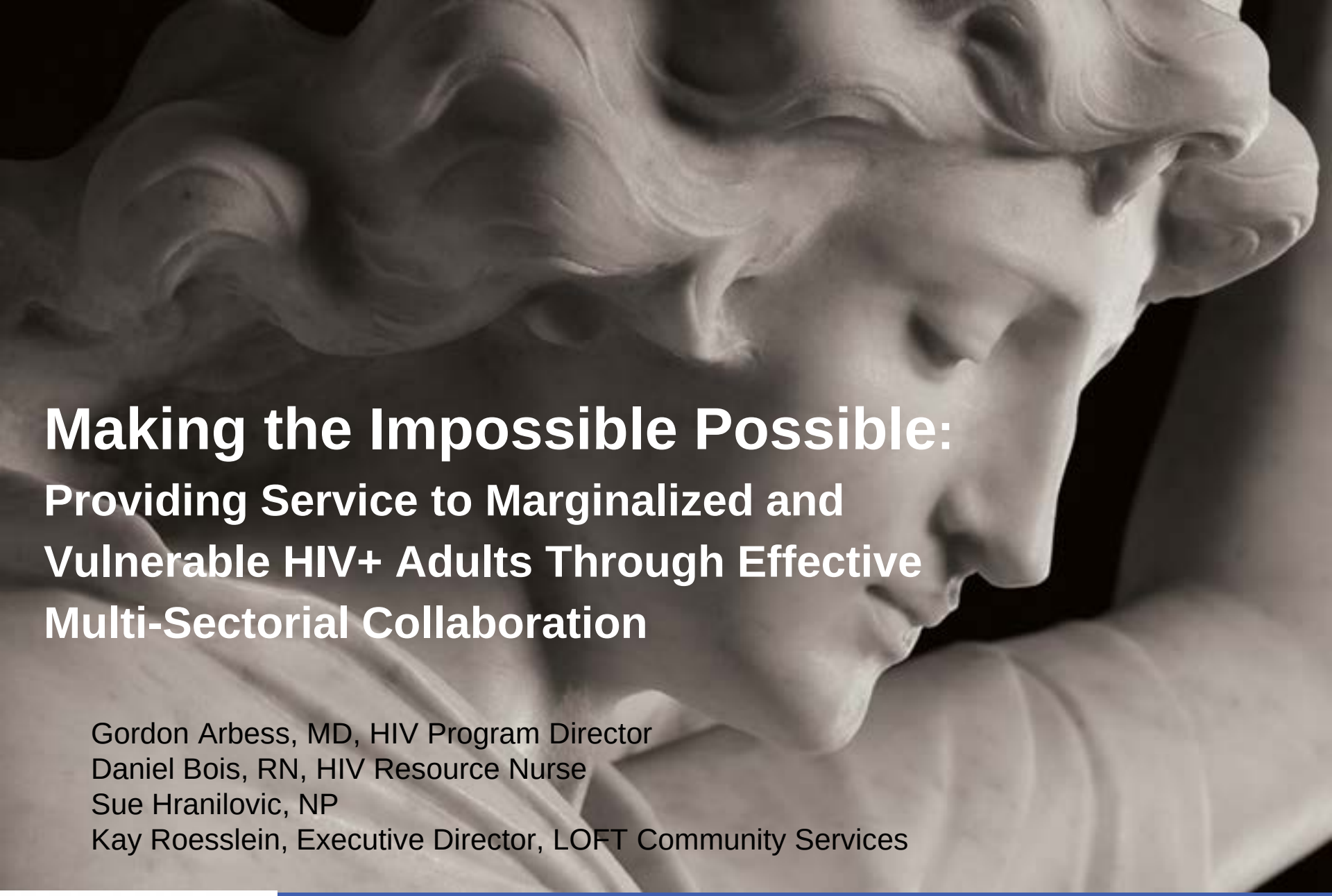

Making the Impossible Possible:

Providing Service to Marginalized and Vulnerable HIV+ Adults Through Effective Multi-Sectorial Collaboration

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Disclosure and Acknowledgement

We do not have an affiliation (financial or otherwise) with a pharmaceutical, medical device, or communications organization.

