Crossing Sectors Together: Forging a New Path Home for Medically Complex Chronically Homeless Patients

Cohort:
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Location:
Buffalo, New York

Focus Areas:
Behavioral and Mental Health
Health Care Access
Social Determinants of Health

Short Project Summary

Buffalo's wicked problem of lack of housing for medically complex chronically homeless patients leaving area hospitals is compounded by baseline poverty, poor health outcomes, and barriers to care. This proposal seeks to establish the only medical respite unit in the region, supported by relational, evidence-based care transitions partnerships between interdisciplinary providers from the Buffalo City Mission, University at Buffalo School of Nursing, and Erie County Medical Center. Once established, project stakeholders aim to launch a regional cross-sector collaborative network to better track, collaborate, and improve the outcomes of medically complex chronically homeless patients in our city and beyond. Through these achievements, we aim to reduce health care recidivism, increase transition to housing and self-management of chronic disease, and establish collaborative care networks for Buffalo's sickest homeless citizens.

Wicked Problem Description

In a city like Buffalo, with a third of the population living below the poverty level, high rates of eviction and job scarcity, and minimal municipal infrastructure for housing

security, homelessness is a devastating reality for thousands of residents each year. Heart disease, cerebrovascular, and suicide rates greatly exceed those across the state, making many homeless residents both chronically homeless and chronically ill. Private community-based organizations try to patch together solutions with social services and area health systems, but all too often these incredibly vulnerable citizens become trapped on a well-worn path between our shelters, our hospitals, and the streets.

A possible solution to the crisis of medically complex chronic homelessness is medical respite care. Medical respite care can decrease low value health care utilization, readmissions, and increase long term success achieving income and returning to housing. A medical respite is also a way for health care systems and community-based organizations to collaborate in providing care for their most complex patients. Unfortunately, the closest medical respite facility is over two hundred miles from Buffalo.

This project aims to reduce health care recidivism, increase transition to permanent housing, and create a cross-sector care provider network across the Western New York region through the launch of an evidence-based practice medical respite unit for medically complex chronically homeless clients based in Buffalo's largest emergency shelter.

Proposed Project Plan

The Buffalo City Mission (BCM), our city's largest emergency and transitional shelter, accepts men being discharged from area hospitals with post-discharge care needs, but with limitations, as 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 often face logistical barriers due to a lack of structure in the transfer of care across organizations, compounded by low healthcare literacy.

The Erie County Medical Center (ECMC), our city's largest public hospital, discharges the highest number of patients to BCM each year. ECMC patients are the city's sickest, poorest, and with the highest barriers to care, and unfortunately, those discharged to BCM return to the ED approximately 30% of the time. Administration and staff struggle with the pressures of throughput, administrative limitations, and a lack of community-based options for these particularly complex patients. Discharge planners have built personal relationships with 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.

Without a formal handoff or transportation procedure, neither sender nor receiver can be certain whether patients are safe, or if they take hospital-provided cabs to another location. As such, the majority of patients referred to BCM from ECMC never arrive, and patients who do arrive, come without things that are crucial to their recovery like medications, discharge instructions, and follow-up appointments. More often than not, BCM staff is forced to return patients to the emergency department

for problems that they feel could be solved if only they knew who in the hospital they could call.

Our proposed project of opening the first medical respite unit in the region will meet the community's need for medical respite beds and reduce the health care recidivism of Buffalo's sickest homeless citizens. By combining resources of the Buffalo City Mission, care transitions researchers from the University at Buffalo School of Nursing, and the shelter's largest hospital partner, Erie County Medical Center, we will launch a new medical respite program that is safe, sanitary, and supported by evidence-based standards. From the network which will be created while launching the respite unit, we will kick off a relationship-based regional process improvement taskforce for the most complex of the respite patients. Through aligned outcome assessment and tracking, this taskforce, which will also be the first of its kind in the region, will serve as a cross-sector complex care team for those in our community who need care continuity the most.

We believe that by establishing a collective, relationship-based program that successfully fosters meaningful and measured collaboration across settings of care, we will be able to forge a new path toward housing and health for the men that are served, and improve the cross-sector relationships and care continuity around the region.

Anticipated Outcomes

The first goal of this project is to reduce health care recidivism of medically complex chronically homeless patients through the creation of a medical respite unit in partnership with area health systems. Our long-term outcome related to this goal is 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 include the establishment of a safe, evidence-based medical respite unit, validated tracking mechanisms for health care recidivism, and a collaboration between stakeholders at BCM, ECMC, and consulting care providers.

The second goal of this project is to establish continuity of care of medically complex chronically homeless patients through the creation of a network of cross-sector care providers. Our long-term outcome is to create a cross-sector network of regional 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 launch and manage respite patients, an outcomes database and dashboard, and criteria with which to identify complex patients and their care team members.

Timeline

The focus of the first year of this project will be to safely launch the medical respite unit with 24/7 escalation coverage, and to establish a true baseline of healthcare

recidivism for medical respite patients, and a mechanism and shared database for tracking respite patients will be in place. In addition, a cross-sector educational toolkit will be created, and all medical respite partners trained, and all partners will engage in weekly medical respite case review conferences, and a common dashboard will be maintained and shared monthly.

During our second year, we will focus on increasing services in the respite unit beyond ECMC, continue necessary quality assurance and improvement mechanisms to decrease health care recidivism and increase respite patient transitions into transitional housing. In addition, we will expand our collaborative case conferences to a cross-sector network of regional care providers that will have established council meetings, at least 5 deliverables for medical respite patients, and a shared list of the region's most complex utilizers.

In our third year, we will begin to achieve health care recidivism of respite patients at rates comparable to that of the chronically ill Medicaid population by refining our care model, training and cross-sector collaboration in the respite unit. In addition, our regularly meeting cross-sector regional network of care providers will establish a comprehensive directory of the region's most complex patients, an assessment of their social needs, and the clinicians responsible for each that will be updated and shared across all systems of care uniformly.

Partnerships

Because of the shelter-based collaborative model that is intended for the respite unit at BCM, collaborative partnerships are paramount to the success of this project. Establishment of key stakeholders and workgroups to address the clinical, administrative, labor and safety needs of the patients will be done through strategic alliances. These partnerships will include area home care providers, co-located Jericho Road Community Health Center and Spectrum Health & Human Services specialty care providers, ECMC case management and administrative health system partners, and community-based social and clinical service agencies such as HEALTHeLINK Clinical Information Exchange. Once the respite unit is established, partnerships will extend to the regional Community of Care, Housing Alliance of Western New York, for the establishment and expansion of the cross-sector network.

Evaluation Strategies

Although our long-term goal is to reduce health care recidivism in the chronically homeless population (patient outcome), the evaluation will focus on implementation outcomes using Proctor's framework. At the individual patient level, we will access acceptability and appropriateness of the unit and care coordination provided by the clinical team using semi-structured interviews on a sample of clients admitted to the unit in years 1-3. For the two partner organizations, we will evaluate adoption and

feasibility in quarterly focus groups, implementation costs and sustainability at the cross-sector level using semi-structured interviews, and will develop a plan to address the penetration to other cross-sector organizations.

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