The effectiveness of specialist and mainstream primary health care services for people who are homeless: the HEARTH study

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Background

- 1970s onwards: specialist health services for people who are homeless developed in some UK towns / cities.
- Very few evaluations or comparisons of above services. Long-standing debates about specialist versus mainstream primary health care provision.
- 2010: Department of Health identifies need for evidence about the effectiveness of primary health care services for people who are homeless.
- 2013: National Institute for Health and Care Research (NIHR) calls for studies on effectiveness and cost-effectiveness of innovative and integrated health and care services for people who are homeless in England.
- 2015-21: **HEARTH study**, funded by the NIHR (HSDR 13/156/03).

The views and opinions expressed in this presentation are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the HSDR programme or the Department of Health and Social Care.

Objectives of HEARTH study

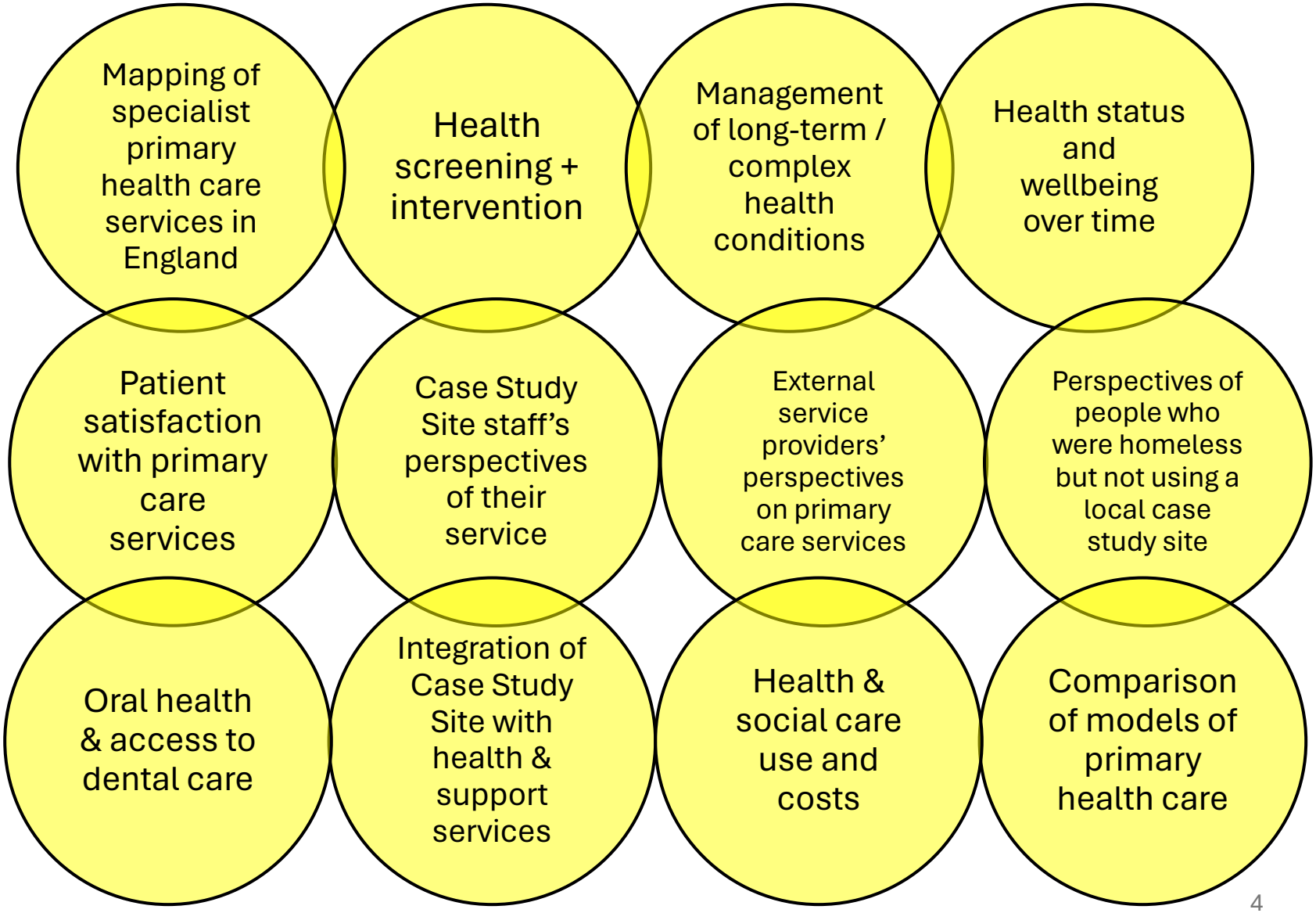
Overall aim

- To evaluate the effectiveness and service use costs of different models of primary health services for single people who are homeless.