Relationship with commercial interests: None

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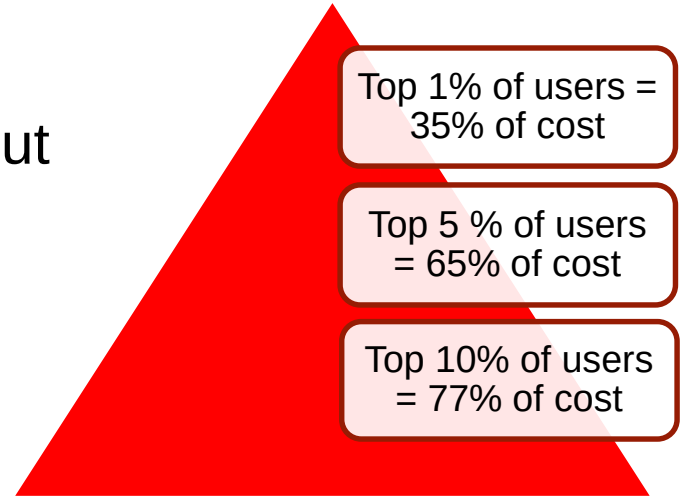
Setting the Stage: A Primer on Health Links

Health Links were designed to bring together existing health and support service providers to better integrate care and facilitate transitions between providers across the health care continuum for the patients with the most complex needs.

The top 5% of patients account for about two-thirds of health care spending and yet, this group often receive the most poorly integrated care.



The goal through care coordination, is to improve health outcomes for complex patients and improve the patient experience.

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Coordinated Care Planning & Management

Care coordination ensures that providers in the circle of care work together to support clients with complex health needs in reaching their health related goals.

Providers may include primary care, CCAC, MHA, CSS, hospitals, social services, housing, justice, as well as family and other supports.

Ideally the client experiences one team working together to provide seamless care.

Coordinated Care Planning & Management requires that all health care providers involved in a client's care:

- Understand the client's health related goals
- Work together with the client to develop a Coordinated Care Plan (CCP)
- Communicate on an ongoing basis to manage and update the client's care plan – providing Coordinated Care Management

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Target Population for Health Links

Target Population	Patients or clients with 4 or more chronic and/or high cost conditions		
Considerations	Consider patients or clients with: o Economic characteristics (low income, median household income, government transfers as a proportion of income, unemployment) o Social determinants (housing, living alone, language, immigration, community and social services etc)		
Identified Sub-Groups	Mental Health & Addiction	Palliative	Frail Elderly

