Government of **Western Australia**
Department of **Health**
Chief Allied Health Office

Integrated primary health care for adults who have experienced homelessness

Phase one research summary

May 2023

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Acknowledgement of Country and People

Department of Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Using the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

Contents

Research summary overview

This document summarises the research findings of phase one of a Health Innovation Fund - Stage Two Schedule to the Federation Funding Agreement – *Comprehensive Healthcare for People Experiencing Homelessness* project. It presents the overall project and research objectives, as well as the methods, key findings, and next steps.

The findings will help plan effective integrated health services for people who have experienced or are at risk of homelessness. An article is being prepared for publication in a scientific journal. For more information, or for a copy of the article once published, contact CAHO.CED@health.wa.gov.au

This report was prepared by Suzi Taylor and Mark Petrich of the Chief Allied Health Office, Clinical Excellence Division, Western Australian Department of Health.

Project aim

This project addressed an aim of the Health Innovation Fund (HIF) grant to assist with the planning of integrated service models and had 4 research objectives, to:

1. understand the international and interjurisdictional evidence for integrated and multidisciplinary health services for people experiencing – or at risk of – homelessness
2. identify the most effective core components of integrated models from the literature
3. understand if service providers and service users agree with the identified core components
4. identify which core components are recommended to inform development of integrated healthcare models for Western Australia.

Method

To achieve the objectives, two research methods were used, a literature review and stakeholder interviews.

The research was underpinned by realist evaluation methods because the approach suits evaluation of complex interventions delivered in health and social services to understand what works, for whom, and in what circumstances.

The project was approved by Sir Charles Gairdner and Osborne Park Health Care Group Human Research Ethics Committee (#5371).

Introduction

The Chief Allied Health Office (CAHO) is responsible for the Homeless Health portfolio within the Western Australian Department of Health. Projects and policy developments are focussed on interfaces between the WA health system and other agencies and sectors, aiming to provide equitable, coordinated, effective and person-centred health care for this population.

Funded by a Commonwealth HIF grant, the CAHO Homeless Health portfolio is undertaking a research program to develop integrated primary health care models for people experiencing or at risk of homelessness. The research has two phases:

- Phase one – planning of integrated service models
- Phase two – trialling the delivery of integrated service models in Perth.

Phase one of the research was completed in 2022 and results will be discussed in the following, as well as the next steps and plan for phase two.

Background

Integrated care can improve access to health and social support services for people experiencing homelessness. Rather than leaving responsibility for accessing services solely with the individuals, coordinating care around a person can reduce unnecessary hospital use and crisis care. However, consensus on what an integrated service model is and its core operational components, is absent in homelessness literature. Health and social care providers, service managers and commissioners need to make informed decisions. It is vital to understand the core components of integrated health care for people facing homelessness, and the implementation strategies suited to local care systems.

For people experiencing primary, secondary, and tertiary homelessness, the importance of accessing appropriate and timely health care is recognised internationally. Organisations and practitioners across the health, housing and social sectors need to work together to achieve this ambition. Although there are successful examples of integrated health and social care, such as the Common Ground model in Australia, and National Institute for Health and Care Excellence guidelines in the United Kingdom, the models do not identify the core components needed for the successful implementation of integrated primary health care specific to Western Australia. There is a unique opportunity to trial and strengthen the service approaches and processes in existing homeless healthcare settings in Perth. But first we needed to understand the core components of integrated health care as much as possible.

Phase one results

The literature review was completed between March and May 2022. From 294 records screened, 26 peer-reviewed research articles and two grey literature sources were included. The review identified many possible core components of integrated health care. However, because the articles and grey literature were from national and international sources, we couldn't be sure these components were directly applicable to Western Australia.

To identify the content specific to Western Australia we interviewed 27 participants about the core components from the literature between July and August 2022:

- 7 people from Perth with a lived experience of homelessness
- 14 homelessness service providers from Perth
- 6 interstate Common Ground providers.

We then grouped information from the interviews into core components of successful integrated homeless primary health care and compared these with what we had found in the literature review.

Twelve core components were identified and 10 from the literature were supported. Notably absent in the literature, but present in the interviews were:

- the concept of individual agency and the importance of a person exercising choice either when selecting a provider, opting to share their personal data (and to whom, where and when), or choosing whether to engage in health care at all
- the subtleties of service delivery and staff-intrinsic qualities that help build trust with clients and the idea of providers supporting dignity of risk, a warm return to services when people are ready, and walking alongside someone.

