Homeless Health Outreach

Victoria Hirst

29/03/18

Objectives

- What is Outreach?
- Current outreach practice.
- Research project.

What is Outreach?

- Treatment modality for engaging isolated and underserved populations in health care

- Taking our services to the homeless population in non-traditional settings

Why Outreach?

Health Issue	Homeless Population	General Population
Long term physical health problems	41%	28%
Diagnosed mental health problems	45%	25%
Taken drugs in the past month	36%	5%

(Source: Homeless Link, Health Audit, 2014)

47

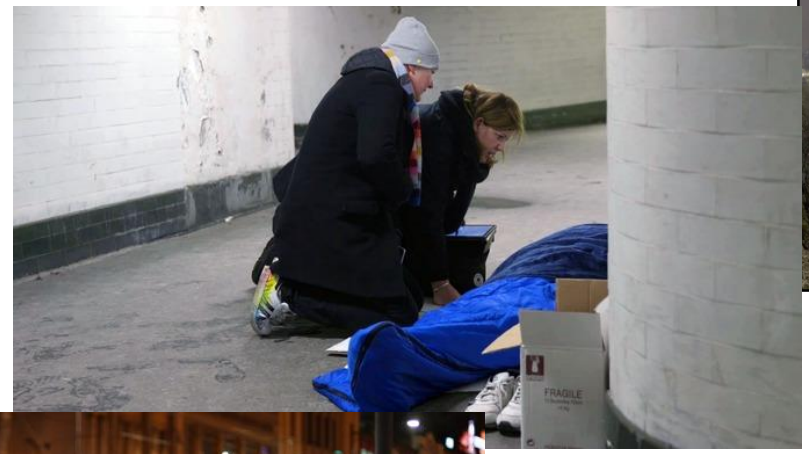
- Traditional GP model was not designed to meet the needs of the homeless population.
- A ‘one size fits all’ approach does not work and the varying needs of people affected by homelessness should be addressed **individually** and **flexibly**.
- Different models of primary health care provision have developed – initially specialist ‘walk in’ centres for homeless patients.
- Despite these specialist services there are ongoing barriers to patients accessing healthcare.

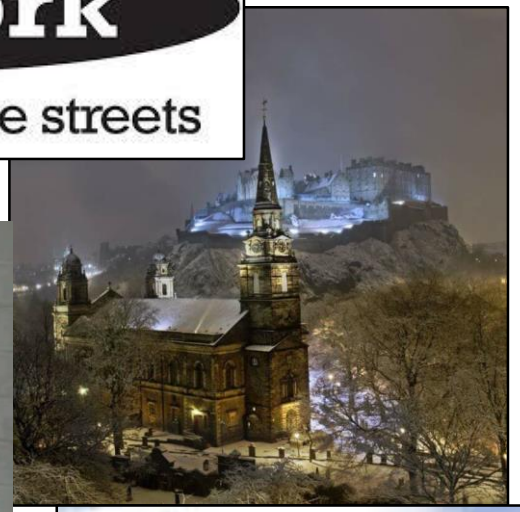
Outreach

- Working even more flexibly
- Tailoring services to meet the needs of our patients
- Taking services to the patient
- Engaging the most vulnerable and hard to reach patients

Where?

- 3rd sector organisations
- Crisis centres
- Community centres
- Hostels
- Food drop ins
- Soup runs
- Night shelters
- On the street





Where?

Glasgow

- GP- hostels
- Pharmacy assertive outreach team
- HIV outreach
- Podiatry outreach

Edinburgh

- GP and CPN- Streetwork
- EAP clinical support worker outreach
- CPN – night shelters

Ayrshire and Arran

- Homeless outreach nurses

Dundee

- Homeless health outreach team

Perth and Kinross

- Community health and wellbeing team

THE UNIVERSITY of EDINBURGH

School of Health in Social Science

An exploration of homeless patients' experience of General Practice care in an outreach setting.

Vicky Hirst and Fiona Cuthill
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Aim

- To explore homeless patients' experience of general practice care in an outreach setting

Research Questions

- What are the barriers and enablers to using GP outreach services as experienced by people who are homeless?

- What do homeless patients perceive as advantages and disadvantages to having a GP service that operates in an outreach setting?

Methodology

- Qualitative research study.
- Semi-structured interviews with patients using the GP at the outreach setting.
- The study took place across two different cities (Edinburgh and Bradford) in 3 different settings.
- 10 interviews in Edinburgh, 12 in Bradford

Methodology

- Ethical approval given
  - NHS Ethics Committee and University of Edinburgh Ethics Committee
- Recruitment
  - posters and information session held for staff at the outreach setting.
  - Staff recommended eligible patients and informed the researcher
- Analysis
  - interviews transcribed, coded, categorized
  - thematic analysis conducted

Settings

Setting	Services	Hours	Outreach
1 Crisis centre	Shower facilities, washing machines, support work, internet access.	7am -10pm Mon-Sun	Weekly 8am – 12noon
2 Food drop-in	Breakfast and hot lunch, clothing bank, literacy teaching, housing/legal advice, hairdresser.	9am – 1pm Weekly	Weekly 9am -12noon
3 Food drop-in	Drink and hot meal, clothing bank.	9-11am 6-8pm Twice weekly.	Every session

