1-3 NOVEMBER 2017, SURFERS PARADISE MARRIOTT

10TH HEALTH SERVICES & POLICY RESEARCH CONFERENCE

Shifting priorities: balancing acute and primary care services

Abstracts Book

Presented by
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#hsr17
www.healthservicesconference.com
Queensland Health is addressing the balance between acute and primary care services through the Integrated Care Innovation Fund (ICIF).

ICIF supports the development and progression of new models of care and approaches to integrated service delivery.

These models and approaches enhance primary health care and technology and allow patients, particularly those in rural and remote locations, to access care closer to home.

Learn more about ICIF by attending HSRAANZ 2017 Symposium 2 on Wednesday 1 November 2017.

Or visit www.health.qld.gov.au/improvement
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WELCOME:
HEALTH SERVICES RESEARCH ASSOCIATION OF AUSTRALIA AND NEW ZEALAND (HSRAANZ) EXECUTIVE

On behalf of the Health Services Research Association of Australia and New Zealand (HSRAANZ) Executive, it is my great pleasure to welcome you to the 10th Health Services and Policy Research Conference.

For over 15 years, HSRAANZ has facilitated communication across researchers, and between researchers and policymakers. Every two years, we advance this conversation with the Health Services and Policy Research Conference.

Recognised as the preeminent health services research event in Australasia, the conference provides health services researchers, including clinicians, with a single national opportunity to share their research, and to build capacity by strengthening collaborations across health sectors.

The conference theme, “Shifting priorities: balancing acute and primary care services” focuses on current and future priorities for resources in acute and primary care as we work towards a sustainable, future-ready, patient focused healthcare system. This theme is highly relevant to the current priorities of Queensland Health, Principal Partner of HSRAANZ 2017.

The conference strengthens our support of health services research, the healthcare sector and Indigenous health. HSRAANZ 2017 includes key programming of Indigenous researchers and delivers a strong programme of early career researcher events.

On behalf of the HSRAANZ Executive, I thank our sponsors, corporate members, conference organising committee and scientific review committee for their commitment and support. The conference could not exist without your ongoing and significant support.

Enjoy the conference!
Jon Karnon
HSRAANZ President

ABOUT HSRAANZ

Founded in 2001, the Health Services Research Association of Australia & New Zealand (HSRAANZ) supports and promotes the conduct and dissemination of applied research to improve the delivery and organisation of health services in Australia and New Zealand.

With a wide range of individual and corporate members from universities, research centres, government departments, independent government agencies, and consumer groups, the Association bridges the gap between research and policy, as well as reflecting consumer issues.

We also have two special interest groups, focussing on Emerging Researchers and Indigenous Health Services Research, both of which have a prominent role at HSRAANZ 2017.
WELCOME:
AUSTRALIAN CENTRE FOR HEALTH SERVICES INNOVATION (AusHSI)

The time for value-based, patient-centred healthcare is here.

AusHSI’s mission is to empower health decision-makers to implement and sustain innovations for better health services by providing insights from research. In keeping with this, AusHSI is proud to be hosting the 10th Health Services and Policy Research conference.

AusHSI has worked closely with our partner Queensland Health, to ensure the conference features the latest in outcomes-focused research, promoting partnerships between clinicians and academics from Australia and abroad.

Conference workshops include a half-day intensive on translating knowledge into practice, further highlighting our commitment to enabling the uptake of research.

We are committed to bringing new ideas, and have introduced themed plenary sessions: ‘Academia meets Practising Clinicians’. These sessions build on the applied nature of the conference, relevant to our clinician and researcher audience and allow for two perspectives on a topic.

A Shark Tank session will close our conference, as health service innovators ‘pitch’ an integrated care innovation to senior health services decision makers.

I look forward to meeting with you at HSRAANZ 2017.

Megan Campbell  Nicholas Graves
AusHSI Centre Director  AusHSI Academic Director

ABOUT AUSHSI

The Australian Centre for Health Services Innovation (AusHSI) is a research, consultancy and training organisation. Combining leading-edge knowledge with hands-on, practical experience, AusHSI partners to deliver innovation and improvements for better health services.

We integrate research findings into policy and practice, and help make changes that result in greater efficiencies and enhanced patient outcomes. We are committed to advancing new ideas with positive impact and championing partnerships between researchers, clinicians and policymakers.

Our team includes internationally leading health economists, epidemiologists, statisticians, health service and implementation researchers and consultants. We share a commitment to seeking out new ideas, translating knowledge into practice and using resources wisely to accomplish more with less.
WELCOME: QUEENSLAND HEALTH
Welcome to the 10th Health Services and Policy Research Conference, an event Queensland Health is pleased to support in 2017 as a principal partner.

The conference theme ‘Shifting priorities: balancing acute and primary care services’ has application across Queensland Health and our geographically dispersed state.

Queensland Health has been addressing this balance through numerous initiatives including the Queensland Government’s $35 million Integrated Care Innovation Fund. ICIF supports Queensland’s Hospitals and Health Services to collaborate with Primary Healthcare Networks and other community health providers to develop and progress new models of care and approaches to integrated service delivery.

This genuine commitment to better integrating healthcare in Queensland also targets the dual health system challenges of chronic disease and service fragmentation.

Twenty-three locally-led ICIF initiatives are now being implemented across Queensland. This investment enables clinicians to work across traditional professional and organisational boundaries to provide services that ‘better meet the needs of the patient’.

It also enhances primary health care and technology and allows patients, particularly those in rural and remote locations, to access care closer to home.

You can learn more about ICIF, among HSRAANZ 2017’s wealth of high-quality presentations and information, by attending Symposium 2 on Wednesday 1 November 2017.

HSRAANZ 2017 provides attendees with a unique opportunity to learn and grow and to consider whether successful local models, policies or research might have application in their own healthcare setting.

The HSRAANZ 2017 conference programme genuinely offers ‘something for everyone’ as we collectively strive to deliver sustainable and functional health systems into the future. Enjoy!

ABOUT QUEENSLAND HEALTH
Queensland Health is the state’s largest healthcare provider, delivering a healthcare system that ranks amongst the best in the world. Through a network of 16 Hospital and Health Services, as well as the Mater Hospitals, Queensland Health delivers a range of integrated services.

These services include hospital inpatient, outpatient and emergency services, community and mental health services, aged care services, and public health and health promotion programs.

Queensland Health is committed to ensuring all Queenslanders have access to a range of public hospitals and healthcare services aimed at achieving good health and wellbeing.

Collectively Queensland Health will aspire to achieve our common vision that ‘By 2026 Queenslanders will be among the healthiest people in the world’.
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Adrienne Young, Royal Brisbane and Women’s Hospital
CALL FOR ABSTRACTS

HSRAANZ 2017 invited researchers and clinicians to present a research project or health services innovation on the theme of “Shifting priorities: balancing acute and primary care services”. The range of work invited included: applied research, methodology papers, incomplete work, opinion pieces and research outcomes.

Presenters were asked to submit their research project or health services innovation in the format of an unstructured overview or traditional structured format (background, aims, methods, results and conclusion), with the review committee interested in what their research did, and why; what it achieved; and what the impact has been (if known).

Authors were required to select one primary and two secondary ‘tags’ to describe their work and submissions were favoured at review if they incorporated original data of high quality and/or an analysis that extends existing knowledge (rather than projects that are underway, or presentations of research protocols).

A streamlined submission and review process allowed for a smaller Scientific Review Committee of 30 members, a mix of researchers and clinicians. The committee, formed with representatives of the conference organising committee and external invitees graded each abstract with a “yes”, “no” or “maybe” with individual reviewer comments.

SYMPOSIUM ORAL PRESENTATIONS
A group of related presentations (3-5 presenters) as a symposium proposal around a central theme; each symposia will have a 90 minute (75 minutes presentation followed by 15 minutes for questions) allocated time slot.

INDIVIDUAL ORAL PRESENTATIONS
Oral presentations will have a 15 minute time slot (12 minutes presentation followed by 3 minutes for questions).

ORAL POSTER PRESENTATIONS
Authors will have three minutes to highlight key points of their work in a brief oral presentation, and will be available for further questions and discussion at the conclusion of presentations.

STANDARD POSTER PRESENTATIONS
Printed posters have been allocated a one-day time slot, for display at the venue during the conference, with attendees able to view posters during catering breaks.

THREE MINUTE THESIS COMPETITION (3MT)
Higher degree research students, or Early Career Researchers who have completed a higher degree by research within the last 2 years will present their work in the 3-Minute Thesis competition. Each speaker has strictly 3 minutes to present an overview of their higher degree thesis, with a single static PowerPoint slide permitted.
AWARDS
The Health Services Association of Australia and New Zealand (HSRAANZ) and HSRAANZ 2017 conference awards allow us to celebrate colleagues by recognising the achievements of the health services research sector and acknowledge our ‘Best In’ conference.

HSRAANZ AWARDS
Each year the Health Services Research Association of Australia and New Zealand (HSRAANZ) makes a number of awards recognising the best health services research and researchers. Winners of the following awards will be announced at the Welcome Cocktail Reception.

The Distinguished Investigator Award
These awards recognise researchers who have made significant contributions to the field of health services and health policy research in Australia and New Zealand through scholarship and teaching, advancement of science and methods, and leadership (relative to level of award). This year awards will be made for:

- Lifetime Award
- Mid-career Award

Health Services and Policy Research Papers of the Year
These awards recognise the best scientific published works in the field of health services and policy research. This year’s awards will be awarded to:

- Best overall paper
- Best paper by an early career researcher
- Best paper by a PhD student

BEST IN CONFERENCE AWARDS
Awards recognising the selected best work at the conference.

Three Minute Thesis competition (3MT)
We gratefully acknowledge our award prize sponsor, the Journal of Health Organization and Management (JHOM)

Presentations for the best-judged, and audience favourite presentation will be awarded during the Welcome Cocktail Reception.

Conference delegates may vote via the conference app, or via paper vote. Votes will be tallied at the end of the session, and delegates must be present to vote. Please consider originality, aesthetics, clarity and scientific merit when making your selection.

Individual Oral Abstracts
The best abstracts were nominated by our Scientific Review committee, and judged by members of both our Organising Committee and the HSRAANZ Executive. Abstracts were judged on how well their research aligned with the theme of the conference, the tags selected and with Health Services Research methods and outcomes.

We are delighted to present awards to the following abstracts, selected as the very best from a high quality of submissions. Awards will be presented at the Welcome Cocktail Reception.
The Best (Highest Ranked) Abstract:
Using a hybrid discrete-event /agent-based model to examine improved triaging of GP-referred patients to colonoscopies
**Thomas Elliott**, QIMR Berghofer Medical Research Institute
*Oral presented on Wednesday November 1, 11.30am during concurrent session: Acute/Ambulatory care pathways*

Highly Commended:
Gaming the New Zealand Emergency Department target. How did it vary between hospitals, and why?
**Tim Tenbensel**, University of Auckland
*Oral presented on Thursday November 2, 11.15am during concurrent session: Efficiency in the Emergency Department*

The Best (Highest Ranked) Abstract by an ECR:
Journeys to healthcare transformation: Partnering for change through Community-based Participatory Research with Manitoba First Nations
**Grace Kyoon-Achan**, University of Manitoba, Canada
*Oral presented on Wednesday November 1, 1.45pm, during concurrent session: An international Indigenous perspective. This oral will be presented by Josée G. Lavoie, University of Manitoba.*

Oral Posters
The conference includes three concurrent sessions of Oral Poster presentations. One Oral Poster presenter per session will be awarded the opportunity to present their work before a plenary audience.

Conference keynote and plenary speakers will judge the Oral Poster sessions, and rank their scores alongside conference delegate rankings to select one Best Poster per session.

Conference delegates attending the Oral Poster sessions may vote for best Oral Poster, via the conference app. Please consider originality, aesthetics, clarity and scientific merit when making your selection.

Winners receive the opportunity to speak before a plenary audience, Friday November 3, 1.45pm.
WEDNESDAY 1 NOVEMBER

8.30 AM - 9.00AM: PLENARY SESSION

OFFICIAL CONFERENCE OPENING
Megan Campbell, Australian Centre for Health Services Innovation Centre Manager
Welcome to Country
Jonathan Karnon, Health Services Research Association of Australia and New Zealand President
Laura Wilkinson-Meyers, Health Services Research Association of Australia and New Zealand Vice-President

9.00AM - 10.30AM: PLENARY SESSION

KEYNOTE ADDRESS
Session Chair: Jon Karnon, HSRAANZ President

Making the shift: why community-based care will never be the cheaper option
Professor Judith Smith
Director, Health Services Management Centre, University of Birmingham, UK

In this session, Professor Judith Smith will examine the long-standing international policy interest in making a shift of acute care into community-based settings. She will explore and challenge some of the assumptions upon which this desired shift is based, in particular the belief that community-based care will deliver cost savings and reduce pressures on emergency demand for hospital services. Judith will set out a case for sustainable, person-centred and integrated care, exploring what this is likely to entail in practice. She will conclude by arguing that health services research needs to make an important shift if it is to provide the evidence, advice and support required for new forms of care delivery and organisation.

One system to rule them all: governance, professionalism and the search for Mount Doom
Professor Robin Gauld
Pro-Vice-Chancellor (Commerce) and Dean, Otago Business School and Co-Director, Centre for Health Systems and Technology, University of Otago, New Zealand

Health systems have become characterised by complexity, which has increased over time. Examples of this are ubiquitous. Despite the best of efforts, health systems in which complexity has been reduced or eradicated are rare. Ironically, efforts to reduce complexity often have the opposite effect. Meanwhile, questions over health system performance persist as we continue to build and reinforce processes and systems within systems. Some fundamental changes are needed in order to traverse the institutionalised nature of health systems and create arrangements in which everyone works for common goals. This talk will suggest key shifts demanded in terms of governance, and in professionalism and the organisation of professionals.
11.00AM - 12.30PM: CONCURRENT SESSION

SYMPOSIUM 1: HCF RESEARCH FOUNDATION: DRIVING TRANSLATION IN HEALTH SERVICES RESEARCH
Session Chair: Liz Rummery, HCF Research Foundation Director

The HCF Research Foundation proudly commits all research funds to the field of health services research. As a corporate sponsor of the HSRAANZ, and a platinum sponsor of the HSRAANZ biennial conference, the HCF Research Foundation Symposium will provide conference attendees with an overview of key research activities at the HCF Research Foundation that are encouraging positive change in health care policy and practice:

Low-value care – the next quality frontier
Professor Adam Elshaug¹
¹HCF Research Foundation Professorial Fellow

Professor Elshaug is internationally renowned for his efforts to minimise low-value health care. Adam will provide an overview of his work with Choosing Wisely Australia, as well as his ground breaking research which is informing the Federal Governments MBS Review.

iPASS – My tummy hurts: could it be appendicitis?
Dr Mary McCaskill¹
¹Executive Medical Director, Paediatric Emergency Physician, The Children’s Hospital at Westmead, Sydney Children’s Hospitals Network

Mary will present a treatment model for children with abdominal pain using the Paediatric Appendicitis Score (PAS), aimed at reducing unnecessary admissions to hospitals and associated family burden.

Feasibility of implementing the ICHOM Standard Set for Osteoarthritis in clinical practice
Associate Professor Ilana Ackerman¹
¹Department of Epidemiology and Preventive Medicine, Monash University

Ilana will discuss the patient reported outcome implementation program being implemented at Royal Melbourne Hospital using the ICHOM Standard Set for Osteoarthritis.

Inpatient rehabilitation after TKA: what we know, what we don’t know and the path forward
Conjoint Associate Professor Justine Naylor¹²
¹Whitlam Orthopaedic Research Centre, SWSLHD, UNSW; ²Ingham Institute of Applied Medical Research

Justine will provide an overview of three high-level research projects which provide evidence and solutions to assist development of sustainable rehabilitation health care models in Australia.
SYMPOSIUM 2: INTEGRATED CARE INNOVATION FUND

Session Chair: Kaye Hewson, Director Strategic Initiatives, Genetics Health Queensland, Metro North Hospital and Health Service

The Queensland Government’s $35 million Integrated Care Innovation Fund supports Queensland’s Hospitals and Health Services to collaborate with Primary Healthcare Networks and other community health providers to develop and progress new models of care and approaches to integrated service delivery.

Twenty-three locally-led ICIF initiatives are now being implemented across Queensland. This investment enables clinicians to work across traditional professional and organisational boundaries to provide services that ‘better meet the needs of the patient’.

The session will provide an overview of five ICIF projects, detailed below.

**Buying Time: The MNHHS-QCAT Guardianship Process Initiative**

*Mitchell Potts¹, Mary Humphrey², Luke Worth³, Adrian Barnett⁴*

¹Manager Service Improvement Projects, Royal Brisbane and Women’s Hospital; ²QCAT Social Work Coordinator, MNHHS; ³Executive Director Ipswich Hospital; ⁴Statistician, AusHSI

The intervention focused on MNHHS inpatients who lack capacity to make decisions about their care and required the appointment of a substitute decision maker by QCAT. It targeted a reduction in waiting time from application to hearing date through staffing enhancements, process improvement and funding of additional hospital-based hearing days. During 2016/17, data from 255 patients indicates a high probability that the intervention reduced waiting times by around 48 days per patient and length of stay by around 25 days per patient, saving an average of 4,767 bed days at a median cost of $101 per bed day.

**Using the ECHO (TM) model to empower GPs to manage children and young people with Attention Deficit Hyperactivity Disorder (ADHD)**

*Dana Newcomb¹, Perrin Moss¹*

¹Children’s Health Queensland Hospital and Health Service

ADHD is rapidly becoming a major burden for public paediatric outpatient services. Management of children with ADHD is typically provided by paediatricians, despite many children being medically stable and suitable for management by their General Practitioner (GP). Compared to hospital outpatient care, GP-led care would be closer to home, more accessible, and deliver holistic care for the entire family. This hasn’t previously occurred due to lack of GP training in ADHD management.

