Community based Transitional Care Model in HIV Care

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#IHISSummit
Session Objectives

• Implementation of a person centered care model with HIV/AIDS clients enabling clients to attain their optimum level of health from their perspective.
  • Understand how this person centered model minimizes client vulnerability and maximizes the control and dignity.

• Development of a community based model of care for HIV/AIDS patients transitioning from acute care to the community in a demonstrated lower cost model.

• Demonstrate the opportunity to build partnerships with local health authorities to deliver an alternative level of care in the community setting with enhanced results.
“These presenters have nothing to disclose.”

We are the Volunteer Board Chair and Vice Board Chair of this Non-Profit Community based organization

Sanctum Care Group Inc.
Sanctum

Definition - a place of privacy, a place affording peace.

- *Merriam-Webster Dictionary*
Who are we?

• We are a group of inter-agency professionals who work directly with populations affected by HIV, addiction, mental health, homelessness and poverty.

• We have formed a non profit, charitable organization called Sanctum
  – our goal is to provide stable supportive care through improved coordination of transitional care for patient living with Chronic disease burdens without the social or financial supports they require.
Who are we? – Our Volunteer Board

- Dr. Morris Markentin
- Corey Miller
- Dr Bruce Reeder
- Bishop Don Bolen
- Dr Peter Butt
- Dr. Lexy Regush
- Michelle Horvath
- Jaris Swidrovich
- Brad Paquin
- Patient representative
- Non voting – SPH and SHR representatives
Mission

“To provide care to people living with HIV/AIDS that is dignified, non-judgmental and unconditional.”
Vision

“Our vision is for a community in which individuals requiring this assistance are able to attain their optimum level of health from their perspective, minimizing their vulnerability and maximizing their control and dignity. Sanctum recognizes the need to provide care with humility and without prejudice”
Sanctum

Our mission and vision will be achieved with a philosophy of harm reduction and person centered care; demonstrated through Sanctum’s core values of compassion, collaboration and innovation.
Current Community Landscape

- Homelessness
- Mental Illness
- Addiction
- Poverty
- Multigenerational issues
- Hopelessness
- Stigma
- Lack of supportive care and coordination with community services and supports
Our Current Care Landscape

- Hospitals are geared towards acute care
- Lack of resources to deal with mental health issue
- Lack of on ward addiction services
- Lack of appropriate discharge planning
- Lack of addiction services in the ER
- Lack of Long Term Care and Personal/ Mental Health Homes willing to take HIV positive patients
- Lack of home care services in the inner city
1. Supportive Care

- Clients are admitted for supportive, sub acute or rehabilitative care from hospital with concurrent homelessness, mental illness and addiction or their level of care does not meet long term care or they cannot access homecare due to their current living situation.
- Generally up to 3 months.
- May involve wound care, home IV therapy.
2. Palliative Hospice Care

• Clients with HIV/AIDS requiring end of life care will be admitted as a priority. Palliative care would include pain control and symptom management

• The hospice aspect will allow clients to die in a familiar, supportive and peaceful setting
3. Respite Care

- There is 1 dedicated bed for clients who need to stay up to 14 days while either waiting for appropriate supports in their own home or requiring a temporary short term stay or post operative care.
Sanctum Residents

• Majority of residents reported history of sexual trauma, violence, emotional abuse, death of family member/close friend, serious accident or physical impairment, failed/dropped out of school, concurrent mental health, suicidal ideation, victim of crime, physical assault, parental abuse of drugs/alcohol, addictions and chronic homelessness

• Most reported involvement foster care, with justice system, income assistance, child and family services, health care system

• Average educational level gr. 8
Sanctum Residents – Outcomes

Better Health

• All residents saw an improved CD4 count on discharge
• All residents saw a decline in viral load, most achieving viral suppression
• All residents had increase in community supports including those related directly to their HIV including HIV physician, specialist and HIV Case Management on average 5 referrals a month
• 96% reported homeless on admission and all but 1 (due to personal choice) were housed on discharge
SANCTUM
(Providing Support to the Saskatoon HIV Population)
Welcome to Sanctum Video

*Sanctum Video.xspf*

- [http://youtu.be/w74GkSBOFoc](http://youtu.be/w74GkSBOFoc)
What have we “Learned” at Sanctum?

• It’s not about a disease – Chronic Disease Management
  – It’s about the care model
• Care Model
  – Patient Centered
  – Harm reduction
• Partner / Partner / Partner
  – Be everybody’s favorite community based partner
• There is more than one way to get it done
  – Just remember to keep moving the projects forward
What have we “Learned” at Sanctum?

• Transitional Care from Acute Care to Community
• Transitions in Care for marginalized populations need to be flexible and tailored to the clients needs.
  – Housing
  – Financial supports
  – Transportation
  – Home supports / home care
  – Health literacy and cognitive impairment.
  – Love and Compassion – listening to their needs
And we are still Learning

• Community Coordination post transition from Sanctum is very important
  – Coordination in Housing
  – Coordination in Care
  – Support group follow on care and support

• This Transitional Care Model for homeless and marginalized populations would be beneficial for most Chronic Diseases.

