



California Health Care  
Safety Net Institute

*Advancing community health  
through California's open door providers*

## **Beyond the Revolving Door**

California's Open Door Providers Address the Needs of  
Frequent Users of Medical Services



## Introduction and Purpose

The California Health Care Safety Net Institute (SNI) is a 501(c)(3) research and education affiliate of the California Association of Public Hospitals and Health Systems (CAPH) dedicated to enhancing the capacity of open door providers and their strategic partners to advance community health. Open door providers are health care facilities or systems dedicated by mission or mandate to ensuring access to a full spectrum of health care services, beyond emergency and stabilization services required by law, to all individuals in their community regardless of insurance status or ability to pay. The work of SNI builds on the belief that, as open door providers, California's public hospitals and health systems are uniquely well-qualified and dedicated to addressing the health needs of vulnerable populations and at-risk communities.

In serving their communities' most vulnerable residents, open door providers have begun to implement strategies to address the needs of frequent users of medical services. Assistance such as case management and linkage to housing services, primary medical care, mental health and substance abuse treatment services can improve the health of medically and socially complex patients and reduce overutilization, costs and emergency department overcrowding.

San Francisco General Hospital pioneered one of the first efforts to more effectively address the needs of frequent users back in 1995. Since then, several more open door providers have developed programs to address frequent users, and foundations have taken an interest in this important issue. Most recently, The California Endowment and the California HealthCare Foundation jointly launched a five-year project, the Frequent Users of Health Services Initiative, which aims to improve the quality, outcome and delivery of care to chronically ill patients who frequently utilize health services, and to identify and work towards addressing systematic changes needed to break the cycle of costly, ineffective use of health care services in California. SNI and CAPH leadership participate on the advisory committee for this initiative.

In the summer of 2002, with increasing attention on the need for effective strategies to address this patient population, SNI undertook a survey of frequent-user programs

**The vision is to create a truly seamless system of care that encompasses all of the patient's health and social needs.**

at public hospitals and health systems in California. The purpose of this study was to identify frequent-user programs, discern the salient characteristics of the programs and their target populations, highlight outcomes achieved, and determine what resources and/or additional knowledge is needed in order to move such efforts to the next stage of development. A vision for how these frequent-user programs could become optimally effective includes building the capacity to track patients, collect utilization data, share patient-specific information across various health and social services agencies, and create a truly seamless system of care that encompasses all of the patient's health and social needs. Eight frequent-user programs in five public hospitals and health systems were identified. Follow-up interviews were conducted with key staff overseeing these programs.

The results of the survey revealed many innovative programs, each emphasizing case management and ongoing access to needed health and social services.

These programs attempt to address the complex array of issues faced by these patients such as acute medical conditions, chronic disease, multiple diagnoses, mental illness, homelessness and drug and/or alcohol addiction. Although these programs have been successful in helping meet the needs of frequent users, the survey revealed there is still tremendous unmet need.

There are several factors that affect the number of patients who participate in frequent-user programs. Limited resources often require open door providers to target programs to patients with the highest frequency of overutilization. Therefore there are many more patients who may be considered frequent users but whom, because of limited resources, are unable to be served by current programs. In addition, many programs have been in operation three years or less and target the highest users of services in an attempt to both control program size and gauge program impact. Despite variances in the threshold used to determine participation, frequent-user programs have all identified a significant number of patients in need of services. Moreover, the survey results indicate that programs

**Open door providers recognize the need to broaden the traditional medical model of care to include a range of social and psychological services.**

are in need of additional resources such as more staff, staff training and program evaluation, as well as additional housing and mental health services.

This report provides an overview of frequent-user programs underway at public hospitals and health systems, in addition to individual profiles of the various programs identified in our survey. These programs are important because they help improve health outcomes for patients and reduce critical community-wide problems with hospital and emergency room overcrowding. We hope you will find this report useful and welcome your comments.

## Overview

To address the unique needs of patients who overutilize hospital inpatient, ambulatory and emergency services, California's open door providers operate programs emphasizing medical case management and linkages to needed social services. These patients are commonly known as "frequent users" and suffer from a variety of acute medical conditions or may have multiple diagnoses. Care for frequent users is complicated by issues of addiction, homelessness and mental illness that can serve as barriers to good health outcomes in the absence of appropriate supportive services. Open door providers have recognized the need to broaden the traditional medical model of care to include a range of social and psychological services.

