THE HOMELESS HEALTHCARE HUB

EVALUATION SNAPSHOT – AUGUST 2022

HOMELESS HEALTHCARE

BACKGROUND TO THE HUB AND THE HOMELESS HEALTHCARE MODEL OF CARE

The Hub is Homeless Healthcare's (HHC's) fixed-site, primary care clinic for people with a current or past lived experience of homelessness. Formerly known as the HHC Transitions clinic, it was based in Leederville until HHC relocated its expanding service to the more central location of Lord Street in Highgate in 2020.

The name of **the Hub** derives from the **HHC 'hub and spokes' model of care**, within which HHC staff work across multiple services and settings to ensure that individuals who are or have experienced homelessness can access:

1. coordinated care from a range of health professionals and healthcare providers;
2. healthcare in places that are familiar, trusted, trauma informed and accessible to them;
3. primary care in community to reduce hospital presentations
4. continuity of staff and care throughout their health care journeys
5. referrals and support to access housing and other social sector and community services

A key aim of HHC and The Hub is to reduce barriers to healthcare access and navigation, and facilitate the building of trust and rapport with a population that often has negative prior experiences with the health system.

The **HHC ethos and model of care** is based on the premise that the single, biggest thing that can be done to improve the health of people who are experiencing homelessness is to find them safe, secure housing while concurrently stabilising and treating their health issues. Recognising that a raft of social factors impact upon the health and wellbeing of this population, **the model** thereby incorporates, as essential components, psychosocial support and connections of patients to communities and other support services.

This report is based on findings from an ongoing evaluation of homeless healthcare by the UNDA Home2Health Research Team. Authors: Lisa Wood, Matthew Tuson, Isaac Wood and Shannen Vallesi.

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THE HHC HUB CONSISTS OF

A FIXED-SITE, PRIMARY CARE CLINIC	Ten GP clinics per week, supported by registered nurses (RNs) who also see each patient prior A trauma-informed ethos across the reception, waiting room, clinics and staff
A BASE FOR ALLIED HEALTH SERVICES	• Physiotherapy • Occupational Therapy • Podiatry • Psychological Counselling • Potential future space for a dental clinic
A COORDINATING OPERATIONS BASE FOR A RANGE OF HHC SERVICES	• *Street Health – Outreach* to street-present people, led by RNs and caseworkers • *Mobile clinics* to drop-in centres, transitional accommodation services, domestic violence shelters and drug and alcohol rehabilitation services • *Home-Visiting GP Service* • *The After-hours Support Service (AHSS)*
A WOMEN'S CLINIC	A fortnightly clinic that enables victims of family and domestic violence and others who find mixed-gender clinics challenging to see a female GP in a safe and understanding environment
EDUCATION & TRAINING	• Staff training, professional development • Patient education activity area • Debrief and reflective practice space for staff
COORDINATION FOR RESPONSE TO WA HEALTH PRIORITIES	Coordination of integrated responses to current and emerging issues across HHC *(e.g., COVID-19, the syphilis outbreak, influence vaccination uptake, HIV)*

HOW THE HUB DIFFERS FROM MAINSTREAM GP PRACTICES

- Consultation times are longer, which is necessary so that patients who have experienced trauma can engage, and so that the often complex, inter-related health needs of people experiencing homelessness can be managed
- Nursing ratios are higher (due to health complexity), and a range of nurse-led health care that is not billable to Medicare is provided
- All patients are bulk-billed to Medicare, regardless of their consult duration. Patients without Medicare cards are still seen
- Appointment times can be fluid, and, within reason, patients arriving early or late will be accommodated. Missed appointments are re-scheduled without judgement
- Patients are heavily supported by reception staff to maintain their appointments (including via the provision of multiple reminders, public transit cards, and notifications of caseworkers and/or carers
- Patients can be transported to the clinic to receive care that cannot be administered on the street or at drop-in centres
- Counselling and allied health services are available at same clinic, where patients feel safe and comfortable to attend

Importantly, given its homeless clientele, The Hub is easily accessible via public transport; within walking distance (10-15 minutes) of a number of homelessness services and drop-in centres; and conveniently located within both 1 km of Royal Perth Hospital (the public hospital that sees the greatest proportion of homeless patients in WA) and 2 km of the Medical Respite Centre for people experiencing homelessness who are being discharged from hospital.

"Many of our patients have experienced trauma both prior to and while experiencing homelessness, and its impacts do not end when someone gets a roof over the head. Continuity of trust and healthcare is paramount for people who have survived chronic homelessness. After years of homelessness, many of our patients also find it really overwhelming when they are first housed, and the risks of returning to homelessness are something we look out for. Continuity of trust and health care is paramount for people who have lived through chronic homelessness."

– Dr Andrew Davies, Homeless Healthcare CEO

WHO WAS SUPPORTED AT THE HUB?

1 JULY 2017 – 30 JUNE 2022 (LAST 5 YEARS)

2,480
INDIVIDUALS SUPPORTED

22% ABORIGINAL AND/OR TORRES STRAIT ISLANDER

60% MALE

40% FEMALE

45 YEARS OLD, ON AVERAGE
(range: 0 – 89 years old)

94% ADULTS

6% CHILDREN AND ADOLESCENTS

HOMELESSNESS STATUS OF PEOPLE SEEN AT THE HUB

88% OF HUB PATIENTS HAVE EXPERIENCED CHRONIC HOMELESSNESS

10% OF HUB PATIENTS ARE CURRENTLY AT RISK OF HOMELESSNESS

69% OF HUB PATIENTS ARE HOUSED IN LONG-TERM ACCOMMODATION

31% OF HUB PATIENTS ARE ROUGH SLEEPING OR IN SHORT-TERM ACCOMMODATION

"Although two-thirds of Hub patients are currently housed in long-term permanent accommodation, this is often precarious for years after they are first housed. The impact of chronic homelessness is pervasive and without consistent healthcare access and psychosocial support, we sadly often see patients return to homelessness, with both their physical and mental health worsening as a result of this."

