Amy Coopes reported on The Centre for Primary Health Care and Equity’s (CPHCE) annual forum at The University of Sydney on 14 August 2019, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. http://croakey.org
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#CPHCE19 Forum preview: Picking up the pace on the journey to integrated health care

Why is timely, coordinated access to all the sectors and services needed to maintain health and address health care needs often so hard?

Is this a wicked problem, or are there examples of programs that have transcended the siloed landscape of primary care, tertiary institutions, specialist services, community organisations and other entities involved in our health needs, to produce truly integrated care?

A forum hosted by the Centre for Primary Health Care and Equity (CPHCE) at the University of NSW, sought to provide a platform for creative solutions to the problem of fragmentation in health care and, indeed, across all the sectors that influence health. Croakey’s Amy Coopes reported on the day for the Croakey Conference News Service.
Amy Coopes writes:

Health service silos, and the “glacial” pace of reforms to bridge the divides between them will come under scrutiny this week at a Sydney summit on health care access and integrated care.

The Centre for Primary Health Care and Equity’s (CPHCE) annual forum, to be held at the University of New South Wales on Wednesday August 14, will showcase success stories at the interface of primary care and tertiary or specialist settings, with a keynote from Jean Frederic Levesque, who is chief executive of the NSW Agency for Clinical Innovation.

Levesque, who is renowned for his work on access to healthcare, will deliver the Ian Webster Health For All oration on art, relationships and science in primary care research.

The glacial pace of reform

Themed ‘Integrated Care’, the event will focus on systemic challenges in the health sector and efforts to overcome fragmentation between hospital and community sectors, as well as the transition between specialist and follow-up care.

Professor Mark Harris, executive director of the CPHCE, has been working in this space for more than 30 years, and said while progress had been made in areas such as provision of hospital discharge summaries to GPs and shared care of diabetes and antenatal patients, the pace of reform had been “glacial”.

“We’ve made incremental progress; one of the things is just how slow progress has been,” said Harris. “It’s a challenging theme.”

Harris said the interfaces between primary care and emergency departments, and GPs and cancer care, remained particularly difficult, and that the latter was increasingly an issue as treatments and survival rates improved. Research on both these topics will be presented at Wednesday’s forum.

Another gap that Harris said was often overlooked but presented real opportunities for preventing hospitalisations was integration between primary care and allied health. He said this involved “not just the GP doing a care plan, but the provision” of these services. CPHCE Associate Professor Margo Barr, an epidemiologist, will be presenting data on this issue, drawing on findings from the 45 and Up study, a longitudinal examination of healthy ageing in a cohort of more than 250,000 people in NSW.

Hurdles and barriers

Harris said the fragmentation of funding, infrastructure and services between the Commonwealth and states remained the single biggest hurdle in health care integration, along with the proliferation of bureaucratic silos in primary care including the Primary Health Networks and Local Health Districts, and non-government organisations commissioned to provide services.

As health services became increasingly specialised there was a tendency for KPIs to dominate, at the expense of good patient care, he added.

“Health services, particularly specialist services within hospitals and so on, are pressured to perform and they tend to do what their performance measures say. That’s getting people dealt with quickly and being safe within the hospital, but it doesn’t mean people necessarily get adequately dealt with once they leave.”
Information systems were also a significant barrier, with sharing of data between primary care, community-based health services and the Local Health Districts beset by both technical and trust issues, Harris said.

“It’s actually not [IT] firewalls, it’s policy that’s the problem,”

With data breaches plaguing both the commercial and health sectors – the recent hacking of Singapore’s National Electronic Health Record being just one notable example – Harris said there were “legitimate concerns” about privacy and the security of health information.

“But what that gets translated to is a kind of bureaucratic inertia, and it’s very hard to get anywhere with that,” he said.

Searching for solutions

Harris said that, in the current conditions, stopgap measures and “band-aid” add-ons tended to flourish, with varying degrees of success. Unless they were properly integrated with primary care systems, these solutions became “just another bit of the system that connects imperfectly.”

Addressing fragmentation was not just an issue within the health sector but also for services intersecting with it, including major government initiatives like the National Disability Insurance Scheme, My Aged Care and Carer Gateway, added Associate Professor Frederic Sitas, director of the CPHCE.

