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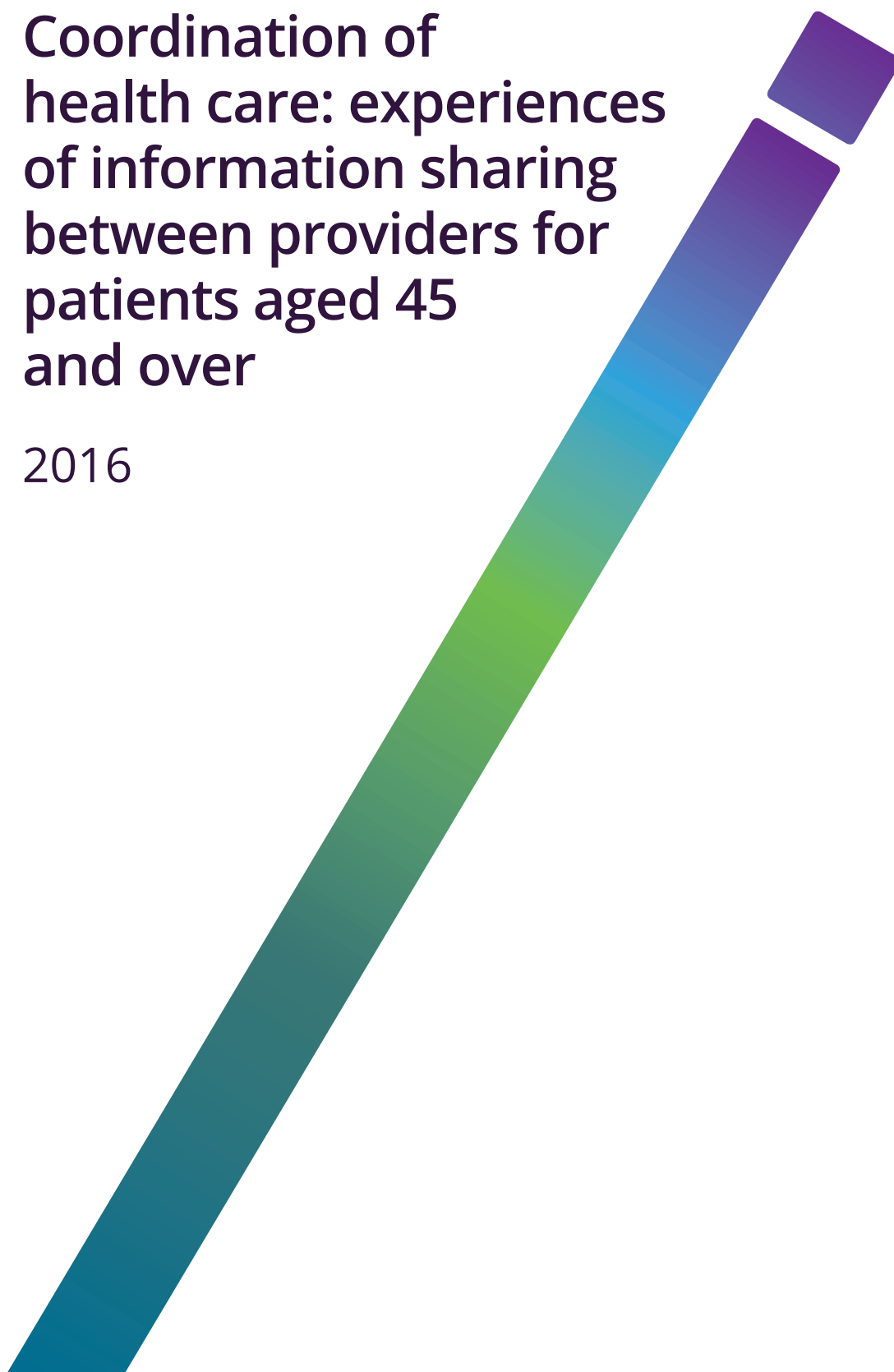
Coordination of health care: experiences of information sharing between providers for patients aged 45 and over

2016



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Summary

This report uses results from the 2016 Survey of Health Care to examine patients' experiences of 'information continuity'—the sharing of their health information—between general practitioners (GPs) and other health-care providers, such as specialists, hospitals (including emergency departments), and allied health professionals.

It looks at differences across remoteness areas and Australia's 31 Primary Health Network (PHN) areas, and the influence of sociodemographic factors, such as a person's age, and the language they speak at home.

The report is the second in the AIHW's coordination of health care series. The first report, *Coordination of health care: experiences with GP care among patients aged 45 and over 2016*, looked at ongoing relationships between patients and their usual GP or place of care. It found that the vast majority (98%) of patients surveyed had either a usual GP or usual place of care.

The 2016 Survey of Health Care focused on Australians aged 45 and over who had seen a GP between November 2014 and November 2015.

Nearly all patients say their GP is aware of their health-care history

Of patients who had visited either a usual GP or place of care, almost all (98%) reported that their usual GP or others in their usual place of care seemed aware of their health-care history.

Of the people who reported that they had health-care needs and preferences, 9 in 10 (92%) felt that their health professional understood those well.

Of patients who said that they needed information about their care or treatment, 9 in 10 (92%) said that they received enough information overall.

Patients aged 45–54 are most likely to say that they do not receive enough information about their care

A higher proportion of patients aged 45–54 reported more negative experiences of information sharing. Patients in this age group (12%) were twice as likely as patients aged 65 and over (6%) to report that they did not receive enough information about their care or treatment.

Similar results were found on information sharing to and from providers. Patients aged 45–54 (17%) were more likely than those aged 85 and over (6%) to report that their usual GP or place of care did not seem informed about their specialist care.

Patients who live in remote areas are more likely to say their GP is not informed of visits to other providers

People who live in remote areas face unique challenges of distance and barriers to accessing their health care. This report shows that for almost all measures, patients living in more remote areas more often felt that their usual GP or place of care was not informed of their visits to other providers.

Compared with patients in *Major cities*, patients in *Remote/Very remote* areas were more likely to report that:




- their usual GP or place of care was not informed after their most recent visit to a specialist (10% and 19%, respectively)

- there was at least one time when their specialist doctor did not have their medical information or test results (8% compared with 15%)
- their usual GP or place of care did not seem informed of their follow-up needs or medication changes from their last admission to hospital (14% and 25%, respectively).

Patients living in the PHN areas with the largest rural or remote areas also reported the highest dissatisfaction with sharing of information, particularly in the Northern Territory and Western Queensland.

People with no usual GP were 2–3 times as likely to report poor sharing of information as those with a usual GP

Patients who had a usual place of care only, and no usual GP, were more likely to report worse experiences of information sharing than both those with a usual GP only, and those with a usual GP and place of care.

Service provided		Health information was not shared		
		Usual GP and usual place of care	Usual GP only	Usual place only
Specialist care		9%	9%	27%
Emergency department		22%	22%	43%
Last admission to hospital		13%	13%	31%

Of patients who visit an emergency department, 1 in 4 say information is not shared with their usual GP or usual place of care

Almost 1 in 4 patients (23%) who visited a hospital emergency department (ED) reported that there was inadequate sharing of information back to their usual GP or usual place of care, with:

- 1 in 7 (14%) saying that their usual GP or usual place of care did not seem informed of their follow-up needs
- 1 in 11 (9%) saying that their usual GP or usual place of care did not know about their ED visit until the patient told them.

Of the patients who were admitted to hospital, 14% reported that their usual GP or usual place of care was not informed of their follow-up needs, with:

- 9% saying that their usual GP or usual place of care did not seem informed
- 5% saying that their usual GP or usual place of care did not know about their follow-up needs until the patient told them.

1 Introduction

People use the health system in different ways. Some might rarely visit a GP or specialist, while others might have regular appointments with various health-care professionals. Irrespective of frequency, each visit generates health information about the patient.

Health information is the common thread linking a person's health-care journey—it links information from one provider to another, and from one health event to another, to give a more coherent, complete picture of the services and treatments a person has received (Haggerty et al. 2003).

This information comes from various sources, such as results from imaging, pathology tests, or scans, discharge summaries from ED visits, letters from specialists or allied health providers, shared care, and treatment plans. The verbal communication between a doctor and a patient also informs a patient's health-care history and health information.

The provision of safe and high-quality health care depends on the sharing of this information between health-care providers (RACGP 2013).

Having access to complete information about a patient's health history enables providers to deliver care that is appropriate, current, and meets a patient's needs. The sharing of health information between health professionals and across care settings is an essential component of health-care management and continuity of care.

What is coordination of care?

Coordination of care is the 'deliberate organisation of patient care activities between 2 or more participants involved in a patient's care to facilitate the appropriate delivery of health care services' (DHHS 2018).

Definitions of coordination of care and continuity of care can vary across disciplines and care settings. Continuity of care becomes increasingly important for people as they age, develop multiple morbidities or complex conditions, or become emotionally or psychologically vulnerable (Freeman & Hughes 2010).

In 2017–18, 1 in 5 (21%) people aged 45 and over saw 3 or more health professionals for the same health condition (ABS 2018). People with chronic diseases or complex conditions are more likely to routinely receive care from across organisations and disciplines, potentially fragmenting care, and reducing all types of continuity (Guthrie et al. 2008).

While health professionals hold pieces of information about each patient, only an individual can describe their entire journey as a patient.

The first report in the Coordination of Health Care Study, *Coordination of health care: experiences with GP care among patients aged 45 and over 2016*, discussed aspects of the GP–patient relationship and continuity of care as the cornerstone to patient-centred care. It showed that established relationships with GPs lead to better patient experiences (AIHW 2018a).

This report assesses information continuity as a theme of continuity of care. While there is no single measure for information continuity, the overall concept can be captured by using multiple measures that relate to the availability of documentation and the completeness of information sharing between providers.

The extent to which this information is interpreted and used by the provider to meet their patient's needs ties the concept together (Reid et al. 2002).

Box 1.1: The Australian Health Performance Framework

The Australian Health Performance Framework will support system-wide reporting on Australia's health and health-care performance, and help Australians navigate health information to make informed decisions about the performance of the system.

The framework is flexible to meet the needs of multiple audiences, populations, and levels of the health system, through tiering and disaggregation of indicators and data.

It covers domains such as determinants of health, health status and the health system. Continuity of care is one of the dimensions within the 'Health system' domain under the framework (National Health Information and Performance Principal Committee 2017).

The Coordination of Health Care Study

The Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS) developed the Coordination of Health Care Study to provide information on patients' experiences of coordination and continuity of care across Australia.

The first part of the study is the 2016 Survey of Health Care. More than 35,000 people gave responses on their experiences and how well information was shared between their health providers, such as specialists and GPs.

These responses were from a representative sample of 124,000 people selected from the 8.8 million Australians aged 45 and over who had seen a GP over the 12 months between November 2014 and November 2015.

Survey questions addressed whether:

- the GP had an understanding of the patient's health-care history
- their results were available at appointments
- their GP seemed informed about specialist care or hospital care
- arrangements were made by hospitals for any services needed after leaving hospital.

A full list of the questions asked in the survey can be accessed at:

www.abs.gov.au/ausstats/abs@.nsf/mf/4343.0.

The survey was specifically designed to provide robust estimates for each of the 31 PHN areas. To ensure valid estimates for those with high health-care needs, it oversampled people who had seen a GP 12 or more times in the previous 12 months.

The Survey's design, scope, and exclusions have been discussed in *Coordination of health care: experiences with GP care among patients aged 45 and over, 2016* (AIHW 2018a).

Box 1.2: Why does patient experience matter?

Good medical practice is patient-centred (Medical Board of Australia 2014). Understanding a patient's needs, preferences, beliefs, and attitudes, and adapting care to meet their expectations is central to an effective patient–doctor relationship.

Patient experiences provide a unique perspective on health care that moves beyond system performance metrics to provide insights on patient journeys and their quality of care.

Tools to measure patient experience, such as patient surveys, are internationally recognised as a key marker of quality of care (Raleigh et al. 2015).

Measuring the effectiveness of coordination of care from a patient's perspective is a crucial step towards defining improvements to the safety, quality, and effectiveness of health-care services.

Purpose of this report

This report uses results from the 2016 Survey of Health Care to look at patients' experiences of information sharing as a theme of information continuity. It brings together multiple measures from the survey to create a picture of the gaps in information sharing between providers.

The terms 'information continuity' and 'information sharing' are used interchangeably throughout this report.

All information in this report refers to people aged 45 and over who had at least 1 GP visit in the 12 months between November 2014 and November 2015. Their self-reported experiences relate to care received during 2015–16.

Structure of this report

- Chapter 2 presents information on experiences of information sharing from a patient perspective, such as whether patients felt that their GP knew about their health-care history, and whether there was a health professional who was aware of their health-care needs and preferences.
- Chapter 3 presents results on information sharing between providers, including between specialist doctors and GPs, and from hospital settings (including EDs) to GPs and allied health professionals.
- Chapter 4 compares information sharing between providers across PHN areas.
- Chapter 5 discusses the themes of the results, and some current policy initiatives or strategies that might improve information sharing.
- Chapter 6 summarises the survey characteristics, strengths, and limitations, and provides next steps.