The below 12 core components are further discussed on pages 17-21:

1. Homeless primary healthcare providers increase access to their services
2. Homeless primary healthcare providers support access to mainstream health services
3. Connected homeless primary healthcare services
4. Person-centred service coordination
5. Personal agency, choice and control in health care
6. Skilled and non-judgemental primary healthcare workers
7. Collaboration between service providers
8. Personalised services
9. Key philosophies on primary health care
10. Organisational policies and systems
11. Health system responsibilities
12. Whole-of-government response

The next pages contain Figures 1-12 which are the 12 core components of integrated primary health care with example quotes from the stakeholder interviews.

Figure 1. Homeless primary healthcare providers increase access to their services

'We've got to be making things easy for people to access. So that when they are ready to reach out...they can do so quickly and get the assistance that they need. If we put in barriers at that point, we lose them, there's a window of opportunities.'

(Service provider #1)

'Because the population of people we're working with, have so many additional challenges... If at that time they want help, they have to wait or there's a transport issue...it doesn't work. It gets stuck.'

(Service provider #6)

Increasing homeless health access through:

- improved availability, flexibility and visibility
- free services
- communicating using methods tailored to thier clients
- provision of a comfortable, friendly, familiar and safe health care environment
- providing access support
- being responsive to needs as they arise

'At the doctors...the receptionists there are very good...they explain things to you properly. They'll book an appointment for you and they won't let you go unless you've got that appointment booked...and they'll send you a message the day before your appointment... There's flexibility. No punishment for your mental illness.'

(Service user #7)

Figure 2. Homeless primary healthcare providers support access to mainstream health services

'The clients won't stay if they're on their own. They won't wait. Even to wait 15 minutes is a no-no. And you particularly find that for an emergency presentation to an emergency department. It's really good to have the nurses take the patient…'

(Service provider #14)

Increasing mainstream health access through:

- taking a proactive approach to transitions between care settings
- advocating for clients
- working with mainstream providers to identify and refer people experiencing homelessness

'He [client] came to our service and was engaged with one of our doctors. And one of the doctors was kind of a liaison to the hospital in a way. He [client] feels safe and was like, okay, someone is listening.'

(Service provider #20)

'I wouldn't have gone to the hospital. When they make you feel like they make you feel I wouldn't have gone… Its not all [staff] but…it's like all the bad ones make a name for all of them. There's two bad cops in a hundred, but they still give cops a bad name…'

(Service user #2)

Figure 3. Connected homeless primary healthcare services

'And for that social worker to be there to help that person to find the resources. So they can say, "This is what I'm struggling with" and they can say, "Okay, I can help you find some resources for that". '

(Service user #1)

'What's important is that initial engagement that they have with the service. Generally, that sits with outreach and if it's been a good experience. They will come back.'

(Service provider #7)

Connected healthcare services through:

- assessment and diagnosis to support needs
- physical and mental health services, alcohol and other drug services, social support, medical outreach specialties (including student and volunteer practitioners)
- outreach
- concierge services
- links to existing complementary health and non-health services

'So, you need a GP team. So whether that's GP, nurse practitioner, trained nurses, I think you need all of them. And I think we underutilise nurse practitioners in this country... I think that you do need a variety of allied health. I think OTs [occupational therapists] are underestimated.'

(Service provider #16)

'It [the concierge] lends itself so wonderfully to that safety and security part. It lends an ear to people who aren't necessarily going to have that contact with the professional supports...'

(Service provider #3)

Figure 4. Person-centred service coordination

'It's kind of personalised. You don't get that in mainstream, but again, it's really acknowledging that some of this stuff is very much relationship-based stuff. People that haven't accessed services for a really long time. That even kindness aspect of it, that relational aspect of it is really important.'

(Service provider #12)

'If you [health services] suddenly are in one place and everything's fixed and you can't go anywhere else. Suddenly you're the system again. You become the health system. And "the health system is not my friend". So I think sometimes...sort of "them and us thing". But what we want is; we can help you. And to do that, we will come to you.'

(Service provider #4)

Person-centred service coordination through:

- coordinating and connecting existing services
- a main service centre and No Wrong Door approach
- tailored, sensitive and practical services
- familiar staff
- practical use of time in waiting rooms
- consideration of building design and physical spaces
- strategic and complementary location of services
- understanding that coordinated wraparound care could discourage clients from seeking help from outside or offsite services, potentially reinforcing their feelings of exclusion

'So having a wraparound means that people don't have to be formally referred into different services or to another site. The referrals can be very warm referrals. They [staff] can be literally walking the person from one room into the next room.'

