REHABILITATION IN A DAY HEALTH PROGRAM FOR ADULTS LIVING WITH HIV

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CASEY HOUSE

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Outline & Objectives

- ***Casey House*** – past to present
- ***Day Health Program*** overview
- ***Rehabilitation*** in the Day Health Program
- Integration of ***Research***

UNEQUIVOCAL COMPASSION

INFORMED CLIENT-DRIVEN CARE

DELIBERATE INCLUSIVITY

COURAGEOUS ADVOCACY

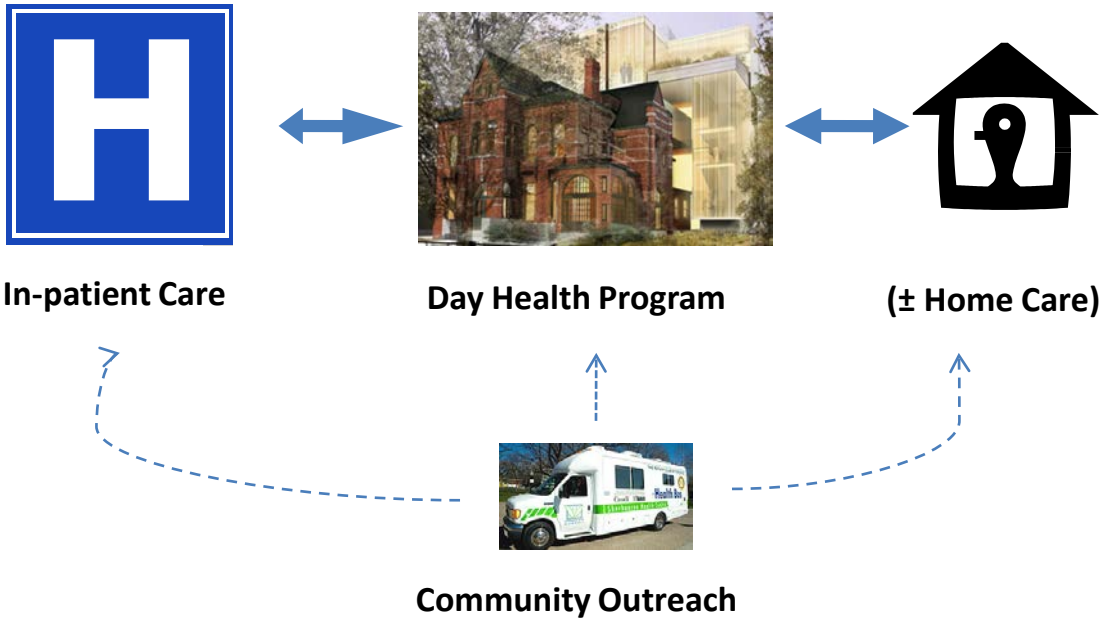
CREATIVE, MINDFUL COLLABORATION

RESPONSIVE INNOVATION

Casey House - *past*

- Est. 1988
- Initially exclusively end-of-life care
- 13 sub-acute care beds, home care, community programs
- Interdisciplinary care: medical, nursing, social work, rehabilitation therapists

Expanding the Continuum of HIV Care



Casey House - *present*

- New 58,000 sq ft purpose built facility
- 14 sub-acute care beds, ***day health program,*** home care, community programs
- Interdisciplinary care: medical, nursing, social work, rehabilitation therapists, case managers

Day Health Program

Time limited, goal-centred health services for adults living with HIV at risk for, or experiencing, deteriorating health.

Goals may include:

- to stabilize health issue(s)
- improve wellness, functionality, mobility, quality of life
- navigate health systems
- pain management
- substance use / harm reduction
- treatment adherence
- connections to community, peers, services, supports

Intensity of service & team members matched to client need

Avoid duplication of services

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RESPONSIVE INNOVATION

Day Health Program – Rehabilitation lens

- Physiotherapy*
- Massage therapy
- Wellness activities – e.g. yoga, stretching
- Health education programs – e.g. cooking

Integration of Research

- Participatory approach to evaluation (CIHR)
- 7 sessions held with clients; 1 session with staff; 1 session with administration

Top priorities for clients:

- Pain
- Mental health
- Purpose

Key Message #1

(Point to ponder)

There are increasing rates of multimorbidity and desire for non-pharmacological strategies for managing pain in people living with HIV, yet significant barriers to accessing rehabilitation remain.

- What evidence-based strategies or programs can we introduce in an integrated inter-professional health program to address pain?

Informing the Integration of Physical Therapy

- MScPT student project:
  - Interdisciplinary health professionals
  - PLHIV

DISABILITY AND REHABILITATION, 2018
https://doi.org/10.1080/09638288.2018.1448469

Taylor & Francis
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ORIGINAL ARTICLE

Check for updates

Where and how does physical therapy fit? Integrating physical therapy into interprofessional HIV care

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ABSTRACT

Purpose: To investigate the role of physical therapy in HIV care from the perspective of people living with HIV and health care professionals with expertise in HIV care.

Methods: We conducted a qualitative descriptive study using semistructured interviews (with health care professionals) and focus groups (with people living with HIV). We purposively sampled health care professionals and recruited people living with HIV in collaboration with an HIV-specialty hospital. We asked participants about their knowledge of and experiences with physical therapy, and perceptions of the physical therapy role in interprofessional HIV care. We analyzed data using content analytical techniques.