CHQ will address this problem by training GPs to manage ADHD using Project ECHO (TM) – a model of collaborative, case-based medical education delivered via videoconference. Aims: 1) To increase GP self-efficacy and knowledge in the management of ADHD 2) To deliver family-centred care for children with ADHD in the community 3) To pilot the ECHO (TM) model, with a view to implementing it for other conditions and in other settings. Evaluation will consist of: 1) Measurement of GP self-efficacy and knowledge before and after ECHO (TM) -training 2) Use of Consolidated Framework for Implementation Research to evaluate the implementation of ECHO (TM) in an inner-metro, outer metro, and regional setting 3) Comparison of family satisfaction, clinical outcomes and out of pocket costs associated with outpatient-care versus GP-led care. The project will run until June 2018. Clinical and family satisfaction will not be known until that time, but as training of the first cohort of GPs is due for completion in early July, we will be able to present GP knowledge and self-efficacy outcomes, and interim implementation outcomes.
Maximising access to Hepatitis C (HCV) treatment – The Hepatology Partnership project

*James O’Beirne*¹, Clare Orme¹, Lisa Hall², David Brain², Jon Harper³, Jonathan Mitchell¹

¹ Sunshine Coast University Hospital; ² Australian Centre for Heath Services Innovation, QUT; ³ Central Queensland Wide Bay Sunshine Coast PHN

**Introduction:** Maximizing access to directly acting antiviral agents (DAA) is central to achieving eradication of HCV from Australia. Treatment models based in secondary care represent a barrier to access. Sunshine Coast Hospital and Health Service (SCHHS) has explored new models of DAA therapy to increase access. Methods: SCHHS offers 3 models of care for HCV patients. 1. Traditional secondary care: treatment initiated and monitored by hospital staff, 2. Rapid evaluation liver clinic (RELIC): treatment recommendation made and treatment is initiated and monitored in primary care. 3. Nurse led regional Fibroscan assessment clinics: treatment recommendation by remote MDT and initiation and monitoring of DAA in primary care (Hepatology partnership).

These models maximise access to HCV therapy whilst identifying patients with advanced fibrosis who require secondary care. Results: Since March 2016, 647 patients have been initiated on DAA therapy. 482 secondary care, 110 through RELIC and 55 through the Hepatology partnership. Mean age 50 yrs (18-69), 50% Genotype 1, 40% Genotype 3. 30% F4 and 26% treatment experienced. Sustained virological response (SVR) data is available for 412 patients (356 Hospital based, 56 RELIC). Overall SVR rate is 96.7%. In the hospital cohort SVR rate was 97.5% and in the primary care treated cohort SVR was 95%. (P=NS).Conclusion: Initiation and monitoring of DAA treatment in primary care results in excellent SVR rates which are similar to secondary care. The cost effectiveness of this model is being evaluated as part of the Hepatology partnership program.

**Integrated oral health in remote primary health care locations.**

*Yvonne Mangan*¹, *Stephen Power*², *UU Sheraton*³

¹ Clinical Lead, Torres and Cape Hospital and Health Service; ² Project Manager, Torres and Cape Hospital and Health Service; ³ Clinical Educator, Torres and Cape Hospital and Health Service

Oral conditions rate as one of the major contributing factors in acute preventable hospital admissions in Australia (Health, 2016). The National Oral Health Plan 2015-2024 identifies that oral disease is a burden in remote communities across Australia and a significant cause of preventable hospital admissions. Following screenings in 2015 it was identified that a lack of appropriately trained personnel, oral health promotion and access to oral health services contributed to an increase in serious oral health conditions in the Torres Strait. The Torres Strait Primary Oral Health project aims to address these issues through innovative use of technology and telecommunications in clinical, education, triage and ongoing care environments.

**Integrated Care and Innovation – Floresco Toowoomba, Darling Downs QLD**

*Ms Jacklyn Whybrow*¹, *Ms Leah Christie*²

¹ Acting Regional Manager West- Aftercare QLD; ² Credentialed Mental Health Nurse, Service Manager – Floresco Toowoomba – Aftercare QLD

The Floresco centre will provide an innovative mental health service for adults experiencing mental health illness who require integrated care in the community. The model of care was developed by Aftercare who is already delivering this service in the Ipswich QLD area. The aim of the model is to provide a one-stop clinical support and self-help comprehensive response for people who may be experiencing complex mental health concerns and illnesses, their families and carers. Delivery of service occurs with the partnership between the following services of Aftercare, Queensland Health and the Primary Health Network.
The emphasis is on co-located partnerships with other services such as Alcohol & Drug services, employment, housing, general practice and psychological support services, which are paramount to achieve the aim of providing integrated care to persons experiencing mental illness living in the Darling Downs Toowoomba area.

ORAL PRESENTATIONS (1): ACUTE/AMBULATORY PATHWAYS
Session Chair: Rachael Morton, The University of Sydney

1A: Differences in determinants of hospital utilisation between those with and without disability in the first year following stroke

Nadine Andrew1, Monique F Kilkenny2, Vijaya Sundararajan3, Joosup Kim2, Amanda G Thrift2, Trisha Johnston4, Rohan Grimley5, Melina Gattellari6, Judith Katzenellenbogen7, James Boyd8, Felicity Flack9, Ying Chen10, Dominique A Cadilhac2

1Peninsula Clinical School, Monash University; 2School of Clinical Sciences at Monash Health, Monash University; 3St. Vincent’s Hospital, Melbourne University; 4Health Statistics Branch, Queensland Department of Health; 5University of Queensland; 6Ingham Institute for Applied Medical Research; 7School of Population and Global Health, The University of Western Australia; 8Centre for Population Health Research, Curtin University; 9Population Health Research Network Program Office; 10Clinical Outcomes Research Branch, Victorian Agency for Health Information

Introduction: Patients with stroke often have complex needs requiring resource intensive healthcare. We examined determinants of hospital admissions following stroke in those with and without disability.

Methods: In this longitudinal cohort study we used person-level linkages between the Australian Stroke Clinical Registry (AuSCR 2009-2013) and hospital inpatient separation data from Victoria, Queensland, New South Wales and Western Australia. AuSCR registrants who provided health status (EQ-5D-3L) data at 90-180 days post-stroke were included. Disability was determined from EQ-5D responses. Prior comorbidities were identified using ICD-10 discharge diagnosis codes (Elixhauser index). Admissions at 30-365 days pre-stroke were compared to those 30-365 days post-stroke. Negative binomial regression, stratified by disability, was used adjusting for patient clustering by hospital and pre-stroke admissions.

Results: 5,141 adults (56% male, median age 74 years, 84% ischaemic, 45% with disability) were included from 39 hospitals. Comparing the period of 30-365 days pre-stroke to 30-365 days post-stroke, admissions increased from 0.8 to 2.3 per person in those with disability and 0.7 to 1.5 in those without (p<0.001). Increased admissions in those with disability were associated with younger age (<65 vs 85+ years, IRR:2.5, 95%CI:1.5, 4.0), residence in a major city (IRR:1.4, 95%CI:1.1, 1.8) and spasticity (IRR:1.2, 95%CI:1.01, 1.4). In those without disability, having health insurance/compensation (IRR:1.6, 95%CI:1.2, 2.1) and high compared to low socioeconomic advantage (IRR:1.6, 95%CI:1.2, 2.0) were associated with increased admissions.

Conclusion: Determinants of hospital utilisation post-stroke differed between those with and without disability. Knowledge of disability may assist targeting of interventions to reduce post-stroke admissions.
1B: Super Saturday Clinic: co-designing outpatient clinics with consumers for a patient and family centred approach
Tiffany Best1, Alana Petith2
1 Principal Project Manager iCARE, Children’s Health Queensland, 2Project Officer iCARE, Children’s Health Queensland

The Super Saturday Clinic provided patients and families with the opportunity to access a range of services on the same day. Family feedback demonstrated the importance of integrated care as families were appreciative to access services all in one day and in the same clinic. Working closely with consumers, the co-designed clinic was structured around patient centred care, and proved to be a great success. The Super Saturday Clinic concept emerged after feedback from consumers told us that many families travel from across Queensland to attend multiple appointments at Lady Cilento Children’s Hospital. These appointments are often scheduled across different days, resulting in travel and accommodation costs, plus time away from work, school and the rest of the family. They also noted that appointments scheduled across several days result in service gaps and missed opportunities for education. The co-designed outpatient clinic with consumers saw a range of clinicians and specialties come together to deliver a clinic outside of business hours on a Saturday. This included Rheumatology and Gastroenterology consultants and clinical nurses, physiotherapy, occupational therapy, dietetics, social work, welfare, pharmacy and immunisation. Overall, 119 consultations were delivered within 6 hours. There were 20 patients with 18 of which had 4 or more consults and 5 of these patients had 7 or 8 consults. Families also had access with NGOs to find out about additional support available from the community. This clinic was a success, and consumers appreciated the access to services that they previously may not have had access to.

1C: Using a hybrid discrete-event/agent-based model to examine improved triaging of GP-referred patients to colonoscopies
Thomas Elliott1, Anton Lord1, Lisa Simms1, Graham Radford-Smith2, L.Gordon1
1QIMR Berghofer Medical Research Institute; 2Royal Brisbane and Women’s Hospital

★ The Best (Highest Ranked) Abstract

Background: Demand for colonoscopy services is placing significant pressure on health resources in Australia with over 700,000 procedures annually and costing over $1.1 billion. Current triaging processes do not effectively discriminate patients who will or will not show significant bowel disease (SBD). A new risk assessment tool may improve system efficiency and enhance patient care.

Methods: We constructed a hybrid discrete event/agent-based model in AnyLogic software to simulate the GP-referral patterns, triaging, appointment booking, waiting times and costs for colonoscopies at the Royal Brisbane and Women’s Hospital (RBWH). Using data from a cohort study of 466 GP-referred patients with lower abdominal symptoms, we utilised a newly designed clinical risk assessment tool (RAT) to model the current inefficiency in treatment urgency categorisation. The RAT had a specificity of 98%, showing its appropriateness for use as a rule-in test. We examined the RAT’s effect on waiting times and costs through simulation modelling at the hospital system level.

Results: Approximately 2,200 patients referred to the colonoscopy clinic at the RBWH are treated each year. The RAT improved triaging for 9% of moderate urgent and 4% of least urgent patients. Over a year approximately 89 patients with SBD could receive more timely care. Moderately urgent patients with SBD received care 121 days earlier, while least urgent patients received care 114 days earlier.
Conclusion: Our preliminary analyses indicate the RAT has significant potential to improve the coordination of patient care, improve patient outcomes, spare some patients from colonoscopies, while also saving substantial hospital expenditure.

1D: Impact of an aged-care driven hospital avoidance program on detection of subacute episodes and hospital admissions

Lynne Parkinson¹, Trudy Dwyer¹, Barbara J O’Neill¹, Kerry A Reid-Searl¹, Dee Jeffrey²
¹CQUniversity, School of Nursing, Midwifery & Social Sciences; ²PresCare

Background and Aims: PresCare, a Queensland residential aged care provider developed and successfully introduced a SubAcute Care hospital avoidance program to support staff in proactively identifying and managing deteriorating health of residents. Reduced hospital transfers and lengths of stay were achieved in the pilot program, which was well supported by staff. This study describes one level of evaluation of the roll out of the program (EDDIE [Early Detection of Deterioration in the Elderly]) to a second site.

Method: The study used a participatory action research design and the iterative process of “look, think and act”. Evaluation used a mixed methods approach. The focus of this paper is data from monthly hospital transfer audits.

Results: Eight-nine residents were identified as having a sub-acute episode during the EDDIE program, from June 2016 to February 2017; mean age was 84 (SD=9) years and 65% were women. Twenty-nine percent (n=24) were transferred to hospital during eight months of the program. This contrasts with 103 subacute admissions in the two years beforehand. There was a significant trend for a decrease in subacute admissions after implementation of the EDDIE program. There was no significant difference in length of stay pre and post the Program.

Conclusions: The EDDIE hospital avoidance program appears to have reduced hospital admission for subacute episodes, but not Length of Stay. The year-long assessment identified and addressed potential barriers and introduced actions that contributed to the implementation of this aged-care driven HA program.

1E: Applying sequence clustering techniques to explore practice-based ambulatory care pathways in insurance claims data

Verena Vogt¹, Stefan Scholz², Leonie Sundmacher³
¹Department of Health Care Management, Technische Universität Berlin, Berlin, Germany; ²Bielefeld University, Germany; ³Ludwig-Maximilians-Universität München, Germany

Background Care pathways are a widely-used mean to ensure well-coordinated and high quality care by defining the optimal timing and interval of health services for a specific disease or indication. However, evidence on common sequences of services or treatment patterns actually followed by patients has rarely been quantified. This study aims to explore whether sequence clustering techniques can be used to empirically identify typical treatment sequences in ambulatory care for heart failure (HF) patients and compare the effectiveness of the identified sequences.

Methods: Routine data of HF patients has been provided by a large statutory health insurance fund in Germany from Jan 2009 until Dec 2011. Treatment sequences in ambulatory care were modelled on patient level using each billing quarter as one event. Events have been categorized by either 1) the specialty of the physician, 2) the type of service/procedure provided and 3) the medication prescribed. K-medoids clustering has been applied to identify distinct subgroups of sequences. We used logistic regression to identify the most effective sequences for avoiding hospitalizations.
Results: Routine data of 982 incident HF patients has been analysed to identify typical treatment sequences. Cluster analysis revealed 3 distinct clusters of specialty sequences, 4 clusters of procedure sequences and 4 clusters of prescription sequences. Clusters differ by timing and interval of physician visits, procedures and drug prescriptions as well as comorbidities and HF hospitalization rates.

Conclusions: Sequence clustering techniques can be used as an explorative tool to systematically extract, describe, compare, and analyse treatment sequences and associated characteristics.

1F: STAT model for access and triage reduces waiting in ambulatory and community health services

Katherine Harding1,2, Nicholas Taylor1,2, Sandy Leggat1, Jenny Watts3, Bridie Kent4
1La Trobe University, 2Eastern Health, 3Deakin University, 4Plymouth University, UK

Recent health system reforms in Australia have focused on improving flow through the health system to achieve national access targets. While waiting times for emergency care and elective surgery regularly hit media headlines, long waits for a sub-acute outpatient and community services are also common. Poor access to these services has health and economic costs, and increases pressure on other parts of the health continuum.

The STAT model (Specific timely Appointments for Triage) was developed on evidence based principles known to improve patient flow. It involves a single injection of resources to reduce existing backlogs, coupled with an analysis of supply and demand and creation of protected appointments for initial assessment that aim to maintain patient flow at the rate of demand. This model was trialled in an NHMRC funded step wedge randomised control trial involving 8 sites and 3116 participants. Mean time from referral to first appointment reduced by 24 days (95% CI 21.2 to 27.5 days) from 60 days pre-intervention to 36 days (40%) in the post-intervention period across all sites. Variation in waiting time was also reduced, suggesting a reduction in the ‘tail’ of patients previously classified as low priority waiting excessively long periods for assessment.

Results of this trial suggest that waiting times for ambulatory services are not the inevitable result of too much demand for the available supply. Improvements in access can be achieved by addressing service inefficiencies and encouraging service providers to make priority decisions about service delivery in response to demand.

1.30PM – 3.00PM: CONCURRENT SESSION

SYMPOSIUM 3: WHAT’S HAPPENING IN MENTAL HEALTH CARE FOR AUSTRALIAN CHILDREN? PRIMARY, SPECIALIST, AND EMERGENCY DEPARTMENT CARE, AND TRANSITION TO ADULT SERVICES

Session Chair: Professor Harriet Hiscock, Health Services Research Unit, Royal Children’s Hospital, Melbourne; Centre for Community Child Health, Murdoch Children’s Research Institute, Melbourne; Department of Paediatrics, University of Melbourne

Child and adolescent mental health disorders represent a high burden to the health system, regardless of whether they are assessed based on prevalence, short and long-term morbidity, or costs, both in fiscal and human terms. At any given time, 14% of 4-17 year-olds in Australia (580,000 children and adolescents) are experiencing mental disorders, and 50% of these disorders begin before the age of 14 years. Despite this, the 2013 National Child and Adolescent Mental Health Survey found that only 50% of children with a mental health disorder received professional care.
Understanding who is receiving care, who is not, where care is accessed, and clinician concerns about current service models can help policy makers, clinicians and service providers to better meet the needs of Australian children and youth with mental health difficulties. This symposium will present contemporary data on child and youth mental health service use, highlighting current inequities and variation in care, as well as emerging concerns about the primary/specialist care interface, use of emergency departments for care, and transition to adult mental health services.

Predictors of health service use in Australian children with mental health problems

Professor Harriet Hiscock1,2,3, Michael Sawyer4,5, Melissa Mulraney6, David Coghill6,7, Daryl Efron2,3,8, Hayley Warren2, Susan Donath9, Noel Cranswick8,10, Gary Freed11

1 Health Services Research Unit, Royal Children’s Hospital, Melbourne; 2 Centre for Community Child Health, Murdoch Children’s Research Institute, Melbourne; 3 Department of Paediatrics, University of Melbourne; 4 Research and Evaluation Unit, Women’s and Children’s Health Network, South Australia; 5 Discipline of Paediatrics, University of Adelaide; 6 Mental Health, Royal Children’s Hospital, Melbourne; 7 Child Neuropsychology, Murdoch Children’s Research Institute, Melbourne; 8 General Medicine, Royal Children’s Hospital, Melbourne; 9 Clinical Epidemiology & Biostatistics, Murdoch Children’s Research Institute, Melbourne; 10 Melbourne Children’s Trials Centre, Murdoch Children’s Research Institute, Melbourne; 11 Department of Health Management and Policy, University of Michigan, USA

Aims: Quantify type and costs of services used by children with mental health difficulties, and characteristics associated with inequity in care.

Method: Cross-sectional analyses of linked MBS data for 4 to 17 year-olds with mental health difficulties (scoring above cut point on Strengths and Difficulties Questionnaire) across 7 waves of the K cohort, Longitudinal Study of Australian Children.

Results: Trends in GP, specialist and allied health use overall, and for children in high vs low socioeconomic and metropolitan vs rural areas.

