CBD HOMELESSNESS HEALTH ACCESS PROTOCOL

A good practice guide to improving health service access for people experiencing homelessness in Melbourne's CBD.

mvm primary care partnership

city of Melbourne

Contents

1.	Introduction	4
	1.1 Aim and objectives of the Protocol	4
	1.2 When should the Protocol be used?	4
2.	The Protocol in operation	6
3.	Good practice guidelines for making referrals to health services	9
4.	Obtaining client consent	11
5.	Information to assist workers make health referrals	11
6.	Making a referral to a general practitioner a priority	11
7.	Choosing the method of referral	12
8.	Documenting referrals	14
9.	Undertaking initial needs identification	14
10.	Referring to Key Information and Access Points	14
11.	Good practice guidelines for health services in receiving referrals	16
12.	Organisational check list for implementing the Protocol	16

Appendix 1

Travelling Well Guidelines	18
Footnotes	18

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This Project was funded by the City of Melbourne and the Department of Human Services (DHS), Primary Care Branch to improve homeless people's access to primary health and mental health services within the Melbourne Central Business District by building service pathways between primary health services, mental health services and the homeless sector.

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We would like to thank the agencies that participated in the photography. These included Living Room, Foot Patrol, Young Peoples Health Service, Ozanam Community Centre.

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“Everyone has the right to a standard of living adequate for health and wellbeing… including (access to) food, clothing, housing and medical care”

- UN Declaration of Human Rights

1. Introduction

Article 25 of the Universal Declaration of Human Rights states that *"Everyone has the right to a standard of living adequate for health and wellbeing… including (access to) food, clothing, housing and medical care."* [1]

This Protocol has been developed by health and community service providers to ensure that people experiencing homelessness in Melbourne's CBD receive the health services they need in accordance with this fundamental right.

Compared to the broader population, people experiencing homelessness experience poor physical and mental health, higher levels of drug and alcohol addiction, live with unacceptable levels of pain due to chronic or untreated conditions. They are also less likely to be included in health prevention strategies and less likely to access the health services they need without support.[2]

Since 2000 a number of reports prepared with support of the City of Melbourne and the Moonee Valley-Melbourne Primary Care Partnership have detailed the need for improved service delivery and access, particularly for those who require a complex range of services and supports in order to meet their health needs.

The City of Melbourne has an active role in responding to the needs of people experiencing homelessness and those with complex needs, and is committed to strengthening information provision, coordination and service responses to homeless and vulnerable people in the City of Melbourne.

This is articulated in key City of Melbourne policies including *CityHealth 2005-2009* and the *Homelessness Framework 2007-2009.*

Aim and Objectives of the CBD Homelessness Health Access Protocol

The Protocol aims to improve health service access to people experiencing homelessness in Melbourne's CBD by assisting health and community services providers to:

- build better referral relationships, increasing communication and coordination of services between the community and health sectors;
- enhance referral practice informed by good practice;
- implement transparent policies that prioritise homeless people's access to health services;
- support reorientation and innovation within health services to respond to the needs of homeless people;
- through the implementation of the Travelling Well initiative (see Appendix 1) identify possible increases in the number or type of primary health services to cater for the needs of homeless people within Melbourne's CBD; [3] and
- strategically plan and advocate for service growth to funding bodies.

When should the CBD Homelessness Health Access Protocol be used?

The Protocol sets out the agreed good practice for encouraging and supporting people experiencing homelessness to use primary health services when needed.

It encourages community service workers to engage with their clients and to undertake health service referrals.

It also provides workers with the necessary health service information and standard templates for written referral documentation if, and when, this is required.

Most importantly, the Protocol addresses the issue of obtaining "client consent" in a way that ensures that this policy itself is not a barrier to accessing health services.

For primary health agencies, the Protocol supplements the generic *Good Practice Guidelines for Workers for Initial Contact, Initial Needs Identification and Referral included in the Good Practice Guide for Practitioners - a resource of the Victorian Service Coordination Practice Manual.* [4]

These guidelines are the agreed standard across the State for how primary health, local government and other member agencies of Primary Care Partnerships work together to improve consumer care.