- Alison Sayer, COO Homeless Healthcare

HEALTH CONDITIONS OF PEOPLE ACCESSING THE HUB

1 JULY 2017 – 30 JUNE 2022 (LAST 5 YEARS)

Below are the most common chronic conditions the 2,480 people who accessed The Hub during the 3-year pre-first contact period were diagnosed with and treated for. This does not account for the complex multi-morbidity that most patients had; **70% of patients had at least two chronic conditions**, and 35% had 5 or more such conditions.

43% DEPRESSION (N=1,076)

30% CHRONIC PAIN (N=736)

30% ANXIETY (N=731)

23% ALCOHOL USE DISORDER (N=568)

21% HEPATITIS C (N=520)

19% AMPHETAMINE USE DISORDER (N=473)

16% BENZODIAZEPINE USE DISORDER (N=398)

16% OPIATE/HEROIN USE DISORDER (N=392)

15% PTSD (N=381)

14% ASTHMA (N=337)

13% GORD (N=329)

12% SCHIZOPHRENIA (N=301)

SUPPORT PROVIDED BY THE HUB

1 JULY 2017 – 30 JUNE 2022 (LAST 5 YEARS)

40,960
APPOINTMENTS
(over 5 years)

94% WITH A GP AND/OR NURSE

6% WITH AN ALLIED HEALTH PROFESSIONAL
(including counsellor, podiatrist, physiotherapist, caseworker and occupational therapist)

9,407 APPOINTMENTS IN THE LAST YEAR
(2021-22 financial year)

42% INCREASE IN NUMBER OF INDIVIDUALS SEEN AT THE HUB *(in the past five years)*

22% INCREASE IN NUMBER OF HUB APPOINTMENTS *(in the past two years)*

INCREASE IN INDIVIDUAL PATIENTS SEEN EACH YEAR, WITH 1,043 PEOPLE SEEN IN 2021-22

HOSPITAL USE PRE-HUB CONTACT

FOR A SUBSET OF 1,258 PATIENTS WITH FOLLOW-UP, OVER THE 3-YEAR PERIOD PRIOR TO FIRST HUB CONTACT

In the three years prior to Hub contact, patients had very high rates of hospital use, with an upward trajectory in hospital use the longer they were homeless:

71% PRESENTED TO AN ED *at least once*

7,271 ED PRESENTATIONS *in total*

47% TOOK AN AMBULANCE TO HOSPITAL *at least once*

2,924 AMBULANCE ARRIVALS *in total*

58% HAD AT LEAST ONE INPATIENT ADMISSION

14,489 INPATIENT 'BED' DAYS *in total*

$49,407,236^ *in costs associated with hospital use*

EQUIVALENT TO
$13.1K PER PERSON, PER YEAR OVER THE 3-YEAR PERIOD

IMPACT OF MULTI-SITE HHC ACCESS ON REDUCING HOSPITAL USE

Background: Greg (now in early forties), had a history of childhood trauma, family breakdown, early drug use. He first saw HHC on a GP hospital ward round in 2017, at which time he had been homeless on and off for years. Between mid-2016 and 2018 he had 16 ED presentations and 12 hospital admissions (mostly at RPH), the latter accounting for 60 inpatient days. Most of his hospital use was associated with alcohol dependence; however, a lengthy admission for a severe lung infection at one point saw him transferred to a palliative ward (despite being only 37 years at the time). As noted by HHC GPs, homelessness was a stressor that exacerbated his drinking, perpetuating a cycle of hospital use, stress, and deteriorating health.

Support Provided: In the first year after HHC contact, there was considerable liaison between the RPH Homeless Team and HHC GPs to support him with alcohol withdrawal, manage his alcohol and source accommodation. Greg began to see an HHC GP several times per month at The Hub, or sometimes at HHC mobile clinics. There continued to be close collaboration between the Hub and the RPH Homeless Team when he presented to hospital.

Greg then secured transitional accommodation at a location where HHC conducts a weekly clinic, and continued to see HHC GPs both there and at The Hub. While his efforts to abstain from alcohol have been up-and-down over the last three years, he has maintained regular contact with HHC GPs throughout. Those GPs, in addition to providing medical support, have provided support letters for accommodation and Centrelink applications, and encouraged him in his TAFE studies and volunteering. As for many people in Greg's situation, the risk of returning to homelessness remains a concern, and psychosocial support continues to be as critical as the medical aspects of his healthcare.

Current Situation: Greg has sustained his accommodation in a semi-supported, independent living unit for people who have been homeless, and still has regular Hub appointments. His hospital use has steadily declined, reflecting the benefits of regular engagement with HHC and its role in securing him accommodation. Whilst some of the damage to his health is irreversible, his health issues are now primarily managed via primary care, complemented by regular outpatient clinic appointments.