Demographics

Edinburgh
10 participants in total all currently homeless
8 male; 2 female
5 UK born; 5 born abroad (3 EC; 2 International)
Age range 19-54

Bradford
12 participants in total all of whom have been homeless within the last year
7 male; 5 female
All UK born
Age range 33-60

Comfortable, safe and a sense of belonging; ‘It’s just like one big family’

Comfortable

‘It’s more, I don’t know its more formal at the doctors place and its more relaxed here and these people are going through a very similar thing. You do see it at the specialist GP practice as there is a more stressful feeling there if you know what I mean, there is a lot more people there and you are boxed in and when you sit there you’ve got to actually sit there. **[Steve]**

‘It’s ok going to the GP surgery but when you go to the GP surgery you are just sat there you know and there is no body talking to you. Here it is different, you are free to talk, you know, like people to talk to while you are waiting. That’s a really good thing, it calms you down as well.’ **[Graham]**

‘It’s just like waiting with friends, you know talking with friends. There is no one up there to really talk to while you are waiting. So yeah, just communication with other people and that here, better than just being sat on your own waiting up there (specialist homeless practice) for the doctor.’ **[Sharon]**

Safe

'It's controlled. There are, not strict limits, but behavioural patterns of some people out on the street are less than sort of what you would like to encounter, where as here it's all controlled, regulated, you know it's a queue for a shower, queue for a washing machine. Everyone is treated with the same level of respect, if you like. So it is quite a safe sort of place to come in,' **[Jim]**

Sense of belonging

'*When I walk through the door I get greeted, you know, normally by name, and they (the volunteers) ask me how I am doing and they will ask me if I need the doctor or anything else that is here that day.'* **[Graham]**

'People are on your level aren't they, you understand where people are coming from, you know what they are talking about. It is virtually the same faces every week so you get to know the people, you get to know the atmosphere, you get to know the volunteers.' **[Robert]**

Convenient, opportunistic and a one stop shop; ‘It’s a bonus thought here’

Convenient

‘Sometimes it is difficult to get up at nine o’clock because of whatever circumstances you are in so it is easier just to see the doctor here. They don’t just visit here, they visit other places at well. There is always a meeting place where you can meet them where it is actually convenient for you, you know what I mean’ **[Robert]**

Opportunistic

‘*I stumbled across it (the GP outreach service) at first. I was just told it was a food place and they clothe you and give you sleeping bags and what not because I was on the streets when I first came and then I got told there was a doctor here and they came round with a form and I put my name down.’* **[Steve]**

‘Aye, you know, it is that sort of impulse buy, if you like. But the fact that she is here (GP at outreach service) and she is like that sort of dear sweet Aunt that always looks out for you. ‘Oh I need to see you!’ And it is quite reassuring to know that.’ **[Duncan]**

One stop shop

'It's (the GP outreach) a bonus thought here because you get your food here and stuff and you can get lots more help as well' **[Steve]**

'Oh they (service users) come here for food, for drinks, to see the doctor, speak to the workers, to mingle with other people' **[Sharon]**

'This is a comforting situation (at outreach setting) because this is in one place here…so I can take shower, eat breakfast and come back here to see my GP' **[Arthur]**

Being heard, having more time and breaking down barriers; ‘Less of a white coat syndrome here’

Being heard

‘A homeless guy actually said Darren there is a place up there where you can get a sandwich for free and there is actually a doctor what will sit and listen to you and not just give you a prescription and rush you out the door’ **[Darren]**

‘The doctors and the nurses are coming out to see us’ **[Alex]**

More time

*‘He (the doctor) didn’t seem to rush me like my normal doctor does’***[Karen]**

‘Up here you can talk to the doctor for about half an hour if you want. You can talk about anything with doctors up here because they’ve got time for you’ **[Alan]**

Breaking down barriers

'It (GP outreach) is far more approachable, you know, there doesn't seem to be, whichever doctor it is or the nurse, it doesn't seem to be I-am-a-doctor, I-am-a-nurse. You know, its I-am-a-person, you-are-a-person , what's wrong with you? Which is the way it should be' **[Jim]**

'…see that's it here when they (the doctors) are walking around you can stop them and ask them' **[Graham]**

'At 'the outreach setting', it is far more approachable and friendly sort of atmosphere. I don't know how it works for them (the GPs) but certainly for us, for us it makes it feel a bit, a bit less of a white coat syndrome, you know, you're about to see the doctor' **[Duncan]**

Conclusions and implications for practice

- Findings were consistent across all three settings.
- The participants valued the outreach service and compared it favourably with specialist homeless GP services.
- The environment within the outreach settings was a key factor in facilitating engagement with the outreach GP.
- Current services should consider improving waiting room environments with a focus on meaningful activity.
- Patient feedback suggests that a service model where health and social care are closely aligned with third sector organisations in a ‘one stop shop’ may improve engagement with the underserved homeless population.

Discussion

- What current outreach work is going on in your area?
- Can you think of barriers to patients accessing health care within your service?
- How could outreach working be implemented to overcome some of these barriers?
- What are the limitations to providing outreach care?

