phn
CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

COORDINATED CARE

2025-2027 Needs Assessment

Table of contents

List of tables *2*
Overview *3*
Summary 3
Key issues 3
Key gaps 3
Service navigation *3*
Health literacy 3
Tools to support service navigation and referrals 4
Specific care coordination challenges *4*
Veterans 4
People leaving the criminal justice system 5
People living with a disability 5
People experiencing family and domestic violence 6
Older people 6
Joint planning 6
Digital health and interoperability *6*
My Health Record 7
Secure messaging 7
Smart forms and eReferrals 8
Electronic prescribing 8
Shared Care 8
MyMedicare 8
Disaster management *8*
Key issues for the Central and Eastern Sydney region *9*
Improving care coordination for specific population groups 9
Uptake of My Health Record 9
Need for more connection between general practice and allied health 9
Need for improved information sharing between primary and acute care 9
Opportunities *10*
References *11*

List of tables

Table 1: Digital health initiatives in the CESPHN region, as at September 2024 7
Table 2 Electronic prescribing capable practices in the CESPHN region, September 2024 8

Overview

Summary

Coordinated care focuses on ensuring seamless and integrated healthcare services across various providers and stages of care. This approach emphasises the importance of maintaining consistent and coherent care over time, which is particularly crucial for patients with chronic conditions or complex health needs.

Key issues

- Low health literacy and lack of coordinated care between systems, particularly among vulnerable and priority groups including:
  - Veterans
  - People leaving the criminal justice system
  - People living with a disability
  - People experiencing family and domestic violence
  - Older people.
- Workforce scopes of practice and provider issues with identifying appropriate services and connecting with other providers due to lack of system interoperability
- The NSW Health implementation and rollout of the Single Digital Patient Record across NSW over the next five years
  - Though this has the potential to improve communications between general practice, acute and virtual care services.

Key gaps

- More effective communication and information sharing among healthcare providers, including system interoperability that enables continuity of care across primary, secondary and tertiary care
- Increased multidisciplinary teamwork
- Increased patient-centred care that respects individual preferences and needs
- Utilisation of My Health Record.

Service navigation

Community and stakeholder consultations identified the following key issues impacting the ability to navigate health services in the CESPHN region:

- Low health literacy
- Provider and consumer challenges with identifying and navigating services.

Health literacy

Low health literacy is associated with a range of factors including poorer health outcomes, limited engagement with the healthcare sector, limited ability to navigate the healthcare system, limited knowledge, and uptake of preventive actions, as well as impaired self-management and increased use of emergency care, hospitalisations, and mortality rates. The combination of low health literacy

and complex health needs amplify the difficulties patients experience when navigating a fragmented health care system.

In the 2018 Health Literacy Survey, only 41% of adult Australians had a level of literacy that would allow them to meet their complex health needs. The survey also indicated that health literacy was lower in those who speak English as a second language (21%), highlighting the requirement for health-related information to be available in languages other than English.

CESPHN has commissioned a Multicultural Health Navigator Service to assist people within the region with limited or no English proficiency who speak Mandarin, Cantonese, Arabic, Korean or Nepali to navigate health and related services. The service is due to commence in early 2025. More broadly as part of our Multicultural Health Plan we are working with primary care providers and our commissioned providers to ensure their services are responsive to cultural issues.

Further education for consumers around when to go to the GP, pharmacy or Emergency Department is required.

Tools to support service navigation and referrals

Identification and navigation of services most appropriate to a patient's needs is a challenge for providers, particularly when their patients have complex health needs. CESPHN, SLHD, SESLHD and SVHN jointly fund HealthPathways, an online health information portal to support local GPs and health professionals. It provides clinical decision support frameworks on how to assess and manage medical conditions and how to appropriately refer patients to local services and specialists.

CESPHN has also developed a health and community services directory and a mental health services directory to assist people and providers find services within the region. Headstart is a mental health service directory aimed at helping community members find mental health support.

