Toolkit for a Cross-Sector Approach to Implementing Medical Respite Care Delivery

CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

Toolkit for a Cross-Sector Approach to Implementing Medical Respite Care Delivery

AUTHORS

- **Sharon Hewner**, PhD, RN, FAAN, University at Buffalo School of Nursing
- **Amanda Anderson**, PhD(c), MSN, MPA, RN, University at Buffalo School of Nursing
- **Donna Gatti**, RN, Jericho Community Health Center
- **Deb Heigl**, RN, CCN, Jericho Road Community Health Center

ABOUT

The Buffalo City Mission Recuperative Care Collaborative Toolkit guides you through the journey our team and our partners at Buffalo City Mission, Erie County Medical Center, Jericho Road Community Health Center, and Spectrum Health and Human Services took in opening the first medical respite unit in the city of Buffalo. The Mission's vision of a social model of medical respite, called recuperative care, housed in the second largest metropolitan area in New York State, also known as "city of good neighbors," directed our path.

CONTACT

For more information, email: hewner@buffalo.edu

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Executive Summary

Addressing hospital recidivism for homeless patients.

In a city like Buffalo, where 30% of the population lives below the poverty level and eviction rates are double that of comparable cities, housing insecurity and homelessness is a devastating reality for over 7,000 residents each year. Many of the population of people experiencing homelessness in Buffalo also suffer from complex, chronic illness, and disability. Because of the lack of resources in our community to handle the subset of the unhoused population with complex medical needs, these vulnerable citizens often become trapped on a well-worn path between our shelters and hospitals. The Buffalo City Mission (BCM), our city's largest homeless shelter, accepts patients with medical needs, but unfortunately, its capacity is limited, and its current model does not include clinicians. The shelter case managers do their best to engage with area hospital staff to accept as many patients as possible, but a real barrier to accepting these medically complex homeless patients is a lack of structure in the transfer of care across organizations, compounded by the low healthcare literacy of non-clinical BCM staff.

The Erie County Medical Center (ECMC), our city's largest public hospital, sends the most patients to the BCM each year. Administration and staff struggle with the pressures of throughput, administrative limitations, and a lack of community-based options for these particularly hard to place patients. Discharge planners have built personal relationships with the BCM case management team, but under pressure to make room for more acute patients and cut long lengths of stay, they are often forced to send those accepted by BCM as soon as they can.

A possible solution to this crisis is medical respite care. Unfortunately, the closest medical respite facility is over 200 miles from Buffalo. In the summer of 2020, BCM opened a physical space with 13 beds set aside for a medical respite. Both BCM and ECMC teams reviewed the current hospital intake processes and outcomes and recognized the need to ensure that patients sent to the new unit are safe and supported through a collaborative model of care, recuperative care.

The first goal of *Buffalo City Mission Recuperative Care Collaborative* was to reduce health care recidivism of medically complex chronically homeless patients through the launch of a medical respite unit in partnership with area health systems. This was achieved when the program launched in February 2021. Our long-term outcome related to this goal was to achieve a 25% reduction in health care recidivism for respite patients, and for 25% of patients to transition to permanent supportive housing. To achieve this outcome, our short-term goals included the establishment of a safe, evidence-based medical respite unit, and a collaboration between stakeholders at the BCM, ECMC, and consulting care providers. In the first 18-months of operation, the **medical respite program successfully achieved a readmission rate of 15% for the nearly 100 patients admitted to our program.** This rate is significantly lower than the regional readmission rate tracked by CMS Hospital Compare. Additionally, we realized a 15% increase in patients with primary care providers between admission and discharge, which is a key metric of continuity.

The second goal of this project was to establish continuity of care for people experiencing homelessness with medical complexity through the creation of a network of regional cross-sector care providers and a regional directory of respite patients who are most complex utilizers. To achieve this outcome, our short-term goals include the establishment of a collaborative provider group to manage respite patients, an outcomes database and dashboard, and criteria with which to identify complex patients and their care team members. We are currently focusing on the creation and enrichment of the collaborative provider group through the development of educational opportunities and resources, and through establishment of working teams that foster increased engagement and accountability.

Planning

Medical respite care is an established model of service delivery for people experiencing homelessness and medical complexity. This model of care provides a place, program, and pathway is nationally tracked and supported by National Healthcare for the Homeless Council (NHCHC) and their subsidiary the National Institute for Medical Respite Care (NIMRC). Our previous work in primary care showed that creating a stronger link between the acute hospital and primary care at the time of discharge could reduce recidivism and readmission (Hewner, et al., 2017). However, historical regional relationships between health and social organizations were strained and relied on personal relationships between hospital discharge planners and social service case managers. The net result was healthcare disparity, patient and caregiver burden, and system inefficiencies.

When BCM included a 13-bed space for medical respite in their 2020 facility expansion project, it created an opportunity to address the lack of cross-sector collaboration for medically complex persons experiencing homelessness. BCM included space for a behavioral health clinical that was staffed by Spectrum Health and Human Services (SHHS), and for a primary care clinical staffed by Jericho Road Community Health Center (JRCHC). These behavioral health and health care providers would manage the complex health needs of the population while BCM staff addressed social needs. Thus, BCM had identified and secured the clinical skill sets needed to manage the complex care needs of the population. The question remained, how can we overcome the historical barriers of mistrust and develop a truly collaborative team in these three organizations with very different missions and goals.

Key Skill Sets

Our plan was to build a core team that included representatives from the regional safety-net hospital, Erie County Medical Center (ECMC: D. Gatti & D. Heigl), the Buffalo City Mission (J. Swift) and experts from the University at Buffalo School of Nursing (SON: A. Anderson & S. Hewner) to develop policies and protocols that would support development of a cross-sector team, and ultimately, to guide the launch of the recuperative care unit (RCU). We relied on resources from the NHCHC to guide development of policies for the RCU. As we created the program and defined our role in it, we realized some unique attributes that set this RCU program apart from the national trend documented in real-time dashboards by the NIMRC. BCM:

- Operated using a social model of care and couldn't hire clinicians,
- Lacked skill in maneuvering expectations of healthcare organizations, and
- Lacked project management skills to facilitate cross-sector collaboration.