Results: Thirteen people living with HIV and 12 health care professionals conceptualized physical therapy as positively influencing independence and social participation, and as a valuable ally in interprofessional collaboration. The *Framework of Physical Therapy Role in HIV Care* consists of two components: (1) multidimensional and client-centered roles of physical therapy addressing physical, psychological and social health domains; and (2) contextual factors important to consider for the role of physical therapy: aging, episodic nature of HIV, multimorbidity, competing priorities, continuity of care, stigma, resource security and social isolation. The interaction between contextual factors and health domains can influence the role of physical therapy.

Conclusion: The role of physical therapy in HIV is multidimensional and client-centered. This Framework can be used by rehabilitation professionals working with people living with HIV.

ARTICLE HISTORY
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KEYWORDS
Physical therapy; HIV/AIDS; disability; rehabilitation; aging; client-centered care

Key Message #2

(Point to ponder)

Casey House clients conceptualized physical therapy as positively influencing physical and mental health, independence and social participation.

- In a complex client population how can physical therapy be delivered safely and effectively in groups settings, to increase capacity?

Promoting Physical Activity & Exercise

- MScPT student project
  - PLHIV & multimorbidity

Open Access Research

BMJ Open

Are you ready? Exploring readiness to engage in exercise among people living with HIV and multimorbidity in Toronto, Canada: a qualitative study

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ABSTRACT

Objectives: Our aim was to explore readiness to engage in exercise among people living with HIV and multimorbidity.

Design: We conducted a descriptive qualitative study using face-to-face semistructured interviews with adults living with HIV.

Setting: We recruited adults (18 years or older) who self-identified as living with HIV and 2 or more additional health-related conditions from a specialty hospital in Toronto, Canada.

Participants: 14 participants with a median age of 50 years and median number of 9 concurrent health-related conditions participated in the study. The majority of participants were men (64%) with an undetectable viral load (71%).

Outcome measures: We asked participants to describe their readiness to engage in exercise and explored how contextual factors influenced their readiness. We analysed interview transcripts using thematic analysis.

Results: We developed a framework to describe readiness to engage in exercise and the interplay of factors and their influence on readiness among adults with HIV and multimorbidity. Readiness was described as a diverse, dynamic and fluctuating spectrum ranging from not thinking about exercise to routinely engaging in daily exercise. Readiness was influenced by the complex and episodic nature of HIV and multimorbidity comprised of physical impairments, mental health challenges and uncertainty from HIV and concurrent health conditions. This key factor created a context within which 4 additional subfactors (social

Strengths and limitations of this study

- To our knowledge, this is the first qualitative study to explore readiness to engage in exercise among people living with HIV and multimorbidity.
- Using a qualitative approach with one-on-one semistructured interviews provided valuable insight into the perspectives, attitudes and conditions that influence readiness to engage in exercise among people living with HIV.
- Healthcare providers may use this Framework to consider the interplay of factors that may enhance or hinder physical activity among people living with HIV and multimorbidity.
- This study was conducted at a specialty HIV hospital in an urban setting in Canada; hence, it is unclear how the results may transfer to the experiences of people living with HIV and multimorbidity in low-income or rural settings.
- Additional factors, beyond those outlined in this study, may impact readiness to engage in exercise among people living with HIV and multimorbidity and further research should endeavour to explain the relationships between factors.

INTRODUCTION

As people living with HIV (PLWH) are living longer, they are susceptible to developing health conditions arising from HIV, long-term use of highly active antiretroviral

Key Message #3

(Point to ponder)

The complex and episodic nature of HIV and multimorbidity strongly influences readiness to exercise in people living with HIV and multimorbidity.

- How can we promote increased physical activity in people who are not ready to start exercising? And, how do community-based exercise programs need to be designed / modified for people living with HIV and multimorbidity?

Looking forward

- Refine and expand clinically driven interventions
- Program evaluation
- Research integration

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Table 1. Baseline characteristics of Casey House clients (April 1 2009 to March 31 2015) and HIV-positive general cohort

	Casey House clients	HIV-positive general cohort* (including 267/268 CH clients)
n	268	19765
Age (mean ± SD)	48.7 ± 10.1	46.0 ± 11.6
Sex n(%)		
Male	222 (82.8%)	15794 (79.9%)
Female	46 (17.2%)	3971 (20.1%)
Aggregated Diagnosis Groups (ADG)**		
0	1 - 5#	3,096 (15.7%)
1-4	3 - 7#	5,677 (28.7%)
5-9	47 (17.5%)	7,314 (37.0%)
10-14	129 (48.1%)	3,012 (15.2%)
15+	84 (31.3%)	666 (3.4%)
mean ± SD	12.5 ± 4.1	5.6 ± 4.3
median (IQR)	13 (10, 15)	5 (2, 8)

Table 2. Rates of Health care utilization in the year before and after Casey House client's first admission vs HIV-positive general cohort (April 1, 2009 to March 31, 2015 admissions)

Rate of Health Care Utilization (per person-years)	Casey House clients (n=268)	HIV-positive general cohort (n=19765)
	Prior to admission	Prior to index date
Rate of CCAC visits (per person-years)	27.25	2.95
Rate GP/FP visits (per person-years)	7.20	1.96
Rate of Specialist visits (per person-years)	21.46	3.69
Oncology	0.12	0.01
Psychiatry	0.93	0.18
Palliative	1.46	0.05
All other specialties	20.41	3.51
Rate of physician visits (per person-years)	28.66	5.65
Rate of emergency visits (per person-years)	4.86	0.68