(Service provider #1)

'But I can100 per cent say that places like this [integrated service centre] ...'cause I mean people that are homeless you know, they don't want to really be around in public. They don't want to have to go from that office to that suburb to this appointment down the street and it's all here. It's like a little hub... We need more safe hubs like this. Everywhere.'

(Service user #1)

Figure 5. Personal agency, choice and control in health care

‘You can take it home and think about it and you’ve got options. So it is so liberating when you know you’ve got options and choice. Something that fits right for you. Because we’re all different. All our problems are different for everyone. No ones the same.’

(Service user #1)

Support client’s personal agency through:

- options to choose different staff or services
- service delivery models that promote choice
- staff who can assist clients to have choice and control over their lives

‘But it’s also about being mindful of the relationship between agency and power… So I think a paternal prescriptive kind of practice is probably where we started… but as the community has developed, it’s developed its own strengths, its own identity, its own voice, and then it’s our job to hear those things, see those things. Champion those things.’

(Service provider #3)

‘It’s not about what we [staff] think is right. It’s about what they [clients] know is right…’

(Service provider #13)

Figure 6. Skilled and non-judgemental primary health care workers

'You can't just come into this role and pick it up. There is so much life experience. Just experience in the role, I think... There are so many unseen unarticulated parts of the role that are really important.'

(Service provider #6)

'I guess when you feel really alone, it's so nice to have like I get it's their job, but they're thriving in their roles... Also like even just pre-filling in the info 'cause... they've listened. It's nice to feel, like, heard'

(Service user #2)

Skilled and non-judgemental primary health care workers with:

- a wide range of clinical skills
- people skills and life experience
- a deep understanding of individuals and homelessness

Delivering service models where:

- all staff are considered part of the treatment model and philosophy of care
- authentic and trusting relationships are developed between staff and clients
- mentorship and supervision are provided, offering a range of relevant training topics
- an ideology of being safe and inclusive is adopted

'It's compassion you know? And I walked away from that [GP] appointment feeling a hell of a lot better.'

(Service user #6)

'So, I like to call it unconditional positive regard...how you approach someone and it's very much, you take them as they are. You are positive, you're coming from a strength space where you're assuming the best of someone and you are treating them with respect, with dignity.'

(Service provider #12)

Figure 7. Collaboration between service providers

'If it is just say, one doctor that could get somebody else to another service. That's helpful. Because a lot of people just have no idea.'

(Service user #2)

Collaboration through:

- working together with service models designed and implemented in partnership
- informal relationships between providers
- formal collaborative agreements
- data sharing (with consent)
- services being aware of each other and connecting clients to a range of services
- established trust between providers

'And I think the other benefit of having that sort of co-located community approach is there's more knowledge... We are really well connected with all sorts of services.'

(Service provider #4)

You need to know where to take the client, what to offer the client.'

(Service provider #10)

'Having a warm referral, that relationship... Very important. Established pathways wherever possible. You've got an understanding, the other party has an understanding and will trust your referral as a provider.'

(Service provider #1)

Figure 8. Personalised services

'Lived experience involvement in the sector that's really important, both from a service design kind of thing, but also having peer support workers.'

(Service provider #16)

'Our service is good because it's different. It's Aboriginal owned, run, managed, different, different language, different processes, different everything. Word of mouth is important.'

(Service provider #10)

Personalised services through:

- authentic co-design and client involvement opportunities
- shared and transparent decision making and enhanced service reputation and trust

' If the consumers don't think the service is good, it's not good... If you want them to continue to give feedback, they have to feel that the feedback that they've given before was listened to.'

(Service provider #5)

'I wanted to go back to work and I was, "I need you to lift my medical..." Because I had really high blood pressure. They [doctors] were worried... They talked me down from it a couple of times... They didn't want me doing anything too physical. They made me aware of the dangers...'

(Service user #6)

Figure 9. Key philosophies on primary health care

‘Human rights is a charter, a declaration of human rights that health care should be available for every human being, no matter your social circumstances or financial circumstances.’

(Service provider #13)

‘I have to sometimes look at the very basic social needs of the person. And I think if you don’t, it will just be on a continual roundabout.’