Pharmacist Assertive Outreach

NHS
Greater Glasgow and Clyde

Introductions

Pharmacy Homeless Health Outreach Team
NHS GGC

Aim today to give a snapshot of our service

NHS
Greater Glasgow and Clyde

Lauren Gibson – Clinical Pharmacist
Kate Stock – Clinical Pharmacist
Sharon Lucey – Simon Community Liaison
Richard Lowrie – Lead Pharmacist (in clinic)

Plan

1. Introductions
2. What is the problem we are trying to solve?
3. Why clinical pharmacists might help
4. Service model
5. Kate- A typical day working in the Service
6. Kate- Patient Journey in the Service
7. Kate- Case Studies
8. Sharon- Simon Community Link
9. Challenges
10. Evaluation

What is the problem we are trying to solve?

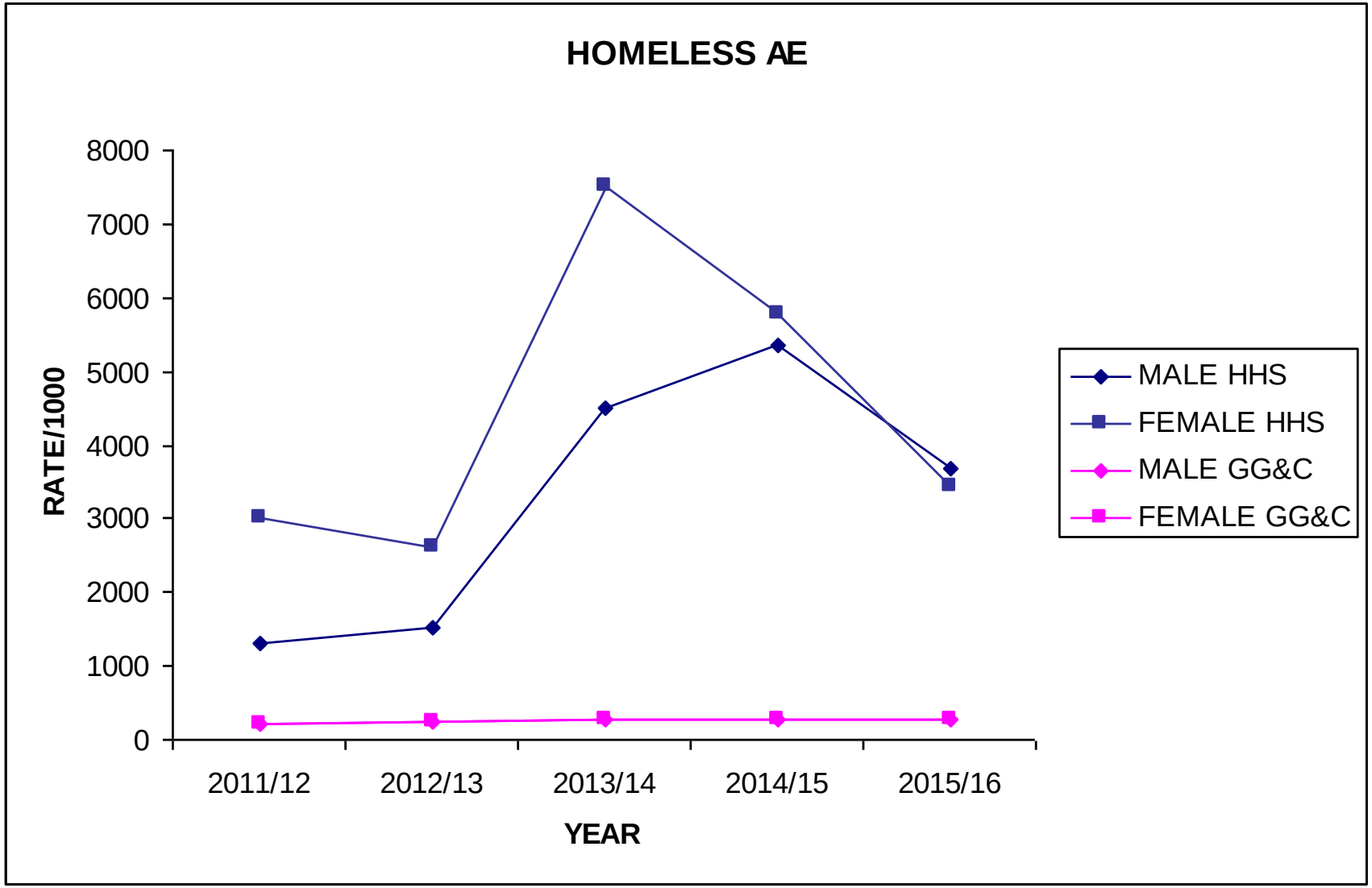
Target those not accessing services

- Sub Group not engaging
- Take healthcare TO the people
- Poor health outcomes
- High mortality
- High emergency care

Target those NOT engaging

- Homeless Services
  - Time & Resources
- Individualised care needed
- Vulnerable patient group