2 What do patients say about their health-care needs, preferences, and history?

Key findings

Nationally, of relevant populations

- nearly all (98%) patients reported that their usual GP or others in their usual place of care seemed aware of their health-care history
- a high proportion (92%) of patients felt that they had a health professional with a good understanding of their health-care needs and preferences
- patients were more like to report that they did not receive enough information about their care or treatment if they had poor self-assessed health status, had no usual GP or place of care, or did not speak English as their main language.

This chapter reviews patients' perceived experiences of information continuity—such as whether patients felt they received enough information about their treatment and whether their test results were always available.

The 2016 Survey of Health Care asked patients about their general experiences of information transfer, including measures on whether patients felt:

- there was a health professional with a good understanding of their health, health-care needs and preferences
- they received enough information about their care or treatment overall
- their usual GP or place of care was aware of their health-care history

Patients were also asked about the availability of their test results, such as X-rays and scans, at the time of their health-care appointment.



National results

Of patients who had visited either a usual GP or place of care, almost all (98%) patients reported that their usual GP or others in their usual place of care seemed aware of their health-care history.

Of patients who had health-care needs or preferences, a very high proportion (92%) felt that they had a health professional who understood those well.

Similarly, of those who said they needed information about their care or treatment, 92% said they received enough information overall about their care or treatment.

Although most patients felt like they had a positive experience overall, this still leaves some whose health-care needs and preferences were not understood (8%), or who did not receive enough information about their care or treatment (8%). This varied by sociodemographic characteristics such as age, self-assessed health status, geographic area, and primary care setting.

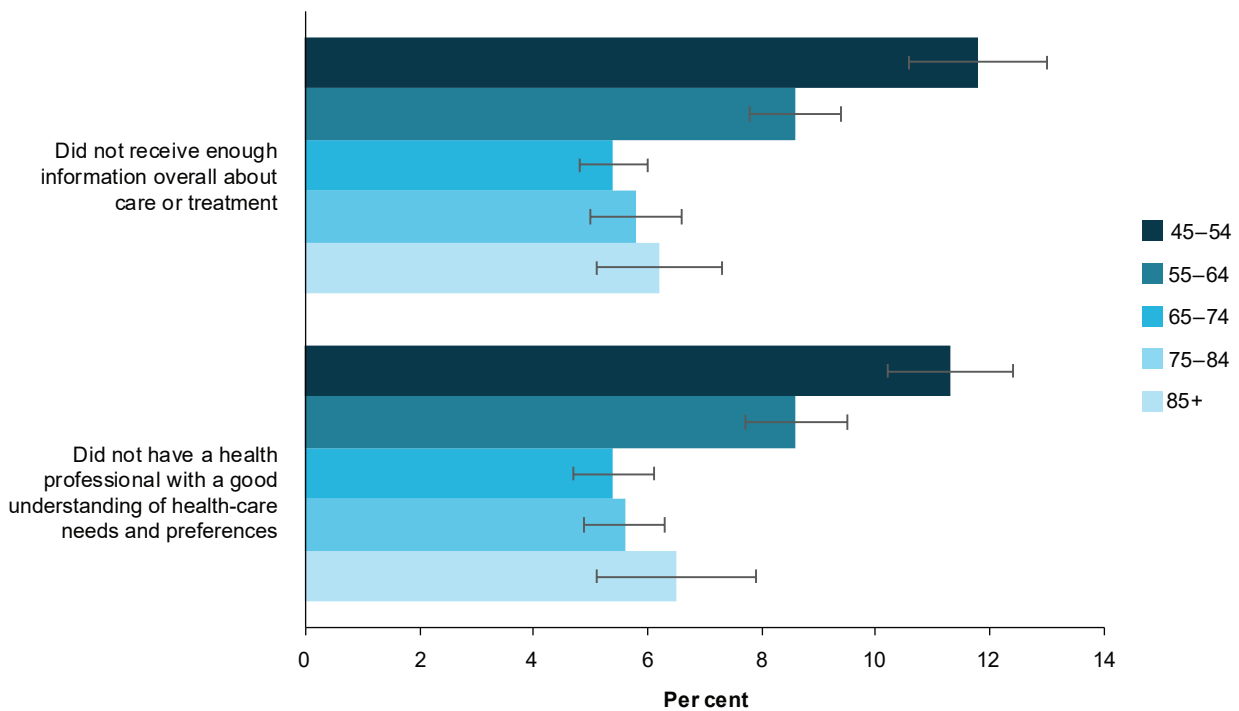
The following sections explore some of these results in more detail.

Age

Younger patients were more likely to report negative experiences than older patients (Figure 2.1). Of respondents who said that they needed information about their care or treatment, those aged 45–54 (12%) were twice as likely as patients aged 65 and over (6%) to report that they did not receive enough information.

Similarly, of patients who had health-care needs or preferences, those aged 45–54 (11%) were more likely than patients aged 85 and over (7%) to report not having a health professional who understood those well.

Figure 2.1: Measures of overall experience, patients aged 45 and over, by age group, 2016



Source: AIHW analysis of ABS Survey of Health Care 2016.

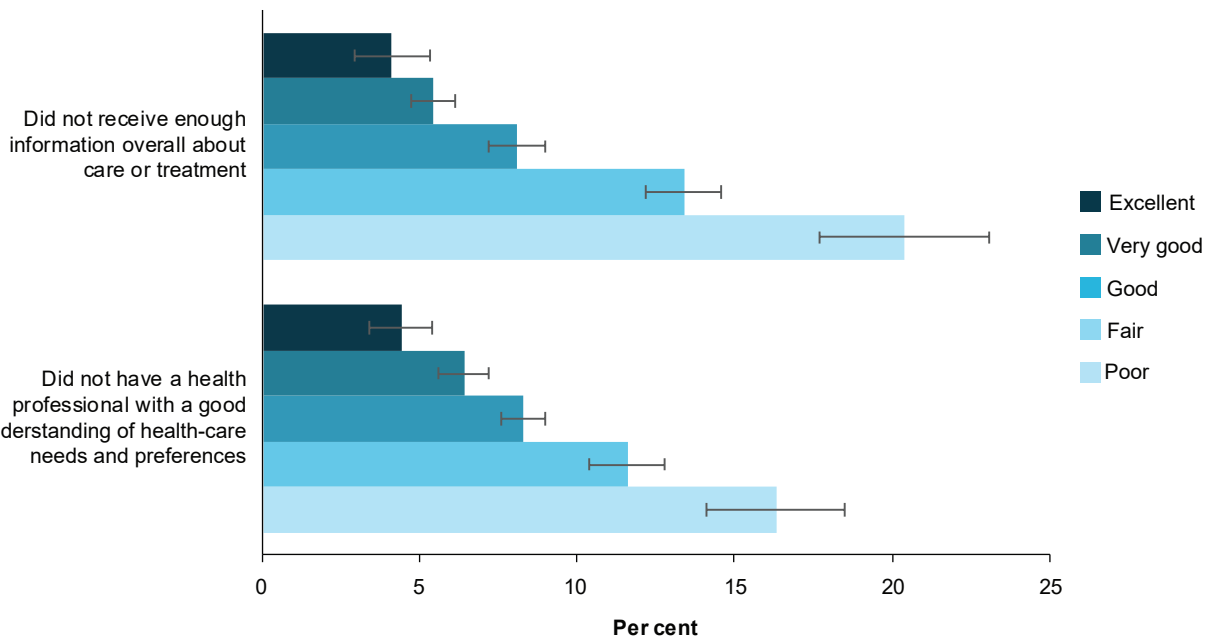


Self-assessed health status

Of patients who rated their health as poor, 1 in 5 (20%) reported not receiving enough information about their care or treatment. This compared with 1 in 25 (4%) of patients who rated their health as excellent (Figure 2.2).

Similarly, those who rated their health as poor (16%) were more likely than those who rated their health as excellent (4%) to feel that they did not have a health professional with a good understanding of their needs.

Figure 2.2: Measures of overall experience, patients aged 45 and over, by self-assessed health status, 2016



Source: AIHW analysis of ABS Survey of Health Care 2016.



Usual GP and place of care

GPs provide most Australians with their primary health care. The Survey of Health Care used the concepts 'a usual GP' and 'a usual place of care'.

- A 'usual GP' is the GP whom a person visits for the majority of their health care.
- A 'usual place of care' is the usual place that a person goes to if they are sick or need advice about their health care.

Examples of usual place of care settings include a clinic with GPs only or with GPs and other health professionals, a community health centre, an Aboriginal Medical service, or, for some patients, a hospital ED (AIHW 2018a).

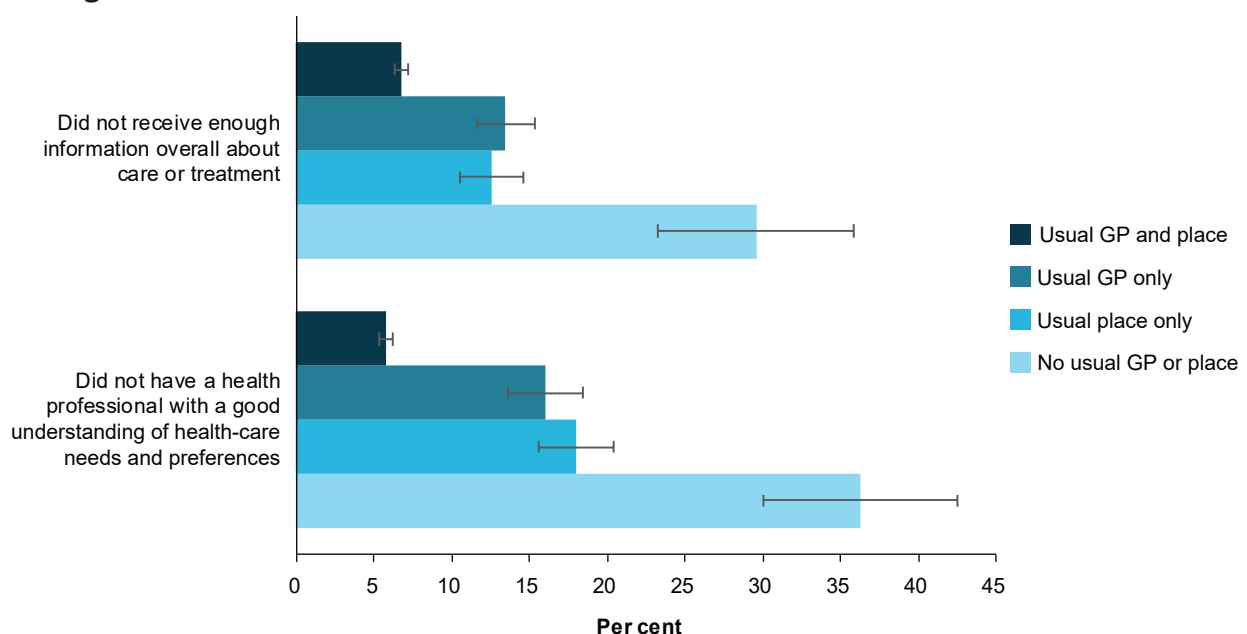
Almost all patients (98%) had a usual GP or a usual place of care. More than half (53%) of patients attended a GP clinic with GPs only, and 43% attended a GP clinic with GPs and other health professionals.

Although having a usual GP generally means that a patient has a usual place of care, this is not always the case. For example, older patients could have a usual GP only if they live in residential care (AIHW 2018a).

Patients' experiences of information sharing varied according to where they received their care (Figure 2.3). Patients who had no usual GP or place of care (30%) were more likely than those who had a usual GP and place of care (7%) to report that they did not receive enough information.

More than one-third (36%) of patients with no usual GP or place of care felt that they did not have a health professional with a good understanding of their health-care needs and preferences, compared with 6% of those with a usual GP and place of care.

Figure 2.3: Measures of overall experience, patients aged 45 and over, by type of care setting, 2016



Source: AIHW analysis of ABS Survey of Health Care 2016.



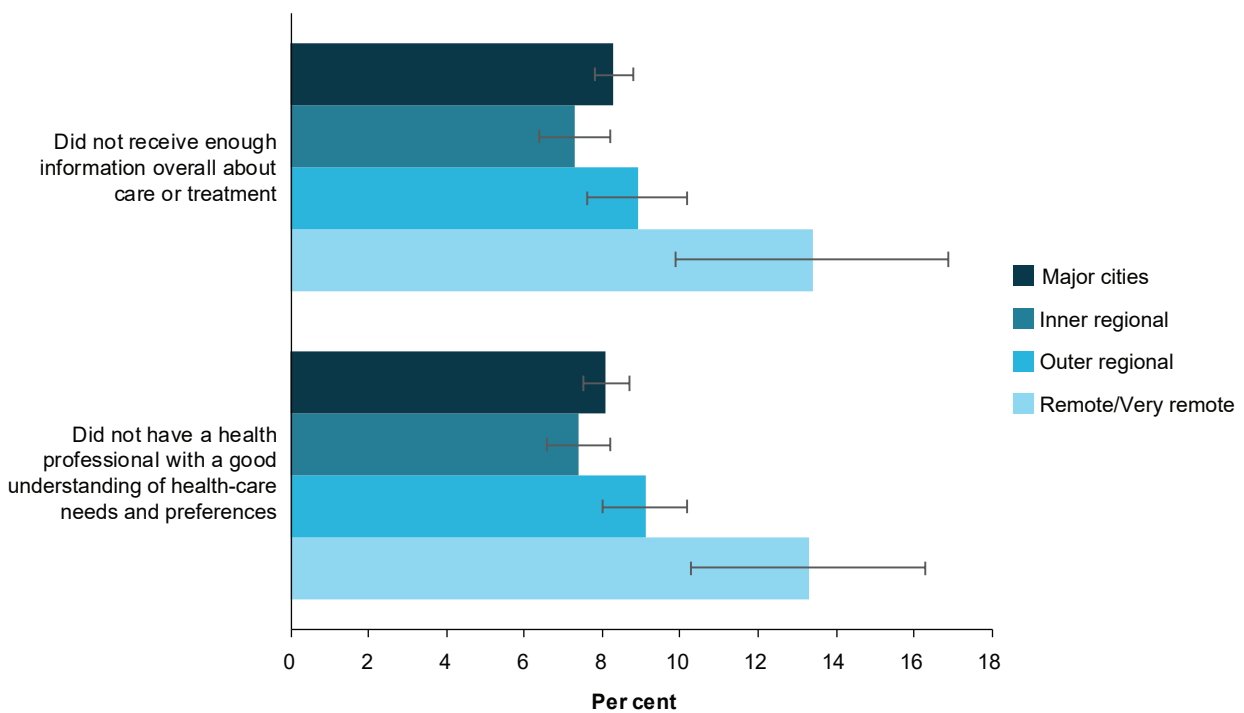
Remoteness areas

Patients who live in *Major cities*, *Inner regional* areas and *Outer regional* areas generally reported better overall experiences than those living in *Remote/Very remote* areas.

