# The PATHWAY approach – addressing the revolving door of homelessness and hospital

## Supporting homeless people in hospital to stay out of hospital

# Remit of Edinburgh Access Practice (EAP)

"To provide primary care services to patients who are homeless, at risk of homelessness or who have a severe and established difficulty in engaging with mainstream services"


Edinburgh
Access Practice
SPITTAL
STREET

# Multiple Exclusion Homelessness

- Health is socially determined
- Homelessness is a health issue
- Very poor quality of life, with high rates of multi-morbidity + social dislocation and isolation
- Life expectancy is short – 47 years
- Societal costs are high - £19,000 per year per person (conservative estimate, Hard Edges 2015)

# Health burden  in Homelessness

- 150 randomly sampled EAP patients, 78% men, Av. Age 39.4 yrs
- 86.7% of patients with a long term physical health problem – av. no. per person is 3 conditions
- 28 % suffer with chronic pain
- 87% with a long term mental health condition
- History of attempted suicide or self harm in 36%
- 73% drug use problem
- 37 % have a diagnosis of alcohol problems
- 70 % with triple morbidity of physical, mental health and substance use problems
- 33% with a recorded history of childhood abuse or neglect
- 30% had been in prison in the previous year
- Health profile comparable to that of a general population cohort in their 80s

# EAP admissions, Sept ’13-Aug ’14

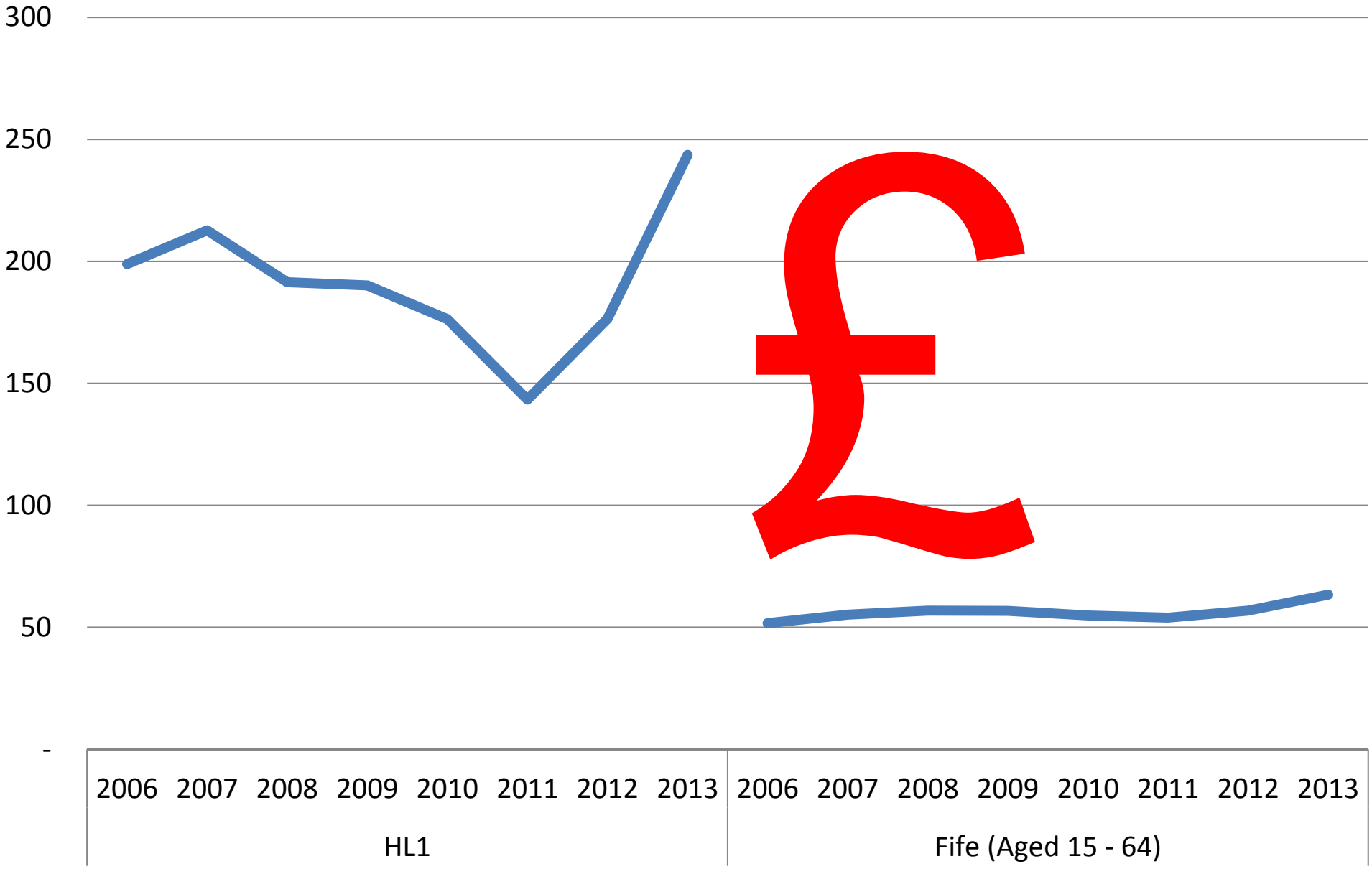
- 187 Patients admitted from a list size of approx. 600
- 534 Hospital admissions;
- 90 patients 1 admission
- 59 patients 2-4 admissions
- 25 patients 5-9 admissions
- 12 patients 10-14 admissions (Ave. 1.19 days)

