inclusive health and wellness hub
OVERCOMING HEALTH INEQUALITY

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

MICAH PROJECTS
Breaking Social Isolation
Building Community

Health, Home, Hope.

A research report on Inclusive Health and Wellness Partnerships

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CHAPTER 1. INTRODUCTION

1.1 Rationale

People experiencing homelessness live significantly shorter and less healthy lives than people who are securely housed (Seastres et al., 2020). Inaccessibility of basic social determinants of health (i.e., housing) and health care services drive such poorer health outcomes. People with lived experience of homelessness encounter a complex mix of systemic, logistical, and psycho-social barriers to accessing primary health care that affect opportunities for good health, for example lack of trust, stigma, trauma, transportation, wait times, health literacy, and knowledge of service availability (Becker & Foli, 2021), as well as delivery models that can exclude clients from mainstream health care when they do not adhere to rigid attendance and behaviour policies (Moensted & Day, 2022). People with lived experience of homelessness frequently attend acute care settings when primary health care would be better equipped to meet their health needs (Doran, 2016). At the same time, addressing the health needs of people experiencing homelessness through primary health care reduces burden on health systems and generates cost savings for the public purse (Davies & Wood, 2018; Micah Projects, 2016).

Beyond economic rationale, disrupting the association of homelessness and poor health serves to tackle entrenched health inequities that disproportionately affect individuals and communities already experiencing significant social disadvantage and marginalisation. For instance, people affected by domestic and family violence, disability, chronic mental ill-health, and substance use are overrepresented among people who experience homelessness (Pawson et al., 2022), compounding barriers to utilising mainstream health care services. First Nations people continue to experience the impact of colonisation as barriers to health care (Bastos et al., 2018) and housing (Pawson et al., 2022). Likewise, people from Culturally and Racially Marginalised (CARM) backgrounds face challenges to secure housing and psychosocial support within an exceedingly complex health and social care landscape (Olson et al., 2022). This positions the accessibility of health services as an urgent social justice matter.

Challenges in providing primary health care to people who experience homelessness have led to the development of alternative service delivery models that facilitate greater access to health care and thereby contribute to reducing health inequities (Baker et al., 2020, 2021; Davies & Wood, 2018). The Inclusive Health and Wellness Hub ('Inclusive Health') examined in this report is one such manifestation of an alternative health care model that aims to "improve access to healthcare for people experiencing difficulties in accessing mainstream healthcare services" (inclusivehealth.org.au).

At the time of the study, Inclusive Health was operated by Inclusive Health Partnerships, a collaboration between Micah Projects and Tzu Chi Buddhist Compassionate Relief. This partnership's mission is "to improve access to healthcare, housing, wellbeing, and social services for people experiencing disadvantage and homelessness" (IHP, 2021, p. 1). Located in Brisbane, Southeast Queensland, Australia, this not-for-profit health service provides care to marginalised people across multiple sites. It is structured to be a health resource within the community for people experiencing homelessness, disability, poverty, mental illness, chronic disease and/or substance use.

1.2 Aims and research questions

This research report aims to present findings and reflections on the Inclusive Health and Wellbeing Hub's service delivery model and implementation. In particular, we identify what worked well during the study period and what areas would benefit from further development. We articulate recommendations that can inform Inclusive Health's strategic objectives as well as transfer learnings for health care practice to other inclusive care settings.

We approach health care as embedded in social relations and structures that vary across different organisational and historical contexts (Mol, 2008; Plage & Parsell, 2022) to address the research questions:

RQ1 What values, principles and practices underpin the service delivery model implemented at the Inclusive Health and Wellness Hub?

RQ2 How is the service delivery model integrating various clinical and non-clinical services across multiple sites?

RQ3 How do people accessing the Inclusive Health and Wellness Hub experience these services?

RQ4 What works well in the implementation of the Inclusive Health and Wellness Hub service model?

RQ5 What are potential areas for improving and/or expanding the Inclusive Health and Wellness Hub's services?

1.3 Our approach

To answer these questions, we begin by outlining the research design and data sources on which we base our analyses. We then present three findings chapters; first, we identify values and principles that shape the service delivery at the Inclusive Health and Wellness Hub; second, we describe the service delivery in practice with a specific focus on the impact of the February 2022 flood event; third, we shine a light on issues around service integration within and beyond the Inclusive Health and Wellness Hub. We conclude by offering six recommendations to strengthen and promote the relational model of health care practiced at Inclusive Health.

1.4 Methods and data

We took an ethnographic approach to data collection with various stakeholders of Inclusive Health, including observations of service delivery encounters, participant-produced photography, and in-depth interviews with service providers and people with lived experience of homelessness supported by Micah Projects. Data collection took place between November 2021 and October 2022. After ethical approval (2021/HE002663), we invited clinical and non-clinical, volunteer, and salaried Inclusive Health and Micah Projects staff and partners to participate in the study. We then recruited people with experience of homelessness in Inclusive Health's catchment for study participation. To capture a broad range of experiences, we included participants who (i) were housed and supported by Micah Projects to sustain a tenancy after past experience of homelessness; or (ii) had sought housing support services for the first time in the 12 months prior to the study; or (iii) fit the definition of chronic homelessness, with at least one debilitating health condition and multiple, extended episodes of homelessness (Padgett, Henwood & Tsemberis, 2016).

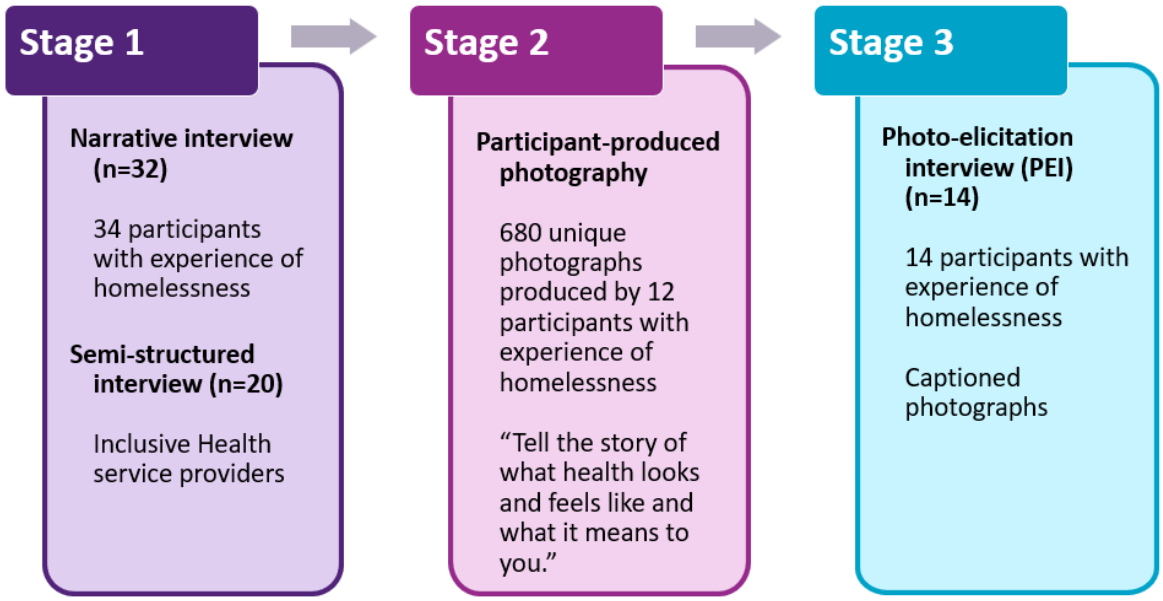
We note that Micah Projects operate the Inclusive Health and Wellness Hub alongside many other social care and outreach services. This facilitated recruitment of people with experience of homelessness who use Inclusive Health's services and those who do not. We recruited 18 participants who had engaged with Inclusive Health's GP and/or wellness offerings - some of them regularly - alongside 14 participants who had reportedly not used Inclusive Health's services. While direct comparisons between service users and participants who rely on mainstream services are beyond the qualitative analysis we conducted, this gave us an opportunity discern nuances in health experiences across both participant groups.