Of people living in *Remote/Very remote* areas, 13% reported that they did not receive enough information about care or treatment, which was higher than those living in *Outer regional* areas (9%), *Inner regional* areas (7%), and *Major cities* (8%) (Figure 2.4).

The pattern was similar for patients reporting they did not have a health professional with a good understanding of their health-care needs and preferences, at 13% in *Remote/Very remote* areas and 8% in *Major cities*.

Figure 2.4: Measures of overall experience, patients aged 45 and over, by remoteness area, 2016



Source: AIHW analysis of ABS Survey of Health Care 2016.

Main language spoken at home

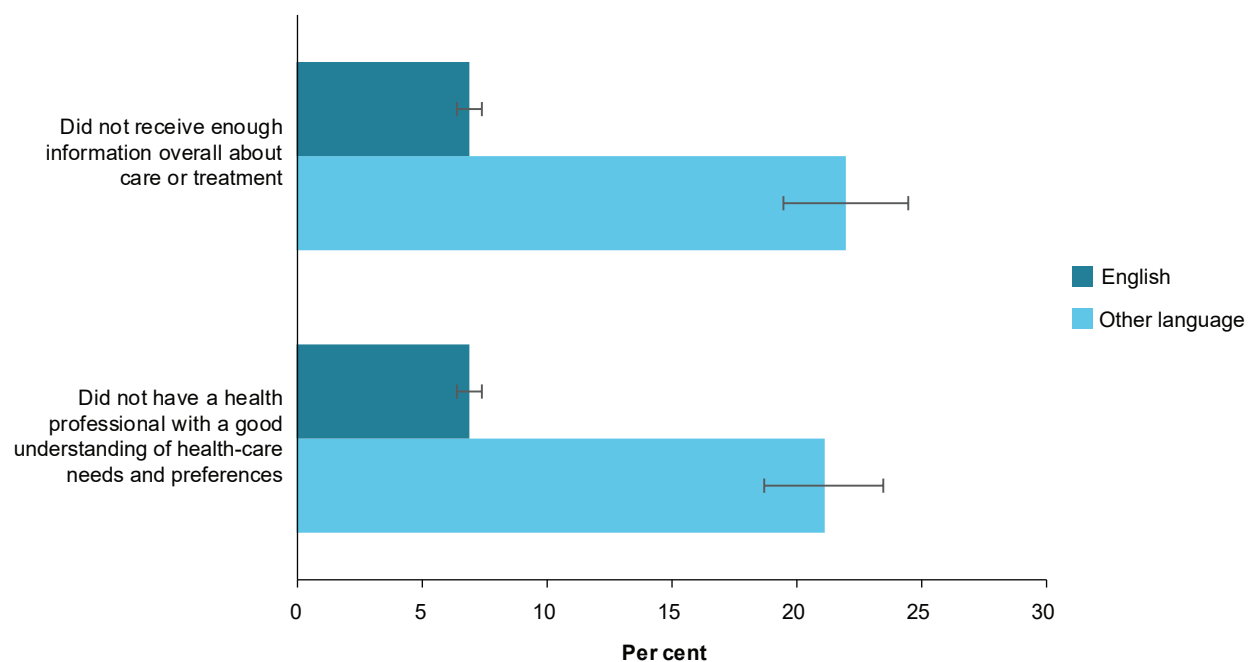
The way people experience their health care can be affected by language. This can lead to differing expectations and understanding of health related issues (ACSQHC 2014).

The results show large differences for people who did not speak English as their main language at home compared with those who did (Figure 2.5).

Patients who spoke a language other than English (22%) were 3 times as likely as those who spoke English (7%) to report that they did not receive enough information about care or treatment.

They were also 3 times as likely to report they didn't have a health professional with a good understanding of their health-care needs and preferences (21% compared with 7%).

Figure 2.5: Measures of overall experience, patients aged 45 and over, by main language spoken at home, 2016



Source: AIHW analysis of ABS Survey of Health Care 2016.

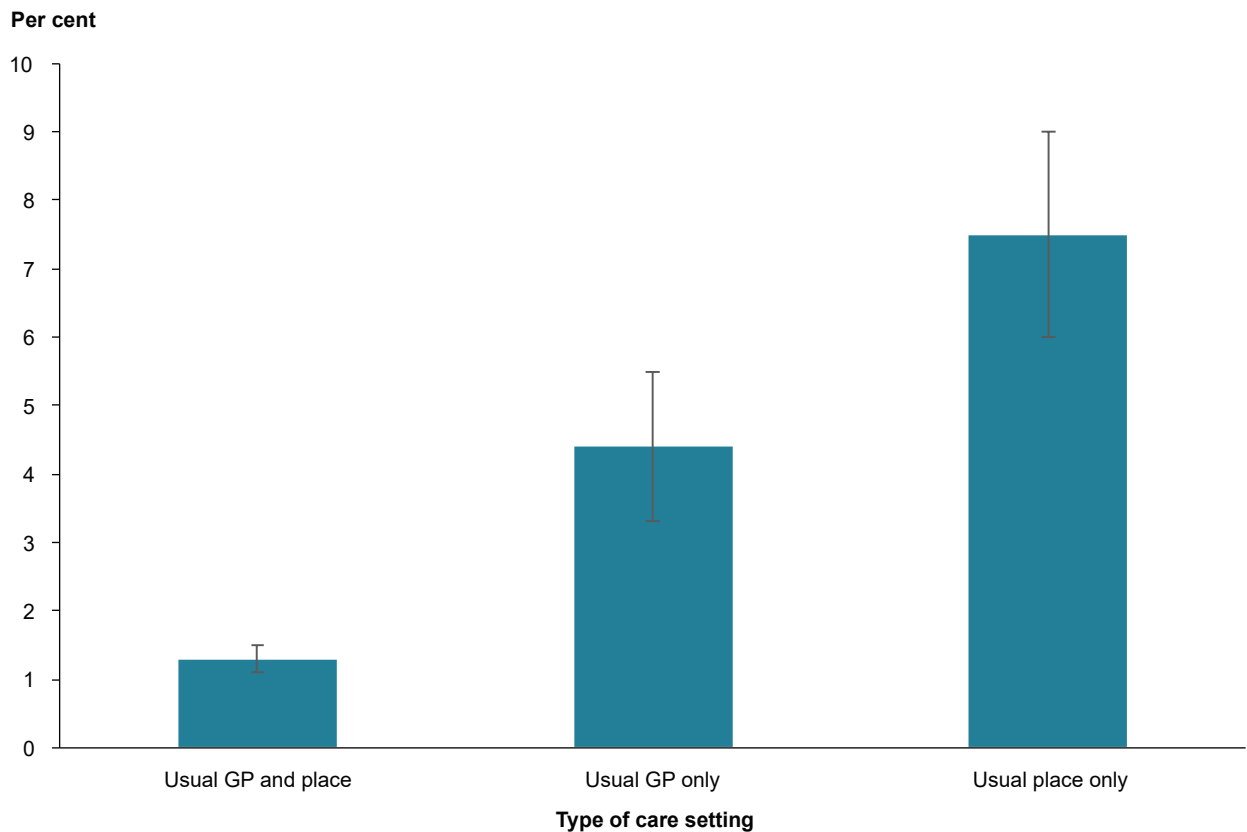


Usual GP's awareness of health-care history

Having a health-care professional who is aware of a patient's health-care history alleviates the need for a patient to repeat their medical history at each appointment, resulting in a better patient experience.

The survey results show that patients who had a usual place of care only were far more likely to report that their usual GP or place of care was never aware of their health-care history (8%) than those with both a usual GP and a usual place of care (1%) (Figure 2.6).

Figure 2.6: Patients aged 45 and over who reported their usual GP or place of care was never aware of their health-care history, by type of care setting, 2016



Note: These data are based on survey responses from patients who had visited a usual GP or usual place of care in the 12 months before completing the survey.

Source: AIHW analysis of ABS Survey of Health Care 2016.

Test, X-ray and scan results

Patients were asked about whether their test results, such as X-rays and scan results, were always available at the time of their health-care appointment. Nationally, 94% of patients said that they were, but this varied across age groups, remoteness areas and type of care setting.



Age

Patients aged 75 and over (97%) were the most likely to report that their test results were always available at their scheduled health-care appointment. This compared with 91% of patients aged 45–54 (Table 2.1).

Table 2.1: Patients aged 45 and over who reported that test, X-ray, or scan results were always available at scheduled appointment, by age, 2016

Age group (years)	%	95% CI
45–54	90.6	(89.4–91.7)
55–64	92.5	(91.6–93.4)
65–74	95.5	(94.6–96.3)
75–84	96.9	(96.1–97.6)
85+	96.8	(95.4–98.2)

Source: AIHW analysis of ABS Survey of Health Care 2016.



Type of care setting

Patients with a usual GP only (96%) were the most likely to report that their test, X-ray, or scan results were always available, followed by those who had both a usual GP and place of care (94%), then those who had a usual place only (91%), and those who had no usual GP or place (88%) (Table 2.2).

Table 2.2: Patients aged 45 and over who reported that test, X-ray, or scan results were always available at scheduled appointment, by type of care setting, 2016

Type of care setting	%	95% CI
Usual GP and place of care	93.7	(93.3–94.1)
Usual GP only	95.8	(94.3–97.3)
Usual place of care only	90.7	(88.8–92.6)
No usual GP or place of care	87.8	(85.0–90.7)

Source: AIHW analysis of ABS Survey of Health Care 2016.



Remoteness area

Patients in *Major cities* and *Inner regional* areas (both 94%) were the most likely to report that their test results were always available at the time of their health-care appointment (Table 2.3).

Table 2.3: Patients aged 45 and over who reported that test, X-ray or scan results were always available at scheduled appointment, by remoteness area, 2016

Remoteness area	%	95% CI
Major cities	94.0	(93.5–94.4)
Inner regional	93.7	(92.9–94.4)
Outer regional	90.3	(88.8–91.8)
Remote/Very remote	86.1	(82.7–89.5)

Source: AIHW analysis of ABS Survey of Health Care 2016.

3 Was information shared between health-care providers?

Key findings

- Patients were more likely to report that their usual GP or place of care did not seem informed about their specialist care if they were aged 45–54, only had a usual place of care, or lived in a *Remote/Very remote* area.
- Generally, patients with poorer health, or 3 or more long-term conditions reported their specialist had less availability of their medical information or test results.
- Generally, patients who reported that their usual GP did not seem informed about their follow-up needs and medication changes from their last admission to hospital or ED visit were younger, or lived in *Remote/Very remote* areas.
- Of patients who had seen an allied health professional for their physical health, 77% felt their usual GP or others in their usual place of care seemed at least sometimes informed of the care they had received.

Health-care professionals, service providers, and care organisations work collectively to navigate large volumes of health information to meet patient need. The availability and completeness of documentation and information transfer between providers, together with good communication within and between multidisciplinary teams, colleagues, and institutions, is the cornerstone of health-care management (Freeman & Hughes 2010).

This chapter looks at patient-reported measures that relate to information sharing between selected health-care providers (including specialists, hospitals, and allied health professionals) to show whether their usual GP or others in their usual place of care were informed of:

- the care received during their last visit to the specialist
- their follow-up needs or medication changes after their most recent admission to hospital
- their follow-up needs or medication changes after the last time they went to the ED
- their care provided by an allied health professional for their physical health
- their care provided by an allied health professional for their emotional or psychological health.

Where possible, the results are grouped by provider type, such as hospitals. All results apply to care received in the 12 months before the survey.

Information sharing to and from specialists

A visit to a specialist usually requires a referral from a GP, with the expectation that the specialist reports back to the referring GP (Better Health Channel 2015). The GP and their care team usually coordinate the patient's health care, with input from specialists and other health professionals, as required.

In 2016, an estimated 4.8 million (55%) patients aged 45 and over saw a specialist. More than half of these reported seeing more than 1 specialist, and about 9% saw 4 or more specialists, highlighting the need for care coordination. The frequency of their visits and how many different specialists they visited is shown in Table 3.1.