Nationally Healthdirect operate a website and phone line that provides 24-hour health advice. The website includes information on individual general practice, pharmacy and allied health services. People calling the phone line are directed to the most appropriate health service for their condition. Community awareness of this service is still relatively low and greater promotion would be beneficial.

Eight NSW PHNs are co-funding a Medicare Mental Health Phone Line whose aim is to direct people to the right mental health services and support and avoid people having to re-tell their story multiple times. The phone line provides 24 hour support.

Specific care coordination challenges

We have identified a range of groups within the CESPHN population who would benefit from improved care coordination. These include veterans, people exiting the justice system, people with a disability and people experiencing family and domestic violence.

Veterans

In a collectivist culture, service members are taught to prioritise service above their own needs. This can lead to issues in accessing health and mental health support, such as feelings of shame, worry about letting the team down, and a sense of loss upon discharge. There is significant underreporting among members; the 2020-2022 National Study of Mental Health Wellbeing found that veterans were less likely to have reported a mental health disorder in the previous 12 months when compared with

non-veterans, at 17% and 22%, respectively. PTSD is often underreported, minimised, or not coded appropriately, and there are high levels of suicide ideation among veterans (1). According to the 2021 Census, a total of 152,170 individuals have served or are serving in New South Wales of which 18,007 are currently serving in the regular service and 6,506 are currently serving in the reserves service (2).

Primary care providers often struggle to support veterans because they do not have access to medical histories from within the military. Although veterans are given their medical history and a handover letter, they do not always share these with primary care providers. Serving members or veterans might not link their service history to their medical presentations, but if clinicians ask, it can lead to better understanding and potentially more entitlements to health checks and other benefits. A new system is being developed to link military medical history with civilian history, which should be released soon.

People leaving the criminal justice system

NSW has the largest prisoner population with 12,897 adults and 209 juveniles in custody as of September 2024, 12-month increases of 5.1% and 6.1% respectively (3). There is an overrepresentation of Aboriginal persons (31.3% of adults and 50% of juveniles in custody) (4).

The prisoner population is fluid with people constantly entering and being released from the system. This constant movement means that the health issues of people in custody become the health issues of the community. Over the 12-month period to September 2024, 1,388 adults and 16 juveniles in NSW were discharged due to their sentence expiring (3). By December 2023, 43.6% of adults and 73.6% of juveniles who were released from sentenced custody had reoffended within 12 months of discharge (5).

Although the Justice Health and Forensic Mental Health Network has implemented several projects aiming to better support people when they leave prison, such as reminders to collect their medications and health summaries, these projects can be challenging due to the ad-hoc nature and constant movement of people. For example, a large number of prison departures may not be planned. The Single Digital Patient Record (SDPR) system may overcome some of these issues however this is also dependent on the capability of SDPR to integrate with primary care systems.

Mental health and alcohol and other drug support services are delivered through Community Corrections, a division within Corrective Services NSW that manages and supervises offenders sentenced to various types of community-based orders by the courts or released from prison on parole to complete the remainder of their sentence in the community. Often these are people with very complex needs that often end up sleeping rough and experiencing recidivism.

People living with a disability

There are approximately 180,000 people living with a disability in the CESPHN region. There is a need for improved coordination between primary care and disability services and multidisciplinary, integrated models of care. AIHW data indicates that 26.4% of people with a severe or profound disability who saw 3 or more health professionals for the same condition felt the health professional did not help coordinate care. CESPHN hosts a Disability Network that includes a broad range of stakeholders including people with a lived experience, disability providers and primary care providers. This group provides an opportunity to strengthen coordination. CESPHN also delivers training to primary care providers on how to best support people with an intellectual disability and the importance of working together with the person's Disability Support Team.