The key skill sets that we brought to the project were expertise in discharge planning and care coordination of medically complex persons with social need. We had expertise in healthcare administration, project management, and quality improvement.

"We knew that collaboration between the hospital and Mission was essential to develop dynamic processes which address a patient's complex needs and assist the care providers. The population who we serve together requires assistance to address the physical, psychological, and social stressors which confront them daily."

- Donna Gatti, Clinical Scholar

Project Team

Amanda Anderson: Registered Nurse and SON PhD Student

Deb Heigl: Registered Nurse and ECMC Care Coordinator

Sharon Hewner: Project Lead and Registered Nurse / SON Professor

Donna Gatti: Registered Nurse and ECMC Administrator

Jim Swift: Social Worker and BCM Administrator

Felicia Montella: RCU Manager and Counselor

Tameka Ealy: RCU Case Manager

Malene White: Behavioral Health Counselor

Karyanne Cox Carrizales: Physician Assistant

Salvatore Durante: BCM Executive Administrator

Resources

Our first meetings as clinical scholars focused on creating stronger relationships between our three organizations (ECMC, SON, BCM) as each of the scholars shared what they could contribute to the efforts. We reviewed the literature and identified regional health and social data to define the project baseline. Resources included: County Health Rankings; Continuum of Care data; National Healthcare for the Homeless Council & National Institute for Medical Respite Care resources; Ethnographic and experiential observations; Dr. Hewner's prior research on care transitions in the region; Amanda Anderson's prior project management and nursing administration in care transitions in New York City; Donna Gatti & Deb Heigl active regional work in social and behavioral sector.

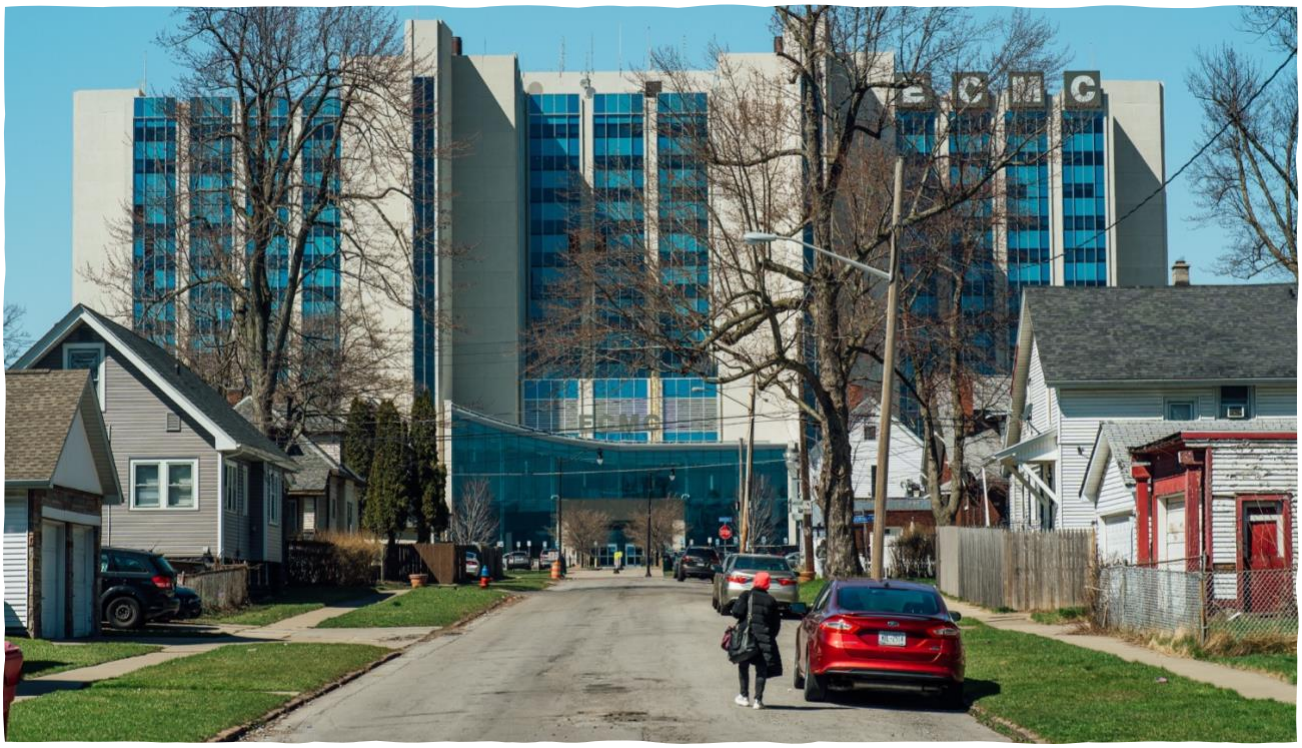
Early work also focused on assisting the BCM with setting up revenue sources for the newly created RCU. To do this, we drew heavily on consultations from NIMRC, speaking directly with medical respite leaders from across the country specifically on fashioning data to drive funding sources with hospitals, payers, and other community stakeholders. Initial success came through the resource of funding by ECMC, which was contracted on a per diem basis for each night of care received, and over the course of the project, grew to include all area hospitals and individual managed care organizations with specific contracts.

Some of the resources that we used to define our problem, led us to understand that to succeed in this collaborative model of care delivery model, we needed to expand to team members from sectors critical to the care transition process – hospital discharge planners and shelter providers needed to join with our academic and research expertise.

Community Partnerships

Although many of the organizations involved in the project completed cross-agency tasks across the continuum of care for people experiencing homelessness – sending referrals, answering clarifying questions, returning people to the Emergency Department – very few did so around structured protocols or formal relationships. Optimizing key relational linkages from existing connections and creating feasible policy and protocol around them to safeguard transitions, was a focus of early stages of implementation.

