



inclusive
health

PARTNERSHIPS LTD



ANNUAL REPORT

2024–2025



Inclusive Health Partnerships Ltd

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佛教慈濟基金會澳洲分會
Buddhist Compassion Relief Tzu Chi Foundation Australia Inc.

MICAH PROJECTS 
Breaking Social Isolation
Building Community

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Acknowledgement

Inclusive Health Partnerships Ltd acknowledges and pays respect to the traditional custodians of the Greater Brisbane area: the Turrbal people, the Jagera people, the Yugarapul people, and the Elders both past and present on whose land we walk, work, and live. We recognise that sovereignty of their land was never ceded.

Our mission is informed by the social and clinical determinants of health and, as such, we are committed to overcoming health inequality by providing high quality, integrated and holistic care.



General Practice (GP)

The Inclusive Health and Wellness Hub (IHWH/The Hub) continued to provide General Practice (GP), nursing, dental and wellness programs, vaccination clinics, outreach clinics and commenced a Social Work in General Practice Pilot program.

For various time periods throughout the financial year The Hub team consisted of five GPs. All GPs have a particular interest in delivering healthcare to people experiencing homelessness. They are often faced with unique challenges managing people with complex multimorbid chronic diseases and navigating the associated care coordination required to provide optimal care. The Hub's GPs have a special interest in mental health, substance use and addictions, women's health, skin health and chronic conditions management.

The team of nurses working at The Hub, includes one part time Nurse Practitioner (NP) and a part time NP candidate, and a chronic disease and treatment room nurse. Our NP's provide outreach and clinic services, supporting patients in both primary care and Hepatitis C treatment.

Our Practice Support Team consists of a Practice and Nurse Manager and two medical administration/ reception staff.

Visiting Services: The Hub continues to host a visiting endocrinologist from the Princess Alexandra Hospital, who works with our Clinical Lead GP for a monthly diabetes clinic. This is part of the Diabetes Street Hub program which includes a Diabetes Educator outreach service. We also continue to host monthly bulk billing podiatrist services through Flexicare Podiatry.

We acknowledge and thank Flexicare for partnering and providing podiatry services at the Inclusive Health and Wellness Hub.



Meeting the need

The steady growth in participants benefiting from the services and the growth in partnerships with other service providers to deliver services are a strong indication that the Inclusive Health and Wellness Hub's approach is meeting the needs of participants.

Internally the IHWH has an active clinical governance framework in place and remains subject to the stringent Royal Australian College of General Practitioners (RACGP) accreditation standards.

Board Directors

Karyn Walsh (Chair)

Patrick Lu

Alice Lu

Michael Kelly

Administration Team

Leanne Papas

Cluster Lead

Sally Upton

Cluster Lead

Kate White

Practice and Nurse Manager
(resigned June 2025)

Steven Cooper

Inclusive Health and Wellness Hub Manager
(commenced June 2025)

Monica Townrow

Fanguna Filimoehala

Dental Services

Xalucie Truong

Tzu Chi Dental Services

Nursing Team

Kim Rayner

Nurse Practitioner

Talay Quinlan

Nurse Practitioner candidate

Kate White

Sian Williams

Wellness Team

Kirsten Baker

Dave Monson

Danielle Rush

Jane Shelton

Eva Zhou

General Practitioners

Dr Kerrie Seeger

Dr Sam Wakista

Clinical Lead

Dr Yu San Tang

Dr Christine Shih

Dr Christopher Hollis

We acknowledge and thank all practitioners for their skill and care provided to patients over the 2024/25 financial year.



General Practice Services

The IHWH remains focused on reducing its 'Did Not Attend' (DNA) rate and has maintained a low percentage for a service supporting this complex patient cohort.

It reflects the excellent collaborative efforts both of Micah Projects to support participants to attend appointments but also reflects the 'Dr to you' nature of the outreach clinics (more information below), where the need for patients to travel to an appointment is removed.

Due to the complex nature of this cohort's situations and the impact of the social determinants on health, taking 'care to the patient' can sometimes be the difference between people receiving any health care or no care at all.

Patient support to attend appointments, for those patients sleeping rough or not in a GP supported crisis accommodation centre, has been identified as one of the major contributors to continuity of engagement and follow-up. Various Micah Projects' support teams assist with transporting patients to appointments at the IHWH. Support also extends to having a support worker attend appointments with the patient, as anxiety also plays a significant role in preventing attendance.