Implications: Contemporary national data will inform policy making, workforce planning and service provision.

Trends in paediatric mental and physical health presentations to Victorian EDs

Ms Rachel Neely1, 2, Harriet Hiscock1,2,3, Shaoke Lei1,2, Gary Freed4

1 Health Services Research Unit, Royal Children’s Hospital, Melbourne; 2 Centre for Community Child Health, Murdoch Children’s Research Institute, Melbourne; 3 Department of Paediatrics, University of Melbourne; 4 Department of Health Management and Policy, University of Michigan, USA

Aims: Examine trends in Victorian children’s mental versus physical health ED presentations.

Method: ED presentations between 2008/09 - 2014/15. Number and rate of presentations and characteristics compared for mental versus physical health.

Results: Rate per 1,000 children aged 0-19 years is increasing faster for mental (50%) than physical health (6%). Alcohol and drug related presentations are stable; anxiety and depression are rising. Compared to physical health, mental health presentations are more likely to be triaged as more urgent, occur after hours, stay longer, and be admitted.

Implications: The rise in anxiety and depression presentations, and potential solutions, warrants further examination.
State variation in ADHD medication dispensing for Australian children: an analysis of Medicare data

Dr Shaoke Lei1, 2, Harriet Hiscock1, 2, 3, Li Huang2, 4, Rachel Neely1, 2, Kim Dalziel2, 4
1 Health Services Research Unit, Royal Children’s Hospital, Melbourne; 2 Centre for Community Child Health, Murdoch Children’s Research Institute, Melbourne; 3 Department of Paediatrics, University of Melbourne; 4 Health Economics Unit, Centre for Health Policy, University of Melbourne

Aims: Describe and compare the utilization and cost of ADHD medicine prescribing for 0 to 17 year-olds across states/territories.


Results: Cost and prevalence per 10,000 children in ADHD medication use differs widely from one state to another.

Implications: The results warrant further investigation as to whether increased use of medication is associated with better outcomes. This would require systematic collection of patient outcomes.

Systems of care for children with complex mental health conditions: Clinician perspectives

Ms Kate Paton2, Harriet Hiscock1, 2, 3
1 Health Services Research Unit, Royal Children’s Hospital, Melbourne; 2 Centre for Community Child Health, Murdoch Children’s Research Institute, Melbourne; 3 Department of Paediatrics, University of Melbourne

Aims: Examine the interface between primary and secondary/tertiary care including barriers and enablers of support for children with complex mental health conditions using ADHD and Autism as examples.

Method: Mixed methods incorporating qualitative and quantitative data. Semi-structured interviews with paediatricians, child and adolescent psychiatrists and psychologists utilising surveys designed to capture ‘best practice’ and gaps in the current Australian system.

Results: Service delivery variation across states and rural/urban areas, identification of potentially modifiable factors to improve the primary/secondary/tertiary care interface, for more efficient, patient-centred care for Australian children with complex mental health conditions.

Implications: Potential for optimisation of service delivery.
Leaving the cocoon: Transition from paediatric to adult services for young people with developmental disabilities +/- mental health problems

Dr Daryl Efron1,2,3, Lionel Lubitz4, Nikki Caccamo5, Rebecca Shepherd6, Giuliana Antolovich6,7, Chidambaram Prakash8, Evelyn Culnane6

1General Medicine, Royal Children’s Hospital, Melbourne; 2Centre for Community Child Health, Murdoch Children’s Research Institute, Melbourne; 3Department of Paediatrics, University of Melbourne; 4Neurology, Royal Children’s Hospital, Melbourne; 5Transitional Support Service, Royal Children’s Hospital, Melbourne; 6Developmental Medicine, Royal Children’s Hospital, Melbourne 7Developmental Disability and Rehabilitation Research, Murdoch Children’s Research Institute, Melbourne; 8Hospital Psychiatry, Royal Children’s Hospital, Melbourne

Aims: To explore the experience and perspectives of clinicians involved in transition of patients with Intellectual Disability and/or Autism Spectrum Disorder with associated mental health comorbidities from the Royal Children’s Hospital (RCH) Melbourne, to adult services, so as to inform the development of a systematic and sustainable model of care.

Method: Semi-structured interviews with RCH doctors, primary care clinicians, adult psychiatrists and disability services.

Results: All practitioners reported major challenges with transition, with fragmented care in the adult sector and associated stresses for families.

Implications: This presentation will suggest mechanisms to improve transition for this vulnerable patient group.

ORAL POSTERS (1): PRIMARY CARE

Session Chair: Lisa Hall, The Australian Centre for Health Services Innovations (AusHSI)

Defining and Measuring Potentially Preventable Hospital Readmissions
Aidan O’Brien, Macquarie University, NSW Health

Evaluation of the Partners in Recovery program: a tailored care program for complex and persistent mental health problems
Amelia Gulliver, Centre for Mental Health Research, The Australian National University

How much advanced care planning and palliative care occurs in the primary care setting? A systematic review of resource use and costs.
Ann Livingstone, University of Sydney

Visibility and meanings of partnership in health care for older people
Anna Gregory, University of South Australia

Non-linear relationship between continuity of care and emergency hospitalisation
Bich Tran, Centre for Big Data Research in Health
Regularity of General Practitioner contact - analysis of methods for measurement using administrative data

David Youens, Curtin University

Patterns of potential under and overutilisation of lipid testing in the Australian adult population

Farshid Hajati, Translational Health Research Institute - Western Sydney University; Capital Markets CRC, Sydney

A qualitative study of how Australian decision makers use evidence to inform investment in disease prevention

Huei Ming Liu, The George Institute for Global Health

Ascertaining key themes in chronic disease patients’ experiences of Australian primary care: Findings from practitioner and patient interviews

Hyun Song, University of New South Wales

Improving the provision of genetic health services for Indigenous Australians

Imogen Elsum, University of Melbourne

Metro North GP Alignment Program

Jeanette Tyler, Royal Brisbane and Women's Hospital - Women's & Newborn Services

Trial of the Primary Care Practice Improvement Tool: Building organisational performance in Australian primary health care

Lisa Crossland, Centre for Health System Reform and Integration, Mater-UQ Research Institute

Development of a Tool for the Classification and Identification of Peer Groups Geographies

Ludovico Pinzari, Translational Health Research Institute - Western Sydney University, Capital Market CRC, Sydney

Impact of the "Health Links" program on the patient experience for patients with complex multi morbidity in Ontario, Canada.

Michael Green, Professor and Head, Dept of Family Medicine, Queen's University

Should oral contraceptives be available over-the-counter?

Mutsa Gumbie, Macquarie University Centre for the Health Economy

Cluster analysis of utilisation of general practitioner services and its relationship with potentially preventable diabetic related hospitalisations: A linked data analysis in Western Australia

Ninh Ha, School of Public Health, Curtin University

Trend analysis of outpatient service utilization and associated expenditure across four quarters post-stroke: a descriptive study

Shilpa Tyagi, Saw Swee Hock School of Public Health, NUS
A Cost-effectiveness Analysis of the Prediabetes Intervention Package (PIPI) in Primary Care

Trudy Sullivan, University of Otago

SYMPOSIUM 4: ECONOMICS OF AUSTRALIAN GENERAL PRACTICE

Session Chair: Tony Scott, Melbourne Institute of Applied Economic and Social Research, University of Melbourne

The Australian primary care context is characterised by unrestricted access to general practice services, and the absence of routinely shared clinical information. Current health system reforms (including the Health Care Home roll-out, changes to general practice ownership structure, Medicare Schedule review, and the growing impact of Primary Health Networks) make evaluation of primary care services increasingly important. Attendees at this symposium (co-hosted by the Centre for Health Economics Research and Evaluation at the University of Technology Sydney and the Melbourne Institute of Applied Economic and Social Research, University of Melbourne) will hear from presenters using a variety of available data sources (Medicare, longitudinal data sets) and approaches to analyse the important role primary care plays in the Australian health care system.

These presentations provide new evidence that focus on the behaviours of patients and GPs, including the role of continuity of care, impact on hospital utilisation, drivers of prescribing behaviour, and the role of corporate medical practices. These presentations highlight the practical challenges of evaluating the economic impact of primary care services, but suggest that the effects of future health reform and health policy are not (entirely) unpredictable.

The association between continuity of primary care and mammography rates

Michael Wright¹, Jane Hall¹, Kees van Gool², Marion Haas¹
¹Centre for Health Economics Research and Evaluation, University of Technology Sydney, NSW

Mammographic screening for breast cancer is recommended for women aged between 50 and 74, but screening rates remain below 60% of the target population. General practitioners have a role in increasing women’s confidence in screening and understanding the importance of screening. This research investigates the association between continuity of care with a GP and a practice, and rates of guideline-appropriate mammography. Results reveal that women who have continuity of care with a provider or with a practice have significantly higher rates of mammography compared to women without continuity, even after controlling for multiple patient and practice characteristics.

Factors Affecting General Practitioners’ Decisions to Adopt New Prescription Drugs

Yuting Zhang¹,², Susan Mende³, Anthony Scott³
¹Australian-American Health Policy Fellow, Melbourne Institute of Applied Economic and Social Research, The University of Melbourne, VIC; ²Department of Health Policy and Management, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, PA; ³Melbourne Institute of Applied Economic and Social Research, The University of Melbourne, VIC

This presentation investigates how risk preferences of Australian general practitioners (GPs) affect their decisions to adopt new prescription drugs using the example of novel oral anticoagulants (NOACs) for the prevention of stroke or systemic embolism. We use prescription records from the Pharmaceutical Benefit Scheme (PBS) linked to detailed individual doctor-level panel data on a sample of around 900 GPs from the Medicine in Australia: Balancing Employment and Life (MABEL) survey. Preliminary findings show associations between risk attitudes and speed of adoption of these drugs.
Quelling the impact of hot weather on hospital demand — an analysis of the role of GPs  
Thomas Longden1, Kees van Gool1  
1Centre for Health Economics Research and Evaluation, University of Technology Sydney, NSW

Hot weather events and air pollution are associated with preventable hospitalisations and emergency department presentations for those with cardiac and pulmonary diseases. However, many heatwave response plans do not specifically target at-risk individuals or involve GPs. This presentation assesses whether the risk of a preventable hospital stay and/or emergency department presentation related to hot weather and air pollution can be mitigated by the type of care provided by the patient’s GP. Effective risk management should target those at high risk of a preventable hospitalisation and/or emergency department presentation, while also involving primary care providers.

Associations between corporate general practice and GPs’ practice patterns  
Anthony Scott1, Tamara Taylor1, Grant Russell2,3,4
1Melbourne Institute of Applied Economic and Social Research, The University of Melbourne, VIC  
2 Professor of Primary Care Research in the Department of General Practice, Monash University, Melbourne VIC; 3Director Southern Academic Primary Care Research Unit; 4Australian Principal Investigator: Impact Centre of Research Excellence

There is concern, but no evidence, that the profit-driven motivation of corporate General Practices leads to undesirable practice patterns. This study uses data from the 2015 Medicine in Australia: Balancing Employment and Life (MABEL) survey to compare, for the first time, the activities of GPs in corporate practices compared to those who work in non-corporate practices. The results examine differences in the volume of services, waiting times, skill mix, prices/bulk-billing, and GP’s job satisfaction and work-life balance.

ORAL PRESENTATIONS (2): HEALTH SYSTEMS POLICY  
Session Chair: Claire Jackson, University of Queensland

2A: Engagement of general practice in Australia: learnings from an unsuccessful attempt  
Rajna Ogrin1,2, Tracy Aylen1, Ralph Audehm3, Toni Rice1, Arti Appannah1
1Bolton Clarke; 2Austin Health Clinical School, University of Melbourne; 3Department of General Practice, University of Melbourne

Background: With increasing rates of diabetes, healthcare delivered in the community is considered the most effective approach, requiring general practice engagement. We report qualitative findings of a case study engaging general practice for referral of patients to a pilot of a new model of diabetes care.

Methods: Semi-structured interviews and focus groups of key stakeholders in diabetes management were undertaken. Participants were healthcare providers (15 general practitioners, 5 practice nurses (PNs), 8 diabetes educators (DEs)) who were approached to refer patients for a prospective pilot study evaluating the feasibility of home-based injectable initiation provided by trained community nurses. Interviews and focus groups were undertaken upon cessation of the trial due to low referral numbers.

Results: Three major themes were identified. 1. The intervention model: considered acceptable, however perceived need by GPs was low, with individual GPs reporting few patients with diabetes. 2. Recruitment barriers/enablers: many GPs reported little awareness of the pilot, with PNs and DEs describing significant time and effort required to embed new services. 3. Perception of the
community nursing organisation: the nurses were considered to provide wound, continence and medication support, rather than being partners in chronic disease care.

Conclusions: Engaging GPs in new initiatives is challenging and measures facilitating uptake of new innovations are required. Any new intervention needs to: be developed with GPs to meet their needs; have considerable lead-in time to develop rapport with GPs and raise awareness; and ideally, have dedicated support staff within practices to reduce the demand on already-overburdened practice staff.

2B: Systems levers for Primary Health Networks: a conceptual framework
Carla Meurk¹, Meredith Harris¹, Eryn Wright¹, Nicky Reavley², Roman Scheurer¹, Bridget Bassilios², Caroline Salom¹, Jane Pirkis²
¹University of Queensland; ²The University of Melbourne

Background and Aims: Systems levers are a means by which Primary Health Networks (PHNs) can fulfil the imperative that they influence the health system. However, no bespoke definitions or frameworks exist to help guide PHNs in selecting levers to achieve health system change. Using primary mental health care as a case study, in this talk we will present a typology of systems levers relevant to regional level health governing bodies, such as PHNs. Methods: A rapid review of academic and grey literature published between 2006-2016 from selected countries with comparable health systems was undertaken to describe the use of systems levers in commissioning primary mental health care services. Using a qualitative approach, levers were identified and aggregated into types. Results: We identified 26 levers that could be classified according to six lever types (organisation, engagement, enforcement, information, technology, and finance and payment). Discussion and Conclusions: The typology was derived with respect to primary mental health care but could potentially be applied to other areas of health. We discuss the implications of our findings for the implementation of mental health reforms, with specific reference to stepped care and health care homes frameworks. We will identify important future directions for the field of levers research, including important empirical challenges to be addressed.

2C: Economic Evaluation of Primary Health Networks: A Tale of Two Programs
Haitham Tuffaha¹, Sanjeewa Kularatna², Joshua Byrnes¹, Ruvini M.Hettiarachchi¹, Martin Downes¹, Deborah Davies², Paul Scuffham³
¹Griffith University; ²AusHIS, Queensland University of Technology; ³Gold Coast Primary Health Network

Primary Health Networks (PHNs) have been established by the Australian Government with the key objectives of increasing the efficiency and effectiveness of primary medical services and enhancing coordination of care to improve patient outcomes. Achieving these objectives requires evidence-based decision-making supported by thorough and high quality economic evaluations. Nevertheless, economic evaluation of this new model of care brings several challenges such as dealing with complex interventions and disease conditions, establishing the counterfactual or comparator, selecting an appropriate study design, measuring outcomes and costs and determining a reasonable evaluation period.

In this work, we describe our experience with the economic evaluation of the Gold Coast Primary Health Network (GCPHN) programs. Specifically, two quality improvement programs to improve monitoring and reporting of: i) haemoglobin A1c (HbA1c) in patients with diabetes mellitus, and ii) forced expiratory volume (FEV1) in patients with chronic obstructive pulmonary disease (COPD). We discuss the difficulties we encountered during our economic evaluation and explore practical
methods and approaches that can be used to address them. Finally, we provide key recommendations to facilitate and improve the quality of economic evaluations for PHN programs. We anticipate that our work will significantly contribute to the efforts of developing comprehensive evaluation frameworks for PHNs, which will result in the successful implementation of efficient and sustainable programs to improve patient outcomes and reduce cost.

2D: Developing comprehensive primary care programs: the general practice and patient perspective

Suzanne Robinson¹, Chris Kane², Dr Janice Bell³, Pip Brennan³, Kate Bullow⁴, Jane Harwood²
¹Curtin University; ²WA Primary Health Alliance; ³Western Australian General Practice Education and Training; ⁴Health Consumers Council

Ageing population and changing lifestyles mean that chronic disease is the leading cause of illness, death and disability in Australia, accounting for 90% of all deaths in 2011. Over recent years we have seen a focus on strengthening primary care to enable the prevention and management of chronic disease to occur in the community setting. The Western Australian Primary Health Networks are working with general practice and health consumers to inform the development of a Comprehensive Primary Care (CPC) program aimed at promoting and supporting general practice as the cornerstone of primary health care to deliver high quality services for those with chronic disease.

This qualitative study explored General Practices’ and patient views and perceptions of current and potential service provision for people with chronic health conditions. Methods included deliberative workshops, semi-structured interviews and focus groups.

Results: A total of three workshops, 32 GP interviews and seven consumer focus groups were undertaken. The key themes identified included the importance of team based approaches to care; patient in the team not outside; continuity of doctors; funding incentives and support; difficulty in positive behaviour change for patient and doctor.

Conclusions: This research took a collaborative approach that involved researchers, clinicians and consumer groups in research, we believe this enhanced engagement from GPs and patients and also provided some very rich and informative data to inform policy development and models of care within primary care. Results from this research are shaping the design and development of the WA CPC program.