- **Buffalo City Mission (BCM):** The city's largest shelter, offering services to both men and women at separate sites, has a $10M Annual Budget, and sees over 1000 clients per year, with 60k nights of shelter provided in emergency and transitional housing programs. While the majority of BCM's funding came from charitable sources, the new 13-bed medical respite program offered a novel revenue source and opportunity for formal partnerships with community health systems and providers.
- **University of Buffalo School of Nursing (UB SON):** The city's largest school of nursing, UB SON's graduate program ranked 52nd nationally and offers R1 Research Division training with high departmental NIH funding. The Center for Nursing Research includes focus on informatics and care transitions research.
- **Erie County Medical Center (ECMC):** The region's primary public acute care hospital, located in the zip code with highest rates of poverty, unemployment, cancer, and housing disparities. Historical relationship with Buffalo City Mission with contracted bed for patients transitioning out of acute care after psychiatric emergency.
- **Jericho Road Community Health Center (JRCHC):** Federally Qualified Healthcare Center (FQHC), primarily serving Medicaid patients including refugee and immigrant clients. Opened co-located clinic site within Buffalo City Mission Spring 2021 as primary care provider for RCU.
- **Spectrum Health and Human Services (SHHS):** Co-located behavioral health agency within BCM with dedicated licensed mental health provider.
- **Visiting Nurses Association (VNA):** Preferred home health provider with dedicated team to serve BCM clients, and manager to serve as liaison with the project and track RCU admissions and care.



"In my work, I've realized that building community within community is the best way to get things done around this town."

- Patrick Cray, Buffalo artist and community advocate

Project work

The conceptual model for this project is included in *Appendix A* and depicts how the project transitioned from the dominant healthcare model of care to an emergent model that facilitates cross-sector collaboration. Using this framework, we have:

- Evaluated the baseline level of knowledge regarding care transitions and medical respite care,
- Defined eligibility and exclusion criteria for medical respite patients,
- Educated hospital stakeholders about the need for medical respite care,
- Created and launched a referral website for medical respite patients,
- Formed operational structure to organize collaborative network members,
- Worked through problems in care and operations as they arise,
- Assisted with securing funding mechanisms for Mission administration, and
- Helped create internal and program-specific tracking mechanisms.

Each year of the project represents a different phase of the project. Year 1 focused on developing relationships with new partners, developing tools based on national standards, open the recuperative care unit, establishing weekly case conferences and monthly advisory board meetings. Year 2 activities included implementing revised processes, supporting outreach to referral sources with training, modeling care coordinator role in primary care, and having initial meetings with regional mental health and homelessness service providers. Our final year, year 3 targets developing sustainability and spread of the program, aligning with a cross-sector transitional care management project, and outreach to regional providers. The timeline for the project is included in *Appendix B*.

Year 1: Building Cross-Sector Relationships

The RWJF Clinical Scholar Fellows along with the Buffalo City Mission brought together a cross sector team to develop policies set standards for admission, daily review of referrals and have fostered relationships with the service providers. Very early in the process, the Clinical Scholars team met with staff from our key clinical partners; the Mission, the primary care provider, and the behavioral health provider; to co-develop admission requirements and policies to provide safe care. This group formed the core of the clinical team that met weekly to discuss the cases in the unit and any issues that arose. The clinical team expanded to include discharge planning staff from the acute hospital and a manger from the visiting nurse association (VNA). In addition, the Clinical Scholars developed an Advisory Board with representatives from Buffalo City Mission, School of Nursing, primary care, behavioral health, and visiting nurses which meets quarterly to monitor outcomes of the program both clinically and financially.

Year 2: Implementation

In year 2, the focus turned to maturation of the cross-sector teams, both clinical and advisory. The clinical team's weekly case conference evaluates progress or lack thereof to determine needed next steps to support these individuals. Through observation and participation in the conference, the clinical scholars identified key issues that were essential to effective team function. First it was critical to clarify the scope of practice for non-clinical recuperative care unit staff. This was true for the staff members who weren't sure if they should function as nurse assistants and for acute care discharge planners who tried to send client who needed skilled nursing care. Secondly, it was important to model the care coordination role for social service staff so they could evaluate referrals to the unit and

respond to healthcare provider questions. Finally, the Clinical Scholars helped to develop leadership skills for the care manager so they could effectively communicate during the team conference. We followed a similar path for the Advisory Board, transferring ownership of the board to the Buffalo City Mission administration and expanding the board membership to behavioral health and visiting nurses.

A second focus in year 2 was expansion of the referral network to new hospitals and insurers. Through education and outreach, the network expanded to include the Kaleida Health Network which includes Buffalo General and Millard Fillmore Hospital, and Catholic Health System which includes Sisters of Mercy, Kenmore Mercy, Saint Joseph's and South Buffalo Mercy hospitals. In addition, three managed Medicaid providers Blue Cross Blue Shield, Independent Health and Fidelis have agreed to encourage hospitals and patients to utilize this resource for their patients. The collaborative continued to explore possible new referral sources such as direct admission from the emergency department as part of the hospital diversion program or direct admission from home care for unsafe home situations.

Year 3: Regional Outreach

Targeted staff development of primary care nurse care transitions outreach: With two of our Clinical Scholars members transitioned into roles at our partner primary care organization (Jericho Road Community Healthcare Center), we have been able to expand key care coordinator roles within our medical respite network of providers, that we aim to solidify into sustained scope and practice for the organization. The program has facilitated development of a dedicated nurse care coordinator for the primary care practice. Insights from clinical team development drive redesign of digital infrastructure for care transitions for high need individuals.

Regional outreach to community of health, behavioral health, and social service providers: The program connects key stakeholders across the region for expansion, funding and collaboration that has potential to impact policy. The program is growing to include women and children and will be studied at the regional level using network analysis including preparations to launch a community assessment regarding medical respite needs for female patients serviced by BCM. Through connections with the Erie County Department of Mental Health and Jericho Road Community Healthcare Center, our work to expand to a regional network structure has allowed us to enter key leadership meetings.

The project has provided the opportunity to examine the challenges of cross-sector collaboration and to incorporate these insights into the care alert design for the Personalized Cross-sector Transitional Care Management project. Interviews conducted with persons experiencing homelessness have provided insights into the impact of social need on ability to manage treatment burden after discharge from the hospital and that will be incorporated into a revised tool to measure treatment burden.

