inclusive health
PARTNERSHIPS IN HEALTHCARE FOR ALL

Housing plus Healthcare

Pathways Hospital Admission and Discharge Pilot Project

Summary of the first two years Dec 2014 – Dec 2016

Micah Projects staff through the Home for Good Coordinated Access and Referral Team (CART) and St Vincent's Private Hospital Brisbane nurses have been working with partnering hospital units across the Royal Brisbane and Women's Hospital 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 the Queensland Department of Health for $229,266 per annum plus a small amount of additional resources from Micah Projects, St Vincent's Private Hospital Brisbane and the Mercy Sisters has allowed for the provision of 60 hours of nursing care each week, two days of project/ clinical management and operating costs.

Cost Savings

240 Referrals Received

(**150** Supported Longer-term + **57** Supported Short-term + **33** Diverted to other services or did not engage)

$3.62M (over 2 years)
Net Cost Benefit
based on the **150** participants

When resource-intensity of inpatient use is modeled, the estimates suggest that **Pathways may return as much as**
$7.25 per $1 spent.[1]

Outcomes and Benefits

…for Participants

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

…for Health and Social Systems

- Is targeted
- Is person-centred
- Is evidence-based
- Provides a strong return on investment
- 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 centered 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.

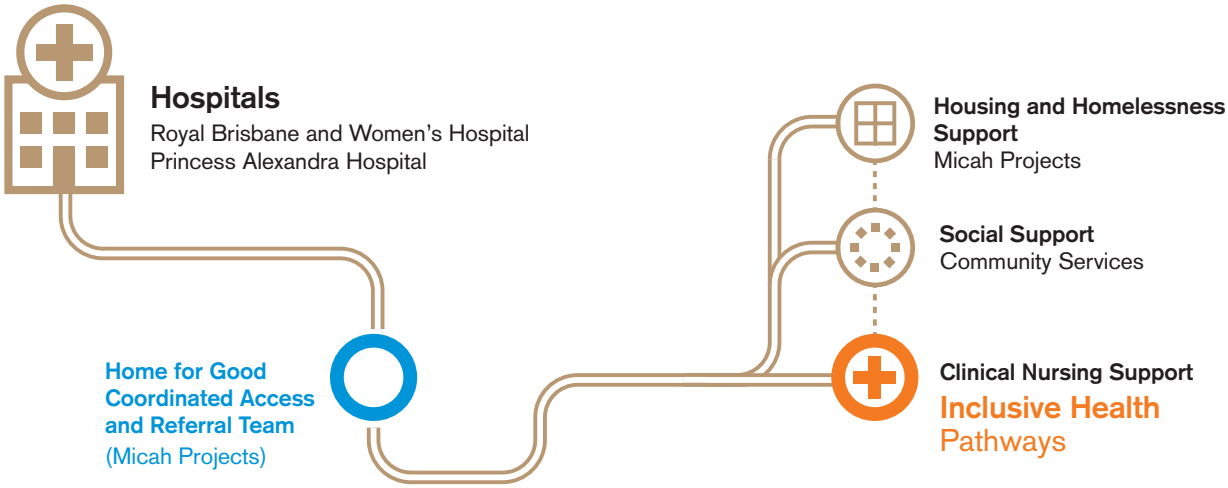
Pathways nurses are integrated with Micah Projects Home for Good Coordinated Access and Referral Team allowing for a stronger model of direct service delivery especially with regards to the provision of housing and crisis assistance.

1. *Pathways Hospital Admission and Discharge Pilot Project for Homeless and Vulnerably Housed People: Second Year Indicative Cost-Benefit Analysis* by Luke B Connelly, PhD and Angela M Maguire, PhD, February 2017

For a copy of the above report and *Addressing health inequality and housing needs: Pathways Hospital Admission and Discharge Pilot Project: Evaluation Report December 2014 – December 2016* by Kim Rayner and Ross Westoby, please visit www.micahprojects.org.au/resources/publications