2E: From evidence to implementation: shifting research priorities to inform scale up and spread of innovations in health service

Sonya Osborne¹
¹Australian Centre for Health Services Innovation (AusHSI) Queensland University of Technology

Evidence-based practice is ubiquitous in contemporary health care. Recent studies have revealed a prevailing gap between the publication of research evidence from well-designed studies and uptake of the evidence into routine practice – the most quoted gap is 17 years. Several factors have been implicated as barriers to uptake, such as the nature of the evidence, how health care professionals view the evidence, the context and culture of where the evidence is being implemented and how the evidence-based innovations are introduced. Clinical research answers the question of efficacy – what works. The evolving field of implementation research answers the equally critical questions of what works for whom, where, why, and how? Answering these latter questions using a systematic research approach can aid in identifying effective implementation strategies. This has implications for increasing uptake, enabling scale-up of health service innovations to increase impact, and accelerating spread of the innovation more widely across the health system. This presentation will demonstrate a case for shifting priorities from clinical research to implementation research.
2F: Improving equitable access to health care services through, designing, testing and implementing a decision making audit tool (DMAT) to support public engagement in making difficult prioritisation decisions

**Peter Littlejohns**¹, Georgina Richardson², Robin Gauld², Barry Smith², Tim Stokes², Fiona Doolan-Noble², Emma Tumilty², Katharina Kieslich³

¹Professor of Public Health, King's College London, UK; ²University of Otago New Zealand; ³Kings College London, UK

All health care systems are facing increasing demands within limited resources. Most countries are introducing systems to prioritise health services that assess “value for money” that they hope have legitimacy with the public on whose behalf they are acting. These processes are a key factor in creating effective and sustainable Universal Health Coverage systems but face legal, political, methodological, philosophical, commercial and ethical challenges. As part of the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in South London UK, funded by the National Institute for Health Research, we have created a new way of encouraging patients and the public to get involved in making these difficult decisions. It is based on a social values framework that we have developed which has been converted into a decision making audit tool (DMAT). We have now developed a digital online version which explores the social values underpinning decision making, both content values eg. clinical and cost effectiveness and those relating to process eg transparency and inclusivity. These could act as principles underpinning decision making. We are piloting the acceptability and effectiveness of this approach in England and New Zealand and exploring the relationship between the application of social values and commissioning services. The online tool and preliminary results from both countries will be presented and implications for expansion of the projects will be discussed. The applicability of the national CLAHRC model for supporting health services research and the implementation of emerging findings into routine practice and policy will be considered.

ORAL PRESENTATIONS (3): AN INTERNATIONAL INDIGENOUS PERSPECTIVE

**Session Chair: Braden Te Ao, Auckland University of Technology**

3A: Prioritizing First Nations community health and healthcare needs as a base to support well-being and self-determination

**Josée G. Lavoie**¹, Grace Kyyoon-Achan¹, Kathi Avery Kinew², Wanda Phillips-Beck², Stephanie Sinclair², Naser Ibrahim¹, Alan Katz¹

¹University of Manitoba; ²First Nations Health and Social Secretariat of Manitoba

Background: First Nations (FNs) perspectives on health and what constitutes appropriate healthcare to support holistic well-being, includes measures to actively promote wellness, support indigenous health practices and strengthening of services to meet the disease management needs of each community. Aims: To discuss FNs conceptions of health and healthcare. To elaborate on community perceptions of primary healthcare (PHC) based geographical, cultural and historical contexts. To bring about FNs health and equitable healthcare requires going beyond adaptations toward FNs self-determination and actualizing the changes FNs develop.

Methods: Qualitative, participatory study involving 8 Manitoba First Nations. Data collection and analysis of a hundred and eighty eight (188) semi-structured in-depth interviews were guided by grounded theory and coded using Nvivo software. Community-based research assistants conducted interviews within their communities to facilitate trust and a better understanding of context and
cultural nuances. Results: Improving health and healthcare performance in Manitoba FNs communities, necessitates the design and implementation of systems based on local knowledge, investment in community-based health priorities and partnerships to support community-driven preventative primary healthcare.

Discussion: The intrinsic relationship between self-determination and the health and well-being of FNs peoples is a critical factor in effective healthcare, with FNs deciding what is important for their health and well-being, adopting service priorities that reflect the needs of the community.

Conclusion: That FNs health priorities may depart from mainstream interests and policies must be “recognized and affirmed” to ensure change toward equitable healthcare and well-being.

3B: Journeys to healthcare transformation: Partnering for change through Community-based Participatory Research with Manitoba First Nations
Grace Kyoon-Achan1, Joséé G. Lavoie1, Kathi Avery Kineiw2, Stephanie Sinclair2
1University of Manitoba; 2First Nations Health and Social Secretariat of Manitoba

★ The Best (Highest Ranked) Abstract by an ECR

Background: Community-based participatory research can help support communities’ efforts in the formulation and implementation of innovative and transformative change. We share a collaborative journey in our work with eight (8) First Nations in Manitoba Canada who were seeking to improve the health of their communities. Participating communities wanted to produce evidence to move toward good health as they define it and to inform changes in healthcare based on community input on how to improve the health of their respective communities.

Methods: Indigenous knowledges and processes guided data gathering and analysis. Community-based participatory methods were used for the conceptualization of the study, data collection, analyses and knowledge translation. A variety of methods were used including: qualitative interviews, administrative health data analyses, surveys and case studies depending on the needs of the studies and the interests of different First Nation stakeholders, health directors and researchers.

Results: Research relationships built upon strong ethics and locally recognized protocols enhance mutual commitment to support community-driven transformation. Collaborative and respectful relationships are platforms for defining and strengthening First Nations health and healthcare priorities. This is an important step in building long term changes that will be sustained long after research projects come to an end.

Conclusion: This study yielded a blueprint for respectful community-based participatory research involving First Nations peoples, communities, University-based researchers and First Nations community-based researchers. The result is a locally owned yet widely recognized process that is effective and sustainable while also having fulfilled researchers and funding obligations.
3C: Significant results from Oranga ki Tua Diabetes Self-Management Education Program

Richard S. Cooper¹, Robin Beck⁶, Dr. Matire Harwood³, Dr. Rawiri Jansen⁴, Elizabeth Tito⁵, Pauline Fitzgerald⁴

¹Ngati Hine, Ngapuhi, Kuki Arani (University of Auckland); ²Ngati Hine, Ngapuhi, (University of Auckland, Papakura Marae); ³Ngati Raukawa and Ngati Hinerangi, (Papakura Marae); ⁴Te Arawa, (Papakura Marae); ⁵Ngati Pakemahia (Papakura Marae); ⁶Ngati Ranginui, Ngati Kahungunu

Introduction: Māori have significantly higher rates of type 2 diabetes. In order to address these health inequities, a diabetes self-management education (DSME) course held at the Papakura Marae Health Clinic has been used as an intervention among a high needs decile 5 with a 95.2% VLCA predominantly Māori & Pacific Island community in South Auckland.

Aim: The purpose of this research was to evaluate the effectiveness of a community-based DSME by using an experimental design based on pre-test-post-test comparisons.

Methods: Outcomes measured included both knowledge and clinical measures (1) knowledge gained by participants as well as (2) change in Hba1c levels among participants and compared these with a ‘control’ group of people with diabetes who did not participate in DSME classes.

Results: Changes in knowledge of diabetes, medications, physical activity, diet and nutrition showed significant values of improvement when post tests were compared with the pre-tests. Hba1c levels were compared and statistical significance was measured with a p-value of 0.0015 (alpha-0.05) for DSME participants. The average drop in Hba1c among DSME participants was 12.09 mmol/mol, and the average drop in Hba1c for patients enrolled in OKT was 4.53 mmol/mol.

Discussion: According to the data and participant responses the OKT DSME programme has proven successful in its approach to diabetes self-management by taking an indigenous-led approach to DSME, utilising traditional Maori games, Kaupapa Maori, Whanaungatanga, Manaakitanga and Wairuatanga. OKT DSME delivered in the local community is associated with increased knowledge, health literacy, statistically significant improved HBA1c levels and was well-liked.

3D: A Māori approach to the diagnosis and management of dementia

Margaret Dudley¹

¹The University of Auckland

The number of Māori (the Indigenous people of New Zealand) elders living beyond 65 years of age has nearly doubled in the last decade. Some elders will be affected by age-related diseases such as dementia. The literature regarding Māori and dementia is almost non-existent and a Māori understanding and Māori experience of dementia is unknown. Given the burgeoning impact of this disease it is vital that we prepare now for a dementia care pathway that is informed by Māori knowledge.

Research Design: There are 7 study locations throughout New Zealand, 14 focus group interviews with older Maori, 8 interviews with family care partners and 3 interviews with individual elders. Interviews are semi-structured although open discussion has been encouraged. Traditional Māori research analyses, and a grounded theory approach are utilised to compare transcripts for similarities and differences.

We will then use that data to inform the development of a cognitive and functional assessment tool for the early detection of dementia in Māori. The tool will be piloted with 40 Māori elders, 20 with a diagnosis of dementia and 20 without. The tool will then be ready for validation.
Preliminary Findings: Data from the focus groups have identified 11 general themes for further analysis: Wairua (spirituality), Functioning in the Māori World, the Role of Māori elders in Society, the Work of Dementia Services and the Role of the Family.

3E: ‘Going back-to-basics’: Aligning programme philosophies across multiple levels of care in early intervention for D/deaf and hearing impaired Māori children in Aotearoa/New Zealand

Kirsten Smiler1, 2
1Māori – Te Whanau a Kai, Te Aitanga a Mahaki, Rongowhakaata and Te Whakatohea; 2Health Services Research Centre, Victoria University of Wellington

In Aotearoa/New Zealand early-intervention services and supports for D/deaf and hearing-impaired children span across all levels of care and require ongoing support across community groups in order to be successful. The last decade has seen a rapid period of innovation, change and tension in this sector; driving these changes are a desire to improve unacceptable inequities in outcomes (mostly centring on language delays and development). The changes have also raised important questions around the nature of partnerships between the various groups and those raising D/deaf children. This presentation reports from doctoral and postdoctoral qualitative research which examines the experiences of Māori whānau (Māori familial unit) raising D/deaf and hearing-impaired children, and of intervention care received from professionals. Critical questions around the nature of partnerships, and the philosophical underpinnings of the intervention sector are also posed across community and professional networks involved in early intervention.

The qualitative findings of this research report fragmented care is experienced by these children and their whānau; underpinning this fragmentation is a lack of understanding of the impact of colonisation, how to apply Māori models of health and wellbeing and socio-cultural frameworks of D/deafness across a multi-disciplinarian workforce. The research suggests the sector revisit the philosophical underpinnings of the intervention programme and adopt an alternative proposed by this research. This proposed programme philosophy places an emphasis on holistic outcomes, demands an integrated approach to care, and recognises that the impact of D/deafness and hearing-impairment extends across the life-trajectory for the child and the intergenerational unit of whānau.

3F: Knowledge and attitudes of health professionals on rongoā Māori (traditional Māori healing) in hospitals

Dr Glenis Mark1, 2, Dr Jonathon Koea3
1Māori, Ngapuhi, Tainui, Ngai Tahu, Ngati Koata; 2Independent Researcher, Auckland, New Zealand; 3General, Hepatobiliary and Upper GI Surgeon, Waitemata Hospital, Auckland

In Aotearoa/New Zealand, rongoā Māori (traditional Māori healing) has remained a marginalised form of healing treatment with little collaboration with medical treatment. Prior research with Māori patients and healers has shown their desire for healers and doctors to work collaboratively to provide combined health and healing treatment for patients, however, research on the attitude of health professionals towards rongoā Māori had not yet been conducted. In order to ascertain the knowledge and attitudes of health professionals on rongoa Māori, an electronic self-administered survey of 1181 staff working in a hospital environment was conducted. This research aimed to assess the knowledge and attitudes of health professionals at Waitemata District Health Board (WDHB) on rongoa Māori. The purpose of this research was to consider possible avenues for education and practice on rongoa Māori within the WDHB environment. Preliminary descriptive statistics analysis of the data showed majority participant support for rongoa treatment to be provided in the hospital environment. Implications for potential pathways for placing rongoa Māori healing treatment in hospitals will be presented.

3.30PM – 4.45PM: PLENARY SESSION
CLINICAL VARIATION AND GOOD INTEGRATION OF CARE
Session Chair: Robin Gauld, University of Otago

This session is about enhancing care, exploring what our current systems are doing well, and the approaches to addressing known problems.

Clinical variation - what do we know about it and is it good or bad or both?
Professor Claire Jackson
Professor in General Practice and Primary Care Research & Director, Centre for Health System Reform and Integration, University of Queensland

This session will explore clinical variation, and ask what do we know about it and is it good or bad or both? The current priorities of health service integration, some success stories and reasons why it is so hard to achieve and sustain, and some current barriers and opportunities to sustainable service integration will also be presented.

The need to enhance primary, GP and community care to help deal with the epidemic of “long-term conditions”.
Professor Harry Rea
Department of Medicine, South Auckland Clinical Campus, University of Auckland & Respiratory Physician, Counties Manukau Health

Counties Manukau Health (CM Health) provides health and disability services to an estimated 512,000 people who reside in the local authorities of Auckland, Waikato and Hauraki District. CM Health has implemented a variety of initiatives over the last five to six years, and found that evaluating these initiatives raised new issues, e.g. the potential need for “realist evaluation”. The range of initiatives trialled included clusters of general practices supported by IT and stronger relationships between hospital specialists, community services, social care and social welfare. In an effort to reduce clinical variation across the district, some of these initiatives have been chosen for standardisation and scale-up and will be used as a discussion subject for on-going Quality Improvement sessions.

Planning, Funding and Purchasing Integrated and Disintegrated Care.
Professor Don Matheson
General Manager, Brisbane North PHN and Metro North HHS Health Alliance

Describing our health systems and what we expect from them, this presentation looks at what the current planning, funding and purchasing environment looks like, as it relates to integrated primary health care in Australia. The fragmentation of planning, funding and purchasing will be described: the disintegrated care that results, that not all care needs to be integrated, but that more of it does and the line where integrated primary health care starts and stops.

This will be followed by a description of an integrated model of planning and purchasing being developed in North Brisbane by Metro-North Hospital Health Service and Brisbane North Primary Health Network, covering commissioning, collective impact approach, and move from rhetoric to reality via patient centred care and research and evaluation to support decentralised models of commissioning.

4.45PM – 5.30PM: PLENARY SESSION
THREE MINUTE THESIS COMPETITION (3MT)
Session Chair: Suzanne Robinson, Curtin University

Cervantée Wild, University of Technology Sydney, CHERE

Modelling the cost-effectiveness of strategies to treat end-stage heart failure using discrete event simulation
Sopany Saing, James Cook University

The role of academic health centres in improving health equity
Alexandra Edelman, Woliata Sodo University

Measuring the Uptake of Research Evidence into Mental Health Policy in Australia: A Retrospective Content Analysis
Kristel Alla, University of Queensland, School of Public Health

Examining the use of telepractice for delivering intensive, prophylactic swallowing therapy to patients with head and neck cancer undergoing (chemo) radiotherapy
Laurelie Wall, School of Health & Rehabilitation Sciences, University of Queensland; and Division of Allied Health, Metro South Hospital and Health Service

A data linkage and patient outcome study of aeromedical retrieval services in Central Queensland
Kristin Edwards, James Cook University

Nurse practitioners and pharmacist prescribers in primary health care: A realist evaluation of the New Zealand experience
Tara Officer, Health Services Research Centre, Victoria University of Wellington

Invisibility of the older person as a partner in health care
Anna Gregory, University of South Australia

Transversal Leadership Training in Health Information Management in Australia
Sarah Low, University of Tasmania

Predictors of Therapeutic Communication between Nurses and Admitted Patients at Jimma University Specialized Hospital, Jimma Zone, Ethiopia
Robera Olana, Woliata Sodo University
STANDARD POSTERS: WEDNESDAY

When is a medicine unwanted, how is it disposed and how might safe disposal be promoted? Insights from the Australian population  
Emilie Bettington, Centre for Applied Health Economics, Griffith University

A More Efficient Hospital Matching Algorithm for Medical Graduates in New South Wales  
Isobel Yeap, Royal North Shore Hospital

Ageing well in New Zealand – is the health of older people related to their housing tenure?  
Janet McDonald, Health Services Research Centre, Victoria University of Wellington

Defensive practices among non-medical health professions: a systematic review  
Massimiliano Panella, University of Eastern Piedmont

Do clinical incident investigation practices reflect the principles of systems thinking?  
Natassia Goode, Centre for Human Factors and Sociotechnical Systems, University of the Sunshine Coast

Do clinical practice guidelines recommend doctors discuss the costs of cancer treatments with their patients?  
Rachael Morton, University of Sydney, Sydney, NSW

Achieving the promise of public reporting of health service performance in Australia  
Rachel Canaway, Melbourne School of Population and Global Health, The University of Melbourne

Research to support collaboration and integration in the delivery of complementary therapy services in primary care  
Rachel Canaway, Freelance research consultant. Affiliated with The University of Melbourne

GP Access for Adolescent and Young Adults with Cancer  
Sarah Baggio, Queensland Youth Cancer Service

Balancing shifting priorities and leading collaborative outcomes - Transversal Leadership for the 21st Century Health Professional  
Sarah Low, University of Tasmania

Collaboration to determine a future health information workforce census: “Consensus to produce a census”  
Sarah Low, University of Tasmania

Delivering better health care to people with severe Chronic Obstructive Pulmonary Disease (COPD) in the Southern Region of New Zealand  
Tim Stokes, Dunedin School of Medicine, University of Otago, NZ

Around the Table: how two New Zealand community-based models of primary healthcare reshaped their funding environments  
Tim Tenbensel, University of Auckland
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THURSDAY 2 NOVEMBER

8.30AM – 9.15AM: PLENARY SESSION

KEYNOTE ADDRESS
Session Chair: John Wakefield, Deputy Director General, Clinical Excellence Division, Queensland Health

The art of compromise: Collaboration between researchers and practitioners to support integrated care
Dr Roman Kislov
Senior Research Fellow, The University of Manchester, Greater Manchester CLAHRC

The principle of collaboration, ‘the action of working with someone to produce something’, is instrumental for ensuring that research makes a difference in the ‘real world’. Within this broader agenda, involving stakeholders and research users in the design and implementation of applied health research is widely regarded to be an important part of increasing its impact on the provision of integrated care. Such ‘co-production’ of research often faces a number of challenges, which arise inevitably from the differing interests, perspectives and needs of the organisations involved.

Drawing on the experience of a large-scale UK-based collaborative research partnership operating at the interface of primary and secondary care, this talk explores how these challenges can be overcome through joint working, discussion and compromise. It reflects on how such compromises are reached in practice and what influence they may have on the design, focus and overall impact of applied health research.