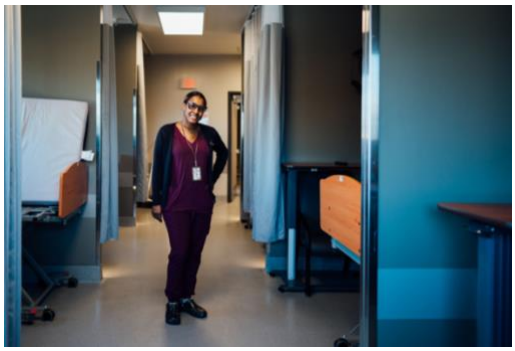
Outreach to New York State Department of Health Bureau of Social Care and Community Supports: Through her network as part of the Clinical Scholar leadership training, Amanda Anderson was able to connect Buffalo City Mission to the New York State Team in charge of the Medicaid 1115 Waiver for medical respite (*Appendix C*). An early step was helping the Chief Program Officer at BCM write an official comment to the New York State Department of Health on proposed regulations for medical respite programs (*Appendix D*). Her outreach culminated in a meeting with staff from the Bureau of Social Care and Community Supports which shared updated information about pilot demonstration project which now would be full phased implementation where they were identifying providers in critical regions of the state for phase 1 implementation. Buffalo City Mission was the first medical respite to reach out and since western New York was a high-risk region, BCM would be eligible for discretionary funding and potentially Medicaid managed care reimbursement. This is a critical step for long-term sustainability of the program.

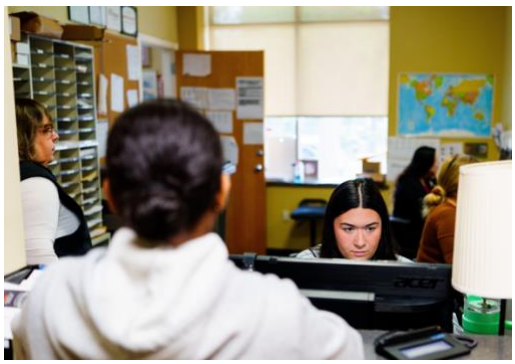
Jesse's Story

Jesse was a faceless person referred by the hospital discharge planner, who asked us to consider for the RCU. His medical record read, 'a 65-year-old male, non-ambulatory, with a history of cardiac issues, diabetes, weeping skin lesions, untreated substance and mental health issues.' By clinical review, we all agreed that he appeared to be an appropriate candidate for our program. But we soon found out that there was more to the story than we could read from the chart: This gentleman was admitted to the RCU, but was often tense, irritable with staff, and appeared to have depressive moods, often sleeping for long periods and not rousing for meals. He often refused wound care when the visiting nurse came to the RCU and denied needing behavioral health outpatient linkage. In time and with great patience, the team discovered he liked his medical provider in the clinic downstairs, and eventually agreed to let her change his dressings twice each day. The social worker from the clinic downstairs met with him unofficially for coffee each morning, and in time the team developed a rapport with Jesse, who began sharing is life with us.

With slowly growing trust Jesse's story began to unfold. He shared that he was once a highly decorated municipal employee who fell from grace after some poor life decisions which led to an early retirement. He found himself living in a rooming house where the landlady had access to his bank accounts and was abusive, controlling all aspects of his life. Jesse was fearful and did not want to return but felt unable to extricate himself from the situation. After unraveling his financial issues and preventing the landlady from carrying out her threats, the Mission involved lawyers to assist and enlisted the dedicated team who were able to help him. As Jesse felt safe, protected, and cared for, he not only shared his story, but received holistic care that gave it additional chapters. We learned that Jesse has a lifetime of stories to tell, more than just a medical record or program referral – one of many with similar stories to tell with hopes, dreams for a better life.

Under the genuine love and concern given by the RCU team offering medical respite care, Jesse transformed, becoming pleasant, affable, and willing to share all his stories with whomever will listen. After clinically stabilizing, Jesse was admitted into the transitional housing program at the Mission, called the Dream program, while he works towards a permanent apartment of his own. One must remember we are all faceless and nameless in the crowd unless we have people who care and willing to make a difference.





Evaluation and Dissemination

Since the onset of this project, we have been on a continuous learning curve to improve our processes to meet the needs of our community and constantly refining the referral process. We have utilized numerous resources including educational tools offered by the RWJF Clinical Scholar Program, best practices from other recuperative care centers, and most importantly collaborative feedback from our internal and external partners. We have established regularly scheduled times for collaboration including our weekly interdisciplinary care team meeting, weekly clinical cohort meeting, and our bi-monthly advisory board meeting. Our team has been intimately involved with all aspects of patient care for our service recipients, often providing our clinical expertise and mentoring.

An important milestone particularly in year 2 has been the outreach and established collaboration with our social network in the Western NY area. Hearing firsthand from our community about the challenges and gaps in services are essential moving forward. A needs assessment was developed as a result which will be implemented soon. This data will be particularly important to see if a RCU needs to be developed for the female population at Cornerstone Manor. Our team will be instrumental in the entire process but sustainability on every level is a priority.

Evaluation Strategy

Our evaluation plan included an analysis of demographic characteristics as well as process and outcome evaluation.

- **Demographics: *Who do we serve?*** The records available at BCM allowed us to classify the reason for homelessness and included eviction, substance use, lack of affordable housing, domestic conflict, job loss and health or medical conditions. Nearly 50% of men admitted to the RCU were homeless because of a medical condition. The most common body systems requiring medical respite care were skin and general physical rehabilitation (52%) and the most common skilled needs were wound care and complex medication management (72%). See *Appendix E.*
- **Process Metrics: *How do we serve them?*** We used AHIMA's Long-Term Care Health Information Practice and Documentation Guidelines to track admissions, discharges, and average length of stay to measure both program utilization and efficiency.
- **Patient Outcomes: *What is our impact?*** In addition to tracking readmissions to the hospital or emergency department, our team was able to facilitate the development of a self-efficacy tool appropriate for low-literacy populations. The tool included knowing how to take medications and when to seek help after discharge. We also tracked discharge outcomes for RCU residents. The most common (over 50%) was the emergency shelter at BCM, followed by rehospitalization (6%), with the rest discharged to a private home, out of area shelter, or co-located transitional housing *(Appendix F).*

Program Impact Evaluation

- **Care Coordination Role Development:** The program has facilitated development of a dedicated nurse care coordinator for the primary care practice.
- **Cross-sector Collaboration:** Insights from team development drive redesign of digital infra-structure for care transitions for high need individuals.
- **Regional Impact:** The program connects key stakeholders across the region for expansion, funding and collaboration that has potential to impact policy.
- **Project & Network Expansion:** The program is growing to include women and children and will be studied at the regional level using network analysis.

