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Strengthening emergency department to community partnerships: qualitative insights from four local health districts in New South Wales

Kanchan Marcus, Philip Haywood and Maria Gabriela Uribe Guajardo
Leeder Centre for Health Policy, Economics and Data, School of Public Health, The University of Sydney, Newtown, Australia
Alison Austen
Central Coast Local Health District, Gosford, Australia
Marguritte Battye
Murrumbidgee Local Health District, Wagga Wagga, Australia
Patrick Bolton
South Eastern Sydney Local Health District, Caringbah, Australia
Miranda Shaw and Shannon Saad
Sydney Local Health District, Camperdown, Australia
Paul Anthony Esplin, Althea Barry and Jenny Cox
South Eastern Sydney Local Health District, Caringbah, Australia
Lisa Parcsi
Department of Clinical Services Integration, Sydney Local Health District, Camperdown, Australia
Angelina Lee
Central Coast Local Health District, Gosford, Australia, and
Carmen Huckel Schneider
Leeder Centre for Health Policy, Economics and Data, School of Public Health, The University of Sydney, Newtown, Australia

Abstract

Purpose – The compounded disadvantage for individuals with unmet social and health care needs often leads to frequent emergency presentations. In Australia, New South Wales, the Emergency Department to Community (EDC) program was devised to support intensive care coordination for patients with complex care. With a lack of qualitative evidence, the aim of this study was to explore the barriers and facilitators of forming, implementing

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and sustaining partnerships with EDC stakeholders in four local health districts: Sydney, Central Coast, South Eastern Sydney and Murrumbidgee.

Design/methodology/approach – Data collection (March–July 2025) comprised documentary analyses of EDC documentation and interviews and focus groups with stakeholders, the allied workforce and community providers. Approvals were obtained, all data were de-identified and data saturation was achieved. Thematic analysis was undertaken pragmatically within the School of Strauss and Corbin. An adapted version of Wodchis's policy framework was applied to assess subtheme alignment and sustainability of EDC partnerships. Triangulation between data sources was undertaken, and a roundtable was held to verify findings. Governance was provided by a steering committee with representatives from LHDs.

Findings – In total, 48 documents and 53 interview/focus group data were analysed. Four key themes are described: EDC patients have diverse complex needs and deep mistrust in the system. Multidisciplinary working and collaboration through cross-sectoral meetings, emergency department (ED) management plans and technological systems helped break silos and connect care across settings. Hidden work, which is not captured in data metrics, was often led by program champions and generalists that build rapport and bridge gaps in care coordination with multiple specialists. The impact of EDC was consistently echoed as "great" with staff satisfaction and a perceived reduction in ED presentations.

Originality/value – The EDC program delivers trauma-informed care for people with complex needs who are excluded from standard care models. Hidden labour and generalists are critical in building connections and rapport with specialists across health and social sectors. The program's policy and social impacts align with equity, supporting the quintuple aim and sustainable development goals by prioritising support for the most disadvantaged groups.

Keywords Intersectoral collaboration, Delivery of health care, Qualitative evaluation, Multidisciplinary teams, Collaborative care

Paper type Research article

Introduction

The quintuple aim comprises an equity focus across five domains: enhancing patient experience, improving population health, reducing costs, supporting health worker well-being and advancing health equity (Bodenheimer and Sinsky, 2014). Unmet health and social needs, particularly in cases involving chronic conditions, multimorbidity, disability, psychological factors and housing instability, among other complex conditions, often result in emergency department (ED) presentations, highlighting gaps in coordinated care (Baird *et al.*, 2021). These overlapping health-social conditions don't exist in isolation but interact in ways that amplify vulnerability and complicate treatment. A review confirmed that marginalised populations face significant gaps in health literacy, limiting their ability to navigate complicated systems and the need for integrated care models (Baker *et al.*, 2022).

Scholarly evidence highlights several types of integrated care models to support complex care needs, including case management approaches, individual care plans, chronic care models and the Kaiser Permanente model, among others (WHO, 2016). Taxonomy for integration also varies, with horizontal (between services), vertical (across services) and sectoral (within sector) forms of integration as defined in existing taxonomies of integrated care (Goodwin, 2016). Overall features of integrated care include shared principles, a common strategic vision, joint funding and service delivery, as well as collaborative evaluation and continuous quality improvement (WHO, 2016). In this study, integrated care refers to the effective coordination of organisations, staff and stakeholders working collaboratively to understand patient needs and deliver joined-up services that improve patient outcomes (Goodwin, 2016).

In Australia, the healthcare system is a mixed model, comprising publicly funded universal access to public hospitals with no out-of-pocket costs, subsidised access to independent primary and specialist care via the single-payer Medicare scheme and a private health sector for which patients can purchase voluntary insurance and out-of-pocket fees (Palmer and Short, 2014). Public hospital services funding and accountability are shared between federal, state, territory and local governments through pooled funds (Duckett and Willcox, 2022). In 2019, there were 682 public hospitals across Australia with 26% in urban locations (Duckett and Willcox, 2022). Primary care includes general practitioners, allied services and not-for-profit providers, with 31 primary health networks that support practice improvement and the commissioning of population health-oriented programs (Duckett and Willcox, 2022). The Australian Department

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of Social Services provides support to the most vulnerable families and co-delivers the National Disability Insurance Scheme (NDIS), which was rolled out nationally in 2020, supporting adults and children with disabilities. Fragmentation between health and social care results in gaps for individuals with highly complex needs that intersect between multiple areas such as disability, mental health, housing and medical conditions (Eastwood *et al.*, 2020; Uribe *et al.*, 2023). Adults aged 25–64 made up 45% of all ED presentations across Australia (AIHW, 2025), underlying the unmet needs of groups that don't fit eligibility criteria for other programs.