Community service agencies in the CBD may wish to familiarise themselves with the *Victorian Service Coordination Practice Manual* [5] and associated resources as it clearly sets out the practice expectations of primary health agencies and this knowledge is empowering for clients and their advocates.

If there is a conflict between the generic practice guidelines referred to above and this Protocol, the latter shall have precedence.

The client:

Lives or spends their days in the CBD of Melbourne and is experiencing any of the following:

- *Primary homelessness*: people without conventional accommodation, for example living on the streets, sleeping in derelict buildings, or using cars for temporary shelter.
- *Secondary homelessness:* people who move from one form of temporary shelter to another, including homelessness services, rooming houses, and residing temporarily with friends.
- *Tertiary homelessness:* people who live in boarding houses on a medium to long-term basis. [6]

And/or has complex needs, defined as:

"A range of health conditions and behaviours - usually co-existing – that seriously limit the individual's ability to access services and/or to obtain and retain housing. These conditions include alcohol or drug dependence, mental illness, acquired brain injury, intellectual and other disability, age related frailty, and chronic health problems, with or without challenging behaviours." [7]

2. The CBD Homelessness Health Access Protocol in operation

Definitions

Advice Access Points (role defined through the Homelessness and Primary Health Service Coordination in the Melbourne CBD Project, hereafter referred to as “the Project”): health service providers who have agreed as part of this Protocol to act as a ‘key’ for opening health service doors to individuals and/or their workers.

In addition to providing their own health services will provide up to date information and a sounding board for community service workers to problem solve issues.

Key health areas: the health area(s) for which the designated Advice and Access Points has agreed to ‘front end’ in order to provide information and support to community service workers.

Initial needs identification: “An initial assessment process where the underlying issues as well as the presenting issues are uncovered to the extent possible. It is not a diagnostic process but is a determination of the consumers risk, eligibility and priority for service and a balancing of the service capacity and the consumers needs.” [8]

Community service providers: refers to the community services agencies engaged through the Project which are based in the Melbourne CBD and provide daily drop-in services to approximately 350 people who live a homeless lifestyle in the CBD.

These agencies include:

- Urban Seed, Café Credo
- Salvation Army Life Crisis Centre
- Lazarus Centre
- Travellers Aide
- Ozanam Community Centre (North Melbourne)

Along with representatives from the health services, these agencies were involved in the development of this Protocol.

Health services: refers to acute and primary health services (unless otherwise specified) which provide services in the Melbourne CBD.

(Other agencies, health, community service, or housing, are invited to become signatories to this Protocol and to contact the Executive Officer of the Moonee Valley Melbourne Primary Care Partnership for further information).

Service Coordination Tool Templates (SCTT) 2006: “a suite of templates developed to support service coordination which is primarily facilitated by Primary Care Partnerships (PCPs).” [9]

> “The experience and consequence of homelessness can seriously limit access to services and to obtain and retain housing”

HEALTH SERVICES

> "Know the health services that welcome and support homeless people and/ or know the service that can assist to find the right services"

3. Guidelines for making referrals

Encourage the person who is experiencing homelessness to attend the health services they need by:

- identifying problems relating to attending appointments and working out ways to assist the person to attend;
- explaining the service and how it works or get someone who can do this for you;
- talking through any expectations which may or may not be achieved;
- providing material aid to reduce barriers for attendance;
- seeking consent to make the referral directly if the person cannot do this for themselves (see Section 4 obtaining client consent); and
- asking how it went and be open to discussing any follow up appointments.

In making a referral to an agency:

- ask about any protocol for priority of access;
- see if it is possible for the person to attend without an appointment;
- discuss needs, such as longer appointments and gender issues;
- seek out a support/contact person within the service to assist;
- define your role with the service; and
- provide referral information to reduce duplicated questioning.

In supporting someone's attendance to a health service:

- where appropriate, accompany or provide your contact details;
- follow up with service and/or person to ensure attendance;
- give feedback that will help the service to be more responsive to the needs of people experiencing homelessness; and
- attend /offer opportunities for workers to share practice.