9.15AM – 10.15AM: PLENARY SESSION

USING DIGITAL INFORMATION TO IMPROVE HEALTH SERVICES
Session Chair: Judith Smith, University of Birmingham

Some success stories from using digital information in health services will be presented, and the potential for future innovations? And whether innovations are likely to come easily in the future?
Dr Enrico Coiera
Professor in Medical Informatics, Macquarie University

Anyone with experience of digital systems has experienced the frustration of system implementation or use. Unanticipated challenges arise frequently and unanticipated consequences may follow. In this talk I will work from first principles, to understand why information technology (IT) is often challenging, identify which IT endeavors are more likely to succeed, and hopefully help predict the best role that technology can play in different tasks and settings. The fundamental purpose of IT is to enhance our ability to undertake tasks, supplying new information that changes what we decide and ultimately what occurs in the world. The value of this information (VOI) can be calculated at different stages of the decision-making process and will vary depending on how technology is used.
We can imagine a task space that describes the relative benefits of task completion by humans or computers and that contains specific areas where humans or computers are superior. There is a third area where neither is strong and a final joint workspace where humans and computers working in partnership produce the best results. By understanding that information has value and that VOI can be quantified, we can make decisions about how best to support the work we do. Evaluation of the expected utility of task completion by humans or computers should allow us to decide whether solutions should depend on technology, humans, or a partnership between the two.

**Data driven decision making is the only way to change and innovate.**

*Dr Clair Sullivan*
Medical Lead Digital Health, Co-Chair DHIN, Consultant Endocrinologist and HITEC Co-Director, Clinical Excellence Division, Queensland Health

The demand for healthcare is rapidly outstripping our existing resources, and data driven decision making is the only way to change and innovate. Data from traditional research studies or paper based audits will not provide adequate information to transform care, and simply digitising existing paper based workflows is unlikely to deliver new and innovate models of care.

A thoughtful, data driven approach to digital transformation of care is needed to improve the quality, efficiency and value of the care we provide to our patients. This presentation outlines a strategy and roadmap for successful digital transformation using data and analytics to improve patient care.

**10:45AM – 12:15AM: CONCURRENT SESSION**

**ORAL PRESENTATIONS (4): EFFICIENCY IN THE EMERGENCY DEPARTMENT**

*Session Chair: Will Parsonage, Royal Brisbane and Women’s Hospital, The Australian Centre for Health Services Innovation (AusHSI)*

**4A: Emergency department attendance after telephone triage**

*Amy Gibson¹, Deborah Randall², Duong Tran², Mary Byrne³, Anthony Lawler⁴, Alys Havard², Maureen Robinson³, Louisa Jorm²*

¹Centre for Big Data Research in Health, UNSW Sydney; ²UNSW Sydney; ³Healthdirect Australia; ⁴University of Tasmania

**Aim:** To measure compliance with telephone helpline advice to attend an emergency department (ED) and the acuity of patients who presented to ED following a call.

**Methods:** Population based, observational cohort study of all calls (n=1.04 million) to the NSW healthdirect helpline over four years, linked to emergency (ED) presentations, hospital admissions and death registrations using probabilistic data linkage. Outcomes: compliance with dispositions to attend an ED, self-referral to ED by patients given low urgency dispositions, predictors of compliance and self-referral, and triage levels at ED presentation.

**Results:** 67.2% of patients were compliant with dispositions to attend an ED, the great majority within four hours. In patients receiving a low-urgency disposition, 6.2% attended ED within 24 hours of the call. Predictors of compliance and self-referral will be presented. After age-adjustment, healthdirect compliant patients who attended ED were significantly less likely (7.7%) to receive the least urgent triage category (ATS 5) compared to the general NSW ED population (16.9%). Compliant healthdirect ED attenders also included a significantly higher proportion of patients triaged as the
more urgent ATS 3 (37.0%) compared to the general NSW population (30.0%). Conversely, patients who self-referred to the ED did not differ significantly from the general population in allocation to lower urgency categories.

Conclusion: This large data linkage study provides precise estimates of ED attendance following calls to a telephone triage service, and details the predictors of ED attendance. Our findings indicate that the healthdirect helpline is not referring substantial numbers of low-urgency patients to EDs.

4B: Statewide Outcomes of ACRE: Putting Research into Practice.

Tanya Milburn¹ William Parsonage², Sarah Ashover¹, Laura Foran¹, Louise McCormack¹, Louise Cullen¹
¹Queensland Health; ²AusHSI QUT

Background: The ADAPT ADP identifies patients at low risk for Acute Coronary Syndrome (ACS).

Aim: The Accelerated Chest Pain Risk Evaluation (ACRE) Project, aimed to translate the ADAPT ADP into clinical practice across Queensland Health Hospitals.

Methods: The ADP was implemented in public hospitals with access to laboratory-based troponin testing. Stepped implementation of the protocol across sites occurred between October 2013 and September 2015. Pooled data from 12 months’ pre-implementation at each site were compared to up to 12 months data following implementation. The mean length of stay, median length of stay and percentage of patients admitted was compared. Published local ED and inpatient costs for a similar cohort were then applied to the outcome measures.

Results: 21.3% of patients were managed on the ADP (95% CI: 16.5-27.0%). Hospital admission rate fell by 19.5% (RR=0.80, 95% CI: 0.72 to 0.89). The mean ED length of stay (LOS) fell by 12.2% (RR=0.88, 95% CI: 0.82-0.94). Total mean hospital LOS fell by 18.0% (RR=0.82 (0.74-0.91). Total median ED LOS fell by 20 min (95% CI: 17.9-22.1 min), while total median hospital LOS fell by 6.1 hours (95% CI: 5.5 to 6.6 hours).

Over the post-implementation period the estimated released capacity was $13.5 million.

Conclusion: Implementation of an evidence based ADP for the evaluation of patients with possible ACS through clinical redesign was rapidly associated with substantial release in health service capacity.

4C: Gaming the New Zealand Emergency Department target. How did it vary between hospitals, and why?

Tim Tenbendel¹, Peter Jones², Linda Chalmers², Sarah Appleton-Dyer¹, Lisa Walton¹
¹University of Auckland; ²Auckland District Health Board

★ Highly Commended Abstract

Background: New Zealand’s Shorter Stays in Emergency Departments target was implemented from 2009 to address ED crowding. The target required 95% of patients to be seen, treated or discharged within six hours. ‘Gaming’ is commonly regarded as an undesirable side-effect of using targets to drive health service improvement.

Aims: Our research sought to identify the presence and extent of gaming after the target’s implementation, and explain variation in gaming across four case-study sites.
Methods: We adopted a mixed-methods approach. To track the extent of gaming, ED utilisation data was collected from four case study hospitals from 2007 (two years pre-target) to 2012. Rates of pre-target ‘spikes’ and ‘digit preference bias’ were derived from this data. We conducted 68 semi-structured interviews about target implementation with ED and hospital clinicians and managers in 2011 and 2012.

Results: Significant ‘spikes’ of the proportion of ED discharges for the time interval immediately prior to the six hour target appeared in all sites after the target’s introduction. At all sites, patients were taken off the target stream (eg moved to short-stay units) to avoid target breaches. However, lower levels of gaming were associated with sites that adopted a ‘whole-of-hospital’ approach to target implementation. Gaming was more prevalent where implementation focused solely on ED staff and processes, without additional resources.

Conclusion: While gaming occurred in all sites, our research demonstrates that a myopic focus on avoiding target breaches within ED accentuates gaming, whereas more holistic approaches to target implementation and additional resources help to reduce it.

4D: Trends in Frequent Attenders to Emergency Departments in a NSW regional health service

Luise Lago¹, Victoria Westley-Wise², Rebekah Zingel², Judy Mullan¹, Wayne Triner², Kathy Eagar¹
¹University of Wollongong; ²Illawarra Shoalhaven Local Health District

Background: Emergency Department (ED) crowding affects healthcare quality and access. In Australia, ED presentations are increasing at approximately 3.4% per year. There is limited evidence about frequent ED attenders from a longitudinal perspective, especially accounting for their attendance at multiple facilities, a common occurrence in this patient group.

Aims: To investigate 10 years of longitudinal ED data from five EDs within a regional Australian Local Health District, to determine: (i) whether there has been any change in the number frequent attenders and their demographic and clinical profile; and (ii) whether frequent attenders remain so over long periods.

Methods: An ‘index’ ED presentation was identified with the following 12-month window used to identify frequent ED attendance. A threshold of 7 attendances per year was used to identify periods of frequent ED attendance. Unlike in other studies, this approach was applied across a large number of years to look at long-term frequent attendance patterns.

Results: Throughout the 10-year period, approximately 82% of frequent ED attenders, were so for only 12 months, and were associated with injury, infections or illness of the ear, nose and throat. A further 12% had two 12-month frequent periods. The remaining 6% were persistent frequent attenders, more likely to be diagnosed with poisoning, psychiatric illness, alcohol/drug abuse, or neurological illness.

Conclusion: The research findings highlight two distinct groups, those who attend within a 12-month period, versus those who attend frequently over a number of years. Appropriate interventions can be developed to provide care based on each group’s needs.
ACRE Project is a successful clinical redesign initiative developed to translate research into practice, to improve the care of emergency patients with possible acute coronary syndrome (ACS). Patients with symptoms of suspected ACS comprise a large proportion of emergency department (ED) presentations, however the proportion ultimately diagnosed with this condition is small. Improvement in the efficiency of assessment strategies, while maintaining clinical safety, is crucial.

The first stage of ACRE implemented the ADAPT accelerated diagnostic protocol into 19 Queensland hospitals and resulted in significant reductions in length of stay (LOS) and hospital admissions for patients presenting with suspected ACS.

Stage Two is implementing the Improved assessment of Chest pain Trial (ImpACT) protocol into practice. ImpACT is the latest strategy investigated by the team at the Royal Brisbane and Women’s Hospital (RBWH) that focused on further streamlining care for patients presenting with suspected ACS. ImpACT allows up to 70% of patients to safely undergo accelerated care by identifying a cohort of very low risk patients (up to 18%) who do not require lengthy investigation for ACS and a larger group (up to 56%) of intermediate risk patients who can undergo early testing for coronary ischemia prior to discharge. It has resulted in a significant reduction in LOS for suspected ACS patients and remained standard practice at the RBWH in 2014 following the trial. This presentation will share some preliminary findings of the ImpACT rollout and we expect to demonstrate similar outcomes to the research.

M.Christien van der Linden1, Naomi van der Linden3, Roeline A.Y. de Beaufort2, Sven A.G. Meylaerts2, Crispijn L. van den Brand2

1Medical Centre Haaglanden, The Hague, The Netherlands; 2 Medical Centre Haaglanden (HMC); 3Centre for Health Economics Research and Evaluation;

Background: A pilot project was organized in an emergency department (ED) in the Netherlands. For a period of 8 weeks in 2016, medical specialists who would have been on-call instead stayed at the ED during peak hours.

Aims: To describe the impact of additional medical specialists (non-Emergency Physicians (EP)), performing direct supervision or a combination of direct and indirect supervision at an EP-led ED on patient flow and satisfaction.

Methods: A three-part study was undertaken including staff surveys (n=379), a before and after 16 week data collection using data of visits during peak hours (n=5,270), and patient questionnaires before and during the pilot. Content analysis and descriptive statistics were used for analyses.

Results: The value of being present at the ED was acknowledged by medical specialists in 49% of their surveys and 35% of the EPs’ and ED nurses’ surveys, only during busy shifts. Radiologists were most often (67.3%) convinced of their value of being on-site, which was agreed upon by ED professionals. Perceived improved quality of care, shortening of length of stay and enhanced peer consultation were mentioned most often. During the pilot period, length of stay of boarded patients decreased from 197 minutes (interquartile range 121 minutes) to 181 minutes (interquartile range 113 minutes, p=0.006), and patient recommendation scores increased from -15 to +20.
Conclusions: Our results suggest a positive impact of additional medical specialists during busy shifts, especially for radiologists. Throughput of admitted patients and patient satisfaction improved during the pilot period.

**ORAL POSTERS (2): HEALTH POLICY AND SYSTEMS**

Session Chair: Rachael Morton, The University of Sydney

**Improving health outcomes for children and young people in out-of-home care**
Celia Lenaghan, Department of Communities, Child Safety and Disability Services - Brisbane Region

**Priority setting in health care resource allocation: Preferences and relative weights**
Emily Lancsar, CHE, Monash University

**Cohort design considerations when using big data and predictive risk modelling (PRM) to identify high-risk populations for performance measurement**
Jill Kaldor, Bureau of Health Information

**Public performance reporting and hospital choice: A cross-sectional study of patients with cancer**
Khic-Houy Prang, Centre for Health Policy, The University of Melbourne

**A data linkage and patient outcome study of aeromedical retrieval services in Queensland**
Kristin Edwards, James Cook University

**Community understanding and attitudes regarding public funding of new health technologies**
Laura Edney, University of Adelaide

**Pathways For Patients With Traumatic Spinal Cord Injury Across NSW- Are They Getting To The Right Place At The Right Time And What Does It Cost, If Not?**
Lisa Sharwood, University of Sydney

**Preparing for an environmental change: A case study from hospital multi-bed to all single rooms.**
Lynette Cusack, The University of Adelaide

**Between-hospital variation in admission for preventable hospitalisation in NSW**
Michael Falster, Centre for Big Data Research in Health UNSW

**Manualising goal setting and Goal Attainment Scaling for patient centred discharge care planning in stroke**
Nadine Andrew, Peninsula Clinical School, Monash University

**Moderating factors of the National University Health System’s (NUHS) Right-Siting Care Model; the health care providers’ perspective**
Pami Shrestha, Regional Health System Planning Office, National University Health System, Singapore
ORAL PRESENTATIONS (5): INNOVATIONS IN ACUTE CARE
Session Chair: Harry Rea, University of Auckland

5A: Trends and patterns in unplanned readmissions in a NSW regional health service
Victoria Westley-Wise1,2,3, Luise Lago1,3, Ms Franca Facci2, Ms Rebekah Zingel1, A/Prof Judy Mullan1,3, Prof Kathy Eagar4
1Centre for Health Research Illawarra Shoalhaven Population (CHRISP), 2Illawarra Shoalhaven Local Health District (ISLHD), 3University of Wollongong (UOW, Australian Health Services Research Institute)

Background: Persistently high and rising rates of unplanned readmissions have been observed in Australia and overseas. Given the costs and the burden placed on services, patients and carers, unplanned readmissions are increasingly being used as a metric of the effectiveness, quality and safety of care.

Aims: To describe trends and patterns in unplanned hospital readmissions over 14 years in a NSW regional health service.

Methods: A longitudinal retrospective study was undertaken of inpatients from a NSW regional health service, between 2002 and 2015, who had an unplanned readmission within 30 days or 1-6 months of discharge.

Results: One in 5 inpatients are readmitted within 6 months of discharge. Rates are highest among older people, those born overseas, without private insurance, resident in low socioeconomic areas, and in specific patient cohorts, including those with longer index stays and those recorded within
specific clinical groupings (e.g. Respiratory) and with specific co-morbidities (e.g. Heart Failure). Marked increases in readmissions within 1-6 months have occurred among older people over the last decade.

Conclusions: From the perspective of a regional health service, exploring trends and patterns in unplanned readmissions can highlight service issues and patient groups where there are opportunities for improved service delivery.


5B: Caesarean section among immigrants with different obstetrical risks in a Local Health District in Australia
Lieu Trinh¹, Hassan Assareh, Helen Achat, Seng Chua, Veth Guevarra, Joanne Stubbs
¹Epidemiology and Health Analytics, Western Sydney Local Health District

Objectives: To determine the variation in rates of CS among women from different cultures and with different obstetrical risks in the hospitals of Western Sydney Local Health District.

Methods: Data between 2011 and 2015 were analysed using the Robson 10-group classification. Multi-level Poisson regression was used to quantify variation between cultures and to calculate adjusted incidence rate ratio.

Results: Information from 48 711 women was analysed. Two-thirds of the women were born overseas (64.0%), and 13 966 had CS (28.7%). Women from South and Central Asia represented the largest group of immigrants with CSs (4139; 29.6%). These women had a high overall adjusted CS rate (31.4%; 95% CI, 30.5%–32.3%) and consistently high adjusted rates of CS for Robson groups 1-4. High adjusted rates of CS were observed among women from Sub-Saharan Africa Robson group 4 and women from South East Asia for Robson group 1.

Conclusions: Rates of CS varied between culture groups and within some Robson groups. Efforts to reduce rates of CS should be focused on the identified groups of women.

5C: Shifting the focus of malnutrition models of care: The SIMPLE Approach
Adrienne Young¹, 2, Jack Bell³, 4, Tracy Comans⁵, 6, Jan Hill⁷, Rhiannon Barnes¹, Heather Keller⁸, Merrilyn Banks¹
¹Royal Brisbane and Women's Hospital; ²Queensland University of Technology; ³The Prince Charles Hospital; ⁴University of Queensland; ⁵Metro North Hospital and Health Service; ⁶Griffith University; ⁷Princess Alexandra Hospital; ⁸University of Waterloo

Malnutrition is a significant problem in hospitals, which affects 25-30% of inpatients and has considerable impacts on patient and health service outcomes. While traditional hospital dietitian roles take a highly individualised approach, recent evidence suggests that systems-level interventions to improve food services, mealtime assistance, team-based care and optimising assistant workforces may provide a more efficient and effective solution to hospital malnutrition. A state-wide survey conducted by our group revealed that systematic nutrition care processes are implemented routinely in only 5 out of 23 Queensland hospitals. In response to this, we developed an evidence-based, systematized, interdisciplinary malnutrition program called the SIMPLE Approach. We hypothesise that the SIMPLE approach will deliver more appropriate nutrition care to more patients, at a lower cost per patient, without compromising overall health outcomes.
Evaluation includes pre and post measurement of changes to nutrition care, patient and health service outcomes, as well as a comprehensive evaluation of the implementation process (informed by knowledge translation frameworks and facilitation models). The SIMPLE approach is currently being implemented in six Queensland hospitals. At the time of abstract submission, 103 patients have been recruited to the study. Work is underway to improve practice gaps through implementation with results available in 2018. This work will directly inform the way that malnutrition care is provided across Queensland hospitals, with the desired outcome being disinvesting in low value dietetics tasks in managing acute malnutrition and redirection of this expensive resource to expanded scope of practice roles, service improvement and research.