Two separate interview guides were developed for service providers and people with experience of homelessness. Topics covered different domains of primary health care, such as continuity of care, health promotion, preventative health, holistic medicine, and self-care. We report findings from 32 interviews with 34 participants who had experienced homelessness (22 male, 11 female, and 1 trans male) and 20 service providers (4 non-clinical; 4 GPs; 6 nurses; 1 pharmacist; 5 wellness). Among the service providers, 17 participants were affiliated with Micah Projects, while 3 participants were employed by other organisations working alongside Micah Projects to improve access to health care for people experiencing homelessness. Interviews with service providers lasted 26 to 74 minutes (average: 44 min), and interviews with people who had experienced homelessness lasted 10 to 105 minutes (average: 43 min).

The interview data was complemented through 65 hours of observations of clinical and non-clinical care encounters across four different Inclusive Health sites, and 15 hours of observations during outreach activities to gain insights into service delivery practices.

Further, participants with experience of homelessness were invited after the initial interview to participate in the photography component of the study (see Graphic 1).

Graphic 1 – Research design



Consenting participants were given a digital camera with a photo assignment asking them to tell the story of what health looks and feels like and what it means to them. The photographic activity was discussed, and photographs captioned during a photo-elicitation interview (PEI). The captioned photography has since been publicly displayed (Plage, Perrier et al., 2023) Fourteen participants

completed the PEI lasting between 42 and 222 minutes (average: 101 min), contributing 680 unique photographs for analysis. The first author also took photographs of the study sites during data collection (where permitted) to document the impact and response to the flood event. Interviews were audio recorded where consent was forthcoming, professionally transcribed and deidentified. A service provider and a participant who had experienced homelessness wished not to be recorded and interview notes were summarised for analysis. Observation notes of care encounters were also typed up and synthesised into common best practice scenarios that highlight specific challenges, principles, strategies, and outcomes using 'scenario' callout boxes.

Inclusive Health engagement workshop

In addition to the data collection described above, we facilitated an engagement activity to share and reflect on emergent findings from this research three months after the conclusion of data collection. This stakeholder engagement workshop took place on 20 January 2023 at Brisbane Common Ground. 17 participants attended the workshop, including practice management, medical, nursing, wellness and administrative staff, social workers and Micah Projects' CEO, Karyn Walsh. The half-day workshop aimed for practitioners to:

1. Learn about and give feedback on the progress of the *Health Home Hope* study
2. Reflect on implications for their practices
3. Provide input into direction of future analyses

Figure 1 - Inclusive Health Engagement Workshop

The workshop design was based on a technique called 'clinician dialogues' and employed deidentified visual and text-based data produced throughout this research (Thille et al., 2018). Clinician dialogues are an interactive and activity-based approach to communication. For example, workshop participants were asked to engage with photographs contributed to the study by the people who are invited to use their services as well as the breadth of experiences on issues such as welcomeness, safety and presence shared by service providers using the SHOWED approach (Wang & Burris, 1997). The intention was to facilitate a mutual understanding of the diversity in current practice, identify best

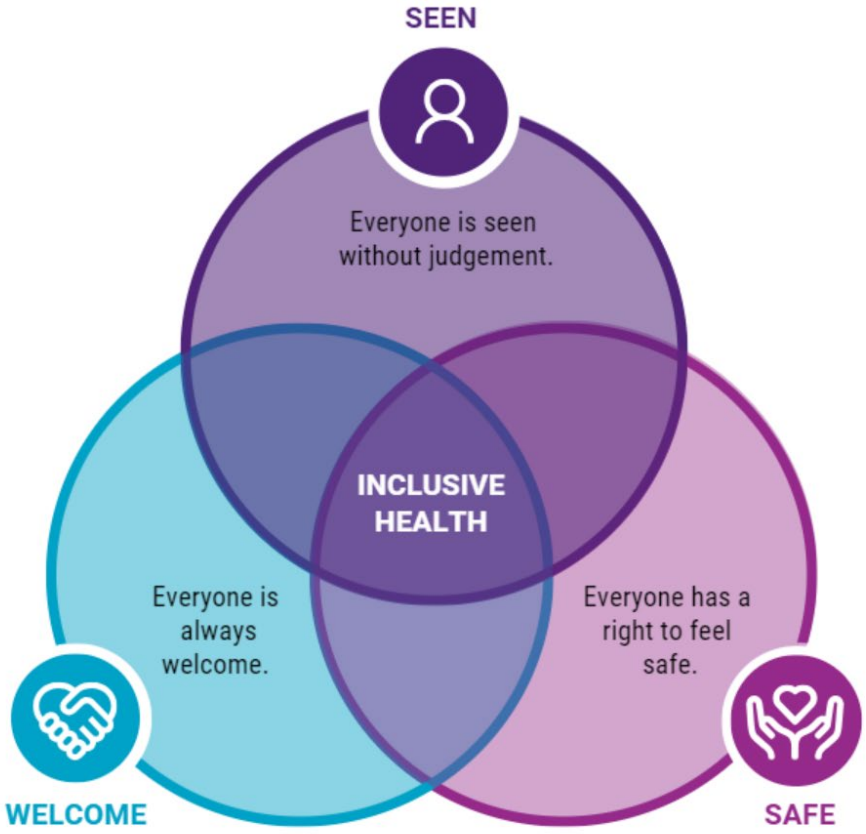
practice and articulate strategies for fostering a community of practice that increases the accessibility of care in inclusive health settings. It also served to identify what Inclusive Health and Wellness Hub and Micah Projects staff and volunteers themselves considered to have had the greatest impact on their service delivery during the study period, and what they regarded as their most significant achievements. The ensuing discussions of the flood response and continuity in service delivery, the challenges of providing services that are coherently integrated within Inclusive Health and in the larger health and social care system as well as their engagement with Inclusive Health and Wellness Hub service users' experiences inform the interpretation of findings in this report. Throughout this research report we use 'reflection' callout boxes to illustrate discussion points and reflections that were raised throughout the workshop.

CHAPTER 2. INCLUSIVE HEALTH'S RELATIONAL MODEL OF CARE

We begin by presenting service provider and service user perspectives on how Inclusive Health enables relations of care in which service users are seen, made to feel safe and welcome to use the available services. This chapter outlines three principles that inform the *Inclusive Health* model to promote greater health equity through affordable, non-stigmatising and safe primary health care (Graphic 2):

1. Everyone is always welcome.
2. Everyone is seen without judgment.
3. Everyone has the right to feel safe.

Graphic 2 – Three principles



Attendance policies and how Inclusive Health manages non-attendance of scheduled appointments are central to putting these principles into practice. As many service providers noted:

> *If people miss 16 appointments and they ring up and they want another appointment, we book them for another appointment. Because I think that's where people fall off and disengage from healthcare.*

People experiencing homelessness often miss scheduled appointments, for example, because they cannot leave their belongings unattended, encounter difficulties getting to the clinic, or because they find it challenging to understand and remember the time of and prioritise booked appointments when

food and shelter for the night are insecure (Becker & Foli, 2021; Parsell et al., 2020). Inclusive Health contrasts with widely practiced non-attendance policies in mainstream health care settings, in which missing scheduled appointments can result in the exclusion from services (Baker et al., 2021). Rigid, or even punitive responses to missed appointments can erode trust within the caring relation and in the health system more generally, consequently undermining help-seeking and exacerbating health inequity (Moensted & Day, 2022).