To ensure that you can support people who experience homelessness to care about their health:

- care about everyone's health and promote good health as a normal part of the work you do;
- if someone looks to be in pain or unwell ask the person if you can help them get some assistance;
- learn about health issues related to homelessness; and
- know the health services that welcome and support people experiencing homelessness in the CBD of Melbourne and/or know the services that can assist to find the right service.

Regular clients become familiar with the route of the Foot Patrollers and meet up with staff on the street.

4. Obtaining client consent

The Protocol requires improved communication between health and community service providers to share health information and coordinate service delivery in making referrals.

This requires the client to be informed about how their personal information will be used so they can consent to the sharing of this information. Both community service and health providers share this fundamental practice principle.

However rigid written consent policies were identified as being a potential barrier to access for this vulnerable target group.

The CBD Project Working Group responsible for the development of the Protocol recommended that providers be encouraged to use the *Service Coordination Tool Template: Consumer Consent to Share Information.*

This form can be downloaded from **www.health.vic.gov.au/pcps/coordination** and can be sent via fax or electronically via email, using a secure messaging service such as ConnectingCare (**www.connectingcare.com.au**).

This recommendation was based on the following:

- The *Consumer Consent to Share Information Form* is used by a large number of agencies and workers.
- The procedure for good practice in obtaining consent is embedded in the documentation.
- The requirement for written consent is not mandatory and does not prevent referrals.
- Both agency 'risk' and 'accountability' are managed in the documentation.

It may be that agencies have their own *Client Consent* forms and procedures. It is recommended they are reviewed to incorporate the essential elements of the *Consumer Consent to Share Information Form.*

This will ensure the practice for protecting client's rights to decision making do not provide a barrier for inter-agency referral.

Whether referrals are written or verbal, a documented process to substantiate how client consent was obtained is required. The *Consumer Consent to Share Information Form* serves this purpose for referring agencies. To assist clients who do not speak English, this form is available in 43 languages. [10]

5. Information to assist workers making health referrals

A list of health services provided by the agencies who participated in the development of this Protocol was prepared through the Project. [11] (Agencies are also referred to the City of Melbourne's, *Helping Out* Booklet. This can be downloaded from **www.melbourne.vic.gov.au**

This information sets out location of health services, session times and any special arrangements for the target group, as a resource for community service workers making referrals to the listed health agencies.

To provide workers with health information relevant to people who live a marginalised and homeless lifestyle the Melbourne General Practice Network has produced *The Homeless Handbook: A Medical Guide*. This guide can be downloaded from **www.mgpn.com.au**

This comprehensive handbook was written by general practitioners with the support of organisations from the health and homeless sectors. It provides care workers with the necessary information to "identify situations where referral to appropriate health care professionals is advisable or necessary." [11]

6. Making a referral to a general practitioner a priority

We all need to visit a general practitioner (GP) on a regular basis to ensure optimum good health and wellbeing. People who live a homeless lifestyle often have complex health issues and are exposed to significant health risks.

Therefore the best first step in health referral is to support individual members of the target group to engage with a GP so they can undertake a comprehensive health assessment and refer to specialists if required.

GP's in both the public and private health systems can provide the necessary access to the tertiary and primary health care sectors. *The Health Service Information Guide* lists the session times and location of a number of GP's who work from agencies.

These GP's will be welcoming and responsive to the needs of the target group. The Melbourne General Practice Network is committed to increasing GP access to this target group and will lead further planning and advocacy work.

SOLU TIONS

7. Choosing the method of referral

The Protocol values the judgment and relationship of the referring worker to the client. To support a referral to a health service, workers will either:

- provide information about services to individuals so they can themselves attend a service;
- make a referral on behalf of the person experiencing homelessness and/or attend with the person needing the service;
- include in this referral information a summary of the clients' presenting issues identified through initial needs identification (INI) - as defined in Section 2 - so health services can better engage with the client; or
- contact an Advice or Access Point (see Section 8 of this document) to undertake the referral process and/or the initial needs identification.

All four referral methods can be completed verbally, however agencies are encouraged to provide a written referral where possible. This is particularly the case where referring workers have an established relationship with the client and are better able to engage the client in identifying their health needs.