“How will these new big initiatives integrate into the health space?” said Sitas.

Theory can make a difference to patient outcomes

Frederic Levesque, a physician with a doctorate in public health and a masters in community health, has worked as a primary care researcher in India, Canada and Australia and will reflect, in the Ian Webster Health For All oration, on “zombies, ghosts and other metaphors” at the intersection of theory and practice.

During his PhD studies on access to care in urban south India and as a clinician working in refugee health in Montreal, Levesque saw first-hand how research findings could drive an evolution in theoretical frameworks, and how clinical work grounded in theory could make a real difference to patients.

“Working in clinical practice with people who could really mobilise concepts demonstrated to me that they were also better able to understand their patients, and certainly better able to organise care in a way that responded to their entire patient population.”

In Montreal, his clinic drew heavily on conceptual frameworks, working with an anthropologist to better understand the flow of patients through their practice, how to be more responsive to patients’ needs and also “their vulnerability and how health care could contribute to it,” Levesque said.

“Life can actually be informed by theories, it’s just about balancing it with more pragmatic realities to support action, and not just using theories as an object of discourse,”

As head of the NSW Agency for Clinical Innovation, Levesque said he too often saw initiatives that didn’t work because “we run and we try to change things quickly, and we are not really thinking about things enough and not realising the complexity of all of the influences that prevent or support people from changing.”
“Unfortunately even in improvement and innovation work, very often we don’t try to understand how things work. We don’t harness the power of theories and concepts enough,” he said.

Levesque, who is renowned for developing the access framework for health, will reflect on three projects he was involved in in Canada, exploring patients’ experiences of primary care, the drivers of utilisation, and the impacts of reform on both how services are experienced and on health outcomes.

He will also share his doctoral research experiences working in medical anthropology, and some of the lessons other disciplines including sociology, organizational theory and statistical theory have to offer in terms of conceptual frameworks in primary care research, particularly when working with Indigenous or vulnerable populations.

Levesque said a strong conceptual foundation was not only essential to navigating the “chaos of analysis” but also in shaping a narrative to inform policymakers and drive reform.

### Getting rid of ghosts and zombies

Crafting his own narrative, Levesque will counsel against chasing ghosts – outdated models whose ideas and purpose are no longer relevant – or zombies in primary care research.

Some of his zombies – ideas that never die – include the quadruple or triple aim (“there is no evidence that this framework has actually helped anyone do anything”) and Barbara Starfield’s work on continuity of care and the doctor-patient relationship.

“There’s lots of theories showing that in reality we can’t run healthcare systems just based on those individual relationships anymore, because everything has changed,” said Levesque.

> “The amount of knowledge clinicians now need to have is significant, but also the actual competencies and qualities that various people have cannot fit with all of the different needs of patients. Care needs to be team-based.”

Speaking directly to the event’s theme, Levesque said one of the enduring zombies in the Australian context is the notion that “we can’t do anything because primary care is Commonwealth funded and hospitals are state funded.”

“That’s not even entirely true, and technically, in systems elsewhere where those funding streams are integrated, there is often exactly the same fragmentation between the two sectors,” he said.

Levesque said the thrust of his talk was perfectly captured by Richard Wagamese, an Indigenous Ojibway author from Manitoba, who wrote:

> “Knowledge is not wisdom, but wisdom is knowledge in action.

> I command a lot of facts. I comprehend a lot of concepts. That does not make me wise or even intelligent. It just indicates what I have memorized. But when I activate those facts and concepts to find the greatest, grandest version of myself, and then use them to work towards that vision, I begin the process of wisdom.

You can track the event on Twitter via the hashtag #CPHCE19, and Amy Coopes @coopesdetat, who reported live for the Croakey Conference News Service.

You can read our previous CPHCE forum coverage here, here and here.
Bridging health care silos: complexity, communication and more from #CPHCE19

Amy Coopes writes:

Bureaucracy and technology are major barriers to effective patient care across the fragmented silos of Australia’s health system, but the key to better integration lies in communication, relationships and an approach that considers the person – and all the determinants of their health – before their diagnoses.

