



Frequent Users Systems Engagement (FUSE)

Washtenaw County, MI | April 2016



INITIATIVE OVERVIEW

- ◆ Bring together community partners from a variety of sectors to connect frequent users to housing, healthcare, and care coordination is both the goal and lasting outcome of the Frequent Users Systems Engagement (FUSE) initiative in Washtenaw County, Michigan – a subgrantee of the CSH’s Social Innovation. Other health centers, housing and service providers can learn and replicate these coordination efforts. Avalon Housing, a permanent supportive Housing First provider, is the lead agency for this initiative. They work closely with the University of Michigan Health System, St. Joseph Mercy Health System, Packard Health (the local Health Center Program grantee), Community Mental Health, the Shelter Association, the Ann Arbor Housing Commission, and other service providers.
- ◆ The FUSE project targets individuals who meet threshold criteria for frequent utilization of crisis systems, including homelessness or housing instability, low income, behavioral health conditions, chronic physical health conditions, and frequent emergency room utilization and/or hospitalizations.
- ◆ By providing housing navigation, intensive case management, and care coordination for primary and behavioral health services, the FUSE project intends to demonstrate a reduction in use of emergency systems, improved health outcomes for fragile individuals, and cost savings across multiple systems.
- ◆ Challenges: Affordable housing resources are limited in Washtenaw County’s high rental market, and state budget cuts have resulted in a reduction of available vouchers. The research study was delayed by unanticipated work needed to meet Institutional Review Board (IRB) requirements, which in turn delayed the start of the program. Sustainable funding also remains a challenge.
- ◆ Opportunities: Avalon’s 20 years of PSH experience, and Washtenaw’s existing provider relationships through the Continuum of Care and other local coordinating bodies provided a solid foundation to build on. Effective community prioritization through a central access point made for clear and effective targeting.

KEY FEATURES & INNOVATIONS

- ◆ **Cross-sector Partnership:** The community brought together a diverse collaborative of hospitals, housing agencies, health centers, behavioral health providers, social service organizations and government agencies.
- ◆ **Data-Driven Strategy:** Data matching across multiple systems was used to identify high utilizers during the early part of the study. The project moved to referrals based on a utilization threshold.
- ◆ **Outreach, Engagement, and Recruitment:** An Outreach Coordinator provides assertive outreach into hospitals, jails, institutional and other homeless service settings.
- ◆ **Housing:** Multiple partners came together to increase access to housing. PSH units, owned, and operated by Avalon Housing, are prioritized for project participants. The local public housing authority (PHA) provides public housing units and Housing Choice Vouchers. Two local housing providers provide Shelter Plus Care subsidies.
- ◆ **Integrated Health and Housing Services:** A strong partnership between Avalon Housing, hospital systems, and the local health center elevates inpatient care coordination and access to primary care.
- ◆ **Rigorous 3rd Party Evaluation:** This project is being independently evaluated by NYU using a control and intervention group, a process evaluation with annual site visits and key partner interviews.
- ◆ **Building Community:** Community building is an integral aspect of the services model with an average of 75 community events each month.

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INITIATIVE DETAILS

History

- ◆ Avalon Housing has been providing permanent supportive housing for over twenty years and has a strong history of activism and advocacy in the community.
- ◆ Systems level collaboration with the Washtenaw Housing Alliance and strong mental health advocacy from Community Mental Health's street outreach team helped lay the groundwork for this initiative to succeed.
- ◆ At the start of the FUSE project, the previous lead agency had a program in place with the local ambulance service to provide case management to frequent utilizers.
- ◆ Existing supportive housing teams had brought to light the entanglement of the health care and homeless service systems, and the lack of communication and coordination across systems. Washtenaw County was well positioned to participate in the Social Innovation Fund opportunity and share experience with the other three research sites.
- ◆ The relationship with the University of Michigan Complex Care Management Program helped jump-start the formal collaboration and the data-driven targeting process with U-M and other partners.

