HOMELESS HEALTHCARE

EVALUATION REPORT SUMMARY OCTOBER 2018

Lisa Wood, Angela Gazey, Shannen Vallesi, Craig Cumming and Nuala Chapple

Being homeless is associated with higher morbidity, reduced life expectancy and greater usage of acute services, and there is a costly revolving door between homelessness and the health system.

Background

Since Homeless Healthcare (HHC) commenced in 2008, the pervasiveness of homelessness in Perth and Western Australia has become increasingly apparent, with factors such as housing affordability and domestic violence contributing to the burgeoning problem. People experiencing homelessness have a shorter life expectancy, chronic poor health and complex psychosocial issues, and often present frequently to Emergency Departments (ED). These health disparities coupled with reduced access to primary and preventative healthcare result in a large and costly burden on the acute hospital system.

Homeless Healthcare is a specialised multi-site General Practice (GP) that seeks to meet primary healthcare needs of people who are homeless, while assisting patients to access housing and other support to break the cycle of homelessness. Although the physical delivery of healthcare is the entry point, HHC recognises that the causes of homelessness and associated poor health are multifactorial and that more tailored and multi-pronged solutions are necessary.

Evaluation Overview

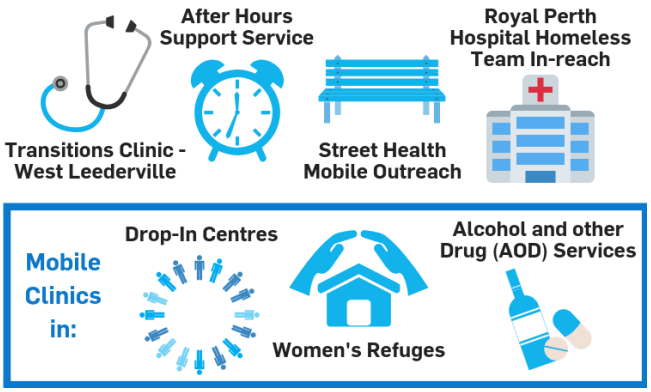
This snapshot is based on findings from the first evaluation report for HHC. The evaluation report provides an overview of the HHC model of care and the scope of service delivery. Drawing on hospital and HHC data, patient interviews and case studies, the demographic profile, complex health needs and patterns of hospital utilisation of HHC patients are described. Changes in health outcomes are examined for patients where longitudinal data was available. Current health service gaps for Perth's homeless population are also identified, along with the policy imperative for housing to be an integral part of health system responses to homelessness.

Homeless Healthcare Model of Care

The HHC Model of Care is grounded in a *'social determinants of health'* ethos, with strong collaborative partnerships with homelessness, housing and social sector organisations. There are eight core principles underpinning the way in which healthcare is provided to its patients:

"Without Homeless Healthcare I reckon I'd be dead"
– HHC Patient

Homeless Healthcare provides primary care in a wide range of settings familiar to people who are experiencing homelessness. These include:



School of Population and Global Health
The University of Western Australia

Demographic Profile of HHC Patients

Homeless Healthcare provides healthcare and support to people across the spectrum of homelessness and risk of homelessness. This includes rough sleepers, people in crisis/transitional accommodation, and those who have been re-housed. Many of its patients have not had a GP prior to connecting with HHC.

This snapshot draws primarily on data relating to active HHC patients (defined as those who have had at least three appointments in the past two years). Of the 1,962 current active patients, about two thirds (65%) are male, and the majority are aged between 25 and 44 years (49%). Homelessness is over-represented among Aboriginal people in WA, and this mirrored in the fact that 20% of HHC active patients identify as Aboriginal or Torres Strait Islander.

Health Needs

The majority of HHC's active patients have multiple serious health conditions. Psychiatric conditions are common among active patients, with depression (35%), anxiety (32%), and schizophrenia (9%), the most frequent conditions. Comorbidity is common among individuals experiencing homelessness: 34% of active patients have two or more morbidities relating to diabetes, respiratory conditions, cardiovascular disease, musculoskeletal conditions, kidney disease and mental health conditions. Additionally, there are high rates underlying risk factors such as daily smoking (81%), contributing to the poor health of HHC patients.