HOMELESS AE HHS VS GGC, MALE VS FEMALE



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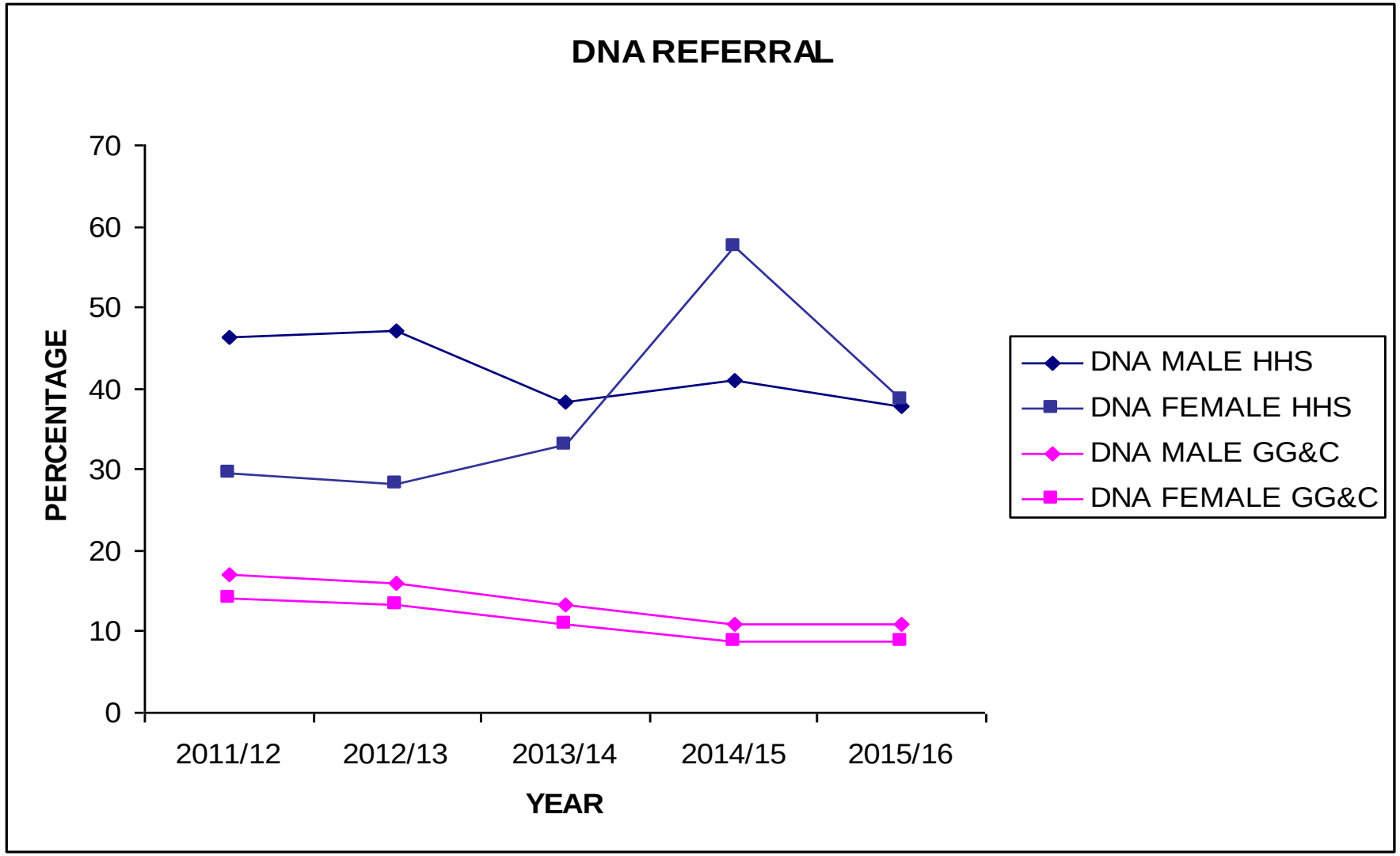
FEMALE:FEMALE HHS VS GGC = 15.0, 10.5, 28.4, 20.5, 13.0