Target Population



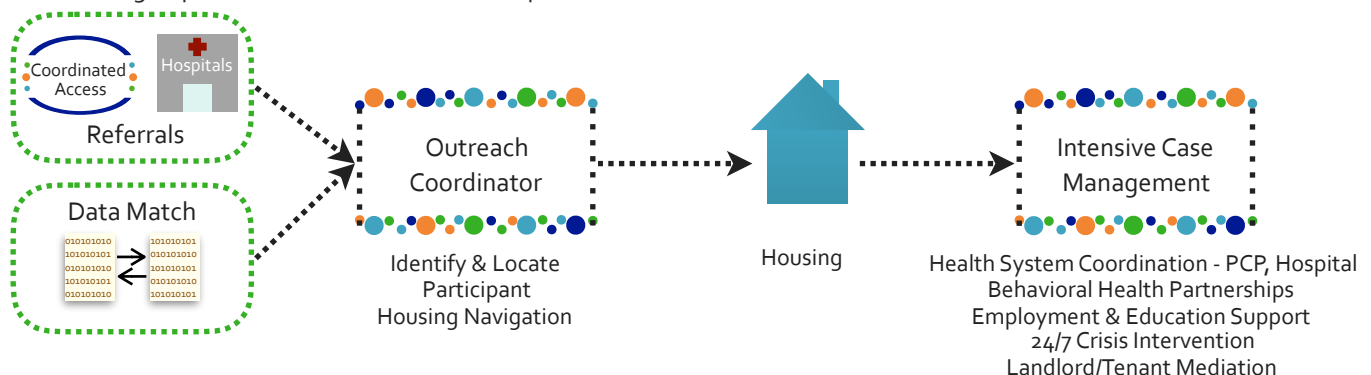
- ◆ Very low income
- ◆ Have a diagnosed mental health condition or substance use disorder
- ◆ One or more chronic physical health condition
- ◆ Homeless or in persistent housing crisis
- ◆ High utilizers of crisis health services - defined as (1) **8 or more ER visits** or (2) **1 or more hospitalizations & 3 ER visits** in last year

Approach

The Washtenaw County FUSE initiative adopted a team-based approach to care with intensive case management serving as an integral component. The team meets weekly to discuss incoming referrals, care plans for current clients, and complex cases. FUSE clients were initially identified through a data match process with the two hospital systems, homeless shelter providers, and behavioral health providers to create a recruitment list. Now in its fourth year, the project has moved to a direct referral system using the utilization threshold listed above.

Once identified, the outreach coordinator works to engage the individual, locate housing, and assists the participant through move-in, where they are assigned a case manager. Case Managers maintain low caseloads, with an average of 1:20, balanced by the acuity of client need. They complete a comprehensive assessment, and link them to needed supports such as medication management, legal advocacy, employment and education. Case Managers coordinate care to address physical and behavioral health needs, linking clients to a primary care provider and assisting with navigation of mental health and substance abuse treatment systems. The team is trained on evidence-based practices such as motivational interviewing, assertive outreach, trauma informed care, housing-first and harm reduction approaches.

Packard Health, the Health Center partner, provides comprehensive primary care and integrated services through their Patient Centered Medical Home model and is working to provide onsite services to FUSE participants. Packard also designated a nurse practitioner to participate on the FUSE care team, which helps to create a warm hand-off into primary care from hospital and housing partners. Their participation is in recognition of the value of stabilizing health and providing preventative care in addition to stable housing to prevent future ER visits and hospitalizations.



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"Prior to FUSE I self medicated. I was getting kicked out of everywhere. I tried to take myself out a couple of times and then I met my FUSE worker. She has helped me so much. I've been housed for almost three years now. I think the FUSE program is so awesome. I wouldn't change anything. Even though bad stuff has happened I'm not a hot mess anymore. I don't drink like I used to. I don't have to go to the emergency room a lot anymore. If I don't answer my door I get 15 million texts from my worker. I'm in a much better place. FUSE, they rock, they do.

Being with FUSE I don't go to the hospital anymore. I have a regular doctor I go and see. I've gained weight so I'm a little healthier. I like the fact that they care about healthiness and about what we think. The one on one face to face with us makes a difference."