# EAP hospital admissions

- Longest stay 161 days
- 3 admissions 3wks +
- 3 admissions 2-3 weeks
- Vast majority 0 or 1-2 days

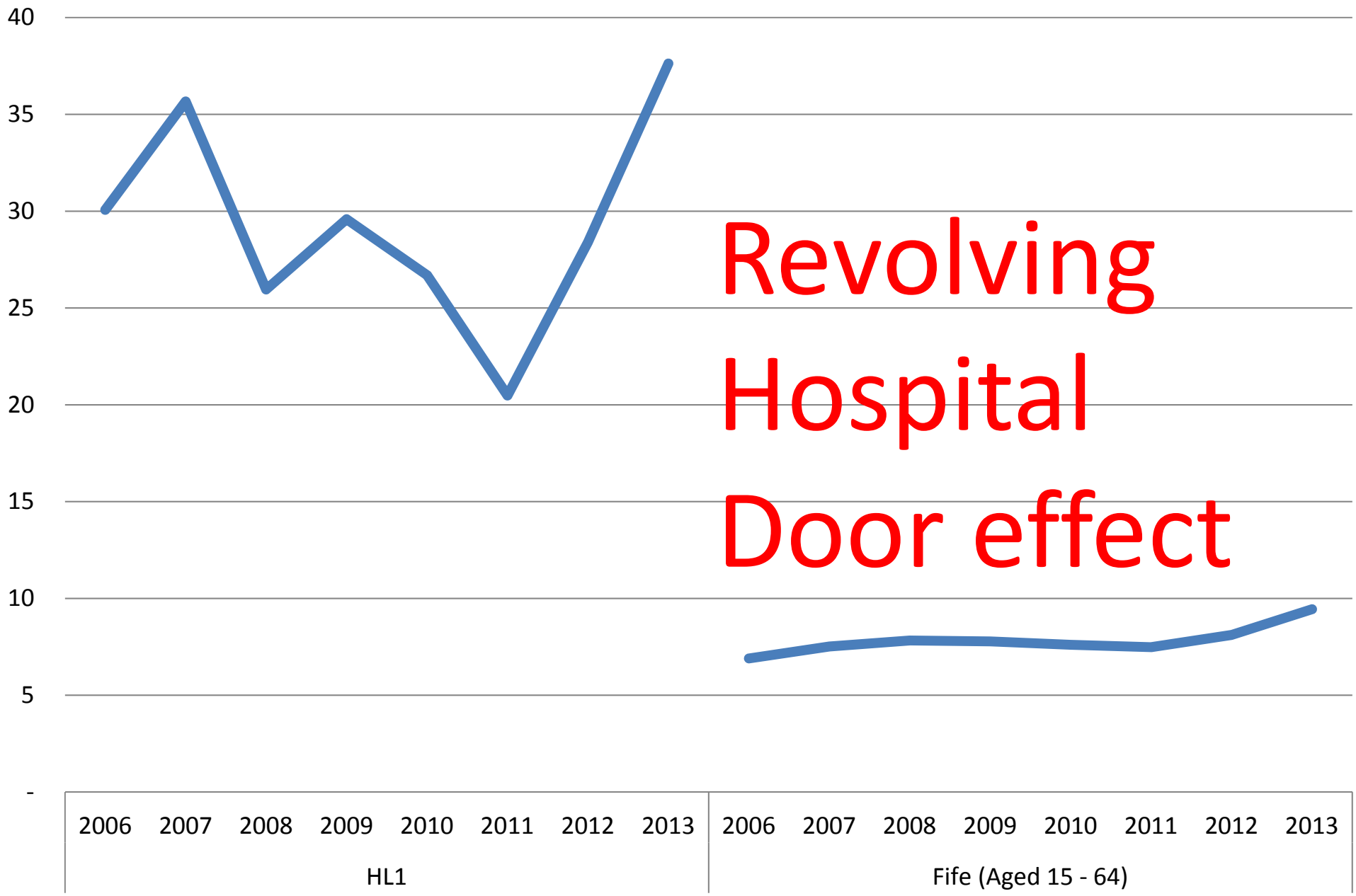
# Emergency Admission Rate per 1,000 Population