In New South Wales (NSW), the Emergency Department to Community (EDC) initiative provides intensive case management and specialist care coordination to individuals, improving their health-social care and reducing the need for hospitalisation. The EDC program evolved from the checkpoint initiative, targeting patients with frequent ED use, defined as 10 or more presentations over 12 months (Baird *et al.*, 2021) with South Eastern Sydney criteria of 17 + presentations. Eligibility criteria require patients to be 18 to 65 or 70 years old, depending on LHD (as other initiatives are available for older adults); have ongoing health conditions; engage with multiple services and present with complex care needs. Patients presenting 10 or more times are flagged in a portal for review. These individuals are often highly disadvantaged, experiencing complex intersecting challenges such as disability, mental health issues, unstable housing, alcohol use, co-morbidities and chronic pain. Referral pathways vary by local health districts (LHDs) and can include direct ED referrals or ambulance referrals into the EDC program. Dedicated EDC nurses or social workers conduct deep file reviews to identify care gaps and present cases to multidisciplinary teams (MDT), which include allied health and specialist input. Care plans are developed collaboratively, with patient consent and goals guiding coordination. Discharge from the EDC initiative occurs once care is linked across services in community and primary services including general practitioners, NDIS, housing and non-government organisations (NGOs). Care coordination is a central focus of the EDC initiative, which emphasises continuity of care across community and primary care settings to ensure safe discharge and sustained support beyond the hospital. Accordingly, this paper focuses upon care coordination.

A growing body of quantitative evidence shows that integrated care can improve health outcomes and reduce costs (Baird *et al.*, 2021; O'Callaghan *et al.*, 2022). Yet, qualitative research that explores the deeper challenges and opportunities to strengthen EDC remains limited. Furthermore, partnerships working is central to integrated care (Glasby and Dickinson, 2009), helping reduce duplication and support shared outcomes, yet it remains challenging to achieve in practice. Evidence also underscores the need for strong relationships and cultural understanding (Glasby and Dickinson, 2009), but how these dynamics operate within Australian health and social care initiatives is still largely unknown. To address this gap, the aim of this study was to explore the barriers and facilitators of forming, implementing and sustaining partnerships with EDC stakeholders and assess context-specific insights on what works well to strengthen EDC partnerships in four LHDs: Sydney (SLHD), Central Coast (CCLHD), South Eastern Sydney (SESLHD) and Murrumbidgee (MLHD). Explicitly, this paper identifies EDC partnership mechanisms across LHD contexts, characterising coordination roles as relational infrastructure and information sharing to support continuity of care.

Methods

Setting

The qualitative evaluation was based on a rigorous concurrent design (Creswell and Creswell, 2018), comprising documentary analyses and interview and focus groups with stakeholders, allied health professionals and community providers in four LHDs in NSW. This pilot project was conducted within 12 months (September 2024–September 2025), and a roundtable was held with stakeholders to validate findings and provide feedback. Study governance, co-design and researcher positionality are provided in Appendix A, Table i.

In 2021, there were 346,596 people residing in the regional area of CCLHD (ABS, 2021). There are two major hospitals in this region with EDs, one healthcare centre, one hospital without

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an ED and nine community health centres. There is a large Aboriginal population in this region, and 17.9% of residents have a bachelor's degree or higher, which is lower than the NSW average of 27.8% (ABS, 2021). Long-term health conditions are generally higher than the NSW average; for instance, 11.5% have arthritis in CCLHD compared to 8.4% in NSW (ABS, 2021). Mental health conditions are slightly higher at 11% in this region compared to 8% in NSW. In MLHD, a total of 249,164 persons reside across this rural geographic area as of 2022, spanning 125,243 kilometres (MLHD, 2024). The region is home to 33 public hospitals and 12 community health centres, many of which serve areas of significant disadvantage – where approximately one in 17 people live with a profound or severe disability (MLHD, 2024). Aboriginal people make up 5.9% of the population in MLHD, higher than the NSW average of 3.4% (MLHD, 2024). In SESLHD, there are over one million people living in the urban location (NSW Government, 2025). This comprises 8 public hospitals, and by 2040, the total population residing in this area is expected to grow to over one million people (NSW Government, 2025). Around 40% of residents in South Eastern Sydney are born outside Australia, with nearly one-third originating from countries where English is not the primary language (SESLHD, 2024). SLHD is an urban location, servicing 705,482 people as of 2025 (NSW Government, 2025). The region comprises 7,000 Aboriginal people and a large population experiencing homelessness, widespread housing insecurity and the highest concentration of boarding houses in NSW (SLHD, 2025). Mental health conditions affect approximately one in five residents, while 8% are living with diabetes. Additionally, 7% report managing a long-term health condition (SLHD, 2025). Significantly, in SLHD the EDC program operates under Australia's first virtual hospital model, whereby virtual consultation is accessible to patients day and night using video/phone services.

Participants

In-depth semi-structured interviews and focus groups were conducted with key stakeholders, allied health professionals and community-based decision-makers. Purposive sampling was undertaken and broken into phases. For this process, each LHD lead compiled a list of potential participants that had been involved in EDC cases or meetings about EDC patients, including specialists and executive workers that were involved in EDC implementation. This list included participants from various sectors, including integrated care nurses, social workers, mental health teams, drug and alcohol teams, ambulance, NSW Indigenous support workers, not-for-profit organisations, general practitioners and NDIS providers. This was also comparatively checked across the four LHDs to ensure representativeness at meetings. In phase one, participants were initially invited if they were actively involved in EDC programs with LHDs but were not part of the EDC Steering Committee. The second phase of sampling involved inviting participants with minimal EDC involvement – for instance, health staff that hadn't specifically referred patients to the EDC program. The final phase of sampling involved inviting EDC Steering Committee members to participate, as they were deeply engaged in EDC programs in their LHD. This was done to minimise research bias and to support the achievement of data saturation prior to the last phase of sampling.