People experiencing family and domestic violence

Primary care has a role in recognising domestic and family violence (DFV) and providing trauma informed and culturally safe care to victims. There is a need for a more coordinated approach between primary care and domestic violence support services as well as increased training and support provided to primary care services to respond better to DFV. Navigating the DFV service sector to seek support for a patient can be challenging and CESPHN has established DFV Assist to provide a navigation service for health professionals to better support their patients experiencing DFV.

Older people

As people age their care typically becomes more complex and reliant on a range of service providers including community aged care, residential aged care, primary care and acute care. It is currently very difficult to share information between these various providers creating delays and inefficiencies in the system. CESPHN has provided telehealth equipment to residential aged care homes to enable telehealth consultations with their GPs and other health care providers. Further work needs to occur to better integrate community aged care providers.

Joint planning

Joint planning between primary health networks, local health districts, and other consumer and provider organisations can assist to improve care coordination.

CESPHN participates in numerous partnership committees with the local health districts and speciality health networks in our region that cover mental health, alcohol and other drugs, disability, sexual health and viral hepatitis, diabetes and aged care.

There are a number of regional plans that have been developed with partners including the Joint Regional Mental Health and Suicide Prevention Plan, the Intersectoral Homelessness Health Strategy and the Inner West Child Health and Wellbeing Plan.

Digital health and interoperability

The COVID-19 pandemic accelerated the rollout of technologies that streamline the flow of relevant patient information between service providers, however ensuring the consistent and meaningful use of these tools is a continuing challenge for the region. Consultations with GPs, allied health professionals, hospitals and local health districts demonstrated that the use of digital health technologies by clinicians and services were related to the level of digital health maturity within each setting, as well as the interoperability between digital health systems across service providers and between acute and primary care.

NSW Health has commenced rolling out the Single Digital Patient Record (SDPR) program across the state and this system has the capacity to share data between providers as well as with patients. Primary health networks are advocating strongly for the involvement of primary care in the design of the SDPR and especially the portal between general practice and acute care.

Between 2023 and 2024, the number of computerised general practices increased from 90.1% to 96.8%. My Health Record uptake remained stable at 85.7% of general practices, while the number of practices registered for secure messaging increased from 89.3% to 94.5% (6).

Table 1: Digital health initiatives in the CESPHN region, as at September 2024

Digital health initiatives	No. of general practices 2023	No. of general practices 2024	% of computerised practices 2023	% of computerised practices 2024	% of general practices 2023	% of general practices 2024
Computerised practices (clinical software)	523	545	100.0	100.0	90.1	96.8
Registered to access MyHR	484	484	92.5	88.8	83.9	85.7
Use secure messaging solution	515	532	98.5	97.6	89.3	94.5

Source: CESPHN CRM database, 2024

*** % of computerised practices value is against the aggregate number of computerised practices*

My Health Record

Meaningful use of My Health Record (MyHR) can improve health outcomes by supporting the sharing of patient information between providers across the health system, which can reduce duplication of services, lessen medication errors and increase patient participation in their care. As organisations decommission faxes, MyHR offers a suitable enhancement for the transfer of patient data. MyHR statistics generally demonstrate increases in views and uploads by various health care services in the CESPHN region, largely propelled by software vendors continuing to integrate MyHR functionality. As of September 2024, 438 out of 453 pharmacies were MyHR registered (6).

Despite the high rate of general practice MyHR registration in the CESPHN region, uptake has slowed and few practices upload at least one summary per week indicating that more work is required to integrate MyHR into daily practice activity. As the upload of shared health summaries is one of the requirements of the Practice Incentive Program eHealth Incentive (ePIP), with the required number being a proportion of the practice's standard whole patient equivalent (SWPE), uploads are often performed to meet the requirement rather than utilise the MyHR system for its intended purpose. As such, the viewing and uploading of documents that are not associated with incentives demonstrates legitimate use of the system.

