2014 ONPHA Conference and Trade Show

Making an impact!

HIV/AIDS Complex Care Pilot Project: Enhancing Community Care and Housing

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ONPHA Ontario Non-Profit Housing Association

A "Hidden epidemic" of aging with HIV

"Toronto's HIV/AIDS experts and activists are growing increasingly alarmed by "a hidden epidemic" — infected people who have lived decades longer than anyone imagined and are being hit with a host of aging illnesses in their 30s, 40s and 50s. They include dementia, cardiovascular and liver disease, cancers, diabetes, osteoporosis, emphysema and kidney problems."

– *When HIV Moves into Nursing Homes*, Toronto Star, *27 February 2011*

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Fife House Foundation

- Fife House is an innovative, client-focused provider of secure and supportive affordable housing and services to people living with HIV/AIDS in the Greater Toronto Area.
- In 2013/2014 Fife House served 600 plus residents & clients. We provided support services to more than 200 residents/clients through our five Supportive Housing Programs and to an additional 390 clients, including 45 families, through our Homeless Outreach Program.

Setting a new priority based on past success & experience

- Building on success and experience of Service Coordination Project and Addiction Supportive Housing Program
  - Taking advantage of high level of engagement and collaboration
  - Buy-in and ownership from wide cross-section stakeholders
- Toronto HIVAIDS Network Housing Working Group struck a roundtable to explore the epidemic that they were seeing daily—not so "hidden" after all
  - To explore PHA and service provider on-the-ground experience and perspectives

Community Roundtable on HIV, housing, aging, complex care and cognitive issues

- Organized by THN and Fife House, June 2011
- 64 key stakeholders
  - ASO's, hospitals, community health, mental health, rehabilitation, addictions services, long-term care facilities, housing, criminal justice, funders
- Main Goals
  - Identify issues and challenges facing Aging PHAs, and to identify current resources, and gaps in services
  - Develop model solutions—based on service innovation—to be implemented within 18 months
  - Brainstorm about longer-term solutions and collaborations

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Roundtable identified PHAs' issues and challenges

The cascade:

- physical health
- changing identities
- access & equity
- stigma & discrimination
- caregiver burnout
- lack of community response to complexity
- Knowledge & training gaps
- poor navigation / advocacy support
- lack of housing options
- poor service integration
- restrictive service eligibility criteria

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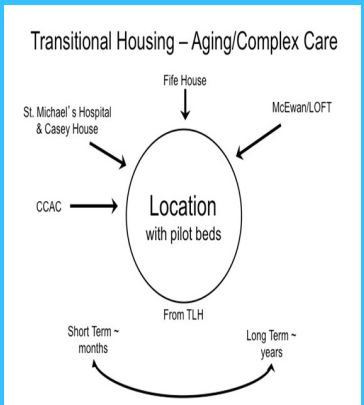
Roundtable identified potential models of service innovation: two examples

Hub of community & clinical expertise

- **Inter-disciplinary clinic**
  - Core team: Nursing, Case Manager, Pharmacist, Social Worker etc
- **Comprehensive assessment**
- **Clinical and Support Plans of care**
- **Coordination of community-delivered services**
- **Notable features**
  - ER diversion through case management resources
  - Virtual hospital ward: 1- 6 weeks home care (provide clinical care services in the home)

Transitional housing aging/ complex care



HIV/AIDS Complex Care Pilot Project: Developing & delivering a continuum of enhanced community care and housing through partnerships

Roundtable resulted in community mobilization & action

- Led by THN Housing Working Group
- Developed funding application for new 7-partner pilot project
  - responded to PHA "issues & challenges"
  - drew upon "potential models of service innovation"

Goals

- Create a program to address gaps in service, changing care and service needs of PHAs (aging, aging-related illnesses, complex care, cognition issues)
- Increase collaboration & partnerships
- Increase access to high-quality care

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HIV/AIDS Complex Care Pilot Project FAQS

PHAC funded

- Two-year initial pilot project funding from AIDS Community Action Program (ACAP) 2012-2104; 3 year funding renewal 2014-2017 (ACAP)