	Total
 Total episodes of care for clinical services: GP and nurse services	7,527
 Health appointments attended: GPs, nurses, nurse practitioner, allied health and diabetes education	8,436
 Unique patients	1,436
 Did not Attend (DNA) rate	16.87%



Click on the QR Code to view Henry's story.



Dental – Tzu Chi Foundation

Dentists

Dr Alice Lu

Dr Amiel Jane Cassidy

Dr Angela Lok Tong Chan

Dr Cheryl Mee Len Chin

Dr Christy Chu

Dr Ellie Lou

Dr George Phillip Nichols

Dr Janak Patel

Dr Kent Nakahashi

Dr Kumiko Yokota

Dr Lichen Yang

Dr Norah Ayad

Dr Renu Baidya

Dr Tasleem Khan

Dr Ting-Shi Samantha Lo

Dr Wade Hsu

Dr Wei William Chen

Specialists

Dr Lydia See

Specialist in Special Needs Dentistry

Dr Jen-Ti (Rachel) Hsieh

Specialist in Maxillofacial Surgery

Dr Sarah Chaw

Specialist in Oral Medicine

Other Tzu Chi Foundation practitioners

Dr Jones Chen

General Practitioner

Ms. Eva Zhou

Chinese Medicine Practitioner

Ms. Helen Liang

Counsellor/Play Therapist

We would like to acknowledge the voluntary work and compassionate care that the Tzu Chi clinicians have provided to patients over the 2024/25 financial year.



Services Provided by Tzu Chi Foundation

\$140,586 total value of treatment provided.

\$12,895.65 worth of medical consumables donated and used for delivery of services.

 Dental appointments	361
 Counselling appointments	3
 Chinese Medicine appointments	32
Total	396

Volunteer Contribution from Tzu Chi Foundation

466 instances of volunteer contribution | **2,485.5 hours** of volunteering

Specialist	206 hrs	\$26,780
Dentist	357 hrs	\$35,700
GP	6 hrs	\$960
Chinese medicine	73.5 hrs	\$2,940
Counselling	9.5 hrs	\$475
Dental assistants	830 hrs	\$20,750
Team Coordination	678 hrs	\$88,772
General	325.5 hrs	\$8,140
Total	2,485.5	\$184,517

*average cost of salary contribution



Case Study



Mr J is a 30-year-old male with an intellectual disability and dental anxiety, who was referred by the Micah Projects Tenant Sustainability Team.

Due to his complex medical condition, Mr J has been under the care of our volunteer Special Needs Dental Specialist, Dr. Lydia See, and Dr. Amiel Cassidy (Specialist in training, completing placement hours with the Tzu Chi IHWH Dental Team).

Mr J relies on his support workers to manage and attend to his health needs. We are grateful for the collaboration with the Micah Projects’ Support Team, whose assistance has made every appointment possible. Their support - providing transportation and being present during visits - has greatly encouraged and motivated Mr. J to continue his dental care.

From being highly anxious and only able to tolerate short periods in the dental chair, Mr J has gradually become more comfortable and is now coping well with longer treatments, including root canal therapy. Even after being discharged from Micah Projects’ support, Mr J has expressed his wish to continue care at our clinic and has proactively asked his new support team to contact the Inclusive Health Dental Clinic for follow-up dental care.

We are delighted to be part of such a wonderful collaboration and deeply grateful to our volunteer specialists for their compassionate and holistic approach in caring for one of our community’s most vulnerable members.



Wellness and Allied Health

Another consistent year of integrative health service delivery was had across the 24/25 financial year.

The provision of important allied therapies, such as acupuncture, and complementary healthcare, such as myotherapy, shiatsu, reflexology & massage, was provided to participants at The Hub.

Our trauma-informed practitioners Danielle Rush, Dave Monson, Erin, Eva Zhou, Jane Shelton and Rachel continued to provide expert complementary care alongside general practice and nursing. We welcomed Aki Okada in the community acupuncture space for clinical placement as part of her Master’s degree through RMIT, Melbourne. The team completed training with Maddie from the Pelvic Pain Foundation of Australia as part of their professional development.

Community acupuncture continues to run as a part of the ‘Her Health’ program on Monday mornings, and then as per usual on Wednesdays and Thursdays. Myotherapy continues Thursdays and Fridays; Shiatsu on Wednesday, Reflexology on Tuesday afternoons and Relaxation massage appointments can be booked for Monday afternoons.

Volunteer Contribution Clinical data shows that for the course of the 2024-25 financial year, wellness practitioners delivered:



Myotherapy treatments 593

Shiatsu treatments 204

Reflexology sessions 103

Relaxation massages 85

Acupuncture treatments 1,245



GP Outreach Clinics

The GP outreach clinics continue to operate with two new sites commencing in this reporting period bringing the number of clinics to a total of five.