(Service provider #2)

Key philosophies through:

- being proactive and preventative but not paternalistic
- supportive before supported
- responsive, agile, holistic and at people’s own pace
- addressing social needs

Service providers ensure:

- clients are never lost to care
- training missions (such as teaching clinics, links with teaching hospitals and universities)
- Person-centred, trauma-informed, culturally safe and responsive, strengths-based

‘But your mention of a holistic approach is not just a really cool thing and a really smart way it’s the only way. Like how long have you and I, our peers, been talking about a better response to comorbidity?’

(Service provider #3)

‘Every appointment she [client] laid there, she was scared. She cried, [staff member] held her hand every appointment… That made her [the client] feel that she could manage it.’

(Service provider #15)

Figure 10. Organisational policies and systems

'So they've [new staff] got to fit with our set of vision, mission, and values. And we've got our values really basic - treat everyone with respect. Remove the stigma, I mean we are trying to create this place as a warm, welcoming space for people to be.'

(Service provider #1)

Organisational policies and systems to support integrated working through:

- shared organisational vision, mission, or values
- clarity around service responsibilities
- processes for secure and consented information sharing, and effective referral pathways
- compliance with state and national legislation, safety and quality, and other policies to protect safety of staff and clients
- deliver services in a way that policies and procedures don't become a barrier to service delivery.

'There's one intake form and it's shared amongst all the service providers. That sort of stuff. It cuts down on that duplication and having to send the same information to four different places. With one consent, you know, people can consent to all or can consent to one. You know. That's been an option for people.'

(Service provider #7)

'[Interviewer: Would you feel comfortable if there was some sort of information-sharing system that could connect the [local] hospital?]. Interviewee: Well, yes because then I don't have to worry about, "oh I've forgot to mention that." Like they would have it in there.'

(Service user #2)

Figure 11. Health system responsibilities

'I think a flexible model of funding is absolutely crucial to do more of what works...of course, line of sight and make sure we're providing on outcomes, but trust in the service providers to have flexibility.'

(Service provider #6)

Health system responsibilities through:

- funding models that support innovation, flexibility and complexity of client needs
- governance and coordination to support integrated working
- adequately and sustainably resourced homeless health services
- recognition of health care sector workforce including career progression opportunities
- enhanced connections between health providers and communities

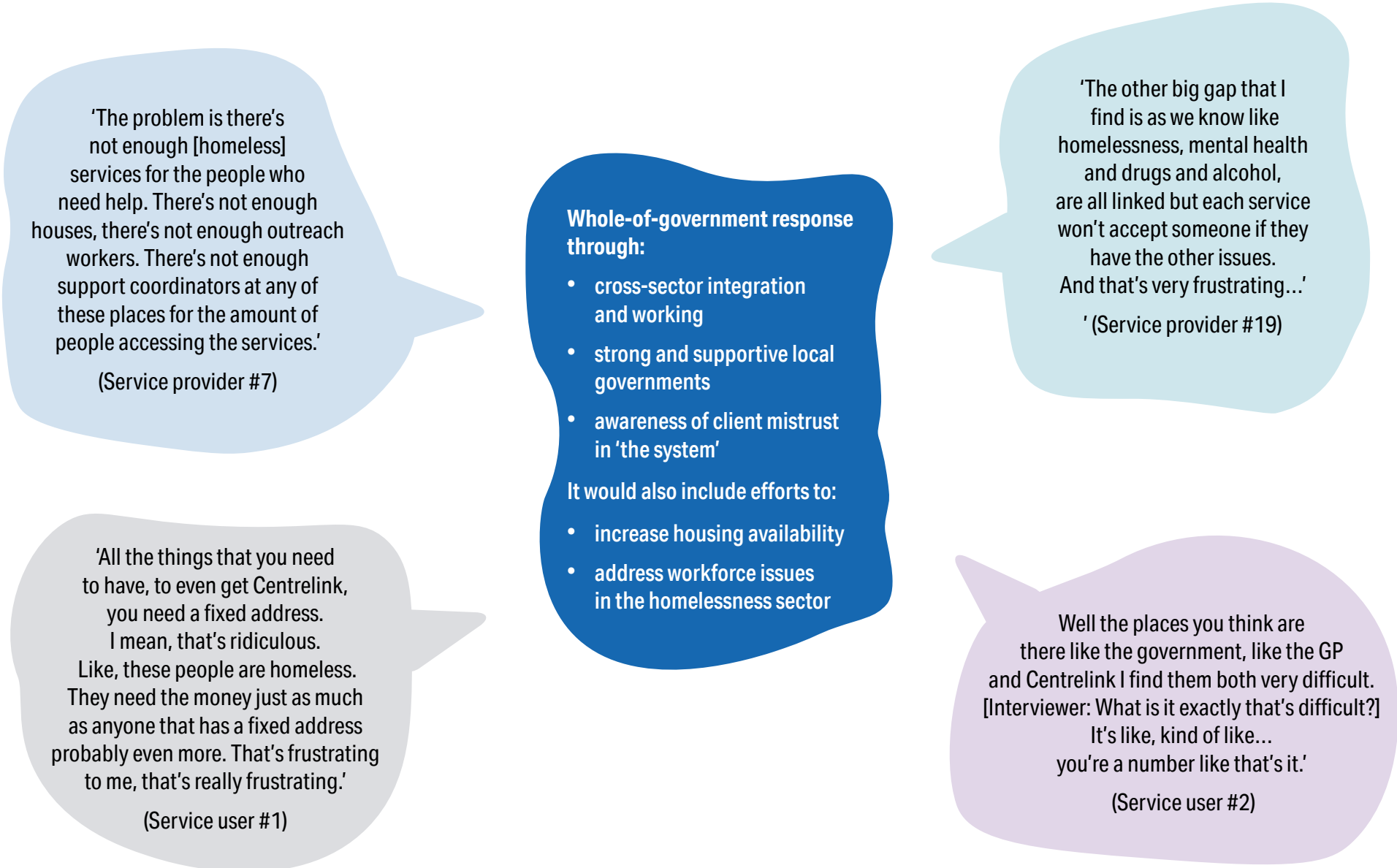
'There's an item number for a consult in a surgery, there's an item number for a consult in a home or place of residence. There's an item number for telehealth. But if I go up to someone in the street and have a consult there, I can't bill Medicare'