5D: Universal Assessment and Screening in the Acute Care Setting

Nancye Peel¹, Yvonne Hornby-Turner², Leonard Gray²
¹Centre for Health Services Research, University of Queensland; ²University of Queensland

Background: The interRAI Acute Care is a new assessment system designed to identify functional and psychosocial problems among adult patients admitted to acute care. It comprises 56 clinical observations and a series of algorithms that perform diagnostic and risk screening, measure problem severity (scales) and assess quality of care.

Aims: A field trial was undertaken to determine the frequency distributions of the clinical observations among adult patients, to provide the evidence-base for wider implementation.

Methods: Participants included adult patients in four Australian hospitals: a large tertiary facility, a medium size community hospital, and 2 small rural hospitals. Assessments were performed by trained nurses within 12 hours of admission to an inpatient unit.

Results: The median age of the study population (n=910) was 66, ranging from 18 to 99 years of age, with 393 (43.2%) aged ≥ 70 years. While the prevalence of having at least one geriatric syndrome was high, as expected, among the cohort ≥ 70 compared with the cohort <70 years (82.1% vs 47.7%; p<0.001), there were a number of problems that were unexpectedly prevalent among younger patients. For example, high prevalence’s were present across age groups for mood disturbances, unintended weight loss, problems with skin integrity, pain, sleep disorders and dependence in mobility and basic activities of daily living.

Conclusion: Functional and psychosocial problems are sufficiently prevalent among younger hospitalised patients that universal screening is warranted for all adult patients. A “whole of hospital” implementation and evaluation is being undertaken, supported by an AusHSI grant.

5E: Received care compared to ADP-guided care of patients admitted to hospital with chest pain of possible cardiac origin

Ian Scott¹, Michael Perera², Leena Aggarwal², Bentley Logan²
¹Director of Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital, Brisbane; ²Medical Assessment and Planning Unit, Princess Alexandra Hospital, Brisbane

Background: Chest pain is a common presentation to emergency departments (EDs). Accelerated diagnostic protocols (ADPs) can identify low risk patients eligible for early ED discharge.

Aims: Compare outcomes of ADP-guided care versus usual care.

Methods: Retrospective study of 290 consecutive patients admitted with chest pain following initial negative ED work-up (no acute ECG changes or elevated initial serum troponin). Demographic data,
serial ECG and troponin, Thrombolysis in Myocardial Infarction (TIMI) score, investigations and outcomes (confirmed acute coronary syndrome [ACS] at discharge and major adverse cardiac events [MACE]) over 6 months follow-up were analysed. Outcomes of care guided by application of validated TIMI score based ADP (ADAPT-ADP) were compared with those of care actually received.

Results: Patients had mean TIMI score of 1.8 (+/-1.7) with six (2.0%) diagnosed with ACS at discharge. At 6 months, one patient (0.3%) represented with ACS and two (0.6%) died of non-coronary causes. The ADAPT-ADP defined 97 (33.4%) patients as being low risk and eligible for early ED discharge, but who instead were admitted overnight with mean hospital stay of 1.5 days, 40.2% in telemetry beds, and 21.6% subject to non-invasive testing with only one positive result for coronary artery disease. None had ACS as discharge diagnosis or developed MACE at 6 months.

Conclusion: More than 90% of chest pain patients with negative investigations in ED experienced no ACS, death or cardiac-related readmission at 6 months. Application of the ADAPT-ADP identified a third of these patients as being eligible for safe discharge from ED.

5F: Improving the services provided by small hospitals - the Kilcoy connect project
Maree Raymer1,3, Tracy Comans1,2, Anne Padayachee1, Cassandra Ranatunga2
1Metro North Hospital and Health Service; 2Griffith University; 3QUT

Rural hospitals have seen a decline in services provided as the specialisation of care has increased. Aligning hospital services with the needs of larger centres can improve the utilisation of these hospitals. This project converted beds in a small rural hospital of 21 beds (Kilcoy hospital) to become geriatric evaluation and management (GEM) beds servicing the nearby Caboolture hospital. To run the GEM service, a mixed model was developed using telehealth for geriatrician consults and onsite allied health and allied health assistant workforce to manage the patients.

The aim of this paper is to establish that GEMs patients can be accommodated safely and managed to an equivalent standard in a rural hospital (Kilcoy) as compared to a larger metropolitan hospital (Caboolture). A secondary aim is to compare the resource use in terms of staffing and costs between the two services.

The trial was able to improve the bed occupancy and improve the use of telehealth at Kilcoy hospital. Length of stay (14 vs 15 days) and improvement in function (18 vs 17 points) was similar between the two models. The cost of the care provided was not different between the hospitals. The project led to ongoing funding for this model with on site medical support now in place.

Rural hospitals are at risk of losing services and bed closures. By utilising telehealth and providing an allied health led model of care, GEM patients can be cared for at an equivalent standard and at similar cost to a larger centre.
6A: Community Eye Care: A collaborative model for chronic eye disease management in Western Sydney

Belinda Ford¹,², A/Prof Andrew White³,⁴, A/Prof Lisa Keay⁵, A/Prof Gerald Liew¹,³
¹Westmead Eye Clinic- Western Sydney Local Health District; ²The George Institute; ³Westmead Institute for Medical Research; ⁴Head of Westmead Eye Clinic- Western Sydney Local Health District; ⁵The George Institute for Global Health, UNSW Sydney

Public hospital ophthalmology clinics are unable to meet service delivery needs for chronic eye patients. Collaborative care models can improve service efficiency but few have been tested in Australia.

Aim: To assess the feasibility of a collaborative eye care model in Western Sydney

Methods: Westmead Eye Clinic (WEC) partnered with local optometrists to establish a collaborative care model (Community Eye Care- CEYEC). Low risk patients were examined and underwent imaging with local optometrists in the CEYEC pathway. A store and forward tele-health model was used whereby results were reviewed remotely by a consultant WEC ophthalmologist and final diagnoses and management decided. A trial of CEYEC ran from Jan-Mar 2017. The RE-AIM Framework was used to evaluate CEYEC.

Results: One hospital and two optometry practices participated in the trial. Of 327 low risk patients referred to CEYEC optometrists; 242 (69%) underwent assessment, 13% of assessments were incomplete. Two-thirds (65%) received glaucoma assessment. Following assessment, 47% patients required no follow-up at WEC, 43% CEYEC follow-up; 4% discharged. Substantial agreement was observed for management plans (77%, k= 0.647); and diagnoses: overall (70%, k= 0.668), glaucoma (69%, k=0.639) and diabetes (81%, k=0.753). Most patients (85%) expressed confidence with CEYEC. There were sufficient numbers of low risk patients suitable for this pathway.

Conclusion: CEYEC has reduced hospital appointments by 47% for chronic eye disease patients, and is acceptable to patients. High agreement between providers suggests clinical standards of care are maintained in the model. The model appears feasible and further evaluation will support broader implementation.

6B: Implementing a successful diabetic retinopathy screening service in general practice: What does the evidence tell us?

Lisa Crossland¹, Prof Claire Jackson¹
¹Centre for Health System Reform and Integration, Mater-UQ Research Institute

Background: The authors previously demonstrated that general practice based DR screening offers improved recording of screening outcomes for Australians with type 2 diabetes and better follow up, especially of those with screen abnormalities. This work contributed to the launch of 2 new MBS item numbers to support DR screening in general practice. However, there is little evidence-based information to guide practices in successfully implementing DR screening models.

Methods: In-depth interviews were completed with clinical and non-clinical staff involved in DR screening. Additional observational data were also gathered. Thematic analysis identified and
classified recurrent themes and was used to develop a framework to guide successful DR screening in general practice.

Results: Three unique approaches to DR screening were identified. Four themes related to the successful implementation of these approaches and formed a guiding framework for practices: (i) a ‘DR champion’ in practice; (ii) up-to-date diabetes registers; (iii) appropriate infrastructure and workforce; and (iv) management of internal and external professional relationships. Non-clinical benefits of DR screening included (i) ability to detect other pathology and conditions (ii) reduction of unnecessary travel for patients (iii) improved opportunities for education and training.

Significance: The framework has been launched as a guide to general practices in successful implementation DR screening and utilisation of the MBS item numbers and considerations relating to an effective business model. We have also developed an online accredited training program to support GPs and other health service staff to establish effective DR screening approaches in their practice.

6C: QUality improvement to prevent hospitalisations and improve Effectiveness and efficiency for people living with heart disease (QUEL) Partnership

**Julie Redfern**¹, Clara Chow², Chris Reid³, Nick Zwar⁴, Timothy Usherwood², Mark Woodward⁵, David Hare⁶, Tom Briffa⁷

¹The George Institute for Global Health, ²University of Sydney; ³Curtin University of Technology, ⁴University of Wollongong; ⁵UNSW Sydney; ⁶University of Melbourne; ⁷University WA

Implementation of practice-level quality improvement (QI) initiatives in primary care have excellent potential to improve patient outcomes, but knowledge is needed on how they are best implemented, scaled and what measurable outcomes they can achieve. Our partnership team have been working collaboratively for the past 3 years as the National Secondary Prevention Alliance and our aim is to improve care of patients in the primary care setting. The project is important due to (i) increasing burden of CHD and need for better patient management after hospital discharge, (ii) current interest of the Federal Government in a QI Practice Incentive Payment (PIP) in primary care (QI PIP), (iii) availability of a practice-ready QI program that uses data-drive improvement in performance, (iii) need for robust evidence of reduced hospitalisations and costs if the QI PIP were implemented and (iv) a desire by Primary Health Networks (PHNs) and clinical groups to have evidence-based strategies that improve service efficiency and patient outcomes. Ultimately, this project will expand the international evidence-base and inform government decision-making relating to PIP redesign and implementation.

The presentation will provide an overview of evidence for quality improvement (QI) in primary care as a means to make ongoing management more systematic and to close the gaps in post-discharge care. The Federal Government’s current focus on PIP redesign and how it might be implemented will also be discussed. The presentation will also outline methodology of a nationwide cluster randomised controlled trial with nested cost and process evaluations plus development of policy recommendations.
6D: Cost saving with a GP-led integrated health service delivery model for complex chronic disease: an optimal Beacon practice

Claire Jackson\(^1\), Luke Connelly\(^1\), Bharat Vaikuntam\(^1\), Maria Donald\(^1\), Samantha Hollingworth\(^1\), Anthony Russell\(^1\)

\(^1\)University of Queensland

Health policy internationally is promoting the benefit of delivering complex chronic disease care in the community rather than the hospital setting. The Beacon model is designed as a primary-secondary integrated model of outpatient substitution whereby patients with complex diabetes receive care through a community-based practice where GPs with a special interest (GPwSI) and advanced training in diabetes work alongside an endocrinologist and diabetes nurse educator (DNE). We draw on over a decade of research to sketch a profile of an optimal Beacon clinic in terms of capacity and cost. We measured costs at two hospitals and three Beacon sites and computed the Beacon clinic duration and patient load that minimises the costs of treatment, whilst producing non-inferior outcomes. While the costs varied across sites, an optimal Beacon is a lower cost alternative to usual hospital outpatient care. An optimal Beacon costs $4,998, would operate for four hours with two GPwSI treating 14 patients, with the DNE employed 3-days/week. This estimate is based on an urban setting in which patient treatment needs are sufficient to support the weekly/fortnightly treatment of this number of patients.

The model holds promise as a way to cost-effectively manage complex chronic conditions, while freeing resources in hospital settings to attend to acute and inpatient services. It is delivered via a shared Commonwealth and state funding model, currently an uncommon arrangement for chronic disease management. However, proposed pooled funding arrangements at the local level designed to support better coordination of care could provide leverage for the model.

6E: How much can an education program improve the diagnosis and management of dementia in general practice?

Anne Parkinson\(^1\), M Mofizul Islam\(^2\), Laurann Yen\(^1\)

\(^1\)The Australian National University; \(^2\)LaTrobe University

People concerned about signs of dementia report long delays in reaching a diagnosis, and often say they get little help from general practice in providing information about and support for the condition.

The “Timely Diagnosis and Management of Dementia in General Practice” offered GPs a set of six education modules, which could be taken face-to-face or online, between July 2015 and May 2017. A total of 1,523 GPs undertook the 6-module training with 559 GPs attending face-to-face education in small regional workshops, or in one of the capital city conferences. A further 964 GPs completed 6-modules online.

Participants provided information about their current practice in relation to dementia prior to the start of the education, and their practice intentions immediately post education. Participants were asked about their current practice again at follow up 6 months later. In addition, participants were surveyed at three time points to assess changes in awareness, knowledge, confidence and practice intention in relation to dementia diagnosis and management. Demographic information was also sought about age, gender, years of practice and size and location practice.

Substantial increases in awareness, knowledge, confidence were seen across all the course elements, including intention for future practice, from pre-training to immediate post-training survey. While the 6-month follow-up showed a drop back in all areas, the sustained increases
compared with pre-training were significant at the \( p<0.01 \) level. Online education showed stronger maintained changes compared with face-to-face education.

**6F: A model of pharmacist and general practitioner care to reduce readmissions in high risk patients: THE REMAIN HOME Study**


University of Queensland; University of Birmingham; Princess Alexandra Hospital; Royal Brisbane and Women's Hospital; Brisbane South PHN; University of East Anglia; Monash Health; Mater Health Services; Monash University

For patients with complex comorbidity, the transition from hospital back into primary care is a critical time associated with medication misadventure and re-hospitalisation. A model of pharmacist and general practitioner (GP) collaboration provides an opportunity to improve information transfer between hospitals and primary care, reduce medication-related problems and provide better support to patients after discharge. This study will investigate whether integrating a pharmacist into the general practice team will reduce unplanned hospital readmissions at 12 months.

This a stepped wedge cluster randomised trial that will recruit 2240 patients in hospital who attend an enrolled medical centre, take five or more medicines or whose reason for admission was related to heart failure or chronic obstructive pulmonary disease.

The intervention is a multi-faceted service that will be sequentially rolled out in 14 different medical centres in a randomised order. Following hospital discharge, patients will meet with the practice pharmacist and their GP to review and reconcile their medicines and discuss changes made in hospital. The pharmacist will follow up with the patient and liaise with other health professionals involved in the patient’s care.

The analysis will adjust for any underlying temporal trends, to provide a robust estimate of the effectiveness of an intervention in a pragmatic and naturalistic setting.

This model of collaborative care has the potential to reduce unplanned hospital readmissions. This study will inform the potential establishment of funding models to support the role of pharmacists in medical centres in Australia.

**ORAL PRESENTATIONS (7): SOLUTIONS FOR CHRONIC DISEASES FOR ABORIGINAL AND TORRES STRAIT ISLANDER POPULATIONS**

Session Chair: Veronica Mathews, The University of Sydney, University Centre for Rural Health - North Coast

**7A: Aboriginal experience of chronic disease care in the Illawarra Shoalhaven region**

*Kathleen Clapham*, Scott Winch, Kate Senior, Zane Rice

Australian Health Services Research Institute; University of Wollongong

Background: Aboriginal Australians experience chronic diseases at much higher rates than other Australians, but little is known about how this is managed, by particularly in urban communities.

Aims: This qualitative study explored the ways in which Aboriginal people experience the health system in the Illawarra Shoalhaven Local Health District (NSW) in order to inform health planning and policy.
Methods: Over an 18 month period we 1) conducted qualitative interviews and focus group discussions (FGDs) with Aboriginal people managing chronic illness in the community; health service providers; managers of chronic disease programs and systems stakeholders, and 2) reviewed guidelines for chronic disease management.

Results: 88 interviews, 4 FGDs and were conducted (56% of participants Aboriginal). We will report findings about Aboriginal people’s experience of the health care system including: hospital and discharge; accessing health care and programs in the community; and suggestions for improvement.

Conclusions: Better linkages between health and social services are needed to address the underlying social and cultural determinants of Aboriginal health. Eight broad recommendations draw attention to the complexity of the health care system and address barriers and enablers to achieving district level policy change and health service improvement, including a strategy to address Aboriginal health workforce.

7B: Can better access to coordinated, multidisciplinary care really close the gap in life expectancy for indigenous people with complex chronic conditions? Evaluation of a primary care service to change indigenous health outcomes

Jacqueline Davis1, Annie Young2
1Curtin University; 2WA Primary Health Alliance

Background: Access to mainstream health services can be difficult for Indigenous people due to socioeconomic disadvantage, geographical distance and a lack of culturally appropriate health services. The Integrated Team Care (ITC) Activity was implemented by PHNs to address these needs. Curtin University is undertaking an independent evaluation in WA. The study will evaluate the uptake, effectiveness and outcomes of ITC over 18 months and will provide guidance on program delivery improvements by taking an action research approach.

Methods: A mixed methods evaluation design including:
1. Desktop review of relevant evidence
2. Review of reported client engagement and data gathered from semi-structured interviews with health service providers, GPs and ITC workforce
3. Analysis of quantitative information regarding cost, quality and outcomes.

Results: Data is analysed at a range of collection points to inform formative and summative evaluations. Early findings indicate that the service has huge potential to empower indigenous people to self-manage their chronic conditions. There is genuine commitment to the success of this service at a local and system’s level. The formative evaluation results will be available in July 2017 - which will include qualitative analysis of stakeholder interviews.