Health services also advise that written referral information reduces the amount of information which may be repeatedly asked of clients, thereby addressing a common concern of the target group.

Table 1 provides information on the referral forms proposed to make referrals including:

- a basic referral to an agency with minimum information; or
- a referral which includes minimum information
- a summary of the clients' presenting issues.

For detailed description on the use of the templates and guide to their use: *Service Coordination Tool Templates user guide* (DHS, 2006). Refer to **www.health.vic.gov.au/pcps/coordination** for the templates.

Table 1: Guide to use of referral forms

Method of referral	Confidential Referral Cover Sheet	Consumer Consent to Share Information Form	Consumer Information Form	Summary and Referral Information Form
Verbal referral		Important to have this document on referring agencies records. Health services require consent to liaise with other services.		
Written referral	Indicate referral is part of the CBD Homeless Health Service Access Protocols in "Other Notes"			
Written referral plus INI			Do not leave information blank on consumer information form – rather write 'not known'.	This additional information assists with determining priority for services and better quality of initial care. Agencies may seek a key health provider to undertake the Initial Needs Identification.
Referring agency receiving feedback	Referral acknowledgement included on form and is used as a tool to feedback information to referring agencies.			Agency relationships mapping is essential for coordinated care.

Service Coordination Tool Templates (SCTT), 2006: "a suite of templates developed to support service coordination which is primarily facilitated by Primary Care Partnerships (PCPs)

8. Documenting referrals

Most community service providers consulted through the Project indicated they did not use standard referral forms for a health service referral.

The CBD Project Working Group considered the Service Coordination Tool Templates (SCTT), 2006 and the *Victorian Service Coordination Practice Manual* to identify which referral documentation would best meet the needs of community service providers making a potential health referral.

The SCTTs considered relevant by the working group are those listed in the box below. These are the core Service Coordination Tool templates. [12]

Copies can be downloaded from **www.health.vic.gov.au/pcps/coordination**. A set of combined forms can be downloaded from the MVM PCP website, **www.mvcc.vic.gov.au/mvmpcp.**

Referral forms for improved health access

1. Confidential Referral Cover Sheet
2. Consumer Consent to Share Information Form
3. Consumer Information Form
4. Summary and Referral Information Form

9. Undertaking Initial Needs Identification

The two page Summary and Referral Information Form provides the template for community service workers to engage with the client to undertake an Initial Needs Identification (INI) process.

This identifies a client's:

- initial health needs;
- health and wellbeing risks; and
- network of agencies involved in support.

Health services who participated in the development of the Protocol encourage community service workers to undertake an initial health needs identification process with the client. Health services acknowledge community service workers generally have the necessary skills to undertake this role.

Community service workers also have highly developed engagement skills. These skills may enable a more thorough identification of health needs and issues, particularly within a social model of health paradigm.

The provision of thorough health information assists with determining priority for service, managing client risks and better tailoring of services to individual needs.

The referring worker may however choose to engage another service better placed to undertake the initial needs identification to provide a summary of the client's presenting issues (see Section 10).

Alternatively, the referring worker may decide that they are best placed to engage the client in this process but do not believe it appropriate to complete all sections of the Summary and Referral Information Form. Where this is the case, they are advised to write 'not known' in the relevant section of the document rather than leave it blank. This will ensure further follow up of this information by the health service at a later date.

10. Referring to Advice and Access Points

Many people who have lived a homeless lifestyle have chronic and complex health issues which require a range of health services to be provided. [13]

For many workers (and the client) complex questions arise, for example:

- Where do I start in making the first referral?
- Is my concern about the health of one of my clients justified?
- Do I have the expertise to make the right referral?
- Can I manage the complexity of this person's health issues once I start?
- Is there another agency that can better provide case management or coordination of services?

The Project identified a number of key health areas and linked each of these areas with an Advice and Access Point (See Table 2). Essentially these agencies not only provide health services themselves, but they can also act as keys for opening health service doors to individuals and/or their workers.

These providers will provide up to date information and a sounding board for community service workers for problem solving issues. Some of these key services can also coordinate an episode of health care or provide short term case management as part of their service delivery model.

By identifying and promoting access to different health service systems it is expected that members of the target group will have improved access to services and better coordination of services.