^ Costs based on: the latest Independent Hospital Pricing Authority (Round 24) figures for the 2019-20 financial year for WA (for average ED presentation and inpatient day costs);[1] the mental health patient day cost for 2019-20 from the 2022 AIHW Mental Health services in Australia Report (for average psychiatric inpatient day costs);[2] and the 2022 Report on Government Services, Part E, Section 11 on Ambulance services for 2020-21 (for average ambulance arrival costs).[3]

SUPPORTING PATIENTS TO ACCESS MORE COMPREHENSIVE CHRONIC DISEASE MANAGEMENT AND COORDINATED MENTAL HEALTH CARE

Mental health and chronic disease account for a significant burden on hospitals and health system costs across Australia, and hence a key pillar of the Australian Government's Better Access initiative has been to bolster community access to comprehensive chronic disease management and coordinated mental health care through General Practice. Chronic Disease Management Plans and Mental Health Care Plans (MHCPs) are funded by the Medicare Benefits Schedule (MBS), and both are developed collaboratively between GPs and patients.[4] In the case of a MHCP, GP support can be complemented by access to 10 subsidised sessions with a psychologist per year (plus, currently, an additional 10 COVID-19-related sessions).

People who are on a Chronic Disease Management Plan may be eligible for Medicare rebates for certain allied health services, on referral from their GP. However, in recent literature and policy discourse, concerns have been raised about the equity of access to primary care plans in Australia for people who are more socio-economically disadvantaged, despite them being of higher need.[5]

AMONG HUB PATIENTS SEEN SINCE 2017:

20% HAVE HAD ONE (OR MORE) MENTAL HEALTH CARE PLANS

21% HAVE HAD ONE (OR MORE) CHRONIC DISEASE GP MANAGEMENT PLANS

"Prior to becoming Homeless Healthcare Hub patients, many of the people we see did not have a GP, which is a significant barrier in accessing chronic disease management and mental health care plans. Through Hub clinics, our GPs have been able to develop comprehensive, coordinated care plans to address health issues that have often been undiagnosed or inadequately treated for many years."

– Dr Andrew Davies, Homeless Healthcare CEO

IMPORTANCE OF LONG-TERM SUPPORT AND CONTINUITY OF CARE

Background: Melissa is in her late fifties and had been homeless for more than a decade when she first engaged with HHC. She has extensive trauma, dating back to her childhood, exacerbated by domestic violence, complex family relationships and traumatic experiences while homeless. She had multiple mental health issues, including depression, anxiety, post-traumatic stress disorder (PTSD) and a history of self-harm. When she first came into contacted with HHC, she was also experiencing severe back pain and had become addicted to painkillers.

Support provided by HHC and The Hub: Due to trauma, Melissa was extremely anxious about attending homeless drop-in centres and being around men; hence, it was critical that she could visit HHC at its fixed site clinic and feel safe. Her HHC GP began advocating with the Department of Housing to get Melissa housed and away from the re-traumatising circumstances of street life. Melissa commenced on a Mental Health Care Plan that included regular GP appointments at The Hub, and a referral for fortnightly counselling, with a counsellor who has extensive experience working with, and supporting, individuals who have experienced trauma while homeless. These counselling sessions were also at The Hub.

Melissa was finally housed after 14 years of homelessness, and as the transition to being housed was a very anxious time for her, and the stability of being able to see her HHC GP and counsellor regularly at a location where she felt safe was vital. Early on after being housed, Melissa expressed acute anxiety as to whether she could still attend HHC if no longer homeless. She was reassured that her continuity of trust and care could continue with the HHC GP practice – this is vital where there has been extensive trauma.

Current Situation: Over time, Melissa's mental and physical health has improved significantly; however, she remains vulnerable to setbacks, and still sees her HHC GP and the counsellor regularly at The Hub. The fact that she has not presented to hospital since 2015 has been recognised by the Clinical Lead of the RPH Homeless Team as a marker of the preventive difference that continuity of primary care, coupled with community mental health support and stable housing, can make: *"The life history of this patient is very distressing to read – that we haven't seen her in hospital reflects the amazing job done by HHC over many years, keeping her out of the hospital system and working slowly on her issues."*

IMPACT OF THE HUB UPON HOSPITAL UTILISATION

As part of the overall longitudinal evaluation of HHC that commenced in 2017, linked administrative hospital data for HHC patients, where available, are periodically obtained. For this evaluation, data from nine hospital sites,^^ including Perth's three primary tertiary hospitals and six other public metropolitan hospitals, were available for the period 1 January 2013 to 31 December 2021.

To evaluate the impact of patient engagement with the Hub over an extended period on hospital use, hospital data for **234 patients** whose first Hub appointment occurred between 1 January and 31 December 2018 were examined. These patients were those seen for the first time between 1 July 2017 and 30 June 2022, who additionally had at least three years of follow-up both prior to and following their first Hub appointment.

Specifically, the frequency of **four measures of health service use** were examined:

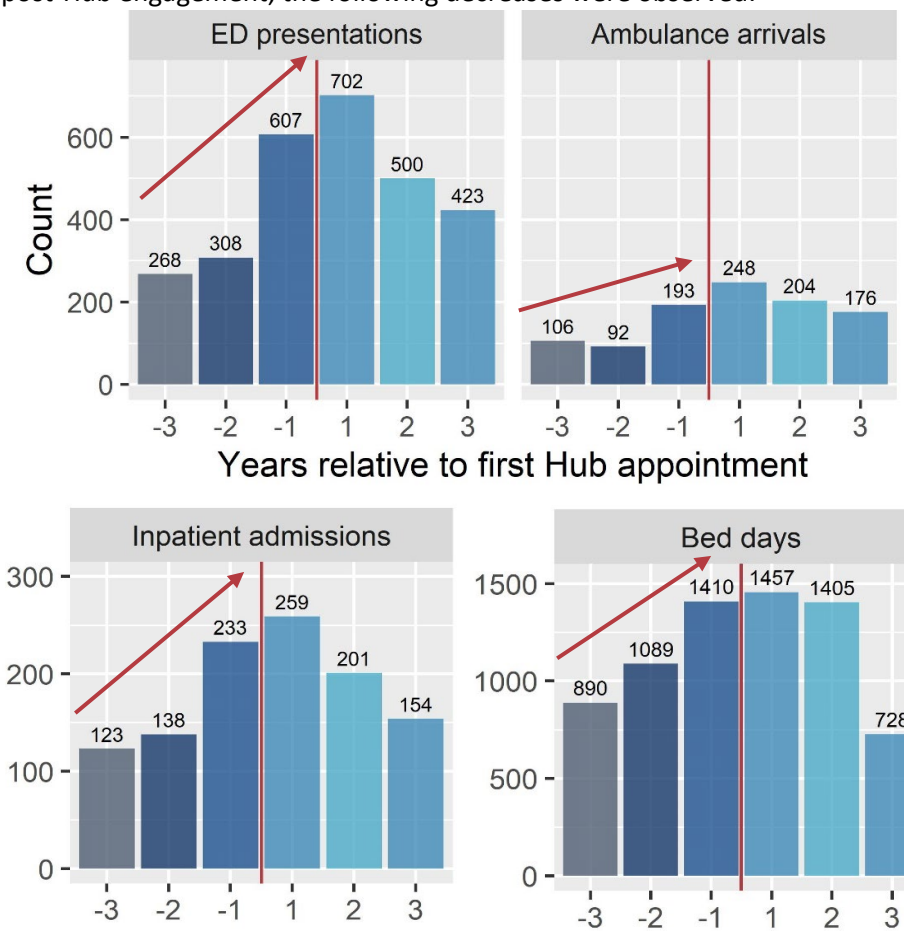
1. ED Presentations
2. Ambulance Arrivals to ED
3. Inpatient Admissions
4. Inpatient Days Admitted

HOSPITAL USE PRIOR TO HUB ENGAGEMENT

Among the cohort of 234 Hub patients, ED presentations, inpatient admissions and accumulated inpatient 'bed' days all increased over the 3-year period prior to Hub engagement (see arrows in the below graphs). These patterns reflect the finding of both the literature and our previous research[6] – that **health deteriorates, and acute hospital use increases, the longer people remain homeless**.

CHANGES IN HOSPITAL USE POST-HUB ENGAGEMENT

The majority of patients seen at The Hub have multiple co-existing health conditions and histories of trauma are common. Further, these health issues are often undiagnosed. Consequently, it frequently takes multiple appointments, often over several years, to compile a full medical history and to begin to stabilise conditions. Therefore, it is not realistic to expect significant hospital decreases due to primary care intervention in the short term, particularly where people remain homeless. However, when comparing hospital use between the first and third years post-Hub engagement, the following decreases were observed:



40%

DECREASE IN ED PRESENTATIONS
(from 702 to 423 presentations)

29%

DECREASE IN AMBULANCE ARRIVALS
(from 248 to 176 arrivals)

41%

DECREASE IN INPATIENT ADMISSIONS
(from 259 to 154 admissions)

50%

DECREASE IN ADMITTED INPATIENT DAYS
(from 1,457 to 728 days)

^^ Hospitals include: Armadale Kelmscott Health Service, Bentley Health Service, Fiona Stanley Hospital, Graylands Hospital, Kalamunda District Community Hospital, King Edward Memorial Hospital, Rockingham Kwinana Mental Health Service, Royal Perth Hospital, Sir Charles Gairdner Hospital

ASSOCIATED REDUCTIONS IN COSTS TO THE HEALTH SYSTEM ASSOCIATED WITH HUB

Changes in cost^ to the health system among these 234 people with 3 years pre/post Hub hospital data:

$20,933 PER PERSON IN THE FIRST YEAR AFTER HUB

$10,953 PER PERSON THREE YEARS POST HUB

48% REDUCTION IN ASSOCIATED HOSPITAL COSTS

$4,898,274/YEAR	**$2,562,918/YEAR**	=	**$2.3M LESS**

HOW DOES THIS COMPARE TO THE COST OF OPERATING THE HUB?

For the 1,043 patients supported in the 2021-22 financial year, the equivalent per-person cost of The Hub was:

$831^^^ **TO SUPPORT EACH PERSON AT THE HUB FOR A WHOLE YEAR**

THIS IS LESS THAN ONE ED PRESENTATION IN WA *($922 per ED presentation)*[i]

AND IS:

3.3x CHEAPER THAN A SINGLE BED-DAY IN A WA PUBLIC HOSPITAL *($2,758 per day admitted)*[ii]

SUPPORTING PATIENTS TO ENGAGE IN OUTPATIENT CLINICS

As was noted in the 2016 WA Clinical Senate on Homelessness,[7] outpatient clinic attendance by people of no fixed address is often very low. **Yet outpatient care is far less costly to the health system than having patients re-present to hospital.**

"Many homeless patients are given outpatient referrals when discharged from hospital, but without an address, appointment notification dates and referrals often don't reach them. If they don't have a regular GP, they are less likely to get encouragement to attend outpatient appointments. It is also hard to keep track of time and dates when you live on the streets."

