Our mission: To maximise the health and well-being of the community by leading high quality, priority-driven research and supporting its uptake into primary health care policy, programs and services.
The Australian Primary Health Care Research Institute (APHCRI) supports primary health care research focussed on identifying primary health care policies, programs and services which will maximise the health of the Australian population.

This research covers a range of areas relevant to primary health care, including policy, workforce, governance, health service management, technology, personal behaviours, funding, and organisational structure.

APHCRI takes a ‘health systems’ approach to research and facilitates involvement of the potential research user in the research process from the initial funding to dissemination of findings.

The process – known as knowledge translation and exchange (KTE) - ensures that the research is driven by the health care needs of the Australian community and can directly inform the development and implementation of health policies and services (and vice versa).

APHCRI research strengthens our primary health care sector and maximises the health and well-being of the Australian population.

APHCRI’s goals are:

1. To support priority-driven primary health care research
2. To increase the capacity to undertake primary health care research
3. To drive the implementation of research into primary health care policy and practice

How can I get involved?
APHCRI regularly calls for applications to research priority areas of interest in the National Health Reform Strategy. Announcements are made on the APHCRI website, Twitter and advertised in national newspapers.

APHCRI has funded work on:
> Aboriginal and Torres Strait Islander primary health care
> Adolescent/child health
> Chronic disease management
> Drivers of successful primary health care
> Knowledge exchange & translation
> Mental health
> Multidisciplinary teams
> Practice nursing
> Primary health care models/ delivery
> Primary health care performance
> Rural and remote primary health care
> Workforce
> Consumer engagement

KEEP IN TOUCH
To stay up to date with APHCRI’s latest research and funding opportunities, you can:
> Visit the APHCRI website
> Follow @APHCRInet on Twitter
> Call or email us!

APHCRI is supported by a grant from the Australian Government Department of Health under the Primary Health Care Research, Evaluation and Development Strategy.
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APHCRI CENTRES OF RESEARCH EXCELLENCE
EVIDENCE INFORMING THE FUTURE OF AUSTRALIAN PRIMARY HEALTH CARE

ANU College of Medicine, Biology & Environment
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FOREWORD

The Australian Primary Health Care Research Institute is supported under the Australian Government Department of Health’s Primary Health Care Research, Evaluation and Development (PHC RED) Strategy.

The research that is funded by the APHCRI Centres of Research Excellence covers a wide array of the health issues that we currently confront:

- tackling obesity and its causes;
- closing the gap in Indigenous disadvantage by addressing the health needs of urban Indigenous children and early interventions to minimise the impact of chronic diseases;
- chronic disease prevention in rural and remote communities;
- bridging the oral health gap by forging links between dental health and primary health care services;
- enhancing quality, performance measurement, sustainability and integration within the primary care system;
- investigating improved financing mechanisms to help make the system more sustainable; and
- bringing Canadian and Australian experts together to develop and share ways to improve the delivery of primary health care services.

This Research Portrait highlights the inspiring range of work that is being undertaken by researchers across Australia. Readers can learn about the partnerships involved, the investigations being undertaken, and the innovative solutions being developed.

The research that APHCRI funds is based on national priorities and informs politicians, policy makers, health care providers and consumers about how primary health care and the primary health care system can be improved. It has a tangible impact on policy and practice.

Associate Professor Terry Findlay
Head of Programs
People who are overweight or obese are at a higher risk of a number of chronic diseases including cardiovascular disease, type 2 diabetes and cancer. With recent studies showing that three out of five Australians are either overweight or obese, weight management has become an increasingly important health issue for which primary health care plays an important role.

Established in 2012, the Centre for Obesity Management and Prevention Research Excellence in Primary Health Care (COMPaRE-PHC) aims to inform primary health care guidelines on the prevention and management of obesity in disadvantaged populations across Australia, particularly in relation to socially and economically vulnerable groups.

Since its establishment, the Centre has developed or identified a number of weight-management and obesity-prevention initiatives for trial in the Australian context.

As part of the Growing Healthy project, researchers are developing and testing an infant feeding app and website for mothers and babies, while the Better Management of Weight in General Practice (BMwGP) trial is developing and evaluating an intervention to assist general practices to support obese patients to manage their weight.

Feasibility studies are underway in Adelaide and Sydney, to determine the feasibility and acceptability of the Counterweight Program to Australian general practices and patients. The Counterweight Program was developed in the UK and is one of the few weight-loss programs that have been successfully rolled out across a health system after research.

COMPaRE-PHC is also concerned with the cost-effectiveness of weight management interventions delivered by primary health care. The Preventive Evidence into Practice (PEP) study involved the development and trial of an intervention that aimed to assist general practices to implement guidelines on the prevention of chronic disease, including assessment and education relating to physical inactivity and diet.

COMPaRE-PHC is now matching the data from this study with Medicare data to identify the cost-effectiveness of the intervention.

As referral to weight loss interventions occurs too infrequently to have a widespread impact, COMPaRE-PHC is now conducting a qualitative study to investigate factors influencing GP decision making about which patients with a BMI above 30 they refer to specialists.

While it is currently undertaking a number of exciting new projects, the Centre's research has already been used to inform the Australian Government's National Preventative Health Strategy and the implementation of the Obesity Prevention and Management Guidelines, produced by the National Health and Medical Research Council.

For more information please visit: http://compare-phc.unsw.edu.au/
Chronic disease in Indigenous Australians remains a pivotal target; a key opportunity to develop responsive health policy that delivers improved cost-effective prevention, early detection, and management.

Chronic disease causes around 80% of the mortality gap for Indigenous Australians aged 35 to 74 years. Established in December 2010, the Centre of Research Excellence for Indigenous Primary Health Care Intervention Research in Chronic Disease aims to improve the health of Indigenous Australians suffering from, or at risk of, chronic diseases such as diabetes, heart disease and kidney disease.

Since its establishment researchers at the Centre have collaborated with Aboriginal Medical Services to investigate the barriers to quality primary health care, and to evaluate strategies to improve the availability, quality and safety of this care. Importantly, the Centre is helping to build the capacity of community and current health-care services to conduct high-quality research in chronic disease prevention.

In partnership with the previously-established Kanyini Vascular Collaboration (KVC), the Centre has documented gaps between evidence and practice in the primary health care screening and management of Indigenous Australians at high vascular risk. Through its work with the KVC, the Centre has identified significant barriers to, and enablers of, chronic disease management across the care continuum. This work includes completion of a multi-centre, randomised-controlled trial across urban, rural and remote settings to explore whether a polypill-based strategy improves medication adherence amongst people at high vascular risk. Findings from this trial were published in early 2014.

The Centre is currently working on two health service research studies in collaboration with a number of Aboriginal Community Controlled Health Services. The first is the ‘Well-being Model’, which aims to improve quality of care, health outcomes and importantly the quality of life for Aboriginal and Torres Strait Islander people living with a chronic disease. The second is the Home-based Outreach chronic disease Management Exploratory Study (HOMES), which explores novel approaches to addressing chronic disease management in home-based outreach settings.

Through its focus on capacity building, the Centre aims to help current primary health care services respond and adapt to health reform over time, and equip them with the necessary systems and skills to effectively identify, manage and prevent chronic conditions in their local Indigenous communities. The Centre also seeks to examine the utility and effectiveness of the Australian Government’s ‘Closing the Gap’ package within the primary health care sector, and inform its future evolution.