Table 3.1: Patients aged 45 and over who saw a specialist in the previous 12 months, by number of visits to a specialist and number of different specialists seen, 2016

	%	95% CI
Number of visits		
1 visit	26.2	(25.3–27.1)
2 visits	25.6	(24.9–26.3)
3 visits	14.1	(13.5–14.7)
4 visits	10.6	(10.1–11.1)
5 or more visits	23.5	(22.8–24.2)
Number of different specialists		
1 specialist	47.1	(46.0–48.2)
2 specialists	30.8	(29.8–31.8)
3 specialists	13.1	(12.6–13.6)
4 specialists	4.9	(4.5–5.3)
5 or more specialists	4.0	(3.7–4.3)

Source: AIHW analysis of ABS Survey of Health Care 2016.



National results

The availability of health information is an important contributor to continuity of care. Patients were asked whether there was at least one time when their specialist did not have their medical information or test results.

Almost 1 in 10 (9%) patients who saw a specialist reported that there was at least one time when their specialist did not have their medical information or test results. This excludes those who said they did not know (4%).

Patients were also asked whether their usual GP or others in their usual place of care seemed informed about the care they received during their last visit to a specialist, with 10% reporting that they did not. This comprised of 6.6% of patients who reported that their usual GP or place of care did not seem informed, and 3.8% of patients who reported that their usual GP or place of care did not know until the patient told them.

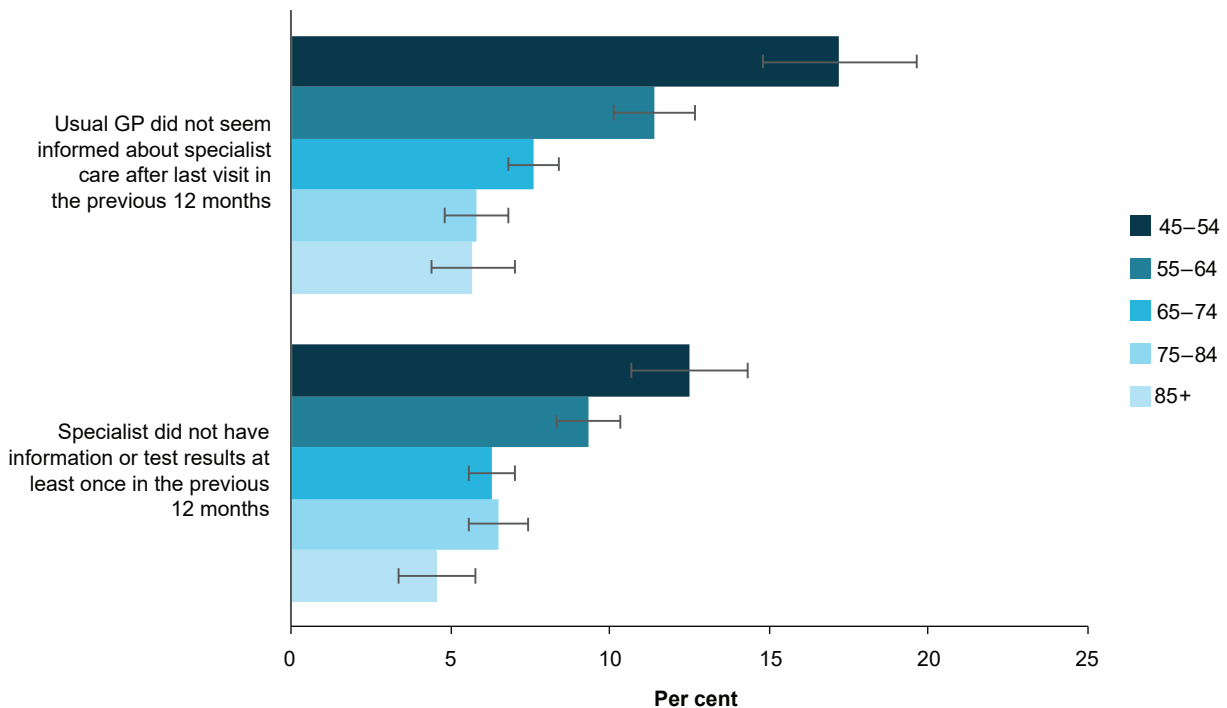
The following sections look at these results by age, self-assessed health, type of care setting, and remoteness area.

Age

Patients aged 45–54 (17%) were more likely than those aged 85 and over (6%) to report that their usual GP did not seem informed about their specialist care (Figure 3.1).

Patients aged 45–54 (13%) were also more likely than those aged 85 and over (5%) to report that there was at least one time when their specialist did not have their medical information or test results.

Figure 3.1: Measures of information transfer with specialist in the previous 12 months, patients aged 45 and over, by age group, 2016



Notes

1. 'Usual GP did not seem informed about specialist care after last visit in the previous 12 months' is based on survey responses from patients who had visited their usual GP or place of care after their most recent specialist visit in the previous 12 months.
2. 'Specialist did not have information or test results at least once in the previous 12 months' is based on survey responses from patients who had visited a specialist in the previous 12 months.

Source: AIHW analysis of ABS Survey of Health Care 2016.

Health status and long-term health conditions

Patients who rated their health as poor (20%) were far more likely than those who rated their health as excellent (5%) to report that their specialist doctor did not have their medical information or test results at least once.

Patients with 3 or more long-term health conditions (11%) were twice as likely as those with no long-term health condition (5%) to report that their specialist did not have their results (Table 3.2).

Patients with poorer health are significantly more likely to see a specialist doctor more often than those with excellent health, so there is more opportunity for test results to be unavailable.

Table 3.2: Patients aged 45 and over who reported a specialist did not have their medical information or test results at least once in the previous 12 months, 2016

	%	95% CI
Self-assessed health status		
Excellent	4.7	(2.8–6.6)
Very good	6.0	(5.0–7.0)
Good	7.7	(6.7–8.8)
Fair	13.3	(11.7–15.0)
Poor	19.8	(15.9–23.6)
Number of long-term conditions		
None	4.9	(3.5–6.2)
1	7.6	(6.4–8.8)
2	8.1	(7.0–9.2)
3 or more	11.2	(10.3–12.2)

Notes

1. Based on survey responses from patients who had visited a specialist in the previous 12 months.

2. For definition of 'long-term health condition', see Glossary.

Source: AIHW analysis of ABS Survey of Health Care 2016.



Type of care setting

Patients who reported having only a usual place of care but not a usual GP (27%) were 3 times as likely as those who had a usual GP and usual place of care (9%), or those who had a usual GP only (9%) to report that their usual place of care did not seem informed about the care received from a specialist doctor. Those with no usual GP or place of care are excluded from this result.

The results for whether a specialist did not have medical information or test results at the time of a patient's appointment did not vary significantly across type of care setting.

Table 3.3: Patients aged 45 and over who reported their usual GP or place of care was not informed about their most recent specialist visit, by type of care setting, 2016

Type of care setting	%	95% CI
Usual GP and place of care	9.3	(8.5–10.1)
Usual GP only	8.8	(6.3–11.4)
Usual place of care only	27.3	(21.8–32.9)

Note: Based on survey responses from patients who had visited their usual GP or place of care after their most recent specialist visit in the previous 12 months.

Source: AIHW analysis of ABS Survey of Health Care 2016.



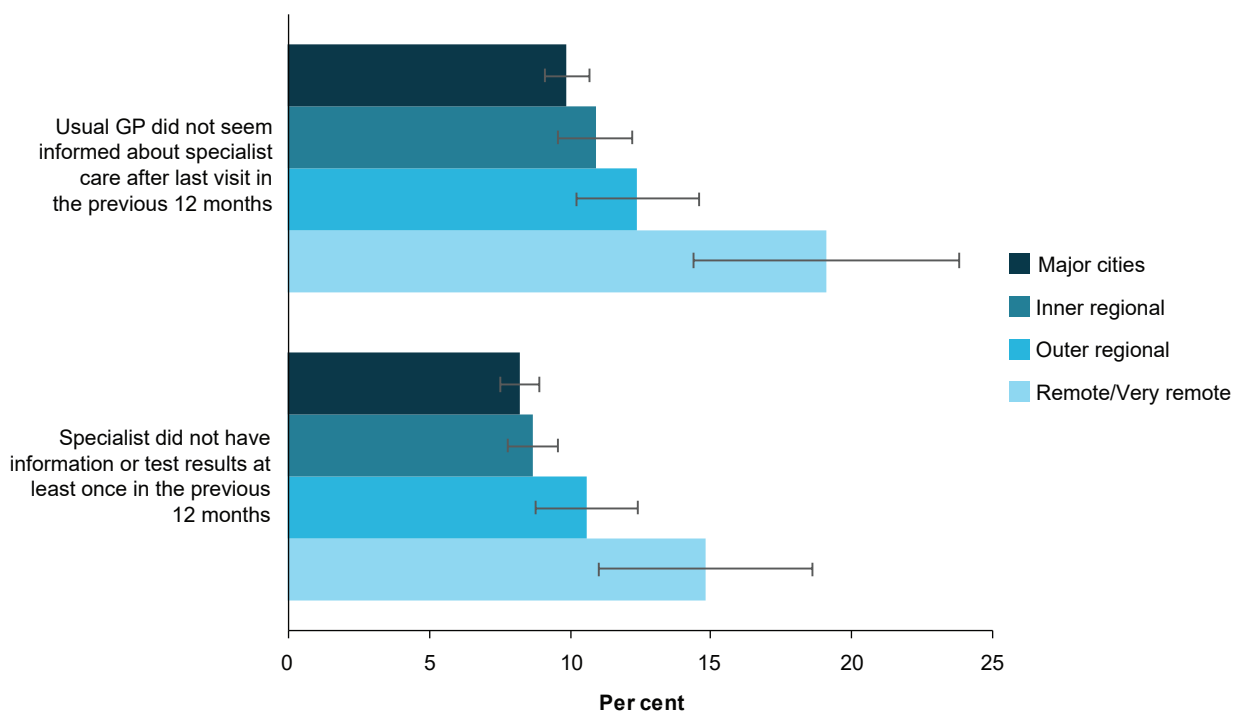
Remoteness area

Information transfer decreases as remoteness increases. Patients in *Remote/Very remote* areas (19%) were the most likely to report that their usual GP or place of care did not seem informed about care they had received from a specialist doctor after their most recent visit. This compared with 10% of patients in *Major cities* (Figure 3.2).

Patients in *Remote/Very remote* areas (15%) were also the most likely to report that there was at least one time when their specialist doctor did not have their medical information or test results. This compared with 8% in *Major cities*.

One possible explanation for these differences is that patients in *Remote/Very remote* areas are more likely to have a usual place of care only, and patients with a usual place of care only are much more likely to experience poor sharing of information.

Figure 3.2: Measures of information transfer with specialist in the previous 12 months, patients aged 45 and over, by remoteness area, 2016



Notes

1. 'Usual GP did not seem informed about specialist care after last visit in the previous 12 months' is based on survey responses from patients who had visited their usual GP or place of care after their most recent specialist visit in the previous 12 months.
2. 'Specialist did not have information or test results at least once in the previous 12 months' is based on survey responses from patients who had visited a specialist in the previous 12 months.

Source: AIHW analysis of ABS Survey of Health Care 2016.

Information sharing from hospitals

The transition from acute care to the community setting is a known area of risk for patient harm (ACSQHC 2017). As such, health service core standards stipulate timely, relevant, and structured clinical handover that ensures safe patient care (ACSQHC 2012). Breakdown in the sharing of information is one of the most important contributing factors in serious adverse events, and is a major preventable cause of patient harm.



National results

At the time of the survey, an estimated 1.9 million (22%) patients aged 45 and over had been admitted to hospital in the previous 12 months.

Of those who had follow-up needs or medication changes, and had visited their usual GP since their admission, 14% experienced poor information sharing back to their usual GP. This comprised of 9% who reported that their usual GP did not seem informed and 5% who reported their usual GP did not know about their follow-up needs until the patient told them.

These results exclude the 12% of patients who did not have any follow-up needs or medication changes after their last admission to hospital.

An estimated 1.6 million (18%) patients aged 45 and over had been to an ED.

Of those who had follow-up needs or medication changes, and had visited their usual GP since going to the ED, 23% experienced poor information sharing back to their usual GP—14% because their usual GP or usual place of care did not seem informed, and 9% because their usual GP or usual place of care did not know about their ED visit until the patient told them.

These results exclude the 6% of patients who did not have any follow-up needs. Appendix A provides detailed definitions for all measures.