Cross-sector partnership among 10 agencies

- Significant in-kind contributions

Model of care focuses on three keys areas:

1. Enhanced coordinated care & support in the community
2. Extended respite & health stabilization
3. Transitional & re-integration into housing

Project Partnerships: the essential element

- HIV supporting housing provider **Fife House Foundation**
- Housing & support service provider - people w addictions, homeless, at risk **McEwan/Loft**
- Mental health, community support, rehab provider **COTA Inspires**
- Government run community health service coordinator **Toronto Central Community Care Access Centre (CCAC)**
- AIDS service organization **Toronto PWA Foundation**
- Large municipal social housing provider **Toronto Community Housing**
- HIV/AIDS hospice & community care **Casey House**
- Large, urban hospital **St. Michael's**
- Home health care, complex rehab **St. Elizabeth Health Care**

In-kind contributions from project partners: a partial list

Dedicated staff resources

- Clinical nursing lead (Casey House, 1.0 FTE)
- Case managers & community personal support worker (McEwan/Loft, 0.25 to 0.75 FTE)
- Case manager (COTA Health, 0.25 to 0.75 FTE)
- Care liaison coordinator (Toronto Community Care Access Centre)
- Social worker liaison (St. Michael's Hospital)
- Psychiatry liaison (St Michael's Hospital)
- Nurse Practitioner (St Michaels Hospital)

In-kind contributions from project partners: a partial list

- Access (priority, dedicated, exceptional) to existing programs
  - 8 dedicated new support-centred RGI housing units for reintegration (Toronto Community Housing / Fife House/WCRI)
  - 2 dedicated transitional housing units (Fife House)
  - 10 dedicated spots in food access program (Toronto PWA)
- Renovation of existing office space for project office (Fife House)
- Dedicated Project Client Information System (McEwan/Loft)
- Dedicated Care Liaison Coordinator (Toronto CCAC)
- Commitment to explore …(all partners)
  - creation of staff liaison roles, development referral processes, alternative pathways to access services, coordinated care services outside of regular practices/hours/eligibility criteria

Services within Model of Care

- Intense wrap around clinical and support service
  - mental health and addictions case management
  - HIV community nursing
  - enhanced personal support and care
  - occupational therapy, and physiotherapy
- Coordinated referral/intake, ongoing care and case coordination
- 10 supportive housing units currently
- Streamlined access to psychiatric assessment and care, crisis intervention, respite and health stabilization
- Primary care health reconnection
- Substance use support

Intake Eligibility Criteria

Basic Criteria

- HIV +
- 30 years old or older
- 2 or more other health conditions (co-morbidities including mental health and addictions, and/or acute health conditions) other than HIV that you have received treatment for in the past year.
- Currently housed and/or housing is at risk.

Intake Eligibility Criteria

Service Usage Criteria

- **Inpatient Hospital Admission**- 20 inpatient hospital days in the year prior, or more than one hospital admission in the last two months,

  or

- **Emergency Department** Visits- 3 Emergency Room Visits in the prior three months, or more than one visit within the last 30 days.

  or

- **Receiving in Home Clinical Supports-** Received in home nursing and personal care supports for two weeks continuously once in the last three months, and more than once in the year; or have utilized a respite stay of 2 weeks or more in the last three months or more than one stay in the last year.

  or

- **Have received medical treatment for more than one acute health conditions** in the past year without receiving in home supports or care, and through clinical assessment it has been determined a higher level of care and support is needed.

Client Profile January 2013 - Present

- 29 male and 2 female
- Mean age is 56
- 80 % of all clients had cognitive issues
- 28.6% mild to moderate cognitive impairment
- 71.4% with moderate to severe cognitive impairment
- 55% had concurrent mental health/addiction issues
- 100% of clients had three or more health conditions other than HIV, with close to 50% having five or more.