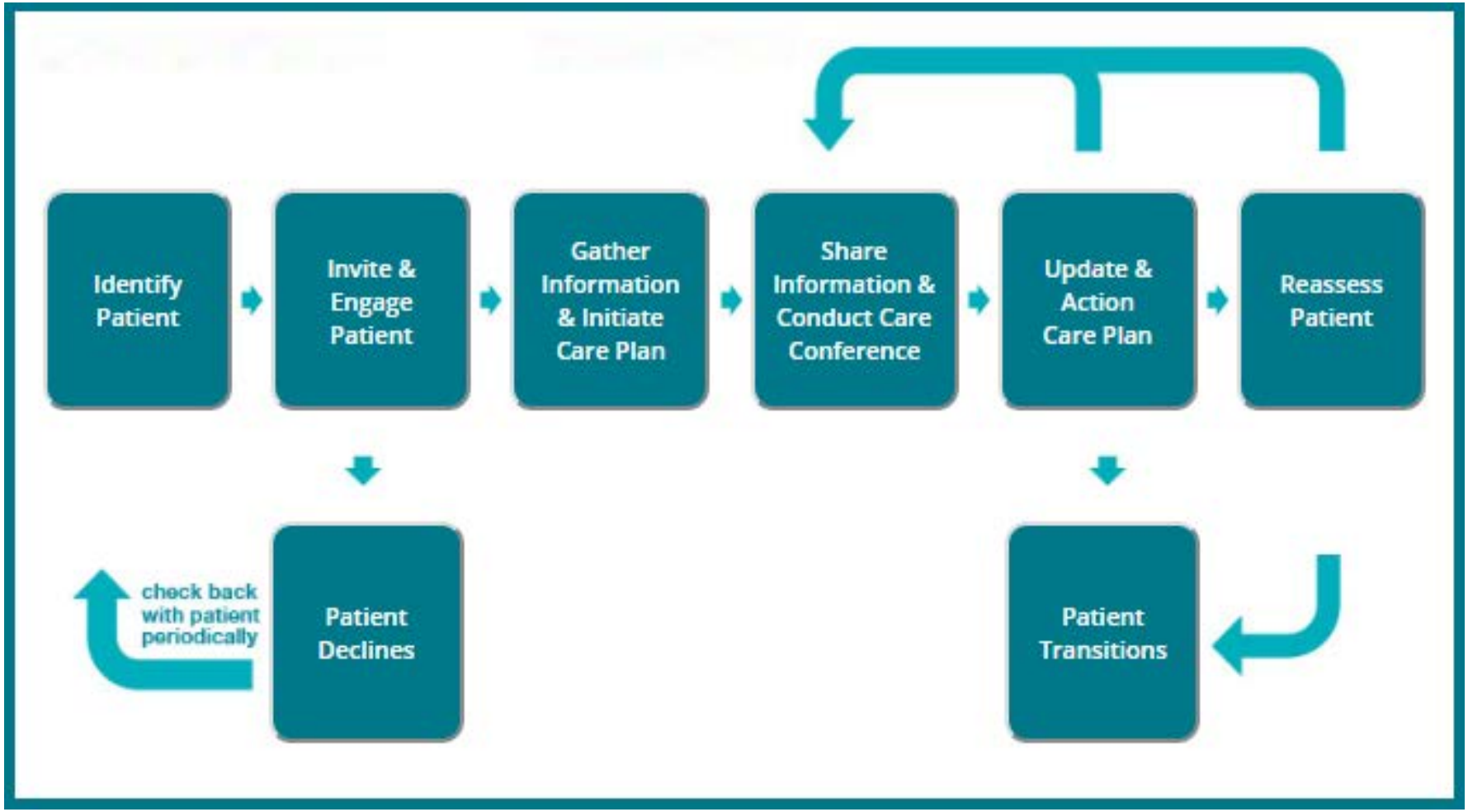
Chronic and/or High Cost Conditions Checklist

Chronic and/or High Cost Conditions – 4 or More					
	ALS (Lou Gehrig's Disease)		Amputation		Anxiety Disorders
	Arthritis and Related Disorders		Asthma		Bipolar
	Blood Disorders (anemia, coagulation defects)		Brain Injury		Cardiac Arrhythmia
	Cerebral Palsy		Chronic Obstructive Pulmonary Disease		Coma
	Congenital Malformations		(Congestive) Heart Failure		Crohn's Disease/Colitis
	Cystic Fibrosis		Dementia		Depression
	Developmental Disorders		Diabetes		Eating Disorders
	Epilepsy & Seizure Disorders		Fracture		Hernia
	Hip Replacement		HIV/ AIDS		Huntington's Disease
	Hypertension		Influenza		Ischaemic Heart Disease
	Knee Replacement		Liver disease (cirrhosis, hepatitis etc.)		Low Birth Weight
	Malignant Neoplasms (cancer)		Mental Health Conditions (unspecified/unknown)		Multiple Sclerosis
	Muscular Dystrophy		Osteoporosis Including Pathological Bone Fracture		Other Perinatal Conditions
	Pain Management		Palliative Care		Paralysis And Spinal Cord Injury
	Parkinson's Disease		Peripheral Vascular Disease and Atherosclerosis		Personality Disorders
	Pneumonia		Renal Failure		Schizophrenia & Delusional Disorders
	Sepsis		Stroke		Substance Related Disorders
	Transplant		Ulcer		