DNA REFERRAL HHS VS GGC, MALE VS FEMALE



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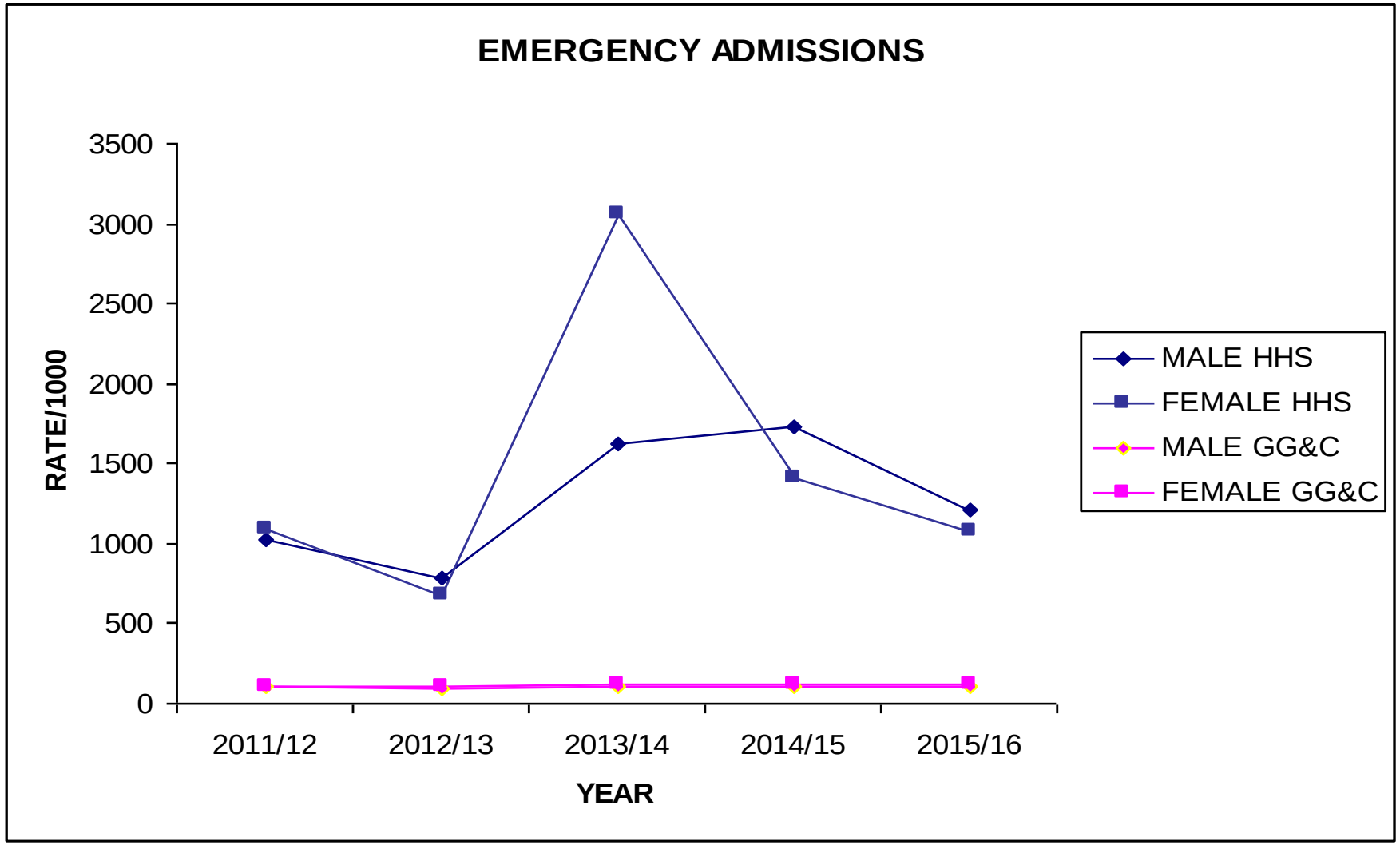
FEMALE:FEMALE HHS VS GGC = 2.1, 2.1, 3.0, 6.5, 4.4

EMERGENCY ADMISSIONS HHS VS GGC, MALE VS FEMALE



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Why clinical pharmacists can help

- GP Workforce Crisis
- Can give time
- Extra resources
- Well placed for an Add-On Service

- Pharmacists in GP practices common
- Independent Prescribers
- Experts in Medicines
- Chronic Disease Manager
- Medication Reviews
- Triage
- Red Flag Recognition

Service Model

Go to the People

- Pharmacist led outreach team in Glasgow City Centre
- **Anticipatory care model**
  Move away from reactive crisis –driven approach
- **Taking healthcare to the people who don't engage with current system**
- Venues throughout Glasgow City Centre where people would naturally congregate
- Comfortable, safe environment
- Serve free food, Activities
- Non threatening
- Relaxed environment

Simon Community Scotland

glasgow city mission
CHRISTIAN CARE SINCE 1826

Lodging House Mission

Glasgow City Mission
Lodging House Mission
Marie Trust Day Centre
Clyde Place Hostel

THE Marie TRUST
helping homeless people in Glasgow to help themselves

Service Model

Full Health Check (MOT)

- Comprehensive
- Early Identification
- Add on service
- More time to give
- 45 mins consults
- Time to follow up/chase
- Independent Prescribers
  - Prescribe where appropriate

EQ5DL- QoL

Medication Review
Secondary Prevention?

Cardiovascular
BP, Pulse, ECG ASSIGN

Respiratory
PEFR, RR, Smoking, COPD

Mental Health

BBV

Sexual Health

Nutrition (BMI)

Addiction Issues

Podiatry

Y = YES / N = NO / Blank = NO. Not Filled in - TR (Time Restraints), NCR (Not Clinically Relevant), N

Health Check- Pharmacy Team- Version Dec 2017

Date	
Location	
Completed by	
Engagement/referral	
Patient code	

Data Collection Key

Y= YES / N = NO / Blank = NO. Not Filled in - TR (Time Restraints), NCR(Not Clinically Relevant), ND (Not D

1. Consent

Do you consent to this health check? Yes /No
Do you consent for us to share this health check information with your registered Dr? Yes/ No
Do you consent to share your contact details (for follow up results etc) with SCS Street team? Yes/No
Do you consent for us to contact you again in a few months for follow up? Yes/No

***Patient Signature.....

2. Patient Details

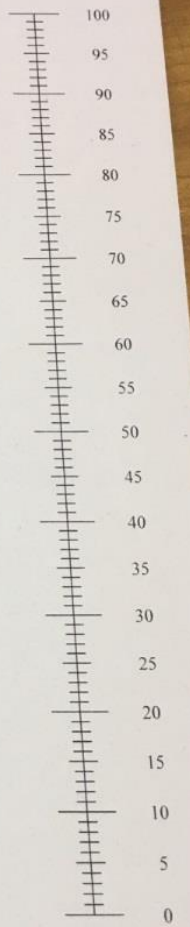
Demographics	
Name	
DOB	
Age	
Ethnicity	
Visit number	
CHI:	
Best way to contact you? Phone Number?/ Hostel/ Worker?	
Living Situation	
Where are you living?	
Rough sleeping? / Ever Rough Slept?	
Have you made a homeless application?/ In past 6 months?	
How long have you been homeless?	
General Health Information	
Last Registered GP? (& Address)	
Last visit to GP	
Last time had a health check?	
Any known health conditions?	
Any medications or take any vitamins/supplements?	
What pharmacy do you use?	
Other health workers engaged with?	
Other services engaged with	