Frequent-user programs have proven successful in helping improve patient health outcomes. Moreover, they help improve community access to health services by reducing emergency room and hospital inpatient overutilization. Frequent-user programs can be successful in decreasing medical service utilization, medical costs, homelessness and substance abuse, as well as increasing the number of patients with health insurance and regular access to primary care. The programs are often funded from a variety of sources, including the hospital's operations budget, local government and grants. Our research indicates that despite the large numbers of frequent users seeking services at public hospitals and health systems, only limited resources are available to address current needs. Indeed, additional support for program evaluation, housing resources, increased staffing, staff training and mobile outreach is sorely needed.

## Program Design & Structure

Frequent-user programs typically use case management and referral services to address overutilization. Open door providers collaborate where appropriate with the larger health care and social services system, local law enforcement officials and various non-profit community-based organizations for referral to a range of needed medical, mental health and social services. However, the breadth of services

available differs among programs, depending upon staffing and the characteristics of frequent users. Most of the programs described in this document have been in operation less than three years. The following describes the major components typical of most of these frequent-user programs.

*Target Populations* - Frequent-user programs target patients who present in the emergency, acute care and inpatient departments of public hospitals and health systems for acute medical conditions. They are usually medically complex patients who suffer from a variety of serious medical conditions such as congestive heart failure, HIV/AIDS, chronic obstruction pulmonary disease, Hepatitis C, asthma, diabetes, head trauma, skin abscesses and chronic pain from conditions such as migraines and backaches. Multiple diagnoses are common among this population. Many of the programs target patients with acute medical conditions whose primary or secondary diagnoses are related to substance abuse or mental illness and whose care may be further complicated by homelessness. Many programs have identified the characteristics of their most common frequent users of health care services. The characteristics of these patients may differ from community to community. The following illustrates some typical patient profiles identified in programs we researched:

- Homeless, mentally ill and/or substance abusing patients with serious medical conditions or with acute conditions related to their substance abuse;
- Men between the age of 40 and 50 with chronic pain-related illnesses;
- Chronic disease patients with acute or emergency conditions related to their disease.

*Services Provided* – Open door providers use case management and referral services to help reduce patient overutilization. Case management services are generally based at the hospital and are provided during regular business hours. Providing case management services 24-hours a day, especially in the emergency room environment, is an important identified need in many of the programs. Services provided by frequent-user programs include:

- Intake assessment to evaluate comprehensive patient needs and referral to housing, mental health, substance abuse, employment, public health and other needed services;
- Linking patients with a primary care provider and serving as a liaison between the patient and providers;

- Community-based case management, home visits, transportation assistance and mobile outreach;
- Assistance making appointments, securing prescribed medication and applying for benefits, programs and services for which the patient is eligible.

*Participation Requirements* – Identification of a potential participant in a frequent-user program is usually based on that patient’s prior year’s utilization rate, or an assessment of his or her potential to become a high utilizer. The utilization threshold may vary among programs. For example Santa Clara Valley Medical Center identifies those patients with nine or more visits to its emergency department in the last year, while one San Francisco General Hospital program targets patients admitted three or more times to select inpatient units. Identified patients are targeted for recruitment into the program on their next visit to the hospital. This allows for program caseload to grow at a reasonable pace for available staff, a resource in short supply for many of these programs. More importantly, it offers an important “teachable moment” to engage patients in discussion regarding the program, explain the program benefits and elicit the patient’s commitment to participate. Electronic patient record systems, which track patient utilization, can allow staff to easily identify frequent users when they present for care.

Apart from the benefits of case management and referral services, which include regular and coordinated access to medical and social services, most frequent-user programs offer no additional incentives for patients to participate. There are two exceptions: Santa Clara Valley Medical Center offers participants a one-time \$25 financial incentive to join the program and complete the patient intake process; and in one UC San Diego Medical Center program that targets alcohol-dependent patients, law enforcement agencies offer clients the option to participate in the program in lieu of jail time.

*Program Demand* - Current programs target patients with high levels of utilization. In 2001, Santa Clara Valley Medical Center identified 212 patients with nine or more visits who accounted for approximately 2,000 emergency room visits to the hospital. A lower utilization threshold for determining program participation would likely reveal a much larger patient population in need of program services. Moreover, many frequent-user programs limit operation to the regular business hours (8:00 am to 5:00 pm). With many of the programs targeted to address overutilization in the emergency and inpatient departments, which operate 24-hours a day, a tremendous need exists for additional resources to expand the programs to mirror the hospital’s round-the-clock operations.