Chronic and/or High Cost Conditions Checklist

Social Economic Stress Factors		
Financial challenges		Homeless
Lives Alone		Housing Challenges
Homebound		Mobility Issues
No knowledge of English		Recent Immigration issues
Isolated-Limited social Network		Transportation Challenges

HQO Coordinated Care Management Process



Mandate: Coordinated Care Planning & Management

- The client and care team work together to develop a Coordinated Care Plan based on the client's goal for care – care team should always include the primary care provider
- CCP is documented and shared with the care team and client
- The client and care team watch out for transitions or crises requiring coordination
- Team communicates on an ongoing basis to manage and update the client's care plan as the client's needs change

Guiding Principles

Client Choice	• Ensure all components of the process are guided by the patient's choice to the greatest degree possible
Lead Care Coordinator	• CCPs coordinated by an assigned Lead
Partners in the Care Team	• CCPs supported by the right team members
Manage Transitions	• Team facilitates smooth and timely care transitions
Evolving Care Plan	• Team creates accessible, effective and evolving CCP & provides Coordinated Care Management

Mandate: Identify and Engage the Client

Identify appropriate clients based on the Health Link target population definition, and on who would benefit from coordination of care where:

- There are a minimum of two providers involved
- Providers need to work as a team ongoing

Engage clients to:

- Explain the coordinated care planning and management process and get their agreement to participate
- Begin to identify the client's health related goals
- Identify who should be the lead and who should be included in the care team
- Get the client's consent to talk to the other providers involved and to track the CCP process

Mandate: Care Team Roles and Responsibilities

The Lead Care Coordinator will:

- Be available to client for care coordination issues and concerns
- Be responsible for distributing and updating the care plan
- Communicate updates or new information to the care team
- Call the care team together when agreed to or when needed

Care team members will:

- Be responsible for providing updates of relevant information, or changes in the care plan to the Lead Care Coordinator
- Carry out responsibilities agreed in the care plan
- Agree not to withdraw from service without consulting with the care team

Why Partnerships and Collaborations?

- Overcomes barriers, creates access
- Identifies friendly/cooperative agencies & resources
- Improves internal and external communication and relationships
- Increases knowledge of available resources and services
- Improves coordination and streamlining of services
- Greater accountability
- Engenders comprehensive and holistic services
- Identifies gaps and unmet needs
- Avoids mixed messaging and splitting
- Provides funding opportunities for agencies
- Ensures “Best Practices”: Client centered and strengths based
- Improves health and wellness

Who Are We? Health Centre at 410

- St. Michael's Academic Family Health Team
- Web: www.stmichaelshospital.com/programs/familypractice
- Six sites within the Toronto downtown core
- Number of patients at 410: approximately 18,000 in a larger FHT of over 40,000 patients
- Number of **active** HIV+ patients: 1,191
- High propensity of disease burden
- Decreased access to all social determinants of health

Who are we?

- MDs
- NP
- RN (*)
- SW (*)
- Dietician (*)
- Pharmacist (*)
- Front desk and administrative team
- Specialty services: gynecology, gastroenterology, psychiatry, addiction medicine, diabetes, smoking cessation