From an allied health perspective, technology integration with MyHR is poor. Most platforms used by allied health are not able to integrate with MyHR, and the National Provider Portal only facilitates viewing and downloading, not uploading. To date, 600 allied health practices are registered in our region.

Secure messaging

Secure messaging is a core capability for safe, seamless, secure, and confidential provider-to-provider communication, enabling electronic access to patient information. It has not reached its potential in terms of application, however the introduction of online solutions such as the MyHealthLink Portal has helped increase uptake by providers that would otherwise be ineligible due to their software configuration. Furthermore, the industry-wide push for interoperability is continuing to increase the efficiency of secure messaging, particularly between general practices using differing platforms. The need for improved access to patient information from hospitals is continually raised by GPs. The rollout of the Single Digital Patient Record (SDPR) in NSW presents an opportunity to address this long-running issue. Until more permanent solutions are implemented CESPHN continues to work closely with the local health districts and specialty health networks to resolve specific problems.

Smart forms and eReferrals

Smart Forms and eReferrals allow for documents to be pre-filled with clinical data and transmitted point-to-point. As with secure messaging, the promotion of technologies that facilitate the efficient transfer of information between service providers has resulted in a significant increase in the number of providers configured to send Smart Forms and eReferrals. However, medical specialist practice adoption remains low, which can be attributed to ongoing interoperability issues and the high cost of secure messaging services, which limits secure messaging to those who are both able to afford the service and have the digital health maturity to use it. The recent acquisition of Argus by Healthlink will help with increasing adoption by medical specialist practices.

As of June 2024, 510 general practices and 424 medical specialist practices were configured to send Smart Forms and eReferrals. Between July 2023 to June 2024, 129,327 eReferrals were sent in the CESPHN region and 78,162 specialist letters were uploaded to MyHR.

Electronic prescribing

Electronic prescribing provides an option for prescribers and their patients to use an electronic Pharmaceutical Benefits Scheme (PBS) prescription in place of a paper prescription and is delivered via a prescription exchange service. As of September 2024, 96.1% of pharmacies were able to dispense electronic prescriptions and 86.8% of computerised general practices were able to issue electronic prescriptions.

Table 2 Electronic prescribing capable practices in the CESPHN region, September 2024

Type	No. of practices
General practice	373
Pharmacy	424

Source: CESPHN CRM database, 2024

Shared Care

CESPHN and the local health districts are working together on a ranged of shared care initiatives to ensure coordinated care for people requiring complex care. These initiatives exist in mental health, antenatal care, cancer care and alcohol and other drugs. Having an electronic shared health care plan would further streamline the delivery of shared care but this has proven problematic given system interoperability issues.

MyMedicare

MyMedicare is a voluntary patient registration model that provides incentives for both general practices and patients when patients register with a particular practice. This link between patients and their preferred general practice has the possibility to lead to greater continuity of care. Currently, this is for telehealth items only, but the Department of Health and Aged Care plans to expand to chronic disease manage management that can only be conducted at their registered GP in 2025. As of December 2024, 362 general practices in the central and eastern Sydney region have enrolled in the MyMedicare program.

Disaster management

Primary care needs to be better integrated in disaster management plans. CESPHN is establishing a Primary Care Emergency Response Team to ensure continuity of access to primary care when there is a disaster or critical incident and to support the emergency response by addressing immediate health needs in a disaster situation or an unexpected event. The team will include GPs, practice

nurses, pharmacists and mental health professionals. Once the team is established, we will look to integrate further with local councils and other key stakeholders.

The types of events that may require an emergency response could include:

- Natural events – bushfires, heatwaves, severe storms, flooding, earthquake
- Public safety threats and major transport accidents
- Hazardous materials accidents
- Major public health threats.

Key issues for the Central and Eastern Sydney region

Improving care coordination for specific population groups

Groups most impacted by lack of coordinated care include veterans, people leaving the criminal justice system, people living with a disability, people experiencing family and domestic violence and older people. Further work needs to occur with partners to improve care for these groups of people.

