Addressing health inequality and housing needs

PATHWAYS
Hospital Admission and Discharge Pilot Project with Home for Good

Evaluation Report
December 2014 – December 2016

Kim Rayner and Ross Westoby (February 2017)
Participant Feedback

“Kept me focused and balanced when I wasn’t.”

“Pathways has given me the help, support, ability and kindness to make my journey easier. And I’m thoroughly grateful for their help kindness and understanding.

“100% difference, they were there for me.

“They made me feel that I had been given back my dignity, and my self-worth as an individual. Think Pathways made a difference to my life.

“I have gone from homeless to living in a beautiful unit with lovely places.

“Assisted me greatly with my health and getting my life on track.

“Everything, helped me so much.

“Improved life heaps, feel markedly better. Previously I would have been ranting and raving and now I’m calmer. Wish I had met you people years ago it would have made a big difference to my life.

“Gave me confidence to live in the community and get on top of my health.

Ross happy in his new home.
Hospital Pilot Site Feedback

“...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 and if confidentiality allowed, I would happily share their stories. The Pathways program has been instrumental in improving the quality of life for these people in the most trying of circumstances. There is no other service providing the link between hospital and community like they do for this very vulnerable and stigmatised group of patients.

Increased discharge speed. Reduced work from my point of view in locating services that are appropriate. I know Pathways is a good option for this cohort.

Without the Pathways program the hospital will be “stuck” with extremely challenging patients with complex discharge needs. Patients themselves will have no ongoing support to bridge the transition from hospital to community.

Faster discharges, more successful discharges; sustained healthcare and improved well-being for patients/clients. Reduced risk for readmissions.

...The Pathways team have been a good link for people that have fallen into gaps in the health system and will sometimes go above and beyond to not give up on engaging with the people that are in the gap.
Acknowledgements

The authors and the Inclusive Health Management team would like to thank partnering hospital staff, steering committee members and community organizations for their collaboration and support of this pilot project. Their commitment to working in partnership with Pathways staff to ensure better outcomes post hospital discharge for some of Brisbane’s most disadvantaged individuals has contributed significantly to the outcomes achieved.

A big thank you to the Pathways nurses - Sue Andersen, Jenna Vandyk and Anna Strikis who have worked tirelessly to support and deliver high quality nursing care and care coordination to every participant and to also facilitate housing access and stability with members of Micah Projects Home for Good – CART team. Thank you also to Micah Projects CART Team, Maria O’Connor for her work in conducting the stakeholder feedback surveys and supporting project management functions and other Micah Projects teams who have supported the pilot service.

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Executive Summary

The Pathways Hospital Admission and Discharge Pilot Project commenced on the 1st December 2014 and has achieved positive health outcomes for participants across hospital avoidance, housing, GP engagement and improved self-management over the two-year, one-month period. The Pilot receives $229,266 per annum of funding from Queensland Health to provide 60 hours of community nursing per week with an additional 15 hours dedicated to project and clinical management functions. Pathways nurses are integrated with Micah Projects - Home for Good – Co-ordinated Access and Referral Team (CART) allowing for a stronger model of service delivery.

The Pathways team provides person centred admission and discharge planning, care coordination, direct nursing care and housing assistance to people being discharged from hospital who are homeless and/or vulnerably housed with multiple morbidities and complex social needs. While filling a service gap, the pilot has also significantly reduced rates of hospital (re)admissions and emergency department presentations by integrating assertive housing and healthcare interventions that are targeted and proactive in their approach. The Princess Alexandra Hospital (PAH) and the Royal Brisbane and Women’s Hospital (RBWH) have been the two pilot partnering hospitals. Since December 2014, 240 referrals have been received from all hospitals through Micah Projects intake process, with 217 of these coming from the PAH and RBWH through established partnerships within each hospital unit and alignment with their discharge processes and social work staff.

One Hundred and fifty homeless and vulnerably housed individuals with multiple and complex needs have received a longer term targeted post-hospital discharge service. These 150 people form the basis of this report with regards to outcome reporting. An additional 90 people were provided with a shorter term response by CART and the Pathways nurses through targeted interventions and/or diversion to more appropriate services.

From December 2014 to December 2016 reporting period, we have had:

- 150 Pathways longer term participants (32% female and 68% male) who form the basis of this report;
- 91% of those had medium to high acuity levels according to the VI SPDAT (level of vulnerability and need) highlighting that the service is reaching those most in need and the intended target group. Of those surveyed, the average period of homelessness was 2.25 years; 71% use drugs or alcohol; 87% identify as having a mental health condition with a tri-morbidity rate at 59%.
- High rates of chronic disease exist where 33% have asthma; 31% have heart disease; 25% have liver disease and 19% have diabetes.
- Involvement with police and the criminal justice system is high with Pathways participants having had an average of 5.8 interactions with police in the six months prior to service entry and rates of prior imprisonment are 32%.

Service Provision Activity:

- Between December 2014 and December 2016 a total of 6,389 individual occasions of direct nursing care has been provided which is an average of 261 occasions of direct nursing care per month.
- 55.3% of service delivery occurred on the North side of Brisbane, 44.3% was on the South side of Brisbane and 0.4% was outside the Brisbane LGA.
→ A total of 31,830 direct care activities were undertaken by the nursing staff over the two-year period. The top twelve direct care activities were: Advocacy (14.0%); Client Care Coordination/Collaboration (12.7%); Post-discharge follow-up nursing care (12.3%); Post-discharge care coordination planning (7.1%); Engagement (6.1%); Secondary consultation (6.1%); Self-management education and assistance (5.4%); Assessment (5.1%); Chronic Condition Management and Planning (3.6%); Health Education/Promotion (3.5%); Counselling (2.9%); and Housing Assistance (2.8%).