*Funded in part by the AIDS Bureau of Ontario

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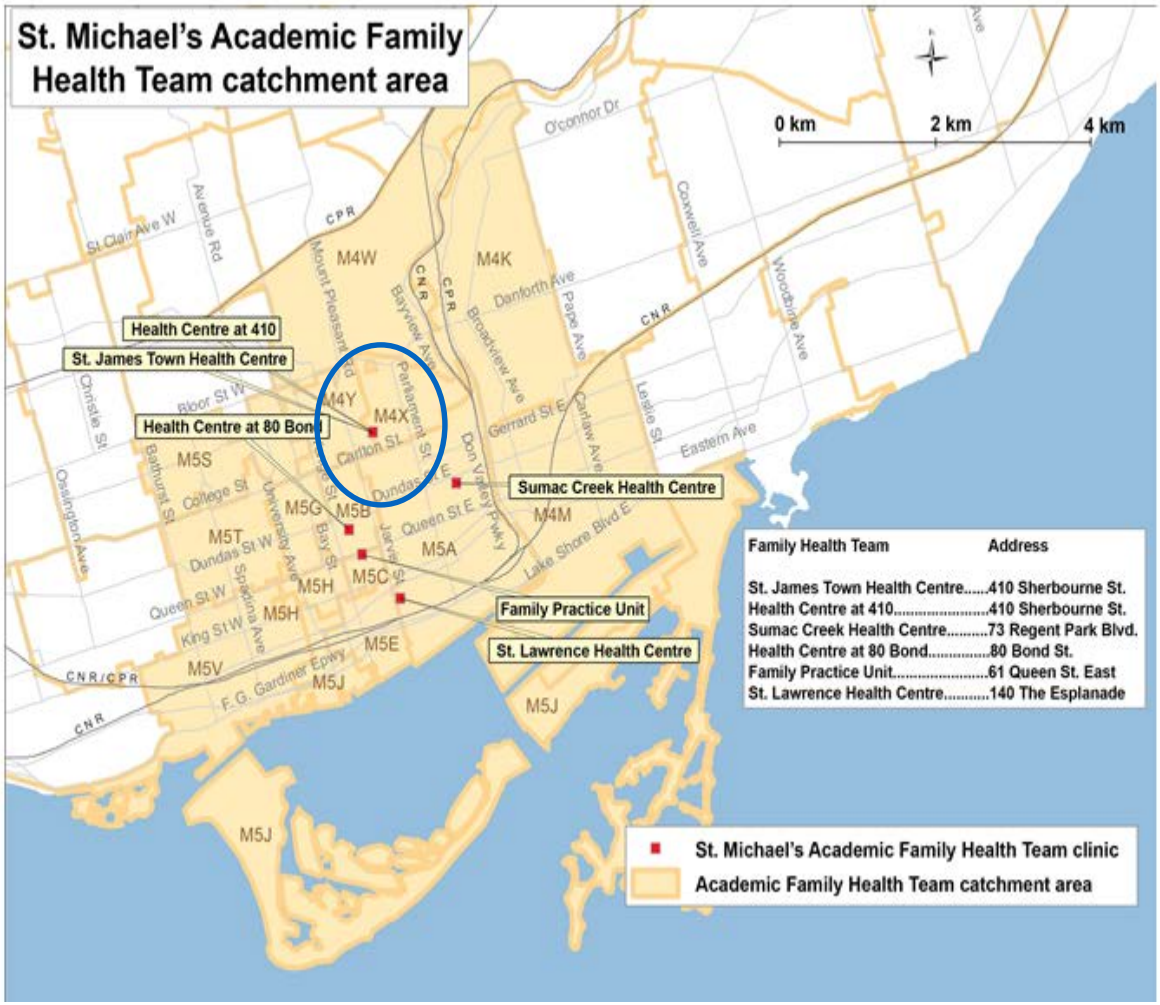
Our Neighborhood



Who Do We Serve?

- People who are precariously housed and employed
- People who are homeless and unemployed
- People living in poverty and isolation
- People living with multiple medical and psychiatric comorbidities
- People living with addictions
- People living with trauma, stigma, and discrimination

Our history with LOFT

Memo of Understanding (MOU) Development:

- In 2009, we joined the (Positive) Service Coordination Project for Homeless People with Mental Health and Addiction Challenges living with HIV/AIDS as a member agency.