*Program Funding and Staffing* - Frequent-user programs are funded from a variety of sources, including the hospital’s operating budget, grants, local law enforcement,

## **Programs Work: Outcome Measures and Evaluation** ***San Francisco General Hospital***

A study of San Francisco General Hospital's Emergency Department Case Management Program indicated the following improvements as a result of the program:

- a reduction in the median number of emergency department visits from 15 to 9
- a decrease in the median inpatient costs from \$8,330 to \$2,786
- a decrease in homelessness (57%), alcoholism (22%) and drug use (26%)
- a 74% increase in the number of patients with links to primary care services
- a 54% increase in the number of medically indigent patients enrolled in Medi-Cal
- a \$1.44 savings in hospital costs for every dollar spent on the program

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local government, tobacco settlement funds, and hospital provider groups. A combination of registered nurses, licensed clinical social workers, physicians, police officers, psychiatric technicians, social workers, administrative staff and program managers typically staff frequent-user programs.

*Outcome Measures and Evaluation* - Most of the programs surveyed have not conducted impact assessments or evaluations of their frequent-user programs. Program managers expressed a desire to perform evaluation, but lack the resources and staff to do so. To date, a few programs have done an impact assessment using a pre- and post-intervention analysis that measured various utilization statistics for the twelve months prior to the implementation of the program and then for twelve months after. Benefits found from these studies include decreases in utilization of emergency and inpatient services, homelessness and addiction, as well as an increase in the number of patients with health insurance and regular access to primary care.

## Future Challenges and Unmet Need

There is little doubt that a great demand exists for frequent-user services at California's open door providers. Unfortunately, limited resources as well as the infancy of the programs usually require public hospitals to target their programs narrowly, serving only those patients with the highest historical utilization. Moreover, frequent-user programs lack access to a variety of resources that would enhance the quality and effectiveness of their programs. Such resources include increased access to mental health services, resources for program evaluation and impact assessment, additional staffing to support program demand, resources for ongoing staff training, and mobile outreach services to provide ongoing medical monitoring and case management to patients in their communities. Finally, one of the most significant challenges faced by frequent-user programs is the need for stable supportive housing services for patients, who, because of unstable living situations, may be unable to recover from recent illness or carry out medical instructions adequately or fully.

**UC San Diego  
Medical Center's  
Serial Inebriate  
Program resulted  
in a 60 percent  
decrease in  
emergency room  
visits.**

## Conclusion

This report provides a glimpse of efforts underway at California's open door providers to address the complex medical and social needs of frequent users of medical services. The following pages provide greater detail on the eight programs we surveyed. These innovative and effective programs have only begun to address the tremendous need among frequent users. Frequent-user programs could be greatly enhanced with additional resources for staff, training, mental health and housing services, and other needs. The overutilization of medical services by frequent users impacts access to health care for all members of a community. While open door providers have paved the way to address this issue, there is still much more that needs to be done.

California's open door providers have developed effective, community-based strategies for better managing the health care needs of patients who are frequent users of medical services.

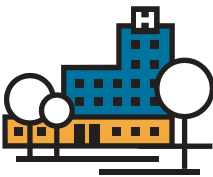


# Patients

What are some typical characteristics of frequent users of medical services?

- Complex and acute medical conditions
- Multiple diagnoses
- Overutilization of health services
- Lack of health insurance
- Lack of access to social and psychological services

# Programs



How does a typical frequent-user program at an open door provider work?

- 1) Hospital identifies frequent users of emergency department, acute care and inpatient services.
- 2) Staff engage patients and encourage participation in and commitment to frequent-user program.
- 3) Case manager is assigned to patient and:
  - a) Performs intake assessment to evaluate comprehensive patient needs
  - b) Coordinates patient care
  - c) Links patients to needed services and programs
  - d) Serves as an ongoing patient resource



These strategies often rely on community collaborations to coordinate the needs of patients with complex medical and psychosocial needs.



# Funders

Who provides financial and operational support for frequent-users programs?

- Local government
- Public hospitals & health systems
- Foundations
- Community-based organizations



# Partners

What kinds of community providers typically collaborate with frequent-user programs?

- Primary and preventive care
- Drug and alcohol treatment
- Housing assistance
- Mental health services
- Social services



# San Joaquin General Hospital

<i>Program Name:</i>	Case management services
<i>Lead Agency:</i>	San Joaquin General Hospital
<i>Collaborating Partners:</i>	Su Salud Community Disease Prevention and Education Center
<i>Target Population:</i>	Recurrent users in the Emergency and Acute Medicine Departments
<i>Most Common Diagnosis:</i>	Chronic diseases, such as asthma, hypertension and diabetes, as well as chemical dependency
<i>Scope of Services:</i>	Assistance linking patients to routine primary care services, health education, home visits and referral to benefits counseling and other community-based organizations providing health care, mental health, public health, and social services
<i>Staff Composition:</i>	Two registered nurses and one office assistant
<i>Funding Source(s):</i>	San Joaquin General Hospital
<i>Unique Characteristic(s):</i>	Partnership with Su Salud Community Disease Prevention and Education Center to assist in the provision of health and disease management education, screening, counseling and referral services
<i>Contact:</i>	Jeffrey Thompson Deputy Director Ambulatory Services (209) 468-6756 jthompson@sjgh.hs.co.san-joaquin.ca.us