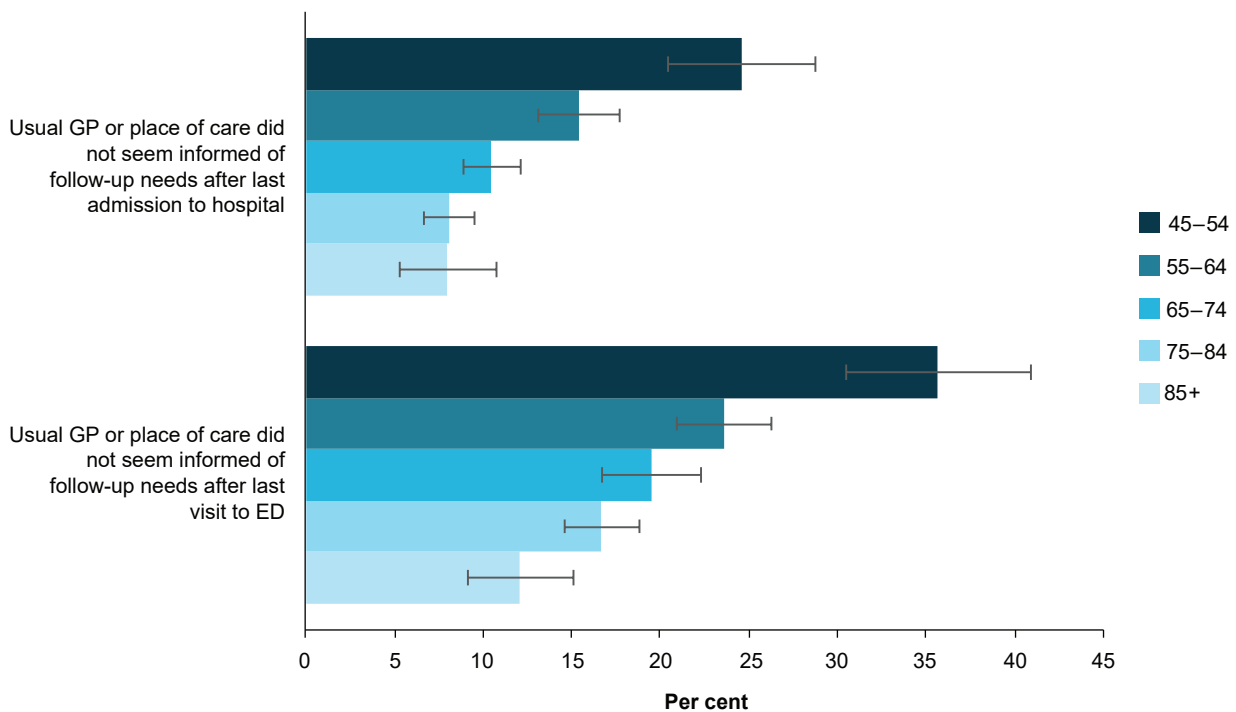
Age

Patients aged 45–54 were more likely than other age groups to report that their usual GP or place of care was not informed of their follow-up needs across both hospitals and EDs (Figure 3.3).

One-quarter (25%) of patients aged 45–54 felt that their usual GP or place of care did not seem informed of their follow-up needs after their most recent visit to hospital, compared with 8% of those aged 85 or over.

This was even higher for EDs, where 36% of those aged 45–54 reported that their usual GP or place of care did not seem informed of their follow up needs, or did not know until the patient told them, compared with 12% of those aged 85 or over.

Figure 3.3: Measures of information transfer to usual GP or place of care about follow-up needs or medication changes after last visit to hospital or ED, patients aged 45 and over, by age group, 2016



Note: Based on survey responses from patients who had visited their usual GP or place of care after their last hospital admission or visit to ED in the previous 12 months.

Source: AIHW analysis of ABS Survey of Health Care 2016.

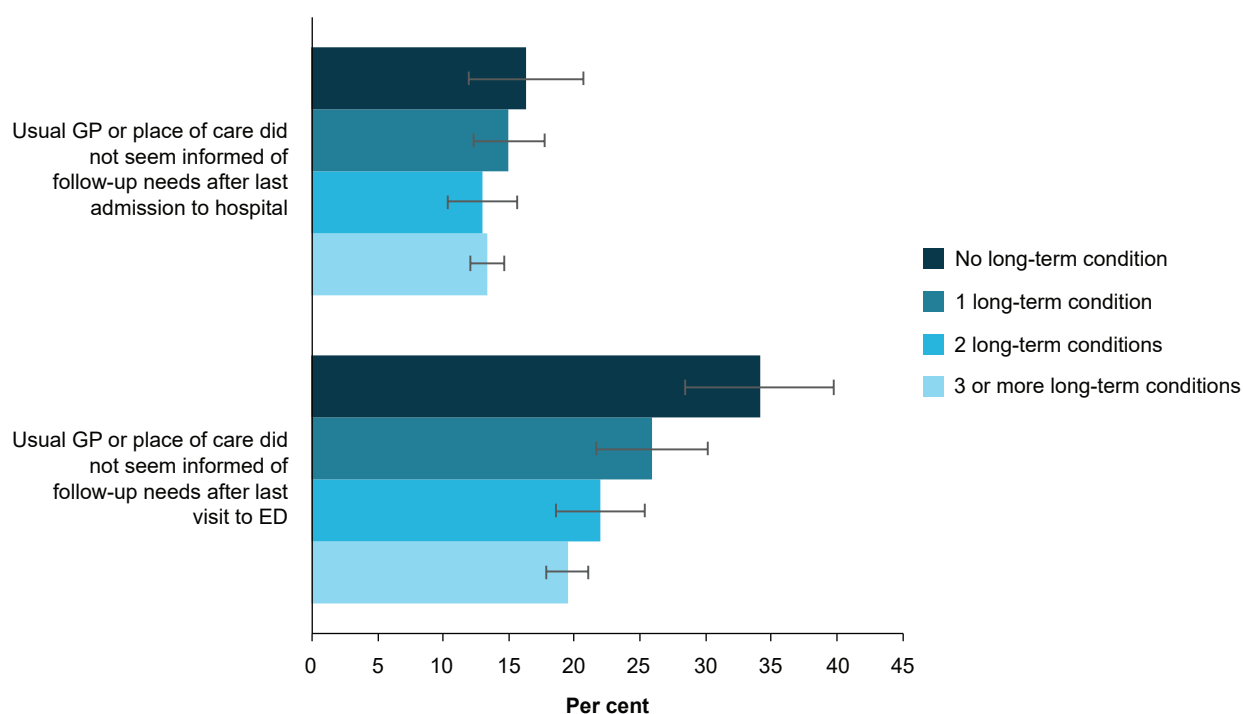


Long-term health conditions

Patients with no long-term health condition (34%) were much more likely to report that there was inadequate sharing of information from the ED to their usual GP or place of care than those who had 3 or more long-term conditions (20%).

There were no significant differences across long-term health conditions for patients who had been admitted to hospital (Figure 3.4).

Figure 3.4: Measures of information transfer to usual GP or place of care about follow-up needs or medication changes after last visit to hospital or ED, patients aged 45 and over, by number of long-term conditions, 2016



Notes

1. Based on survey responses from patients who had visited their usual GP or place of care after their last hospital admission or visit to ED in the previous 12 months.
2. For definition of 'long-term health condition', see Glossary.

Source: AIHW analysis of ABS Survey of Health Care 2016.

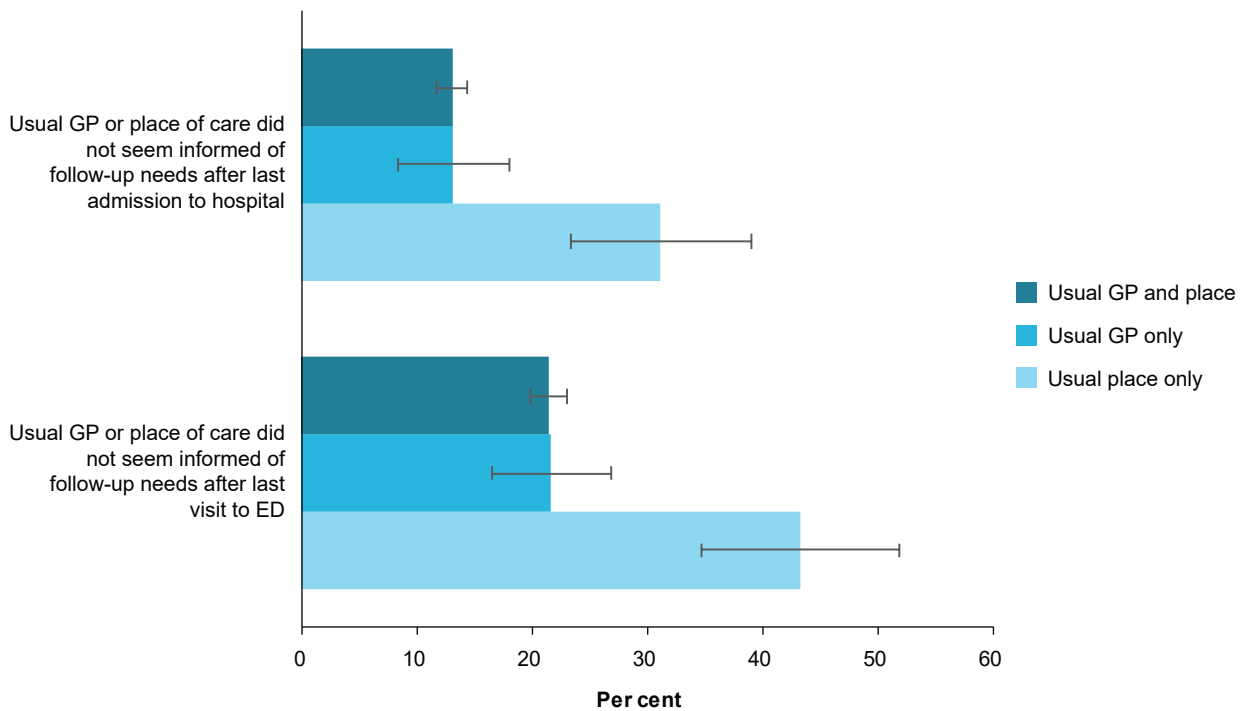


Type of care setting

Patients who reported having a usual place of care only (43%) were much more likely to report that there was inadequate sharing of information from the ED to their usual place of care than those who had a usual GP and place of care (22%) or a usual GP only (22%) (Figure 3.5).

Patients who had a usual place of care only (31%) were also more likely to report that their usual place of care was not informed of their follow-up needs following their last admission to hospital than those who had a usual GP and place of care (13%) or a usual GP only (13%).

Figure 3.5: Measures of information transfer to usual GP or place of care about follow-up needs or medication changes after last visit to hospital or ED, patients aged 45 and over, by type of care setting, 2016



Note: Based on survey responses from patients who had visited their usual GP or place of care after their last hospital admission or visit to ED in the previous 12 months.

Source: AIHW analysis of ABS Survey of Health Care 2016.

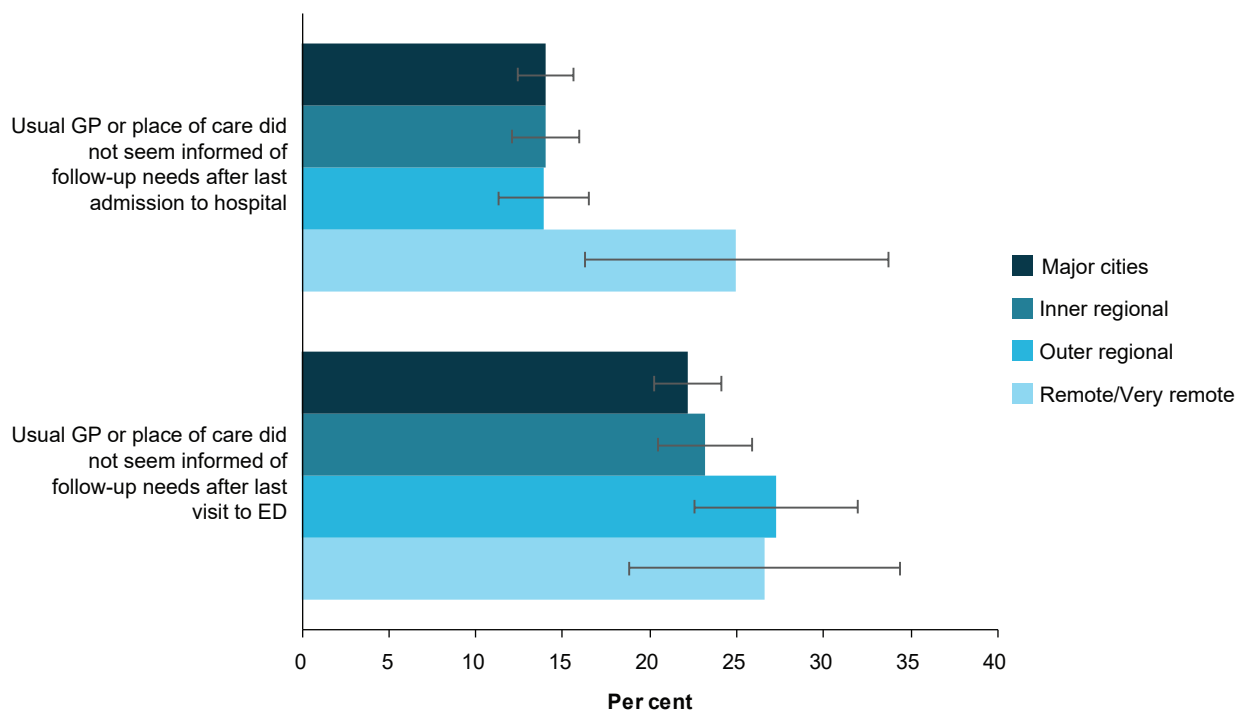


Remoteness areas

One-quarter (25%) of patients who had follow-up needs or medication changes from their last admission to hospital in *Remote/Very remote* areas felt that their usual GP or place of care did not seem informed, compared with 14% of patients in *Major cities* (Figure 3.6).