- All clinics are held for approx. 4 hours.
- Additional support provided at GP outreach clinics by IHWH nursing and admin staff.
- At 3rd Space we collaborated with the nurses from Anglicare to provide care to mutual patients.

GP Outreach clinic	Partners	Outreach Site	Clinic description	Clinic sessions	Patient numbers
2024 – 25 (Weekly)	Bric Housing Mission Australia	Spring Hill	Crisis accommodation	45	234
2022 – Current (Weekly)	St Vincent De Paul	The Park Hotel	Crisis accommodations	47	244
2024-25 (Twice weekly)	3rd Space	Fortitude Valley	Day-time drop-in centre for people experiencing homelessness.	90	703
2024-25 (Weekly)	Greenslopes House	Greenslopes	Level 3 Supported accommodation	49	546

We would like to acknowledge and thank all Partners who partner with, support and work with IHWH.





Her Health Day

Monday morning at The Hub is reserved for specialised women's health services.

Our objective is to create a safe, welcoming and trauma-sensitive environment for women experiencing homelessness, domestic violence or hardship to access preventative screening, healthcare and wellness therapies on a weekly basis.

Available services include pre-pregnancy planning, antenatal and postpartum care, as well as support for various health conditions often related to domestic violence, mental health, and substance use.

A GP provides gynaecological care, preconception planning, prenatal and postnatal care, contraception options, vaccinations, STI screening and support for perimenopausal and menopause. A Nurse Practitioner Candidate provides comprehensive women's healthcare, domestic violence support, sexual health screening and education. A Wellness Practitioner is available to provide acupuncture and massage.

Referral and Outreach: Her Health Day health professionals work with Micah Projects' outreach teams and local organisations to ensure referrals are received from women who would benefit from a specialised service and space. Working in collaboration with the Street to Home and Families teams to provide outreach or support to the clinic along with working on housing and social needs.

Safe Access Study – evaluation of Her Health Day clinic on access to healthcare for women

We undertook a four staged co-designed evaluation of the 'Her Health Day Clinic', Micah Projects. The 'Her Health Day Clinic' is provided every Monday morning, with the intent of improving access to women's health for women experiencing extreme poverty, domestic violence and/or homelessness.

Stage 1 involved establishing a co-design team of women with lived experience of domestic violence and marginalisation, clinicians and academics.

Stage 2 involved co-designing the evaluation.

Stage 3 involved collecting data from women attending the Her Health Day Clinic. Data collection was undertaken by a researcher and a lived experience co-design team member at 10 clinic sessions. All women participating in the study did so voluntarily and received a food voucher (\$9) for completing the survey and a \$30 Visa Card voucher for completing an interview.

Stage 4 involved analysing the data with the co-design team members.

Participants

The study comprised n=15 participants aged 25 to 72 years old. 7 participants were attending the clinic for the first time, one participant had attended 12 times previously and one 14 times previously

Cultural Background		Main purpose for attending		Living situation	
Aboriginal	2	Women's health concerns	9	Had a safe place to stay	12
Indian	1	Pain	3	Felt unsafe at home	2
Philippines	1	Mental Health	1	Unknown	1
Did not say	3	Chronic disease	1		
Australian	8	Injury	1		



Survey and Interview

13 participants completed the satisfaction survey, responding using a rating scale (smiling face to unhappy face).

	Disagree	Neutral	Agree
3 participants were visiting the clinic for the first time			
They felt physically safe in the clinic	-	1	2
They felt emotionally safe in the clinic	-	1	2
The clinic was sensitive to their cultural needs	-	-	3
Their health and wellbeing needs were met	-	-	3
They felt involved in decision making about their care	-	-	3
Visiting the clinic was helpful	-	-	3
10 participants were returning to the clinic			
They felt physically safe in the clinic	-	1	9
They felt emotionally safe in the clinic	1	2	7
The clinic was sensitive to their cultural needs	-	-	10
Their health and wellbeing needs were met	-	2	8
They felt involved in decision making about their care	1	1	8
Visiting the clinic was helpful	-	1	9

Interview findings were largely positive and indicated that the clinic promoted a sense of safety.

I've had so many doctors just trying to find help and trying to get help, this is probably the first place that I've actually gotten help, and probably the longest time I've been with a doctor... (Participant 12)

Not all participants were completely satisfied with the approach of some of the doctors.