## Patients admitted to hospital as an emergency

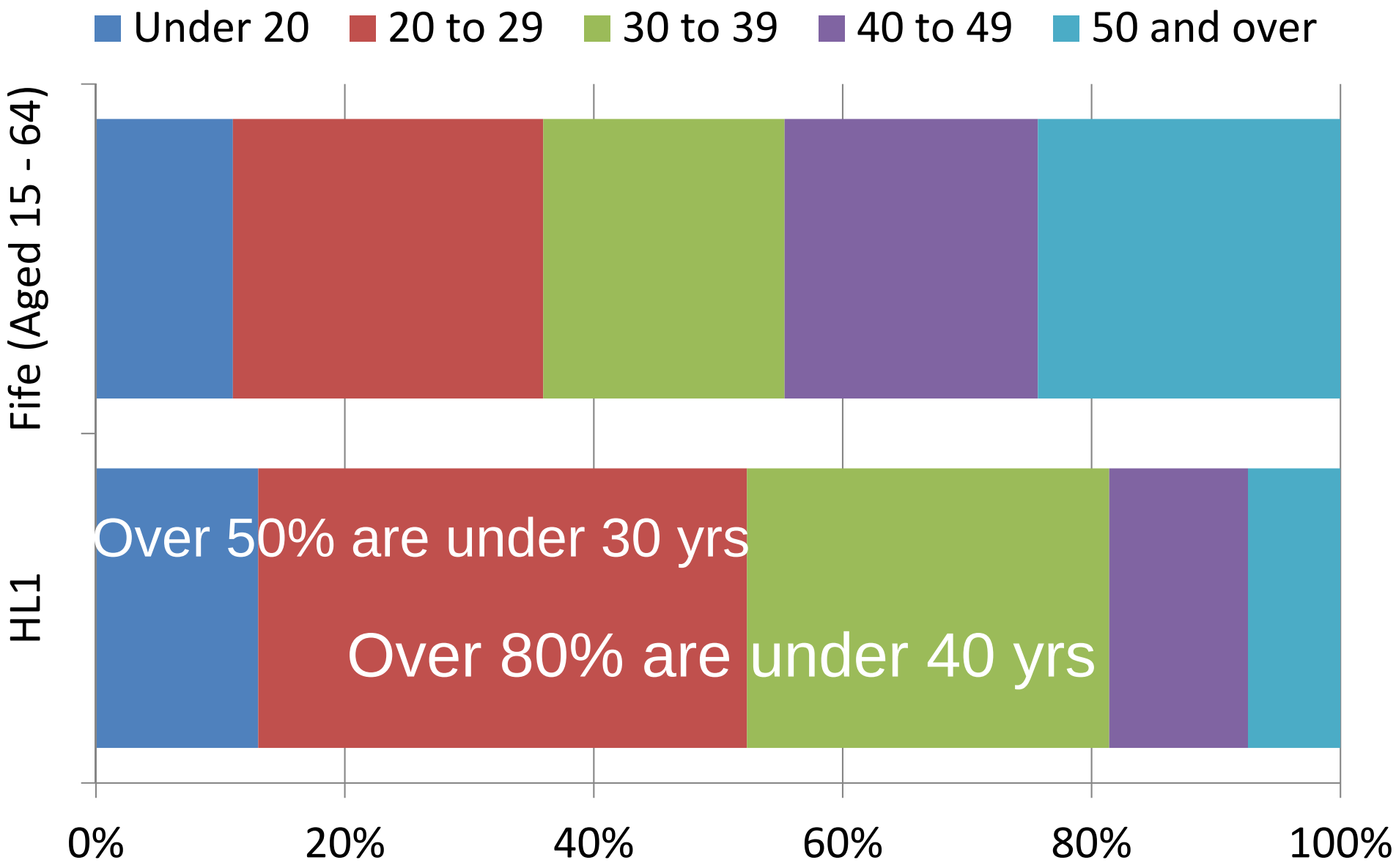