However there were no significant differences across remoteness areas for ED follow-up needs. A reason for this might be that there are different models of care in some *Very remote* areas, where the ED can be used as primary care setting (or usual place of care) to bridge service gaps.

Figure 3.6: Measures of information transfer to usual GP or place of care about follow-up needs or medication changes after last visit to hospital or ED, patients aged 45 and over, by remoteness area, 2016



Note: Based on survey responses from patients who had visited their usual GP or place of care after their last hospital admission or visit to ED in the previous 12 months.

Source: AIHW analysis of ABS Survey of Health Care 2016.

Private health insurance

Of patients with private health insurance, 13% felt that their usual GP or place of care was not informed about their last hospital admission, compared with 16% of patients without private health insurance. However, for ED visits, having private health insurance made little difference in whether a patient's usual GP was informed about follow-up needs or medication changes (both 23%).

Arrangements made by the hospital for services needed

Discharge from hospital has been described as a key transition period within the health system, where patients' contact with services shapes their subjective experience (Bate & Robert 2006).

The survey asked patients whether arrangements were made by the hospital for any services needed after their last admission. More than one-third (35%) of patients said that they did not require any services after their hospital admission. Of those who did require services after their hospital admission, 20% reported that arrangements were not made by the hospital.

Sex

Women (22%) were more likely than men (18%) to report that arrangements had not been made.



Long-term health conditions

Patients who had 3 or more long-term conditions (21%) were more likely to report that the hospital had not arranged for services they required after their last admission to hospital than patients who had no long-term conditions (14%) (Table 3.4).

Table 3.4: Patients aged 45 and over who reported that arrangements were not made for any services required after last hospital admission, by number of long term conditions, 2016

Number of long-term conditions	%	95% CI
None	14.4	(10.3–18.5)
1	19.5	(16.4–22.7)
2	19.6	(16.2–23.0)
3 or more	21.3	(19.4–23.2)

Notes

1. Based on patients who required services after their most recent hospital admission in the 12 months before the survey.
2. For definition of 'long-term health condition', see Glossary.

Source: AIHW analysis of ABS Survey of Health Care 2016.

Information sharing from allied health professionals

Many types of allied health professionals often work as part of a multidisciplinary team across various settings to provide specialised support for patients (Allied Health Professionals Australia 2017).

The Survey of Health Care asked participants about their interactions with allied health professionals for their physical health (such as physiotherapists, podiatrists, and dietitians), and for their emotional and psychological health (such as psychologists, counsellors, or social workers).

Information sharing between allied health professionals and GPs depends on the patient's situation. In general, there is no standard practice for allied health professionals to return information about a patient back to their usual GP.

However patients with chronic and complex conditions who qualify for a GP Management Plan and/or Team Care Arrangement can claim a set number of allied health services annually, and the provider is required to report back to the GP on these visits (DoH 2014).

For patients who use allied health services outside of these arrangements, the cost is not covered by Medicare, and there is no professional requirement for allied health practitioners to return information about a patient back to their usual GP.

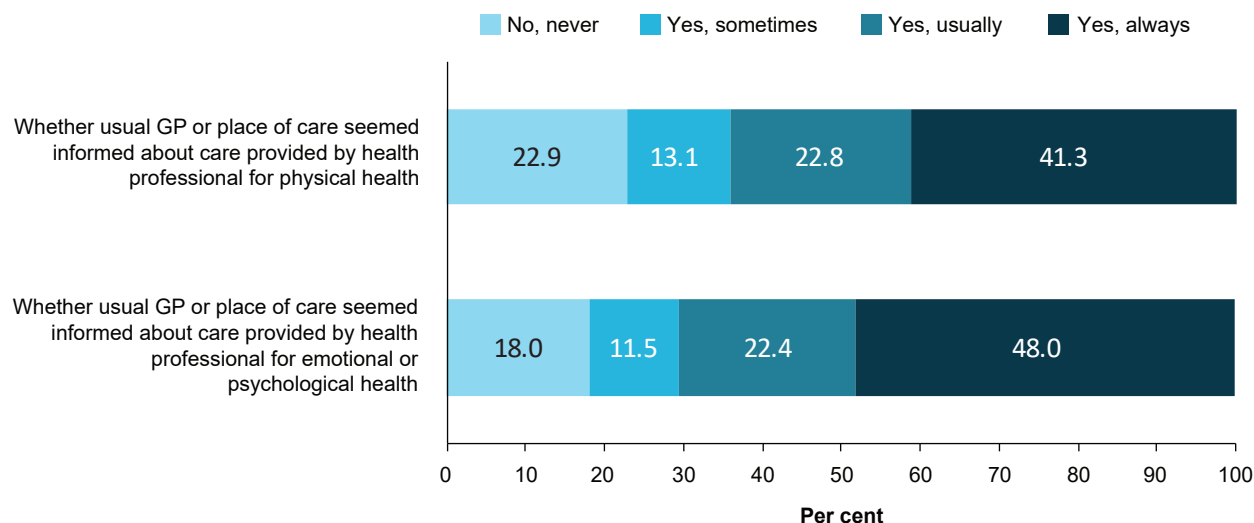
There might be some circumstances where an allied health practitioner has a good working relationship with, and informs, the patient’s GP, or where the patient discusses the care that they have received with their GP.

An estimated 3.9 million (45%) patients aged 45 and over received care from an allied health professional for their physical health. Of these, 77% felt that their usual GP or others in their usual place of care seemed at least sometimes informed of care they had received (Figure 3.7).

An estimated 819,000 (9%) patients aged 45 and over received care from a health professional for their emotional or psychological health. Of these, 82% felt that their usual GP or place of care was at least sometimes informed of care received.

The proportion of people who had received care from a health professional for physical health was much higher than for emotional or psychological health, however the distribution of responses was similar, with the most common category being ‘Yes, always’ for both.

Figure 3.7: Measures of information transfer from allied health professionals, by response category, 2016



Note: Based on survey responses from patients who had a usual GP or usual place of care, and had received care for their physical health and/or for their emotional or psychological health in the previous 12 months from allied health professionals
Source: AIHW analysis of ABS Survey of Health Care 2016.

4 How did results vary across Primary Health Networks?

Key finding

Patients in the more remote PHNs, such as in the Northern Territory and Western Queensland, were more likely to report that their usual GP was not informed of care received from their specialist or their follow-up needs from their hospital admission.

In 2016, across PHN areas, of the patients who had seen a specialist, the proportion who felt that their usual GP or place of care was not informed of their care ranged from 22% in the Northern Territory to 7% in both Tasmania and Western Victoria (Figure 4.1).

Of patients who reportedly had a hospital admission in the previous 12 months, the proportion who felt that their usual GP or place of care was not informed of their follow-up needs ranged from 35% in the Northern Territory to 9% on the Gold Coast (Figure 4.2).

More than one-third (36%) of patients in the Northern Territory felt that their usual GP or place of care was not informed of their follow-up needs, after their recent visit to an ED, compared with 14% of patients in Tasmania and 14% in Northern Sydney (Figure 4.3).

Figure 4.1: Patients aged 45 and over who reported their usual GP or place of care was not informed of their recent specialist care, by PHN area, 2016

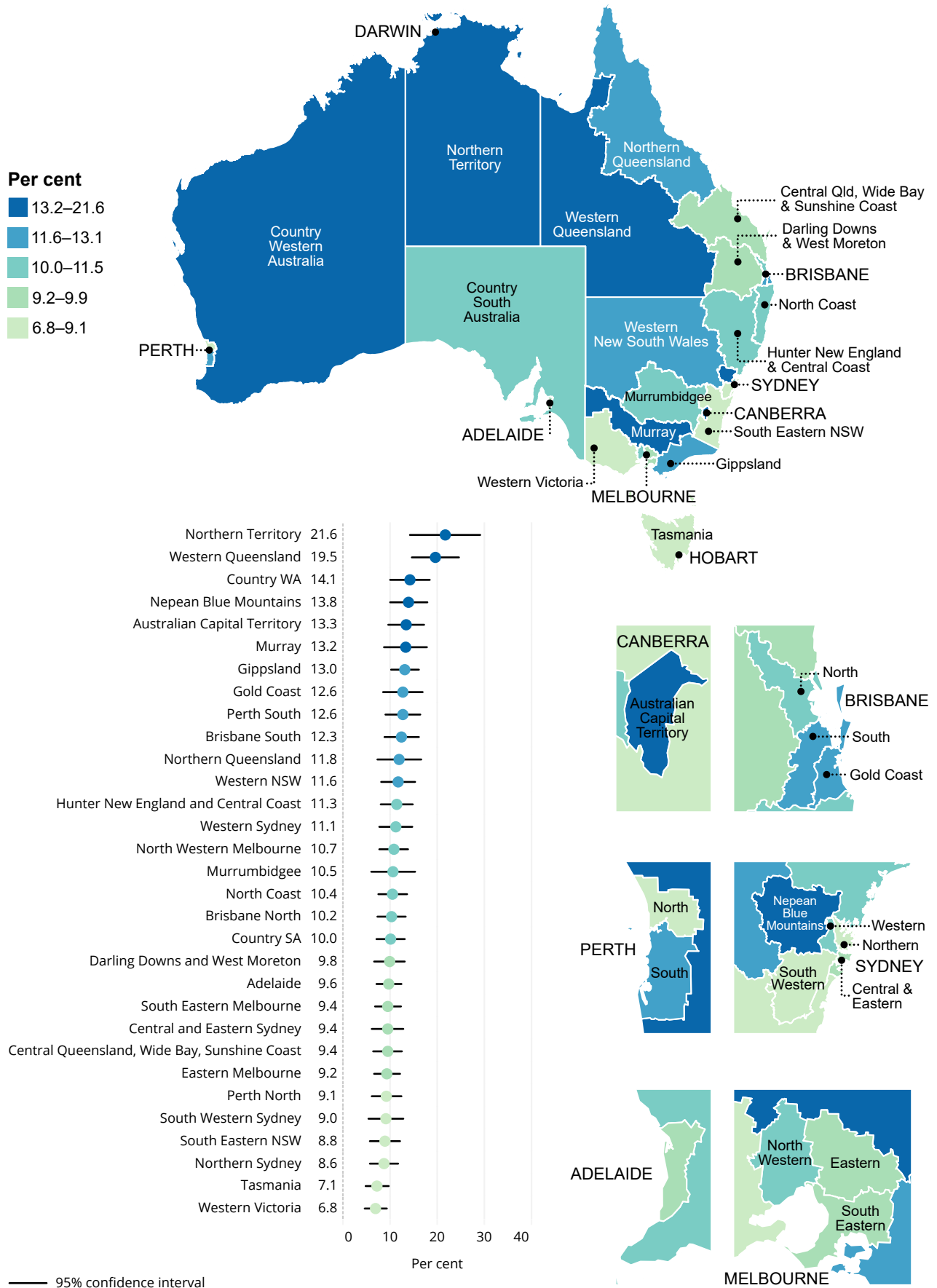


Figure 4.2: Patients aged 45 and over who reported their usual GP or place of care was not informed of their follow-up needs or medication changes after their recent hospital admission, by PHN area, 2016