Find out more about this Centre on the ROAR database: <www.phcris.org.au/organisation/4585>
Chronic diseases are the leading causes of death and disability in Australia, and impact heavily on the health care system. Due to the substantial burden on resources and funding, the prevention of chronic disease, particularly in rural and remote communities, is a major health priority for both National and State governments.

Established in 2012, the Centre of Research Excellence in Chronic Disease Prevention in Rural and Remote Communities aims to reduce the incidence and impact of diabetes, heart disease and renal disease in isolated populations by innovating and evaluating community-based interventions to help combat obesity, smoking, drug and alcohol abuse, and poor nutrition.

To achieve this, the Centre is following a cohort of adults and children from rural and remote communities in South Australia and Queensland over an extended period of time, assessing the health impact of primary health care initiatives on chronic disease management at each stage of the care continuum.

Results from this cohort have already shown that one third of participating Torres Strait Islander adults with diabetes do not manage their condition optimally (HbA1c >8.5%), and only half of these adults receive insulin – in comparison to less than 10% in the AusDiAB national sample. The Centre has also found that due to poor execution, smoking interventions implemented in Indigenous communities are having a low impact on behavioural change.

In addition to management and intervention, the Centre’s research into nutrition has shown that remote populations rely far too much on low nutrient, high sodium, white bread as their primary source of vitamins and minerals. To address this problem, the Centre is currently examining a modelling exercise, which looks at the impact of food subsidies and pricing policy on purchasing patterns in remote communities.

The Centre is also conducting the first systematic evaluation of the impacts of Alcohol Management Plans (AMPs) in Queensland, a study which has relevance for similar strategies in other jurisdictions.

Director: Professor Robyn McDermott, Professor of Public Health, Sansom Institute for Health Research, University of South Australia and the School of Public Health, Tropical Medicine and Rehabilitation Sciences, James Cook University

Headquarters: Sansom Institute for Health Research, University of South Australia and the School of Public Health, Tropical Medicine and Rehabilitation Sciences, James Cook University

Funding Period: January 2012 - December 2015

So far, the qualitative phase of the AMP evaluation has documented the views of over 250 key stakeholders and almost 800 adult community residents in affected communities. The data analysed points to a very strong consensus that each community’s Local Government Council should take a lead role in managing alcohol use and related problems.

The Queensland Government is currently reviewing the AMPs, with the intention of translating the Centre’s extensive research into policy.

For more information please visit:
Managed through three tiers of government, and funded privately and publically, Australia’s primary health care system is as complex as it is disparate. To assist in transitioning this system from a series of unrelated sectors to an integrated whole body, the Centre of Research Excellence in Primary Health Care Microsystems was established in 2011 to address the key governance, performance, quality and sustainability issues identified within the national health reform agenda.

Since its establishment, the Centre has developed Australia’s first online Primary Care Practice Improvement Tool (PC-PIT). Designed to work within the existing quality improvement cycles of primary health care Microsystems, the PC-PIT uses a whole-of-practice approach to enhance quality, performance measurement, sustainability and integration within the primary health care system. Following a successful pilot stage, the Phase 1 national trial and validation process for PC-PIT is set to be completed by the end of 2014. So far, the PC-PIT has provided opportunities for primary care practices to improve quality and build accreditation options and will be further embedded into existing quality improvement frameworks nationally from 2015.

In addition, the Centre has developed a governance framework for multi-organisational health service delivery, within a multidisciplinary setting. This will soon be implemented as a best practice governance framework to support integrated primary and secondary care.

The Centre also investigates the range of factors that influence patient safety and quality of care within general practice. With input from key partners and experts internationally, it has drafted a Patient Safety Collaborative Manual, and completed a study and report on the enablers and barriers for uptake, and the spread of collaborative health care. By identifying the characteristics of high-performing general practices, the Centre will inform ongoing system improvement that delivers timely access to health care for all Australians, as well as sufficient choice in providers, continuity of care, inter-sectoral coordination, and a high level of patient engagement. The Patient Safety Collaborative Manual, which has been endorsed in a foreword written by the Australian Government Chief Medical Officer, has now been handed over to the Improvement Foundation, which intends to establish the first patient safety collaborative in 2015.

For more information visit: http://www.aphcricremicrosystems.org.au/
THE CENTRE OF RESEARCH EXCELLENCE IN PRIMARY ORAL HEALTH CARE

A recent study into Australia's oral health showed that three out of ten adults had untreated tooth decay. Australia's suboptimal oral health is predominately due to the isolation of oral health from mainstream health services, and the lack of linkages to community care services for those who are ageing, disabled or living in remote and rural areas.

Established in 2012, the Centre of Research Excellence in Primary Oral Health Care works to bridge the oral health gap by forging links between dental health and primary health care services. It works to achieve this by focusing on four key research areas, including: successful ageing and oral health; rural oral health; indigenous oral health; and the oral health of those with physical and intellectual disability.

Successful ongoing projects include a community based trial evaluating GP referrals for priority dental care for elderly consumers, and a project that aims to incorporate dental professionals into aged care facilities. The Centre’s rural oral health researchers are currently investigating the attitudes towards living and working in rural areas, among Australian dental practitioners. In addition, researchers are looking into the positive impact of inter-professional collaborations on the oral health of consumers in rural areas.

Through the mapping and analysis of key state and national policy documents, governing oral health, the Centre’s research is also currently being used to seed a program of grant applications, research collaborations and mentoring opportunities in oral health policy research.

For more information visit:
Countries around the world are exploring how to develop their health systems to meet the challenges of ageing populations with increasing rates of chronic disease, while delivering services that are financially sustainable. Established in 2012, the Centre of Research Excellence in the Finance and Economics of Primary Health Care uses cutting-edge economic and econometric techniques to answer key questions about how primary health care is financed in Australia, and how this could be improved.

To better understand how Australians pay for primary health care, the Centre has explored the use of blended payment systems. It has also looked at the impact of financial incentives to target new services and overcome maldistribution of providers. So far, the Centre has found that the uptake of new financial incentives such as service incentive payments (SIPs) is extremely variable. It also found that there is a high turnover among doctors who participate, while overall participation rates are falling. The Centre also found that rural doctors and those in bigger practices, with more administrative staff, are most likely to claim incentive payments. In addition, findings have shown that incentives are complex and expensive, with the cost often outweighing the impact.

The Centre also investigates consumer behaviours, such as how and when consumers decide to use primary health care, and which provider they use. Researchers recently conducted a survey of approximately 2,500 consumers, asking for patients’ experiences of selecting a GP. Results from this survey showed that patients were generally satisfied with their provider, and that most continued to see the same doctor. The study also showed that those who sought bulk-billing practices were more likely to visit multiple providers, while around one third of those surveyed reported putting off a needed visit; this was much more likely to be due to time pressures, however, than cost.

The Centre’s research on predicting future costs has addressed the drivers of expenditure growth, and how different patterns of disease and treatment affect this. A recent study showed that increased risk of hospitalisation, and longer stays once admitted, is associated with living alone. This is likely to increase the pressure on hospitals, as the proportion of single person households is expected to increase in mid-older age groups.

Through engagement with the Department of Health, Medicare Locals (in future, Primary Health Networks) and other stakeholder groups, the Centre has already had a significant impact on policy and practice, and aims to continue to influence the development of new financing policies into the future.

For more information visit:
Despite the fact that 60% of the health gap between Aboriginal and non-Aboriginal Australians has been attributed to those living in cities, little is known about the health needs and health trajectories among urban Aboriginal children. Established in 2012, the Centre of Research Excellence in Urban Aboriginal Child Health is using research evidence to develop and test strategies to support sustainable and transferable improvements in Aboriginal primary health care.