Referrals:
→ 829 referrals (over the two-year evaluation period) were made to other health and welfare services, the most frequent being to GPs; Micah Projects Street to Home Team; H2H After Hours Health Service for follow up nursing care in the evenings, the Homeless Health Outreach Mental Health Team (HHOT), and community support agencies. The above referrals do not include housing referrals made by CART Support and Advocacy workers to crisis accommodation services, boarding houses, supported accommodation and public housing. Considerable effort is made to identify appropriate referral points and to facilitate and support initial visits, monitor involvement with services in the community and to access and sustain housing.

Hospital pilot site engagement.
→ While the pilot sites from the Princess Alexandra Hospital and the Royal Brisbane and Women’s Hospital make up the majority of referrals, a total of 33 different hospital units referred into the service over the two-year period demonstrating the pilots reach and access.
→ There has been an increase in the number of discharge summaries received from the hospitals up from 47% at the beginning of the service to 64% at the 2 year mark. Timely access to discharge summaries and post-acute care requirements is critical to ensuring the Individual receives the care and follow up they require in the community.
→ Feedback from hospital units and social work staff has been overwhelmingly positive. Respondents identified the positive impact of the service on patient flow and discharge outcomes and on reducing the risk of hospital presentations and (re) admissions for such a high needs population group.

Outcomes
→ Pathways has continued to deliver positive outcomes across housing, hospital avoidance, GP engagement and improved self-management across the second year reporting period.
→ There has been a 78 - 85% reduction across all hospital and ambulance usage measures when compared to the baseline during the Pathways intervention. Emergency department presentations are down from an average of 1.73 visits 30 days prior to entry (baseline) to the service to 0.38 at exit from the service. Equally, hospital readmission rates after discharge and while involved in Pathways went from an average of 1.18 hospital admissions in the 30 days prior to entry into Pathways to 0.23 admissions reported at the point of exit from the service. Finally, ambulance usage was down from an average 1.25 transports 30 days prior to entry to the service to 0.19 transports at exit from the service.
→ The Pathways model has continued to deliver strong results throughout the second year, preventing unnecessary hospital and ambulance use which has in turn freed up health system capacity. A repeat economic analysis for the entire two years of operation has been undertaken by Professor Luke Connelly and Angie Maguire to
demonstrate the added economic impact of an additional year. The return on investment has continued with net benefits of the Pathways project estimated to exceed its cost of $579,836 by $2.88m. Sensitivity analyses indicate that the net benefits of Pathways may be as great as $3.62m. When resource intensity of inpatient use is modelled, the estimates suggest that Pathways may return as much as $7.25 per dollar spent.

→ 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.

→ At exit from the service 93% of those surveyed were reconnected or connected to a GP and 99% had reconnected or connected with community support provider/s through the Pathways coordination and advocacy approach.

→ There was also noted improvement and higher levels of comprehensive understanding over time in the person’s health literacy and self-management of their condition/s.

The Pathways Pilot Project has continued to deliver significant health and social benefits through its assertive engagement and delivery of critical clinical and social support services to homeless and vulnerably housed individuals with complex needs post hospital discharge. For the majority of participants, Pathways has directly impacted on reducing and ceasing the person’s use of acute care and emergency services by providing needed healthcare and housing access. The Pathways teams’ integration with the RBWH and PAH discharge processes and social work/ hospital staff has been essential to achieving these outcomes and providing the continuum of care required for such a vulnerable population. This report, along with the first year evaluation report; 12 month economic evaluation report and subsequent second year economic evaluation report has shown true return on investment and more importantly the benefits to individual participant lives.

Pathways nurse and CART worker supporting Pathways participant.
1. **Introduction**

This report covers the December 2014 to December 31st 2016 two-year evaluation of the *Pathways – Hospital Admission and Discharge Pilot Project* funded by QLD Health and documents the outcomes of participants throughout their involvement in the service. Since program commencement in December 2014 Micah Projects staff, through the Home for Good – Co-ordinated Access and Referral Team (CART) and St Vincent’s Private Hospital Brisbane nurses, have been working together along with partnering hospital units to establish a unique service in Brisbane that targets vulnerable populations experiencing homelessness with complex health and social support needs. This pilot forms part of the Inclusive Health’s Integrated Programs that are delivered in partnership by Micah Projects, Mater Health Services and St Vincent’s Private Hospital Brisbane. While the budget for Pathways is modest at **$229,266 per annum** the integration of funded nursing staff with CART staff has allowed the service to more fully support and address the range of complex health and social needs.

**The Pathways Pilot Project aims to:**

- Enhance communication and partnerships between the community and Brisbane Public Hospitals (Princess Alexandra Hospital, Royal Brisbane and Women’s Hospital) to improve health, housing and social outcomes for vulnerable individuals;
- Prevent unnecessary hospital admissions and re-presentsations to the accident and emergency departments;
- Pro-actively work with the person to address their housing, health and social support needs through direct care, care coordination and active linkage to health and community services; and
- Improve the ability of the person to self-manage their health and avoid hospital admission where they have the capacity to self-manage.

2. **Service Model**

Pathways is a post-hospital discharge service designed to provide person centered admission and discharge planning to achieve an integrated response across health, housing and community service providers. It is a service that aims to deliver access to health care for vulnerable populations typically experiencing homelessness, unstable housing, social isolation, disability, and multiple health conditions.

The Pathways program operates 5 days per week as an integrated nursing service with Micah Projects – Home for Good – Co-ordinated Access and Referral Team (CART). Additional linkage with the Street to Home - After Hours Health Team has led to the provision of nursing and crisis support after hours and over the weekends when needed.