...train the female doctors a little better. Not in medicine, in – what's the word? Socialising, in bedside care, bedside manners. Just be a little bit more gentle and nurturing when it comes to bedside manner, and actually listening to the emotional side of things. (Participant 14)

The most frequently suggested improvement was to increase people's awareness of the clinic, because many participants became aware of the clinic accidentally.

But I'd never heard of this place, and it was only because of another lady that had been here. So I think my first thought would be more advertising, possibly within - booklets and things. (Participant 11)

Advertising the clinic is challenging because it may have the unintended consequence of encouraging perpetrators of violence to attend to see their partners.

Diabetes Street Hub Project

The diabetes street hub project, delivered in partnership with Metro South Princess Alexandra Hospital and Health Service, is an integrated, community-based service to improve diabetes care for people in unstable housing.

Unstable housing including homelessness is associated with poor glycaemic control, increased complications and more frequent hospital presentations. Many hospital encounters are potentially avoidable if adequate and accessible community-based services are available.

The Diabetes Street Hub was established at the Inclusive Health and Wellness Hub in early 2023 through funding from Queensland Health. A Nurse Navigator/ Diabetes Nurse Educator is co-located at IHWH and works collaboratively with other clinicians at the clinic (and external to the clinic) to contribute towards the multidisciplinary approach to diabetes management.

Aims	Challenges	Solutions
Improve diabetes outcomes for the target population	High non-attendance rate at appointments	The flexible care delivery mode of the service, including community outreach and home visits by the Nurse Navigator
Support other care providers in diabetes management of their patients	Access to transport to attend appointments	A case conference model to support regular care providers
Reduce utilisation of acute care services by delivering appropriate and holistic care within the community	Inability to contact patients, often due to patient's lack of access to phones	Rationalisation and simplifications of medications
Enhance prevention and early case detection.	Adherence to medication and monitoring	Collaboration with social workers and organisations to address and reduce care barriers.
	Healthy food access and food security	
	Co-morbid conditions, including mental illness.	

Activity from 13 February 2024 to 27 June 2024

	Patient encounters at the Diabetes Street Hub Project via face-to-face at the clinic, home visits, phone calls and hospital inpatient ward visits	184
	DNAs Did Not Attend	2
	New patient encounters	67
	Reviews/Follow-up	117

Our referral points during this period were: Micah Projects - mostly through GPs, and outreach staff, Princess Alexandra Hospital, RBWH, Mater Hospital, Logan Hospital, Redcliffe Hospital, Brisbane City council, Mission Australia.

Hepatitis C / Liver Health Program – Nurse Practitioner led

Micah Projects and the Inclusive Health Clinic’s Nurse Practitioner led Hepatitis C/ Liver Health program (0.4FTE) provided:

	Nurse Practitioner (NP) and Registered Nurse (RN) clinical consultations including clinical care coordination was provided to participants by the part time NP (0.4 FTE NP, 1 FTE RN)	660
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Thank you to Kim Rayner (Nurse Practitioner) and Carolyn Henzell (Registered Nurse) for the delivery of care to patients.

	People seen by the NP for reasons including:	187
	<ul style="list-style-type: none"> ▪ Primary health care needs ▪ Clinical assessment ▪ Hepatitis C screening/testing ▪ Pre-treatment work up ▪ Prescribing direct acting antiviral treatment ▪ Chronic disease management ▪ Alcohol and other drugs (AOD) and mental health interventions ▪ Clinical support to complete treatment and achieve a cure 	

	People experiencing homelessness at the time of care	60%
	<p>Of those individuals:</p> <p>38% resided in public housing</p> <p>32% lived in permanent supportive accommodation</p> <p>24% were in a residential rehabilitation centre.</p>	

	People participated in the National Hepatitis C Point of Care Testing (POCT) Pathway to care (Partnership with UNSW/ Kirby Institute)	187
	with 14 outreach POCT clinics held across various homeless and temporary accommodation sites.	

We acknowledge this work with the Kirby Institute and UNSW is part of the broader national research.

Most patients were seen by Kim Rayner (Nurse Practitioner) at outreach sites such as crisis accommodation, hotels, motels, boarding houses, community housing, community drop-in centres and public housing sites linked to the work of Micah Projects Street to Home team. Telehealth also played a critical role in follow-up and sustained engagement while undergoing treatment for some patients.

The majority of people treated for Hepatitis C this year were living with a severe and persistent mental illness (schizophrenia) and a disability.

This pilot program has resulted in \$200,000 of funding for the 2025/26 financial year.