This was the central message of a summit last week examining how and why patients fall through the cracks of Australia’s complex, unwieldy and sometimes dysfunctional tripartite health system.
Primary Care: complex, messy and more important than ever

The Centre for Primary Health Care and Equity’s (CPHCE’s) annual forum put health system integration under the spotlight, profiling a series of research projects at the interfaces of primary care with emergency departments, allied health and cancer care.

While the panoply of stakeholders — each with discrete and often incompatible technological interfaces — was a significant challenge, there were often much more fundamental issues at play involving communication and relationships, the forum heard.

These were hurdles common to, and between, GPs, specialists, and patients alike, underscoring the importance of language, narrative and connection, which were some of the central themes of the Ian Webster Health For All Oration, delivered by Jean Frederic Levesque, head of the NSW Agency for Clinical Innovation.

Introducing the talk that carries his name, Emeritus Professor Ian Webster Webster AO, a towering figure in public health and long-serving chair of CPHCE’s advisory committee, stressed that in an increasingly market-driven, biology/precision medicine-focused world, primary care was more important than ever.

Though it was messy, Webster said primary care was also real and authentic, reflecting the human condition and encountering people at their most vulnerable.

Levesque described health care as “very complex systems made of human beings and a lot of moving parts”, and stressed the importance of language and narrative in primary care – a fundamentally human science.

This was not only so “we really understand the realities of the people that we want to influence”, but so that interventions were framed in a way that way that ensured they were relevant and accessible, particularly when working with Indigenous and other priority groups, he said.

We will now be hearing from @jfredlevesque, who will deliver the Ian Webster oration or the intersection of theory and practice in primary care

#CPHCE19
Use knowledge for the purpose of action and practice he urges. Make research inter, multi and transdisciplinary. Recognise that you are working with people, dynamic moving parts, and appreciate the power of words and language #cphce19

We often use words without appreciating that they may not be understood in the same way by a recipient. Primary care is a human science after all. We can be heroes, if only for one study and only for one day concludes @jfredlevesque #cphce19
The many facets of access

Levesque is renowned for developing the access framework in primary care, a theoretical model placing the person seeking care at the centre of the process, and recognising all the drivers of and potential diversions to that journey.

Levesque explained in an interview with Croakey at the forum:

“Access is not just something that depends on the attributes of the practices where people want to go, it also depends on their ability to interact with those practices. Are they able to identify where they need to go to receive appropriate care, can they actually go there and reach those services? And once they are in the practice, can they actually get the right care from the provider given their capacity to talk about their symptoms and at times negotiate with the providers about what they need and want?”

Watch our interview with Jean Frederic Levesque here:
ED2GP research

The Emergency Department emerged as a key pressure point for integration at the forum, with several studies examining the fate of patients once they were discharged from the ED back into community care.

Dr Andrew Knight and Dr Michael Tam, from Fairfield Hospital’s GP Unit in Southwest Sydney, presented findings from their ED2GP research series, which explores the flow of patients between emergency departments and primary care.

Describing the process as “perhaps the archetype of disintegration in the health care system” with the unfortunate patient serving as the bridge between two very distinct clinical worlds, Knight said it was a high-risk context for duplication, readmission, cost and dissatisfaction.

Hoping to better understand from the perspective of those working on the frontlines what the barriers were, Knight and his colleagues canvassed 19 ED personnel and 20 GPs from the surrounding catchment for their views. Their findings were grouped around three key themes:

- Service provision: how seamlessly EDs and GPs can communicate with each other, refer and return, dollar questions around ‘free’ care in the ED vs out of pocket costs in primary care
- Professional partnerships and collaborations: misconceptions, assumptions, ideologies
- Patient factors: world view, cultural mores around health-seeking and previous experiences in other countries with different health systems (for example, where attending the ED was the norm when unwell), health literacy, language barriers

“Having worked in both general practice and emergency departments, there is a little bit of antagonism, a little bit of tribalism between the two groups,” said Tam.

“EDs might get correspondence from community doctors, from GPs, that they might think might be a little bit hopeless; and as a GP I might sometimes have the same thoughts receiving discharge communication from the ED, even though at a theoretical level we kind of know that people are trying to do their best within their respective health sector.”

As well as barriers, the researchers asked participants to come up with practical suggestions to overcome them, and Tam said work was now underway to rolling some of these out.