Notes

Y = YES / N = NO / Blank = NO. Not Filled in - TR (Time Restraints), NCR (Not Clinically Relevant), ND (Not Disclosed

3. EQ5D5L

Under each heading, please tick the ONE box that best describes your health TODAY.	
MOBILITY	
I have no problems in walking about	❑
I have slight problems in walking about	❑
I have moderate problems in walking about	❑
I have severe problems in walking about	❑
I am unable to walk about	❑
SELF-CARE	
I have no problems washing or dressing myself	❑
I have slight problems washing or dressing myself	❑
I have moderate problems washing or dressing myself	❑
I have severe problems washing or dressing myself	❑
I am unable to wash or dress myself	❑
USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*	
I have no problems doing my usual activities	❑
I have slight problems doing my usual activities	❑
I have moderate problems doing my usual activities	❑
I have severe problems doing my usual activities	❑
I am unable to do my usual activities	❑
PAIN / DISCOMFORT	
I have no pain or discomfort	❑
I have slight pain or discomfort	❑
I have moderate pain or discomfort	❑
I have severe pain or discomfort	❑
I have extreme pain or discomfort	❑
ANXIETY / DEPRESSION	
I am not anxious or depressed	❑
I am slightly anxious or depressed	❑
I am moderately anxious or depressed	❑
I am severely anxious or depressed	❑
I am extremely anxious or depressed	❑



We would like to know how good or bad your health is TODAY
100 means the best health you can imagine.
0 means the worst health you can imagine
Mark an X on the scale to indicate how your health is TODAY
Now, please write the number you marked on the scale in the box below.

Your Health Number Today is = _____
How do you think you could improve this number? _____

= YES / N = NO / Blank = NO. Not Filled in - TR (Time Restraints), NCR (Not Clinically Relevant), NI

What would you like help with today?_____

4. CARDIOVASCULAR HEALTH CHECK- No Cardiovascular Problems ❑ / Section not filled in -TR ❑ NCR ❑

1) Patient History:

Angina	
Heart attack	
Ankle swelling	
CABG	
PCI	
PVD	
Stroke/ TIA (Mini)	

2) Family History:

Mother or father /brother or sister ever suffered:

MI	
Angina	
TIA	
Stroke	
@ under 60yrs?	

3) Physical Clinical Investigations:

BP	
Pulse	
Pulse Rhythm	Reg / Irreg
ECG	Normal AF Abnormal

4) Risk Score:

ASSIGN Score
if no CVD: *http://assign-score.com/estimate-the-ris*
(use population cholesterol score) use QQ1 1QQ p

.....

Lifestyle advice given?- diet (salt, fats etc) exercise and regular checks? Yes/ No

Summary & Follow Up:

5. RESPIRATORY HEALTH CHECK- No Respiratory Problems ❑ / Section not filled in - TR ❑ NCR ❑ NI

1) Patient History

COPD	
Chronic Bronchitis	
Emphysema	
Asthma	
If you have asthma or COPD do you think it is well controlled?	
TB	
Contacts with TB?	

2) Family History

Mother or father /brother sister ever suffered

COPD?	
Asthma?	

3) Current Symptoms

Do you have a cough?	
Do you bring up phlegm?	
Is your breathing ever wheezy (noisy)?	
Do you cough at night?	
Do you get night sweats/fevers?	
Have you coughed up blood?	
Other breathing problems	
Do you get breathless?	
If so, when and what were you doing?	
How breathless do you get?	
MRC1(no restrictions) 2 3 4 5 (SOB any movement)	

4)Smoking Status

Number cigarettes/day	
Rollups/day (half ounce=20)	
Age started.....	
Age stopped.....	
Have you tried to stop ?	
Do you know were to access stop smoking services?	

= YES / N = NO / Blank = NO. Not Filled in - TR (Time Restraints), NCR (Not Clinically Relevant), ND (Not Disclosed

13. SEXUAL HEALTH CHECK- No Problems ❑ / Section not filled in TR ❑ NCR ❑ ND ❑

Sexually active?	
If yes, ever tested for STDs?	
At risk of STD?	
Barrier contraception offered/accepted	
Summary & Follow up:	

**Sexual Health: 2 Sandyford place S'hall St 8.30am-8.00pm drop in: 211 8130

14. FEMALE HEALTH CHECK- No Problems ❑ / Section not filled in TR ❑ NCR ❑ ND ❑

Are you pregnant or chance could be pregnant?	
Last STI test (can cause infertility if untreated STI)	
Do you use contraception? /If so, what do you use? If not, would you consider contraception?	
Last smear test done (3 yearly)?/ Any abnormal smear test results ?	
Hysterectomy?	
Summary & Follow up:	

15. MEDICATION REVIEW CHECK- No Problems ❑ / Section not filled in TR ❑ NCR ❑ ND ❑

Medication	What is it for?	Last taken?	Pharmacy?	Prescribed by?	Any changes indicated?