- **Person-centered discharge planning, care co-ordination and direct nursing care**
  - Integration with each individual hospital unit’s discharge processes
  - Early engagement / in-reach to hospitals
  - Development of post-discharge care co-ordination plan (reviewed every 30 days)
  - Identification of housing, support and health needs
  - Direct nursing care in the community
Pathways Hospital Admissions and Discharge Pilot Project - Evaluation Report (Dec 2014 – Dec 2016)

3. Project Monitoring and Evaluation

Given Pathways is a three-year pilot project (two years and five months’ service delivery) an action research evaluation methodology has been applied drawing on a range of methods and sources of data with reporting, analysis and reflections of findings occurring at six and twelve monthly intervals. While no funding was received for evaluation purposes, resources have been allocated from within the two days of clinical / project management funding and by drawing on other contributions from Micah Projects. The Pathways project aims to improve homeless and vulnerably housed individual’s health and welfare following hospital discharge and to produce evidence of outcomes and benefits to the individual and the acute care service system when a targeted nurse led collaborative post hospital discharge service is provided.

Comprehensive data collection methods have been embedded within the client record system. Service data is collected at every point of intervention with an individual participant and at specific data collection points. These being at point of entry and exit through the program and at 30 day intervals while involved with the Pathways service. Outcomes data attached to key performance indicators regarding hospital usage; ambulance use; housing transitions; connection to GP and community services and improved health literacy and self-care are collected through a baseline survey with the individual, at thirty-day review periods and at point of exit. Additional output data along with consumer and key stakeholder feedback is also collected at set intervals. The inability of the nurses at some interval periods to locate individuals and complete 30 day reviews has led to lower recorded participant responses at some points. Only completed 30 day reviews and exit surveys are represented in the analysis.
4. Referrals

Figure 1 shows the total number of referrals received from hospitals since the pilot commencement. From the 240 referrals received over the two year period, 150 became registered Pathways participants and form the basis of this report, while an additional 90 people were provided with short term nursing care, housing assistance, reconnection back to support services that had been involved with the person or to services more appropriately matched, or did not engage with the service.

There has been an increase in the number of discharge summaries received from the hospitals from 47% at the beginning of the service to 64% at the two year mark. Timely access to discharge summaries and post-acute care requirements is critical to ensuring the Individual receives the care and follow up they require in the community.

Figure 1: Referral Pathway
4.1. Intake/ Referrals from hospitals

Table 1 represents referrals from all hospital units and intake into the Pathways Pilot short-term or a long-term response (> than 30 days) in the 25 months of the service to Dec 2016. Referrals were received from 33 hospital units and 74 Individual referrers (social workers/discharge facilitators). Over the two year period the number of referrers and hospital units increased and moved beyond the original hospital pilot unit sites.

<table>
<thead>
<tr>
<th>Table 1: Hospital Unit Referral Source</th>
<th>Less than 30 Day Response</th>
<th>Greater than 30 Day Response</th>
<th>Total Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Princess Alexandra Hospital</td>
<td>47</td>
<td>68</td>
<td>117</td>
</tr>
<tr>
<td>Hospital (PA) - Emergency Department</td>
<td>13</td>
<td>22</td>
<td>35</td>
</tr>
<tr>
<td>Hospital (PA) - MAPU</td>
<td>8</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Hospital (PA) - Medical Ward</td>
<td>3</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>Hospital (PA) - Mental Health</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Hospital (PA) - Surgical Ward</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Hospital (PA) Cancer Services</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Hospital (PA) Geriatric Rehab</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hospital (PA) Infectious Disease Unit</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Hospital (PA) Renal Unit</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hospital (PA) Brain Injury Rehab. Unit</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hospital (PA) Orthopedics</td>
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<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Hospital (PA) Cardio/Thoracic Surgical</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Hospital (PA) Outpatients Department</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Royal Brisbane and Women’s Hospital</td>
<td>37</td>
<td>67</td>
<td>102</td>
</tr>
<tr>
<td>Hospital (RBWH) – Dept. Emergency Med</td>
<td>4</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Hospital (RBWH) – CIS Community Access &amp; Referral</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Hospital (RBWH) – Medical Wards</td>
<td>4</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>Hospital (RBWH) - Mental Health</td>
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<td>26</td>
<td>43</td>
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<tr>
<td>Hospital (RBWH) - Surgical Ward</td>
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<tr>
<td>Hospital (RBWH) - Burns Unit</td>
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<td>1</td>
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<tr>
<td>Hospital (RBWH) - Cancer Services</td>
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<td>1</td>
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<tr>
<td>Hospital (RBWH) – Renal Unit</td>
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<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Hospital (RBWH) – Geriatric Rehab</td>
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<td>2</td>
<td>5</td>
</tr>
<tr>
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<td>2</td>
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<tr>
<td>Hospital (RBWH) Gynae Oncology</td>
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<td>1</td>
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<td>Mater Adult Hospital</td>
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<td>Hospital (Mater) - Medical wards</td>
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<td>2</td>
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<td>2</td>
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</tr>
<tr>
<td>Other Hospitals</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Hospital (St Vincent’s)</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hospital (TPCH) – Medical Ward</td>
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<tr>
<td>Hospital (QEII)</td>
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<td>Hospital (Bundaberg)</td>
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</tr>
<tr>
<td>Other referral sources</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Micah – CART</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Micah – BCG</td>
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<tr>
<td>Self</td>
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<tr>
<td>Other NGO</td>
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</tr>
<tr>
<td>ADHOT</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL Referrals</td>
<td>90</td>
<td>150</td>
<td>240</td>
</tr>
</tbody>
</table>
5. General Service Data

5.1. Monthly Intake, Current and Exited Pathways Participants

150 people were provided with a Pathways response longer than 30 days and form the basis of the following reporting in terms of outcomes achieved (Refer to page 21). Table 2 shows the number of participants that have entered and exited the Pathways Pilot Project and the total participants supported in the project across the months since the project commenced (Dec 2014 – Dec 2016). The table also shows planned exits and the unplanned exits after multiple unsuccessful attempts to locate and remain engaged with the individual.