- Lamethia, FUSE Participant



OUTCOMES

Goals

Participant Level:

Improve Physical Health by Increased Primary Care Utilization	Improve Mental Health by Increased Service Engagement
Exit Homelessness & Increase Housing Stability	Reduce Substance Use

Program Level:

Reduce Emergency Room Utilization	Reduce Medical and Psychiatric Inpatient Admissions and Hospital Days
Reduce Utilization of Detox Facilities, Shelters, Jails, etc.	

System Level:

Increase Visibility, Awareness, & Understanding	Reduce Public & Private Health Care Costs	Break Down Systemic Barriers to Coordinating Care	Build a Solid Base to Engage Local and State Level Policymakers to Stimulate System Changes that Work Toward Sustaining & Disseminating the Model of Care
Break Down Barriers to Rapid Access to Housing	Integrate Affordable Housing Resources with Health Care System	Decrease Mortality Rates	

Outcomes

Quantitative:

High Housing Retention Rate: 81% Including Negative Exits (Hospitalization, Incarceration, Evictions, Deceased) 101 Housed, 4 Evictions	87% Enrolled in Primary Care	Reduction in Inappropriate ER and Hospital Usage (In 2015 4th Quarter: 46% participants had no ER utilization, 56% participants had no inpatient stays)
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Qualitative:

Improved Quality of Life	Improved Systems Level Care Coordination	Increased Body of Evidence, Awareness, and Recognition Locally and at the State Level Regarding PSH Model and its Impact	Wider Acceptance of Harm Reduction Oriented Care at the Community Level	Multidisciplinary, Cross-system Care Team Established	Bridged Gaps in Previously Fragmented Service Systems
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CHALLENGES AND OPPORTUNITIES

Challenges

- ◆ **Sequestration:** The national budget sequestration in 2013 impacted the ability of the site to access Housing Choice Vouchers from the local PHA when that resource decreased. This meant vouchers were not available for a period of time in the early startup phase of the project. However, they overcame this challenge by leveraging other state and local housing resources.
- ◆ **Housing Market:** Washtenaw County has a high rent market. The fair market rent locally is sometimes higher than the voucher limit. There is a low vacancy rate in the market, making landlord recruitment a challenge.
- ◆ **Harm Reduction:** A shift in the predominant philosophy of care was needed in order to implement harm reduction oriented care at the community level. Washtenaw County has limited access to substance use services for individuals with substance use disorders who are in a pre-contemplative stage of change.
- ◆ **IRB Process:** The local health systems required IRB approval for both the evaluation and data match. IRB approval and subsequent amendments created programmatic delays and unplanned administrative burden.
- ◆ **Medicaid:** Limited Medicaid billing options create complexities. Avalon Housing is a contracted "Community Living Supports" provider with Community Mental Health (CMH), Washtenaw. Under this arrangement there is only one Medicaid code that Avalon can bill under. To bill under this code individuals have to be open to Community Mental Health and meet medical necessity for this service. While it is helpful to have this stable funding stream to support some of their clients, billable services covered under the code does not adequately capture the scope of work.
- ◆ **HUD Funding:** HUD funding prioritizes chronically homeless population. The target population was broader and created limitations on the Washtenaw County's housing options for those who do not meet these criteria.
- ◆ **Complex Needs:** The target population experiences complex medical and behavioral health needs that some staff were not equipped to handle. The community is working on expanding the skill set of staff to meet complex needs population.

Opportunities

- ◆ **Zero:2016:** Being a Zero:2016¹ community helped to improve Washtenaw County's coordinated assessment process.
- ◆ **Established PSH Program:** Avalon Housing's 20 year history of providing PSH enabled the FUSE initiative to build on a well established, successful program model and infrastructure.
- ◆ **Collaboration:** Dedicated commitments from partner agencies helped to create a true cross systems collaborative approach.
- ◆ **Care Model:** Each health system had an established care model, which allowed for natural partnerships to develop. For example, the University of Michigan Health System created a [Complex Care Management Program](#), which coordinates with primary care, community providers, and support agencies to serve patients with a high level of need.
- ◆ **PHA Partner:** Avalon Housing has a strong partnership with local Public Housing Authority. The PHA has created a preference for people experiencing homelessness for permanent housing and renovated an existing single site housing complex.
- ◆ **Leveraging Resources:** The FUSE initiative has allowed the community to leverage new funding sources and housing resources, including direct financial assistance from one of the health systems, which will serve as an opportunity moving forward.