Examples included practice visits, combined education sessions, accessible centralised health records, nominated liaison people, and making followup GP appointments prior to ED discharge.
Communicating followup

Tam presented three connected studies looking at followup of older patients after ED discharge, which had some sobering findings.

Though the majority of people (76%) did follow up with a GP the week after they left the hospital, there was a marked discrepancy by gender, with men (90%) much more likely to do so than women (two thirds), which Tam noted was counter to usual primary care patterns.

A separate study of an exclusively older female cohort revealed a number of factors were at play, including social supports (about half were widowed), access to transport (many did not have a licence), language barriers (most spoke a language other than English), and perceptions of themselves as an inconvenience to others.

Tam said the way followup was framed and communicated to the patient and their family in the ED was also important: if it was emphasised as an essential part of ongoing care rather than a box-ticking exercise, people were more likely to follow through.

The final project, which was still in the data analysis stage, underscored just how significant language barriers could be. Among 172 ED patient–doctor pairs recruited for the study, Tam told the forum a professional translator was used precisely zero (yes, zero) times, a significant gap “between what is perceived as best practice, and what is taking place”.

Watch our interview with Dr Michael Tam:
Access gaps

Associate Professor Margo Barr, an academic from CPHCE, also presented work on GP followup after hospitalisation, and on the burgeoning presentation of older patients (aged 75+) to emergency departments, drawing on data from the 45 and Up study.

Barr’s research identified a particular cohort of older people who were landing in the ED as a result of access gaps, being ineligible for a health care card and bulk-billed primary care but also unable to afford private health insurance or out of pocket costs.

Looking at followup, some of these themes recurred, with older males with lower household incomes and no private cover more likely to see a GP within 2 weeks of being discharged from hospital.

Whether such followup had an impact in terms of readmission to hospital depended on whether the patient ordinarily saw the GP frequently (>8x p.a.) and whether they also saw a specialist: low GP users in the subset of patients who also saw a specialist showed the strongest association with decreased rates of readmission, Barr’s research found.

Overall, she said it showed just how critical communication could be”

“One of the main things that is coming from the research we are doing, and the work of others, is improving [communication].

Improving the discharge summary, improving the information that’s being sent in with patients when they are going into hospital, as well as information for patients when they are going in and out of hospital.

(It’s) being told to go back and see their GP, and being sure that both the hospitals and the GPs are aware that there is a benefit from doing that.”

Seeing a GP and specialist associated with a 30% decrease in 12 month re-hospitalisations for low GP users.
Barr’s research group also explored the impact of social isolation and living alone – terms that she said were often used interchangeably but were actually shown by the data to be quite distinct profiles.

Only three percent of people were identified in their research as belonging to both groups, and living alone was shown by the models to actually be protective against isolation.

“As people age and they do live alone there’s lots of factors that are happening in their lives, but it’s also a measure of resilience and independence. So it’s nice to look at the data and not immediately think that people that live alone are socially isolated or lonely.”

Finally, Barr presented some work on care plans in general practice, and the effectiveness and appropriateness of their use in terms of who was getting them and whether they were having an impact on hospitalisations or ED admissions. The presentation generated some interesting debate online.
Broadly speaking, she said, the data showed that the people who most needed care plans – those with complex chronic diseases, disadvantaged and older populations – were getting access to them, but whether or not they were reducing tertiary presentations was a bit more of a “mixed bag”.

She said:

“Overall we didn’t find an effect, but we did find an effect looking at specific allied health services.

The more times that you were able to access a physiotherapist, then we were certainly seeing a decrease in hospitalisations.”

Barr said the findings suggested that capping care plans at five allied health visits per year across a range of different specialties could be limiting their effectiveness.

Her team also found that care plans were infrequently reviewed by GPs, which she said was another important issue.

You can read more about Barr’s research here.

Watch our interview with Margo Barr:
Technology traps

The proliferation of patient management systems at state, local and practice levels was highlighted as a hurdle to continuity of care by several speakers, including Jane Taggart from CPHCE, who presented a pilot study into a shared health record for cancer patients called inca.