There was agreement across service providers that managing attendance was a daily challenge at Inclusive Health. It required a nuanced approach capable of identifying the reasons for and offered support to address the problems underpinning non-attendance. Making sure as many booked patients and participants as possible are seen requires flexibility and care work from all staff and volunteers, both clinical and non-clinical (see Scenario 1).

Scenario 1: Non-clinical staff contributions to relations of care

A young person arrives at the clinic. On arrival the person learns that there are other people waiting already, and that the specialist is running late. The receptionist knows the person and expects that the wait will be challenging. They approach the next patient in line to propose letting the young person go in first, 'it will only be a brief consultation'. However, the answer is, 'no, I have already been waiting more than half an hour myself'. The young person gets increasingly agitated as time passes by. The receptionist calmly makes conversation until topics run out. The young person now is restless, pacing, and venting frustration loudly to the waiting room. When threatening to leave, the receptionist convinces the young person to wait a few more minutes. While the young person begins to engage in self-soothing strategies, the receptionist checks in on the progress of the ongoing consultation and gives an update: "you're next and they are wrapping up." The relief is palpable as the young person apologizes for the impatience. The specialist consultation begins shortly after.

Challenge: Waiting times are an intrinsic part of health care delivery.
Principles: Everyone is always welcome. Everyone is seen without judgement.
Strategy: Supporting patients by acknowledging their frustration and scaffolding the wait time.
Outcome: Patient is seen for consultation despite wait time.

Many service providers expressed concern about the number of missed appointments at Inclusive Health. They perceived non-attendance as a risk for the financial viability of the Inclusive Health and Wellness Hub. At the same time, they understood that Inclusive Health responded to a need in the community by filling a service gap left by mainstream health care. To minimise non-attendance, Inclusive Health flexibly incorporates drop-ins and appointments for seeing GP and wellness participants. While wellness services operated on a drop-in basis due to the dispersion of services after flooding (see more in Chapter 3), wellness coordinators also booked appointment slots for those who requested them. The GP clinic employs an appointment-only approach to seeing patients; however, this appointment approach is complemented by casual bookings to accommodate urgent presentations. Patients are reminded of their upcoming consultations via text, phone and sometimes in person by a Micah Projects nurse or support worker. Inclusive Health also employs a driver who will pick up and drop off patients and participants who might otherwise be unable to come into the clinic.

Where patients call to cancel appointments, clinical and non-clinical staff work together to pivot to telehealth, where possible. Rather than cancelling an appointment, the receptionist will arrange a call

back from the GP to the patient's phone, or in more complex consultations involve an outreach nurse to attend to a patient at their location to arrange a video call. Administrative staff also assist with scheduling follow-up appointments, specialist consultations and referrals. Flexible service structures and help in getting to and from the clinic were appreciated by service users:

> *I felt good, stress-free. … they took me to appointments, medical, to see the doctor and they drop you off. … just can't get to the places now that I've got ill health with emphysema, COPD. I wouldn't be able to cope with the hills and walking all that far.*

> *Personally, I would like the more structured approach because it's one of the things that I try to maintain in my own life, a little bit of structure and predictability. On the other hand, the positive effects of being able to access this service means I'm happy to take compromises. … if this means shifting booked appointments a little bit back, that's just fair enough.*

Out of the 32 potential service user participants, 18 discussed how they engaged with Inclusive Health as either GP or wellness participants. Of the remaining 14 interviewees, 7 saw mainstream primary health care providers, 3 did not use any primary health care services because they reported not needing them, and 4 did not specify if and how they met their health needs. For the non-service user quoted below, even a relatively small out of pocket expense meant he could not afford to see a mainstream GP when needed:

> *I've just recently been hit by [an escooter] … my [mainstream] GP sending me to a must pay type thing. … I didn't have money on me and couldn't afford to do money on me if I wanted to keep the power on at my house and my mobile phone connected … I said to [receptionist], "Look, I don't get paid. I'm on hardship." "Oh well, that will probably end up being $125, Sir." And that's from [a] doctor's surgery that bulk bills.*

This participant could not work and lost income due to the injuries. This quote illustrates how he had to make difficult choices. Sequelae from wound infection eventually required this participant to undergo surgery and hospitalisation. The experience resulted not only in a return to acute care services, but also undermined a disposition to seek help through primary health care:

> *[I'll] go back up to the ED even though the GPs open, because I'm really not trusting of the GP.*

The Inclusive Health approach to attendance to make sure patients are seen, contrasts with such experiences and resonates with calls to make primary health care more accessible and affordable (Baker et al., 2021; Omerov et al., 2019). Inclusive Health's GPs bulk bill and wellness participants who are supported by Micah Projects can enjoy subsidised services. In other words, they face minimal out of pocket expenses for wellness treatments and some (e.g., acupuncture) are provided at no cost to Micah supported participants.

Moreover, we heard during the interviews how fixed, and short appointment durations for primary health care consultations were considered to make it harder to cultivate reciprocal relationships between services users and providers. Consequently, the Inclusive Health and Wellness Hub aims to allow more time for consultations. As this service provider commented:

> *the biggest problem that I encounter is the complexity of the issues that we're dealing with within the constraints of the system of general practice. We have the luxury [at Inclusive Health], the patients are booked for at least 30 minutes. … this is with clients who, frequently, you need to do as much as you can in that first appointment because you know there's a decent chance that they won't come back.*

Adequate time to listen to patients is important for inclusive healthcare (Baker et al., 2021; Luchenski et al., 2017; Sturman & Matheson, 2020), yet, this service provider feels that it is a 'luxury'. Time constraints are borne out of concerns for financial viability of the General Practice, but allowing less than 25-30 minutes for a consultation can affect the care provided to patients with experience of homelessness, who disproportionally present as tri-morbid (i.e., the co-presence of a mental health condition, substance use, and chronic disease) (Davies & Wood, 2018). Inclusive Health service users appreciated being given the time they needed:

> *I had to change my [mainstream] doctor because he wasn't very nice to me. He wouldn't let me finish, he wouldn't listen, he was talking over the top of me … [Inclusive Health GP] wants the best for me and, yeah, she doesn't tell me what to do. And if she says no, she explains why. So, it's all good. And she listens and she feels and understands what I go through.*

> *[GP] would take the time to understand our needs, apart from the medical, and what's happening in our life. So, he has an overview of what happens that would impact our physical and mental health.*

> *[GP] doesn't miss one trick, which is good. And she's slowly getting things sorted out for me…. it was a couple of days after I'd been here [at crisis accommodation]. … I was expecting [GP consultation] just to be like a catch-up, and I was in there for just over an hour.*

Service providers and participants with experience of homelessness agreed that extra time for consultations allowed for extended diagnostics, making referrals, initiating treatment, or raising medical histories while negotiating data privacy and sharing. Importantly, the time spent with the GP also made participants feel understood and taken seriously, as the participant quotes above demonstrate. Another participant who had experienced homelessness and now used Inclusive Health services reflected on her experiences in mainstream primary care in comparison:

> *I just feel welcome [at Inclusive Health]. … my long-term [mainstream] GP, whom I had a great deal of respect for, I broke down in the surgery [after a domestic violence incident]. And he and his receptionist couldn't get me out fast enough. They just shoved me out the door. … My doctor didn't want anything to do with me after that. I tried to make an appointment.*

While not all participants expressed dissatisfaction about their experiences with mainstream General Practice, reflections as this one highlight the ways in which the Inclusive Health and Wellness Hub is better prepared to meet the needs of people experiencing trauma and social disadvantage (see Scenario 2). Importantly, participants time and time again stressed that having trust in the Inclusive Health staff made them feel welcome and safe, even though the built environment of the service sites sometimes was intimidating, particularly after the flooding (see Figure 2).