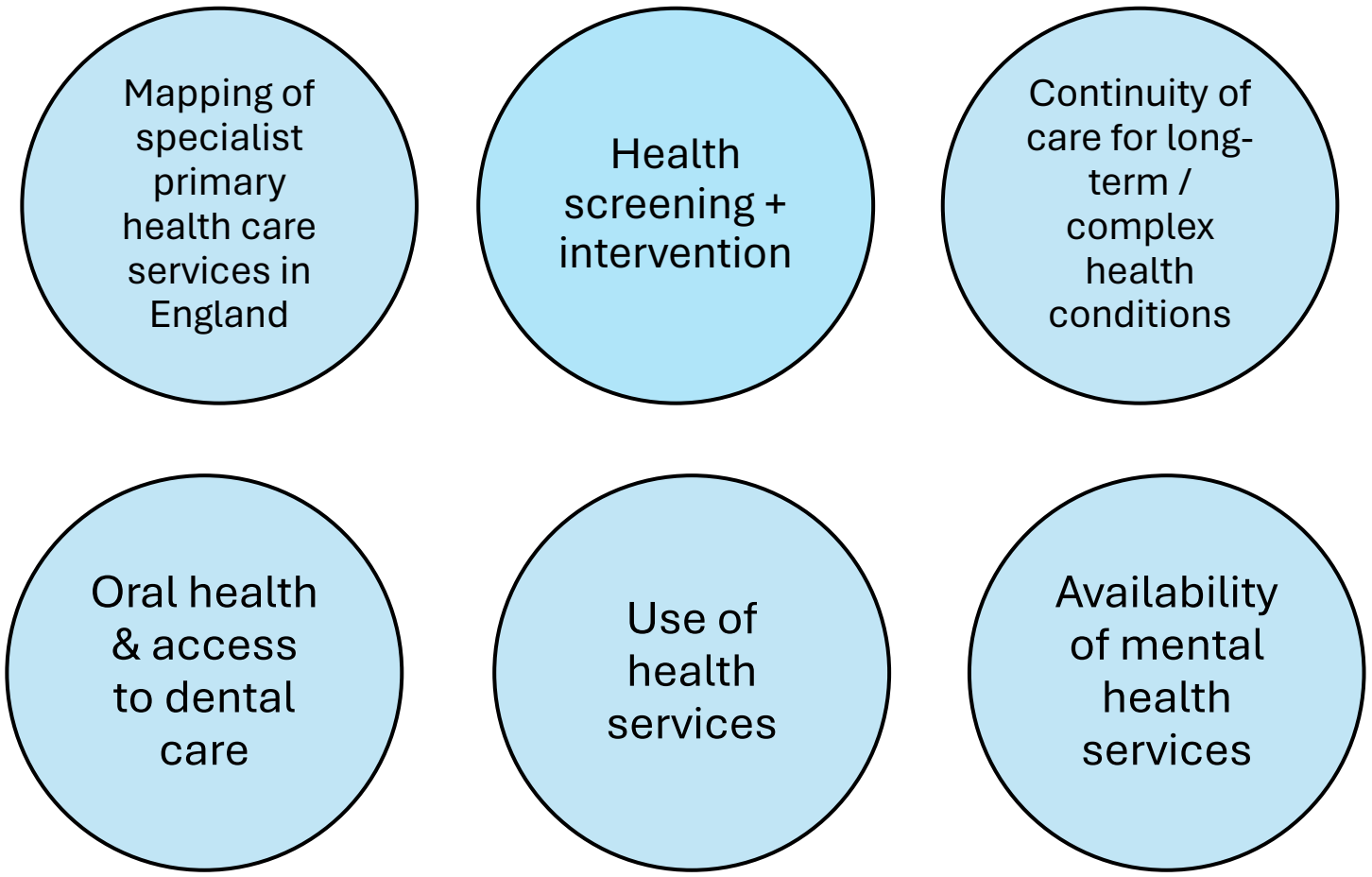
Research questions

- Which models or service elements are more effective:
  - in engaging people who are homeless in health screening and health care?
  - in providing continuity of care for long-term or complex health conditions?
- What are the associations between integration of the models with other services and health outcomes?
- How satisfied are patients, primary health care staff and other agencies with the services?