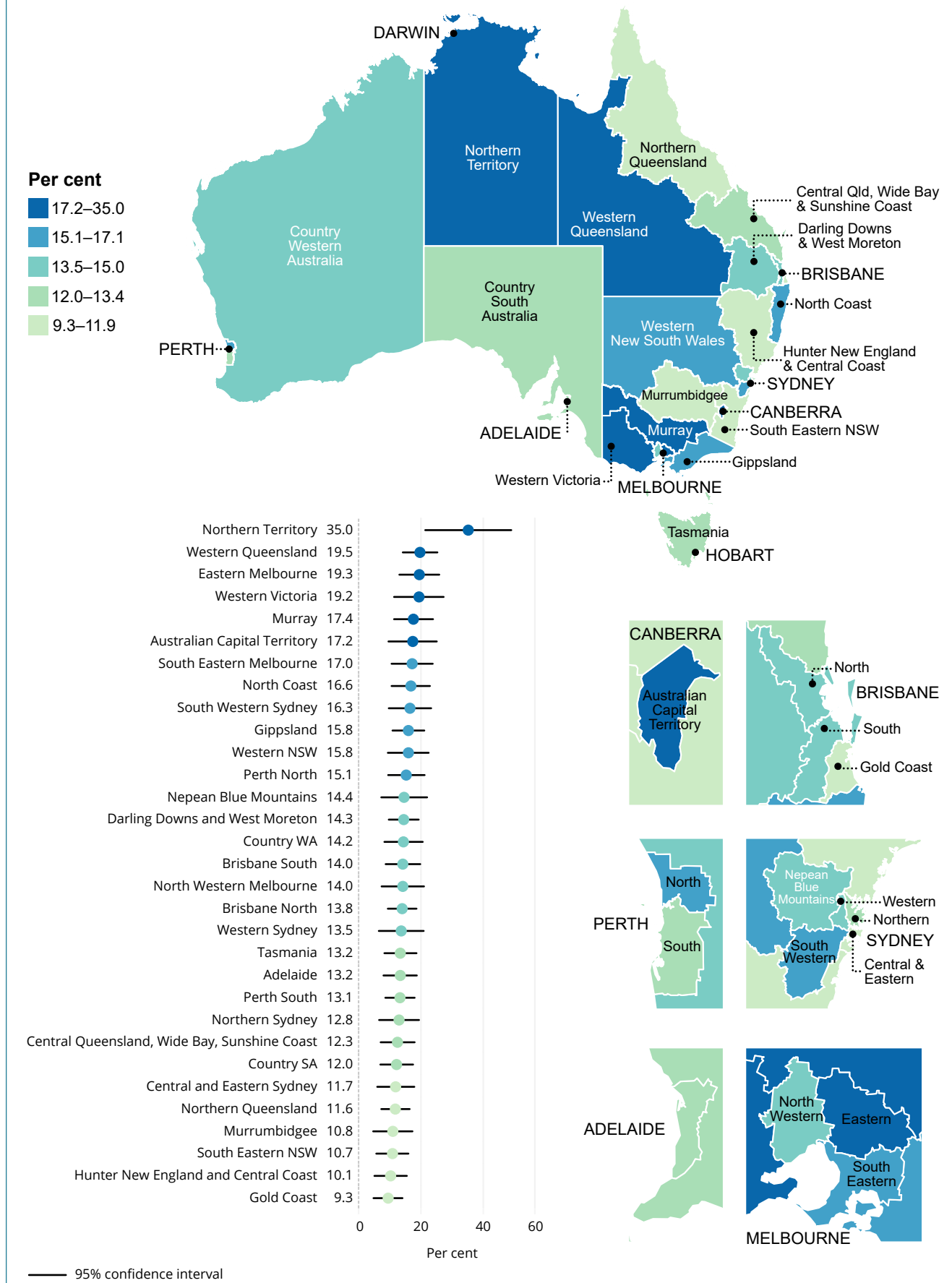
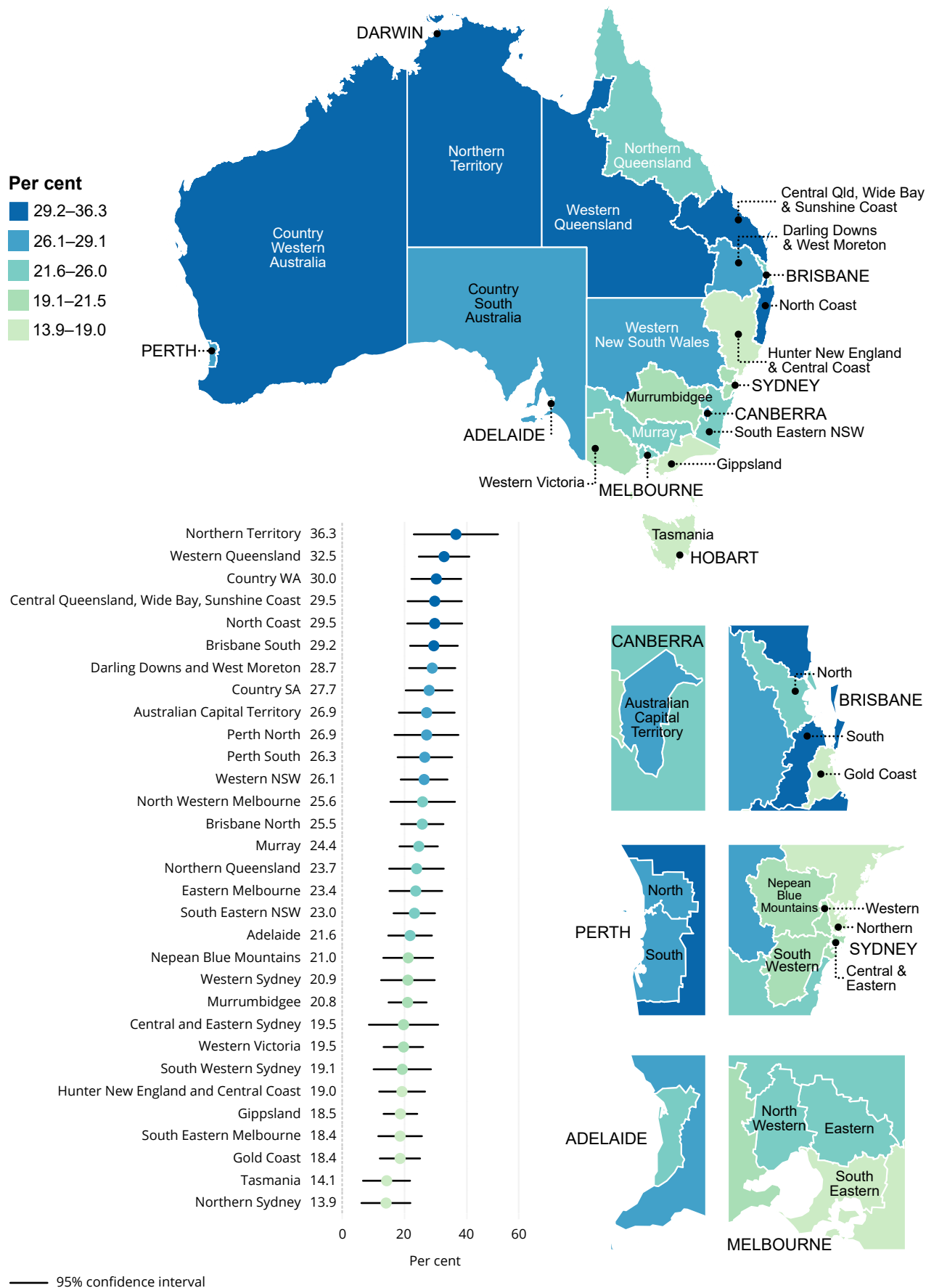


Figure 4.3: Patients aged 45 and over who reported their usual GP or place of care was not informed of their follow-up needs or medication changes after their recent visit to an ED, by PHN area, 2016



5 Discussion

'The provision of information about patients, quality, clinical guidelines, and costs that moves 'seamlessly' between the parts of the system has been a longstanding worthy aspiration of the Australian health system' (Productivity Commission 2017).

The rise of the digital age, development of new technologies, and advancements in the health and medical field create opportunities for timely sharing of information between providers and across the health system. This has the potential to increase the value of the information shared, and to create better coordinated, less fragmented care for the patient.

There is currently a lack of information that looks at continuity of care across Australia. This report shines a light on patient-reported experiences of information continuity. It brings together various patient-reported measures from the 2016 Survey of Health Care to assess where there is a lack of information continuity from a health-care provider back to a patient's usual GP or place of care.

One of the key findings from this report shows that having a usual GP only increases the likelihood of better information sharing across providers and settings, especially when compared with patients who have a usual place of care only.

Continuity with a usual GP is also associated with good communication between the patient and provider, and greater levels of trust with providers (Mainous et al. 2001). Other benefits of having a continuous GP-patient relationship include better diagnoses, better medication management, avoidance of repeat tests, and fewer hospitalisations (Hollander et al. 2009).

This section summarises the key findings, and discusses potential causes and implications in light of recent literature and policy initiatives.

Experiences of information sharing across age groups and remoteness areas

The findings show that a higher proportion of patients aged 45–54 had poorer information sharing from a health-care provider to their usual GP or place of care.

A paper by Taylor & Hill (2014), on behalf of the Deeble Institute, discussed consumer expectations and health care in Australia. It stated that there is a perception that older people are more likely to 'accept what they are given', and have lower expectations of health care when compared with others. However, research on patient-reported experience of health care in the United Kingdom found that older people (60 and over) had higher overall expectations of health care, particularly around communication with the doctor and the information they would receive, but they were more likely than others to feel that their expectations were met, and were satisfied with the health care received (Bowling et al. 2013).

It might be that people in the older age groups have a more established relationship with their usual GP. A previous report on the Coordination of Health Care study found that 71% of people aged 75 and over had been a patient of their usual GP for 5 years or more, providing opportunity to establish ongoing relationships with their GP, and resulting in better quality of care (AIHW 2018a).

The results also varied according to where people lived. For almost all measures, the results in this report show that patients living in more remote areas more often felt that their usual GP or usual place of care was not informed of their visits to other providers.

These findings are consistent with the results from the *Survey of Health Care: selected findings for rural and remote Australians* (AIHW 2018b), which showed that patients living in *Remote/Very remote* areas were more likely to encounter barriers to accessing nearby GPs and specialists.

One plausible explanation for these differences is that patients living in *Remote/Very remote* areas are more likely to have a usual place of care only (26% compared with 9% in *Major cities*), and patients with a usual place of care only are much more likely to experience poor information sharing.

Issues relating to access, such as the availability of appointments and turnover of medical staff in *Remote/Very remote* areas, might complicate the perceived continuity of information transfer from a patient perspective.

Since the implementation of the survey, the technological landscape has shifted. Recent improvements in infrastructure and technologies (for example, cloud-based and mobile technologies) could help increase access to improved care and information sharing in rural and remote areas. The National Digital Health Strategy identified 7 strategic priorities, including that health information is available whenever and wherever it is needed (Australian Digital Health Agency 2017). It also proposes the strengthening of telehealth in rural and remote regions to improve accessibility, quality, safety, and efficiency of health care for people living those areas.

Information sharing in Primary Health Network areas

Across PHN areas, the Northern Territory and, to a lesser extent Western Queensland, report worse experiences of information sharing than other PHN areas.

It is well documented that remote and very remote regions of Australia struggle to attract and retain adequate health workforce numbers, and that there is a high turnover of staff in these areas. This could explain why there was a greater proportion of respondents in Northern Territory PHN and Western Queensland PHN who have a usual place of care only (that is, no usual GP).

Some communities often have vacant health worker positions or are reliant on locums, so have no regular GP. These regions also rely on fly-in/fly-out and drive-in/drive-out models of care for specialist treatment. The 2017 Health Needs Assessment for the Northern Territory PHN highlighted how multidisciplinary care is negatively affected by the high staff turnover and reliance on fly-in/fly-out, drive in/drive out, and locum/agency staff (NT PHN 2017).

The PHN results could be attributed to the broader population characteristics, such as the Northern Territory's transient population. In 2018, the Northern Territory Primary Health Care Workforce Needs Assessment noted that this transience makes maintenance and transfer of health records difficult, particularly in coordinating primary health care (NT PHN 2018).

Gaps in information sharing between hospitals and primary care setting

Ensuring that appropriate arrangements are made by the hospital for any services needed by the patient after they leave is crucial to the transfer-of-care process from the inpatient setting to other care settings. It plays a key role in reducing re-admissions, and improving patient flow through health services. The ideal is to ensure a safe and seamless journey that ensures continuity for the patient (DHHS 2014).

Poor coordination or follow-up of patient needs leaves them at risk of possible re-admission to hospital, patient dissatisfaction, and inefficiencies in follow-up care for the patient (ACSQHC 2012).

A systematic review of literature to characterise the types of deficits in information sharing between hospital-based and primary care doctors found that delayed communication or inaccuracies in information transfer among health professionals can affect continuity of care, patient safety, patient satisfaction, and resource allocation (Kripalani et al. 2007).

The Survey of Health Care 2016 asked patients whether arrangements were made by the hospital for any services needed after their last admission.

Of patients who needed services to be arranged following their hospital admission, 20% reported that arrangements were not made by the hospital. However, the survey does not provide further detail on whether arrangements were made by another health-care provider, or what these arrangements might be.

Good practice suggests that transfer of care is communicated across relevant health-care providers, and should involve a GP (DHHS 2014). Following an acute inpatient service, the transfer of professional responsibility of patient care from one person to another can include to a patient, their GP, primary carer, family member, community service, or aged care facility (DHHS 2014). Any of these people might be involved in arranging follow-up needs for patients.

Health services are encouraged to monitor their own performance, especially at critical stages of the patient journey—evaluation of the effectiveness of transfer of care, and whether it aligned with patients' needs is one such measure, as is patient experience (DHHS 2014).

This type of context is important when considering patients with long-term health conditions, who benefit the most from coordinated and integrated care. Patients who had 3 or more long-term conditions were more likely to report that the hospital had not arranged services they required after their last admission to hospital than patients who had no long-term conditions.

Conversely, patients with no long-term health conditions were much more likely to report that there was inadequate information sharing from the ED to their usual GP than those who had 3 or more long-term conditions.

ED presentations for an acute and treatable or one-off condition might be successfully managed in a short-term hospital visit. Such patients might leave the ED after a matter of hours, and be able to actively manage their conditions post-visit, with little follow-up required from their GP. But a long-term health condition might complicate the treatment and ongoing management of a patient, who will then need closer monitoring from their GP.

The lack of information continuity from hospitals is also reported by GPs. GP dissatisfaction about the dissemination of aspects of a patient's experience in hospitals is common, with many not knowing that their patient has been to hospital at all (Productivity Commission 2017).

Initiatives such as Health Care Homes recognise the need for a central care coordination role for people with long-term and complex conditions. A Health Care Home is a general practice or Aboriginal Community Controlled Health Clinic that coordinates care for patients with chronic and complex conditions, to ensure better coordination and access to care for the patient. This includes communicating with a patient's specialist, and follow-up with the patient's hospital if they go to hospital (DoH 2018).

Electronic Health Record

There is currently a lack of interoperability between the health system infrastructure. This means that health information cannot always be readily communicated between hospitals and GPs, which often leaves the patient to re-tell their story and medical history to multiple providers. This can lead to both inefficiency and increased cost to the health system—especially where duplicate tests are ordered—and creates fragmented and discontinuous care for the patient.