• Peer Support Groups – work both directions
Metrics Matter – to Sanctum and our Partners

• All Sanctum clients are consented to track their health data – pre and post sanctum
• Comprehensive review of client housing, financial, community support, healthcare utilization, and discharge follow up
• Population Health Observatory analysis and review – Proving the Model – to advance Health equity and fill the gaps in the system
Metrics Matter – to our clients

- Decreased viral loads
- Improved overall self assess of health status
- Decreased utilization of inpatient acute care beds and services
- Decreased emergency room visits
- Stable housing
- Follow up supports
- Connection to stable Community Primary Care
# The Sanctum Model – Funding Cost / Benefit Analysis

## Business Plan

## Original Business Plan – Cost/Benefit Analysis

<table>
<thead>
<tr>
<th>Summary of Sanctum Cost / Benefit Analysis</th>
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<tbody>
<tr>
<td><strong>COSTS</strong></td>
</tr>
<tr>
<td>Sanctum proposed expenditures</td>
</tr>
<tr>
<td>SHR ongoing expenditures</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
</tr>
<tr>
<td><strong>BENEFITS</strong></td>
</tr>
<tr>
<td>Emergency visits avoidance (40% reduction = 200 per year x $243 ea)</td>
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<tr>
<td>Reduced inpatient utilization (8 inpatients - 2,920 patient days)</td>
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<tr>
<td><strong>Total Benefits</strong></td>
</tr>
<tr>
<td><strong>Total SANCTUM   NET ANNUAL IMPACT</strong></td>
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The Sanctum Model – Funding Cost / Benefit Analysis
Business Plan – What actually happened

• We ended the first year with an approximately $127,000 surplus.
• Improved patient outcomes
• Improved patient experience

Actual 46% Cost of the acute care model
How did Sanctum go from a concept to reality

• Strong Vision / Strong Leadership / Right People
• Partnership with key Partners
  – St. Paul’s Hospital & Saskatoon Health Region
• Alternative Care Model
  – Lower Cost Model
  – Improved patient outcomes
  – Hospital Readmissions Reduction strategy
  – Emergency Department Avoidance strategy
• Cost Benefit Analysis / Business Plan
• And a little Luck – or Fate!!
What’s next for the Sanctum Care Group?

- Expansion of services and supports in HIV care:
  - HART Team
  - Beehive
  - Sanctum 1.5

- Supporting Marginalized populations with Chronic Diseases:
  - Everest Base Camp
  - MAPs – Managed Alcohol Programs
  - Bariatric transitional care home
  - Safe injection site / support clinic
Staff Training in April 2017 - program begins May 1st

HART HIV/AIDS Response Team
Landscape

• High incidence of multi substance abuse including increasing rates of crystal meth use
• High incidence of mental illness
• Many other issues pertaining to the SDOH which interfer with proper discharge planning and ongoing care
Issues

• People do not engage in hospital – are lost to care and lost to follow up whether they are discharged by medical staff or if by patient initiated discharge

• Patients do not stay on ARV’s, do not link into care and are lost until their next life threatening illness

• Patients often are not continued on their ARV’s and prophylaxis on admission for days
Issues

• Current environment in acute care in Saskatoon hospitals is not set up to deal with this set of chronic problems in this population
• Lack of training in mental health, addictions, SDOH,
• Ignorance = no continuum of care
• Stigma – Stigma – Stigma
HART Dreamteam!!!

• Will offer services to help deal with addictions, mental health, SDOH, discharge planning and ongoing care in the community with an emphasis on connection to primary care

• Will engage clients as early as possible on admission to ensure engagement and retention in care
HART

- Will create an environment of collegiality and support to the acute care team in hospital
- Will hopefully improve education to acute care environments on engaging PWID
- Will hopefully improve engagement and retention of HIV + patient into care and ARV treatment
Opening May 2017

The Beehive – the next logical step in HIV Transitional Housing – Sanctum Care Group

- Transitional apartment for residents of Sanctum
- Most are not ready to leave Sanctum at 3 months
- The beehive will provide 11 semi-furnished suites for residents to transition to where they can reside for up to 6 months at which point they transition to permanent housing
- One suite will be converted into a common space for community supports and peer group expansion
- The beehive will be supported by Sanctum, Aids Saskatoon and the community resources already working with the residents
- Step down approach to care acute-subacute-stabilization
• The Beehive will give residents the time needed after stabilizing at Sanctum to continue to gain life skills and support for effective transition into permanent and independent housing.

• The Beehive will coordinate the provision of services from community supports such as Aids Saskatoon Outreach, HIV Case Management, Mental Health and Addictions outreach and nursing support, Westside Community Clinic and the continued support of Sanctum and its staff.