- Dr Amanda Stafford, ED Consultant and Clinical Lead Homeless Team, RPH

How The Hub encourages outpatient clinic engagement:

- Outpatient referrals and appointment information can be sent to The Hub, and patients can be notified about these directly or via contacting their case worker or nominated contact
- The importance of outpatient attendance is explained and regularly discussed with by GPs and nurses
- Hub reception staff can contact patients to remind them to attend
- HHC nurses can sometimes accompany patients to an outpatient appointment if there are anxious
- Hub GPs are able to provide healthcare and support to complement outpatient clinic treatment, e.g., review of medication side effects or treatment compliance.

Impact of The Hub on Outpatient Clinic Attendance

Between 1 July 2017 and the 30 June 2022, almost 3 in 5 (58%) of all Hub patients had at least one outpatient appointment. These 1,426 individuals had a total of 19,291 outpatient appointments, with the most commonly attended outpatient clinics often corresponding to health issues that previously resulted in hospital use e.g., psychiatry, post hospital rehabilitation, plastic surgery for injury, respiratory medicine, physiotherapy, orthopaedics, gastroenterology, pain management.

For Hub patients, the rates of "non-attendance" at outpatient appointments decreased by 72%, with 9 out of 10 outpatient appointments attended following Hub engagement.

72% DECREASE IN NON-ATTENDANCE AT OUTPATIENT APPOINTMENTS

^^^ Average Hub cost: based on Hub operating costs 2021-22 of $867,272, averaged across 1,043 unique patients seen in same period. Note only 55% of costs covered by Medicare.

HOW HHC AND THE HUB CONTRIBUTES TO REDUCED HOSPITAL USE: CASE STUDIES

The following case studies are two of many examples of the way that the integrated support of HHC through the Hub and its other services, has contributed to significant decreases in hospital use for two Hub patients who were previously frequent presenters to WA hospitals. In the first of these case studies, the patient was one of the most frequent ED presenters in metropolitan Perth in 2021, with a total of 181 ED presentations in this year alone.

ACCOMODATION AND PRIMARY CARE IMPACT OF ACCOMMODATION ON REDUCING FREQUENT HOSPITAL USE

Background: Carl is a male in his early fifties, who has been homeless on and off for over a decade, primarily due to longstanding alcohol dependence. He has a history of frequent ED presentations and hospital admissions, largely associated with alcohol dependence and homelessness. In 2021 alone, Carl presented to an ED 181 times, (equivalent to an ED presentation every two days), equating to $166,882. His vulnerability on the street, and not being able to address his alcohol dependence whilst homeless, exacerbated his hospital use. In late 2020 for example, while intoxicated, Carl sustained a severe neck fracture, requiring a brace for two months. In subsequent months he presented regularly to ED due to falls and assaults as he was an easy target while homeless and wearing a brace. Due to heavy drinking, there were no suitable stable accommodation options for him.

Support Provided: Carl had been known intermittently to HHC via its mobile clinics and street outreach for a number of years. In mid-2021 Carl went into rehab, but rapidly exited and started drinking again, ending up back on the streets, and exhibiting increasing despair at his deteriorating life circumstances. Hospitalisation for pneumonia in late 2021 which gave the RPH Homeless Team a chance to engage with Carl, and it was beneficial that he was already known to HHC. He was supported to access supported accommodation in early 2022, in a setting where HHC runs mobile clinics that he attended. Carl hen commenced seeing a HHC GP at The Hub, and has been supported particularly around treatment of his anxiety, depression and alcohol dependence.

To date (early August 2022), Carl has only presented to ED 8 times, has made enormous progress with his alcohol dependence, and remains in supported accommodation where he is working on rebuilding his life.

IMPACT OF SUSTAINED PRIMARY CARE ACCESS ON REDUCED HOSPITAL USE

Background: Belinda is a woman in her mid-forties who has experienced homelessness on and off for most of her life, exacerbated by trauma and domestic violence. Dependent on alcohol and heroin, she has had several periods in residential rehab. Other health issues include heart disease, Hepatitis C, suicidal ideation, depression, and poor respiratory health.

Support Provided: Belinda's first contacts with HHC were in 2019 via hospital for opiate withdrawal and through contact with the Street Health outreach team. She began to see a HHC GP regularly at drop-in centre clinics, and commenced on treatment for opiate and alcohol dependence and Hep C, as well as regular primary care for other health concerns. When Belinda moved into transitional accommodation, she was encouraged to attend appointments at The Hub, as a way of further supporting her shift away from a rough sleeping way of life. The Hub staff organised for Belinda's first appointment to be with a familiar HHC nurse, providing a familiar face, and a soft introduction to a women's specialist GP. The Hub staff have worked in tandem with Belinda and her case worker to manage her AOD use and support her on a Suboxone program.

Current Situation: The Hub has been vital for Belinda to access primary health care and prioritise her health needs in a supportive and regular setting, rather than continuing to seek out healthcare through street nurse outreach and drop-in centres. She now attends monthly GP appointments at The Hub. As with many people who have experienced chronic homelessness, trauma and AOD dependence, there have been some lapses in AOD use, but she has been supported each time to understand her triggers and try again.

Hospital Use Cost Reduction: There has been a **significant reduction in hospital use by Belinda over the last three years**. In 2019 she had 18 ED presentations and two lengthy inpatient mental health admissions totally 42 days, and 3 other inpatient admissions (3 days total), equating to a hospital use cost of almost $91k. While In 2020 she continued to present to ED frequently, this was mostly associated consequences of homelessness (such as assault, malnutrition, winter pneumonia) as well as relapses in alcohol and opiate use. In 2021 by contrast, Belinda only had 6 ED presentations and 6 inpatient days (equating to $22k), and in the first 6 months of 2022, only 1 ED presentation and one inpatient day.