By creating a secure web-based record accessible by the patient and members of their care team, including their oncologist and GP, inca aimed to bridge the gap between specialist cancer care and follow-up in the community. Taggart said the need for a comprehensive, accessible record was increasingly important as more people were diagnosed and treatments improved, extending survival, and the long-term surveillance and management role for primary care.

Taggart shared some of the teething problems and systemic challenges to rolling out such an initiative, including governance, funding and scalability, but she also said it was a promising model, particularly in spaces like mental health and drug and alcohol, where a multiplicity of providers and fragmentation of service provision could be a real issue for patients.

Speaking on a panel, Andrew Simpson, who works in mental health shared care for the Sydney Local Health District, said the 14 to 23-year mortality gap for people with a severe mental illness illustrated how important holistic, integrated care could be.
Where does responsibility lie when patient needs change, in the cancer shared care model? And what happens to the record (privacy) when patient dies? Taggart says it's a collaborative process between specialist, GP & patient, any and all can update, it's dynamic #cphce19

Haven't looked at the fate of the record postmortem, she says. Only at the start of the journey she says. Plenty of governance issues to consider #cphce19

Taggart asked if she thinks her project really can be scalable, she says yes particularly in the mental health and AOD space. Shared care not for all patients, about choosing carefully #cphce19
What about when patients have lots of comorbidities that may or may not be related to their cancer diagnosis or relevant to the whole team? Would you include everything? Taggart says a real issue that needs to be explored, how integrated would you be #cphce19

Part of the issue is that the oncologist selects the patient as appropriate, GP then initiates the plan. Want it to be interactive but obviously it creates new challenges #cphce19

Andrew Simpson who works in the mental health shared care space says in the Sydney LHD 2000 mental health patients are seeing some 770 discrete GPs (!). Huge challenges #cphce19
People + providers = partnership

While tech tools that made “doing the right thing easy” were seen as part of the solution to integration issues, they were no silver bullet.

The forum urged a greater focus on the people health systems were supposed to serve, and for this to encompass all the determinants of their wellbeing, not just biomedical factors, with relationships and communication integral to success.

Said Levesque:

“If we are to address the various aspects of inequity in access we cannot just work at the clinic level with the providers, we really need to mobilise the community.

Ultimately we need to work on people’s abilities to engage and appropriately access healthcare, while at the same time also reorganising the way we deliver care, and this can really only happen through a conversation and a partnership in trying to improve health care for these communities.”

Leeuw
@evelynedeleeuw

Repeating to @coopesdetat

One reason it is so difficult to establish ‘stellar success’ IMHO is the territorial and funding ‘Divide & Conquer’ fragmentation in the system (hazelwoodinquiry.vic.gov.au/wp-content/upl...)

![Figure 4. The place of a coordinating agent/agency in the competing governance areas of the Australian healthcare “system”](image-url)
Are there stellar examples of success? Duggan says no. Pathways a good support tool but not a solution. ICT challenges are significant in shared care, very far from an active shared plan people can use at present #cphce19

Levesque says affordability, sustainability of reforms an issue. Have to shift dollars in a way that sees approaches that work funded into the future #cphce19

@freddysitas asks do we prioritise diseases or people? If former, which ones? How do we measure the success of what we are doing? #cphce19

Miranda Shaw says the measures should reflect what is important to a patient, which could include secure housing, retention of a child in care, access to AOD services, also effectiveness of collaboration #cphce19
You can track Croakey’s coverage of the conference here.

Bridging health care silos: complexity, communication and more from #CPHCE19

You can watch all our #CPHCE19 interviews at this playlist.

Bookmark this link for all our #CPHCE19 coverage.

Previous CPHCE forum coverage here, here and here.
#CPHCE19 Analytics

Between 13 August and 22 August, Symplur analytics show 87 participants sent 691 tweets using the #CPHCE19 hashtag, creating 5.799 million Twitter impressions.

As of 22 August, the video interviews from the day were viewed 549 times via the Periscope app.

### The #CPHCE19 Influencers

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### The Numbers

- **5,799,000** Impressions
- **691** Tweets
- **87** Participants
- **3** Avg tweets/minute
- **8** Avg names/minute


#### #CPHCE19 Participants

Data for #CPHCE19 can be up to 15 minutes delayed

### Croakey Conference News Service

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