A participant information sheet detailing the study was emailed by LHD administrative staff who disseminated the study. Those interested in participating contacted the first author directly by email who answered any questions. Participants were given the choice to take part in either a focus group or an individual interview, depending on their comfort level. Interview or focus group times were scheduled based on participants' availability and preferences. Verbal consent was obtained from all participants prior to the interview or focus group. Note: a limitation to this study is the lack of service user feedback due to resource constraints.

Data collection

Data collection comprised EDC planning documents for documentary analyses and interview/focus groups. Data collection began in March 2025 and was completed in July 2025. A roundtable was also held for triangulated feedback from a wide range of stakeholders, but this

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is to be described elsewhere. In documentary analyses, EDC planning documents were digitally provided by the four LHD site leads to the research team, all of which comprised de-identified implementation data. Interviews and focus groups were conducted online using Microsoft Teams and transcribed verbatim (note, the below quotes have been cleaned for ease of reading). Audio recordings were captured using a handheld Olympus digital device to ensure transcription accuracy. While auto-transcription from Microsoft Teams was used during interviews, the digital recordings served as a reliable source for verification and correction. Interviews/focus groups lasted between 25 min and 60 min in duration. All interviews were de-identified and audio recordings permanently deleted after transcription corrections. Data saturation was achieved from interviews/focus groups when there were no new concepts, ideas or meanings being reported (Corbin and Strauss, 2008).

Data analysis

Grounded theory principles within the school of Strauss and Corbin were used pragmatically to support thematic analyses (Corbin and Strauss, 2008). Inductive open coding (line by line) enabled concepts to emerge directly from participants' accounts and documents. Theoretical sampling was employed when early analysis revealed differences between LHDs; additional participants were sought from sites where gaps or divergences appeared to deepen understanding of why these variations occurred. Constant comparison was used throughout to refine categories by examining similarities and differences between LHDs, and regular memoing was undertaken by the first author. Analysis was conducted manually into two separate Excel worksheets for documentary analysis and qualitative interviews as the first step. A second stage of axial codes and subthemes were iteratively undertaken using a constant comparative method, moving back and forth between the data. Thirdly, codes and subthemes were sorted into barriers and facilitators (Appendix C, Table iii) and then deductively into a modified version of Wodchis's policy framework to examine alignment between sub themes and assess sustainability of EDC partnerships (Wodchis *et al.*, 2020). The adapted version of Wodchis's framework included governance, funding, multidisciplinary dynamics, value, data and information sharing. Overarching themes were inductively devised by grouping subthemes and interpreting patterns and differences (Corbin and Strauss, 2008). Triangulation occurred in two stages; findings from documentary analysis were compared with interview and focus group data to corroborate, refine or challenge participants' accounts. The second stage involved a roundtable with 25 stakeholders where preliminary findings were presented for feedback and verification.

All stages of coding and analyses were undertaken with the University of Sydney team on a fortnightly basis, the working group on a monthly basis and the EDC Steering Committee on a three-monthly basis. Barriers and facilitators were also synthesised into system-, meso- and micro-levels within a separate Excel worksheet. All data were de-identified and analysed in Excel. Note: theory generation was not the aim of this study.

Results

In total, 48 documents were analysed (provided in Appendix A, Table i), data were collected from 53 interviews and focus group participants. Of these, there were three focus groups of CCLHD participants which had two–three participants in each (see Appendix B, Table ii). Enrolments into the EDC initiative varied between 15 and 50 participants each month, depending on LHDs.

EDC patients

Complex needs and circumstances of patients

The population for the EDC program focuses on individuals with complex and intersecting health and social care challenges, including chronic health conditions, intellectual disability,

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persistent pain, mental health issues, substance use, housing instability and social disadvantage, among others. These overlapping needs often go unmet in fragmented systems, leading to cycles of crisis and disengagement from care.

> . . . So complex especially with the cohort . . . with the intellectual disability who haven't really seen any specialist since they kind of left their pediatric years kind of lost between the cracks . . . they have floated through the community relatively undetected for quite some time and it's not until there's something breaking down that they're then presenting it might be lower socio economic barrier, cultural barriers, and obviously the intellectual disability . . . it's just a circle so I feel like the program has really helped in picking up maybe those missed pieces that there isn't an established pathway (MLHD, Allied Health Professional)

The EDC supports a highly individualised cohort often falling through systemic gaps. This includes younger individuals ineligible for aged care or NDIS or older adults in regional areas with limited aged care services in community or younger patients with intellectual disability, inappropriate housing, homelessness or guardianship arrangements, often presenting with multimorbidity, disability, pain-related issues or complex behaviours. EDC plays a critical bridging role, especially for younger adults with mild to moderate intellectual disability, who have remained undetected in mainstream systems until crisis points emerge.

> . . . young adults with the intellectual disability who haven't really seen any specialist since they kind of left their paediatric years . . . EDC has really helped . . . pulling them out of the mainstream cohort . . . making them available to services like us . . . (MLHD, Allied Health Professional)

Trust, logistical challenges and interacting with the health system

Participants described a deep erosion of trust in the health system among the EDC cohort, often rooted in past experiences of dismissal, misdiagnosis, trauma and fragmented care during vulnerable moments. This breakdown in trust led some to disengage, delay care or rely on crisis services. Rebuilding trust requires time, better service coordination and respectful care.