SUPPORTING PEOPLE ACROSS THE HOMELESSNESS TO HOUSED CONTINUUM

The HHC model of care understands that the journey out of homelessness is not straight forward, nor linear; looking different for everyone affected by homelessness. Resultingly, the hub and spokes model was developed to support people along the homeless-housing continuum.

No two experiences of homelessness are the same, and HHC has a strong focus on individualised person-centred care, supporting patients to disclose and address health and other issues at their own pace in a safe trauma informed environment.

For many HHC patients, their first contact with HHC begins while they are still street-present though the Street Health outreach service, or attending one of HHC clinics run in homelessness drop-in centres. **This initial rapport and trust building that occurs out in the community, 'wherever people are' then paves the way for connecting people to more regular GP appointments at The Hub.**

"The Hub provides a safe point of engagement away from what is often a chaotic and volatile environment in street life. This has proven to be a vital link in retaining health care engagement with many people who are sleeping rough. Once a relationship is established through outreach, we can book someone in to see the same nurse at The Hub, and there informally introduce them to a GP in a safe and supported manner. This then becomes a stepping stone to more regular GP appointments in a familiar, safe environment."

– HHC Street Outreach Nurse

ENGAGEMENT BETWEEN STREET HEALTH OUTREACH, THE HUB AND MRC

Background: Hannah, who is in her early forties, has a long history of domestic violence, chronic homelessness and precarious housing. She has an intellectual disability, has been diagnosed with schizophrenia, depression and PTSD, and has had multiple voluntary mental health admissions. She has cycled between transitional accommodation and the streets for over 15 years, along with several recent periods in domestic violence refuges.

Support Provided: In late 2021, Hannah returned to the streets and was seen by the HHC street outreach nurses, who came across her while she was rough sleeping in late 2021. She was unwell, losing significant weight and experiencing insomnia. She was referred to a GP at The Hub for medical care and assessment. A number of tests were run and a thyroid dysfunction identified, which was deemed life-threatening. Hannah was referred to the MRC so that she had a place to sleep whilst undergoing an urgent endocrinology surgical assessment at RPH, and HHC continued to support her before and after her thyroid surgery.

Current Situation: Although she remains homeless and at risk of domestic violence, Hannah continues to engage with HHC via street outreach and at The Hub. The establishment of trust and the continuity of care between the assertive outreach nurses, Hub GPs, MRC and RPH Homeless Team has been integral and continues.

In addition to the ten GP clinics held each week at The Hub, there is an enormous amount of nurse-led healthcare and support provided in this setting that is an integral part of the comprehensive healthcare and support provided to patients. Whilst vital, such nurse led care is largely not billable to Medicare.

NURSE-LED HEALTHCARE AND SUPPORT AT THE HUB

The Hub provides the opportunity for many nurse-led healthcare and support interactions with patients that are not billable to Medicare, but are a vital part of how Homeless Healthcare works with patients with complex needs and extensive trauma. At all Hub clinics, a nurse will meet first with patients, before they see the GP. Nurses are also able to encourage street present people to come into The Hub for nursing care and assessments that are difficult to undertake in outreach or drop-in centre settings.

Examples of nurse-led patient contacts include:

- Pre- and post- diagnosis counselling, education and management for a range of chronic conditions and infectious diseases
- Health education and promotion to support lifestyle modifications or medication compliance
- Preventive or treatment injections for acute and chronic conditions, including immunisations, syphilis treatment, hormone therapy, opioid pharmacotherapy
- Wound care and dressings for people who would otherwise attend the emergency department
- Opportunistic screening and testing, including cervical screening with is exceedingly low in the homeless population
- Supporting safety planning with patients at risk of self-harm or in domestic violence situations

RECENT INITIATIVES AT THE HUB - THE WOMEN'S CLINIC

The Women's Clinic is a relatively new initiative of HHC which began in August 2021 and is held fortnightly at The Hub, staffed by a female GP and nurse. It receives some funding from HHC's grant from the Department of Health to respond to the syphilis outbreak.

The overarching aim of the Women's Clinic is to provide a safe environment in which women who find mixed gender clinics challenging to see a female GP in a safe and understanding environment. Exposure to sexual abuse and domestic violence among homeless women in Australia is common, and the resulting trauma poses barriers to trust and engagement with health services. Such trauma can be a significant barrier to engaging in sexual healthcare, women's health screenings (e.g., for cervical or breast cancer) and medical examinations that require physical contact.

"The women's clinic has been fantastic in being able to provide a calm and safe environment for women who have experienced trauma. Many women find the drop-in centres too overwhelming, and often have perpetrators of violence that they are avoiding who may access those centres.

We tend to do a lot of sexual healthcare: contraception, pregnancy care, STI screening in this clinic. Women experiencing homelessness have many barriers that prevent them from accessing care in these areas. Proving a free service in a safe and accessible space overcomes some of these barriers.

It's a satisfying clinic as often women will present for one reason, but we are able to address that problem then with nursing support are able to provide additional screening and prevention, such as vaccinations, cervical screening, STI screening and contraception access. The nursing support in this clinic makes a big difference in outcomes."