The Centre uses data collected through the Study of Environment on Aboriginal Resilience and Child Health (SEARCH) from participating Aboriginal Community Controlled Health Services (ACCHSs) to determine the quality of health care administered to Aboriginal children in urban areas. With a focus on ear health, speech development, emotional health, chronic disease, and environmental health, the Centre is working to develop strategies to improve services in these areas.

Projects aimed at improving primary health services for Aboriginal children, building research capacity in the ACCHSs, and supported by evidence from SEARCH, include: The Hearing, EAr health & Language Services (HEAlS) project, the Data enhancement project, and the Housing for Health program.

Since 2013, the HEAlS project has delivered ear, nose and throat and speech therapy services to over 600 Aboriginal children across five ACCHSs in NSW, through an enhanced funding scheme facilitated by the NSW Ministry of Health. The HEAlS intervention has helped to circumvent traditional barriers to health service delivery for Aboriginal children through an effective collaboration between Aboriginal communities, researchers and multiple health agencies. With an economic evaluation now underway for a potential scaling up of this program to a state level, this has significant implications for future Aboriginal health policy and practice.

A key aim of the Centre is to use SEARCH data to drive change. The Centre’s data enhancement project is developing simple tools such as data cubes to provide easy and sustainable access to data via a secure online system. This provision of data is also being accompanied by a range of research capacity building activities to support the use of research in primary health service provision.

The Housing for Health program aims to pilot an intervention program to improve living conditions in a sub-set of households in western Sydney and assess its impact.

Other areas of focus include contributions to improving Aboriginal child health checks and mental health services. All activities carried out by the Centre are developed to have maximum impact on state and national health policy.

Canada and Australia are two of many countries trying to improve their systems for delivering primary health care (PHC). Experts in both countries have devoted much time and effort into schemes to improve the quality of care delivered by PHC providers. However, many consumers are still unable to access quality care.

Access to quality PHC is less than ideal for citizens of both countries—especially for the sick, the poor, or those who are otherwise disadvantaged. Poor PHC access leads to overloaded emergency departments, avoidable hospitalisations and, in the long run, to increased costs and poor health outcomes.

Established in 2013, the Innovative Models Promoting Access-to-Care Transformation (IMPACT) Centre of Research Excellence is a five-year international research program, jointly supported by the Australian Primary Health Care Research Institute, the Canadian Institutes of Health Research and the Fonds de recherche du Québec – Santé.

IMPACT aims to work with consumers, policy makers and providers in six communities (three in Australia and three in Canada) to identify, refine and then trial ‘world’s best practice’ innovations to improve access to primary health care, particularly for vulnerable populations. IMPACT is built upon a participatory approach, which includes all research users, including: policy makers, clinicians and other community members as part of the project team.

In addition to building capacity within primary health care research, IMPACT provides an infrastructure to develop further opportunities for research that can optimise health for vulnerable populations.

Since the publication of IMPACT program’s model of access, in the International Journal for Equity in Health in 2013, there has been increasing international interest in the program. Less than 12 months after the launch of the program, local innovation partnerships have been established at all six sites.

The team has also completed a systematic review of relevant access innovations, and is in the final phases of an international, social media scan of new access initiatives.

For more information please visit: http://www.med.monash.edu.au/sphc/impact/
THE CENTRE OF RESEARCH EXCELLENCE IN RURAL AND REMOTE PRIMARY HEALTH CARE

About one-third of Australia’s population lives in rural and remote areas. However, due to inequitable access to health services, rural and remote communities don’t enjoy the same quality of health care as those living in urban areas.

A major contributor to this imbalance is the failure to translate research evidence and successful rural health models into policy. To overcome this problem the Centre of Research Excellence in Rural and Remote Primary Health Care was established in 2011 to evaluate and benchmark key aspects of sustainable primary health care services in rural and remote contexts throughout Australia. It aims to improve access to quality primary health care services, improve health outcomes and guide resource allocation for people living in rural and remote regions of Australia.

Since its establishment the Centre has pioneered an Index of Access to primary health care services. It has also developed a comprehensive framework for evaluating these services, which have been adapted to, and tested in, remote areas of Australia. The Centre has also defined and published the basket of core primary health care services that all Australians should be able to access, regardless of their location.

The Centre’s most recent work includes the determination of funding benchmarks for rural and remote health services and how funding for chronic disease management in remote communities could be optimised. A recent paper from the Centre shows that the more primary health care visits a patient makes, the less likely they are to be admitted to hospital for their chronic disease, as well as living longer. This research indicates that investment in primary health care has the potential to prevent hospitalisation and save money.

Making an impact on policy and practice, the Centre’s research was referenced extensively in the Senate Enquiry into the “factors affecting the supply of health services and medical professionals in rural areas”.

This work continues to influence high-level decision-making relating to resource allocation in rural and remote areas.

In addition to policy, the Centre’s research into the Index of Access has influenced national discussion about geographic areas classification in rural and remote health. There has also been strong interest in the Centre’s research into the cost of services and chronic disease secondary prevention from the Australian Government Department of Health.

The Centre’s evaluation framework provides health services and policy-makers with a robust tool for monitoring and evaluating the performance and sustainability of primary health care services in rural and remote regions, thereby improving equity and access to primary health care for all Australians.

For more information please visit:
https://www.crerrphc.org.au/

Director: Professor John Wakerman, Associate Dean, Flinders NT, Darwin
Headquarters: School of Rural Health, Monash University
Funding Period: December 2010 - December 2014

APHCRI CENTRES OF RESEARCH EXCELLENCE: EVIDENCE INFORMING THE FUTURE OF AUSTRALIAN PRIMARY HEALTH CARE
Understanding Variation in Primary Health Care

ANU College of Medicine, Biology & Environment
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FOREWORD

The Australian Primary Health Care Research Institute (APHCRI) was established at the ANU in 2003 as part of the Australian Government Department of Health and Ageing funded Primary Health Care Research and Education Development (PHCREd) Strategy. Since then, APHCRI@ANU has established itself as a leading Australian centre for health services research.

The key focus of APHCRI@ANU is understanding variation in health care. Not all Australians have the same health problems, and even when they have the same health problems, do not have the same access to care, receive the same level or types of services, or achieve the same health outcomes.

However, not all variations are harmful. Indeed a major challenge for researchers and practitioners alike is to identify which variations in service provision or care outcomes are warranted and which are not warranted, and which can be addressed through policy and practice.

The research undertaken at APHCRI@ANU is grouped into four key themes:

- The nature and distribution of primary health care related variations;
- The causes of variations in primary health care needs, access, care and outcomes;
- How to address variations in primary health care needs, access, care and outcomes through innovations in policy and practice; and
- How to measure and monitor variations in needs, access, care and outcomes over time.

This research portrait highlights the innovative and inspiring range of work undertaken by APHCRI@ANU researchers across a broad range of areas to inform policy makers, health care providers and consumers.

Associate Professor Lyndall Strazdins
Head, APHCRI@ANU
Variations arise in all health care service provision and outcomes. Studies of spatial variation in health care provision and costs in the USA have shown wide and unexplained diversity. To better understand the nature and distribution of primary health care related variations, APHCRI@ANU researchers have explored a broad range of areas including, spatially based variation, adherence to medication, use of chronic disease management plans, time spent on personal health care and how this relates to multi-morbidity, patient experience with health care, and patient affiliation with General Practitioners.