¹ Zero:2016 is a Community Solutions Initiative involving communities around the country working to end veteran and chronic homelessness. <https://cmtysolutions.org/what-we-do/zero-2016>

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INITIATIVE PARTNERS

Avalon Housing

Key Role: Avalon Housing is the lead agency for this project. They are a supportive housing and service provider and provide case management to FUSE participants.

Hospital Partners: University of Michigan Health System - Complex Care Management Program & St. Joseph Mercy Health System Program for the Uninsured

Key Role: Two local hospital systems work with case managers to coordinate care and health system linkages for the FUSE population.

Washtenaw County Community Mental Health

Key Role: WCCMH is the mental health services provider to the FUSE population. They provide mental health services to adults with a severe and persistent mental illness, children with a severe emotional disturbance, and individuals with a developmental disability.

Washtenaw Health Initiative

Key Role: FUSE is an adopted program of the Washtenaw Health Initiative, that provides county wide collaboration focused on improved access to care and fundraises for the FUSE initiative.

Packard Health

Key Role: FUSE program participants are linked to providers at Packard Health, the local health center program grantee, which provides primary care to the majority of participants and will designate a nurse practitioner to be part of the care team.

Washtenaw Public Health and Washtenaw Housing Alliance

Key Role: Both the Washtenaw Public Health and Washtenaw Housing Alliance assisted with advocacy and community resource prioritization for the FUSE initiative.

Ann Arbor Housing Commission

Key Role: Ann Arbor Housing Commission provides Housing Choice Vouchers and public housing units to the FUSE program.

Michigan Ability Partners and Shelter Association of Washtenaw County

Key Role: Michigan Ability Partners and the shelter association provide Shelter Plus Care rental subsidies to the FUSE program.

KRISTIN'S STORY

Before Avalon, life was hard, never knowing where you will stay or what you will eat. Thinking, where I can go to meet my kids, how can I stay safe? In 2011, after losing my job as an LPN, I became homeless. I had started drinking heavily and my husband and I struggled to find places to stay. We would bounce from family member to family member. Then my husband committed suicide; that was a year ago. After that I lived in tents, the shelter, pretty much anywhere I could stay. To be homeless, feels crappy-

Then you get used to it. It consumes your entire day. It takes hours and hours thinking about where you are going to live, where you are going to stay safe, where you are going to eat. You'll think— "How do I make things better"— but you live in the moment. So much so, there is no planning ahead. You don't know what you are going to wear, where you will wash your clothes, how you are going to see your kids. These thoughts consume you. I have three children, one died of SIDS, it was very traumatizing. The University of Michigan hospital was trying to help me stay sober because I was spending time, a lot of time, in the Emergency Room. But being homeless is hard because you want to numb up and not feel everything you do feel. I mean who wouldn't want to fall asleep instead of your mind racing all night thinking. ... "What am I going to do tomorrow?"

That is when I got the call to come to Avalon. They are working with the hospitals, PORT, and CSS to help 100 people get counseling and get off the streets. It is called the FUSE Program and they give you help with your medical needs, support, and housing.

Since I have been here at Avalon, I get to see my kids regularly. I get to see my doctor regularly, I can eat when I want and all the resources I need are here. My caseworker has helped me with so much, more than she would ever acknowledge. She helped me clear up old warrants from not being able to pay tickets. Those are the types of issues that keep people homeless.

Things have gotten better and I have a second job now. Little by little, I get better. For a long time I felt like my life was nothing but turmoil and I was on a road to self-destruction and probably death. Now, it's like I have a shot, I get to make a choice in the road and I choose Avalon—it's like my big stepping stone. It's given me the opportunity to come up in life and not down. They give me the resources that I need. My life is now pretty good.