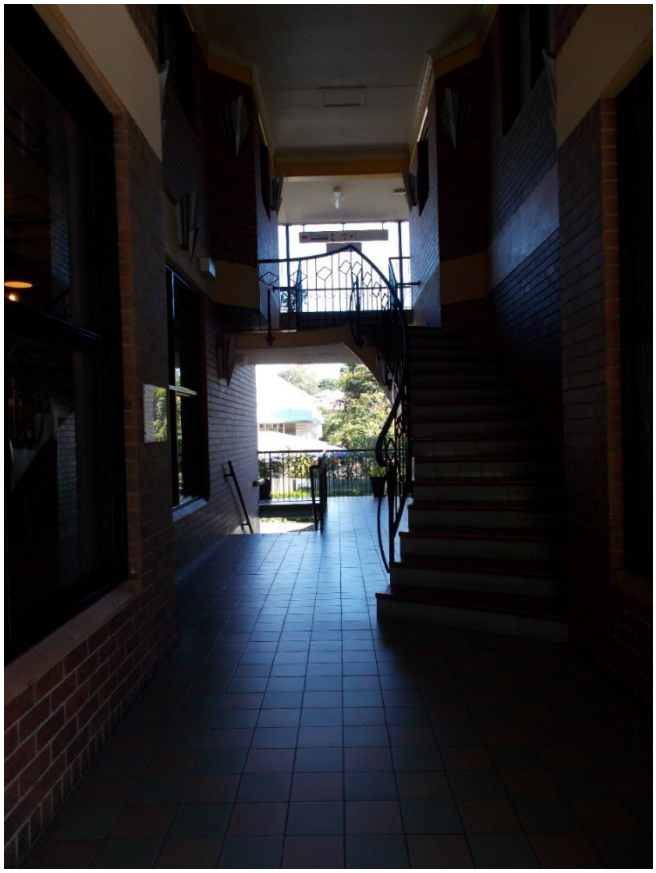


Figure 2 - when we've got safe people, it makes the place safe

Scenario 2: Making patients feel safe within relationships of care

A wellness participant arrives for an appointment in the communal space. The person is welcomed by the wellness coordinator and appears to be in good spirits. The person has come in for wellness appointments many times before and wears comfortable clothing for the appointment under the regular outfit that can quickly be taken off without needing a change room. The wait passes quickly, making animated conversation and preparing for the treatment. Once invited to take a seat in the treatment area, the participant's mood quickly turns to distress. The wellness coordinator responds to the person's trembling and crying by gently whispering and touching a hand. Continuous check ins by the wellness coordinator offering comfort verbally and non-verbally continue until the participant has completed the treatment.

Challenge: Service users' past trauma can be triggered in health care encounters.
Principle: Everyone has the right to feel safe.
Strategy: Using trauma-informed approaches to care via verbal and non-verbal safety cues.
Outcome: Wellness participant completes the treatment.

As we have shown, behaviour, attendance, and service duration policies need to be flexibly implemented to meet service users' needs within a relational approach to primary health care (see also Plage, Baker et al., 2023). We see potential in the implementation of the key principles of making people feel safe, welcome, and seen through attendance, behaviour and consultation policies to promote reciprocal relations of care that ultimately contribute to reducing health inequities.

CHAPTER 3. THE SERVICE DELIVERY MODEL PUT TO THE TEST

The Inclusive Health and Wellness Hub's core services are usually co-located and include general practice (GP), nursing, acupuncture, shiatsu and myotherapy. These are complemented regularly by specialist services, such as podiatry, dental, HEP C, vaccination, and endocrine clinics. In February 2022, flood damage to Inclusive Health's main campus put the service delivery model to the test. Among others, wellness and dental equipment were damaged or destroyed and the Hope Street location was shut down due to essential repairs for almost a year. Nonetheless, Inclusive Health services resumed within one or two weeks–albeit dispersed across different locations. This chapter describes the diversity in service offerings and modalities, sites, and practices during that time and how these responses preserved continuity within the relational model of care (see Reflection 1).

Reflection 1: Presence in the community

Figure 3 - An affordable and available hour of self-care per week

At the Inclusive Health engagement workshop attendees were encouraged to reflect on their practices by discussing a photograph provided by a service user. For this discussion, we provided prompts adapted from the ***SHOWED*** framework (Wang & Burris, 1997):

*What is **S**hown here?* All workshop participants recognised that this is a board advertising wellness services at a temporary location.

*What is really **H**appening?* Considering the caption given to the photograph by its creator, workshop participants discussed how people experiencing homelessness are sometimes misrepresented as not prioritising their health.

*How does this relate to **O**ur practice?* Pop-up, inreach, and outreach service modalities serve to support people experiencing homelessness or social disadvantage in their self-care practices.

***W**hy are things this way?* The flood event in February 2022 led to a prolonged closure of the Inclusive Health main campus, requiring experimentation, innovation, and expansion of how services are delivered to sustain Inclusive Health's presence in the community.

*How could this photograph **E**ducate people?* Workshop participants felt that people could learn from the photograph that if services are made easily available, affordable, and delivered in a respectful way, disadvantaged persons will engage with health care and in self-care.

*What should be **d**one about this?* Workshop participants admitted that the dispersion of services posed challenges to service users and service providers alike. Workshop participants discussed how experiences of disappointment with the health and social care systems were common among their participants and being able to continue services even within limits avoided letting down service users who had come to rely on them. All agreed that after resuming services at the main campus, mutual investment in the caring relations between service users and providers should be reinvigorated.

Following on from the closure of the main campus, a temporary GP clinic was set up on level 2 of the Micah Projects main office. Arrangements were made with a nearby community hall to have regular pop-up clinics for wellness and acupuncture, first once a week, and later twice a week. Myotherapy and massage therapy rooms were moved across the road. A satellite GP clinic at a crisis accommodation that had been offering practice hours on site prior to the flood event, greatly extended its practice hours (see Figures 4-6). Particularly, the latter provided an opportunity to firmly establish this in-reach service as a permanent feature, in partnership with the crisis accommodation provider.