Table 2: Tracking > 30 Day Participants Since Service Inception (December 2014 – December 2016)

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Accepted Participants</th>
<th>Planned Exits</th>
<th>Unplanned Exits</th>
<th>Participants Deceased</th>
<th>TotalExited Participants</th>
<th>Total Participants Supported</th>
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<tbody>
<tr>
<td>2014</td>
<td>December</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>2015</td>
<td>January</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>2015</td>
<td>February</td>
<td>8</td>
<td>2</td>
<td>3</td>
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<td>5</td>
<td>25</td>
</tr>
<tr>
<td>2015</td>
<td>March</td>
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<td>3</td>
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<td>7</td>
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<tr>
<td>2015</td>
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<td>5</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>27</td>
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<tr>
<td>2015</td>
<td>May</td>
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<td>6</td>
<td>2</td>
<td>0</td>
<td>8</td>
<td>28</td>
</tr>
<tr>
<td>2015</td>
<td>June</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>29</td>
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<tr>
<td>2015</td>
<td>July</td>
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<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>29</td>
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<tr>
<td>2015</td>
<td>August</td>
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<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>34</td>
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<tr>
<td>2015</td>
<td>September</td>
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<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>36</td>
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<tr>
<td>2015</td>
<td>October</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>40</td>
</tr>
<tr>
<td>2015</td>
<td>November</td>
<td>4</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>10</td>
<td>37</td>
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<tr>
<td>2015</td>
<td>December</td>
<td>4</td>
<td>3</td>
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<td>31</td>
</tr>
<tr>
<td>2016</td>
<td>January</td>
<td>4</td>
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<td>89</td>
<td>40</td>
<td>1</td>
<td>130</td>
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The 1.5 FTE of nursing attached to the pilot has worked with between 28-36 individuals in any given month. The ideal caseload for optimum service delivery is 26-28 at any one time as previously tested and reported in Year 1. Pathways aims to respond to all referrals whether through a short-term Pathways/CART response or the longer term (more than 30 days) coordinated care and assertive clinical nursing/case management response.

5.2. Length of Stay of Current and Exited Pathways Participants

Table 3 shows that the average length of stay within the program is just over four months. This data shows that participants require ongoing support to achieve the desired health, housing and social outcomes.

<table>
<thead>
<tr>
<th></th>
<th>Average Length</th>
<th>Maximum Length</th>
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</thead>
<tbody>
<tr>
<td>Current Participants</td>
<td>4.0 months</td>
<td>12.4 months</td>
</tr>
<tr>
<td>Exited Participants</td>
<td>4.1 months</td>
<td>17.0 months</td>
</tr>
</tbody>
</table>
6. **Participant Profile**

6.1. **Pathways Participant’s Demographics**

The Pathways participant (n=150) demographics for Dec 2014 – December 2016 are:

- 48 (32%) were female and 102 (68%) were male;
- Average age of 47 years with oldest participant aged 86 and youngest aged 19;
- 16 (11%) participants identified as Aboriginal and/or Torres Strait Islander people;
- 9 (6%) participants identified as coming from a CALD background; and
- 46% of participants (of 96 that shared this information) receive the disability support pension.

6.2. **VI-SPDAT Analysis of Participants**

The Vulnerability Index – Service Prioritisation Decision Assistance Tool (VI-SPDAT) is a tested and validated tool from the United States that assesses the needs of individuals who are homeless or vulnerably housed. The Pathways Program uses this tool as the initial assessment tool to guide future interventions. This tool is particularly useful in collecting baseline data on housing status, vulnerabilities, health data and previous hospital presentations. It is a self-reported assessment tool with practitioner observations made at key sections. An overall score is generated through the database which determines the acuity or level of vulnerability of an individual and assists in determining the necessary support for the individual.

Since service inception, 96 people out of 150 (64%) have completed a VI-SPDAT. The **majority of Pathways participants (91%) have complex needs** (medium to high acuity) and require significant support to address their health, housing and social needs.

Stable and secure accommodation is a major issue for Pathways participants. The location of where the Pathways participants most frequently sleep at intake include: 28% rough sleepers (e.g. cars, tent, park), 19% with friends/family (couch surfing), 19% in boarding houses, and 13% identified the hospital as where they sleep most frequently.
The VI-SPDAT data below profiles the Pathways participants as having, in addition to lengthy periods of homelessness, high incidences of trauma, mental health conditions, drug and alcohol use and chronic disease. Such a profile demonstrates the need for comprehensive healthcare, housing and social support to enable improved quality of life outcomes for this vulnerable group.

**Pathways participants (n=96):**

- **Social History**
  - Homeless for an average of 2.25 years
  - Housed and homeless again in the past three years an average of 4.8 times
  - 18.6% have been in foster care

- **Involvement with Police/ Criminal Justice system**
  - In the previous six months have had an average of 5.8 interactions with the police
  - 60% have been to the watch house
  - 32% have been to prison

- **Drug and Alcohol, Mental Health, Serious Health and Brain Injury**
  - 58% have experienced trauma and not sought help
  - 91% have a serious health condition
  - 71% use drugs and/or alcohol
  - 87% identify as having a mental health condition
  - Dually diagnosed at a rate of 66%
  - Tri-morbid at a rate of 59%
  - 32% stated that they had a brain injury

- **Chronic Diseases (CDs)**
  - 33% have asthma
  - 31% have heart disease
  - 25% have liver disease
  - 19% have diabetes
  - 17% have hepatitis C
  - 17% have cancer
  - 17% have kidney disease
  - 11% have emphysema.
7. Key Performance Outputs

This section tracks the efforts and outputs for the December 2014 to December 2016 reporting period of the 60 hours per week funded nursing positions.