Uptake of My Health Record

While a large number of general practices in the region are registered for My Health Record, allied health and medical specialist organisations are lagging due to incompatible vendor software. General practice uploads of data to My Health Record are low. Furthermore, patient awareness has not been a key focus since the end of the opt-out period for My Health Record registration in January 2019.

Need for more connection between general practice and allied health

There is a need to provide a more holistic approach to care that acknowledges the connection to mental and physical health and the impact of social determinants that affect people's health. For this to occur, there needs to be a continued focus on designing models of service delivery where GP services work closely with allied health, either via outreach models, co-location, or joint care plans. There are small scale pilots being undertaken by CESPHN attempting to offer models for multidisciplinary team care.

Central and Eastern Sydney PHN has an Allied Health Engagement Strategy that focuses on increasing participation of allied health professionals through various avenues, including an allied health network providing professional connections and training, promoting the adoption of digital health tools so that there is consistency between allied health professionals and with primary care, supporting with quality improvement activities and creating professional development and recognition pathways.

Need for improved information sharing between primary and acute care

Improving system integration between primary and acute care provides many advantages for continuity of care, including more effective and efficient treatment in the hospital setting and, in turn, a reduction in preventable hospitalisations. Health system interoperability is the key to addressing this issue.

Supporting care transition across the lifecycle

As people transition through life they receive support from different care providers. There is an opportunity to improve this transition process such as when a child receiving care through local paediatric services over many years becomes an adult and has to receive care under different protocols and by different providers. Similarly, the care needs of someone aged 20-65 is likely to be

very different to that of older people aged in their 70s requiring aged care support. Patient education and improving health literacy and working with service providers will help facilitate this transition.

Opportunities

- Continued focus on improving usage of digital tools among general practices
- Ensure follow up and handover of care to a GP for people leaving justice system
- Improved identification and support of veterans in primary care
- Continued focus on supporting better integration of primary care with disability services
- Work to facilitate improved care coordination between primary care and community aged care
- Implementation of a centralised mental health intake and assessment model to combine intake, assessment, and referral services
- Over the next four years, CESPHN will commission the GP+ program. This program will support smaller general practices to connect to local allied health providers, improve health outcomes through a multidisciplinary approach and enhance patient experiences in primary care
- Consumer education on digital solutions and how to navigate the health system
- Promotion of service directories and Healthdirect
- Incentivise allied health and specialist adoption of My Health Record
- Re-engage general practices on the My Health Record, providing them with updates on new features
- Facilitate communication between GPs and acute care via access to Single Digital Patient Record and an electronic shared care plan
- Improved engagement of primary care in disaster management.
- Supporting care transitions across the lifecycle.

References

1. *Mental Health And Wellbeing Transition Study.* s.l. : Department of Veterans' Affairs, Canberra, 2018.
2. Australian Bureau of Statistics. Service with the Australian Defence Force: Census. *Australian Bureau of Statistics.* [Online] 2022. https://www.abs.gov.au/statistics/people/people-and-communities/service-australian-defence-force-census/2021#data-downloads.
3. NSW Bureau of Crime Statistics and Research. Custody. *NSW Bureau of Crime Statistics and Research.* [Online] September 2024. https://bocsar.nsw.gov.au/statistics-dashboards/custody.html.
4. NSW Bureau of Crime Statistics of Research. Aboriginal over-representation in the NSW Criminal Justice System. *NSW Bureau of Crime Statistics and Research.* [Online] 25 November 2024. https://bocsar.nsw.gov.au/topic-areas/aboriginal-over-representation.html.
5. NSW Bureau of Crime Statistics and Research. Reoffending. *NSW Bureau of Crime Statistics and Research.* [Online] 22 May 2024. https://bocsar.nsw.gov.au/topic-areas/re-offending.html.
6. PHN, Central and Eastern Sydney. *Salesforce.* 2024.