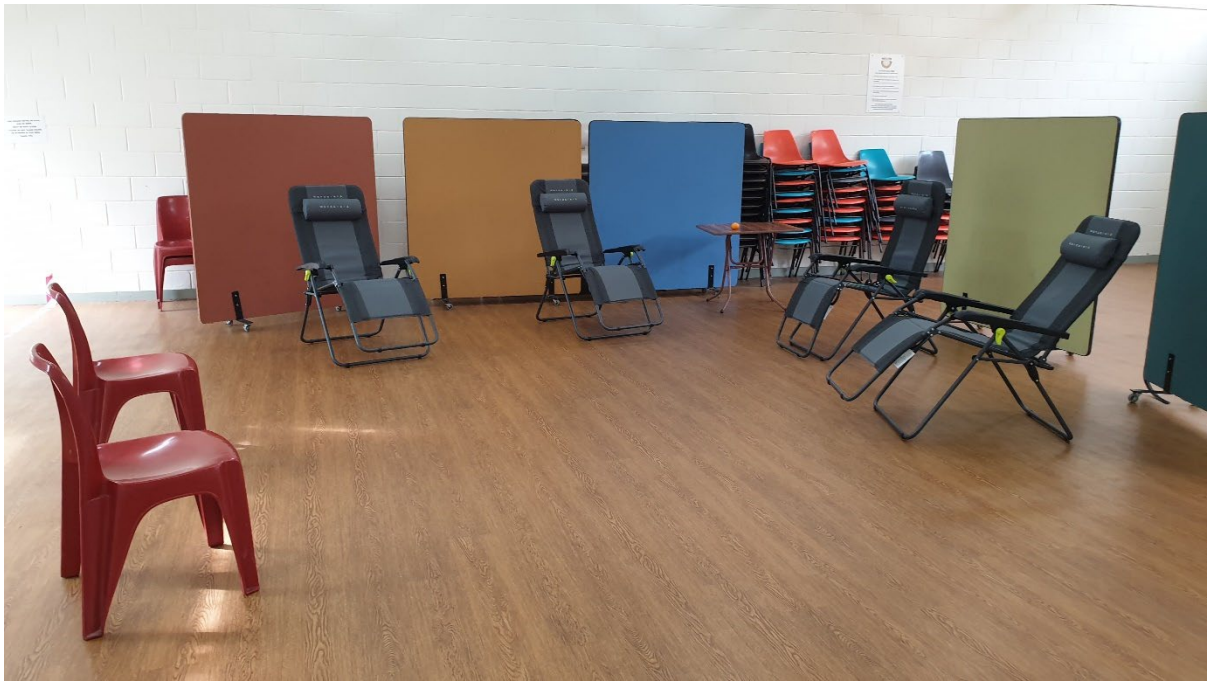


Figure 4 - Acupuncture and wellness set up in a community hall

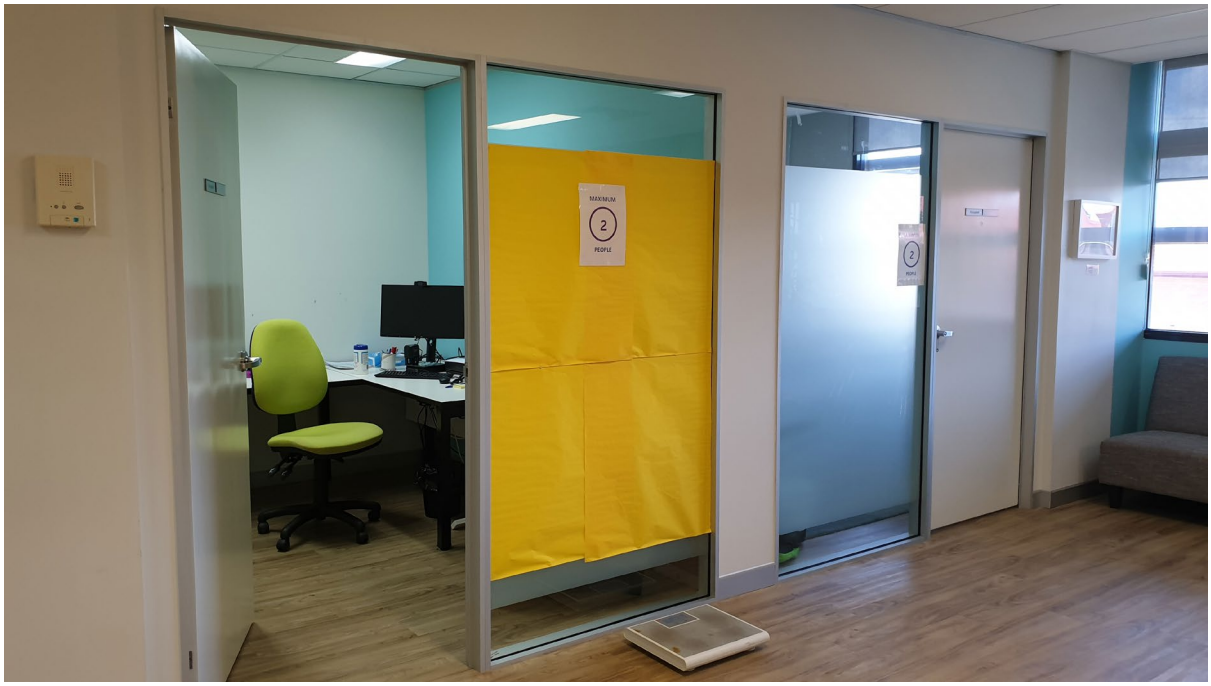


Figure 5 - Impromptu GP clinic set-up using large post-it notes for privacy

Figure 6 – In-reach GP clinic waiting and reception area at crisis accommodation

One of the greatest challenges faced by Inclusive Health and Micah Projects staff in their efforts to minimise the disruption to services was the short time frame in which alternative service delivery arrangements had to be made, materials and equipment sourced, and changes to appointment times and locations communicated to patients and participants. As this service provider explained:

> *we started with telehealth initially, because there were less rooms available and stuff. And we were not set up to do a proper clinic at that given time, within a week time. So we gather all the resources how best we can do and this is what we have*

come up with. … we have to explain each and every call most of the time that, "Oh, why are you not open?"

The immediacy of the response was a cause for stress and confusion for service providers and service users alike. Even after the establishment of the temporary service sites, a sense of confusion among the usual service users remained:

Everyone's all over the place. […Therapist] got to move and they don't know where they're moving to. Because some people are moving from across the street. Things are very chaotic.

I'm supposed to have podiatry through Micah. Because they got flooded out in Hope Street, they got flooded out of that, and, I think, since then they have had a bit of trouble organising something. Because the podiatrist would come to there, and that was like a doctors, they had three doctors there or something, and it didn't happen.

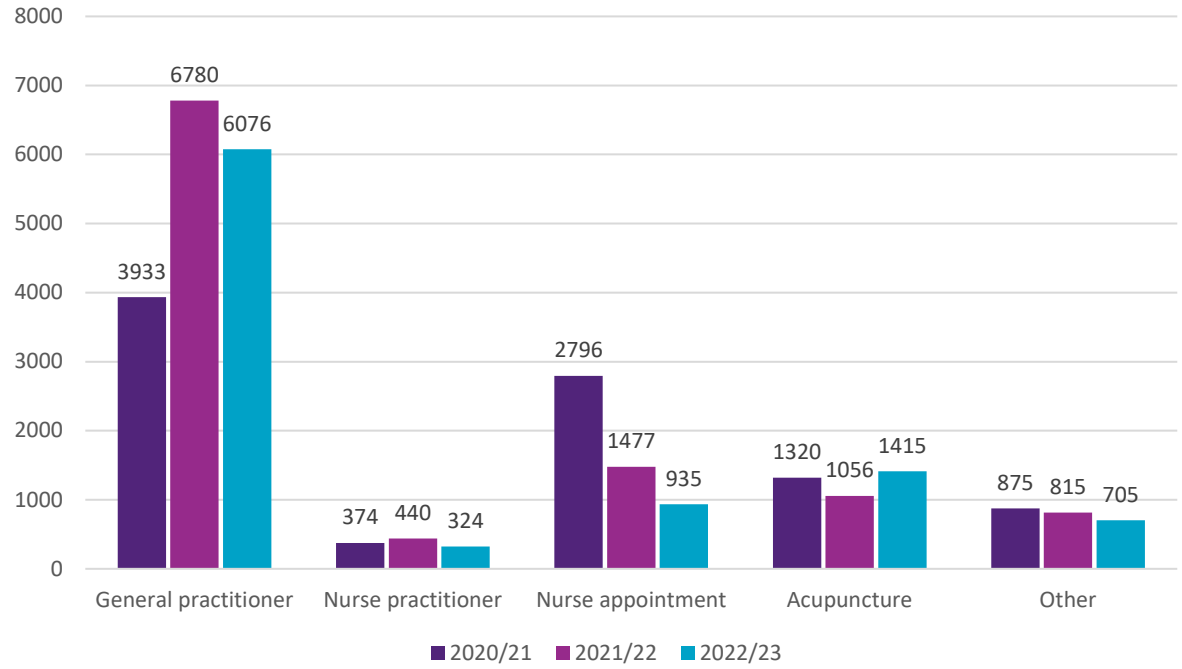
It was all over the shop up there. No one had their place. Everyone was just trying to do the best they could with what they had, but no one knew what was going on. […] I thought I was walking into the doctor, right, to talk to the doctor. And I was sitting down for five minutes talking to the receptionist and started telling her what medication I needed and […] I got all mixed up … it was just confusing going in there.