"The many health issues of homeless individuals cluster with, and are exacerbated by, other social determinants of health such as psychological trauma, poverty, unemployment, domestic violence and social disconnection. This constellation of underlying social issues challenges traditional clinical boundaries: they are not seen as "medical" problems although they are major determinants of health for people experiencing homelessness"
– Dr Amanda Stafford, Royal Perth Hospital

I think because they're less judgmental I think is probably the only way I can put it. You feel that because you've taken drugs, you've had drugs, you're put in a category. That's just me saying that from my point of view, but here [at the HHC clinic] when you talk about that you've got a smiley face looking at you. You've got someone that's not judging you. You've got someone that's wanting to help you. ***– HHC Patient***

Case Study: HHC Patient with Multiple Morbidities

Background

Tyson is a male in his mid-fifties who has been intermittently homeless for six years, spending most of that time rough sleeping. He has suffered trauma, substance abuse, persistent insomnia, and infections exacerbated by the challenges of personal hygiene while living on the street.

> *My foot went gangrene. It wouldn't have gone gangrene if I had a house… if I hadn't been homeless I would have been showering more often, taking care of myself, washing my toes…*

Across a three-year period (2015–2017), Tyson presented to the ED 24 times, had 30 general inpatient days and 27 psychiatric inpatient days. His costs for this period equated to $137,997.[1]

Role of HHC

Tyson had not been engaged with any GP service prior to an admission at Royal Perth Hospital (RPH) in mid-2017. During this admission, he was supported by HHC in-reach services as part of the RPH Homeless Team. Short-term backpacker accommodation was arranged post-discharge to help prevent reinfection. He was then linked with transitional accommodation at The Beacon. Tyson was then able to have regular GP appointments at the HHC mobile clinic run on-site at The Beacon, and this enabled diagnosis and management of his multiple health morbidities, including disease, peripheral vascular disease, type 2 diabetes, schizophrenia, IV drug use, osteomyelitis, hypothyroidism, amphetamine use, cellulitis, anxiety disorders, respiratory infections, insomnia, ulcers and issues with smoking cessation.

Current Health and Housing Situation

Tyson's health has improved substantially since HHC has supported him and he has had only one short admission to RPH since mid-2017. Following The Beacon, he moved to long-term community housing and continues to be supported by HHC.

Health Service Utilisation

The revolving door between homelessness and hospitals is well documented, and the imperative to reduce preventable hospital presentations is an important metric for health systems. In this snapshot, health administrative data were available for 933 active HHC patients from four hospital sites in the East Metropolitan Health Service catchment area (RPH, Bentley, Kalamunda and Armadale).

Between 2014 and 2017, this subsample of 933 active HHC patients had >8,000 ED presentations and spent >11,000 days admitted as inpatients. This equated to **a cost burden of more than $37.6 million over just four years**, or >$10,000 per person per year. This is a conservative figure as it does not include attendances at other Perth hospitals. The most common reasons for ED presentations included injury/poisoning and Alcohol and Other Drug (AOD) use disorders, with mental health often accounting for longer hospital admissions.

HHC Working with Frequent ED Presenters

The recent Sustainable Health Review (SHR) drew attention to the massive increase in ED attendances in WA over the last decade, and the unsustainability of this.[2] One of the Directions put forward by the SHR pertains to "*Better use of resources with more care in the community.*"[2(p29)] Homeless Healthcare is helping to achieve this through the provision of primary health services to many homeless patients who present frequently to ED.

Hospital data for the 50 homeless patients who most frequently presented to RPH ED was examined for 2016 and 2017. Of the 'top 50' in 2016, 56% (n=28) have been active HHC patients over the last two years, and in a number of cases, contact with HHC commenced after an intense period of ED presentations. In 2017, 40% (n=11) of the HHC patients who had been frequent ED presenters in 2016, were no longer among the top 50 homeless RPH ED presenters the following year. Connecting patients to housing and coupling this with tailored primary care and support, has contributed to significant reductions in ED presentations for some of the HHC patients who were previously identified as 'frequent presenters'.

ED presentations are expensive and should be prioritised for urgent needs. Health services for people experiencing or at risk of homelessness can be provided more effectively through a community-based primary health service, coupled with ongoing care and support.

The following case study describes how HHC supported the second most frequent presenter to RPH ED in 2017.

Case Study: HHC Support for a Frequent ED Presenter

Background

Hamish is an amputee in his mid-fifties and is heavily reliant on a wheelchair for mobility and community access. He has a brain injury and a history of trauma and AOD issues. Hamish spent nearly four years living in a psychiatric hostel before undergoing an episode of significant behavioural change in late 2016. He was admitted to a secondary hospital mental health unit. However, no cause was ever identified for his acute psychiatric changes, and he was discharged to the street. This was one of his first experiences of sleeping rough and unable to cope, he returned to an ED within 24 hours of leaving the mental health unit.