7.1. Occasions of Care and Site Visits

Over the two year reporting period from December 2014 to December 2016:

- 6389 occasions of direct nursing care were delivered which equates to 255 occasions of direct nursing care on average per month
- 6.7% of site visits occurred in hospitals; 11.7% in rooming/boarding houses; 4.1% in public housing; and 59.3% occurred over the telephone.

7.2. Distribution of Service Delivery within and outside Brisbane

For the December 2015 - December 2016 period, excluding phone calls where service location cannot be determined, 55.3% of service delivery was on the North side of Brisbane, 44.3% was on the South side of Brisbane, and 0.4% was outside of the Brisbane LGA.
7.3. Direct Care Activities Breakdown

There were 31,830 direct nursing care activities, excluding documentation undertaken over the two year reporting period by the two Pathways nurses (1.5 FTE). During each occasion of direct nursing care several direct care activities may be performed.

Figure 5: Direct Care Activities
(Dec 2014 - Dec 2016)
The top twelve direct care activities were:

- Advocacy (14.0%);
- Client Care Coordination/Collaboration (12.7%);
- Post-discharge follow-up nursing care (12.3%);
- Post-discharge care coordination planning (7.1%);
- Engagement (6.1%);
- Secondary consultation (6.1%);
- Self-management education and assistance (5.4%);
- Assessment (5.1%);
- Chronic Condition Management and Planning (3.6%);
- Health Education/Promotion (3.5%);
- Counselling (2.9%); and
- Housing Assistance (2.8%).

Pathways nurse engaging with Patricia.

7.4. Referrals to Other Services

Figure 6 represents the distribution across referral points of the 829 referrals made to other services during the two year reporting period.
Figure 6: Referrals Made (Dec 2014 - Dec 2016)
7.5. Occasions of Care Outcomes

<table>
<thead>
<tr>
<th>Occasions of Care Outcomes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Entry Initiated &amp; Continuing Care required</td>
<td>4.10%</td>
</tr>
<tr>
<td>Treatment/Intervention provided &amp; Continuing Care required</td>
<td>68.40%</td>
</tr>
<tr>
<td>Treatment/Intervention provided, supportive referral initiated &amp; ongoing Support required</td>
<td>9.90%</td>
</tr>
<tr>
<td>Intervention incomplete. Client refused care</td>
<td>1.20%</td>
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<tr>
<td>Client not seen, unable to locate client</td>
<td>13.70%</td>
</tr>
<tr>
<td>Care provided and client exited from service</td>
<td>1.80%</td>
</tr>
<tr>
<td>Client exited service early</td>
<td>0.90%</td>
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</table>

As the above data shows, continuing care is the most common care outcome after each occasion of care.

7.6. Efficient Use of Resources: direct and indirect care

QLD Health funding ($229,266 per annum) allocated to this pilot project covers 60 hours of nursing work per week, 15.2hrs of clinical and project management per week, and a small allocation for administration and operating expenses. Additional resources have been provided by Micah Projects and St Vincent’s Private Hospital Brisbane, while the cost for leasing one car attached to the program has been funded by the Sisters of Mercy. Below is a breakdown of direct and indirect care against these resources for the 1.5 FTE nursing and project management allocation of the service. Direct services provided by staff within Micah Projects CART team have also been reported to provide an overall picture of effort and integration attached to the Pathways Service.

- Over the January 2015 to December 2016 period, 6180 hours of nursing work should be accounted for;
- There was a shortfall of 637.5 hours of nursing work in the two years due to annual leave and sick leave with minimal backfill capacity given funding constraints and staff turnover.
- The total time that should be accounted for is therefore 5542.5 hours;
- Total Pathways direct nursing service delivery hours provided to individuals from January 2015 to December 2016: 3758.5 hours (included registered and non-registered participants);
- Total Pathways indirect nursing care hours (including staff orientation) was 1784 hours. Other indirect care activities included shift-preparation, inter-disciplinary meetings, team meetings, training and supporting hospital partnerships work;
- Caseload capacity for 1.5 FTE has been 28 to 40 people at any one time, however the ideal caseload is 28 participants at any one time as tested and recorded over the two
years. Ongoing demand for the service has however led to Pathways working with higher numbers in some months to accommodate hospital demand for the service.

- 67.8% of Pathways nursing staff hours are being used in direct care activity with individuals;
- The Micah Projects Coordinated Access and Referral Team’s (CART) contribution of hours to supporting Pathways participants was 1334.5 hours, which is 12.8 full-time hours per week in the provision of housing and social support needs.
- The HtoH After Hours Health Service has also contributed to the Pathways Pilot Project through their direct service provision regarding after hours nursing care and support. The integration of Pathways staff within Micah Projects’ administration functions and service delivery teams has strengthened the model.
- 1580 hours of project / clinical management services and evaluation were also delivered to support the establishment and ongoing management of the project and staff involved.

8. **Key Performance Outcomes**

From December 1\textsuperscript{st} 2014 to December 31\textsuperscript{st} 2016, a 25-month period, the following outcomes data for the participants was elicited through ongoing reviews. The data reported below is drawn from the baseline, 30 day reviews with Pathways participants, and exit outcome surveys that are performed with each participant as they journey within the Pathways service. Below is a summary of key outcomes achieved with regards to hospital use; ambulance use; connection to primary health care and community services; housing access and stability; and health literacy and self-management.