# San Francisco General Hospital

<i>Program Name:</i>	Medical High User Case Management Program
<i>Lead Agency:</i>	San Francisco General Hospital and San Francisco Department of Public Health
<i>Collaborating Partners:</i>	University of California at San Francisco and other community-based organizations providing health care, mental health and social services
<i>Target Population:</i>	Individuals must have been admitted to SFGH at least three times within the last year. Patients must have a primary care provider in one of three clinics: General Medical Clinic, Family Practice, and South East Health Center
<i>Most Common Diagnosis:</i>	Diabetes, chronic obstruction pulmonary disease, congestive heart failure, asthma, HIV/AIDS
<i>Scope of Services:</i>	Medical and psychiatric assessment; ongoing clinic-based consultation with a primary care provider, home visits, mobile outreach, transportation and prescription drug assistance; linkage to psychiatric, homeless and drug and alcohol services
<i>Staff Composition:</i>	Medical director, clinical supervisor, three clinical social workers, registered nurse, psychiatrist, unit clerk
<i>Funding Source(s):</i>	San Francisco General Hospital
<i>Unique Characteristic(s):</i>	Case management team provides outreach to parks, shelters, and other nontraditional sites to provide ongoing case management services for hard-to-reach patients
<i>Contact:</i>	Elyse Miller, LCSW Medical High User Program (415) 206-5148 emiller@medsfgh.ucsf.edu

# San Francisco General Hospital

<i>Program Name:</i>	Emergency Department Case Management Program
<i>Lead Agency:</i>	Joint collaborative of San Francisco General Hospital, the San Francisco Department of Public Health and the University of California at San Francisco
<i>Collaborating Partners:</i>	Community-based organizations providing health care, mental health and social services
<i>Target Population:</i>	Recurrent patients in the Emergency Department with five or more visits in the last year
<i>Most Common Diagnosis:</i>	Hepatitis C, seizures, head trauma, asthma and chronic obstruction pulmonary disease
<i>Scope of Services:</i>	Needs assessment and identification of resources currently available to the patient through other sources; comprehensive case management and referral, including crisis intervention, health and social service application assistance, home visits, primary care, housing services, substance abuse program referral; accompanying patients to their appointments, serving as a liaison between the patient, their primary care provider and their specialist
<i>Staff Composition:</i>	Seven full-time case managers, one part-time primary care physician, one part-time psychiatrist and one full-time nurse practitioner
<i>Funding Source(s):</i>	San Francisco General Hospital, the San Francisco Department of Public Health and the University of California at San Francisco
<i>Unique Characteristic(s):</i>	Program in operation for seven years and has completed an evaluation study on the impact of the program
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# Santa Clara Valley Medical Center

<i>Program Name:</i>	Community-Based Case Management Program (a.k.a. Emergency Department Case Management Program)
<i>Lead Agency:</i>	Hospital Council of Northern and Central California
<i>Collaborating Partners:</i>	Santa Clara Valley Health and Hospital System, San Jose Medical Center and other Santa Clara County hospitals
<i>Target Population:</i>	212 patients with recurrent visits (e.g., nine or more in the prior year) to the emergency department at Santa Clara Valley Medical Center
<i>Most Common Diagnosis:</i>	Pain-related symptoms, such as back and headaches, as well as patients with multiple diagnosis including mental health and substance abuse issues
<i>Scope of Services:</i>	Needs assessment and links to supportive services available through Santa Clara Valley Health and Hospital System, including primary care, public health, mental health, drug and alcohol services
<i>Staff Composition:</i>	Three clinical social workers, one nurse and a program manager
<i>Funding Source(s):</i>	A grant from the Health Trust of Santa Clara County
<i>Unique Characteristic(s):</i>	Participating hospitals share a common database to track health care utilization of participants throughout the county; professional case managers working across organizations provide individualized assessment and support; participants receive a one-time twenty-five dollar cash incentive to participate in the program
<i>Contact:</i>	Carolyn Brown Director, Performance and Outcomes Management (408) 885-2093 carolyn.brown@hhs.co.scl.ca.us

