INTEGRATED CARE FOR VULNERABLE PEOPLE
A person centred approach for people experiencing homelessness

AIM
To develop a local approach to provide opportunistic health interventions and address barriers to healthcare navigation utilising a collaborative method.

BACKGROUND
Homelessness exacerbates poor health. Food and shelter take higher priority to accessing preventative health care. There are also multiple barriers for homeless people to access healthcare that include inflexible scheduling, long wait times and cost (1). Fred’s Place is a daytime care and support service for people experiencing or at risk of homelessness in the Tweed Heads, NSW run by St Vincent de Paul. It provides a range of intervention and prevention services that include basic personal needs, integrated professional ‘in house’ support services inclusive of a GP clinic 2 hours per fortnight. Since March 2017, changes have occurred to the model. The clinic is managed by a local medical centre who provide administrative and medical support. Northern NSW Local Health District provides the nursing hours with a Clinical Nurse Specialist in Chronic Disease management. All aspects of health care identified as important by the individual are addressed.

OPPORTUNITIES FOR CHANGE
1 Access to clients’ health information was often limited. We commenced documentation in NSW Health medical record of presentation and nursing assessment. Clinic documentation is visible by all NSW health providers. Hospital and community documentation accessible by GP/specialist nurse in clinic.

2 Review of clients’ documentation to assess service requirements and supports. Evidence of need shown in areas including:
   ▶ Drug and Alcohol – liaison with service and service change to include increased follow up for clients identifying as homeless/Clinical support to GP clinic/training for clinic nurse/outreach clinic commenced at Fred’s.
   ▶ Mental health education and training for Fred’s place staff, GP practice staff/networking with mental health for point of contact
   ▶ Opportunistic health screening with trackable results within local health district.

3 Advocacy and linking with specialist services according to patient centred needs. Example of community services currently engaged include renal, respiratory, dietetics, wound care and liver clinic.

4 Clients benefit from consistency in clinic staffing and development of therapeutic relationships based on patient centred care. The current focus is on identifying providers with the interest and skills to continue this work within the extended health care system.

NEEDS ANALYSIS
Attendees at GP clinic in first 3 months
- Identified drug and alcohol issue
- Identified mental health and drug and alcohol issue
- Identified mental health issue
- No previous contact with mental health drug and alcohol treatment

Review of 3-month client data determined the opportunities for improved service integration with Drug and Alcohol and Mental Health services. n=44

REFERENCES

CAPABILITY BUILDING
MENTAL HEALTH
Address local issues.
RAISING AWARENESS
Through website and community sessions.
BUILDING PARTNERSHIPS
Local health district and community managed organisations. Share resources & knowledge, improved communication.
EDUCATION
Mental health workplace training, Drug and Alcohol training and support for clinic staff.