The services offered by Advice and Access Points to referring agencies are outlined in the box below. Some key information and access points will be able to undertake all these services listed. In other instances services will need to be negotiated on an individual basis.

Functions of Advice and Access Points:

1. The health service required (or referral to another agency).
2. Health information and health care service information.
3. A sounding board for discussing health issues and assisting the referring worker to identify whether referrals are required.
4. Capacity to undertake a written initial assessment and referral on behalf of the welfare worker and the person who is experiencing homelessness.
5. Needs based outreach to community based services to follow up on individuals.
6. Routine outreach to community based services to undertake primary health prevention and education initiatives.
7. Case management, referral and coordination for complex or specialist health needs.
8. Information on longer term service options to better support individuals and improve health and wellbeing outcomes overall.

Table 2: Advice and Access Points

This table lists health service providers who have agreed as part of this Protocol to act as a Key for opening health service doors, providing a sounding board for community service workers to problem solve issues in addition to providing direct access to services or referral to other services.

Area	Issues	Advice and Access Point	Contact
MENTAL HEALTH SERVICES	• accessing short/long-term case management • day programs • advice with referral into residential services • daily living skills	DOUTTA GALLA COMMUNITY HEALTH SERVICE 15-19 Gracie Street, North Melbourne	Phone: (03) 8327 1700 Ask for: Mental Health Intake Worker
INDEPENDENT LIVING SUPPORT (Aged & Disability)	• aged care packages • meals programs • day programs/social support • allied health • daily living support	CITY OF MELBOURNE (Aged Care Services) Level 3, Council House, 200 Little Collins Street, Melbourne	Phone: (03) 9658 9542 Ask for: Assessment and Intake Worker
WOMEN'S HEALTH (sexual and reproductive health)	• sexual and reproductive health • health screening • antenatal care	THE WOMEN'S HOSPITAL Women's Health Information Centre, Cnr Grattan Street & Flemington Rd, Parkville	Phone: (03) 8345 3045 or 1800 442 007 Ask for: Referral Advice
EMERGENCY & HOSPITAL CARE	• support in emergency/acute care • post-care follow up • residential care post acute • health prevention	ST VINCENT'S HOSPITAL (ALERT Program - 24 hours), Ground Floor, 41 Victoria Parade, Fitzroy *(RMH emergency contact listed in Health Service Guide)*	Phone: (03) 9288 2211 Ask for: Pager 204
INJECTING DRUG TREATMENT	• GP specialist support • self-care • treatment programs • prescriptions and dispensing	THE LIVING ROOM 7-9 Hosier Lane, Melbourne NORTH YARRA COMMUNITY HEALTH - DRUG SAFETY SERVICES 4-6 Johnson St Collingwood	Phone: (03) 9662 4488 Ask for: Intake Worker Phone: (03) 9417 1299 Ask for: Team Leader Primary Health
YOUTH HEALTH	• youth health assessment and follow up • specialist referrals • health prevention and promotion	YOUNG PEOPLE'S HEALTH SERVICE, Centre for Adolescent Health, Royal Childrens Hospital - (at Front Yard) 19 King Street, Melbourne	Phone: (03) 9611 2409 Ask for: Youth Health Nurse
HEALTH GENERAL	• general health assessment • assistance with medication • outreach assessments • wound treatment and after care • general medical & nursing • allied health • social/welfare services • outreach services • Aboriginal health worker (NYCH)	RDNS HOMELESSNESS OUTREACH HEALTH NURSE (based at Living Room) 7-9 Hosier Lane, Melbourne NORTH YARRA COMMUNITY HEALTH 75 Brunswick Street Fitzroy DOUTTA GALLA COMMUNITY HEALTH SERVICES 12 Gower Street Kensington	Phone: (03) 9662 4488 Ask for: RDNS Nurse Phone: (03) 9411 3555 Ask for: Team Leader Allied Health Outreach Team Phone: (03) 8378 1600 Ask for: Intake