- The MOU was renewed in 2013, and is currently undergoing a review and renewal process for 2017 with expanded partnerships and target populations, e.g. transgender population.

PSC: Formal Partners

1) 2-Spirited People of the 1st Nations
2) Casey House
3) Fife House
4) Fred Victor Centre
5) McEwan Housing and Support Services
6) Prisoners' HIV/AIDS Support Action Network (PASAN)
7) Seaton House Shelter, Infirmary Program
8) Sherbourne Health Centre, Infirmary Program
9) St. Michael's Hospital HIV/AIDS Psychiatry & Positive Care Clinic
10) The 519 Church St Community Centre, Trans Program
11) Toronto HIV/AIDS Network
12) Toronto People with AIDS Foundation (PWA)
13) Action Positive
14) Lativos Positivos
15) Africans in Alliance Against AIDS (APAA)
16) The Maple Leaf Health Clinic

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The Work of LOFT

The (Positive) Service Coordination (PSC) Project for Homeless People with Mental Health and Addiction Challenges living with HIV/AIDS

A multi-agency partnership coordinated by LOFT Community Services which exists primarily in the geographic Toronto East Health Links Neighborhood, and the objectives of this multi agency collaborative are:

- To increase access and continuity of services for both health and community support for People Living with HIV/AIDS who are homeless and are having physical health, mental health, and/or substance use issues.

- To increase coordination and integration of services for homeless PHAs between HIV/AIDS based community agencies, and services from the medical and mental health sectors, and shelter and housing services.

PSC: Services Provided 2009-2017

- Intensive Case Management
- Coordinated Referrals/Intakes
- Access to Acute Health Care & Respite Stays
- Community Nursing Case Management
- On-site Psychiatric Assessments
- Crisis Intervention
- Primary Health Care Supports
- Substance Use Supports
- Ethno/Cultural Support
- Benefits & Assistance
- ID clinics
- Access to Dedicated Housing Units
- Peer input opportunities
- Coordinated Care Planning (including Mid-East Toronto Health Links)

MOU Expectations for St. Michael's Hospital

- SMH HIV Psychiatry: psychiatric consultation contingent on confirmation of funding
- SMH Positive Care Clinic: 0.05 FTE (RN and/or SW support)
- SMH Emergency Department: rapid access to the Rotary Club and a social worker
- **410 Sherbourne commitment**: access to an HIV primary care physician for one unattached client per week
- **14 clients** from LOFT PSC received expedited access to HIV Primary Care from Sept 2016 – September 2017

SMH AFHT Intake Process

- Our FHT has made a commitment to decrease barriers to accessing HIV primary health care for this already marginalized patient population
- NO catchment area cut off for LOFT PSC patient referrals
- Centralized intake: ONE clerical administrator holds the referral “binder” for the program, hence one entry point for LOFT PSC staff and patients

SMH AFHT Intake Process

- LOFT case manager or the patient themselves can directly call this clerical administrator (thus avoiding front desk triage) and indicate they are part of LOFT PSC to trigger the process

- The patient will be offered the next new patient appointment with an HIV primary care doctor who is on our HIV rotating roster of providers

- HIV primary care MDs self-identify an interest to provide care to this underserved patient population and this interest is reviewed annually

