Frequent Attenders: Whose problem is it?

DR NATALIE MILLER, GP, GREAT CHAPEL STREET MEDICAL CENTRE, SOHO, LONDON.

Imagine….

- Government crack down on 80yr olds attending A&E
- Meetings – troublesome pensioners
- ‘Time-wasting OAPs’ The Daily Fail
- Bed-blocking grannies

- Frailty
- Multimorbidity
- Social isolation
- Life expectancy

Homeless health

- Life expectancy 40s
- Comorbidity / multi-morbidity
- Lack of protective / resilience factors
- Lack of alternative options
- Stigma
- Marginalisation

Questions

- Why do homeless people attend A&E?
- What can be done to better help these patients?
- Should this be a target for intervention?

Factors associated with frequent attendance

- Health status:
  - Long-term conditions
  - Burden of disease
  - Co-existence of physical and mental illness
- Social status
  - Isolation
  - Lack of protective factors
  - Reduced resilience
  - Profiling
  - Acopia

Studies

- Homeless attend A&E and are admitted to hospital approx. 4 x more than general population[1]
- Biggest factor associated with frequent attendance was homelessness[2] followed by alcohol.
- Social isolation predicts frequent attendance in primary care[3]
- Freq attenders are typically 20-55, male, BIBA or police, more likely to self d/c, more likely to be from deprived areas[4]

Multi-morbidity

- NICE Guidance[5]: 2 or more LTHC which can include:
  - Defined physical or mental health conditions such as diabetes or schizophrenia
  - Ongoing conditions such as LD
  - Symptom complexes such as chronic pain
  - Alcohol and substance misuse
  - Sensory impairment

- BMJ[6]: multimorbidty described as an 'endless struggle' with high levels of psychological distress.

Multimorbidity

- The unhealthy state of homelessness (Homeless Link Health Audit 2014)[1]
  - 73% physical health problem (28% gen pop)
  - 80% MH problem (25%)
  - 66% drug or alcohol problem (5%)

Fit NICE criteria for multimorbidity

Frequent Attender's statistics from Great Chapel Street Medical Centre[7]

- Average over 8 months data – 80% drug / alcohol or mental health problem
- 40% of A&E attendance was from 'high users' (>2 x per month)
- 'Superusers' – 70% rough sleepers, 30% hostels
- 'Superusers' – 60% LTHC, 60% alcohol, 60% MH condition, 80% combination of at least 2 conditions defined in NICE guidelines

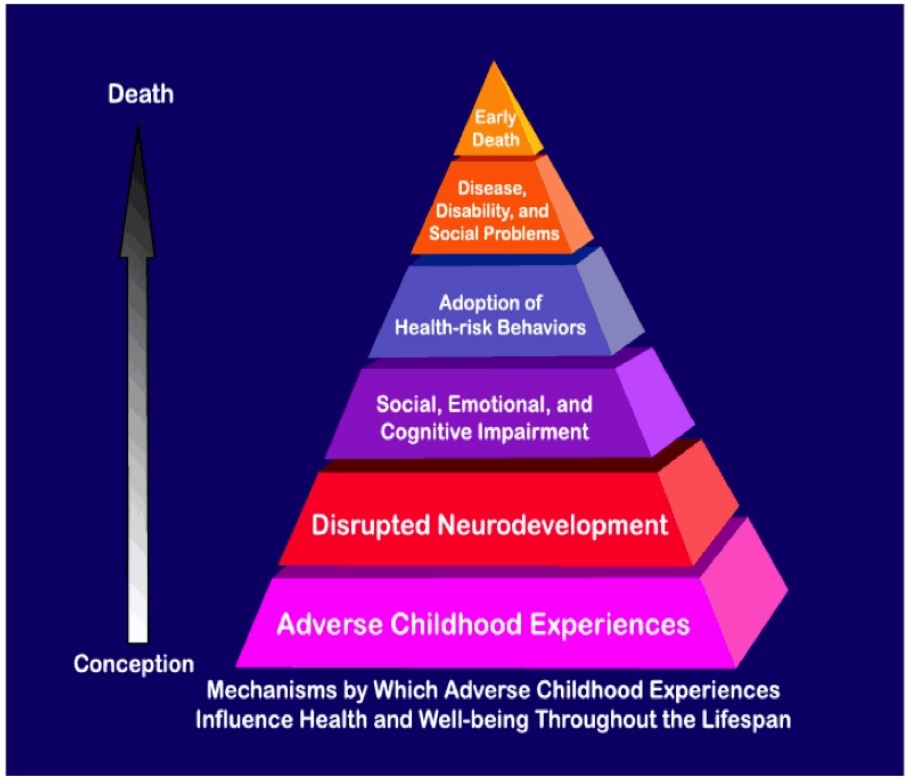
Layers of poor health

- Smoking
- Poor nutrition
- Poor cardiovascular health
- Lack of engagement with screening programme
- Reduced numbers of vaccinations
- Reduced prioritisation of health

Social determinants of health

- Low social group connectedness associated with higher frequency of primary care attendance[3]
- History of disrupted attachments / ACE[8]
  - ACE implicated in 10 leading causes of death in US
  - Negatively associated with health outcomes
  - 85% homeless had 1 ACE
  - 58% homeless had 4 ACE
- Low levels of resilience / coping (note some strong survivors also)
- Low levels of support
- High levels of barriers/ rejection / closed doors
- Cannot access 'mainstream alternatives'
- Warmth / food / TLC