– Dr Anna Chaney, Homeless Healthcare GP

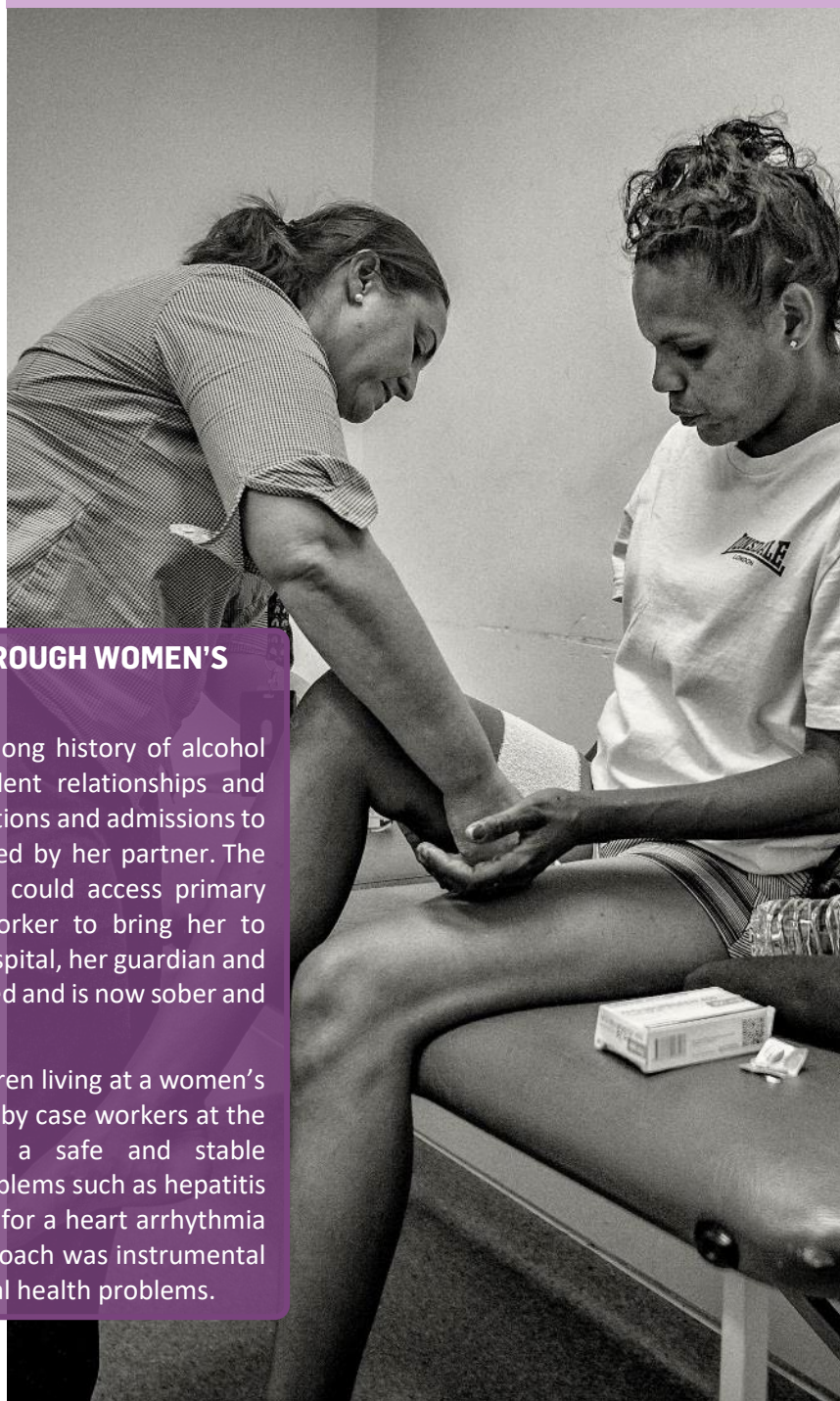
WHO HAS THE WOMEN'S CLINIC SUPPORTED?

304
APPOINTMENTS ATTENDED
(range 1–11)

128
WOMEN ATTENDED WOMEN'S CLINICS

30%
IDENTIFIED AS ABORIGINAL

58%
OF CHILD-BEARING AGE



EXAMPLES OF PATIENTS SUPPORTED THROUGH WOMEN'S CLINIC

Example 1: Amelia is in her mid-fifties and has a long history of alcohol abuse on the background of serial domestic violent relationships and complex trauma. She was having frequent presentations and admissions to hospital due alcohol abuse and violence perpetrated by her partner. The women's clinic provided a safe place that Amelia could access primary health care with the support of a Ruah case worker to bring her to appointments. Collaboration with HHC team, the hospital, her guardian and support workers meant Amelia was eventually housed and is now sober and maintaining her tenancy and living free of violence.

Example 2: Ella is in her early thirties with four children living at a women's refuge. She is supported to visit the Women's clinic by case workers at the women's refuge. The women's clinic provided a safe and stable environment to address Ella's long held medical problems such as hepatitis C and anxiety. Ella was also able to be investigated for a heart arrhythmia and treated for chlamydia. A trauma informed approach was instrumental addressing Ella's multiple complex health and mental health problems.