(Service provider #16)

'All these services here are well used... If you're not on the ball, you're going to miss them... Overall the health system needs help... They seem to be, don't have enough workers at the moment... And where are you going to pluck these workers from?'

(Service user #6)

Figure 12. Whole-of-government response



A large amount of contextual information from the interviews will be collated to help inform the future trial of integrated models. The practical information and final synthesis will be part of a published journal article.

Further matters to consider when reading these results are tensions and conflicting factors that were identified for the core components. For example:

- while the role of GPs addressing social determinants was important, the additional burden to the GP was identified (i.e workload and financial impost)
- trust between service providers is built over time and individual staff-level relationships across organisations are beneficial but can be a risk due to staff movement
- providing familiar, regular staff is an important component for relationship building with clients but can also cause pressure and issues on staffing and the need for boundaries
- organisational policies and procedures can support integrated models but can become a barrier to service delivery. There needs to be flexibility for staff to deliver care in their own style.

Therefore, please keep in mind that this is not a prescriptive list and that review of applicability to individual settings is required.

The centre shape in figures 1-12 provided a visual representation of the findings supported by quotes from the interview participants. The interpretation of these finding are presented in the following under 5 categories with multiple components in each category.

Primary healthcare role

1. Homeless primary healthcare providers increase access to their services

This component relates to offering assistance when needed, such as one-on-one support (forms or appointment booking), brokerage funds, and making sure communication methods meet client preferences (such as text messaging or options that don't rely on technology or a fixed address). Healthcare services are free, and the environment is safe, friendly and familiar, and administrative processes are reduced or simplified. There is flexibility and availability, including low-threshold access (for example, ID or Medicare card not required), walk-in appointments, penalty-free cancellation and non-attendance policies, options for longer-than-standard GP consults, care provided in convenient locations (including mobile clinics), and services promoted and signposted effectively within the community.

2. Homeless primary healthcare providers support access to mainstream health services

Primary healthcare professionals are proactive in supporting transitions between care settings including communication and collaboration with mainstream providers (for example at hospital discharge), co-attending appointments, or advocating on a person's behalf. Primary healthcare professionals work with mainstream providers to identify and refer people who are homeless, and promote secure information sharing and communication systems, including standardised referral pathways. Clients are encouraged to utilise information and resources to access mainstream health care where appropriate, enabling a wider range of options.