Study outcomes



Study outcomes – this presentation



Findings from mapping survey

Conducted October 2015 – March 2017 across England. Overall,123 specialist primary health care services for single people who were homeless. Included:

- 28 health centres primarily for people who were homeless (Dedicated Centres).
- 12 mobile health teams that ran clinics in homelessness sector hostels and day centres (Mobile Teams).
- 61 mainstream GP practices ***with*** special services for patients who were homeless (Specialist GPs).
- 362 hostels and day centres (48% of total surveyed) were NOT covered by specialist primary health care service. Clients relied on mainstream GP practices (Usual Care GPs).
- Many homelessness service managers reported clients had difficulty accessing mainstream GP practices, *e.g.* registering and arranging GP appointments. Compounded by poor transport links and travel costs in some areas.

Evaluation of three specialist models plus usual care

Dedicated Centres Two Case Study Sites 96 participants	**Mobile Teams** Two Case Study Sites 96 participants
Specialist GPs Two Case Study Sites 96 participants	**Usual Care GPs** Four Case Study Sites 75 participants

Case study participants (criteria for inclusion)

- Aged 18+. Currently homeless or in last 12 months.
- Single people, not families / couples with dependent children.
- Registered with Case Study Site ≥ 4 months and seen Case Study Site doctor or nurse in last 4 months.

Data collected across all case study sites

Participant group	Baseline interviews	4-month interviews	8-month interviews	Medical records
Case study participants	363	272	263	349
				Interviews
Case study site (CSS) staff and sessional workers *(e.g., Nurses, GPs, admin staff, drug / mental health workers)*				65
Local service providers and stakeholders *(e.g., Hostels, day centres, outreach teams)*				81
People who were homeless but not using a case study site *(e.g., living in hostel in CSS area, but not used CSS)*				107

Key features of the Health Service Models and case study participants

Dedicated Centres

- Primarily for people who were homeless; number of patients registered considerably smaller than at Specialist GPs and Usual Care GPs.
- Core staff: GPs, practice nurses, receptionists, administrators, social practitioners or case managers.
- Offered daily drop-in clinics, planned appointments and longer than customary GP consultations.
- Multi-agency working a key factor: frequent clinics at CSS by mental health and substance misuse workers. Daily staff meetings attended by CSS staff and sessional workers.
- Close working with homelessness sector services and local hospitals. Both CSSs undertook outreach work.

Mobile Teams

- Core staff: mainly specialist nurse practitioners. Relatively small caseloads.
- No GP on either team so patients encouraged to register with local GP. Close working with some GPs (including joint clinic twice a week by one CSS); in most cases medical records shared.
- Much of their work involved assessing health needs of patients and linking them to GPs or other health services. However, they had contact with some patients throughout study period.
- One CSS had regular discussions with mental health services about patients. One employed part-time mental health nurse. Less integrated with substance misuse services
- Held drop-in clinics in several hostels and / or day centres. Undertook street outreach. Well-integrated with homelessness sector services.
- No ‘fixed’ health site for patient care. Reliant on homelessness services to host clinics. Facilities to see patients ranged from well-equipped medical rooms to use of communal spaces.

Specialist GPs

- Mainstream GP practices; therefore number of patients registered considerably higher than at Dedicated Centres. 4-7% of patients were homeless.
- Core staff: GPs, practice nurses, receptionists, administrators.
- Differences between the 2 CSSs in this model. One site (SP1) provided more intensive services to patients who were homeless than the other site (SP2).
- Services at SP1 comparable to Dedicated Centres, *i.e.* dedicated nurses, case managers, drop-in clinics at CSS, outreach on streets and in homelessness services, on-site clinics by mental health and substance misuse workers.
- SP2 had no staff exclusively for patients who were homeless, no on-site clinics by mental health and substance misuse workers, fewer clinics in homelessness services, no street outreach. According to staff, insufficient resources prevented the delivery of more enhanced services.

