Housing plus Healthcare

Pathways Hospital Admission and Discharge Pilot Project
A Summary of the First 12 Months Jan–Dec 2015

Micah Projects staff through the Brisbane Homeless Service Collaborative (BHSC) and St Vincent's Private Hospital Brisbane nurses have been working with partnering hospital units across the Royal Brisbane and Women's Hospitals and Princess Alexandra Hospital to establish the Pathways Pilot program. Pathways targets vulnerable populations who are homeless or vulnerably housed with multiple and complex health and social support needs prior to discharge from hospital.

Funding from Queensland Health for $239,000 per annum plus a small amount of additional resources from Micah Projects and the Mercy Sisters has allowed for the provision of 60 hours of nursing care each week, two days of project and clinical management, and operating costs.

130 Referrals Received (**88** Supported Longer-term + **42** Supported Short-term) **$2.14M P.A.** Net Cost Benefit based on the **88** participants

Outcomes & Benefits

…for Participants

- Housing stability
- Engagement with GP and social support systems
- Hospital avoidance
- Improved self-management

…for Health & Social Systems

- Is targeted
- Is person-centred
- Is evidence-based
- Fills a service gap
- Integrates health and housing
- Reduces ED presentations/hospital admission rates

Service Model

Pathways is a post-hospital discharge service designed to provide person centred admission and discharge planning, care coordination, direct nursing care and housing assistance in the community. A key objective of the Pathways initiative is to improve the services provided to homeless and vulnerably housed people when they are discharged from hospital. The pilot aims to reduce rates of potentially preventable hospital (re)admissions by integrating housing and healthcare outcomes.

Pathways nurses are integrated with Micah Projects–BHSC allowing for a stronger model of direct service delivery especially with regards to the provision of housing and crisis assistance.

Target Population

Vulnerability

- **2.24** Average years of homelessness
- **75%** use drugs or alcohol
- **74%** identify as having a mental health condition

Chronic Disease

- **35%** have Asthma
- **32%** have heart disease
- **25%** have liver disease
- **20%** have Diabetes

Police & Criminal Justice

- **7** Average number of police interactions in previous 6 months
- **38%** Rate of prior imprisonment

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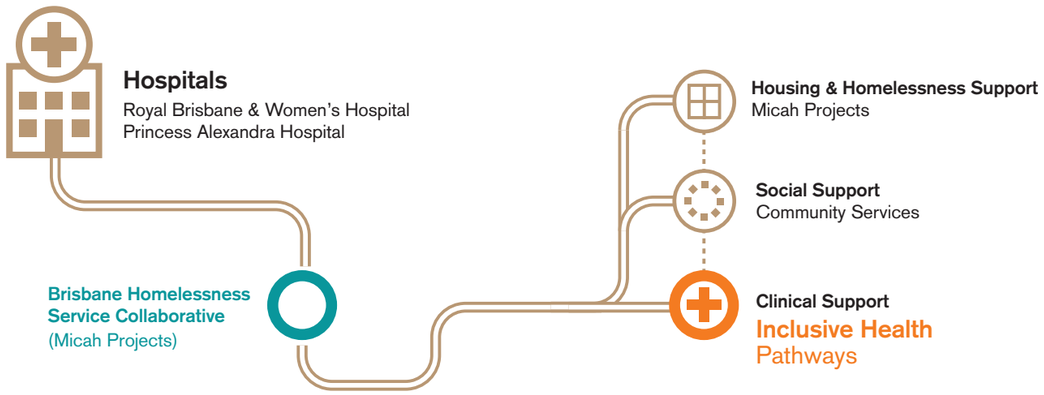
The Full Report

For a **copy of** 'Pathways Hospital Admissions and Discharge Pilot Project: Twelve Month Evaluation Report Jan 2015–Dec 2015' by Kim Rayner and Ross Westoby, please visit www.micahprojects.org.au/resources/publications

In 12 months…

Enhanced community/hospital partnerships
to improve health, housing and wellbeing for vulnerable individuals