> . . . the cohort of patients already have a fractured relationship with health services so they're reluctant to often even to engage with us . . . they already don't trust health services, they don't want more health services involved . . . (SLHD, Allied Health Professional)

EDC patients face compounded challenges: obesity, mental health conditions and disabilities, alongside systemic barriers such as limited mobility, inaccessible transport, stigma and difficulty navigating services not designed for their needs.

> . . . We had a guy who hadn't left his house in 20 years so he's like a 40 something year old, so wasn't known to any healthcare professionals . . . (MLHD, Allied Health Professional)

Multidisciplinary working and collaboration

Breaking down silos

Participants reported that the EDC program is reducing silos and supporting patients with the social determinants of health. While no single service can address every issue, EDC is helping bridge the gaps between fragmented systems.

> . . . we need to work better . . . but the siloing that occurs in programmes being delivered to support exactly the same people . . . the system needs to come together and say this cohort really needs a one system support approach, not a let's integrate a care-give money for EDC let's you know mental health give it for that reason, drug and alcohol that reason you know I think we need to really come together . . . (MLHD, Stakeholder)

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Emergency departments (ED)

ED is an acute setting, while frequent ED presenters require coordinated care across multiple services, such as pain management, mental health support, disability, housing assistance and substance use treatment.

> . . . these patients are always really complex and it's very challenging to you know what we in ED -it's very challenging to know what to do . . . hard to get everyone on board particularly after hours and it's hard to have the time to really you know and get an intervention that's going to make a difference when the whole picture is just so complex so I think that the intensive nature of it, the fact that the ED to community team can really sit down and take a step back and get everyone involved, you know, means that they get a better holistic picture of the patient. (SLHD, Allied Health Professional)

Patients face significant barriers to timely access of bulk-billing General Practitioner (GP) services, while specialist care is often unaffordable and transport costs add further strain. As a result, EDs become the default "free" option, where patients are guaranteed care and not turned away.

> . . . you've got people who can't get into their GPs, but they also there's no transport after hours, so their home care providers don't work after hours and you know they're sick or alone and so they can get an ambulance for free and they don't have transport . . . the cost of the GP . . . and just back to the ED . . . (CCLHD, FG, Allied Health Professional)

EDC staff continue to actively promote the program to ED staff and build rapport.

> . . . but we've done a lot of education with staff in emergency departments and also other sort of key stakeholders about identifying these people earlier cause the research actually picked up the earlier that we identify them and intervene, the more successful we are at redirecting their care . . . (MLHD, Allied Health Professional)

Interprofessional collaboration

MDT meetings or case conferences were highly valued as well as shared care plans. This was perceived to be driving improved patient outcomes through cross-sectoral communication. Online MDTs have proven valuable for enabling collaboration, particularly by allowing specialists to participate from various locations, including rural and regional areas.

> . . . I love the fact that we can have stakeholders meetings and yeah. (SESLHD, Allied Health Professional)

These meetings also support case-specific engagement, with external partners such as NDIS providers and NGOs increasingly involved. The whole of health integration, holistic care or patient-centred care was echoed by participants in the four LHDs.

> . . . whole of health committee pulls together a large number of services across the district to encourage integration of thinking and development of models of care and to essentially communicate widely about all the services that are available to assist with improving outcomes for patients, but effectively the movement from hospital to community . . . (SLHD, Stakeholder)

Allied health professionals were sharing expertise across districts to support complex needs, while mental health teams were improving access to justice-related information that they can access. These collaborative efforts reflect a growing culture of capacity building and integrated service delivery.

> . . . this is where the beauty of having mental health on the ED to community because they have access to things around justice, stuff that we don't have access to so they can tell when people are incarcerated or when they're, you know, in other housing and stuff so having that communication pathway has been really helpful as well and having the Police, Ambulance, Clinical, Early Response (PACER) team

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> having us aware of the PACER team and what they can do is being beneficial as well. (CCLHD, Allied Health Professional)

Informal communication

Effective service delivery was deeply rooted in cross-disciplinary and sectoral collaboration, with informal, conversational approaches often replacing formal referral pathways. Success varied depending on the willingness and organisational culture of partner services, but where engagement was strong, outcomes improved significantly.

> . . . you cannot underestimate relationships with other key stakeholders because if you don't have that, it's really hard to progress anything with the client . . . (SESLHD, Allied Health Professional)

Hybrid virtual and face-to-face communication across teams was meaningful, involving staff, community providers and patients. Informal networks flourished through shared office spaces, known contacts and former staff, helping build trust and continuity.

> . . . I often get called from the ward to say can you come in and chat to him and calm him . . . I'm not even based in the hospital and I do go in cause I want to help, you know, make sure my client is able to access the right care and also to support the staff . . . the staff don't have the time in the hospital to build that relationship with people and then I know the client . . . (SLHD, Community Provider)

Information management and electronic medical record (EMR)

There was consensus from all participants that electronic medical records (EMR) are "clunky" and technological systems are not supporting care coordination. Information and notes sit in multiple systems, and it was described as easier to talk to someone than look at EMR.

> . . . if you look at EMR – you're much better off talking to the people involved, it's much quicker than trawling through documents yeah . . . (SLHD, Allied Health Professional)

> . . . I still have trouble trying to find if someone has an ED Management Plan because they're hidden in the background . . . (CCLHD, Allied Health Professional)

ED management plans were a core enabler that supports consistency in care provision across hospital sites, especially when staff turnovers occur. However, finding ED management plans is hidden in the EMR. To help mitigate this issue, a "pop-up-alert" was suggested for where the ED management plan is located in EMRs.

