THE NORTH AMERICAN HOUSING AND HIV/AIDS RESEARCH SUMMIT

Lessons Learned and Recommendations from the Implementation of a Multi-Agency Cross-Sector Collaboration Addressing the Needs of PHAs Who Are Experiencing Aging Related Illnesses, Accelerated Aging, Complex Care and Cognition Issues.

The North American Housing and HIV/AIDS Research Summit VIII:
Tackling the Social Drivers of HIV
September 15, 2015, Washington DC
Omni Shoreham Hotel

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HIV/AIDS Complex Care Pilot Project FAQS

Public Health Agency of Canada funded:

Two-year initial pilot project funding from AIDS Community Action Program (ACAP) 2012-2014; 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:

- Enhanced coordinated care & support in the community
- Extended respite & health stabilization
- 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 specialty hospital & community care **Casey House**
- Large, urban hospital **St. Michael's**
- Home health care agency **St. Elizabeth Health Care**

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.

Services 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 mental health/ABI/Addictions 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, MH Nursing, 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)
- Monthly Psychiatric Sessional and Clinic
-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 hospitalizations
-Transitions to long term care with supports

Client Profile January 2013 - Present

- 37 male and 3 female
- Medium age is 56
- 80 % of all clients had cognitive issues
- 72% with moderate to severe cognitive impairment
- 55% had concurrent mental health/addiction issues
- 100% of clients had three or more active health conditions other than HIV, **with close to 50% having five or more.**
- 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 to intake.
- Approximately 50 % of all clients at intake were Long Term Care Eligible

Client Outcomes

- 3 client deaths
- 5 clients have gone to LTC
- 2 clients have been discharged to other services
- 19 clients (close to) half as part of the Project have transitioned to higher supportive housing in Fife's new dedicated project units or other supportive housing units.
- 16 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 Implementation Evaluation Findings

The 'ask'-yes

Buying into the vision-yes

Successful partnership development-yes

Enhanced Model of Care development-yes

"I think everybody was willing to change and adapt based on the clients' need is. I think, for all of us, the clients' needs were different than what we were used to working with and I think people were really willing to adapt and provide the support needed in terms of what their service does, being flexible."

Key Elements that made the Partnership Work

Supports – Memorandum of Understanding and the partnership

Supports – Shared Working Guidelines/ Structures

Supports- Strong Back Bone Agency- Leadership/Vision

"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"

Challenges

High-level alignment vs. operational alignment

Challenges - Different world views

Challenges – with in-kind resources

"It's not been perfect, I think it's never going to be perfect when it is a situation where you're asking each and every agency to contribute significant in kind resources to make a project run because they still, they're still the internal priorities of each agency that can sometimes pull back some of those commitments."

Next Steps

- Operational misalignment- engage partnership in recommendations work plan.
- Limitations in-kind resources-securing ongoing funding:
  - Case management
  - Medical supports
  - High support housing model
- Expand project partnership and capacity
  - Long-term care
  - Respite care
  - Rehabilitation, and Geriatric
- Evaluation
  - Develop key performance indicators and outcome measures
  - Secure funding outcome evaluation

Thank-you

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