8.1. **Hospital and Ambulance Outcomes**

The Pathways service is having a direct impact on reducing emergency department presentations, ambulance use and in preventing unnecessary hospital admissions. As Figure 7 demonstrates there has been a significant reduction in usage across all three health and hospital outcome measures as participants progress through the service. The data is presented as an average usage of hospitals and the ambulance service for all participants who complete the 30 day interval review surveys. Review periods as noted in the graph (Figure 7) occur at entry to the service (Baseline - previous 30 days prior to service entry), 30 days after entry to the service, all subsequent 30 day reviews, and the 30 days prior to exit from the service.
There has been between 78%- 85% reduction across all hospital and ambulance usage measures when compared to the baseline during the Pathways intervention. Emergency department presentations are down from an average of 1.73 visits 30 days prior to entry (baseline) to the service to 0.38 in the 30 days prior to exit from the service. Equally, hospital readmission rates after discharge and while involved in Pathways went from an average of 1.18 hospital admissions in the 30 days prior to entry into Pathways to 0.23 admissions reported at the point of exit from the service. Finally, ambulance usage was down from an average 1.25 transports 30 days prior to entry to the service to 0.19 transports at exit from the service. The Pathways service delivery model has continued to deliver strong results throughout the second year, preventing unnecessary hospital and ambulance use which has in turn freed up health system capacity.

A repeat economic analysis for the entire two years of operation has been undertaken by Professor Luke Connelly and Angie Maguire (February 2017) to demonstrate the added economic impact of an additional year of service. The return on investment has continued with net benefits of the Pathways project estimated to exceed its cost of $579,836 by $2.88m. Sensitivity analyses indicate that the net benefits of Pathways may be as great as $3.62m. When resource intensity of inpatient use is modelled, the estimates suggest that Pathways may return as much as $7.25 per dollar spent. (Please refer to the full report under publications at www.micahprojects.org.au ).
8.2. Connection to GPs and Community Services Outcomes

Reconnecting or establishing GP access and care as well as needed support from community providers have been key achievements and remain a key focus of the model of care. Figure 8 demonstrates the situation at point of entry and at point of exit from the service with a 99% achievement rate at exit of those surveyed in connecting with community support services and 93% achievement rate at exit of those surveyed being well connected to a GP.

![Figure 8: Connecting Participants to Services](image)

8.3. Health Literacy and Self-Management Outcomes

A number of questions are asked to gauge the level of health literacy and self-management of the Pathways participants at entry and then at 30 day intervals while in the service. Many of these questions are based on gauging whether the participant has no understanding, partial understanding or comprehensive understanding around their own health, medications and what to do if help is needed. The following graphs summarise the percentage data for this period from point of entry to exit in response to various probing questions around a person’s ability to articulate and recall their understanding and management strategies around their own health.
In addition, when participants have been asked: “Do you feel confident to manage your condition and support needs on your own/ and or with the support services we have linked you to?”

- 89% (n=89) felt more confident and supported after the first 30 days in the service. This then increased to 97% (n=74) at the point of exit demonstrating early and continued confidence in participants self-managing their health condition/s and being supported by services if needed to do so.
As the above graphs illustrate there has been a steady increase in comprehensive understanding around reasons for admission, self-management, medication and self-care aspects as the participant progresses through the program and receives continued education and support.
8.4. Housing Outcomes

Access to more secure, safe and stable forms of housing in order to provide a foundation from which an individual can start to address other aspects of their life such as their mental illness, physical health conditions and social circumstances is a key feature of the Pathways pilot and Micah Projects’ commitment to a ‘Housing First’ approach.

Despite the lack of available, appropriate and affordable housing for this population group, assessing need and then creating and sustaining temporary and long-term housing options has been a core endeavor of the team. Figure 13 illustrates the type of housing occupied at point of entry and at point of exit from the Pathways service for the December 2014 to December 2016 period and highlights the positive shifts into more stable accommodation options.

The majority (65%) of participants at point of entry were in very insecure accommodation arrangements with many identifying the hospital as their accommodation type, as well as significant numbers of people sleeping rough or couch surfing. Participation in the service has led to people accessing more stable and secure forms of housing tenure and sustaining this when reviewed at exit. Additionally, each person is assessed with regards to their public housing eligibility and actively assisted to complete Department of Housing (DOH) and community housing applications if this has not already occurred. The Pathways/CART team completed 68 new DOH applications with participants during the reporting period. This work has been critical to the housing outcomes achieved with many securing public housing while in the service or shortly after exit (not counted in Figure 13).

---

**FIGURE 13: HOUSING PATHWAY**

Increasing Levels of stability according to accommodation type

- **At Point of Entry (n=138)**
- **At Point of Exit (n=88)**
9. **Case Studies**

9.1. **Phillip’s Case**

*(Compiled by the Pathways Nurse: Sue Andersen)*

Phillip was a 59 year old man who was referred to the Pathways Team from PAH Mental Health in late December 2015. His diagnosis was bipolar disorder, suicidal ideations, alcohol misuse, and anxiety. He was residing in a boarding house where he was acting as the onsite manager but was finding this role increased his anxiety. Phillip was concerned that if he resigned from this role there may be negative consequences in regards to his accommodation.

Pathways initially referred Phillip to the Partners in Recovery (PIR) team at Micah Projects for mental health support. He showed confusion about who to contact regarding acute episodes of his mental health symptoms, so a plan was devised outlining that he could contact Micah Projects and leave a message for Pathways/PIR or contact his GP and the afterhours doctor’s phone numbers were supplied.

Phillip was assisted with transport to his post-discharge psychiatric appointments and reconnected with the Homeless Health Outreach Team (HHOT). Pathways regularly liaised with and coordinated communications between PIR, the GP, and HHOT. Phillip remained compliant with his medications but required advocacy regarding his medication dosage when he felt the dosage wasn’t adequate.

An additional referral to a Community based mental health program was arranged for his long-term support and referrals to the Micah Projects Street to Home After Hours Nursing service were made for after hours nursing support when he suffered acute episodes of anxiety/depression.