Services

3. Connected homeless primary healthcare services

People experiencing homelessness should have access to hospital-based care, primary and secondary healthcare services, and community healthcare services when required. The professions that participants most commonly said they would want in a dedicated homeless health care service were general practitioner, senior nurse, dentist, alcohol and other drug counsellor (or staff trained in AOD), mental health worker such as psychologist (or staff trained in mental health), social worker, optometrist, allied health such as physiotherapist, and podiatrist. There is need for a key front-of-house role in the healthcare setting such as a medical receptionist, clinic coordinator, concierge, triage person, or clinical assistant such as a qualified peer worker or social worker. The person or persons in this role would assist with queries, welcome clients and monitor the environment. Within homeless primary health care services, long-term follow up is required incorporating ongoing care for dentistry (including dentures), optometry for spectacles, and services that engage students and volunteer practitioners. Outreach would also form part of models for homeless primary health care.

4. Person-centred service coordination

Care coordinated under one roof supports opportunistic use of services, though not all services would need to be in one building. One option is for a main administrative site that coordinates a mix of co-located in-house services and visiting services, providing a single point of entry for clients (supporting the 'No Wrong Door' approach). These centres could be supported by mobile outreach units, where appropriate, and link to relevant and complementary local services, with purpose-built clinical spaces or dual-purpose spaces to accommodate visiting services. Service reach would be across existing primary and secondary care, medical specialties, social care and mental health providers. Services would be located strategically targeting people experiencing homelessness (in areas of unmet need, and where homelessness is most concentrated) and the choice of services tailored at the right level and circumstances. Clients could choose to see familiar staff and attend multiple interactions with a designated practitioner.

People

5. Personal agency, choice and control in health care

Homeless primary healthcare services understand that people have control over their choices and lives, including their level of engagement with care, what they discuss, and the staff and services with whom they connect. Primary healthcare professionals respect and support clients' individual choice and control over health care and life decisions including lifestyle choices. Service delivery models are designed to promote choice and allow personal agency, enabling clients to choose when to disclose, and allow sharing of their personal health information. The models also enable staff to deliver care in their own style.

6. Skilled and non-judgemental primary healthcare workers

A mix of skills, experience and personal qualities is needed to work in homeless primary healthcare. Practitioners must be able to diagnose and manage a wide range of health problems, prioritise and adapt to the immediate needs of clients and act on multiple health care needs in one encounter, if the client is willing. Primary healthcare professionals need a deep understanding of individuals and homelessness (including the problems and contexts that produce homelessness, and the complexities of the issue) and specialist expertise in alcohol and other drug treatments and mental health.

Training, mentorship and supervision is essential, especially for peer support workers. All healthcare staff would benefit from some exposure to homelessness as part of their training. Reflective practice or a self-reflective approach when working is beneficial, and organisations should adopt an ideology of being safe and inclusive. There are unarticulated aspects within homeless health services that perhaps cannot be provided through training such as intrinsic qualities and life experiences of staff drawn to these roles. There are subtleties of service delivery that build trust between clients and staff, and all staff members (clinicians and administrative staff) deliver care in a non-stigmatising, trauma-informed and empathetic manner and deeply understand client factors.

Relationships

7. Collaboration between service providers

Collaboration is facilitated through formal and informal relationships between providers and/or collaborative agreements. Interprofessional partnerships, pathways, and referral and provider networks for secondary care, inter-sectoral and inter-agency working are established. Individual staff level relationships across organisations are also used but can be a risk due to staff movement.

Trust between providers is built over time, reputation is important, organisations and staff who are well-known or well-respected can be leveraged to improve transition of care between settings. Services are aware of each other. This enables strategic geographical coverage, reduces duplication, and enhances the range of services that complement each other. Secure data sharing (with consent) includes use of electronic medical records, discharge summaries, information contained in My Health Record, By Names List, or other hospital data collections.

8. Personalised services

Genuine co-design and client involvement is supported by inviting lived-experience peers, and people from the target community throughout the design, delivery, and evaluation of services. Processes are in place for receiving and acting on client feedback to improve services. Service reputation and trust is a key factor that increases service use and is often due to word-of-mouth recommendations from clients if they receive high-quality care and have a good experience. There is shared and transparent communication and decision-making between staff and clients, enabling clients to make informed choices.