> . . . I was speaking to a patient yesterday who was in tears because they'd been to another hospital and there for 8 hours, they'd said, "I've got an ED management plan". No-one checked it. Then of course like it got to the point where they're about to discharge against medical advice. They were basically crying, saying why won't someone check it? Of course, someone finally checks it and goes oh, why didn't you speak up and then immediately followed the plan, which was great. And they got the pain relief and you know it all worked perfectly from there . . . (SLHD, Allied Health Professional)

Tools like shared care plans and "live" templates played a key role in collaboration and MDT for patient-centred care. On the contrary, barriers included the inability to see management plans across systems and sites.

> . . . and you can see data across different LHDs but you can't see management plans and so that's been quite problematic . . . (SLHD, Allied Health Professional)

Gaps were also reported with incompatible information technology systems and varying locations of health information that is not updated in a standardised or efficient manner.

> . . . databases are . . . growing and they're ad hoc . . .. got the Primary Health Network, have a great Health Pathways that they have is really good however, you send all your information on a person and

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> then they've got to go in and update all these 16,000 different pages . . . I don't think that the process of keeping that updated is necessarily efficient. (MLHD, Allied Health Professional)

The majority of participants echoed *hope* for the new single-patient digital system that will resolve some of these issues. However, the digital system will be hospital-LHD-wide and not link into primary care sectors.

> I'm hoping the new system will allow for additional space to have that documented in a way that's easy for the user to find . . . (MLHD, Allied Health Professional)

Accountability and responsibility

While MDT or case conferencing was central to integrated care, few participants reported challenges around role clarity, capacity, duplication of effort and uneven distribution of responsibilities, especially staff who are often at capacity.

> Yeah, like I suppose that that's the MDT approach, where there might be all of these disciplines involved, but who's going to be coordinating that care around the consumer? So I think that coordination is really missing in a lot of cases yeah . . . the health professionals are already quite busy and kind of burning out . . . (MLHD, Allied Health Professional)

Challenges were also reported in engagement with some health teams that may be at capacity; however, external providers were keen to be involved due to funding pathways.

> . . . there are groups that we've tried to involve that that don't seem to want to regularly engage and I can understand that it's probably got to do with their own workload (laughs)! You know external care providers are usually very willing to help because they're getting paid – their funding comes from somewhere else, and it's a possible client to them . . . (CCLHD, Allied Health Professional)

Participants also expressed concerns regarding the expectation that community-based providers address both mental health and disability needs, often leading to a cycle where individuals return to EDs due to poorly coordinated care.

> . . . hospital is there for medical emergencies and now it has become almost what you could call a dumping ground for NDIS people that have mental health issues or that are homeless . . . an argument between whose responsibility it is and so like NDIS responsibility – but we don't do mental health and then the hospital says, well, it's not medical, but we're not putting that person into the mental health area because it's NDIS so it just goes round and round . . . (CCLHD, NDIS provider)

Hidden work

Champions

EDC staff and teams were consistently going beyond their formal roles to advocate for patients and coordinate complex care needs. Nurses were stepping into social work functions, handling guardianship paperwork, navigating housing for homeless individuals and securing aged care supports. Operating under tight budgets, teams were expected to "do more with less", often engaging in investigative work to resolve care gaps. Medical leads and allied EDC staff were highly valued by cross-sector partners for their openness, collaboration and commitment to bridging service silos.

> . . . Yeah definitely funding like everywhere – it's just do more with less I'm not a social worker, I don't have connections, we don't have safe housing in a lot of our small towns these are our like so our frequent Flyers, our ED to community patients are our most vulnerable people and we're just letting them down –they have the poorest health literacy and they can't so I have literally just driven to someone's house to pick up their oxygen concentrator because we don't have we don't have a

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> wardsmen here in the town . . . so I've taken an admin staff and the nurse practitioner off the floor so we could take the partner of this woman to go and get her own concentrator. (MLHD, Allied Health Professional)

Staff were going above and beyond their defined responsibilities to fill service gaps without additional resourcing support. While this aligns with the care coordinator function in some LHDs, the way this role is enacted can vary significantly by location. In remote areas like MLHD, staff juggle multiple roles across districts, with persistent outreach efforts to engage vulnerable individuals.

> We were told that there was all this funding for EDC – they're doing this big programme to make sure that these people don't keep presenting to hospital, but basically it's falling back on our care coordinators to see that that happens, but with nothing extra given to them . . . (CCLHD, Allied Health Professional)

> . . . so it's that interagency and if they can link them into kind of social support networks locally, if they can do that – none of this has any system visibility . . . (MLHD, Stakeholder)

Generalists and specialists

Participants reported that generalist roles were just as fundamental as specialist roles and act as a "bridge of communication" between multiple different specialities. Generalist staff fully coordinated and advocated between and within all required services for a complex-needs' cohort.

> . . . probably the easiest way to get expertise is by being narrow so we have a hospital full of . . . "narrowests" . . . but what that misses out is that sometimes people need generalists and so I sometimes describe myself as the mortar between the bricks . . . (SESLHD, Allied Health Professional)

There was consensus across the four LHDs that conducting the file review work is highly time-consuming and often requires specialist input.