11. Good practice guidelines for health services in receiving referrals

- People experiencing homelessness are a priority target group and all staff in the service understand the procedures to fast track their service access.
- Reception/front end staff are welcoming, accepting and understand the reality of the experience of homelessness.
- Respect, acknowledge and where possible, cater for gender and cultural preferences in the provision of services by professionals.
- See beyond any difficult behaviour and work out sensitive ways to contain difficult behaviour.
- Engage with the person, not the health issue and if possible designate someone within the service to build this relationship.
- Provide a service which is of value at the time of first attendance.
- Gauge whether the person is comfortable answering questions and change or stagger assessment practices accordingly.
- Having received permission from the client, communicate openly and work collaboratively with the support people that are available to the person experiencing homelessness.
- Make sure time is spent working out the practical details of care and strategies for self care.
- Provide medicine and treatment materials, and follow up to ensure they are used appropriately.
- Provide access to material aid to support service access.
- Decide who will be responsible for: assertive outreach, service follow up and communication with referring agencies.
- Be pleased to see them again.

12. Organisational list for implementing the Protocol

Signatories to the Protocol, have a responsibility to undertake a review of their current practice and identify key areas for further development. Work will need to occur at three different levels:

- reviewing and identifying practice changes within the agency with all levels of staff;
- reviewing and identifying key relationships that the agency needs to develop or foster; and
- contributing to, and participating in, partnership wide, coordinated events led by the agreed structures for overseeing the Protocol.

The starting point for all agencies is to ensure that staff members are aware of the Protocol and that they are encouraged to work within the Protocol when relating to other agencies.

Workers who have been involved in the Protocol development are important change-agents within agencies and the partnerships. They are encouraged to take a leadership role to support other workers develop the necessary understanding required to implement identified practice.

The following organisational list has been prepared to support agencies to implement the Protocol and in doing so, build effective relationships between the community service and health sectors in the CBD of Melbourne on behalf of their clients.

Organisational

1. Vision

- Staff at all levels within the organisation are aware that their organisation is a signatory to the Protocol and what this means for their practice.
- Staff are aware of the shared goal of improving health service access to people experiencing homelessness in the CBD of Melbourne.
- Staff have a working understanding of the practice changes required in their area of work.
- The relationships developed through the Project are kept alive to leverage off new initiatives and support each agency to achieve their own strategic directions.

2. Leadership

- The agency has assigned someone to be responsible for sponsoring or authorising the implementation of the Protocol within their organisation.
- The agency has identified a change agent who is responsible for processes for solving problems, identifying changes in practice and systems and selling the protocol internally to staff.
- Staff are clear on who they can go to get advice and direction about issues arising from the protocol implementation.
- Success in implementation is acknowledged and promoted.
- Leaders participate in the development of interagency workshops, training, launches, or information sessions.

3. Attitudes

- Staff are aware of their own and other's potential attitudes to people with behavioral difficulties and how this might impact on their behavior.
- Staff include the capacity to engage people who have difficulty engaging with services as a requirement of their professional practice.
- Staff value building relationships across the health and community service sectors.

4. Knowledge

- Staff know about potential health issues relevant to people who live a homeless lifestyle.
- Staff know the services in the CBD who work with homeless people.
- Staff know how to use the Protocol and who to go to for advice.

5. Skills

- Humor, creativity and problem solving is employed on a regular basis.
- Staff have received training in understanding and engaging marginalised people during assessment and service delivery.
- Staff have the capacity to tailor the way they deliver their services to meet individual needs.
- Where relevant, assertive outreach is encouraged and the skills associated with assertive outreach are developed.

6. Partnership

- Staff have an induction which includes visiting agencies who are signatories to the protocol.
- Staff use agencies in the protocol to provide specialist training in their relevant field, for example training on understanding best practice for homeless people or understanding health issues for youth who are homeless.
- Staff are encouraged to develop and/or attend interagency workshops and other key events associated with implementing the protocol.
- Relationship building systems are implemented, for example health/community service buddy systems, creative use of volunteers, assertive outreach.

7. Evaluation and Ongoing Development

- Sponsors monitor the implementation of the protocol and share information about the implementation across the organisation.
- Sponsors participate in ongoing steering committee work designed to monitor and evaluate.
- Learned information is shared and implemented at a broader level.