Current policy measures in Australia recognise the need for a system that enables patients to manage their own health information in a way that ensures it is available across providers and health-care settings.

A national electronic health record system, the My Health Record, is currently being introduced to realise several benefits, including:

- improving continuity of care between providers
- improving patient care, particularly for those with chronic and complex health conditions
- improving patient safety
- improving medical communication
- reducing the need to re-tell medical histories
- reducing adverse drug events
- empowering patients to more fully participate in their health care
- enabling more public health research (The Senate Community Affairs References Committee 2018).

HealthPathways

More local solutions, such as an online health information portal called HealthPathways, have been developed and implemented by some PHNs.

HealthPathways aims to improve communication and collaboration across providers. Using localised pathways containing clinical and referral information, it can be used at the point of care by GPs, specialists, nurses, and allied health professionals to assess, manage, and refer patients (Capital Health Network n.d.).

6 Survey characteristics

Comparisons across provider types

Two main factors limit direct comparisons of information transfer from the different groups of health-care providers (specialists, hospitals, EDs, and allied health professionals) in this report. These factors are:

- variation in the questions asked of these different providers—for example, patients were asked about care received from a specialist, but only about follow-up needs or medication changes from a hospital admission or ED visit
- differences in standards and mechanisms for transferring information back to the primary care setting.

Scope of the survey

The scope of the Survey of Health Care 2016 was people aged 45 and over who had at least one GP visit in the 12 months between 24 November 2014 and 24 November 2015.

While this includes most people aged 45 and over, about 5.5% of people in that age group in the 30 June 2016 estimated resident population did not see a GP in the 2015–16 financial year.

For example, the following people would be out of scope:

- people who did not see a GP in the 12 months before selection of the sample, as they had been in good health and had not needed to see a GP
- people getting care elsewhere (exclusively), where services were not billed through the Medicare Benefits Schedule
- people who are not getting any care at all.

Findings from this report should not be generalised to apply to those outside the scope of the survey cohort.

Survey response

About 124,000 people were selected for the survey. Of these, 35,495 responded, a response rate of 29%. This low response rate might have introduced some non-response bias (that is, survey respondents and non-respondents might have different experiences and characteristics).

The survey has been weighted by the ABS to represent the population in scope of being selected in the survey, but there might be some residual bias that could not be corrected.

To measure this potential bias, the ABS compared the weighted Survey of Health Care 2016 cohort with other national surveys—the Patient Experience Survey 2015–16 (ABS 2016) and the National Health Survey 2014–15 (ABS 2015)—for the same scope of population. This analysis showed that the Survey of Health Care 2016 cohort generally had a slightly higher proportion of people with poorer health.

All survey mail outs included information about the study translated into 10 different languages. People from non-English speaking backgrounds were offered use of an interpreter through the Australian Government Translation and Interpreting Service (TIS) to complete the survey.

Next steps

In late 2018, the Survey of Health Care results were linked to Medicare Benefits Schedule statistics and Pharmaceutical Benefits Scheme data information to show actual health services and medicines used.

Future reports will analyse the results from linking the survey to state and territory ED and hospital data from 1 January 2014 to 30 June 2018. This will help to build a more comprehensive picture of patient journey and pathways of care.

Work is also under way to look at barriers to accessing care, including after-hours access and unmet need. There are also plans to explore the experiences of people with high health care needs.

More information on the Coordination of Health Care Study is available at: www.aihw.gov.au/reports-data/health-welfare-overview/health-care-quality-performance/data-sources

Appendix A: Technical appendix

Geography and sociodemographic characteristics

This report includes supplementary data tables that present information split by several geographies and sociodemographic characteristics. Information is reported at the national level, by state and territory, and by PHN areas.

Results are also reported by various sociodemographic characteristics, including:

- age group
- sex
- self-assessed health status
- number of long-term health conditions
- level of highest educational attainment
- number of people in household
- main language spoken at home
- private health cover
- remoteness area (using the 2016 Australian Statistical Geography Standard Remoteness Structure)
- socioeconomic group (using the 2016 ABS Socio-Economic Indexes for Areas Index of Relative Socio-economic Disadvantage)
- type of care setting
- type of usual place of care.

Measure definitions

Table A1 describes how the measures used in this report have been defined from the Survey of Health Care 2016 questionnaire. This is available from:

www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4343.02016?OpenDocument

People who did not respond to a question (generally a small proportion) are listed as having a response of 'Not stated', and have been excluded when calculating totals and proportions.

Other responses that are not very informative such as 'Don't know' have also been excluded from calculations of proportions.

Table A1: Definition of measures using Survey of Health Care, 2016

Measure description	Survey question	Possible responses
Did not have a health professional with a good understanding of health-care needs and preferences	In the past 12 months, was there a health professional who had a good understanding of your health, health-care needs and preferences?	<ul style="list-style-type: none"> ✓ Yes ✓ No ✗ I didn't have any health-care needs or preferences
Did not receive enough information overall about care or treatment	Overall, in the past 12 months, did you receive enough information about your care or treatment?	<ul style="list-style-type: none"> ✓ Yes ✓ No ✗ I didn't need information about care or treatment
Usual GP or place was never aware of health-care history	In the past 12 months, did your usual GP or others in your usual place of care seem aware of your health-care history?	<ul style="list-style-type: none"> ✓ Yes, always ✓ Yes, usually ✓ Yes, sometimes ✓ No, never ✗ Don't know ✗ I didn't see my usual GP or go to my usual place of care in the past 12 months
Tests, X-ray, or scan results always available at scheduled appointment	Thinking about the past 12 months, were your test, X-ray, or scan results always available at the time of your health-care appointment?	<ul style="list-style-type: none"> ✓ Yes ✓ No ✗ Don't know ✗ I didn't have a health-care appointment
Saw a specialist doctor in previous 12 months	In the past 12 months, have you seen any specialist doctors for your own health (excluding those you saw if you stayed overnight in a hospital)?	<ul style="list-style-type: none"> ✓ Yes ✓ No
Number of visits to a specialist in the previous 12 months	In the past 12 months, how many times have you seen a specialist doctor for your own health?	<ul style="list-style-type: none"> ✓ Numerical field
Number of different specialists seen in the previous 12 months	In the past 12 months, how many different specialist doctors have you seen for your own health?	<ul style="list-style-type: none"> ✓ Numerical field
Specialist did not have information or test results at least once in the previous 12 months	In the past 12 months, was there a time when a specialist doctor did not have your medical information or test results?	<ul style="list-style-type: none"> ✓ Yes ✓ No ✗ Don't know
Usual GP did not seem informed about specialist care after last visit in the previous 12 months	After the last time you went to a specialist doctor, did your usual GP or others in your usual place of care seem informed about your specialist care?	<ul style="list-style-type: none"> ✓ Yes ✓ No ✗ Don't know ✓ GP or others in my usual place of care didn't know until I told them ✗ I didn't go to my usual GP or go to my usual place of care after my specialist doctor visit ✗ I don't have a usual GP or usual place of care

continued

Table A1 (continued): Definition of measures using Survey of Health Care, 2016

Measure description	Survey question	Possible responses
Usual GP or place of care did not seem informed of follow-up needs or medication changes after last visit to ED	Did your usual GP or others at your usual place of care seem informed about your follow-up needs or medication changes, after the last time you went to the hospital emergency department?	<ul style="list-style-type: none"> ✓ Yes ✓ No * Don't know ✓ GP or others in my usual place of care didn't know until I told them * I didn't have follow-up needs or medication changes * I didn't go to my usual GP or go to my usual place of care after my emergency department visit * I don't have a usual GP or usual place of care
Arrangements were not made by the hospital for services needed after discharge	Thinking about the last time you were admitted to hospital, were arrangements made by the hospital for any services you needed when you left hospital?	<ul style="list-style-type: none"> ✓ Yes ✓ No * I didn't need any services
Usual GP or place of care did not seem informed of follow-up needs or medication changes after last admission to hospital	Did your usual GP or others at your usual place of care seem informed about your follow-up needs or medication changes, after the last time you left hospital?	<ul style="list-style-type: none"> ✓ Yes ✓ No * Don't know * I didn't have follow-up needs or medication changes ✓ GP or others in my usual place of care didn't know until I told them * I didn't go to my usual GP or go to my usual place of care after my hospital stay * I don't have a usual GP or usual place of care
Whether usual GP or usual place of care seemed informed about care provided by allied health professionals for physical health	Thinking about the past 12 months, did your usual GP or others in your usual place of care seem informed about care provided to you by health professional(s) (excluding GPs, specialist doctors, or nurses) for your physical health?	<ul style="list-style-type: none"> ✓ Yes, always ✓ Yes, usually ✓ Yes, sometimes ✓ No, never * I don't have a usual GP or usual place of care
Whether usual GP or usual place of care seemed informed about care provided by allied health professionals for emotional or psychological health	Thinking about the past 12 months, did your usual GP or others in your usual place of care seem informed about care provided to you by health professional(s) (excluding GPs, specialist doctors, or nurses) for your emotional or psychological health?	<ul style="list-style-type: none"> ✓ Yes, always ✓ Yes, usually ✓ Yes, sometimes ✓ No, never * I don't have a usual GP or usual place of care

✓ included in denominator; * excluded from denominator; highlighted options used in measure.

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CI	confidence interval
ED	emergency department
GP	general practitioner
PHN	Primary Health Network
TIS	Translation and Interpreting Service

Glossary

confidence interval: A range determined by variability in data, within which there is a specified (usually 95%) chance that the true value of a calculated parameter lies.

continuity of care: The relationship between a single practitioner and a patient that extends beyond specific episodes of illness or disease.

coordination of care: The deliberate organisation of patient care activities between 2 or more participants involved in a patient's care to help the appropriate delivery of health-care services.

information sharing/information continuity: The collection and sharing of information about a patient generated as a result of that patient's movement through, and engagement with, the health system. This information is ideally available to all health-care providers involved with that individual, to provide a smooth transition through the health-care setting. Information sources that are usually relevant to information continuity and sharing include (but are not limited to) pathology results, imaging, correspondence among health-care practitioners (GPs, specialists, allied health professionals), hospital discharge summaries, and shared-care plans.

long-term health condition: A health condition that is expected to last, or has lasted, 6 months or more, and has been diagnosed by a health professional. Respondents were specifically asked whether they had any of the following conditions:

- diabetes
- heart disease
- high blood pressure
- effects of a stroke
- cancer
- asthma
- chronic lung disease
- osteoporosis or low bone density
- arthritis
- mental health condition
- Alzheimer disease or dementia
- moderate or severe pain
- other long-term health condition/long-term injury.

primary care setting: The setting in which a patient receives their GP care. In this report, this comprises:

- a usual GP only
- a usual place of care only
- both a usual GP and place of care.

primary health care: Services that are delivered in many settings—such as general practices, community health centres, Aboriginal health services, and allied health practices (for example, physiotherapy, dietetic, and chiropractic practices)—that are delivered under numerous funding arrangements.

Primary Health Network (PHN): Primary Health Networks are administrative bodies developed to improve primary health-care delivery and coordination for the population they serve, and, in particular, those who are at risk of poor health outcomes. PHNs work across the primary and secondary health-care landscape, including GPs, other primary care providers, hospitals, and communities to deliver the right care in the right place at the right time. There are 31 PHN geographic areas in Australia. For more information, see: www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background.

remoteness areas: Regions divided up in each state and territory based on their relative accessibility to goods and services (such as to GPs, hospitals, and specialist care) as measured by road distance. These regions are based on the Accessibility/Remoteness Index of Australia, and defined as remoteness areas by the Australian Statistical Geographical Standard (2016). The 5 remoteness areas are *Major cities*, *Inner regional areas*, *Outer regional areas*, *Remote areas*, and *Very remote areas*. *Remote* and *Very remote* areas have been combined for analyses in this report, due to smaller numbers of patients in these areas compared with other areas. This is described further at: www.abs.gov.au/ausstats/abs@.nsf/mf/1270.0.55.005.

self-assessed health: A person's general assessment of their own health against a 5-point scale of excellent, very good, good, fair, and poor.

socioeconomic group: A population grouping that indicates how 'well off' a group of people are. In this report, socioeconomic areas are mostly reported using the Socio-Economic Indexes for Areas, typically for 5 groups—from those living in the lowest socioeconomic areas (worst off) to those living in the highest socioeconomic area (best off). The index value reflects the overall or average level of disadvantage of the population of an area; it does not show how individuals living in the same area differ from each other in their socioeconomic group. This report uses the Index of Relative Socio Economic Disadvantage 2016, available at: www.abs.gov.au/ausstats/abs@.nsf/mf/2033.0.55.001.

usual GP: The general practitioner whom a person visits for most of their health care.

usual place of care: The usual place to which people go if they are sick or need advice about their health. Examples of usual place of care settings include a clinic with GPs only, a clinic or with GPs and other health professionals, a community health centre, an Aboriginal Medical Service, or, for some patients, a hospital emergency department.

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Safe and high-quality health care depends on the sharing of health information between health-care providers. In 2016, nearly 1 in 4 patients reported inadequate information sharing between the emergency department they visited and their GP or usual place of care. This report looks at gaps in information sharing between providers, using the 2016 Survey of Health Care.

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