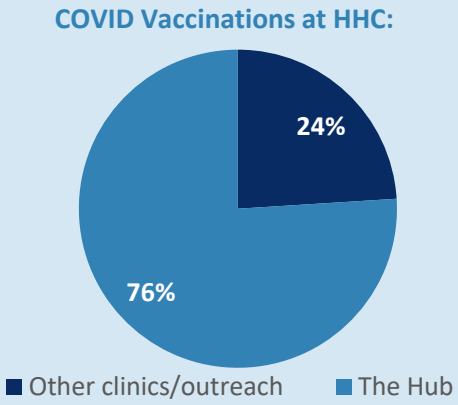
ROLE OF HUB IN SUPPORTING WA HEALTH PRIORITY AND EMERGING ISSUES:

The Homeless Healthcare Hub plays an important coordinating role and service delivery setting for a number of priority issues for WA Health and the wider health system in this state. Over the last year this has included:

1. COVID-19 VACCINATION FOR PEOPLE EXPERIENCING HOMELESSNESS AND/OR AT RISK OF HOMELESSNESS

COVID vaccination has been offered to all patients who attend clinics at the Hub, and in the earlier months of the WA vaccination role out particularly, HHC street health teams and homelessness services were also specifically bringing people to The Hub for COVID vaccination. Of 1,391 COVID vaccinations administered, three quarters were administered at The Hub.

Additionally, The Hub has been the coordination site for vaccinations at mobile clinics and via street health outreach.



2. SUPPORT FOR PEOPLE WHO HAVE CONTRACTED COVID-19

Since COVID-19 entered the Perth community, HHC staff at The Hub have fielded dozens of calls and emails from a) homelessness services concerned about people with COVID-19 infection or symptoms, particularly those who did not have accommodation or support available while in their 7-day infectious period, and b) from people experiencing homelessness themselves who were symptomatic or who had tested positive.

In the earlier stages of COVID-19 spread in WA particularly, HHC staff were regularly liaising with WA Health, the State Health Incident Coordination Centre (SHICC) and the State Welfare Incident Coordination Centre (SWICC) – this included advocating for accommodation for street present people with COVID-19, responding to requests to check on the wellbeing of people in parks with COVID, and providing telehealth consultations for people who were put into hotel accommodation during their COVID-19 infectious period.

3. SYPHILIS OUTBREAK RESPONSE

In May 2021, HHC was invited by the Department of Health's Sexual Health and Blood-borne Virus Program to apply for a 12-month grant to respond to the syphilis outbreak in Perth, with street present people identified as one of several key priority groups. HHC was awarded an initial one-year grant that has recently been extended. Through the grant, HCC has employed a sexual health outreach nurse to undertake education, testing, and treatment for syphilis and other sexually transmitted or blood-borne diseases, as well as increased preventive sexual health promotion more broadly.

In addition to direct patient engagement, a key part of this role is to support and build the capacity of other homelessness services to encourage people experiencing homelessness to access syphilis and sexual health education, screening and treatment (where needed). Some of the people who have received syphilis testing and/or treatment to date have been encouraged to also attend GP appointments at The Hub, and support is provided to transport patients to appointments where possible. As experiences of trauma are widespread in the street present population, The Hub provides a calmer, and more comfortable and private setting for sexual health appointments compared to mobile clinics at drop-in centres. This has also led to the establishment of a fortnightly women's only clinic at The Hub that provides a safe space for women who do not feel comfortable in mixed gender settings

4. INFLUENZA VACCINATIONS 2022 TO DATE

Since 2019, Homeless Healthcare has made a concerted effort to increase the number of people being vaccinated for influenza across all of its clinic locations, including via its street outreach teams. This influenza vaccination strategy is coordinated through The Hub. In 2019, 501 flu vaccinations were administered by HHC, increasing to 619 in 2020. In 2022, 344 flu vaccinations had been administered by HHC as at the 5th of July, with just over 50% of these having been administered at The Hub.

THE HUB AS AN EXEMPLAR OF INTERNATIONAL BEST PRACTICE

The HHC Hub and Spoke model of care and ethos exemplifies many of the key elements and recommendations of the recently released UK NICE 2022 guidelines on **Integrated health and social care for people experiencing homelessness.**[8] These guidelines were developed to inform the commissioning of specialist homelessness health-related services, as well as to improve access and engagement with mainstream services for people experiencing homelessness, underpinned by principles of integration and continuity of care. Whilst they were developed for the UK context, they reflect international best practice, and, with other NICE guidelines, they are internationally recognised for their robust, evidence-based recommendations.

Key principles and recommendations from the NICE guidelines that are particularly pertinent to the provision of primary care within an integrated framework for people impacted by homelessness are summarised below:

CO-DESIGN AND CO-DELIVERY OF SERVICES	Recognise the value of co-designing and co-delivering services with people with lived experience of homelessness, to improve the quality of health and social care (including peers)
SUPPORTING ENGAGEMENT WITH SERVICES	Providing services that: • are person-centred, empathetic, and non-judgemental • aim to address health inequalities • are inclusive and attentive to diverse experiences of people • trauma informed • recognise that people's behaviour and service engagement is influenced by their traumatic experiences, socioeconomic circumstances, and previous experiences
SUSTAINING ENGAGEMENT WITH SERVICES	• Importance of longer contact times in developing and sustaining trusting relationships between frontline health and social care staff and people experiencing homelessness • Promote shared decision making, building self-reliance, and using strengths-based approaches to care. • Recognise that people experiencing homelessness, especially those with experience of rough sleeping, need services that provide a long-term commitment to care to promote recovery, stability, and lasting positive outcomes
COMMUNICATION AND INFORMATION	Health and social care staff working with people experiencing homelessness should: • be empathetic, non-judgemental and use recovery-oriented language that avoids jargon and acronyms • provide extra support for people with low literacy levels or speech/language difficulties • send clear information about contacts or appointments and reminders that reach people in time, and follow up people who do not attend. • Take into account each person's communication and information needs and preferences
COMMISSIONING AND DESIGN OF SERVICES	• Recognise that people experiencing homelessness often need additional resources and a more targeted service delivery

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