HOME LESS

“Workers who have been involved in the Protocol development are important change-agents within agencies and the partnerships. They are encouraged to take a leadership role to support other workers develop the necessary understanding required to implement identified practice”

APPENDIX 1

Moonee Valley Melbourne Primary Care Partnership
Travelling Well Project

Guidelines

1 Introduction

The *Travelling Well Project* will provide 1000 Zone One Metcards to community service providers who are signatories to the *CBD Homelessness Health Access Protocol* (hereafter referred to as "the Protocol") to aide their work in helping people who are experiencing homeless to access the health services they need. The guidelines for this Project were developed by the CBD Project Working Group for the Moonee Valley Melbourne Primary Care Partnership's Project, *Homelessness and Primary Health Service Coordination* in the Melbourne CBD.

Travelling Well objectives

This project will:

- enable people experiencing homelessness in the CBD of Melbourne to access health services by providing where needed, a Zone One Metcard to travel to the service;
- support further health services planning and advocacy work by providing evidence of health services accessed and their locality.

2 Project Operations

Role of coordinating sponsor.

The sponsor will:

- provide a bundle of 50 Zone One Metcards to any welfare/ front end agency which is a signatory to the Protocol and who has signed the *Travelling Well Agreement*.
- be responsible for collecting, collating and disseminating the data to be provided by agencies in receipt of the Metcards.

Project Agreement and reporting requirements

A Project Agreement is to be signed by agencies receiving Metcards as a condition of receipt of the first bundle of Met Cards. In order to receive subsequent bundles of Metcards, agencies are required to submit a completed health service data form to the sponsor.

Agencies in receipt of Metcards through *Traveling Well* are required to adhere to practice guidelines for making referrals as detailed in the Protocol, particularly with regard to maintaining the engagement, privacy and dignity of individuals.

Workers are encouraged to let recipients know about the aim of the *Traveling Well Project* and that client data is non identifiable and to be used for planning purposes only. Workers should use their own discretion in obtaining client usage data for the health service data form balancing the need to be least intrusive into the lives of individuals, with the requirement for planners to evidence base health service need to support future funding applications.

Eligibility for receiving Metcards.

Agencies: community service agencies who are signatories to the Protocol are eligible to receive Metcards.
Clients: any person who is experiencing homelessness and requires assistance to attend to a health service, including health promotion and prevention services, primary care, (dental care, GP mental health, allied health) aged care or Home and Community Care (HACC) services, and/or hospital emergency care.

Future Directions

The resources for this project are for this project alone. However if the Project is successful it is envisaged that further funds will be sought to maintain this service.

FOOTNOTES

[1] Article 25 of the Universal Declaration of Human Rights, United Nations.

[2] Department of Human Services, 2000, Homelessness Strategy Consultation with Homeless Sector on Health Needs, Department of Human Services.

[3] The Travelling Well Project proposes to provide Zone One Metcards to community service providers who are signatories to this Protocol to assist people access health services. The data collected through this Project will provide evidence of health services accessed and their locality.

[4] State Wide Primary Care Partnership Working Group, Good Practice Guide for Practitioners: a resources of the Victorian Service Coordination Practice Manual, Primary Care Partnerships Victoria 2007

[5] State Wide Primary Care Partnership Working Group, Victorian Service Coordination Practice Manual, Primary Care Partnerships Victoria 2007

[6] Chamberlain, C and MacKenzie,D. 2004 Counting the Homeless 2001, Victoria

[7] Howlett K, Better Health Care for People with Complex Needs in the CBD, Moonee Valley Melbourne Primary Care Partnership, 2003

[8] State Wide Primary Care Partnership Working Group, Victorian Service Coordination Practice Manual, Primary Care Partnerships Victoria 2007