Client Profile cont'd

- 20% were homeless or marginally housed at intake.
- 53% at risk of loosing their home due to health condition(s) and/or in need of higher support housing.
- 75% of all clients met inpatient hospital days eligibility criteria at intake; with some as few as 4-5 days twice in a 30 day period, while a significant number of clients (33%) had over 100 inpatient hospital days in the year prior.
- Approximately 40 % of all clients at intake were Long Term Care Eligible

Model of Care and Client Flow

Coordinated Intake and Assessment (Project Coordinator Fife/CCAC/Casey House Nursing Clinical Lead)

Assign Case Management/Development Clinical and Support Care Plan

Client Receives Enhanced Model of Community Care

- Intensive case management services 2-3 times per week
- HIV community nursing and clinical case management weekly or more as needed
- Enhanced levels of personal support work often daily at outset of services
- Occupational Therapy, Physiotherapy , Dietician as needed
- Mental health and specialty nursing as needed
- Psychiatric assessment and follow-up
- Food security

Ongoing Care Coordination, Service Planning, and Model of Care Development

- weekly case management team meetings
- monthly client case management meetings
- Monthly Clinical and Support Rounds Meetings (All Service Providers)
- Quarterly Partnership Meetings

Ongoing Assessment of Needs -Levels of Care and Housing

- Transitions from independent living to medium to high support housing
- Planned respite care and planned hospitalizations
- Transitions to long term care with supports

Client Outcomes

- 2 client deaths
- 2 clients have gone to LTC
- 2 clients have been discharged to other services
- 15 clients as part of the Project have transitioned to higher supportive housing in Fife's new dedicated project units or other supportive housing units.
- 14 clients who live independently in the community have received the 'Enhanced Model of Community Care'.
- The Project has contributed to significant reductions in unplanned hospital admissions and ER visits, and has improved flow within the system.

Key Evaluation Findings

Partnership Development

- The project was **successful in creating a partnership** of ASOs and non-ASOs to serve the needs of this client group with the generous support of much in-kind support from partners and supports from Fife House
- Partners are **aligned with the vision** of the project but **operational misalignment** has caused some challenges in the project

Key Evaluation Findings

Were partners able to work effectively with each other?

Supports – MOU supports the partnership

Supports – Shared Working Guidelines

"I think everyone had a real shared commitment to make this project work. I never ever felt that people weren't really impassioned in this project, I really feel that people really, really wanted to see it succeed"

"certainly was a great feeling of cooperation and how can we help each other? Right from the beginning of the project"

How was the communication between partners?

Communication about the partnership

"It was an open forum, like I said, Fife as the lead, tried to bring as much transparency as possible, so it was really up to the partners to participate in that same framework to be able to work things out and I think we did work things out and it was sort of a being that was evolving. Halfway through the year, Fife brought us back and we looked again at the way we were doing things and made some significant changes."

Key Evaluation Findings-Coordinated Care

Have you been satisfied with the coordinated case management process as part

	Very satisfied	Satisfied	Unsatisfied	Very Unsatisfied
n	11	1	0	1
%	85%	8%	0%	8%

Key Evaluation Findings-Self-Reported Health

When you first entered the program, how would you have rated your health overall? And now?

	Poor	Fair	Good	Very good	Excellent
n	9	1	2	2	0
%	64%	7%	14%	14%	0%
n	2	2	5	4	1
%	14%	14%	36%	29%	7%

Key Evaluation Findings-Medication Use

Compared to before you started in the project, is your ability to take medication as prescribed by your doctor

	Worse now than when I started	The same now than when I started	Better now than when I started	I do not know	Not applicable
n	1	1	9	0	2
%	8%	8%	69%	0%	15%
Adjusted %	9%	9%	82%	0%	

Key Evaluation Findings-Changes in your life

Overall, compared to before you started in the project, would you say that your life is

	Worse now than when I started	The same now than when I started	Better now than when I started	I do not know	Not applicable
n	0	0	13	0	0
%	0%	0%	100%	0%	0%

Comments:

- 'Health improved a great deal and this is because of CC project, just started to get assistance with housing'
- 'Fife is better, resolving relationship loses, moving forward in relationship'

What have been the challenges? What remains as areas for improvement?

- Operational misalignment
- Funding and securing resources
  - Case management
  - Medical supports
  - Housing
  - Long-term care
  - Respite care
- Evaluation

For more information

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