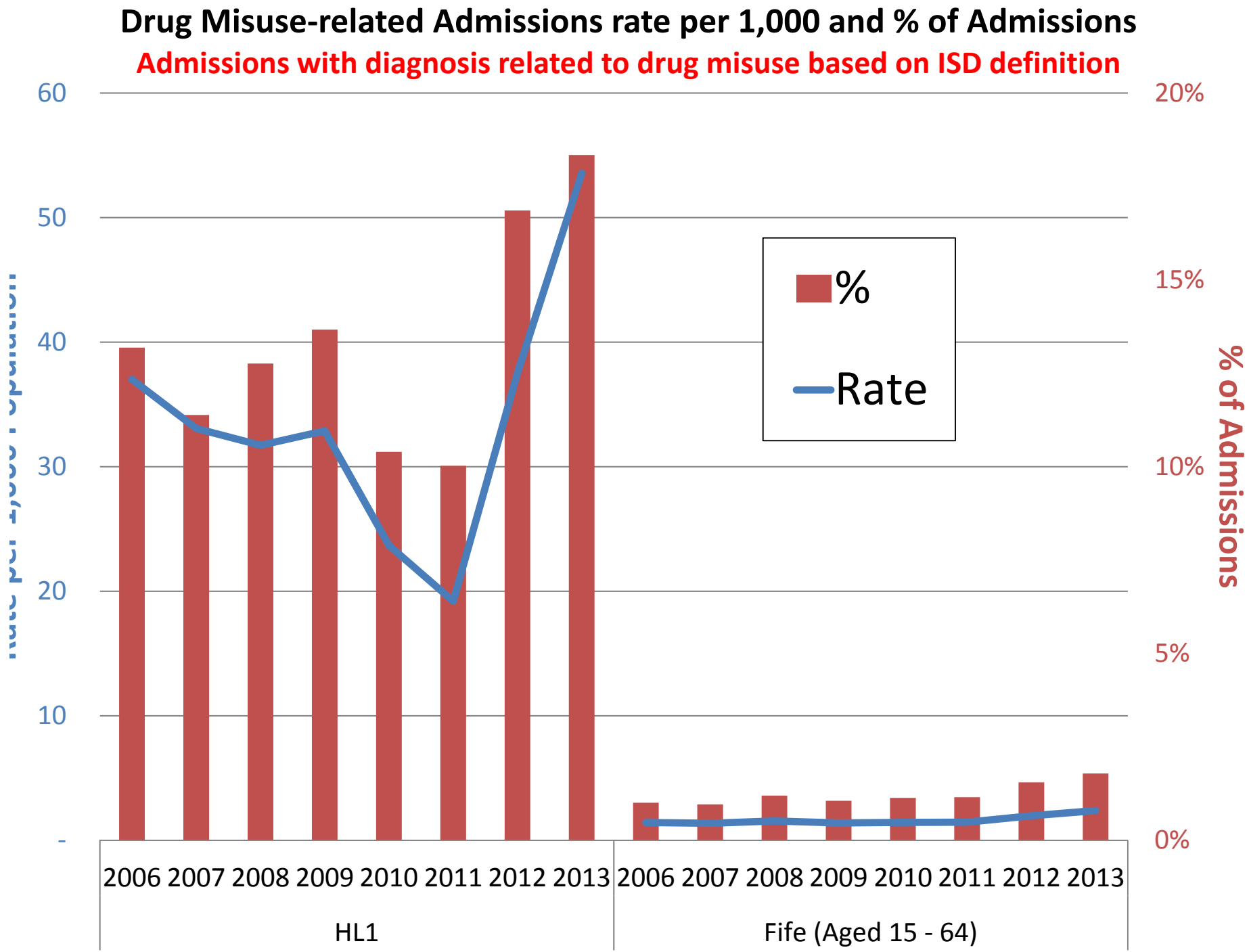
# Multiple Emergency Admission Rate per 1,000 Population