Social Work in General Practice Pilot

In 2024-25, we commenced a pilot program, delivered in partnership and funded by Brisbane South Primary Healthcare Network (BSPHN), supporting participants accessing GP support to navigate complex systems and receive more targeted support, in partnership with the Brisbane South Primary Health Network.

This initiative aims to support patients by addressing the social determinants of health including the barriers that hinder their ability to prioritise their healthcare needs.

45 participants supported



Partners and Funders

The IHWI refers to and receives referrals from many organisations/services, these include:

Hospitals:	Sexual Violence Services	Queensland Positive People
▪ Princess Alexandra Hospital	Domestic and Family Violence Services	YFS
▪ Royal Brisbane and Women’s Hospital	Specialist Homelessness Services	Institute of Urban Indigenous Health
▪ Mater Health Services	Brisbane South Primary Health Network	Bric Housing
▪ Prince Charles Hospital	Brisbane North Primary Health Network	The Park Hotel
▪ Logan Hospital	Common Ground	3rd Space
Queensland Health – Mental Health and Alcohol and Other Drug services (ADHOT and HHOT teams)	St Vincent de Paul	Greenslopes House
Aboriginal and Torres Strait Island Community Health Services (Woolloongabba)	Women’s Health and Equity Queensland	Mission Australia
Queensland Police Service		Communify

We deeply thank our funders who make the IHWI possible:

Queensland Health	Brisbane North Primary Health Network
Brisbane South Primary Health Network	Tzu Chi Foundation

Inclusive Health Partnerships Ltd

Statements of Profit or Loss and Other Comprehensive Income for the year ended 30 June 2025

	2025	2024
	\$	\$
Revenue		
Medicare Income	585,675	513,384
Donations	101,627	140,050
Dentist Income - in kind contribution	140,586	116,215
Grants	163,000	138,960
Insurance Income	387	295
Other Revenue	471,401	231,582
	<u>1,462,676</u>	<u>1,140,486</u>
Less Expenses		
Operating Expense	(111,522)	(141,407)
Salary and Wages Expense	(1,129,567)	(752,438)
Dental Expense - in kind contribution	(140,586)	(116,215)
Depreciation and Amortisation Expense	(106,303)	(106,303)
Medical Equipment and Supplies	(15,380)	(17,071)
Insurance Expense	(21,874)	(24,617)
Property Expense	(83,192)	(36,194)
Interest Expense	(5,086)	(7,336)
Total Expenses	<u>(1,613,510)</u>	<u>(1,201,581)</u>
Income tax expense	<u>0</u>	<u>0</u>
Surplus / (deficit) for the year	<u>(150,834)</u>	<u>(61,095)</u>
Other comprehensive income	<u>0</u>	<u>-0</u>
Total comprehensive surplus/(deficit) for the year	<u>(150,834)</u>	<u>(61,095)</u>

The financial statements and specific disclosures included in this concise financial report have been derived from the financial report. The concise financial report cannot be expected to provide as full an understanding of the financial performance, financial position and financing and investing activities of the entity as the financial report. The presentation currency used is Australian dollars.

If you would like to view the full financial statements including notes for the 2024 - 2025 financial year, please contact The Inclusive Health and Wellness Hub or visit the Australian Charities and Not-for-profits Commission (ACNC) website (www.acnc.gov.au/charity) and search for Inclusive Health Partnerships Ltd.

Inclusive Health Partnerships Ltd

Statement of Financial Position as at 30 June 2025

	2025	2024
	\$	\$
Assets		
Current assets		
Cash & cash equivalents	266,618	433,945
Trade receivables	238,762	127,457
Prepayments	7,435	9,733
Total current assets	<u>512,815</u>	<u>571,135</u>
Non-current assets		
Property, plant and equipment	77,344	130,013
Right of Use Assets	84,921	138,555
Total non-current assets	<u>162,265</u>	<u>268,568</u>
Total assets	<u>675,080</u>	<u>839,703</u>
Liabilities		
Current liabilities		
Trade and other payables	102,448	109,799
Provisions	72,819	29,076
Lease Liability	59,805	57,462
Total current liabilities	<u>235,072</u>	<u>196,337</u>
Non-current liabilities		
Provisions	15,092	7,813
Lease Liability	36,033	95,836
Total non-current liabilities	<u>51,125</u>	<u>103,649</u>
Total liabilities	<u>286,197</u>	<u>299,986</u>
Net assets	<u><u>388,883</u></u>	<u><u>539,717</u></u>
Equity		
Retained Surplus	<u>388,883</u>	<u>539,717</u>
Total equity	<u><u>388,883</u></u>	<u><u>539,717</u></u>

Micah Projects

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