Structures

9. Key philosophies on primary healthcare

Organisations support principles of care that include being supportive before supported and provide proactive and preventative healthcare without being paternalistic. Clients are never lost to care because of assertive follow-up processes and access to an ongoing treatment path, regardless of housing status. Health care is provided across the lifespan. Homeless primary healthcare professionals employ strategies to empower clients, and services and staff are responsive and agile and work at the pace of the individual client. Services are aligned to existing models and frameworks. These include person-centred, trauma-informed, culturally safe and responsive, and strengths-based approaches with understanding of the social determinants of health, Maslow's hierarchy of needs, human rights and humanistic moral principles. There is a holistic approach to care including comorbidity, trimorbidity, and dual diagnosis. Primary healthcare professionals have a role in addressing social needs such as referring people to non-health services or providing information when the need arises such as for housing or other social services. There are standard screening processes to identify housing status, and primary healthcare professionals understand housing is a major concern.

10. Organisational policies and systems

Policies and systems that support integrated models of homeless primary health care include collaborative and effective referral pathways, including electronic and/or hard copy referral forms and referral systems with a network of providers. They also incorporate:

- processes around informed consent and health information sharing and the seeking of consent to use data to advocate on a client's behalf
- a shared organisational vision including a mission, and values and values-based recruitment
- policies to protect the safety and wellbeing of staff, and safety of clients, rules around caseloads, staff ratios and allocated non-clinical time.
- clear roles and responsibilities for internal staff, collocated services and external providers and governance responsibilities
- safety and quality compliance including data capture to improve service performance

It is important to ensure frameworks, polices and guidelines don't become a barrier to service delivery, and that they remain focussed on the needs of frontline staff and clients, and service goals.

11. Health system responsibilities

Funding models support innovation, flexibility and complexity of client needs. Innovative service delivery models are achieved through value-based purchasing schemes that support payment for outcomes, not activity. Address workforce issues by having sufficient staff and services to provide adequate clinical coverage. Staff are recognised and incentivised through opportunity for career progression including substantive positions, adequate position levels, classifications, and wages. Consideration of the impact of short-term funding of services on clients, service providers and communities is needed. Governance and coordination of integrated working is also needed across service-sector entities, including development of homeless health clinic networks, and formal homeless health pathways. The health system must stay connected to health providers and involve providers from the local community in the policy design process via open communication channels.

12. Whole-of-government response

There is a need for strong and supportive local governments who show interest in homelessness issues and are prepared to align their priorities with those identified by homeless services. Councils responsible for areas where homeless services operate, for example, might assume responsibility for the maintenance of amenities and outdoor spaces.

Effective co-ordination is also needed around the systems that can impact those experiencing homelessness such as the healthcare, homelessness and housing sectors, and justice system. Waitlists for housing – including emergency accommodation – should be addressed, and the application process, and eligibility criteria simplified. Governments need to be aware that mistrust in 'the system' can be experienced by clients and that client disappointment and distrust is impacting engagement in a range of services. Comparable pay rates across government and non-government organisations are needed, and service models and funding models should be flexible to move with changes over time to meet need.

Conclusion

This research identified the core components of integrated service models for people experiencing homelessness and validated the concepts with service providers across Australia, and users of healthcare services in Perth. This research provides a conceptual basis for an operational model that can be trialled within real-life settings in phase two of the HIF project. Information from phase one will contribute to the field of research related to models of integrated health care in Australia, determine service requirements, and contribute to improved practice for integrated community-based health care nationally and internationally.

Next steps

Phase two plan

Phase two of the HIF project will involve a trial of a combination of the core components in an existing healthcare setting in Perth. The aim of this will be to understand proposed enablers of accessible and integrated primary health care for people experiencing – or at risk of – homelessness, including:

- connected homeless primary healthcare services (such as concierge services and outreach services)
- personal agency, choice and control in health care (i.e., client choice, staff acceptance and support)
- homeless primary healthcare role in supporting access to mainstream health services (i.e., supporting care transitions)
- collaboration between service providers (i.e., informal, and formal relationships)
- health system responsibilities (i.e., funding models)
- whole-of-government response (i.e., cross-sector integration and working).

The following outcomes are anticipated; increased knowledge of enablers for accessible and integrated primary health care for people experiencing homelessness, and organisational knowledge, skills and practices to better respond to the needs of targeted clients. Phase two will follow the same realist evaluation approach as phase one, including a realist organisational case study to help understand the implementation of core components in a local care system.

This project was made possible by Commonwealth funding through the Health Innovation Fund – Stage Two Schedule. Without this funding we would not have been able to complete this work and provide empirical evidence for integrated healthcare models for people experiencing homelessness in Western Australia.

This document can be made available in alternative formats.

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