At the time that he moved into his community housing property Phillip’s anxiety flared and as HHOT had now ceased their engagement a link to the Acute Care Team (ACT) was arranged to assist Phillip while he settled into the new accommodation. PIR also played a pivotal role in assisting Phillip with outside activities (e.g. going for a drive, walks in the park, fishing etc.) to combat his propensity to withdraw when his depression was acute and he felt overwhelmed.

Phillip’s mental health symptoms continued to be a concern after his move to the new unit so PIR and the Pathways team advocated for him with Fortitude Valley Mental Health. An application for the disability pension was submitted while support to meet the requirements stipulated by his employment agency continued.

When Phillip’s mental health symptoms became acute he self-medicated with alcohol. The Pathways team organised and provided support for him to attend day detoxification at Biala or alternatively arranged detoxification with a community provider.

His main physical health concern required that he present for a colonoscopy. Phillip had cancelled his appointment a number of times due to his anxiety regarding the results and also the difficulties of completing the required prep while using a shared bathroom. The Pathway team was able to liaise with the hospital to facilitate an admission that allowed Phillip to complete his prep in a private bathroom then have overnight admission, eliminating his need to find someone to stay with him after his anesthetic. Phillip was also
linked to the QLD Health Medical Aid Subsidy Scheme for new glasses and the dental hospital for future dental care.

Department of Housing and Community Housing applications were completed for Phillip and the property was offered six months after his Pathways intake. The PIR team assisted with set up of the unit and ongoing support was provided to access a local GP, social supports, and orientation to the surrounding area. Phillip is now independent with the continuing support of community and QLD Health mental health services, his employment service and housing provider.

Phillip was proactive in his healthcare, but the severity of his mental health condition often made it difficult for him to be motivated to manage it and to access health services. With the support and advocacy of The Pathways Team over an eight month period he was able to manage these issues more effectively with secure housing and ongoing community supports.

9.2. John’s Case
(Compiled by the Pathways Nurse: Jenna Vandyk)

John (not his real name) a 71-year-old male, was referred to the Pathways Program by the Princess Alexandra Hospital as requiring health and housing support due to risk of homelessness and vulnerability post-discharge. John did not have any family or other friends and had recently disengaged with his brother.

At the time of admission John was living with a family friend, whose health had deteriorated and was going to be placed in a nursing home and was under Public Guardian and Public Trustee. This outcome meant that John would have to move out of the property and had nowhere to live. John had a complex health history including epilepsy, prostate cancer, cerebral hemorrhage and angina and was not compliant with his medications. John would frequently present to hospital due to his chronic urinary incontinence and infections. John did not have a regular GP at the time of admission.

The Pathways team accepted the referral for John and was able to make contact with him in December post discharge. John presented to Kurilpa Hall to meet with the Micah Projects Coordinated Access and Referral Team (CART) to discuss a Department of Housing application and the Pathways team met with him following this to complete a health assessment and VI-
SPDAT, an assessment tool that measures vulnerability across health, housing and social domains. The Pathways team referred John for an ACAT assessment and linked him to a community nursing service for a continence assessment that would enable him to access continence aids through the QLD Health Medical Aids Subsidy Scheme (MASS). John had his ACAT assessment completed in January and was promptly ACAT approved for permanent residential care, respite care and home care packages, level 1 and 2.

For a couple of months John continued to present to the Princess Alexandra Hospital and Mater Hospital due to incontinence and prostate issues. The Pathways team liaised with the hospitals to advocate for John around the medical management of his health needs including several hospital admissions. The Pathways team often transported John to his specialist and outpatient appointments to ensure that he was able to attend them.

The Pathways team secured accommodation for John in a level 2 classified boarding house. This enabled John to maintain his independence whilst having access to support services. With John’s Aged Care package, the Pathways team were able to involve another community support provider in assisting John with his ADL’s and domestic support. Due to the cost of the boarding house, John struggled to adjust financially and the Pathways team supported John to move into a less expensive boarding house nearby whilst he waited for his Department of Housing application to be approved. The community support provider continued to support John whilst in the boarding house and the Pathways team also organised the Micah Projects Street to Home nurses to provide nursing support to John over the weekend.

The Pathways team, in collaboration with CART, advocated for John to be housed in a Department of Housing Seniors unit which he moved into in July 2016. The Pathways team linked in his previous community provider to continue to support John with ADL’s and domestic support in his property. John joined the local church behind his property and engaged in weekly activities. The Pathways team helped John find a local GP which he attends on a fortnightly basis and now has a Webster pack for his medications. The Pathways team supported John to see an optometrist to receive MASS funded glasses, and attend the dentist to receive his new dentures. John was very happy with his new home and had started to make friends with other residents in the complex. John had also re-engaged with his brother and children. John was exited from Pathways in October 2016.

Figure 15: John’s Hospital & Ambulance Utilisation
10. Consumer Feedback

Seventy-seven participants to date have provided consumer feedback on the service and supports they received. As demonstrated below, feedback from consumers has been overwhelmingly positive with individuals feeling that 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.

Figure 16: To what degree do you feel you have been treated with dignity and respect by the nursing staff? (n=76)

Figure 17: How satisfied were you with the care and support you have received? (n=77)
A few noteworthy comments were provided when participants exited the service.

"They did a terrific job, fantastic!"

"Very good. Access to services, appointments and overturning ACAT results."

"Made a big difference to me as they were always around."

"Very helpful."

"I’ve found them very supportive and caring."
The free text feedback from the participants shows the impact that the Pathways service has on the lives of many of the participants. Examples include:

“Know there is someone to call, I know there is some hope.

“Much better life.

“Kept me focused and balanced when I wasn’t.

“Pathways has given me the help, support, ability and kindness to make my journey easier. And I’m thoroughly grateful for their help kindness and understanding.

“100% difference, they were there for me.

“They made me feel that I had been given back my dignity, and my self-worth as an individual. Think Pathways made a difference to my life.