Conclusion: Chronic diseases can require intensive care and a coordinated approach to disease management to minimise the impact on quality of life and reduce the occurrence of acute phases. This will be the first whole of state evaluation of a specific chronic disease intervention for Indigenous people; it will be used to guide program change and future funding.
7C: Researching emergency department chest pain risk stratification for Aboriginal and Torres Strait Islander people: lessons in study design and community engagement
Laura Foran¹, Tanya Milburn¹, Sarah Ashover¹, Dr Louise McCormack¹, Prof William Parsonage², Prof Louise Cullen¹
¹Queensland Health; ²AusHSI QUT

Based on research conducted at the Royal Brisbane and Women’s Hospital, the Improved Assessment of Chest Pain Trial (ImpACT) Protocol is an approach to risk stratification identifying a larger proportion of patients with suspected Acute Coronary Syndrome (ACS) that can safely undergo accelerated care. This includes identification of a group of patients aged <40 years without other risk factors at very low risk of major adverse cardiac events that no longer need further objective testing for coronary ischemia. The protocol is currently being implemented in the Cairns Hospital. Aboriginal and Torres Strait Islander patients have higher risk of major coronary events compared to other Australians, with rates seven to nine times higher in those under the age of 45. Consequently it is unclear if Aboriginal and Torres Strait Islander patients could be safely regarded as low risk for ACS in accordance with the ImpACT protocol.

The Aboriginal and Torres Strait Islander ImpACT study is a prospective observational trial being conducted in partnership with the Queensland Health Clinical Excellence Division and the Australian Centre for Health Services Innovation (AusHSI), aimed at describing the risk stratification and outcomes for Aboriginal and Torres Strait Islander patients assessed at Cairns Hospital for suspected ACS. Such patients will be managed according to traditional recommendations, including objective testing for coronary ischemia. This presentation will discuss the study design; the lessons learnt from collaborative engagement with Aboriginal Community Controlled Health Organisations in the research process and share some preliminary findings of the research.

7D: The CVD polypill strategy for Aboriginal and Torres Strait Islanders- a post-trial evaluation
Huei Ming Liu¹, Anne-marie Eades², Stephen Jan³
¹The George Institute for Global Health; ²The George Institute for Global Health; ³The George Institute for Global Health. on behalf of the Kanyini Vascular Collaborative Group

Background: There is a call for more collaborative research to increase Indigenous-led interventional research to improve outcomes.

Aims: To identify to what extent was there translation of evidence to practice following a randomized controlled trial conducted by Kanyini Vascular Collaboration in 2013.

Methods: We used the Reach, Effectiveness, Adoption, Implementation and Maintenance (REAIM) framework retrospectively to evaluate the polypill based strategy for cardiovascular prevention. Outcome, process and economic evaluations and insights from the investigators formed the dataset.

Results: Collaborative research enabled research governance by the Aboriginal Community Controlled Health Services, and recruitment of Indigenous participants for an intervention viewed as a health priority. Indigenous participants described the polypill strategy as empowering through the reduction of treatment complexity in face of competing life priorities and other health co-morbidities. Many staff described improvement of clinical skills and greater links between their health service and pharmacies. However, trial implementation required major investments in time and resources. Despite the polypill’s effectiveness, acceptability and potential cost saving- this health service strategy was not adopted into practice and policy post-trial. Key barriers included a
lack of necessary commercial case for polypill manufacture, and uncertainty regarding the suitability of polypill indications by peak regulatory bodies.

Conclusion: Indigenous-led and co-production of interventional research with Aboriginal Community Controlled Health Services is necessary for culturally-safe and relevant evidence. However, to ensure translation of evidence into practice more needs to be done including researchers actively following up studies through long term data collection and advocacy to overcome health system barriers.

7E: The Lighthouse Hospital Project- innovations in improving hospital care for Aboriginal and Torres Strait Islander cardiac patients

Vivian Bryce, Reitai Minogue
1Heart Foundation; 2Princess Alexandra Hospital

For Australia’s First Peoples, heart disease onset is likely to be earlier, and more likely to be associated with complex co-morbidities, frequent hospital admissions and premature death. Rates of potentially preventable hospitalisations for heart disease are higher, and discharge from hospital against medical advice is five times the rate for non-Indigenous Australians.

The Lighthouse Hospital Project, a joint initiative of the Heart Foundation and the Australian Healthcare and Hospitals Association, and funded by the Australian Government, aims to improve health outcomes for Aboriginal and Torres Strait Islander peoples experiencing acute coronary syndrome. The project is occurring over three phases. In Phase 2, 8 hospitals trialed the use of a quality improvement toolkit. The Lighthouse Hospital Project toolkit is based on a conceptual framework that identifies four key domains that need to be addressed to ensure culturally appropriate and clinically competent care. The four domains are: governance, cultural competence, workforce and care pathways.

One of these hospitals was Princess Alexandra Hospital located in the Metro South Health Service in Queensland. Using the toolkit many key successes were achieved. Including but not limited to, a model of care being developed to incorporate Indigenous Health Liaison Officers in the care of Indigenous patients and increased cultural competence of staff through the increased accessibility and flexibility of cultural capability training. Princes Alexandra Hospital along with 17 others across Australia will be participating in Phase 3. The goal is to achieve systemic change through the full implementation of the toolkit and enhancing the care coordination.

7F: Eliminating crusted scabies in remote communities in Australia: a systems based quality improvement approach

Michelle Dowden, Meg Scolyer, Irene Omeara, Hannah Woerle, Karen Gardner
1One Disease; 2UNSW

Crusted scabies is a highly contagious and chronic form of the skin disease scabies. It is a disfiguring and debilitating disease among individuals whose immune systems are unable to control mite replication. One in 460 Indigenous people in the Northern Territory of Australia have crusted scabies and without adequate treatment individuals have a 50% mortality rate over 5 years. A systems based quality improvement program was established in the NT in 2014 to eliminate crusted scabies. The program provides a coordinated approach to the detection, management and treatment of CS in partnership with primary health care services. Lessons from the NT experience will inform roll-out of the program to Western Australia and Queensland services in 2019. The ultimate aim of the program is to eliminate CS from Australia by 2022.
A structured approach to program implementation is accompanied by a systems-based continuous quality improvement approach to achieve five key goals. These are: • To improve detection and diagnosis • To prevent recurrence and ensure that treated clients live in a scabies free zone • To explore and destigmatise CS so that clients and families feel comfortable seeking care from health professionals • To develop a sustainable model of coordinated care that can be replicated in other diseases in remote Indigenous communities • To execute a public private funding campaign to eliminate CS in Australia. In this paper, we discuss the methods used for detection, prevention and management and present early data on case finding, treatment and program impact.

1:15PM – 2:45PM: CONCURRENT SESSION

SYMPOSIUM 5: IMPROVING ACUTE AND EMERGENCY CARE OF OLDER PEOPLE: THE RESULTS OF THE CEDRIC PROJECT
Session Chair: Amanda Glenwright, Regional Program Coordinator, Central Queensland, Wide Bay & Sunshine Coast PHN

Ageing populations increase pressure on provision of aged care services and emergency departments (EDs). This symposium will present the findings from the evaluation of the Care coordination through Emergency Department, Residential Aged Care and Primary Health Collaboration (CEDRIC) project. CEDRIC focused on providing quality healthcare, related to acute illness episodes, for older people dwelling in the community and residential aged care facilities (RACFs). The aim was to avoid transfer or admission to hospital where appropriate. CEDRIC delivered care for older people via two geographically separate, but linked, services. These were the Geriatric Emergency Department Intervention (GEDI) based in the local, regional ED and the Health Intervention Program for Seniors (HIPS) within a RACF. In HIPS, a Nurse Practitioner Candidate worked collaboratively with General Practitioners (GPs) to provide early health assessment and intervention to RACF residents. GEDI consisted of an advanced-practice nurse-led, physician championed ED team with experience and education in care of the frail aged. These services communicated with GPs (as the centre of each person’s ongoing care) and other existing services (offered under the umbrella of community health) and coordinated care between the RACF and ED. The evaluation demonstrated that CEDRIC improves client outcomes and reduces costs.

Care coordination through emergency department, aged care and primary health collaboration: the CEDRIC project

Marianne Wallis¹, Elizabeth Marsden¹,², Kaye Coates³, Andrea Taylor¹,², Alison Craswell¹, Marc Broadbent¹, Amanda Glenwright⁴, Colleen Johnston¹, Adrian Barnett⁵, Kim-Huong Nguyen⁶, Julia Crilly⁶,⁷

¹University of the Sunshine Coast; ²Sunshine Coast Hospital and Health Service; ³Sundale Ltd.; ⁴Central Queensland, Wide Bay and Sunshine Coast PHN; ⁵AusHSI, QUT; ⁶Griffith University; ⁷Gold Coast Health

The CEDRIC model of care is a system wide, nurse-led collaboration focused on improving primary care, inter-sectoral communication, decision-making and emergency care for older adults with acute illness. CEDRIC aims to improve the care of older people and decrease hospital admission where appropriate. In this session we will describe the interconnected elements needed to provide patient-centred care for acutely unwell older adults, the program development approach and evaluative research program undertaken.
The Geriatric Emergency Department Intervention

**Andrea Taylor**1,2, Elizabeth Marsden1,2, Kaye Coates1, Alison Craswell2, Marc Broadbent2, Amanda Glenwright4, Adrian Barnett5, Kim-Huong Nguyen6, Julia Crilly6,7, Marianne Wallis2
1Sunshine Coast Hospital and Health Service; 2University of the Sunshine Coast; 3Sundale Ltd.; 4Central Queensland, Wide Bay and Sunshine Coast PHN; 5AusHSI, QUT; 6Griffith University; 7Gold Coast Health

GEDI is a nurse-led, physician championed innovation based in the emergency department (ED). GEDI streamlines ED service delivery by maximising the provision of geriatric focused care, fast-tracks decision making and reduces ED length of stay. GEDI advanced-practice nurses provide early, rapid, targeted geriatric assessment of frail older persons presenting to the ED through careful inter-facility and interdisciplinary, management and planning. This session will present the positive effects of GEDI on client outcomes and hospital costs.

A Nurse Practitioner Candidate in residential aged care providing the Health Intervention Project for Seniors (HIPS)

**Kaye Coates**1, Andrea Taylor2,3, Elizabeth Marsden1,2, Alison Craswell3, Marc Broadbent3, Amanda Glenwright4, Adrian Barnett5, Kim-Huong Nguyen6, Julia Crilly6,7, Marianne Wallis2
1Sundale Ltd.; 2Sunshine Coast Hospital and Health Service; 3University of the Sunshine Coast; 4Central Queensland, Wide Bay and Sunshine Coast PHN; 5AusHSI, QUT; 6Griffith University; 7Gold Coast Health

This session will focus on healthcare outcomes and health economic analysis of HIPS. The HIPS intervention is led by a Nurse Practitioner Candidate within an aged care facility who provides increased clinical assessment for elders aiming to provide care in the facility and reduce the need for transfer to hospital. This has a threefold advantage in:

1. Decreasing costs in ambulance, emergency departments and hospital services
2. Decreasing risk of iatrogenic complications of transfer particular to frail older people
3. Early assessment and intervention leading to improved health outcomes.

Development of an implementation toolkit for knowledge translation

**Alison Craswell**2, Elizabeth Marsden1, Andrea Taylor1,2, Kaye Coates1, Marc Broadbent2, Colleen Johnston2, Marianne Wallis2
1Sunshine Coast Hospital and Health Service; 2University of the Sunshine Coast; 3Sundale Ltd.

The CEDRiC project dissemination toolkit was developed to enable others to implement this unique model of care. Although each may be implemented as a stand-alone service, the aim of care coordination is to improve primary care for older people in RACFs reducing the need for transfer to emergency departments. In this presentation, the CEDRiC Toolkit is used to demonstrate how to engage clinicians in the research translation of innovative practice, articulating the critical aspects of that practice and the principles and experience of toolkit development. This toolkit will enable knowledge translation of this model into other facilities.
SYMPOSIUM 6: GOLD COAST INTEGRATED CARE: PRIORITIES AT THE ACUTE AND PRIMARY CARE INTERFACE

Session Chair: Kate Johnston, Gold Coast Health, Gold Coast Integrated Care; Menzies Health Institute Queensland, Griffith University

This symposium presents preliminary results from an innovative integrated care program being trialled as a partnership between the local Hospital and Health Service and fifteen general practices. The Gold Coast Integrated Care (GCIC) program has two main themes; hospitalisation risk avoidance and chronic disease management. Our innovative data matching process has identified a baseline population of 92 000 patients, 1 600 of whom have been identified at being of high risk of hospitalisation. Using a novel dataset the system links information from hospital and primary care, allowing us to identify patients with diagnosed chronic conditions and gaps in care from which we can assess and plan cross-sector strategies to mitigate risk and optimise care.

The program has also introduced a new care provider role, the Nurse Navigator, employed jointly by the Health Service and General Practices to work at the interface of the acute and primary care sectors to manage risk and facilitate continuity of patient care through information sharing. In addition, we have developed a number of alternative care models that position hospital clinicians in a community setting to integrate service provision, thereby addressing impending but preventable hospital presentations.

Identifying, assessing and planning care for patients at increased risk of hospitalisation

James Fink1,2, Michelle Cleary1
1Gold Coast Health, Gold Coast Integrated Care; 2Bond University

This presentation will explore the methods by which high risk patients were selected for consideration in GCIC including matching of hospital and general practice data and a dynamic risk stratification tool. In addition a discussion of a comprehensive risk assessment will outline how a Shared Care Plan addressing medical and social needs is formulated, and we present preliminary results of a population view of hospitalisation risk for 1600 patients. Finally, an approach to identifying and assessing the “highest of the high risk” will be outlined.

Nurse Navigators: expanding the primary care role for nurses?

Mirja Vantanen1
1Gold Coast Health, Gold Coast Integrated Care, Health HQ

The role of Nurse Navigator in GCIC extends GP capacity for patient-centred care by acting as a conduit between the patient, the GP and practice staff, and the acute setting. This role enables identification and proactive risk management of patients at high risk of hospitalisation, support for admitted and discharged patients of the practice, recognition of patient deterioration in the community, provision of care for people in their own home and support for general practice in delivery of best practice chronic disease management. Results to date will be presented.

Integrated care alternatives to acute care: Impact and lessons learned

Evelyn Rank1
1Gold Coast Health, Gold Coast Integrated Care

Patients attend hospital emergency departments for low acuity conditions for a number of reasons including the perception that hospital care is required, or access to their general practitioner is difficult. GCIC offers patients the opportunity to attend a community based acute demand service, staffed by a medical specialist, medical registrars and nurses. This service offers care beyond that
available from local GPs but which does not require presentation to hospital. This presentation will discuss uptake of this service, the nature of care delivered and hospitalisations avoided.

Determining chronic disease prevalence and optimising management across the care continuum.

Kate Johnston
1
1Gold Coast Health, Gold Coast Integrated Care; Menzies Health Institute Queensland, Griffith University

Australian researchers continue to search for the most accurate method of determining chronic disease prevalence in the population. This presentation will outline GCIC’s utilisation of both General Practice and Health Service coded and implied data to calculate prevalence of seven common chronic diseases in its program population. The gap between optimal disease monitoring and the reality of achieving this in general practice will be discussed. Finally a chronic disease program to support patients and GPs achieve best practice care and optimise disease management targets will be presented.

ORAL PRESENTATIONS (8): WORKFORCE REDESIGN

Session Chair: Lisa Hall, The Australian Centre for Health Services Innovation (AusHSI)

8A: A pilot evaluation of implementing a program of nurse navigators across four hospital health services in Queensland

Louisa Gordon, Amy Spooner, Natasha Booth, Tai-Rae Downer, Ray Chan
1QIMR Berghofer Medical Research Institute

Background: Patients with complex medical conditions need timely, appropriate, and cost-effective care. We undertook a pilot evaluation of the early experiences of Queensland Health’s commitment to fund 400 nurse navigator (NN) positions to coordinate patient journeys through the healthcare system.

Methods: A mixed-methods design was used combining qualitative interviews with patients and carers (n=25), cross-sectional surveys to NNs (n=23) and their line managers (n=10) and quantitative analysis of patient hospital admissions and costings (n=300). Four hospital health services were sampled: Metro North, West Moreton, Cairns and Hinterland and Children’s Health Queensland. The surveys assessed NN activities within the Advanced Practice Role Delineation Tool, barriers, enablers and professional development needs. Central data linkage provided health service use and costings for patients under NN care (n=100) matched to contemporaneous controls (n=300) over a 3-month period.

Results: Key enabling factors were physician support, feeling valued in the multidisciplinary team, prior service knowledge, networks/technology and good communication skills. The main barrier was the lack of clarity around the NN role and the inability of NNs to make referrals to streamline appointments. Patients under the care of NNs were high users of health services (total 536 hospital admissions, mean length of stay 7.6 days). Resource and costing group comparisons are underway and clinical expert audits will determine if ‘appropriate’ care was achieved by the NNs.

Conclusion: The findings of this pilot will inform a state-wide evaluation, clinical practice, hospital management of patients with complex needs and identify ways to integrate with primary care services.
8B: Geographic Variation in the Supply and Distribution of Comprehensive Primary Care Physicians in Ontario, 2014/15

Michael Green1, Peter Gozdyra, Eliot Frymire, Richard H. Glazier
1Professor and Head, Dept of Family Medicine, Queen's University

Context: Geographic access to primary care is an important factor affecting overall population health. Mapping this access can be a useful resource to further the understanding of physician supply and distribution. Objective: This study examines changes in the availability of primary care physicians and access to various primary care models in 2014-2015 in the province of Ontario.

Design: GIS mapping was performed using administrative data housed at the Institute for Clinical Evaluative Sciences (ICES). A range of spatial analytical methods and maps were used including shaded maps depicting service densities, interpolated grid maps based on Inverse Distance Weighting, as well as accessibility measures such as 2-Step Floating Catchment Area. Setting: The province of Ontario, Canada distinguishing: 1) large urban areas, 2) small communities and rural areas, 3) remote northern communities Participants: All residents (approximately 13 million) and Comprehensive Primary Care Physicians (approximately 8,800) in Ontario. Main and Secondary Outcome: Measures of local availability of and accessibility to FPs. For patient measures, number of patients assigned to a physician was used. Results: Overall, most geographical areas improved slightly over the 2002-2015 period in regards to the supply of comprehensive family physicians. The number, type and mix of local care providers in relation to population need is a key data gap. Uneven distribution remains an issue. Conclusions: The maps contained here are a useful resource to further the understanding of physician supply and distribution of family physicians across a region. By using techniques that are able to produce maps without predefined boundaries.