# UC Irvine Medical Center

<i>Program Name:</i>	Emergency Department Case Management Program
<i>Lead Agency:</i>	UC Irvine Medical Center
<i>Collaborating Partners:</i>	Community-based organizations providing health care, mental health and social services
<i>Target Population:</i>	Recurrent users of emergency department services (currently there are approximately 35 visits per day by recurrent users)
<i>Most Common Diagnosis:</i>	Pain management, chronic diseases such as diabetes, hypertension, and coronary artery disease
<i>Scope of Services:</i>	Referral to community-based services, assistance applying for health and social programs, health education, linkage to a primary care provider, acquisition of medications for uninsured patients
<i>Staff Composition:</i>	Two registered nurse case managers specifically assigned to the Emergency Department 5 days per week, 16 hours per day
<i>Funding Source(s):</i>	UCI Medical Center and UCI Medical Group
<i>Unique Characteristic(s):</i>	Program funded by the hospital in conjunction with the UCI Medical Group to alleviate ED overutilization, improve access to ED services for UCI Medical Group patients, and link frequent ED users to a primary care physician
<i>Contact:</i>	Mary Owen, RN, MPA Director, Outcomes Case Management (714) 456-8964 mowen@uci.edu

# UC Irvine Medical Center

<i>Program Name:</i>	Ambulatory Care Case Management Program
<i>Lead Agency:</i>	UC Irvine Medical Center
<i>Collaborating Partners:</i>	None
<i>Target Population:</i>	Medi-Cal managed care patient population, including over 5,000 patients with Aged, Blind and Disabled benefits
<i>Most Common Diagnosis:</i>	Multiple diagnoses, disabilities, and chronic medical conditions
<i>Scope of Services:</i>	Coordinated patient care including serving as a liaison between patients, their primary care provider and specialist, assistance making and keeping appointments and referral to social and mental health services
<i>Staff Composition:</i>	Five registered nurse case managers
<i>Funding Source(s):</i>	UCI Medical Group
<i>Unique Characteristic(s):</i>	Program funded by the UCI Medical Group to ensure continuity of care, decrease ED over utilization, and increase use of primary care
<i>Contact:</i>	Mary Owen, RN, MPA Director, Outcomes Case Management (714) 456-8964 mowen@uci.edu

## UC San Diego Medical Center

<i>Program Name:</i>	Homeless Outreach Team Program (HOT)
<i>Lead Agency:</i>	San Diego Police Department
<i>Collaborating Partners:</i>	University of California at San Diego Medical Center, San Diego District Attorney's Office, local alcohol, drug, psychiatric emergency, rehabilitation, detoxification, health care and emergency medical service programs
<i>Target Population:</i>	About 700 homeless patients were assisted in 2000
<i>Most Common Diagnosis:</i>	Acute illnesses related to substance abuse
<i>Scope of Services:</i>	Referral to community-based services including residential treatment programs, rehabilitation, health care and housing services
<i>Staff Composition:</i>	Four police officers, two social workers, and two psychiatric emergency response clinicians
<i>Funding Source(s):</i>	San Diego Police Department, San Diego City Council and tobacco settlement funds
<i>Unique Characteristic(s):</i>	Homeless populations are targeted in the community for participation in the program. Evaluation results found that program participants experienced a decrease in the number of detoxification visits from 10.01 to 7.3; a decrease in ED visits; and no decrease in admission rates ( <i>Society for Academic Emergency Medicine 2001 Annual Meeting Abstracts</i> ).
<i>Contact:</i>	Ted Chan Associate Professor, Emergency Department (619) 543-6463 tcchan@ucsd.edu

## UC San Diego Medical Center

<i>Program Name:</i>	Serial Inebriate Program (SIP)
<i>Lead Agency:</i>	San Diego Police Department
<i>Collaborating Partners:</i>	University of California at San Diego Medical Center, San Diego District Attorney's Office, local alcohol, drug, psychiatric emergency, rehabilitation, detoxification, health care and emergency medical service programs
<i>Target Population:</i>	Chronic alcoholics with multiple citations for public drunkenness (approximately 200 patients in 2001)
<i>Most Common Diagnosis:</i>	Acute alcohol-related illnesses
<i>Scope of Services:</i>	Referral to community-based services including residential treatment programs, rehabilitation, health care and housing services
<i>Staff Composition:</i>	Four police officers, two social workers, and two psychiatric emergency response clinicians
<i>Funding Source(s):</i>	San Diego Police Department, San Diego City Council and tobacco settlement funds
<i>Unique Characteristic(s):</i>	Serial inebriates with penal code infractions are offered the option to participate in the program in lieu of jail time. Evaluation results found a 60% decrease in ED visits ( <i>Annals of Emergency Medicine, October 2001, Volume 38, Number 4</i> ).
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