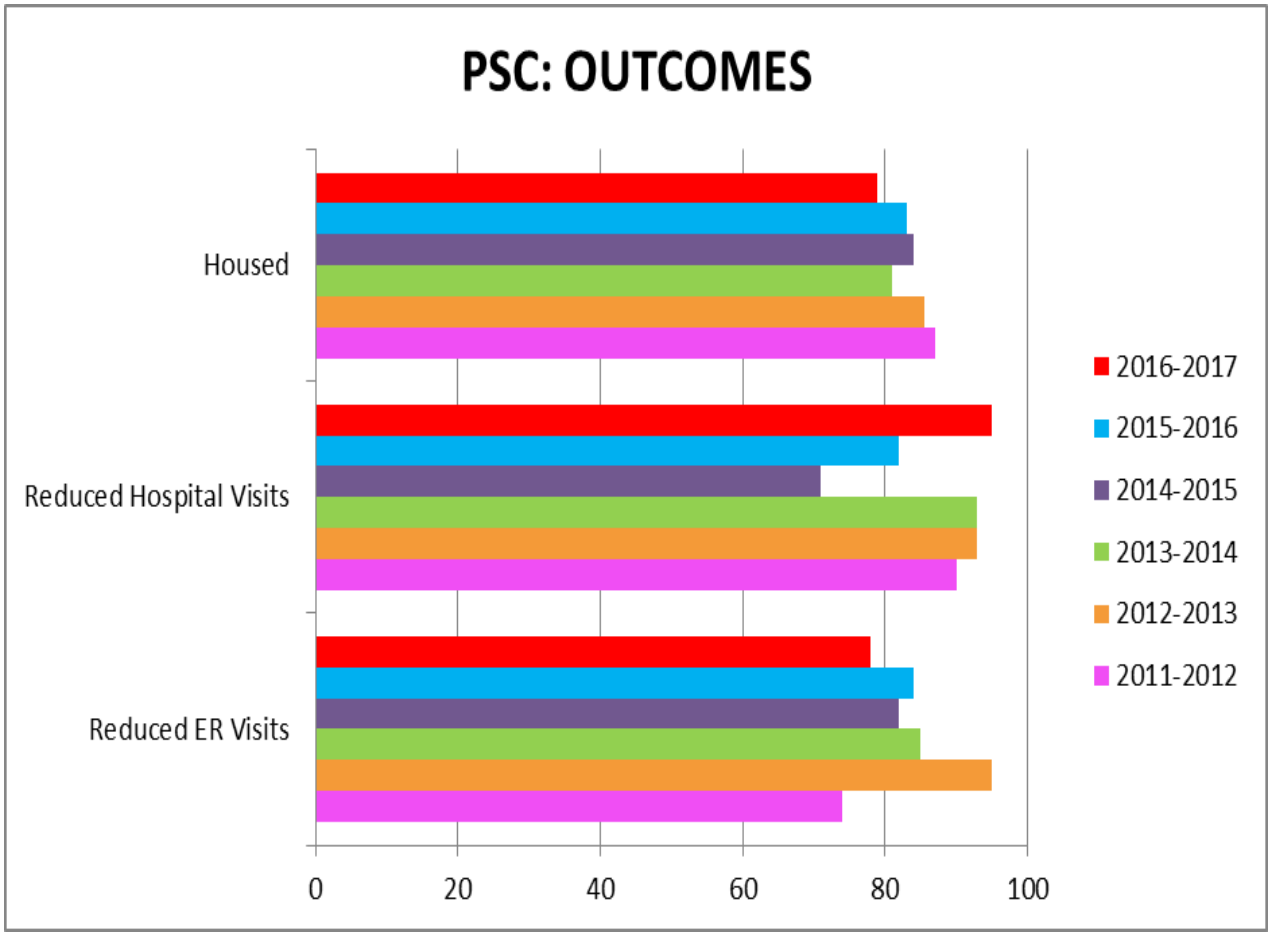
Challenges

- Our capacity to go into the community is limited, and we cannot always participate in CCP planning
- No case management capacity (at 410)
- Partner capacity
- Competing interests (HIV medicine incorporated into Primary Care)
- CCP not always available, or updated
- “This is not easy work”

Successes

- “I got a library card.”
- The coordinated care plan is a living document that is potentially accessible to all stakeholders
- Retention in care
- Improved quality life
- Reduction in pressure/burden and costs to the healthcare system
- Staff satisfaction with shared care

PSC Outcomes



Coordinated Care Planning

https://drive.google.com/file/d/0B1WUSRY3M00lcE9tdEFfTDVfUjg/view

Thank You!

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