> . . . the time that it would take to do the file reviews to see who's presenting to ED, to maybe gather a bit of a background as to as to what that might be, run a safes script right, look at their ED profile like their GP . . . contact the relevant people – even communicate with the person, introduce yourself, build that rapport – that is time consuming! Really time consuming, running the multidisciplinary case conferences, coordinating that, contacting the right services, really time consuming . . .(MLHD, Allied Health Professional)

Rapport building

EDC staff were building rapport with hospital-based health workers across different departments as well as building connections with patients and community providers – who often operated as "lone rangers", valuing the support of EDC teams in coordinating care.

> . . . they don't often do face to face is my understanding but with my client because there was quite significant support needs and I think there was obviously the feedback and the history of engagement with ED and inpatient like when he's on the ward he'd been quite difficult . . . he got to really trust the team and was able to like really listen to what the team was saying and that helped him in his decision making . . . (SLHD, Community Provider)

Connections between NDIS providers, aged care services and health workers were also fostered through inter-reach meetings, word of mouth in ED or conference workshops. Additional suggestions for building cross-sectoral and departmental connections were shared workshops and education days.

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> . . . instigated a meeting once every two months including the hospital and all the service, a representative goes and sometimes one of the nursing aged care facilities, they go so we just sit there at lunchtime and have a bit of a mull over what's happening, if there's anything new from My Aged Care . . . have rapport with the NDIS workers as well, there's lots of service providers in town . . . a lot of my clients are under 65 so they might need to be referred to NDIS . . . (MLHD, Allied Health Professional)

Impact of EDC: "great program"

Participants reported the EDC program was highly valuable, particularly for reaching individuals who don't fit neatly into existing service categories and benefit from coordination to more appropriate supports. Participants stated that it not only improves outcomes for these individuals but also eases pressure on EDs, waiting rooms and hospitals, especially for people with disabilities who may otherwise have traumatic experiences in hospital settings.

> . . . definitely a great program I feel as though the program really is tapping into a missed cohort of people . . . that don't fit into any particular box who need that kind of soft redirection to other more appropriate services . . . not only is it good for the person, but it's good for our health system, it's good for our EDs, our waiting rooms, our wards. It's good for people with disability to not be traumatised by their presenting to hospital and that experience in ED . . . I'm hoping that it still continues cause that's where most my ED referrals have come from (laughs). (MLHD, Allied Health Professional)

Impact of the EDC program on hospital staff, LHDs and staff reported patient outcomes

According to participants, the EDC program has had a positive impact for LHD hospitals, with perceived reductions in ED presentations, while creating a safer, more compassionate environment for both staff and patients.

> . . . had success . . . we've linked them in . . . some of them are missing that ability to grab together and coordinate their cares outside of the hospital so that's where the team that links it all – so once it's in place, yes, that then ends up being less presentations . . . (CCLHD, FG, Allied Health Professional)

Cross-sectoral and department silos

Participants reported that while no single service can address every issue, EDC helped bridge gaps between fragmented systems. Currently, many programs, particularly in mental health, drug and alcohol services and EDs operate in silos despite serving the same populations. The EDC model of care presents an opportunity to unify these efforts and adopt a coordinated, whole-of-system approach to care. This was echoed in program implementation documents, which emphasised the importance of strengthening partnerships with both internal and external providers.

> . . . but also being visible and the teams knowing we work together with them and we work in the community and not in ED – I think there's sometimes a misconception that if you're not in the ED space, you don't work in the ED space . . . (SESLHD, Allied Health Professional)

Culturally appropriate care

EDC staff supported culturally appropriate care for Aboriginal and Torres Strait Islander (ATSI) populations by taking a holistic approach, investing time to develop comprehensive ED management plans that guide clinicians, especially in the ED where doctors rotate frequently.

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. . . one of our (ATSI) patients . . . how we could help her find other ways cause at that time it was a busy-ish ED and she would be frustrated waiting . . . but because it wasn't within the normal medical model we had to work something else out . . . (MLHD, Allied Health Professional)

Participants voiced that the program is considered essential and worth continuing.

. . . It's been great, the NDIS has come on board . . . (CCLHD, Allied Health Professional)

The quintuple aim is used as a policy frame (Bodenheimer and Sinsky, 2014) to interpret the implications of the findings (Figure 1) to help situate the themes within broader system-level priorities. The EDC program operates as a "boundary spanner" with a trauma-informed approach that rebuilds trust with vulnerable populations by addressing complex health, medical, disability and social needs. Success hinges on EDC's ability to take on high-risk patients, relational infrastructure and the hidden work of care coordination, such as advocacy, cross-sector collaboration and problem-solving, which are undervalued by current funding models. Theoretically, this aligns with the quintuple aim by promoting equity in access to