To support research across Australia on spatial variation, APHCRI@ANU established the National Centre for Geographic and Resource Analysis in Primary Health Care (GRAPHC) in 2011 using core funding of $2.6m over three years. This cutting edge resource provides relevant data, analysis and mapping tools to primary health care researchers. GRAPHC now supports a web-based data management and mapping facility with 6,000 indicators and highly flexible tools for mapping both this data and data which researchers themselves may wish to visualise.

GRAPHC includes ABS-based data on population and socio-economic status, data compiled by the Population Health Information Development Unit, University of Adelaide, and data at a Medicare Local level from the MABEL Australian General Practitioner workforce survey.

Recognising the value of collaboration and developing national and international partnerships, APHCRI@ANU researchers have forged links with many institutions including, the Netherlands Institute for Health Services Research; Robert Graham Centre, Washington DC; University of Canterbury, NZ; University of Northumbria, UK.

For more information visit:
http://aphcri.anu.edu.au/research/groups/quantitative-analytics

The GRAPHC team have developed G-Tag: a system to manage individual clinical data that preserves privacy and confidentiality.
PROJECT SPOTLIGHT

MAPPING A HIDDEN MENACE: UNDIAGNOSED DIABETES

Taking such an innovative approach has led to the award of a DECRA fellowship to Dr Bagheri for research on identifying the spatial distribution of chronic illness risk.

This innovative study used both sophisticated modelling and spatial analysis of General Practice clinic-level data to identify a distinct pattern of undiagnosed diabetes that varied by area and socioeconomic status. The pattern could not have been detected using traditional postcode based data. It was made visible using small area data extracted using the purpose designed GRAPHC G-Tag tool.

This study reveals that undiagnosed diabetes may be a problem of less disadvantaged social groups, and geospatial mapping provides a new tool to identify areas with high levels of unmet need. Using our models, policy makers can apply geographic targeting of effective interventions.


Research Team
- Dr Nasser Bagheri
- Dr Ian McRae
- Mr Paul Konings
- Prof Kirsty Douglas
- Dr Peter Del Fante
- Prof Robert Adams

REFERENCES


LIMITATIONS OF THIS STUDY

- The finding differs from previous national data (Dunstan, 2002), which estimated that there was one undiagnosed case for every diagnosed cases of diabetes.
- The ratio of 3-4:1 for diagnosed versus undiagnosed is broadly consistent with the prevalence of undiagnosed diabetes was slightly higher in the least disadvantaged area.
- The prevalence of total expected and diagnosed diabetes was high in the most disadvantaged area.
- Diagnosed, undiagnosed and total expected diabetes prevalence varied widely between the SA1 areas, and between the SA1 areas.
- The estimated overall prevalence of diabetes in people over 18 years old at the GP practice level was 12.8%. The prevalence of total expected diabetes varied considerably between the SA1 areas, ranging from 6.0% to 18%, with a mean of 12.8%. The highest expected diabetes prevalence was seen in the low socioeconomic area, mostly in east and north of Lefevre peninsula.

A total of 9.9% of the practice patient population have been already diagnosed by GPs in the practice. The prevalence of diagnosed diabetes in the SA1 areas varied from 0.6% to 23. The higher diagnosed prevalence rate was observed in the most disadvantaged area in north-east part of the Peninsula.

The difference between expected and diagnosed prevalences provides an estimate of the undiagnosed prevalence. The prevalence of undiagnosed diabetes was estimated as 3% of active patients. This rate ranged from 0% to 12%.
STREAM 2
THE CAUSES OF VARIATIONS IN PRIMARY HEALTH CARE NEEDS, ACCESS, CARE AND OUTCOMES

Consistent with the most significant challenges facing the primary health care sector, work in this area has a strong focus on chronic illness.

Chronic illness challenges the budgets and health systems of all western countries, where health services oriented towards the care of acute and episodic conditions are forced to find new models of care; where health care providers face changes to their traditional ways of working with the need to integrate care across multiple settings and providers, and where the burden of the illness to patients and their families is beginning to be counted and incorporated into models for best management and shared decision making.

Alongside practice and policy interventions, we have limited knowledge of how patient characteristics and needs vary within and between conditions, the extent to which regional variations occur in the use of allied health and dental services or access to a same day appointment with a General Practitioner, or how chronic conditions impact on time use and out of pocket costs contribute to variation in access.

APHCRI@ANU researchers have focused on these knowledge gaps using data from the Menzies-NOUS Survey of Attitudes of Australians towards the health system, the Serious and Continuing Illnesses Policy and Practice Study (SCIPPS), and a national survey of members of National Seniors Australia, National Diabetes Services Scheme and the Lung Foundation.

National and international collaborations and partnerships with APHCRI@ANU researchers include, the University of Manchester, the University of Exeter, Hull and York Medical School, Menzies Centre for Health Policy; the Health Care Consumers Association; and, National Seniors Australia.

For more information visit: http://aphcri.anu.edu.au/research/groups/chronic-disease-management

Health systems world-wide have attempted to create greater standardisation of care for common chronic illnesses to reduce outcome variation.

Laurann Yen, Team Leader
The onset of severe chronic illness and its progression poses a critical situation to the individual. It is experienced as disrupting people’s previously held beliefs and imaginations about their future biographies. The chronically ill individual, Bury suggests, is not subject to the same social obligations of the individual with acute sickness (who should return to health quickly and get back to work). Instead, the very nature of chronicity suggests that the individual cannot return to prior ‘healthy’ modes of social obligation.

Chronic illness creates uncertainty and calls into question the individuals previously held ideas about the world and their future.

First, there is the disruption of taken-for-granted assumptions and behaviours; the breaching of commonsense boundaries ... Second, there are more profound disruptions in explanatory systems normally used by people, such that a fundamental rethinking of the person’s biography and self-concept is involved. Third, there is the response to disruption involving the mobilisation of resources in facing an altered situation (Bury, 1982: 169-170).

The initial ‘breach’ in boundaries brings into focus the misbehaving and even ‘dis-appearing’ body (Williams, 2000). Previously trusted and often unconscious rhythms of the healthy body are disrupted. The chronic illness is experienced profoundly in the body and in relation to social life.

Responses to the theory – research participants

“Well obviously!!”

72 year old woman with COPD

The more chronic illnesses people had, the more time they spent seeing health care providers. For some, the disruption was felt more intensely upon diagnosis, then less so as people found ways of managing their health. For others the disruption only increased with time as hopes and dreams became unreachable

Findings

The social theory of disrupted biography was found to create uncertainty and calls into question the individuals previously held ideas about the world and their future.

To analyze whether chronic illness is biographically disrupting, responses to the theory – research participants

“Well obviously!!”

72 year old woman with COPD

The more chronic illnesses people had, the more time they spent seeing health care providers. For some, the disruption was felt more intensely upon diagnosis, then less so as people found ways of managing their health. For others the disruption only increased with time as hopes and dreams became unreachable.

Way back in 1982, sociologist Michael Bury suggested that chronic illness poses a biographical disruption to people. What on earth does that mean? Was this ever the case? Is the theory still relevant?
STREAM 3

HOW TO ADDRESS VARIATIONS IN PRIMARY HEALTH CARE NEEDS, ACCESS, CARE AND OUTCOMES THROUGH INNOVATIONS IN POLICY AND PRACTICE

Strong primary health care systems that promote access, continuity and coordination of care are associated with improved population health and cost performance. A major challenge for health systems is how to redesign primary health care to make care more accessible, continuous, coordinated and patient centred.