Reduced levels of comfort and ambience resulted in some participants opting out of some services, for example this wellness participant explained:

[Community Hall] is nowhere near as good because it's open and exposed and big and cold and institutional-looking. And I don't feel as safe there. But [wellness practitioner] anchors me, she's like my safety net. … that was the only time I've been there.

For the 2020/21 financial year 3,933 GP and 374 nurse practitioner consultations were held at the Inclusive Health and Wellness Hub, complemented by 1,320 acupuncture and 875 other (e.g., massage, reflexology, podiatry) sessions. Outreach services and telehealth resulted in a significant number of additional nurse appointments (i.e., 2,796). For the 2021/22 financial year GP appointments increased significantly to 6,780 though it is important to note that this number includes vaccination clinic numbers occurring during the Covid-19 pandemic. Nurse practitioner consultations increased to 440 while general nursing was 1,477. Supplementing medical appointments for this reporting period, there were 1,056 acupuncture appointments and 815 other 'wellness' appointments, incorporating shiatsu, myotherapy, therapeutic massage and reflexology. For the 2022/23 reporting period, GP appointment numbers totalled 6076, including vaccination clinic visits. Nurse practitioner and nursing appointments were 324 and 935 respectively while wellness services recorded 1415 acupuncture consults and 705 consultations for body therapies including shiatsu, myotherapy, therapeutic massage and reflexology. While it is difficult to ascertain the impact of the flood event on General Practice due to the immense uptick in vaccinations, wellness appointments seem to have slowed down in its aftermath, bouncing back in the following financial year (Graphic 3).

Graphic 3 – Consultations by financial year



Despite difficulties, these numbers are proof for the persistence of Inclusive Health staff through this transition period, justified as prioritising community need. These service providers explained:

> *that's a bit of a challenge. And I'm sure the GPs are finding it hard. "I can't practise in a room today, so everything will be on the phone. I can't get anywhere, I can't print. I'll set up a printer with another computer next to the other desk." It's not great. It takes time. But it is what it is. You've just got to do it. … because I need to get someone a script, so let's do it.*

> *I find it less satisfying, because I don't get that opportunity to have that organic touch base and, as a practitioner, I don't have the supports of other therapists or an admin team at my fingertips, where I can just go and check-in with them. So yeah, it's much less ideal. Having said that, I still think it's important that we can put the A-frame sandwich board out the front of the hall and say, "Hey," to our community, "we're still here."*

There was an understanding among service users, that the Inclusive Health and Wellness Hub faced many challenges in continuing their services, as these wellness and GP participants noted:

> *It deteriorated slightly, but it's still a very suitable place. And I think it's, in first place, the approach of the practitioners that makes it work. … the main difference is the way that clients are treated, that anybody who comes there is treated with a lot of respect and care, and that is basically independent of the surroundings. … the people that are there are still the same and they have probably the same attitude, if not even a bit of extra care given because of the strange circumstances.*

> *Hope Street will probably be more convenient. Because I get my food from Merivale Street, which is just behind Hope Street. So, yes. But this is still workable for us. Because we understand that Hope Street was inundated by the flood.*

Changes in the work environment put additional strain on Inclusive Health staff, working out of temporary locations and with even greater demands on their adaptability and communication skills. Across service providers and service users there was widespread understanding that this is a state of exception caused by the flood event. Ultimately the service delivery model fell back on its underlying service principles to prioritise continuity in caring relations and ongoing presence in the community to meet urgent need. This approach was supported by relationships with service users cultivated before the flooding.

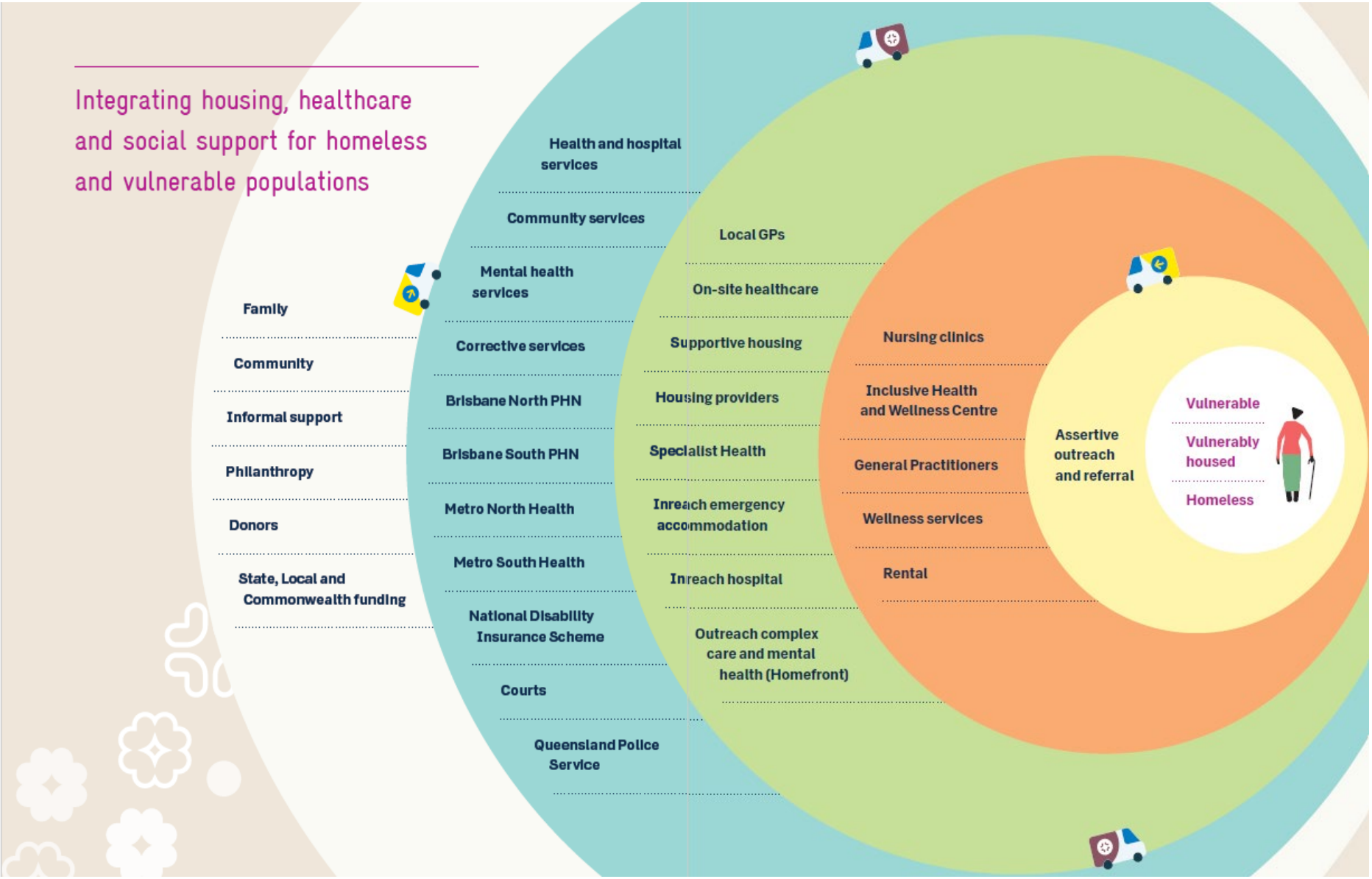
CHAPTER 4. SERVICE INTEGRATION IN AND BEYOND INCLUSIVE HEALTH

This chapter explores how the diverse service offerings and service delivery practices are integrated. Service integration is one of the values that underpins practices at the Inclusive Health and Wellness Hub: “We are committed to integration, to overcoming silos in healthcare and in community support. We work across disciplines and healthcare domains to provide people with what they need to get well.” (inclusivehealth.org.au). Service integration, both internally and into the broader health care landscape, presents ongoing logistical and systemic challenges. Inclusive Health positions itself as a Hub embedded through a Hub-and-Spoke-Model within the health and social care landscape (see Graphic 4). Here, we discuss some strengths and constraints of the present configuration of the Hub and identify health care demands that are not presently met among service users.