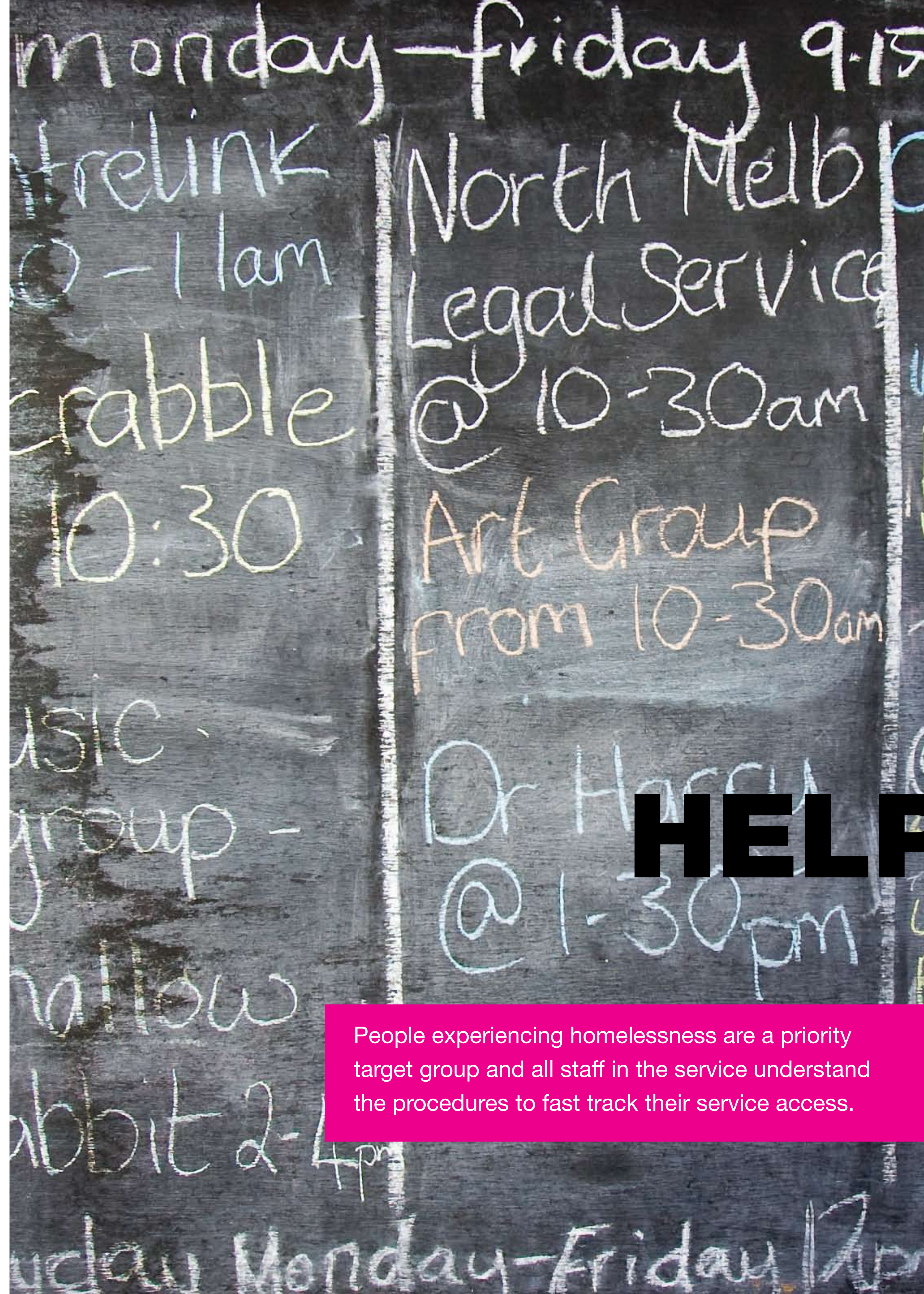
[9] Department of Human Services, Service Coordination Tool Templates 2006 user guide, DHS, Primary Care Branch, Melbourne, 2006.

[10] Department of Human Services, 2006, Service Coordination Tool Templates 2006 user guide, Department of Human Services, Primary Care Branch.

[11] Melbourne Division of General Practice, The Homeless Handbook: A Medical Guide, 1996, P IV.

[12] Department of Human Services, 2006, Service Coordination Tool Templates user guide, DHS Primary Health Branch

[13] South East Health, "Homelessness and Human Services – A Health Service Response" March 2000



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(03) 9280 0725	Việt Ngữ
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