**Patients who have been admitted as an emergency more than once in specified year**



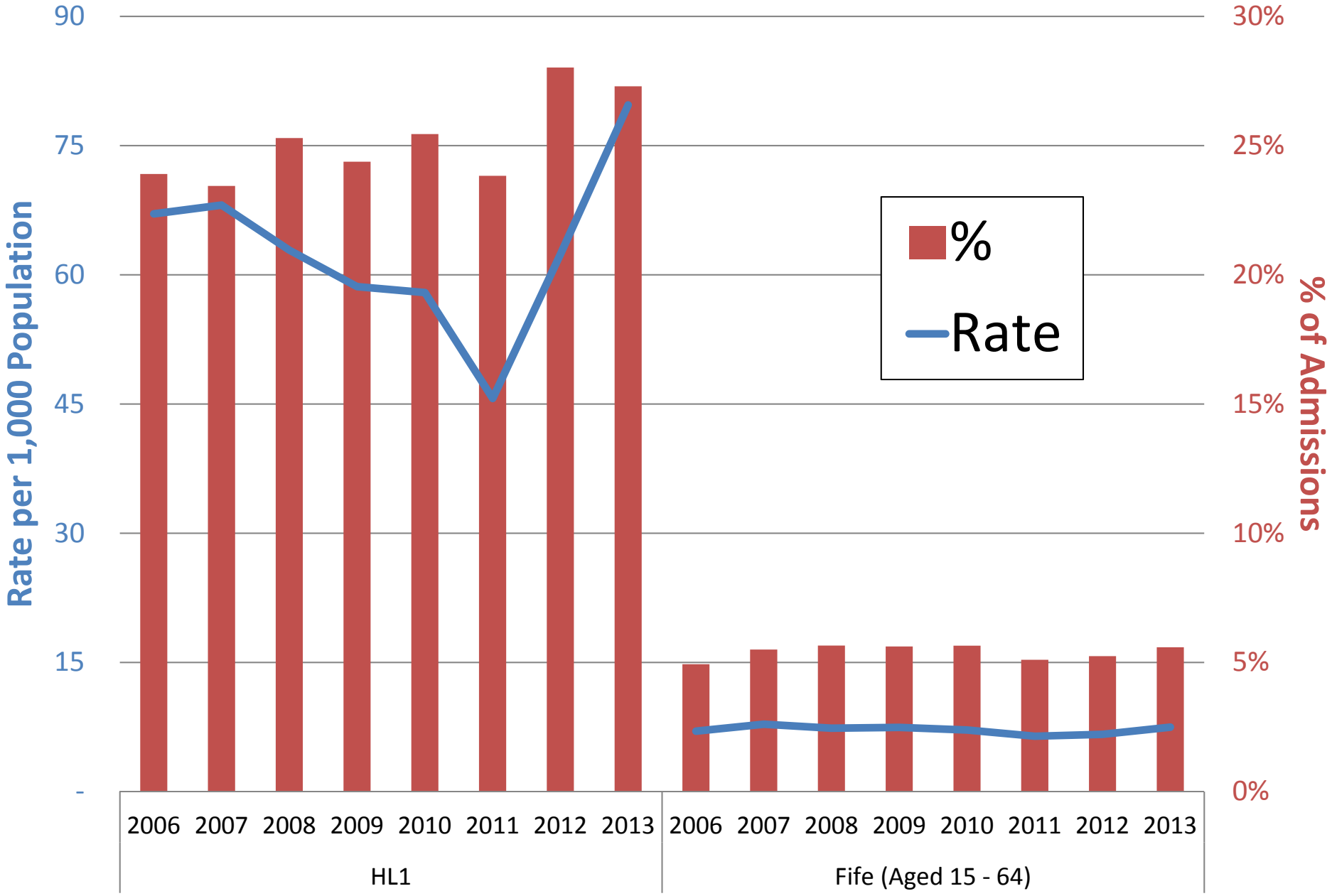
# Age Distribution of A&E Attendances; 2013