Summary:
Follow up:

16. VENEPUNCTURE- Blood: if indicated; if we can follow up; and if patient agreed to act on results. Arm straight btw

Hep C antibody	
PCR	
HIV antibody/ antigen	
BNP	
H Pylori	
Total Cholesterol	
LDL Cholesterol	
If Asylum seeker/refugee: add 25 Hydroxy Vitamin D.	

Blood Bottles

Big purple - Virology

Gold top- Ca, LFTs, Alb, CRP, H Pylori, Total and LDL Chol, U&Es. + Mg if on PPI and / or Bev, 25 hydroxy Vit D

Wee purple - FBC differential, HbA1c

Grey top - Glucose

Standard: U&Es, LFTs, TFTs, FBC, Bone profile: one yellow, one small purple.

Hep C, HIV: one large purple. Alcohol excess: biochem: U&Es, LFTs, GGTs, Glucose

Extra Information

Derived scores:

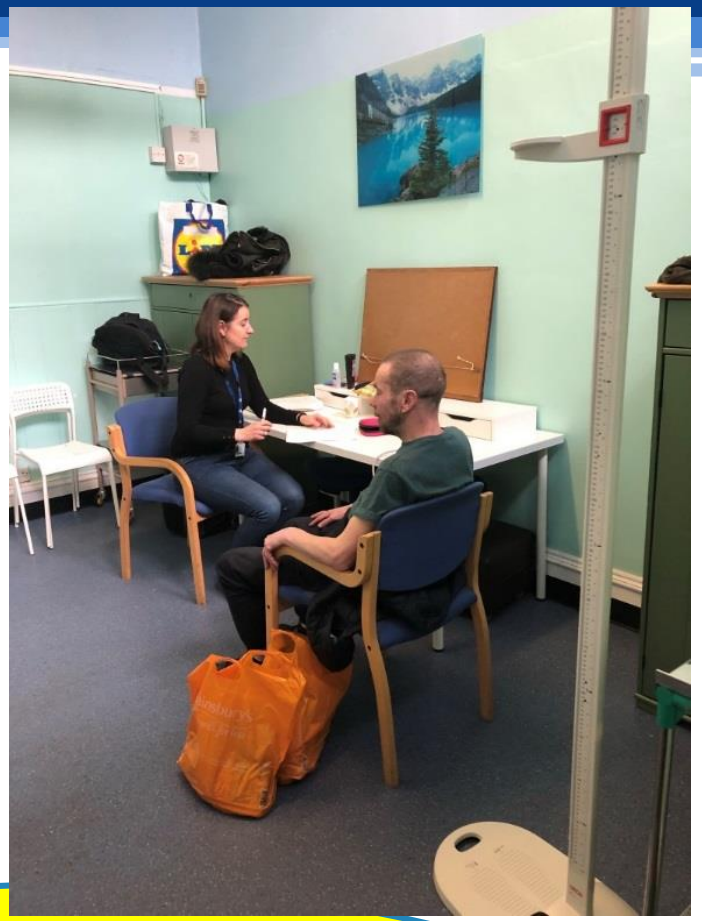
- AF: CHA_2DS_2-VASc Score
- ASSIGN if no CVD: (*http://assign-score.com/estimate-the-risk/*)
- MUST
- FAST
- FRAX
- Depression core features PhQ9/HAS/BD11

Extras

- For both male and female >50 Bowel Screening kit offer .....

Service Model

- Bridge to full homeless GP services
- Referrals to Specialists
- Fix what we can there and then
- Support of mainstream GP practices



Outcomes

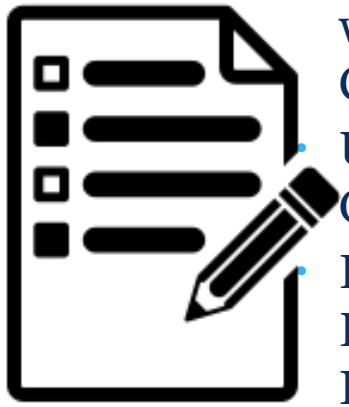
- Reduced A&E admissions
- Reduced emergency admissions
- Reduced minor injury admissions
- Reduced DNAs
- Increased primary care engagement

