento Effective Medical Care Task Force)
- Tulare County—Kaweah Delta Hospital Foundation (Tulare County Frequent Users Project)