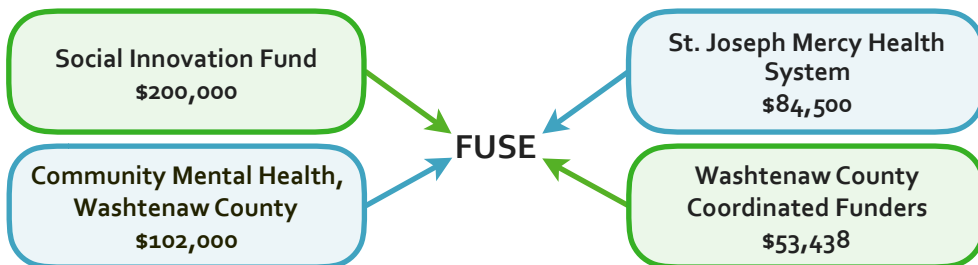
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FINANCES

Funding Sources

Funding from these sources is used to cover case management and data & oversight.
 *SIF funding must be matched by the community.



Housing Resources:

- ◆ Avalon Housing:
 - PSH Units
- ◆ Ann Arbor Housing Commission (PHA):
 - Public Housing Units
 - Housing Choice Vouchers
- ◆ Two Local Housing Providers:
 - Shelter Plus Care Subsidies

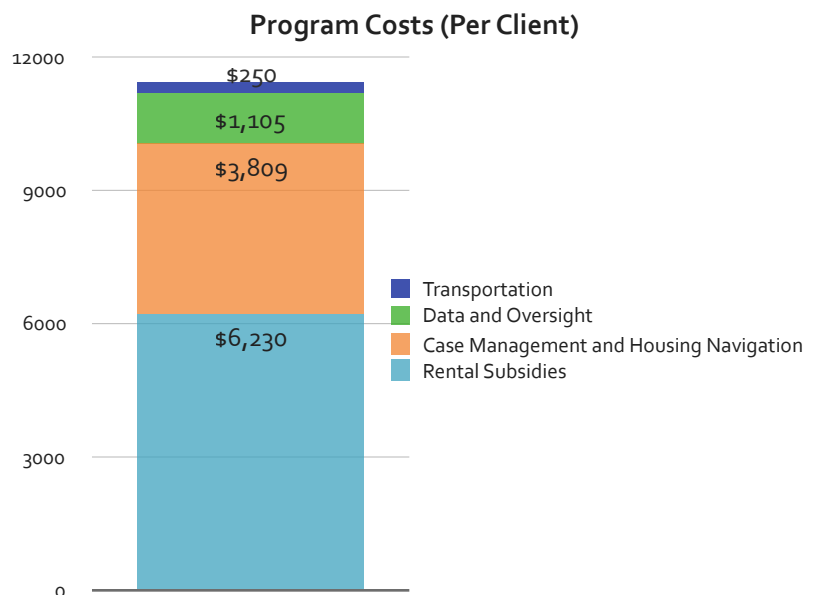
Costs Savings

Results pending.

Program Costs

Total Annual Cost with Rental Assistance:

\$11,394



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"The FUSE program takes me to all my doctors, checks in on me 3-5 times a week. No matter how much help I needed they always helped me. I've been housed for a little over a year now and I'm very happy to be on my own. I don't know what I'd do without my FUSE worker. She tries to make herself available for everything. She's very understanding. There was no support or comparable to what FUSE provides before this."

- Carol, FUSE Participant

All photos depict staff or consumers receiving services from the Washtenaw County FUSE program.

ABOUT CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 20 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

ABOUT NHCHC

The National Health Care for the Homeless Council is a network of doctors, nurses, social workers, patients, and advocates who share the mission to eliminate homelessness. Since 1986 we have been the leading organization to call for comprehensive health care and secure housing for all. We produce leading research in the field and provide the highest level of training and resources related to care for persons experiencing homelessness. We collaborate with government agencies and private institutions in order to solve complex problems associated with homelessness. Additionally, we provide support to publicly funded health centers and Health Care for the Homeless programs in all 50 states. Visit nhchc.org to learn more.

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