Strong internal service integration and co-location offers the Inclusive Health and Wellness Hub several advantages. For instance, social workers have access to Inclusive Health participants to be able to offer assistance not only with appointments, but also with NDIS or housing applications (see Figure 7). During observations, we often witnessed how Micah support workers joined patients waiting for their appointments to answer questions and offer practical support.

Figure 7 - I handed in this pile of paperwork. … That was overwhelming for me. I could not cope with it. That was a shopping bag of paperwork, and he just bang, bang, bang, bang, just getting it started, getting NDIS process started for me.

Graphic 4 - Hub-and-Spoke-Model (reproduced from Inclusive Health Partnerships LTD. Annual Report 2020-2021, p.6-7).



Likewise, through the Hub and Spoke approach Inclusive Health is able to draw on support workers to facilitate medical appointments or referrals, filling of prescriptions or support with financial costs. This was crucial as well for Inclusive Health patients and participants who struggled to keep on top of medications and prescriptions (see Figure 8), as Inclusive Health integrated social care into their primary health care provision and vice versa (see Scenario 3).

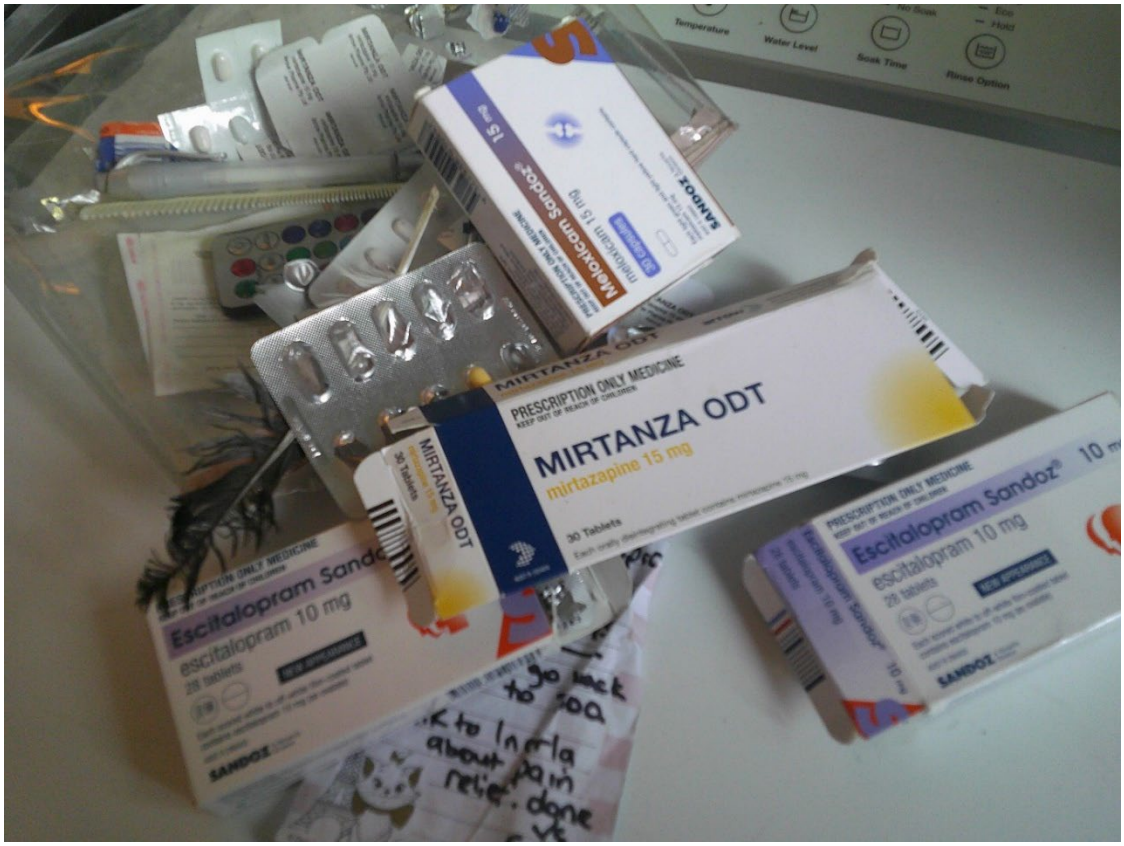


Figure 8 - Caption: health, the whole circle of it: physically, you have to go there to get it - emotional, you have to care about yourself enough to take it - mental, is taking it and feeling good enough to get up and go and get the script

Scenario 3 – Facilitating access to health through working together

A Micah participant is visited by the Sustaining Tenancies team–a team focusing on follow-up care with formerly homeless participants once they are housed. During the standard check in the support worker, who knows the person well, notices an usual degree of restlessness. After some probing it is clear that the person is worried about their medication. The person rarely leaves the house due anxiety and feeling unsafe. Knowing that it is necessary to see a GP, and then go to a pharmacy to fill a script feels overwhelming. The Micah support worker rings Inclusive Health to book in the participant for a consultation. Upon booking, the receptionist contacts the driver to check availability. Shortly after, they confirm with the participant that the driver will be there for pick up in time for the appointment. At the clinic, the GP offers the participant a home medicines review if they have any concerns, 'a pharmacist could come to your house and have a look at if your medicines are still right for you.' The person politely declines the offer this time. Once the consultation is complete the driver is already waiting to take the participant to the pharmacy. The receptionist has called ahead to make sure the prescriptions are ready for dispensing. Finally, the driver drops of the participant at their address with a replenished supply of their medications.

Challenge: The person feels overwhelmed and anxious as the medications run low.
Principle: Everyone is seen without judgment.
Strategy: Internal service integration weaving social and health care together.
Outcome: The person is supported to adhere to a prescribed medicine regimen.

The diversity and integration of wellness and primary care services accommodates diverse practices of delivering care, which is a definitive strength of the Inclusive Health and Wellness Hub. In this way, participants with different preferences, for example with respect to where, when or with whom consultations happen can be catered to. Co-location and integration also allow for internal handover and referrals to involve practitioners from different backgrounds to contribute to a person's care holistically. As these service providers maintained:

> *This is a learning that I've had actually since starting to work [at Inclusive Health] as well, is just how much having a multi-disciplinary team makes a difference to the outcomes.*

> *[…] assess the patient, coming up with a problem list and putting in place a plan for management. And that's not just management by me, but management by a whole team, ranging from staff within the clinic, to […] referral options outside of the clinic.*

However, during the study period service providers perceived a degree of disconnection, exacerbated by the impact of the floods. The dispersal of services was considered as resulting in missed opportunities to nurture a community of practice. New Inclusive Health staff often had little opportunity to meet their colleagues, and knowledge of service offerings was patchy across different areas of service delivery. Consequently, service users at times did not know what or when services were available or how to access them and felt that Inclusive Health staff often only knew these details when it came to their own practice. Inconsistencies became apparent even within the same areas of practice across different practitioners, for example how wellness coordinators handled administrative tasks like scheduling appointments or processing payments. This was a direct consequence of being in a different site than the non-clinical staff members who would usually support this work.

These observations, notwithstanding, a degree of freedom in how services are offered facilitated trusting and supportive relations of care within the Inclusive Health and Wellness Hub model. Of greater importance to the service user opportunities for good health, were concerns stemming from how Inclusive Health is integrated within the broader health care system. Here, areas such as housing and NDIS support, and specialist support around chronic health conditions such as diabetes were considered less challenging, than, for instance, arranging follow-up for mental ill-health or substance use recovery. This was evident also in discussions during the engagement workshop (see Reflection 2).