Dissemination

The main products developed by the project include a policy manual that include escalation policies for medical and behavioral health emergencies, a website for referrals to RCU and internal training for RCU staff and administration on cost models with guest presentation from representative of the National Respite Council, evaluation metrics, and poster presentation for area hospitals. We were able to disseminate the results of the project at national conferences including Dissemination and Implementation Science 2021; Center for translational science institute Health Equities Workshop 2021, 2022; Council for Advancement of Nursing Science 2021, 2022; Clinical Informatics Conference 2021, 2022; and American Medical Informatics Conference 2022. In addition, the team published a care coordination concept analysis and has a manuscript in review about the implementation of the cross-sector collaborative.

Sustainability Plan

During the final summer of the project our efforts at community outreach resulted in the RCU was operating at full capacity and had contracts with multiple hospitals and health insurer to pay for RCU stays. The Clinical Scholars team facilitated outreach to the New York State Department of Health Bureau of Social Care and Community Supports with the goal of developing a Medicaid reimbursement strategy. The role of the care coordinator at the Jericho Road Community Health Center was established and supported by enhanced transitional care alerts provided through the regional health information exchange and facilitated by Clinical Scholar Sharon Hewner. The Clinical Scholars worked with administration to develop a needs assessment tool to be sent to area health, behavioral health, and social service providers for a similar unit in BCM's affiliated women's shelter.

"Did we solve our wicked problem yet? No, not even close. But we've seen relationships between organizations grow from the sites of old wounds and watched long-held misconceptions fall away. And together, we've helped real people heal and mend and find health in ways that weren't before possible. To me, this is crossing sectors together."

- **Amanda Anderson, Clinical Scholar**

Lessons Learned

Challenges

- The expanded role for BCM in sharing information through the regional health information exchange and for developing and tracking metrics for success are not fully realized due to turnover of staff in the data management role. We continue to provide support and guidance in monitoring performance.
- The transition of two Clinical Scholars to the co-located primary care clinic has facilitated closer collaboration and development of an expanded role for nurse care coordinators in managing individuals with social need, and behavioral health and/or chronic illnesses. RWJF has been supportive of the change in roles and multiple updates to the budget in year 2.

Successes

- The program has facilitated development of a dedicated nurse care coordinator for the primary care practice:
    - History of acute care psychiatric discharge planning.
    - Growth in involvement with medical respite project led to increased interest in primary care-based care coordination.
    - Transition to Jericho Road as RCU-specific Care Coordinator covering inpatient-to-respite spectrum.
- The program connects key stakeholders across the region for expansion, funding and collaboration that has potential to impact policy:
    - Historical ties with Erie County Department of Mental Health increases medical respite reach.
    - Hope for structured collaboration to bring medical respite to wider population through innovative referral sources.

Shifts in Thinking

- Insights from clinical team development drive redesign of digital infrastructure for care transitions for high need individuals:
    - Expansion of past work in primary care increased understanding of need for cross-sector health information exchange.
    - Co-organization of medical respite and AHRQ project led to synergy between them and the shared stakeholders on both projects.
- The program is growing to include women and children, and will be studied at the regional level using network analysis:
    - Community needs assessment for Cornerstone Manor (affiliated women's shelter).
    - Testing the value of network analysis to quantify, improve collaboration.

As the medical respite program grows in referrals and reputation throughout the region, supported by the collaborative network and a growing portfolio of financial stakeholders, our project is shifting toward the further establishment and enrichment of the regional provider network. Our initial launch period has shown us that referrals to the medical respite are complex, and often misunderstood by the discharging acute care providers. We are currently designing a curriculum for inpatient health care providers that addresses concepts such as social determinants of health, housing instability, social sector operations, and community-based organizational culture. With practical information and actionable resource-driven content, we are assisting in the education of regional discharge planners, case managers and care coordinators who are responsible for referrals to places like the medical respite program.

- Needs assessment for women's RCU and regional dissemination.
- Social network analysis of relationship between cross sector organizations providing care coordination services.
- Need to develop a stronger communication network for sharing information and for collaborating with cross sector colleagues.

Recommendations

As the housing crisis in America continues, and cost of living increases in cities of all sizes, the problem of homelessness, and people experiencing homelessness with complex medical issues related to chronic disease and increased age, will continue to grow. Medical respite is a care delivery model that is increasingly attractive to health systems and communities looking to manage the needs of people with both complex medical and social needs at hospital discharge, and our project provides practical insights into a way to implement this care delivery option within a collaborative, cost-sharing, cross-sector network. Through this project, our team has learned the importance of relationships and communication as key elements to collaboration and built upon existing work and research in primary care to optimize social sector organizational management of a new subset population of people experiencing homelessness. The collaborative nature of this model adds to its complexity, but also allows for resource-scarce communities to begin work in this domain without extensive cost.

Getting Started

In tandem with NHCHC guidelines for medical respite care, we recommend starting with simple relationship building conversations between health and social sector agencies, with a sense of a convening organization, like an academic partner, to play a leading role. Early dialogues might try to uncover an understanding of the problem from each organization's perspective, knowing that a hospital administrator may see a different priority than a social service agency administrator, but that there is potential for overlap. For example, a hospital administrator might be focused on throughput efficiency, while a social service agency administrator might share stories of unsafe discharges impacting shelter staff and safety. These initial conversations can lead to a more formal needs assessment that quantifies the extent of community potential not only for driving referrals to a medical respite, but for funding one.

After initial conversations and needs assessments, we recommend a meeting with all interested stakeholders to define relationships, roles, and a timeline for the project. Leaders should be appointed by the group, and a dyadic structure set between an advisory group and a frontline workgroup of members responsible for creating policy and procedure. This two-pronged hierarchy will ensure equal organizational representation, and a feedback loop for direction and approval of deliverables. Clear leadership and approval mechanisms will also help to ensure collaboration is effective and shared.