This is a particular challenge for organisations providing care for people with mental health or chronic conditions where care must be accessed from a range of providers within and outside the primary health care sector. It is particularly vital in reaching underserved populations and those whose needs have not traditionally been well met. Working together with key consumer, service and policy stakeholders is essential to tailor intervention research and to support uptake of knowledge into practice since changes in population health outcomes cannot occur unless health care systems, organisations, and professionals adopt them in practice.

This area of research focuses on developing and testing innovative strategies for improving access and quality within the Australian primary health care sector. It incorporates work with both consumers and primary health care providers, including Aboriginal and Torres Strait Islander services, general practices and community health.

Much of the work undertaken by APHCRI@ANU researchers has been conducted through consultancies or in partnerships with key stakeholder groups and has informed the development of new areas for applied research. Linkages have been formed with the Aboriginal Health Council of Western Australia, the Queensland Aboriginal and Islander Health Council, the ACT Medicare Local, the Australian Medicare Local Alliance, ACT Health, Menzies Centre for Health Policy, and the University of Manchester.

Sustainability of innovation is an ongoing implementation and evaluation challenge for the primary health care sector.

For more information visit: http://aphcri.anu.edu.au/research/groups/consumer-perspectives-primary-health-care
PROJECT SPOTLIGHT

CONTINUITY OF CARE: UNLOCKING INFORMATION

Research Team

- Dr Michelle Banfield
- Dr Karen Gardner
- Dr Ian McRae
- Assoc Prof James Gillespie

Care coordination is a key focus of current health policy in Australia. Continuity of care - an aspect of coordination of care - is the patient’s experience of care over time. It is often described in terms of three dimensions: information, relational and management continuity.

This study aimed to (1) explore how information continuity supports coordination; and, (2) investigate conditions required to support information continuity.

Four diverse Australian primary health care initiatives participated in the study. Each with improved coordination as an aim or fundamental principle. Practitioners, managers and decision makers who could provide insight into the use of information for continuity and coordination of care were interviewed.

The study found that availability of information is not sufficient to ensure continuity of care for the patient or coordination of care from the systems perspective. Policy directed at information continuity must give consideration to the broader ‘fit’ with management and relational continuity and provide a broad base that allows for local responsiveness in order for coordination of care to be achieved.

For more information visit: https://researchers.anu.edu.au/researchers/banfield-ma
STREAM 4
HOW TO MEASURE AND MONITOR OVER TIME VARIATIONS IN PRIMARY HEALTH CARE NEEDS, ACCESS, CARE AND OUTCOMES

Monitoring access to services and patient outcomes and experiences is essential for improving quality, stimulating innovation in the design and delivery of health care and improving accountability.

To function effectively and fulfill both system and service-oriented sets of objectives, measures need to address aspects of health care performance that are of relevance to consumers and that are also aligned with measures of organizational and service performance that can be influenced by providers.

The means by which such information might best be collected, analysed and reported to promote the overall standard of care and reduce variation between settings is the subject of research among primary health care providers and consumer advocates in Australia, as it is internationally.

A key emerging area of interest is the use of outcomes based funding to promote quality and efficiency and the governance and other arrangements that are required to support accountability in this context.

A key emerging area of interest is the use of outcomes based funding to promote quality and efficiency and the governance required to support accountability
PROJECT SPOTLIGHT
CONTINUOUS CARE IMPROVEMENT IN ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES: AN INDIGENOUS RESEARCH PARTNERSHIP

Dr Karen Gardner, Project Leader

Research Team
- Dr Karen Gardner
- Assoc Prof Beverly Sibthorpe
- Dr Justin McNab
- Ms Kanupriya Kalia Hehir

In 2012, the Continuous Care Improvement project was developed under the Indigenous Research Partnership between APHCRI@ANU and the Aboriginal Health Council of Western Australia (AHCW). The current and ongoing project tests the feasibility of embedding a new model of Continuous Quality Improvement (CQI) in six Western Australian Aboriginal Community Controlled Health Services.

The model involves the nomination of a ‘Quality Lead’ person in each service and the use of information technology to implement three core components:
- mentor supported online training and practice;
- rapid Plan-do-Study-Act (PdSA) cycles; and
- AHCW-based clinical governance support for uptake of evidence in services and communities.

There has been a decade of investment in CQI in Aboriginal and Torres Strait Islander primary health care services. However, CQI activities have not been embedded in everyday practice in many services.
PROJECT SPOTLIGHT

NATIONAL CENTRE FOR GEOGRAPHIC & RESOURCE ANALYSIS IN PRIMARY HEALTH CARE (GRAPHC)

Research Team

Dr Ian McRae
Dr Soumya Mazumdar

Paul Konings
Le Ma

Michael Hewett
Lisa Cornish

Dr Nasser Bagheri

GRAPHC was established in 2011 to support geographic and location-based aspects of primary health care research. It aims to promote and facilitate the use of geographically based data and analytical tools to develop evidence base for research into the primary health care system in Australia.

Geographic Information Systems (GIS) are ideal tools for analysing disparities in health outcomes, availability of services, environmental risks, workforce shortages and other contemporary issues in primary health care.

GRAPHC’s tools allow users to view, compare, extract and investigate data, and upload their own data without compromising confidentiality. The tools are free to use and are available on the GRAPHC website.

GRAPHC actively engages with researchers nationally, supporting a variety of activities including geo-attribution, workforce analysis, medical student mapping, spatial aggregation, sample stratification and visualisation and mapping for reports and journals.

For more information visit: http://graphc.aphcri.anu.edu.au

Paul Konings, Spatial Scientist

Informing locally relevant and equitable solutions for targeting health resources and services
APHCRI RESEARCH STREAMS
EVIDENCE INFORMING THE FUTURE OF
AUSTRALIAN PRIMARY HEALTH CARE
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2015
FOREWORD

The Australian Primary Health Care Research Institute (APHCRI) is supported under the Australian Government Department of Health’s Primary Health Care Research, Evaluation and Development (PHC RED) Strategy.

The research that APHCRI funds is based on national priorities and informs politicians, policy makers, health care providers and consumers about how primary health care and the primary health care system can be improved. It has a tangible impact on policy and practice.

The projects that APHCRI funds through the Research Streams are in areas that have been identified as government priorities. Funding is typically for 18 months with a maximum of $150,000.

Over the years APHCRI has funded a number of Research Streams, covering a wide array of issues related to primary health care. This Research Portrait looks specifically at the projects that have been funded since 2012 under three Research Streams:

- Coordination and the Vulnerable Consumer
- The Relationship Between Sub-Acute Care and Primary Care
- Integrated Primary Care Centres

Information about earlier projects funded through Research Streams is available on the APHCRI website.

This is a companion volume to two other Research Portraits which encompass research funded through the Centres of Research Excellence and research conducted in-house by APHCRI@ANU. These are also available on the APHCRI website.

Associate Professor Terry Findlay
Head of Programs
COORDINATION AND THE VULNERABLE CONSUMER

APHCRI awarded funding for six projects under the Coordination and the Vulnerable Consumer Health Care Research Stream. Vulnerable consumers often have complex and health and social needs and the delivery of primary health care services to these consumers involves contributions from many different professionals and organisations, including some outside the health care system. These projects investigated how primary health care for such vulnerable consumers can be consumer centred, best delivered and coordinated.

All of these projects are now completed. Reports from each project are available on the APHCRI website.
This study identified key attributes of successful care coordination models in order to improve health outcomes for people with an intellectual disability in rural Australia.