Picture credit: ACE study – ACE Response 2018



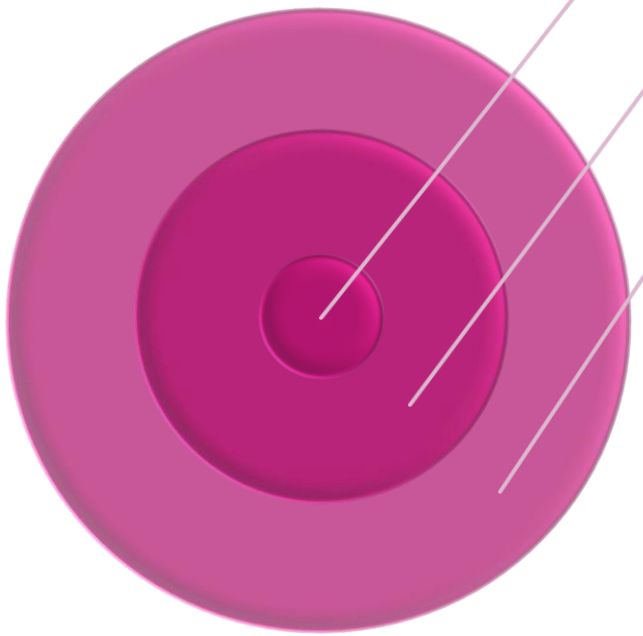
Resilience factors: American Psychological Association[9]

- The capacity to make realistic plans and take steps to carry them out.
- A positive view of yourself and confidence in your strengths and abilities.
- Skills in communication and problem solving.
- The capacity to manage strong feelings and impulses

Social Support and living conditions

- Friends and family have greatest influence on health and wellbeing (more so than health professsionals (Edelman Health Barometer Global Survey 2011)[10]
- Damp, cold and overcrowding linked to poor health outcomes (National Housing Federation)[11]
- Social and emotional support and it's implications on health showed robust relationship on protective factors for health[12]

The Frequent Attender's 'Onion'



Poor baseline health (ACE/smoking etc)

Lack screening, reduced prioritization of health, multimorbidity

Reduced support, reduced resilience, reduced availability of home comforts

Mitigating factors / Strategies for frequent attenders

- Rapid response teams – Require a ‘home’
- Frailty assessments and medicines reconciliation – Not often applicable
- Falls clinics
- Social services – Often disinterested / require address
- Home visits and district nursing – challenging

Strategies for reducing frequent A&E attendance

- Study 2001 by E. Burns.[13]
  - Older people have higher need for A&E due to increased risk of accidents and medical emergencies
  - Inadequate attention to functional ability in A&E in those discharged home requires urgent review
  - Functional impairment linked to repeat A&E attendance

NHSE 'Interventions for reducing emergency admissions'[14]

- Education and support for self-management
- Rehabilitation for those suffering from exacerbation COPD etc
- Early rv by senior clinicians in A&E
- Structured discharge planning
- 'External' factors influencing attendance – deprivation / demographics / need / socio-cultural norms / public health / social care
  - Deprivation
  - Smoking
  - LTHC (correlated with age)

Conclusions

- Health status of homeless people is **poor**
- Many homeless people will fit criteria for **multi-morbidity**
- Many homeless people will have additional **layers** contributing to poor health including low baseline and lack of protective and resilience factors
- Many homeless people experience **barriers** to accessing 'mainstream' services
- Many homeless people will experience episodes of **crisis** perceived as in need of urgent care
- Homeless people **die young**

Conclusions / Questions

- Greater recognition by commissioners of the poor health and high health needs of the homeless
- Cannot focus on health intervention alone as social determinants are a large part
- Greater education for hostels/day centres of alternative options (incl 111 / OOH) and up-skilling these services for treating homeless people
- Let's stop talking about it as a **behaviour problem** and start talking about it as a **public health issue**.

References

- 1 – **The Unhealthy state of Homelessness**, Health Audit 2014, Homeless Link
- 2 –Med J Aust. 2016 Feb 15;204(3):111.e1-7.**Factors contributing to frequent attendance to the emergency department of a remote Northern Territory hospital.**
- 3 – **Social Isolation Predicts Frequent Attendance in Primary Care** .Tegan Cruwys, PhD Juliet R H Wakefield, PhD Fabio Sani, PhDGenevieve A Dingle, PhD Jolanda Jetten, PhD*Annals of Behavioral Medicine*, kax054, https://doi.org/10.1093/abm/kax054
- 4 – **Managing Frequent Attenders to the ED: Challenges, opportunities and lessons learnt** The Tower Hamlets Frequent Attenders Project Rikke Albert – Nurse consultant, RAID Dr Hannah Osborne, Lead Clinical Psychologist – RAID Hannah Ryan, Assistant Psychologist, RAID
- 5 – https://www.nice.org.uk/guidance/qs153
- 6 – BMJ 2015;350:h176
- 7 – Frequent attenders data 2016-2018, Great Chapel Street Medical Centre
- 8 - ACE Response – aceresponse.org

References cont..

- 9 - Resilience factors: American Psychological Association
- 10 – Edelman Health Barometer Global Survey 2011
- 11 – National Housing Federation
- 12 – Social and emotional support and it's implications on health (https://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=18332671)
- 13 – Older People in A&E departments – Age & ageing 2001, E. Burns.
- 14 – NHS England: 'Interventions for Reducing Emergency Admissions'

Questions?

- **natalie.miller9@nhs.net**