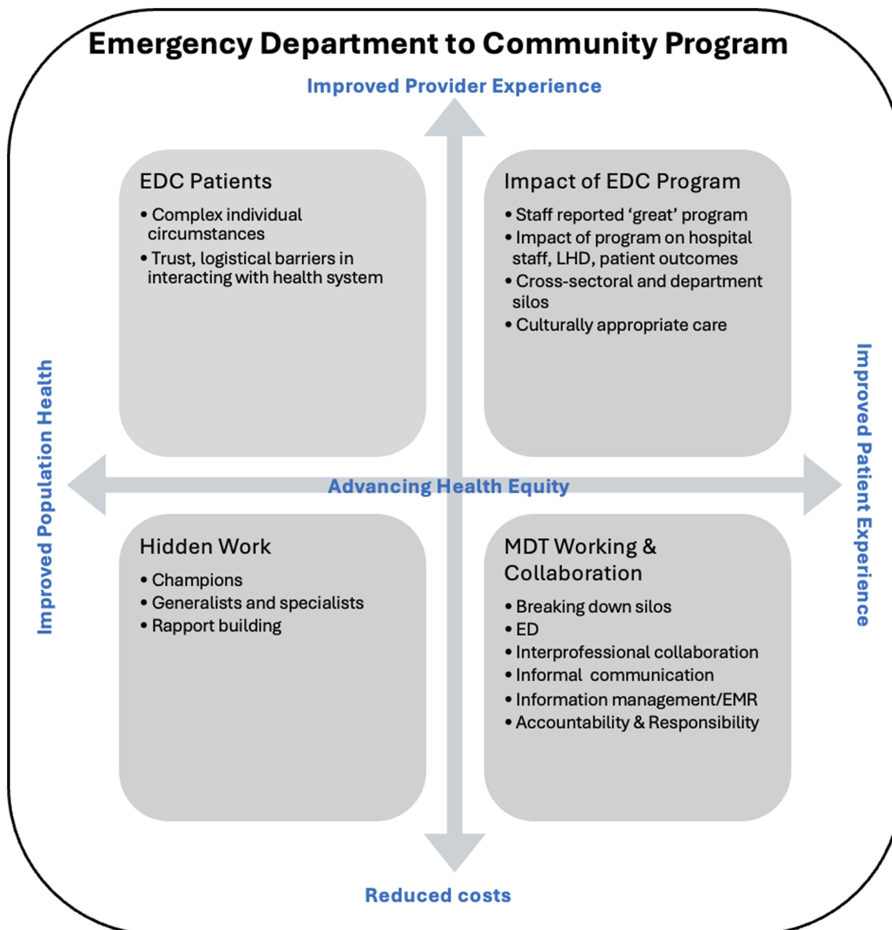

Figure 1. Findings align with the quintuple aim with an emphasis on equity for the most disadvantaged populations. Source: Authors' own work

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health and social care for the most disadvantaged patients in society. It enhanced staff satisfaction as per direct participant feedback, fostered interdisciplinary collaboration via regular meetings that break down silos and supported patient-centred care. Standardised ED management plans reduced duplication (by avoiding repeated unnecessary tests) and unnecessary ED presentations by encouraging patient care in community settings. Participants stated that patients benefit by avoiding repeated retelling of traumatic histories, reinforcing dignity and continuity of care as well as receiving culturally appropriate care.

Discussion

This qualitative evaluation of the EDC initiative in partnership with four LHDs in NSW reveals critical insights into the hidden relational labour and trauma-informed care underpinning EDC care coordination. Participants consistently described the program's impact as highly positive, underlining its value in improving care coordination and in addressing service gaps, with MDTs, champions and generalists as "mortar between the bricks". Compounded intersectional disadvantage with unmet social and medical needs, including broken trust, underscores the systemic failures experienced by EDC patients, suggesting that rebuilding trust requires relational continuity, trauma-informed care and cultural safety. This is supported in the evidence base where Eastwood *et al.* reported the significance of trust and interpersonal relationships in supporting vulnerable populations with the Healthy Homes and Neighbourhood initiative (Eastwood *et al.*, 2020). Results also correspond with the former checkpoint program whereby EDC clients visited the ED for a combination of complex psycho-social and medical issues (Baird *et al.*, 2021).

This study aligns with the research evidence by *bridging professional gaps* and *negotiating* these overlaps across MDTs and staff across different sectors and *making space* through MDT or case conferencing that enables this to happen (Schot *et al.*, 2020). Significant enablers highlight the structural value of MDTs using video conferencing, supporting specialists to join from varied locations. These hybrid meetings provided an opportunity to collaborate across specialists and cross-disciplinary staff on complex patient needs, using direct communication. Prior research in NSW highlights the importance of MDTs, cross-sectoral health professional communication and sharing of information, as patients felt their conditions were treated separately rather than through coordinated, team-based care (Maneze *et al.*, 2014). Although MDT attendance differed across LHDs, especially between urban and rural settings, participants consistently identified social workers, nurses, ambulance personnel, mental health clinicians, ED doctors, disability specialists, drug and alcohol clinicians, Aboriginal health support providers and pain specialists as critical to effective coordination and continuity of care. Individual cases that required the involvement of NDIS and other NGO providers at MDTs were regarded as highly valuable. While many MDT meetings in our study were well-chaired and inclusive, they are not yet standard practice across all settings, often relying on strong relationships, rapport building and leadership. Evidence highlights persistent barriers to collaboration, including limited awareness, unclear role accountability, confidentiality concerns and funding constraints (Supper *et al.*, 2015). Structured mechanisms for strengthening collaboration, such as resolving conflicting service priorities and improving information sharing protocols, are critical (Eastwood *et al.*, 2020). Regular time slots for online MDT meetings and stakeholder engagement enabled broader participation, supporting EDC program objectives. This aligns with broader evidence: better communication and coordination enhance clinical care, especially through improved information sharing (Elliott *et al.*, 2021).

Another key enabler was the ED management plan that provides standardised information that is patient-centred, thereby streamlining care, especially with staff turnover in ED. In 2023–2024, people from the most disadvantaged areas accounted for 24% of ED visits, followed closely by those in the next most disadvantaged areas at 23% (AIHW, 2025). ED management plans enable care consistency across hospitals if easily located in EMR.

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Information systems could be improved with an "alert pop-up" function for the location of the ED management plan. Tools significantly improved information sharing, although challenges remained due to outdated processes (i.e. fax) and consent concerns. Qualitative evidence underscores the need for robust information systems and tools that enable timely information sharing across integrated care teams (Vimalananda *et al*., 2018).