People with an intellectual disability make up 2-3% of the population. They suffer from higher mortality and reduced life expectancy rates and further suffering is caused by a range of physical, attitudinal, communication and systemic barriers to accessing mainstream health care services. Disability services are especially limited in rural areas.

The study showed that in order to improve the health outcomes of people with an intellectual disability in rural areas, there must be sustainable, long-term models of care coordination. Care coordinators should be situated in local primary health care organisations and must act as trusted navigators for clients. This study also proposed benchmarks for health outcomes for people living with an intellectual disability and explored the feasibility of measuring these against local and practice population data to help enforce health care service accountability.
The impact of equity focused health impact assessments (EFHIA) on local planning for after hours care to better meet the needs of vulnerable populations

Chief Investigator: Dr Elizabeth Harris

Based at: Centre for Health Equity Training, Research and Evaluation, University of New South Wales, NSW

This exploratory study sought to establish whether utilising Equity Focused Health Impact Assessments (EFHIAs) would be an effective strategy for improving access and equity to vulnerable population groups. It also aimed to establish whether engaging health consumers and vulnerable groups in local health planning would improve access and equity.

A key role of Medicare Locals / Primary Health Networks is to address issues of access and equity of health care programs, to all members of the community; in addressing this issue Medicare Locals are developing after hours care plans. Populations identified as having the most difficulty accessing high quality after hours care are remote and regional communities, Indigenous Australians, recent immigrants, elderly people and people from disadvantaged backgrounds.

This study developed methodologies to assist Medicare Locals / Primary Health Networks in the consideration of access and equity issues in planning and development. These methodologies include EFHIAs and using an equity lens or equity audits.
OVERCOMING BARRIERS FOR TRANSITIONING VULNERABLE CLIENTS FROM TARGETED PROGRAMS TO MAINSTREAM PRIMARY CARE

Chief Investigator: Associate Professor Virginia Lewis
Based at: Australian Institute for Primary Care & Ageing, La Trobe University, VIC

This project considered the refugee health needs in a large inner suburban community health service. It investigated, through conducting a literature review and a series of interviews, ways to improve management and coordination of long term primary health care service delivery to vulnerable consumers.

Identifying need is a strategy in policy development which helps to focus attention on groups that might otherwise be marginalised in the health care system. A systematic response is required to ensure primary health care for vulnerable consumers is timely, appropriate and responsive.

The study suggested that at the service level, defining consumers as “vulnerable” only by virtue of their belonging to a population group rather than as a dynamic set of individual characteristics and circumstances that can change over time undermines the system’s capacity to ensure access to care for those with most need. Providing primary health care to vulnerable consumers is complex and time-consuming. Regular assessments of individuals who receive specialised primary health care services can determine the level of care required and assist with their transition to mainstream health care services when this is appropriate.
Y HEALTH—STAYING DEADLY

Chief Investigator: Dr Annapurna Nori
Based at: Watto Purrunna Aboriginal Health Services, SA

This project used a Community Based Participatory and Translational Action Research approach to develop and implement a Youth Health Check and, in partnership with the Menzies School of Health Research, also developed a Youth Audit tool.

Indigenous youth are at-risk health consumers, largely overlooked as seekers of health care. The Medicare Benefits Schedule Aboriginal & Torres Strait Islander Health Checks (MBS Item 715) covers children, adults and older persons, but is unsatisfactory in addressing youth health needs.

Support for a youth specific health check was found in the local and broader Indigenous community. An evidence-informed, strengths-based and culturally valid Youth Health Check was developed and successfully implemented. Efforts are underway to seek an adjustment of the MBS Item 715 to include a Youth category (12-14 years). This study addressed significant gaps in appropriate preventive screening for Indigenous youth and highlights the role of prevention as a core component of the Australian Government’s Close the Gap efforts. It also increased research capacity within Indigenous primary care, in particular that of Indigenous researchers.
COORDINATED PRIMARY HEALTH CARE FOR REFUGEES: A BEST PRACTICE FRAMEWORK FOR AUSTRALIA

Chief Investigator: Professor Grant Russell
Based at: Southern Academic Primary Care Research Unit, School of Primary Health Care, Monash University, VIC

This project reviewed international evidence and conducted new research into developing a framework for the delivery of accessible and coordinated primary health care to refugees. Australia permanently resettles over 20,000 refugees each year. The complex social, physical and mental health problems faced by refugees require high quality, accessible and coordinated primary health care.

The research found that consumer-focused, accessible and coordinated primary health care can emerge from a model where permanently resettled refugees could receive an initial six months of care from generalist, refugee-focused primary health care services, prior to transitioning to mainstream primary care. Ongoing care benefitted from health case managers, qualified interpreters, and minimal barriers to cost. This model requires partnership between the Commonwealth Department of Health, State Governments, Primary Care Networks, Local Health Authorities, and educational organisations. A National Refugee Health Network could further support the work.

Our work highlighted how easy it is for refugees to "fall through the cracks" between the many services charged with easing their transition into a new country.
THE SPRINT PROJECT: PRIMARY HEALTH CARE SERVICES BETTER MEETING THE HEALTH NEEDS OF ABORIGINAL AUSTRALIANS TRANSITIONING FROM PRISON TO THE COMMUNITY

Chief Investigator: Dr Jane Lloyd
Based at: Centre for Primary Health Care and Equity, University of New South Wales, NSW

The SPRINT project involved a partnership between the University of New South Wales, the Aboriginal Medical Service Western Sydney, the University of Western Sydney and the University of Technology Sydney. The project looked at the primary health care needs of Aboriginal Australians as they transition from custody back into the community.

Indigenous Australians transitioning from the criminal justice system to the community have multiple, long-standing health issues, and are at high risk of illness and injury in the 12 months post release. While their need for social support and health interventions is high, they are likely to face many barriers in accessing the essential services required to settle back into community life. This has serious consequences, particularly with respect to health. A lack of support for prisoners during transition has also been shown to increase the likelihood of reoffending.

Through conducting systematic literature reviews, linked dataset analysis and qualitative interviews, this study found there is inadequate continuity of comprehensive health care in the context of Aboriginal inmates’ complex needs and significant emotional distress and anxiety. This contributes to the higher risk of injury and illness experienced by Aboriginal former inmates post release, and to the institutionalisation of Aboriginal people within and outside the criminal justice system. To ensure continuity of health care in custody and post-release, policy makers need to develop relevant governance and infrastructure to support effective “throughcare” programs for Indigenous people. This may include expanding the duty of care of corrective services or supporting community agencies to run transition programs for Indigenous people, enabling the use of Medicare items for Indigenous people in custody, and involving community service providers and family members in the development of individual discharge plans.
APHCRI is funding five projects under the Relationship Between Sub-Acute and Primary Care Research Stream. This Research Stream uses aged care and/or mental health care as examples to:

- Trial with relevant Medicare Locals / Primary Health Networks the smooth transition between sub-acute care and primary care, noting that for many people in the above two categories it is during the transfer from one system to another that they become disadvantaged.
- Specifically examine the hospital/aged care interface, noting the gaps that become evident for the elderly when they transition from one sector to another.
- Explore the patient journey including the ‘Living Will’.
- Reduce the number of elderly patients who present in emergency departments unnecessarily through a better understanding of the patient journey.
- Design the ‘Service Response’ for both the elderly and patients requiring mental health care.
- Link Medicare Locals / Primary Health Networks to a wide range of social services.
- Develop strategies for preventing patient re-entry from primary health care to sub-acute or acute care.