Usual Care GPs

- Mainstream GP practices; therefore number of patients registered considerably higher than at Dedicated Centres (three had >15,000 patients). Less than 5% of patients were homeless.
- Core staff: GPs, practice nurses, receptionists, administrators.
- Clinic at one CSS by mental health worker, and at 2 CSSs by substance misuse worker.
- No targeted or flexible services for patients who were homeless. No dedicated staff or drop-in clinics, no outreach, and few links to homelessness sector services.
- According to staff, insufficient resources prevented them from working in more proactive and targeted ways with patients who were homeless.

Characteristics of case study participants at baseline (*N* = 363)

- 80% male; average age 42 years.
- 80% born in UK
- 94% physical health problems; 91% mental health problems.
- 32% harmful drinking (35+ units weekly women; 50+ units men).
- 60% drug misuse: 40% Class A drugs; 23% injected drugs.
- Length of time homeless varied: < one year (9%); 10+ years (33%).
- 52% in hostel / similar; 21% sleeping rough; 19% other temporary accommodation; 8% own tenancy.
- 26% changed accommodation 4+ times during 12-month study period.

Health screening

Health Screening Indicators – criteria

Health Screening Indicator	Measure from medical records
Body Mass Index (BMI)	Documented in last 12 months and action if BMI shows underweight or overweight
Mental health	Record of screening for mental health problems in last 12 months and intervention if required
Alcohol use	Record of screening for alcohol problems in last 12 months and intervention if required
TB	Record of screening in last 12 months or screening offered
Smoking	Smoking status recorded in last 24 months and intervention if a smoker
Hepatitis A	• Record of two vaccinations for Hepatitis A in preceding 10 years, *or* • Vaccination programme in progress, *or* • Record of immunity

Health Screening Indicators – scoring

- Evidence extracted from **medical records** included screening and interventions documented in CSS consultations, A&E reports, outpatient letters, other sources
- Mobile team patient medical records included GP medical records in most cases

Scoring criteria for <u>each</u> health screening indicator	**Score**
Screening undertaken *and* intervention offered if indicated (advice, referral, monitoring or treatment)	1
No record of screening, or no intervention offered if problem identified	0
Total score per participant ranged from 0 to maximum of 6 (most favourable)	

Outcomes of health screening

Number of HSIs screened per participant	Dedicated Centre	Mobile Team	Specialist GP	Usual Care GP	All
Mean	3.54	2.90	3.34	3.51	3.30

- **Highest number screened:** Dedicated Centres and Usual Care GPs.
- **Fewest number screened:** Mobile Teams
- **Differences between Specialist GPs site scores:** SP1 very high (4.16); SP2 low (2.42).
- **Screening template resulted in relatively high scores:** Used by two Usual Care GP sites for people who were homeless

Regression analyses

- No significant differences in scores between Dedicated Centres, Specialist GPs and Usual Care GPs.
- Mobile Teams had highly statistically significant lower score.

Continuity of care for long-term or complex health conditions

Assessing continuity of care

Aim: How the CSSs managed health conditions that require follow-up over time and / or the involvement of shared care with specialist agencies, e.g. mental health or substance misuse services.

Four health conditions selected: (i) chronic respiratory problems; (ii) depression; (iii) alcohol problems; and (iv) drug problems. All common among people who are homeless.

For *each* condition documented in the medical records**, was continuity of care or follow-up provided over the study period?** Different criteria for each condition. Data only from medical records.

Continuity of care provision

Health conditions	Dedicated Centre %	Mobile Team %	Specialist GP %	Usual Care GP %	Mobile Team + GP practice %
Chronic respiratory problems	88	47	76	67	*60*
Depression	70	34	65	52	*69*
Alcohol problems	73	30	61	46	*49*
Drug problems	85	26	57	15	*49*

- Dedicated Centres, followed by Specialist GPs, most likely continuity of care for *each* SHC.
- Mobile Teams least likely (apart from drug problems), but rates increased when GPs added.
- Usual Care GPs very low for drug problems.
- Significant associations between substance misuse clinics at CSS and continuity of care for alcohol and drug problems.