• This approach not only benefits the client’s but utilizes existing supports and services more effectively and efficiently in one facility for improved service provision and support.
Phase 2

SANctum 1.5
Sanctum 1.5

- Prenatal home for moms living with HIV
- Fills the gap in services for these women
- Safe environment for mom and the unborn baby
- Transition to programs already in existence
- Improve process for working with other agencies before and after delivery
Goals

• To prevent vertical transmission of HIV to fetus
• Provide hope to the hopeless
• Provide a nurturing environment for mom and baby
• Prevent children from entering the foster care
Sanctum 1.5

• For the past 3 years we have had 7 to 10 HIV+ women pregnant at any given time

• We have not seen a HIV + baby in the Saskatoon Health Region since 2011 but we have had 3 positive babies born in the province of Saskatchewan in the last year.

• With the rise of crystal meth use in our PWID population we are seeing a rise in the disconnection to care
Sanctum 1.5

• We see the need for a 8 to 10 bed home in Saskatoon for women to provide pre-natal support
• There is currently no other services like this in Saskatchewan but many proven successful models across Canada
• Low barrier, high tolerance environment
• Providing basic needs as well as specialized medical, social, spiritual and cultural support
• Counselling support for addictions, trauma
• Support in life skills, prenatal classes and planning for the unborn baby to prevent foster care involvement
Sanctum 1.5

- Preventing first nations children from entering the foster care system all together by working with mothers prenatally to work on parenting themselves, locating healthy family or empowering women through engagement in the adoption process rather then the apprehension process
Sanctum 1.5

• Hope for the hopeless
• Help for the helpless
Supporting other Chronic Diseases with Transitional Care Models:

- Decreased hospital readmissions
- Reduced costs for acute care
- Less ER visits and lessening the burden on acute services
- Integrated care and reduced duplication of services
- Reduced fragmented and episodic care
- Improved care and quality of life for a population which has been underserved.
Everest Base Camp
COPD Transitional Care Home and Hospice
Everest Base Camp

• Base camp used for acclimatization to high altitude low oxygen environments

• Many with COPD feel like they at the top of Everest – air hungry

• Our base camp will allow them to acclimatize and rehab before moving back home
COPD

- Average cost per patient for hospital care $7,000/stay
- Cost of care Nationally for AECOPDs approx 700 million per year
- Sask estimated yearly inpatient cost $47 million
COPD

- Factors affecting readmission
  - Low socioeconomic status
    - Low income support
    - Unstable housing
    - Poor access to transportation
    - Poor access to food
COPD – other factors

- Severe depression (40%)
- Poorer psychological functioning
- Fatigue
- Anxiety
COPD – other factors

- Increased ER visits
- Poor access to primary care
- Episodic fragmented and reactive care
- Social isolation
- Physical restrictions
- Often Housebound
COPD – Readmissions

- Hospital discharge process
- Socioeconomic resources
- Access to care after hospital discharge
- Health care seeking behaviors
- Patient anxiety on discharge
- Self management education
Option 1- Permanent Housing

- The COPD home would offer these patients affordable housing with supports and services that would enhance their quality of life and reduce hospital utilization.

- Permanent supported housing to patients with COPD who also have housing instability, lack of supports and self-management skills and high rates of hospital utilization.
Option 2 – Transitional Care Home and 4 Permanent beds

• A COPD Alternative Care Facility with 10 transitional units and 4 permanent units. This facility would take people with COPD who are in hospital and transition them to this facility for up to one month.
Smoke Jumpers – COPD Outreach Team

- Smoke Jumpers - to provide highly-trained, experienced firefighters and leadership for quick initial attack
- Our COPD Outreach team will be highly trained experienced team to put out fires in our copd community – preventing admission to hospital
Registered COPD Nurse

- Will lead the team and coordinate response to needs of patients
- Will work with the ER department in assessment of needs related to COPD and social determinants of health
- Will work with the hospital team and specialist with assessment, treatment plans and discharge to COPD home
- Will liaison with primary care physicians to ensure timely and appropriate care in the community
Impact

• Decreased hospital readmissions
• Reduced costs for acute care
• Less ER visits and lessening the burden on acute services
• Integrated care and reduced duplication of services
• Reduced fragmented and episodic care
• Improved care and quality of life for a population which has been underserved.
Other Sanctum
Transitions in Care Projects:

- MAPs – Managed Alcohol Programs
- Bariatric transitional care home
- Safe injection site / support clinic
Sanctum Community Support

Sanctum PROUDLY part of the local Core Community

• Community Barbeques
• Work Bees
• Operations Santa
• A safe haven for those in need
Sanctum Community Support

Local Celebrity Challenge

• Raised Resources
  – Towards Sanctum 1.5
• Raised Public awareness
  – SANCTUM
  – Homelessness
SANCTUM CARE GROUP Inc.

Our People
SANCTUM CARE GROUP Inc.

Proud to be Advancing Health Equity
Better Health
Better Care
Better Value

For the Clients we SERVE