These projects are all funded for the period from March 2014 to April 2015. Further information is available on the APHCRI website.
JOIN THE CONVERSATION: EVALUATING THE EFFECTIVENESS OF EXPERIENCED BASED CO-DESIGN IN IMPROVING THE CLIENT EXPERIENCE OF MENTAL HEALTH TRANSITION ACROSS HEALTH SECTOR INTERFACES

Chief Investigator: Ms Kathryn Cranwell
Based at: College of Health and Biomedicine, Victoria University, VIC

This research targets consumers with mental health and complex health care needs who are frequent presenters to hospital emergency departments and high users of health care. It is following their experience as they make the transition from sub-acute care to primary care services and is gathering ‘touch points’ (emotionally significant points) or opportunities to improve their experience.

Mental health issues have been prioritised as a high need area by the health service providers of the western region of Melbourne. There is a pressing and regionally supported call for an organised and systemic approach that breaks the cycles of repeated crisis intervention and fragmented care experienced by people with complex mental, medical and social health care needs.

The Western Region Experienced Based Co-Design research project, led by Western Health, focuses on working together with consumers of mental health services to improve their experience as they transition from sub-acute to primary care services and self-management support. The research project is working specifically with the Western Health Mental Health Hospital Admission at Risk Program, which is a step-down service providing intensive care coordination and support to consumers with mental health issues that frequently present to tertiary, and primary care services (principally GPs). Researchers are gathering the experience of consumers, their families and those who work in the industry and aims to promote service and system integration to improve the consumer experience in the future. This research methodology does not simply request feedback from consumers but actually involves them and their experience in shaping the design of future services. This approach has proved successful in making a tangible and sustainable difference to consumers.
This project is using a qualitative methodology to examine the journey by older people presenting at emergency departments who are referred to the Geriatric Evaluation and Management (GEM) service and discharged to the community. It is examining service experience, needs and access to services from the perspective of patients, carers and service providers.

The GEM model of care is a national policy direction for multidisciplinary, coordinated care of older patients with multiple conditions and complex health care needs who present at the hospital emergency department. There is compelling evidence that a GEM model of care is effective in reducing functional decline, mortality and discharge to residential aged care. However, due to system fragmentation and the complex needs of older patients following discharge, a GEM service is unlikely to significantly impact on avoidable hospital admissions unless issues at the acute, sub-acute and primary care interfaces are also identified and addressed.

The study, based on the regional centre of Cairns, will provide a longitudinal perspective on the patient journey through acute, sub-acute and primary care and empirical evidence of what matters to patients in sub-acute care. It will identify service gaps in addressing health and social care needs across the spectrum of care and specify the critical components of integrated care for older people in the community. It will provide policy makers and health service planners with evidence-based recommendations for improving the quality of sub-acute care and system interfaces so that fewer older patients present unnecessarily for hospital care.

Chief Investigator: Dr Edward Strivens
Based at: Cairns and Hinterland Hospital and Health Service, QLD
IMPROVING THE ‘NETWORK PLANNING AND MANAGEMENT’ OF INTEGRATED PRIMARY MENTAL HEALTH CARE FOR OLDER PEOPLE IN RURAL REGIONS

Chief Investigator: Professor Jeffrey Fuller

Based at: School of Nursing and Midwifery, Flinders University, SA

The aim of this project is to validate and test a model for Medicare Locals / Primary Health Networks to plan and manage the development of integrated primary mental health care for older people, using a participatory Plan, Do, Study, Act cycle. A rural region in South Australia is being used as a case study to examine the interaction between mental health services, primary health care, aged care and other community services as they seek to meet the mental health care needs of older people.

There is significant unmet need for mental health care for people aged over 65, with serious consequences for their mental and physical health. Older people in rural communities are particularly disadvantaged in terms of availability and access to mental health care services. Linkages and collaboration between mental health, generalist primary health, specialist medical and other human services has been advocated in Australian national policies relating to mental health care.

An evidence-based theoretical model for managing integrated primary mental health care services has been developed that consists of two parts: (1) Model Components – a systematic literature review will establish the linkage strategies and management enablers that lead to effective outcomes for integrated primary mental health care; and (2) Model Process – a participatory Service Network Analysis to assess the extent and effectiveness of the current primary mental health care network in the region and how this can be improved. The main outcome will be a tested network planning model for a Medicare Local / Primary Health Network to engage sub-acute and primary health care services in a rural region to improve service coordination, develop agreed protocols, strengthen partnerships and establish network commitment for older persons’ mental health care.

A well networked range of local services can help carers get the necessary care for their older relatives with mental health issues.
FUNCTIONAL DECLINE IN COMMUNITY-DWELLING OLDER PEOPLE AND THE MEDICARE 75+ HEALTH ASSESSMENTS

Chief Investigator: Professor Karen Grimmer
Based at: School of Health Sciences, University of South Australia, SA

This project aims to understand why and how Functional Decline (FD) in older people often goes unrecognised in the community until it is too late to arrest it, and how this can be rectified by better linkages between sub-acute and primary health care sectors. The focus is on people who are on the cusp of, or have incipient FD and are not receiving formal community supports to assist them to live independently and safely in the community.

Functional Decline is the loss of ability to live independently and safely in the community. FD reflects increasing physical, social and cognitive frailty, and we know that age alone is not a good FD predictor. FD usually occurs insidiously, and unless health care providers in primary and sub-acute settings are alert to, and aware of, its features, and unless older people, their families and neighbours are aware of its manifestations, crises can occur without warning.

The project will identify critical elements of FD from the literature, coupled with health care providers, community and individual perspectives, and ways in which these critical elements of incipient FD can be translated into policy. The goal is to develop strategies for comprehensive community FD identification, which supports timely interventions within, and better linkages between, primary and sub-acute care sectors.
REDIRECT: REDUCING OLDER PATIENTS’ AVOIDABLE PRESENTATIONS FOR EMERGENCY CARE TREATMENT

Chief Investigator: Professor Danielle Mazza
Based at: Department of General Practice, Monash University, VIC

This project aims to better understand the journey of older patients who present to hospital emergency departments unnecessarily and re-enter acute or sub-acute care from primary care.

Caring for an ageing population raises significant challenges to the health care system, including emergency care. Research shows that increasing numbers of older patients (≥ 70 years) are attending emergency departments, many four or more times per year.

The project involves the analyses of four highly relevant datasets: MAGNET (Melbourne East Monash General Practice Database), MMDS (Melbourne Medical Deputising Services) dataset, VEMD (Victorian Emergency Minimum Dataset), and DYNOPTA (Dynamic Analyses to Optimise Ageing) dataset. Synthesise of these findings and interviews and focus groups with key stakeholders will enable the development of alternative care models applicable at a local level. Their generalisability to other settings will be explored.

Too often older Australians bypass GPs and go straight to hospital EDs with non-emergency conditions; we need to improve the options for managing health care of the elderly in primary and community settings.
INTEGRATED PRIMARY CARE CENTRES

APHCRI is funding five projects under the Integrated Primary Care Centres Research Stream. These projects are directed at finding answers to the following questions around effective integration:

➢ What are the enablers and barriers to achieving integration of different service types, for example allied health, social care, acute care?
➢ What are the enablers or barriers to co-located services achieving objectives of improved integration and access?
➢ Are there any differences between GP Super Clinics and other co-located models such as Health One/ GP Plus that have an impact on achieving objectives of improved integration and access?
➢ Using individual GP Super Clinics as case studies:
   ➢ what has been the role of the centres in diverting emergency department presentations? what factors have contributed to successful diversion e.g. co-location, triage and service profile?
   ➢ what has been the experience of consumers and what education/communication strategies have been required and effective?
   ➢ what has been their role in development and implementation of e-health initiatives and virtual networks to support integration?
   ➢ what measures of service quality have been adopted for individual services and for the centre as whole?
➢ What are the potential frameworks that would support quality improvement in multi-service/discipline integrated care settings?