Other outcomes / findings

Contact with GPs and primary care nurses

Contact over 12 months	Dedicated Centres	Mobile Teams	Specialist GPs	Usual Care GPs	General population
GP: mean number	18.6	7.2	10.0	5.8	*3.7*
Nurse / HCA: mean number	9.1	16.4	2.4	4.4	*1.3*

- All models – GP and nurse contacts higher than among general population.
- Dedicated Centre participants: substantially more GP and nurse contacts over 12-month study period than participants of Specialist GPs and Usual Care GPs.
- Regression analyses: strong association between number of contacts with GP or nurse and health screening. *More contacts led to improved health screening*.

Hospital admissions and use of out-of-hours services

During 12 month study period:

- 33% of participants had at least one hospital admission.
- 65% used out-of-hours (OOH) services (A&E, NHS walk-in clinics, NHS 111, ambulance call-out). 13% had 10+ contacts with OOH services (maximum number of contacts was 92).
- Number of OOH service contacts positively correlated with number of GP / nurse contacts. Suggests OOH services *not* used as substitute for GP / nurse consultations. Some participants frequent users of both types of services.
- No significant differences between models for use of OOH services and for nights spent in hospital.
- Only significant predictor of OOH service contacts was number of changes of accommodation during study. Each additional change = 1.45 times more likely to use OOH services.

Oral health and use of dental services

- **All models**: Poor oral health common. Many participants not registered with dentist, did not seek dental care, dental pain and other problems unaddressed.
- Dental anxiety and dental phobia more common among participants than general population.
- Dental services specifically for people who were homeless or vulnerable available at or near **seven** CSSs, but most had little integration or established formal networks with the CSSs.
- Dental services not effectively engaging with people who were homeless, and primary health care teams failing to screen for oral health problems and link participants with dental problems to dental care providers.

Availability of mental health services

91% of case study participants reported mental health problems.

CSS staff and external agencies from ***nine out of ten*** CSSs reported mental health services poorly available in their area – affecting patients' health and work of primary care providers.

Problems included:

- Long waits for people to be assessed and start treatment;
- Insufficient services for people with mild to moderate mental illness;
- Long waits / barriers to services for people with combined mental health and substance misuse problems;
- Lack of community mental health nurses and of hospital provision.

Conclusions and considerations

Conclusions

- **Dedicated Centres and Specialist GPs** (particularly SP1) – more favourable outcomes. Service delivery factors likely contributed to their success e.g. dedicated staff, flexible services, multi-disciplinary working, outreach.
- **Mobile Teams**. Less favourable scores for some outcomes. Primary health care by both Mobile Team nurses *and* local GPs. Patients not registered at same GP practice, so nurses needed to collaborate with several GP practices. Delivery of health care by *multiple* providers at *different* sites likely to have affected outcomes.
- **Usual Care GPs**. Model has key role in health care delivery to large number of people who are homeless. Study found poor performance for some outcomes. Likely affected by large practice size lists, no dedicated staff or targeted services for patients who were homeless, inflexible services.
- **Mental health and dental services** not meeting needs of people who are homeless.

Considerations for health service commissioners / managers

1. Are the **primary health care needs** of people who are homeless in a locality being met? If not, what **model of health care provision** would be most beneficial and feasible?
2. What is the role of **Mobile Teams**? Should they be:
   a. more involved in health screening and care for long-term conditions?
   b. part of a general practice rather than a separate service, while maintaining outreach?
3. Do **Usual Care GPs** have the capacity to provide health care to patients who are homeless?
   a. When is a more enhanced service required?
   b. Would a ‘homelessness lead’ in these practices be advantageous and feasible?
4. How can the **mental health** and **dental needs** of people who are homeless be adequately addressed?

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- Dr Sarah Coward

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People with experience of homelessness

Outputs / contact details

The following outputs are available for downloading at:

https://www.kcl.ac.uk/research/hearth

The final report

Briefing paper for NHS Primary Care and Integrated Care Commissioners

Briefing paper for NHS Primary Care Managers and Practice Staff

Summary report

Reports of mapping exercise

Inventory of primary health care services for people who are homeless

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