In two years…

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



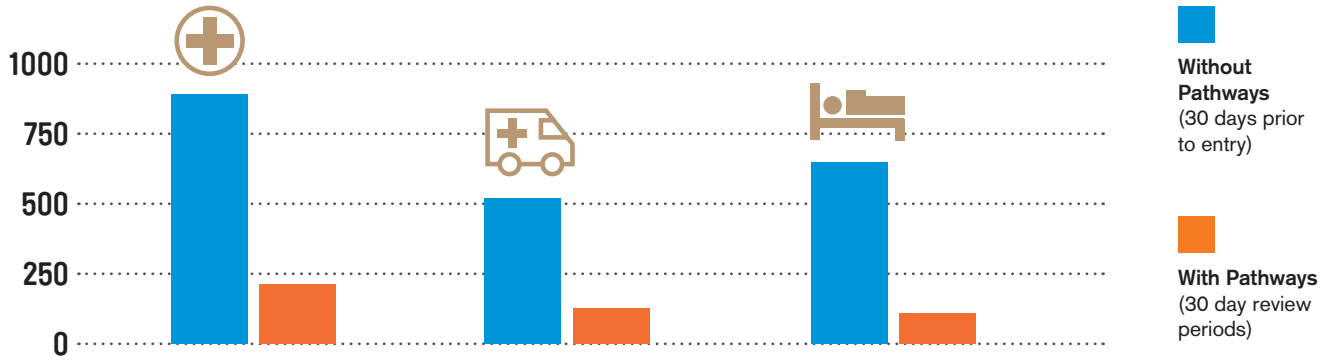
LINKED WITH
33 HOSPITAL UNITS
across Pathways partner hospitals

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

JAN 2015 → DEC 2016
47% → 64%
Improvements in the number of hospital discharge summaries received

→→ Reduced the cohort's hospital (re)admissions and presentations to the accident and emergency departments while in the Pathways program

Total number of ED presentations, ambulance transfers and inpatient admissions[1]



↓ 76%
REDUCTION IN EMERGENCY DEPT. PRESENTATIONS

↓ 83%
REDUCTION IN AMBULANCE USAGE

↓ 76%
REDUCTION IN INPATIENT ADMISSIONS

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

Health

6,389 OCCASIONS OF NURSING CARE
carried out by the Pathways nurses

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

Social Support

	On Entry	By Exit
Accessing Community Support	22%	99%
Connected with a GP	64%	93%

Housing

The majority of people at entry to the service (65%) were either rough sleepers, couch surfers, in emergency/crisis accommodation or identified the hospital as their accommodation type. **At the point of exit from the service this shifted to more stable and secure forms of housing such as public and community housing.**

→→ 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.

Target Population for Pathways

Vulnerability

- **2.25** average years of homelessness
- **71%** use drugs or alcohol
- **87%** identify as having a mental health condition
- **46%** receive a disability support pension

Chronic Disease

- **33%** have asthma
- **31%** have heart disease
- **25%** have liver disease
- **19%** have diabetes

Police and Criminal Justice

- **5.8** average number of police interactions in previous 6 months
- **32%** rate of prior imprisonment

Feedback

OVERWHELMINGLY POSITIVE

feedback on services and support

Individuals feel 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.

"They made me feel that I had been given back my dignity, and my self-worth as an individual."

– Pathways Participant

"The staff have dealt with my most complex and challenging patients with respect, dignity, hard work and a sense of humour. I can think of three extremely challenging patients who would still be sitting here in an acute hospital if it wasn't for the Pathways program... ."

– 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 AND 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 two years of service delivery, data shows that unnecessary and costly hospital (re)presentations and inpatient stays are being prevented through the assertive nursing care, housing assistance and linkage to needed medical and community services that the Pathways nurses and Home for Good staff provide.

COST over 2 years
$579,836

NET BENEFIT over 2 years
$3,620,000[1]

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.

EVIDENCE-BASED

Confirms local evidence that an average intervention period of four 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 in the community for vulnerable populations.

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 care in a timely and flexible manner.
- Facilitates access and transition to a primary healthcare or community support service.

For more information contact

- **Karyn Walsh**, CEO, Micah Projects | 0413 619 785 | karyn.walsh@micahprojects.org.au
- **Kim Rayner,** Manager, Inclusive Health | (07) 3029 7000

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PARTNERSHIPS IN HEALTHCARE FOR ALL

Economic evaluations funded by St Vincent's Private Hospital, Brisbane and Micah Projects

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