Drug Misuse-related Admissions rate per 1,000 and % of Admissions
Admissions with diagnosis related to drug misuse based on ISD definition
60
50
40
30
20
10
-
20%
15%
10%
5%
0%
% of Admissions
%
Rate
2006 2007 2008 2009 2010 2011 2012 2013
2006 2007 2008 2009 2010 2011 2012 2013
HL1
Fife (Aged 15 - 64)

## Alcohol-related Admissions rate per 1,000 and % of Admissions

Admissions with diagnosis related to alcohol based on ISD definition



**Psychiatric Admission Rate per 1,000 Population**

Admissions to Psychiatric specialty including readmissions, excludes Learning Disability

# Pathway aims

- Identify homeless in-patients
- Holistic assesssment inc mental health, addiction issues, physical and social needs
- Confirm housing status
- Liase with medical team + discharge plannng process
- Care co-ordination
- Ensure access to appropriate accommodation on discharge - arrange intermediary care/accommodation if needed
- Case management - proactively support patient in engaging with relevant community services inc health, benefits and tenancy support through transition period

# Pathway team

- 2 fulltime general nurses (band 6)
- 2 full time case managers/support workers
- ½ time housing advisor
- ½ time administrator
- 2 GP sessions/week
- Peer support workers

# Outcomes

- Improved social stability and safety
- Improved physical and mental health
- Appropriate length of hospital stays
- Reduction in recurrent hospital admissions
- Awareness raising, training and education role in hospital + community services

# London Pathway Outcomes

- Average duration of unscheduled admissions for homeless patients at UCL reduced by 3.2 days per patient
- Projected annual net savings of £300k for the health community following application of the London Pathway at UCH
- Appropriate durations of stay increased with double the number of homeless patients staying 6-10 days
- 30% reduction in annual bed days - savings mainly generated by reducing the number of homeless patients staying longer than 30 days from 14% to 3%
- Weekly multi-agency care planning meetings for complex homeless patients implemented
- Total proportion of homeless patients discharged with multi-agency care plans increased tenfold from 3.5% to 35%
- Care planning extended to include homeless frequent attenders at A&E and homeless patients referred for routine surgery
- Where liaison psychiatric assessments carried out, proportion summarised in discharge letter increased from 33% to 75%
- Where methadone treatment plans necessary, information in discharge letter increased from 25% to 100%