Reflection 2: System complexity

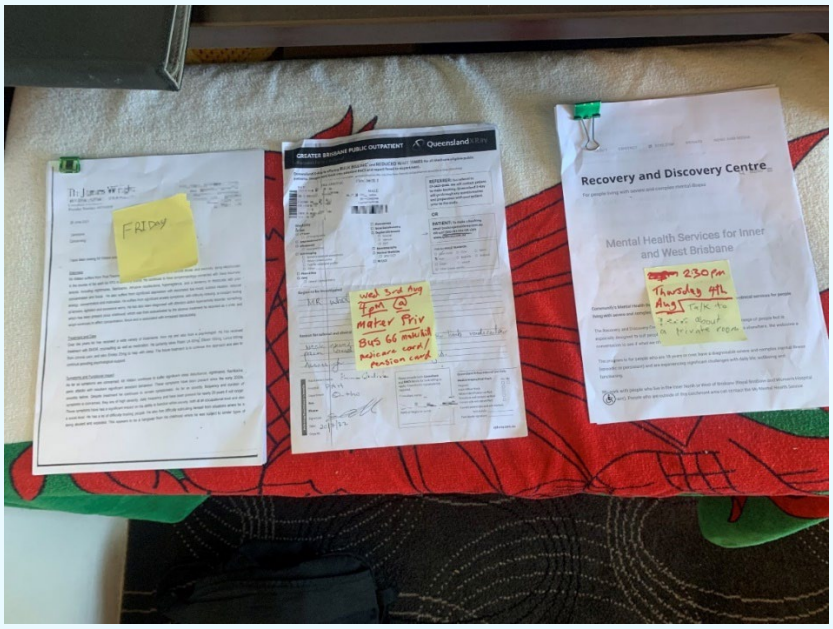


Figure 9 - Uncaptioned

At the Inclusive Health engagement workshop attendees were encouraged to reflect on their practices by discussing a photograph contributed by a service user. For this discussion, we provided prompts adapted from the ***SHOWED*** framework (Wang & Burris, 1997): *What is **S**hown here?* All workshop participants recognised that upcoming medical appointments of a participant with mental and physical ill-health, housing and substance use issues are shown.

*What is really **H**appening?* Pointing to the yellow post-it notes, workshop participants described what is happening here as a social worker providing logistical and practical support to ensure the participant will attend scheduled appointments.

*How does this relate to **O**ur practice?* Workshop participants recognised this as a part of their daily practice requiring close collaboration of clinical and non-clinical staff, as well as across organisations in government and industry sectors.

***W**hy are things this way?* The health and social care system is extremely complex to navigate, even more so for people in crisis and with the physical and mental health concerns the photographed materials indicate.

*How could this photograph **E**ducate people?* A workshop participant suggested using this photograph in induction and professional development sessions for clinical and non-clinical staff.

*What should be **d**one about this?* Workshop participants recognised the urgent need to make it easier for people in crisis to access health services, particularly highlighting the push for stronger systems integration. The role of transport also loomed large in the discussion. Arranging transport for participants to and from appointments was considered as more than a means to get access to health care. Transport provided crucial opportunities to spend time with service users, learn about what's going on in their lives, and build rapport. There was agreement how valuable this time is, and that license to take this time together should be made explicit within the remit of supporting participants. There is interest in linking administrative data collated by Inclusive Health with administrative data held by Queensland Health to track Inclusive Health participants' trajectories in their health care experiences.

Service providers and service users were keenly aware of the limited options available for specialist services beyond Inclusive Health's remit, including unmet demand for alcohol, drug and mental health services. Service providers commented on the mismatch between mainstream and Inclusive Health:

> *I'm managing this patient alone with the knowledge that I have and we've got him in. We now have a mental health team within Micah Projects, and so I've got that team on board, and then they're going to help him to connect with a psychologist. But the same problem arises for him, in that he can't afford to see a psychologist and he can't access a psychologist through the public system. So, it's not easy.*
>
> *We have a mental health nurse practitioner here now who's booked solid. And we are struggling to find bulk billing psychologists, and we have a lot of on-call for that now.*

Especially, the free and high-quality dental service offered by Inclusive Health prior to the flood took time to be reestablished due to the loss of expensive equipment. This left a service gap, which instantly affected service users:

> *Well, I'd like to get to see a dentist sometime. I'm still waiting on Micah. Put a call into it tomorrow, I think. Last night, busted another bit of teeth off.*
>
> *Free dentists, you can go to a free dentist, but they're amateurs, they just training. And where if you go to Inclusive Health, that's professional. They're not new at it. They know what they're doing. […] Yeah, I need to see a dentist. But because the dentist hasn't got their equipment up there. […] So there might not be any dentists, not until it's been cleaned up.*

Service providers were also aware of the constraints on their practice coming from the dynamics with a different service delivery model in mainstream health care. These service providers noted:

> *often you'll get [specialists] reporting back, "Oh, so, and so didn't turn up to this appointment." Why didn't they turn up? That's the question you need to ask. Why didn't they turn up? Now go and address the barriers to that.*
>
> *I used to liaise with [Queensland Health's mental health team] all the time. […] "We did all of this and you never turned up, the person left. They then presented to the ED in a psychotic state two days later. What we predicted." "Oh, but they didn't want to engage with us. They weren't consenting." "No, because they're mentally unwell." So I get very frustrated by that, and I do say, "How do people consent if they're very unwell?"*

This raises questions about overcoming challenges to broader health system integration to be addressed in future research and practice innovation: Where does Inclusive Health sit relative to mainstream health services? How can the viability of the service be secured in the current health funding landscape? How can continuity of care for Inclusive Health participants be achieved when being referred on to specialist or mainstream health services operating along different service delivery principles?

CHAPTER 5. CONCLUSIONS AND RECOMMENDATIONS

Safety, welcomeness, and seeing patients and participants without judgment are key service principles of a relational model of care practiced at the Inclusive Health and Wellness Hub to tackle health inequity in primary health care. After flooding at Inclusive Health's main location in Hope Street early in 2022, Inclusive Health's service delivery faced substantial challenges leading to the dispersal of services and experimentation with a wide range of ways to deliver services to minimise service disruption. While the continuation of Inclusive Health services after the flooding leveraged and sustained prior relations of care between service users and service providers, there were notable short-term impacts on service delivery associated with the dispersion of services across multiple sites. These include an initial drop in attendance for some Inclusive Health services (i.e., wellness and acupuncture), that later picked up again. It would merit further examination if the aftermath of the flooding has also resulted in a shift of the service user profile, for example from participants supported by Micah Projects towards walk-in and private appointments from the new locations.

The main conclusion from this study is that flexibility of practice is key in the health care service delivery to marginalised people, in particular those with experience of homelessness: there is more than one right way to do things at Inclusive Health. Based on the findings presented in this report, we suggest the below recommendations to support the health and wellness practices of service users.

Recommendations:

1. Continue and/or extend the elements of the Inclusive Health and Wellness Hub that work well, including transport to and from services, and weaving health and social care together.
2. Advocate for greater health system integration and explore opportunities across not-for-profit and government sectors.
3. Create opportunities for Inclusive Health and Micah Projects staff and volunteers to meet regularly and engage with the service catalogue. This will enable greater knowledge around what services are on offer and how to promote access for participants.
4. Improve the presence and the visibility of the Inclusive Health and Wellness Hub's services available in the community, leveraging online and offline resources.
5. Explore funding options to expand services to meet demands for alcohol and drug support, mental health services and dental services.
6. Recognise the important contributions of non-clinical staff to care work. It is crucial to acknowledge the necessity for skilled staff–both clinical and non-clinical–aligned with core service values to sustain a relational model of care.

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