Main things to avoid center around acting prior to assessment. Working with cross-sector agencies is challenging and often ripe with historical bias. Organizations may have been working in overlapping ways without direct lines of communication for years, and so assumptions and misconceptions might start off the project poorly. Taking time to discuss, understand each other's perspectives and goals, and apply frameworks for team building is important. Skipping this step, no matter how urgently the ask is presented, will result in back-tracking and loss of collaborative power sharing. Take time to talk, get to know each other within organizational confines and outside of them. Dive into research that helps you understand how complex work processes are changed or implemented, like Relational Coordination, Collective Action, or Implementation Science in general.

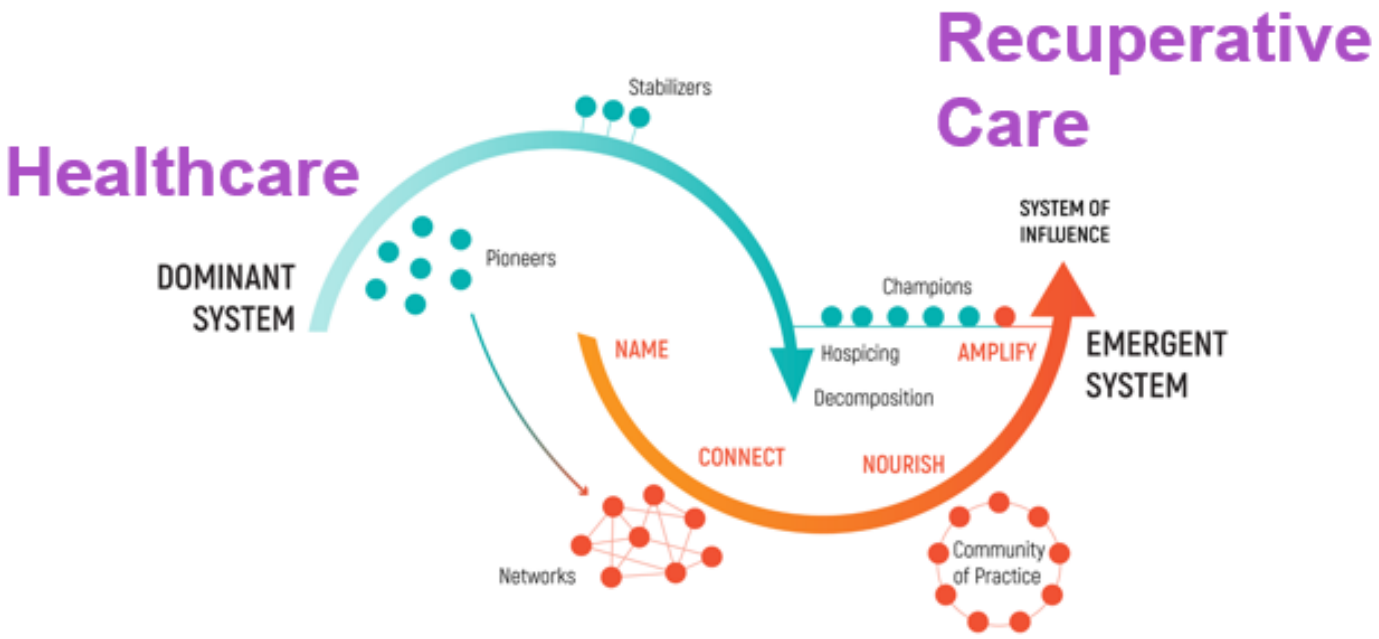
Best Practices

As much as we hope that a research study or published protocol of guidelines could teach us best practices, often implementation of complex work processes like cross-sector collaborative care models is best learned through trial and error, relationships, and reflection. Some of our best practices are:

- **Amanda:** I wish I would have known that spending 80% of a meeting in small talk led to more productivity in the remaining 20% than jumping in with a bulleted agenda item list of things to get through. In the beginning, people in other, especially non-healthcare agencies, just wanted to let their stories out, share their experiences, be heard. They had worked for so long in the shadow of the "silent" hospital systems, never having access to a person or process to share their perspectives, that talking about this was all that mattered. Once I figured this out, I not only got a heck of a lot more done, but I began to understand their sector of work in a new way, which I feel enriched my own health-centric way of thinking.
- **Donna:** I would have wanted to know how much we wouldn't have control of for the success of our project. Also, if there were professional life changes how to navigate them, 3 years is a long time and there have been many changes professionally with our group members.
- **Deb:** The bonds which were developed within our group whose dedication and selflessness are focused on bettering the lives of others. The reassurance and pride of being associated with RWJ Scholars who are working towards similar goals in their communities.
- **Sharon:** One of the things that stood out for me was how differently the people admitted to the RCU and BCM described their challenges from the way we think about treatment burden in the healthcare sector. Even with the current interest in social determinants of health and efforts to make social need visible in the electronic health record, healthcare providers often fail to understand what is important to the individual and to have them prioritize the next steps in their care.

Appendix

Appendix A: Conceptual Model



Appendix B: Project Timeline

	YEAR 1	YEAR 2	YEAR 3
GOAL 1: Launch RCU & Reduce Health Care Recidivism	• Fully operating RCU with 24/7 clinical coverage • Evaluation method, baseline measurement, & database established	• 25% decrease in RCU patient health care recidivism • 25% of medical respite patients entered transitional housing	• Health care recidivism rate equal to Medicaid population • 25% RCU patients entered permanent supportive housing
GOAL 2: Establish Cross-Sector Provider Network	• Cross-sector educational toolkit developed and deployed • BCM-ECMC handoff mechanism established • Weekly case review conferences and shared dashboard launched	• Expand RCU coverage across region • Launch regional cross-sector provider network	Regional cross-sector provider network accomplishes: • Shared directory of region's most complex patients • RCU Patient social needs assessment • Directory of regional clinicians linked to complex patients

Appendix C: Process to Connect BCM to NYS Team in Charge of Medicaid 1115 Waiver for Medical Respite

Amanda Anderson

As a part of Clinical Scholars, I was asked to connect with potential mentors that aligned with my work. For this process, I reached out to several research scientists doing with housing, people experiencing homelessness, and social determinants of health. One of the people I spoke with was Dr. Kelly Doran, who studies health and housing issues related to delivering emergency services care at New York University. In our conversation, we spoke about our WPIP project, and she directed me to The Health & Housing Consortium downstate, and I signed up for their email distributions. Through this distribution, I learned of the recently enacted NYS Medicaid 1115 Waiver that had been enacted to address social determinants of health, including medical respite funding, and assisted Sal Durante with the drafting and submission of a public comment regarding the proposed regulations for medical respite certification in early December. I also learned about their 2022 12th Annual Convening and was able to attend by Zoom in December so that I could hear the presentation by Ms. Emily Engel, Director of the New York State Department of Health Bureau of Social Care and Community Supports, who spoke about the New York State Medicaid 1115 Waiver. Through the chat in this presentation, I was able to obtain her direct email address, which I used early this year to arrange for the BCM and Clinical Scholars Fellows team to meet with Ms. Engel and her team.