Hospital Presentations

Hamish had only one ED presentation in the two years prior to becoming homeless, but once he began living on the streets, his use of acute and emergency healthcare rose rapidly. For 13 months, between late 2016 and early 2018, he amassed 64 ED visits and 11 inpatient admissions (totalling 58 inpatient days). His healthcare costs for this 13 months equated to $48,960 in ED and $157,644 as an inpatient.[1] When admitted, he was often aggressive and rapidly discharged before social issues could be addressed, leading to a revolving door of frequent admission and discharge. This frustrated efforts to get him housed, although his disability and medical issues were clearly incompatible with street homelessness.

Role of HHC

HHC via the RPH Homeless Team advocated for Hamish and helped secure a longer admission with a suitable medication regime to settle his aggressive behaviour. HHC and the RPH Homeless Team support extended also to assisting him to get into an aged care hostel of his choosing.

Current Situation

Residing in the aged care hostel since early 2018, Hamish has had no inpatient admissions and has only presented to ED once, instead attending a handful of non-acute outpatient clinics which is far less costly to the health system than ED presentations.

Changes in Patient Hospital Use after Housing

Having safe stable housing is essential for attaining and maintaining good health, with the absence of housing perpetuating many health problems. A core premise of HHC is that patients need to be housed before health to improve significantly. HHC is a key founding partner in WA's inaugural Housing First initiative, 50 Lives 50 Homes project (50 Lives) and in this first HHC evaluation, changes in hospital use among HHC patients housed for six months or more through 50 Lives was examined.

Via 50 Lives, 63 active HHC patients have been **housed for more than six months**. Even within this short period, observable changes have been detected in hospital use, including a 39% reduction in total ED presentations, and a 48% reduction in total days spent admitted as an inpatient across this cohort of HHC patients now housed. For the 43 active HHC patients who had been **housed for more than 12 months** via 50 Lives, there was a 57% reduction in total ED presentations, and a 41% reduction in admitted inpatient days. Crude cost reductions associated with changes in ED and inpatient use for those housed for at least 12 months, amounted to a reduction of $423,054. This is a cost saving that more than offsets the costs of providing housing, support and GP care.

There is More to be Done...

Since its small beginnings in 2008, HHC has made massive strides in providing healthcare and support to a vulnerable population group that often falls through the cracks of the health system. This is a patient cohort with highly complex health and psychosocial needs, often compounded by trauma. The demand for the type of specialist homelessness GP care provided by HHC is growing, with hospitals and homelessness services across Perth continuing to see many people who are homeless with complex health needs and without a GP.

Homeless Healthcare currently receives some government funding but is increasingly reliant on philanthropic donations to sustain its essential services. Yet as shown in this snapshot, the work of HHC is yielding substantial savings for the health system through reduced hospital use. There are also critical health service gaps that merit funding, including tailored mobile clinics for women who are homeless (many of whom have been affected by domestic violence and trauma), young people experiencing homelessness, and for the large number of people with dual mental health and AOD issues.

Perth also lacks a place where people who are homeless can go to recoup from or prepare for hospital treatment. The Medical Recovery Centre proposed by HHC and based on the successful North American model is but one example of HHC's drive to identify and address gaps in the provision of healthcare for one of society's most vulnerable population groups.

> *It is futile to simply patch up the health of people who are homeless while their health continues to deteriorate without a safe and stable place to sleep or call home.* ***– Dr Andrew Davies, HHC***

THE FULL HHC EVALUATION REPORT IS AVAILABLE ON THE HOMELESS HEALTHCARE WEBSITE:
https://homelesshealthcare.org.au/reports-findings/

This summary was based on findings reported in:
Wood L, Gazey A, Vallesi S, Cumming C, Chapple N. Tackling Health Disparities among People Experiencing Homelessness – The Impact of Homeless Healthcare. School of Population and Global Health, The University of Western Australia, Perth Western Australia. 2018.

References:
1. Independent Hospital Pricing Authority. National Hospital Cost Data Collection, Public Hospitals Cost Report, Round 20 (Financial year 2015-16). 2018. Available from: https://www.ihpa.gov.au/publications/national-hospital-cost-data-collection-public-hospitals-cost-report-round-20-financial
2. Sustainable Health Review: Interim Report to the Western Australian Government. 2018 [cited 18 Oct 2018]. Available from: http://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Sustainable%20Health%20Review/sustainable-health-review-interim-report.pdf