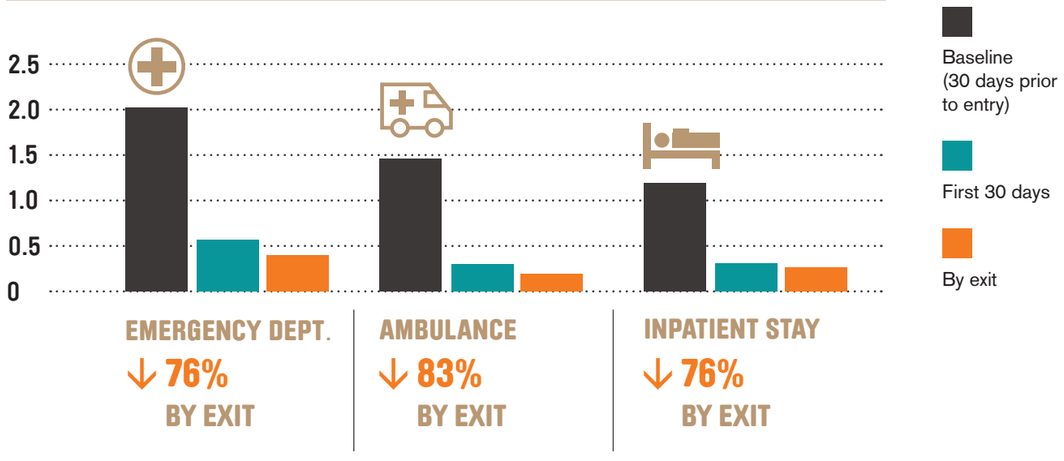
LINKED WITH
10 HOSPITAL UNITS
across Pathways partner hospitals

RECEIVED REFERRALS FROM
50 INDIVIDUALS
(discharge facilitators and social workers)

JAN 2015 → DEC 2015
47% → 73%
Increased proportion of Hospital Discharge Summaries received

Prevented unnecessary hospital (re)admissions and (re)presentations
to the accident and emergency departments while with Pathways

Average Number of Usages



Pro-actively worked to address housing, health and social support needs
through direct care, care coordination and assertive linkage to health, housing and community services

Health

3,246 OCCASIONS OF NURSING CARE
carried out by the Pathways nurses

518 REFERRALS
made to GPs, primary healthcare services and community support agencies.

Social Support

On Entry	By Exit	
25%	→ 98%	Accessing Community Support
69%	→ 93%	Connected with a GP

Housing

The majority of people at entry to the service identified the hospital as their main accommodation type followed by rough-sleeping and couch-surfing at the point of entry to Pathways.

At the point of exit from the service this shifted to more stable forms of housing with **no one sleeping rough.**

Exiting Pathways…

40/46 HOUSED*
in more secure forms of accommodation

* An audit of public housing applications in January 2016 identified an additional 8 people secured public housing not long after exiting Pathways.

Improved the ability of the person to manage their health
and avoid hospital admission where they had the capacity to self-manage

As they progressed through Pathways, participants increased their ability to manage their health with a majority gaining a comprehensive understanding of their health conditions and how to self-manage their health and medication requirements.

Feedback

OVERWHELMINGLY POSITIVE
feedback on services and support

Individuals felt they have been treated with dignity and respect and provided with the necessary nursing care, support, health education and housing assistance to address their needs.

"My experience with other services is that they look for reasons not to support people with the complexity of the person I referred. Pathways was the only service willing to pick him up."

– Hospital Social Worker

Benefits

FILLS A SERVICE GAP

Provides timely engagement while the person is in hospital and assertive follow up care post-discharge, and targets those most in need and with complex histories.

INTEGRATES HEALTH & HOUSING

Both clinical nursing and non-clinical staff are committed to providing targeted services that see housing as a health outcome and healthcare as a housing outcome.

SAVES MONEY AND HELPS TO FREE UP HEALTH SYSTEM CAPACITY

After 12 months of service delivery, data shows that unnecessary and costly hospital (re)presentations are being prevented through the assertive nursing care, housing assistance and linkage to needed medical and community services that the Pathways nurses and BHSC staff provide.

COST P.A.
$283,896

NET BENEFIT P.A.
$2,140,000[1]

1. *Pathways—Post Hospital Discharge Pilot Project for Homeless and Vulnerably Housed People: An Indicative Cost–Benefit Analysis* by Luke B Connelly (May 2016)

IS PERSON-CENTRED

Engages the individual prior to discharge or soon after through regular visits and phone communications. Aims to stay connected no matter what the challenge or behaviour exhibited.

IS EVIDENCE-BASED

Provides local evidence that a period of 3–4 months can stabilize a person's situation while facilitating access to ongoing supports as required. Contributes to the body of international evidence (incl. Pathway UK pathway.org.uk) on models of post-discharge care for vulnerable populations.

IS TARGETED

- Provides **assertive advocacy** and care coordination to overcome barriers to healthcare and housing services.
- Identifies health issues and poorly controlled physical and mental health conditions to be assessed and treated.
- Provides direct nursing when required in order to ensure care can be provided in a timely and flexible manner.
- Facilitates transition to a primary healthcare or community support service.

inclusive health
PARTNERSHIPS IN HEALTHCARE FOR ALL

Economic evaluation funded by
St Vincent's Private Hospital, Brisbane

ST VINCENT'S PRIVATE HOSPITAL
BRISBANE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

Summary compiled by
Micah Projects

MICAH PROJECTS INC
Breaking Social Isolation
Building Community