Appendix D: BCM Official Comment to NYSDOH Proposed Regulations for Medical Respite

Buffalo City Mission Public Comment to NYS DOH Proposed Regulations for Medical Respite

Created by Salvatore Durante, Chief Program Officer, 12/20/22

Buffalo City Mission started in 1917 to feed and care for those suffering from life's hardships. From a simple soup kitchen, we now serve and care for thousands of homeless and those on the brink of homelessness throughout Western New York and have become the largest and pre-eminent multi-disciplinary homeless shelter for men, women and children in Buffalo, Erie County and Western New York (WNY).

For over 100 years, Buffalo City Mission has seen the City of Buffalo and its people through hard times on every level imaginable. Through the widespread devastation of the Great Depression, both World Wars, economic downturns in our city, and most recently the COVID-19 Pandemic, the Mission has opened its doors to help men, women and children restore their hope, dignity, and lives. The Mission has met the spiritual and practical needs of the poor through the demonstration of Christ's love and the preaching of the Gospel. Each year, more men, women, and children come to us for help. At the same time, their needs become increasingly complex. Providing food and shelter to people in crisis is simply not enough.

Today, Buffalo City Mission offers long-term recovery programs, counseling, work and life-skills training, education assistance, educational and vocational services and health-care services for homeless men, women and families committed to turning their lives around. We offer outreach programs to prevent homelessness for individuals and families in the low-income community. Each year, more than 2000 men seek services at the Buffalo City Mission's Men's Community Center. Often, we find that, once a man has received basic care services such as food and shelter, he will consider making a more transformative choice like joining the Mission's Dream Transitional Housing Program—a program that offers freedom from the past and hope for the future!

In 2021, Buffalo City Mission was pleased to open, after more than two years of planning, our 13-bed men's medical respite program – called our Recuperative Care Unit (RCU). We recognized that today Western New York has a great need for intensive, coordinated care for homeless patients' post-hospitalization. Homeless patients are four times more likely to be readmitted within 30 days of discharge. This specialized medical respite unit provides comprehensive supportive services and programs provided by BCM and in collaboration with community partners such as our colocated primary care clinic, behavioral healthcare program, and University at Buffalo School of Nursing academic partners. The newly design recuperative care unit offers a safe, efficacious, and efficient care to medically complex clients and is recognized as a tier one community-based organization and provides the only medical respite facility within a 250-mile radius. The foundation

model of the Recuperative Care Unit is to have readmission reduction principles and improve hospital capacity at the forefront when collaborating with area healthcare providers -– since our launch in February 2021, we have served over 100 individuals who were difficult for hospital discharge providers to place in the community and achieved a readmission rate far below our geographic average.

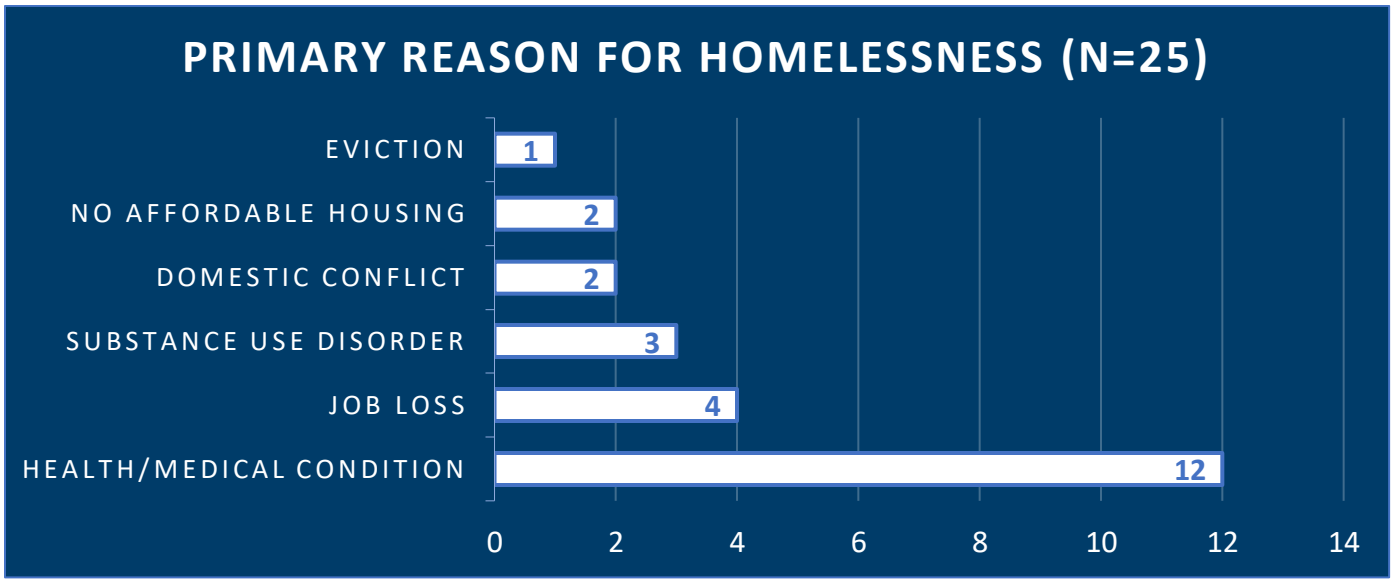
What makes the Buffalo City Mission RCU unique? We are the only medical respite program that is embedded within a homeless shelter, which also has immediate access to post-RCU discharge into our men's homeless shelter or our Transitional Housing Program. This immediate access to post-discharge housing allows our RCU patients to be safely discharged significantly sooner than with other programs. Specifically, the average length of stay (ALOS) at stand-along medical respite units across the country is approximately 45 days; the ALOS at the Buffalo City Mission's RCU is approximately 14 days. This creates an environment of quicker healing and discharge for the patient and reduces the healthcare cost to the hospitals and insurance companies in WNY.