Kate- Clinical Pharmacist

Typical Day Working in the Service
Typical Patient Journey
Case Studies

A Typical Day working in the Service

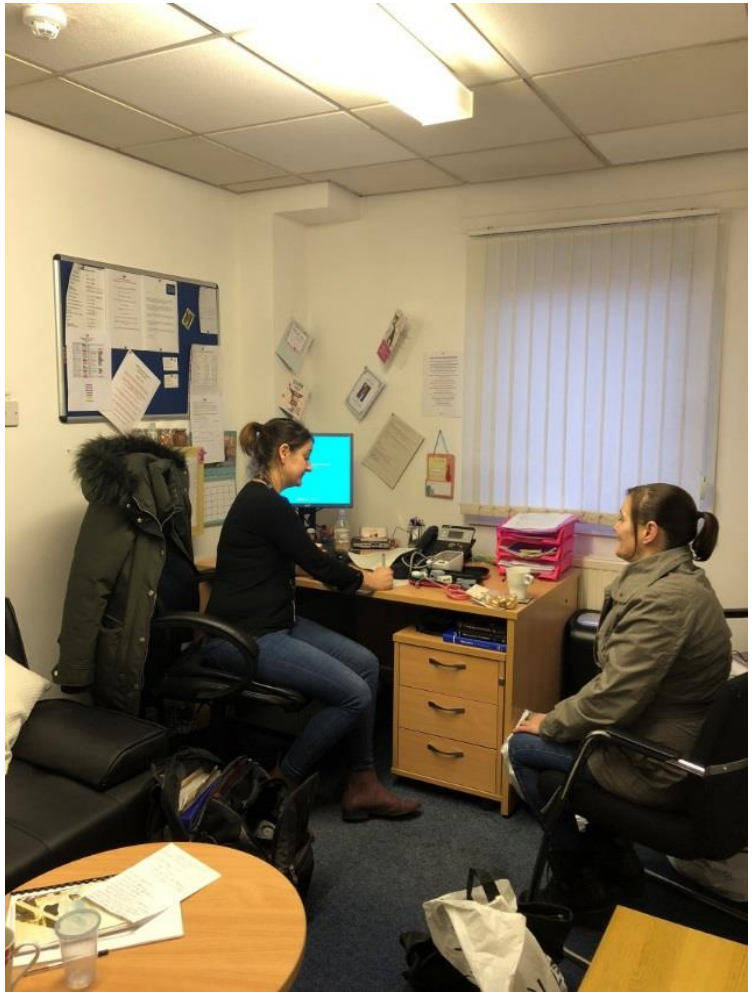
- Various locations throughout Glasgow City Centre
- Lodging House Mission
  - Health check.
    - High Blood pressure. Thiamine. Low mood. Arrange to get sleeping bags.
- Kingston Halls
  - Review patient after hospital discharge.
    - Chest examination. Organise taxi to get methadone and phone a prescription through to chemist. Contact HAT to arrange a new chemist.



- William Hunter House
  - Saw 4 patients
    - BP check, encourage smoking cessation, help write down questions for Consultant appointment.
    - Urine sample to hand in at GP
    - Prescription for thiamine. Dropped it in to chemist. Encouraged exercise. Note to GP re mood
    - Arranged a BBV test

Typical Patient Journey in Service

- Patient presents
- Particular problem or identify issues through questions and examination/tests
- Decide best course of action
  - Refer
  - Prescribe
  - Manage
  - Follow up



Case Studies

- AD
- 44 year old male
- Difficulty swallowing
- 2 stone weight loss

- PMH: Depression, fractured neck, ex IVDA

- Other issues: pain control, COPD

- Outcomes: urgent referral to GP – scope
  Ensure plus, patches for pain.
  Inhaler counselling

- Follow up:
  Lansoprazole
  4lb weight gain
  Pain control improved

- Next review
  Weight check
  Swallowing improvement
  Reduction gabapentin

Case Studies

- RJ
- 42 year old male
- Recent hospital discharge for wound and chest infection

- PMH: IVDU

- Issues: Chest, shortness of breath, weight loss.
  Needed assistance to get methadone

- Outcomes: prescription for antibiotics, steroids, inhaler, ensure.

Taxi to get methadone and prescription. New chemist for following day.
Microbiology for previous sample results to optimise medication

- Relay info to GP

- Follow up: via telephone. Discussions with GP and HAT worker

- Next review
  weight check. COPD check. Treatment.

Sharon - Simon Community

The Role of the Simon Community in this project

Simon Community Input

- Mainly link work

- Engaging and promoting the service to:
  - target population group
  - wider health care practitioners
  - addiction services
  - RSVP Teams
  - residential supported and emergency accommodations
  - other homeless organisations/ charities in Glasgow
  - homeless police and hospital liaison staff


Homeless people here
with a lovely natured dog
In desperate need of a room / private let if
anyone can help please help us
*rent will be payed straight from D.W.P to landlord
If someone can find it in there
hearts to help please do so
We need somewhere to feel safe.
Thanks You. X
God Bless

Challenges

- Professional challenge of Non Medical Prescribing
  - Balance of need, professional limitations & competence
  - Boundaries & clinical safety
    - how far to prescribe?

- Patients registered with mainstream GPs
  - Limited Care & Non Engaging?
  - Slipping through the net
  - Role for specialist teams working with mainstream GPs
    new link?

- Working with other homeless services
  - Disjointed, waiting times
  - Lots of different teams & faces
  - Need to join the dots better
  - Cannot run like a mainstream service

Evaluation & Research

1. Describe health/service utilisation of homeless in Glasgow

2. Systematic review of homeless health interventions (in press)

Hanlon P et al. Interventions by healthcare professionals to improve management of physical long-term conditions in adults who are homeless: a systematic review protocol. BMJ Open 2017

3. Pilot study of effectiveness & reach (HIS)

4. Qualitative work (Sarah Johnsen, Fiona Cuthill)

5. Multicentre RCT
   Effectiveness, cost effectiveness, reach

6. Robust case for sustainable funding?

Close

How do we reach out to him?

Thanks

Contact:

Lauren.gibson@ggc.scot.nhs.uk
Kate.stock@ggc.scot.nhs.uk
Richard.lowrie@ggc.scot.nhs.uk