“I have gone from homeless to living in a beautiful unit with lovely places.

“Assisted me greatly with my health and getting my life on track.

“The biggest thing has been support to get public housing.

“Everything, helped me so much.

“Improved life heaps, feel markedly better. Previously I would have been ranting and raving and now I’m calmer. Wish I had met you people years ago it would have made a big difference to my life.

“Gave me confidence to live in the community and get on top of my health.
11. **Hospital Pilot Site Feedback – January, 2017**

A short survey was sent in early January, 2017 to the email addresses of 74 social workers, discharge facilitators and clinical nurses who referred into the Pathways – Hospital Admission and Discharge Pilot Project over the two years of service delivery requesting their feedback. A second email was sent to the group a week later to repeat the request. A total of 13 responses was received. Overall, feedback on the service was very positive with only one respondent providing negative feedback around the lack of response to the referrer. There were six survey questions in total. Four questions asked for a response on a 1 – 5 Likert scale as well as free text feedback. The remaining two questions asked for free text responses only. A summary of the results are outlined below.

**Q. 1. To what level do you feel that the Pathways service meets its proposed goals of providing integrated nursing care, care co-ordination, housing and social support post hospital discharge for vulnerable people?**

Feedback in free text section included comments such as: prompt, efficient service and professionalism; responsive to complex social and chronic medical issues; good coordination; significant assistance to find stable accommodation; and able to engage when we can’t.

**Q. 2. What is your level of satisfaction around communication with the Pathways staff?**
The free text section of this question had a number of responses that were about the ease of access and ability to contact the staff readily. Other feedback included: helpful, flexible, pleasant, sometimes hard to contact if they are out of the office – maybe additional staff would assist in this; explains the options clearly to patients; the team is also very approachable and willing to assist within their scope of practice; accessible by phone and able to assist within 24 hrs.; excellent communication – even after discharge the staff let me know how a patient is getting on; they have attended outpatient appointments with our patients and we have been able to case conference ongoing issues to try to maximize the well-being of the patient while also avoiding readmissions; and finally great to work with.

Q. 3. How satisfied are you with the referral process? (Call, email, hospital visit?)

Feedback on the referral form was provided including: how easy it was to use, the fact that it can be emailed and was straightforward. Feedback was also provided on improving the form through placing next of kin, cultural background and other important information on it. Capacity was identified as one of the limiting factors to the response times to referrals being made with staff shortages proposed as to why referrals might not have been picked up as quickly.

One person stated that the option of having the Pathways staff attend to the bedside at the hospital prior to, or on the day of discharge has been extremely helpful to engage with the patient.

Q. 4. Previous feedback from hospital social workers and discharge facilitators identified that the Pathways Pilot Project has been filling a service gap for the target population. To what degree do you agree with this comment and why/why not?
Overall feedback was positive with only one negative response which was due to the fact that they were unaware of the outcome of the two referrals they made. Positive feedback included: this population rarely gets support to manage their health conditions, which are usually complex and confusing; stable housing assists in reduced representations due to safety, reduced infection, and ability to attend follow up; being able to discuss possible options with the team for a particular client has been extremely helpful; and the team being able to access various service providers has also made discharge easier.

A number of responses were made about this population falling through the cracks and being missed by the system and that Pathways provides a valuable ‘pathway’ for this population group. It was also stated that this group frequently present to hospital and the role of such a service in reducing admissions and readmission rates and supporting discharges.

A final comment shows the value of the Pathways Pilot Project:

“\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 and if confidentiality allowed, I would happily share their stories. The pathways program has been instrumental in improving the quality of life for these people in the most trying of circumstances. There is no other service providing the link between hospital and community like they do for this very vulnerable and stigmatized group of patients.

Q. 5. What effect has the program had on patient flow and discharge processes from your hospital unit? (n = 13)

The respondents generally reported that being able to refer to Pathways increased the pace of discharge processes for the people they referred and many also commented on the benefits for the person being referred. One respondent did not know the outcome and therefore was unsure of the effect. Positive responses on the pace and impact on hospitals included: increased discharge speed, reduced work from my point of view in locating services that are appropriate; I know Pathways is a good option for this cohort; has improved considerably; faster discharges, more successful discharges and reduced risk for readmissions.
The effect on patients was also elicited in this question and included comments such as: the program has been the difference between clients accessing lifesaving/extending treatment or not being able to have the treatment; good for referrals to your demographic, easy to discuss and refer on the same day, receptive to taking on “difficult” clients, receptive to seeing people with complex issues; without the Pathways program the hospital will be “stuck” with extremely challenging patients with complex discharge needs and patients themselves will have no ongoing support to bridge the transition from hospital to community; and sustained healthcare and improved well-being for patients/clients.

Q. 6. Do you have any suggestions on how the service may be improved? (n = 12)

There were very few suggestions for improvement of the service with most stating that staff were doing a “great job”. Two suggestions were made for the referral and the outcome of patients to be more evident and to liaise with new staff at hospitals to inform them of the service. Most of the feedback under this section centered on increasing staff funding for this service. Once again the importance of this service was reiterated with six people stating that more staff and funding is need to enhance this vital service that has had meaningful impact for the hospital and the target population.

12. Conclusion

The Pathways Hospital Admission and Discharge Pilot Service has continued to deliver significant health and social benefits through its assertive engagement and delivery of critical clinical and social support services to homeless and vulnerably housed individuals post hospital discharge. The Pathways teams’ integration with the RBWH and PAH discharge processes and social work staff has been essential to achieving these outcomes and providing the continuum of care required for such a vulnerable population. This report, along with the first year evaluation report, 12 month economic evaluation report and subsequent second year economic evaluation report has shown true return on investment and more importantly the benefits to individual participants’ lives.

13. References