Almost 90% of the operating revenue for the Buffalo City Mission comes from private giving – individual donors, corporate donors, and foundations. We strive to fund our programs through mechanisms that allow us to continue to provide care, shelter, and support to men and women in need according to our Christian beliefs. Although we go above and beyond to work as a community partner with regulating bodies, offering valuable insights, services, and data, our concerns with the regulations stem from our deep conviction that The God of the Bible is our chief guiding regulator. Our principles and dedication to the wellbeing of our clients lead to exceptional care that far exceeds regulatory expectations, and while we are willing to dialogue and further understand the proposed regulations under review and believe that our functioning respite would be a prime candidate for the Medicaid waiver respite demonstration project, our historical experiences with regulating bodies limit our confidence in this proposed measure as one that fits our values.

Adhering to the proposed NYS DOH medical respite program regulations would also create operational challenges. We find that there are extensive proposals in the regulations that will cause financial hardships for the Buffalo City Mission's RCU for the following reasons: physical plant modifications to our existing facility may be required, which incur cost, planning and possible interruptions to care. Our primary concern is the intensive planning, creation and organization of tools that will be required for data gathering, monitoring and quality assurance. Will these requirements be supported by the Department of Health through sharing of templates, guidance, and free training opportunities? Will staff be available to guide us through creation of a tracking system, appropriate communication tools for clients, and reporting requirements? While we currently operate our facility using a complex record-keeping system, our read of the guidelines gives us pause as to the knowledge, skills, and time required to achieve and maintain the regulations specific to the documentation required. While these elements may come naturally to a healthcare dominant respite, ours is primarily led by case managers and homeless service providers. Furthermore, we strive to achieve the highest level of privacy for our patients, and the requirements address extensive data sharing tasks that could compromise this standard.

Ultimately, we believe in medical respite care and in our model at the RCU here in Buffalo. Our goal is to help facilitate this model of care further, and we have great interest in the possible benefit that the regulations could have to doing so in a safe and efficacious way. We are interested in serving as a pilot site for the Medicaid demonstration project and will eagerly await additional information about this. The Buffalo City Mission is a longstanding community organization that is known for its dedication to ending the problem of homelessness in the Western New York area – whatever it takes. We hope that you will consider our concerns and our innate values, as you proceed with this regulatory journey.

Appendix E: Social and Medical Needs



Measure	%	n
Clinical Discharge Diagnosis: Body System		
Skin	32%	8
General Physical Rehabilitation	20%	5
Neurology	12%	3
Oncology	12%	3
Pulmonary	12%	3
Orthopedic	8%	2
Urology	4%	1
Clinical Discharge Diagnosis: Skill Need		
Wound care	40%	10
Complex Medication Management	32%	8
General Rehabilitation	24%	6
Device Management	4%	1

Appendix F: Case Exemplars

Case Exemplar - Data

In the past year of our work with our social sector partners, we have created definable, reproducible data definitions and protocols to measure our work. Using the social sector record system, and working in tandem with their quality staff members, we designed data tracking mechanisms that help to streamline medical respite unit operations and benchmark our progress. The creation of a report that could be generated daily that serves as a unit census document has allowed for respite staff members to understand a key tracking mechanism and communication document for relaying real-time information about patients in the unit, especially when collaborative partners come to provide services. This data literacy measure was created with their comfort level and knowledge in mind, and our work helped them to learn parts of their record system that had the capacity to refine care delivery and improve collaboration.

Wanting to record and disseminate the results of our first year of operation, we worked to achieve University at Buffalo Institutional Review Board approval to perform a retrospective record review of all patients served. Using the Gravity Project domains to measure social risk, and information available from documents sent by acute care agencies referring clients to evaluate health risk and clinical needs of the patients that we served, we were able to understand our program baseline in a quantitative, pragmatic way. The structure that we used to aggregate data has become the outline for a recurring report that is used in our partner's internal reporting, fundraising efforts, and quality improvement initiatives.

Our efforts to define our work in terms of data through the lens of social sector providers has had its limitations and challenges. Data definitions are heavily dependent upon available data, and extraction is largely manual. Although the record system has a reporting function, and we have been given access to it from our partners, the shelter quality staff was recently downsized, leading to challenges in sustaining implementation of data tracking and entry quality. Future work to refine what data is pertinent to our program, streamlining inefficient practices, and holding collaborative partners accountable for reporting, will be key in achieving high quality evaluation and the impact of improvement efforts over time.

Case Exemplar - Cross-Sector Collaboration

Since the onset of this project, we have been on a continuous learning curve to improve our processes to meet the needs of our community and constantly refining the referral process. We have utilized numerous resources including educational tools offered by the RWJF Clinical Scholar Program, best practices from other recuperative care centers, and most importantly collaborative feedback from our internal and external partners. We have established regularly scheduled times for collaboration including our weekly interdisciplinary care team meeting, weekly clinical cohort meeting, and our bi-monthly advisory board meeting. Our team has been intimately involved with all aspects of patient care for our service recipients, often providing our clinical expertise and mentoring.

An important milestone particularly in year 2 has been the outreach and established collaboration with our social network in the Western NY area. Hearing firsthand from our community about the challenges and gaps in services are essential moving forward. A needs assessment was developed as a result which will be implemented soon. This data will be particularly important to see if a RCU needs to be developed for the female population at Cornerstone Manor. Our team will be instrumental in the entire process but sustainability on every level is a priority. Our team has been focusing on how to transition for future success. Training of City Mission staff is ongoing as they are not clinical, there is a significant learning curve. Jericho Road Community Health Center has onboarded Deb Heigl and used her as an essential team member as a nurse care coordinator. Her years of experience are invaluable, most nurses do not have this skill set. Donna Gatti also transitioned to Jericho Road Community Health Center as the Director of Nursing and will make this a priority over the next year to train a successor and use her as a mentor to learn this complex piece which is key to sustainability.