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”
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

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<th>Year</th>
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Multiple Emergency Admission Rate per 1,000 Population

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

Revolving Hospital Door effect
Age Distribution of A&E Attendances; 2013

Age of patient attending A&E

Over 50% are under 30 yrs

Over 80% are under 40 yrs
Drug Misuse-related Admissions rate per 1,000 and % of Admissions

Admissions with diagnosis related to drug misuse based on ISD definition

- Rate

%
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

The very tip of the mental distress homeless iceberg
Pathway aims

• Identify homeless in-patients
• Holistic assessment inc mental health, addiction issues, physical and social needs
• Confirm housing status
• Liaise with medical team + discharge planning process
• Care coordination
• 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%