Participants echoed the need for both specialist and generalist roles to support clients with complex care needs, as the program serves patients who fall outside standard healthcare models. These cases require innovative, non-traditional approaches, with the ED becoming a default for unresolved, non-acute issues, highlighting the need for earlier intervention. The program fills gaps for patients excluded from other services, revealing systemic issues and accepting higher risk levels typically avoided elsewhere. The theme of "hidden work" underscores the value of informal contributions and rapport building, not captured by traditional metrics, pointing to the need for evaluative frameworks that include relational and qualitative dimensions and modes of funding services to reflect this. Furthermore, emotional strain has been shown to contribute to staff burnout and lower job satisfaction, as reported in social work research (Roh *et al*., 2016).

Champions – nurses, social workers and medical leads – acted as informal connectors across services, though their contributions often went unrecognised. Coordination was strongest between clinicians in similar roles, consistent with existing evidence (Vimalananda *et al*., 2018). The EDC's role in linking hospital and community services shows promise in reducing silos and improving care transitions; however, building connections beyond the hospital district structure required more time and resources and relationship building. Rawlinson *et al*. also highlight that cross-sector collaboration is enabled by funding, policy, clear roles and strong communication (Rawlinson *et al*., 2021). Embedding trauma-informed care and cultural safety, particularly for Aboriginal peoples, advances health equity and supports the sustainable development goals. Trauma-informed care requires providers to build trusting, collaborative relationships through compassionate communication and shared decision-making, minimising distress while also engaging in coordinated, multidisciplinary collaboration (Reeves, 2015). Our findings reinforce existing evidence that trauma-informed training equips allied health professionals to deliver culturally safe, responsive care to refugees (Kelton *et al*., 2022).

There are study limitations, one of which is the lack of data gathered directly from patients on their experience. This was unfortunately not feasible within the time frame of this project. Further iterations for study expansion, which would include patients' lived experiences and quantitative analyses are contingent upon funding. Despite outreach efforts, community-based GPs did not engage in recruitment; however, few hospital-based GPs participated. Qualitative study designs offer contextual findings and are not representative of all contexts nor do they offer causality in findings. Future research with specific populations and data measures to capture "hidden work" when coordinating complex care would be beneficial to augment the integration of health-social systems. Comparative studies using mixed-methods or longitudinal designs could help test the transferability of these coordination mechanisms across different LHD or international contexts. Such approaches would also enable researchers to link changes in information sharing and cross-sector routines to measurable continuity-of-care outcomes.

Conclusions

Findings highlight the positive impact of the EDC program across multiple system levels. At the macro level, the program aligns with broader health policy goals, contributing to the quintuple aim (Figure 1) and sustainable development goals by promoting equity, access and improved health outcomes for disadvantaged populations. At the meso level, the EDC program strengthens cross-sector collaboration through informal communication methods by generalists connecting and building rapport with specialists between and within health-social

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and community services, enabling more holistic, trauma-informed care. Serving patients who often fall outside standard healthcare models, the program addresses complex, non-traditional needs with innovative approaches, often accepting higher risk where other services do not. Participants appreciated the program's equity focus and the contributions of often-overlooked champions, underscoring the need to broaden how program impact is assessed and remunerated and to intervene earlier to prevent ED default. At the micro level, the program effectively bridges hospital-community gaps for individuals with complex needs, reducing ED presentations and supporting continuity of care. These findings contribute to the field of integrated health and social care by reinforcing the importance of MDT, system-level alignment and qualitative evaluation frameworks.

Author contributions

This pilot project was funded by CREHSCI for a research fellow (KM) to undertake within 12 months. KM drafted the pilot project, conceptualisation, design, methods, analysis, project coordination and administration, writing of original drafts, reviewing and editing - with ongoing feedback, revisions and supervision from CHS, GU, PH. De-identified documents were provided by AA, MB, PB, MS for analysis, while all authors (KM, PH, GU, AA, MB, PB, MS, SS, PE, AB, JC, LP, AL, CHS) participated in regular project governance (progress, updates, analysis), contributed extensively to participant sampling and recruitment processes, investigation, supervision, analysis feedback and consultation with stakeholders. KM drafted the first version of this paper and all authors reviewed, commented and agreed to this final submitted version.

Data sharing and availability

The data that support the findings of this study are not available as all data is presented and as the due to privacy and ethical restrictions.

Public contribution

Patient and public involvement and engagement (PPIE) was not feasible during this initial stage of the pilot project due to significant time constraints, multilevel ethics approval processes and the challenges associated with recruiting a highly vulnerable cohort. This cohort experiences high levels of disadvantage – homelessness, substance use issues, disability, mental health and lacks stable contact details such as addresses or phone access. Further funding is required to provide participant support to engage in the project (payment, such as vouchers) and sufficient time for multiple outreach efforts, which were beyond the scope of this pilot. PPIE is being formulated in the next iteration of a larger project grant (2026) that builds upon this study, dependent on funding outcomes.

Ethics approval

The study was provided with ethics approvals from the Sydney Local Health District Royal Prince Alfred Research Ethics and Governance Committee (2024/PID03166) and site-specific approvals obtained from each participating LHD: Central Coast, Murrumbidgee, South Eastern Sydney and Sydney LHDs.

Participant consent

Verbal consent was obtained from each participant after providing the Participant Information Sheet and answering all questions. Documents and participants were de-identified. The interview/focus groups were audio-recorded with consent.

Artificial intelligence (AI)

All content created is based on study findings as interpreted by authors and feedback from the broader team. AI was not used in any portion of the manuscript nor methods section.

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Supplementary material
The supplementary material for this article can be found online.

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Corresponding author
Kanchan Marcus can be contacted at: kanchan.marcus@sydney.edu.au

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