These projects are all funded for the period from April 2014 to October 2015. Further information is available on the APHCRI website.
ANALYSIS OF THE SUPPORTS AND HINDRANCES TO THE INTEGRATION OF CO-LOCATED SERVICES IN MULTIPLE MODELS OF PRIMARY HEALTH CARE DELIVERY

Chief Investigator: Professor Nigel Stocks
Based at: Discipline of General Practice, University of Adelaide, SA

The aim of this project is to produce a plain language report that identifies enablers of and barriers to integrated health care. Importantly this work will include patients’ response to this form of service provision.

There are no prescriptive guidelines for the provision of integrated care and a variety of models has been set up to provide multidisciplinary approaches to patient care; these include GP Super Clinics, the GP Plus model, and private co-located health services. This project is investigating mechanisms supporting and hindering health service integration in community and primary care by examining different co-location models that are representative of the diversity of models operating throughout Australia.

The six participating case study sites in South Australia all provide integrated multidisciplinary approaches to patient care. This project is exploring how integration is operationalised within these different service sites, as well as examining extent of integration with other levels of care external to the case sites. A research framework is being used to investigate a comprehensive range of components, including methods and supports for integration, patient experience of integration and the tools used, and a mixed method research approach is being used to closely examine how service integration is supported or confounded in the different models.
EMERGING MODELS OF INTEGRATED PRIMARY HEALTH CARE CENTRES: THEIR IMPACT ON ACCESS AND INTEGRATION OF CARE AND CONTRIBUTING FACTORS

Chief Investigator: Dr Julie McDonald

Based at: Centre for Primary Health Care and Equity, University of New South Wales, NSW

The study will identify effective strategies and gaps in ensuring access and integration within Integrated Primary Health Centres (IPHCs) and the factors which contribute to these, including aspects of national and state policy. It will describe the processes by which these strategies are developed and the systems and routines which sustain them. This will be valuable to services wishing to improve access and integration, and also for governments wishing to ensure that their programs support high quality primary care.

Increasing rates of chronic illness within an ageing population will require increasingly accessible and well integrated primary care services. Although there is some evidence that IPHCs can improve access and integration, we do not currently know which types of IPHCs are best able to do this in the Australian context, the most effective approaches for them to adopt, or what aspects of government policy best support them. This study will show how successful different types of IPHCs are at maximising access and integrating care, the strategies they use and how this can be supported through policy.

Case study methodology is being used to describe the approaches (systems, arrangements and organisational routines) that IPHCs use to maximise access and integration of care, with a particular focus on people with chronic conditions as an identifiable group for whom access and integration are of particular importance. This involves site visits to undertake interviews, reviews of documents and administrative data, and staff surveys.
PRINCIPLES AND PRACTICE OF PRIMARY HEALTH CARE INTEGRATION: LEARNING AND UP-SCALING RESULTS FROM A REGIONAL GP SUPERCLINIC

Chief Investigator: Professor Susan Nancarrow
Based at: School of Health and Human Sciences, Southern Cross University, NSW

This project will have two significant outcomes. Firstly, an understanding of the nature and extent of integration at the Lismore GP Super Clinic, together with some tools to assist change, as appropriate; secondly, an understanding of the general nature of integration from the three-tiered perspective (patient, service and system), with special insights for working with demographic sub-groups within the wider community. This will culminate in a practice guide that can be used by other primary care services to enhance their integration.

The literature demonstrates that patients are less likely to access prescribed health and medical services when this involves them going through multiple steps. Therefore, having co-located services, and streamlined referral processes, not only makes life easier for health and medical consumers, but should improve community health outcomes. GP Super Clinics are designed to meet this demand by providing a “one stop shop” of health and medical services for consumers.

This case study of the Lismore GP Super Clinic is exploring how primary care services are integrated at the patient, service and system level. It is looking at patient referral networks and referral pathways (service-level integrations) and how the Super Clinic is integrated with the wider regional community (systems-level integration), to assess how far these networks spread and their density with regard to populations with particular demographic characteristics. Based on the findings, from both qualitative (thematic analysis of the narratives) and network analysis, an integration ‘model’ will be developed.
INTEGRATING CARE: ORGANISATIONAL PROCESS, PATIENT-CENTRED OUTCOME OR BOTH? LEARNING FROM FIRST GENERATION INTEGRATED PRIMARY HEALTH CARE CENTRES

Chief Investigator: Associate Professor Kirsty Douglas
Based at: Medical School, Australian National University, ACT

This project uses case studies in two award winning comprehensive primary health care centres with complex and vulnerable patient populations to systematically explore the formal and informal mechanisms that support integrated interdisciplinay practice for co-located primary health care services.

The project views integration from two perspectives: as an organisational through-put or process and as a service or system outcome for the patient. In the former, integration refers to the clinical and administrative coordination undertaken by individuals and teams to deliver services in an ‘integrated way’: it can be described in terms of the processes which are enacted to achieve clinical goals, improve service access or system efficiency. In the latter, integration is perceived from the patient’s standpoint and reflects on the connectivity, alignment and coherence of the lived experience of service utilisation.

Mixed qualitative methods including physical mapping, social network analysis, oral histories and patient journeys are being utilised to describe both organisational (processes) and the patient (outcome) perspectives. Project data from case studies will be to develop a set of system attributes which can be applied via a case base simulation exercise to assess the integration of medical and social care. This exercise is a translational tool which can be utilised by other multidisciplinary primary care services (including Super Clinics) to help them to explore drivers and constraints of integration, targeting both processes (collaboration, communication, coordination) and outputs (organisational strength, patient experience).
E-HEALTH INITIATIVES AND HEALTH CARE INTEGRATION IN GP SUPER CLINICS

Chief Investigator: Professor Siaw-Teng Liaw

Based at: School of Public Health and Community Medicine, University of New South Wales, NSW

This project involves eight Integrated Primary Care Centres (IPHCs) selected from NSW, Victoria, and South Australia. The focus is on the extent that e-health tools are used to achieve integration and integrated care. Differences, gaps and possible barriers and facilitators in the development and implementation of e-health initiatives will be detailed and reflect on how the findings might guide policy and practice to improve integration and integrated care in the three most populous states in Australia.

The National Primary Health Care Strategy has emphasised e-health as one of five key system-wide building blocks to underpin a responsive and integrated primary health care system for the 21st century.

This study will: (1) explore the extent to which the e-Health initiatives are implemented and used to support integration by the selected IPHCs; (2) understand how e-health initiatives and virtual networks are used in the IPHCs to facilitate integration and integrated care globally; and (3) understand the underlying mechanisms, barriers, enablers and contextual factors that have influenced the development and use of e-health tools to support integration and continuity of care. A core principle is that e-health supported and enhanced integration of inter-professional care must be organised around needs of patients and carers. Analysis and benchmarking will draw on international experience with primary health care and e-health models and tools, including the concept and requirements for a patient-centred medical home in the context of a health/medical neighbourhood.