8C: Video-consultation as part of rural outreach services: how are specialists using it and does it reduce their travel?

Belinda O'Sullivan1, Dr Matthew McGrail1
1Monash University

Background: In Australia, around one in five medical specialists undertakes regular rural outreach services, however, a consistent policy question is whether rural outreach services can be substituted by video consultations (VCs).

Aims: How common is VC used as part of rural outreach services, for what clinical areas is it considered relevant? Does VC reduce the frequency of outreach travel and improve the sustainability of outreach work.

Methods: An online survey of 390 specialists in Victoria December 2016-March 2017, all subsidised by the Australian government to provide rural outreach services in Victoria.

Results: Of 65 included respondents, 57% used VC to provide clinical services to their rural outreach site (median use of 6.5 sessions per year and median of 3 patients per session). VC use was just as common among rural and metropolitan-based specialists. Applications were mainly for non-complicated healthcare, to support rural GPs, to enable tertiary team support, clinical review or to see urgent new patients expediently. Key restrictions were inability to conduct physical examinations and undertake complex assessments. VC did not reduce outreach travel for half of specialist users and 43% reported it took more time than face to face consultations. Use did not relate to the intention to continue outreach 5 or more years (57% v 61%; P=0.7)
Conclusion: VC has some complementary application within rural outreach services, although infrequently and for restricted clinical scenarios. It does not replace the utility of face to face outreach services, can take more time and may not improve outreach sustainability.

8D: How is Australia tracking towards rural medical workforce self-sufficiency?
Matthew McGrail¹,², Belinda O'Sullivan³, Deborah Russell²
¹Monash University, ²Monash Rural Health

Background: Self-sufficiency of Australia’s medical workforce was espoused in Australia’s National Health Workforce Strategic Framework in 2004, with recently signalled plans to remove medical occupations from the Skilled Occupation List (thus limiting international recruitment). However, there has been minimal application of workforce evidence to address goals of a skilled, well-distributed and stable rural medical workforce and to target the required policy strategies.

Aims: Apply evidence from the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey of Australian doctors to inform self-sufficiency and future rural medical workforce policies.


Results: Australia’s medical workforce has grown in recent times but recent graduates are increasingly likely to subspecialise into metropolitan practice. Rural areas, particularly smaller towns remain strongly dependent on a mix of domestic and international medical graduates. Leveraging more domestic students to work rurally is strengthened through coordinated effort and pathways through all stages of medical training, continued support for rural-background and rural-interest students, and increasing doctors with broad skills to suit rural populations. Although just as satisfied, rural doctors need more sustainable rural work conditions, including locum support and professional development, critical to attracting the next generation of (increasingly female) doctors seeking good work-life balance.

Conclusion:
Australia is tracking well on number of doctors but reduced reliance on migrant personnel in smaller rural towns requires increasing proportion with generalist skills, who are prepared for rural practice and rural living, together with policy support for improved work conditions, particularly in small towns.

8E: Development of a policy framework for enhanced pharmacist roles in primary care
John Jackson¹, Carl Kirkpatrick¹, Bianca Levkovich¹, Vivienne Mak¹
¹Monash University

Funding for pharmacists’ services in ambulatory care is predominantly linked to dispensing and consequently the application of their expertise is largely confined to this role and to community pharmacy premises. Pharmacists possess a unique body of knowledge and set of skills which could be used to deliver a wider range of services in a larger number of care settings. Enhanced application of pharmacists’ expertise in ambulatory care will potentially improve medication utilisation, provide improved public access to the healthcare system and reduced demand on tertiary care services.

In developing a framework for enhanced pharmacist services, a literature review identified more than fifty roles of which forty are as yet not widely adopted in Australia. Potentially relevant roles have been grouped in three practice themes, namely medication management, primary care and public health functions and a conceptual model has been developed for each theme. A study of the emergence of common enhanced roles in the comparative health systems of Scotland, New Zealand and the Canadian province of Alberta, indicated the importance of alignment of government and
profession-based visions for the development of pharmacists’ practice. Analysis of the local pharmacist workforce demonstrated both capacity and capability to undertake enhanced roles.

Based on these parameters, a patient-centric framework for enhanced roles for pharmacists incorporating the three practice themes, has been postulated. The framework identifies six aspect of pharmacists’ practice environment that need to be addressed for enhanced roles to emerge, namely policies, economics, workforce, stakeholder expectations, technology and governance.

8F: Dietetics Research Translation Award (My Translation Rules) – A platform for health services collaboration and education in research translation

Ingrid Hickman¹, ², Amy Davis¹, Sonya Osborne³, Barbara van der Meij⁴, Shelley Wilkinson⁴, Adrienne Young⁵

¹Department Nutrition and Dietetics Princess Alexandra Hospital; ²The Mater Research Institute – UQ; ³The Australian Centre for Health Services Innovation (AusHSI); ⁴Department Nutrition and Dietetics, Mater Health Services; ⁵Department Nutrition and Dietetics, Royal Brisbane and Women’s Hospital

In response to the known time lag between knowledge generation and translation to clinical practice, the Dietetics Research Translation Award Initiative (My Translation Rules) was designed to offer accessible research translation education and annual showcase of recognition for clinicians translating evidence into their everyday practice. The education package consisted of four webinars and four real world case studies covering topics such as ‘identifying a clinical problem’, ‘critical appraisal’, ‘implementation science’ and ‘outcome measurement’. New partnerships with Brisbane Diamantina Health Partners, AusHSI and research fellows from participating health services provided expert assistance for syllabus development. It was designed as a “taster package” to provide exposure to robust implementation science methodologies and encourage cross-site networking.

To date, the distribution across 10 Brisbane metropolitan health services has achieved 429 views of webinar content. Evaluation of the process and content has been completed by 132 clinicians. Increased knowledge has been demonstrated with content questions correctly answered by 84-100% of participants and a perceived increase in skills and confidence associated with research translation. Importantly, participants have stated that the education package was accessible and has changed the way they think about incorporating literature searches into their practice and that they could confidently choose appropriate outcome measures when attempting practice change. At least 17 new research translation projects are currently being considered for submission to the 2017 My Translation Rules Event. Equitable access to research translation education for allied health professionals can address gaps in translation of evidence and produce a positive impact on health care.
9A: Mater Aged Care In An Emergency (MACIAE) - a partnership model to manage the frail living in Aged Care Facilities
Sophie Shrapnel\textsuperscript{1}, Caroline Nicholson\textsuperscript{1}
\textsuperscript{1}Mater Research Institute - University of Queensland

Introduction: MACIAE is a service dedicated to supporting aged care facility residents, their families, facility carers and GPs; with the goal of providing a seamless care transition between primary and tertiary sectors in order to ensure the highest and safest standard of care with the upmost compassion and dignity.

Method: MACIAE has collected data on Aged Care Facility (ACF) residents presenting to the Mater Hospital Brisbane 2014-2017: the care they receive whilst at the Mater, and the effect that specialised hospital nurse coordination combined with the development of care partnerships with care providers external to the hospital had on this patient group’s clinical health outcomes, and Aged Care Facility (ACF) stakeholder satisfaction (patients, family members, ACF nursing staff, General Practitioners, community care providers) toward an acute hospital experience.

Results:
- Reduced ward admissions of ACF residents by 40% to currently less than 36% (National average 60%).
- Reduced LOS from 6.5 to 4.0 days (national average 8.0 days).
- 88% of patients commenced on an End of Life (EoL) pathway were able to be transferred to their environment of preference (ACF), rather than experience EoL as an in-patient (admission Av LOS 5-7days).
- Initiation of over 300 Advanced Care Plans
- Positive feedback from providers - ACF staff, GPs, Mater staff
- Qualitative feedback from families - the program supports families and carers
- Cost benefit analysis result 10:1

Conclusion: A sustainable model of care has been developed in partnership with hospital, primary care and community providers and carers/families.

9B: The awareness of treatments for dementia in the general public in Australia: A population survey
Miia Rahja\textsuperscript{1,2}, Kate Laver\textsuperscript{1,2}, Maria Crotty\textsuperscript{1,2}
\textsuperscript{1}Flinders University; \textsuperscript{2}Cognitive Decline Partnership Centre (CDPC)

Background People’s knowledge about an illness is associated with their illness-related behaviour. Many people with dementia never receive a diagnosis or delay seeking help; this may be because they do not believe there are effective treatments. Recent clinical practice guidelines for dementia recommend a number of treatments for dementia, shown to be effective in randomised trials.

Aim To understand members of the general publics’ awareness and attitudes regarding the availability and effectiveness of treatments for dementia.

Method Participants completed a survey about the current level of knowledge regarding treatments for dementia. Inclusion criteria were: registered member of a company that conducts nationwide online surveys, living in Australia and aged 18 years or over. The survey included questions regarding
family connections with dementia, knowing of any treatments for dementia, and being aware of evidence based treatments for people with dementia.

Results Out of the 1001 respondents across all states in Australia, more than half (62%) initially reported they did not know of any treatments that improved outcomes for people with dementia. Of the specific treatments proposed, brain training was considered to be very likely to be effective by half (47%) of the respondents, followed by education and training for family members and caregivers, and healthy diet.

Conclusion This survey provides insight into the awareness and attitudes about dementia treatment in different population groups in different locations in Australia. This is a call for policy makers and health service providers to address any service (mis)beliefs about dementia treatment through health service campaigns.

9C: An Australian Dashboard for Age-Related Disability

Hamish Robertson¹, Nick Nicholas², Amit Dhagat³, Joanne Travaglia³
¹University of New South Wales; ²The Demographer’s Workshop; ³Data of Things P/L; ⁴University of Technology Sydney

Objectives: Ageing and disability are two distinct but intersecting policy domains in Australia’s emerging demographic future. This project took elements of two previous research projects conducted using New South Wales data and extended them to produce a trial model of national dementia-related disability. The aim is to illustrate how national, state and local level complexities can be managed within a spatially informed data visualisation environment.

Methods: We used the Tableau software package to produce a national-level model of the two variables of (1) age-related dementias, including major sub-types, and (2) disability estimates by age and sex for the SA2 level across Australia. State and territory specific disability rates were based on the 2015 DACS Survey data.

Lessons Learned: A key lesson learned is that it is possible to manage the complexity of existing and emerging population-level epidemiological concerns in a visual data environment. The use of visual dashboards means that the same data, or data selections, can be seen and manipulated to produce a meaningful narrative of population-level changes at different geographical scales.

Implications: This is a novel approach arising from several years of academic and practical work on issues associated with population-level ageing and shifting patterns of disability in Australia. These include rising acuity in both the aged and disability fields as well as managing complexity in a time of major policy change. We briefly illustrate how the demand issues can be connected to service providers to identify gaps and opportunities for improvement.

9D: Out of Hospital at Last- Now What? A Pilot Project to Evaluate Specialist Brain Injury Transitional Rehabilitation

Areti Kennedy¹, Kerrin Watter¹,², Mandy Nielsen¹,²
¹ The Hopkins Centre, Division of Rehabilitation (DOR), Princess Alexandra Hospital (PAH); ²Menzies Health Institute QLD, Griffith University

The transition from hospital to home is a critical phase in recovery and rehabilitation after Acquired Brain Injury (ABI), during which individuals and their families begin adjusting and adapting to living with the impact of ABI in the home and community environments. The literature suggests the transition phase is often characterised by a decline in psychosocial functioning, and difficulties
engaging in meaningful activities of daily living.

The growing volume of research evidence concerning transition has led the formal acknowledgement of a distinct transition phase within the ABI rehabilitation continuum, with over 20 peer-reviewed publications since 2007 from local research on this topic. This research has promoted the conceptualisation of innovative rehabilitation service models for transition. Now, further research is needed to examine the operational implementation of these models and establish proof of concept for a specialist ABI transitional rehabilitation service in Queensland.

Princess Alexandra Hospital (PAH) has secured 5-year seed funding from the Motor Accident Insurance Commission (MAIC) to develop and evaluate a specialist ABI Transitional Rehabilitation Service (ABI TRS) within its existing Brain Injury Rehabilitation Services (BIRS) continuum.

The ABI TRS will become a key linkage in the BIRS continuum, providing a coordinated clinical pathway, and improved access to intensive post-discharge rehabilitation for adults with ABI and their families. It will seek to improve service efficiency through integrated referral pathways, improved patient flow, and improve longer-term community outcomes, with attendant economic benefits. Research evidence and it’s translation to early clinical service implementation since January 2017 will be presented.

9E: Long-term service utilisation patterns following traumatic brain injury or spinal cord injury

Rob Gordon¹, Associate Professor Grahame Simpson²
¹University of Wollongong; ²Ingham Institute of Applied Medical Research

Background: Following severe traumatic brain injury (TBI) or spinal cord injury (SCI), a wide array of health and community services are often critical to creating an environment where a person is best placed to achieve their goals.

There has been little theory-driven research examining how different factors influence long-term service utilisation patterns. Previous research has largely examined a one or two year period post-injury and has not captured the intensity service utilisation.

This paper presents the results of a recently completed study that involved an in-depth investigation of long-term utilisation patterns across the spectrum of services for a sample of individuals who sustained a severe TBI or SCI in a motor vehicle accident in NSW.

Methods: A prospective, cross-sectional, multi-centre investigation of 111 participants between 2 and 37 years post-injury. During a face to face interview, detailed demographic, clinical and service utilisation data were collected. Outcomes of interest were functional, psychosocial and quality of life, patterns of service utilisation, and associated costs. Using Andersen’s health-behavioural model as a conceptual framework, sequential multivariate regression and generalised linear modelling was used to explore service utilisation.

Results: A range of novel findings emerged. Injury severity for the TBI group, and time since injury for both injury groups were found to be predictors of service utilisation. The annual cost of providing care was more than $95,000 with formal and informal care easily the most expensive service.

Conclusion: This paper will introduce the study findings and discuss the policy implications for providers, policy-makers and planners.
9F: Navigating systems: Assault related traumatic brain injuries
Durc Fahrenhorst-Jones¹, Lyndel Bates¹,², Annerley Bates³
¹School of Criminology and Criminal Justice, Griffith University; ²Griffith Criminology Institute, Griffith University; ³Brain Injury Rehabilitation Service, Social Work Department, Princess Alexandra Hospital

In Australia, assaults account for 14% of all Traumatic Brain Injuries (TBI) (Jamieson, Harrison, & Berry, 2008). Due to complications surrounding the injury, individuals often require rehabilitation. Costs for rehabilitation are expensive with the lifetime cost associated with severe-TBIs $4.8 million per person and the estimated direct hospital cost of an assault-related TBI $15.7 million per annum in Australia. Despite this, there is little information about assault-related TBIs (Bates, Matthews, Simpson & Bates, 2016).

Therefore, the aim of this study was to ascertain the proportion of individuals with an alleged assault/assault-related TBI presenting at a state-wide Brain Injury Rehabilitation Service (BIRS), in Queensland Australia. We examined the hospital records to identify socio-demographic and other factors associated with this group. We studied the files of all patients admitted to BIRS between 2011 and 2015 with a TBI (N = 467), 84 (18%) were found to be assault-related. Given the size of this group, there is a need to develop targeted interventions for these individuals. This could include supporting the families and caregivers of individuals with assault-related TBIs as they navigate both the criminal justice system and health care service.

ORAL PRESENTATIONS (10): SUPPORT AND SERVICES: MENTAL HEALTH / DRUGS AND ALCOHOL/OTHER
Session Chair: Sara McMillan, Griffith University

10A: Understanding the mix of hospital and community-based mental health services funded by the Australian private health insurance sector: A person-level profile
Joanna Khoo¹,², Kathy Eagar¹, Helen Hasan¹
¹Australia Health Services Research Institute (AHSRI), University of Wollongong; ²CMCRC

Background: The private health insurance sector is a significant funder of mental health services, especially those provided by private hospitals. Although national statistics report the volume of admitted patient activity in the private hospital sector for mental health, there is little research into the patterns of service access of insured individuals.

Aims: This presentation examines the type of hospital and community-based mental health services that insured individuals access using their private health insurance and assesses follow-up care in the private sector following an overnight hospitalisation.

Methods: Analysing de-identified private health insurance claims data for a two-year period, this study categorises individuals with mental health related hospitalisations according to whether they accessed same-day, overnight or a combination of same-day and overnight services. Overall resource utilisation for each group is assessed including length of stay, costs and the incidence of additional mental health related service contacts in the 28 days after discharge from an overnight hospitalisation.

Results and conclusion: Findings of this study indicate that the highest proportion of patients with a mental health related hospital claim only received care through overnight hospitalisations. There are
opportunities for the private sector, both private health insurance funds and hospitals, to increase levels of follow-up care and coordination for people with mental health issues accessing care in the private sector.

10B: The impact of a person-centred community pharmacy mental health medication support service on consumer outcomes

Amanda Wheeler1,2,3, Sara McMillan1, Fiona Kelly1, Laetitia Hattingh4, Jane Fowler1, Gabor Mihala1
1Griffith University, 2Menzies Health Institute, 3Quality Use of Medicines Network; 4Curtin University;

More than seven million Australians will experience a mental illness during their lifetime, and medication is commonly used to manage these often long-term conditions. Community pharmacies are well positioned to provide additional support to mental health consumers; in 2012, the Australian Government funded a project exploring how this healthcare destination could further assist this vulnerable population. A comprehensive study design informed the development of a mental health medication support service. Pharmacy staff in WA, QLD and NSW were trained to work with mental health consumers to identify individual medication and health-related goals, and to implement strategies to meet these goals. The effectiveness of the 3-6 month support service will be presented in terms of consumer related outcomes: perceptions of illness and health-related quality of life, medication beliefs, treatment satisfaction, and medication adherence.

Fifty-five of 100 trained pharmacies completed the service with 295 of the 418 recruited consumers (70.6% completion rate); 51.2% of consumers received two or more follow-ups. Significant improvements were reported by consumers for overall perceptions of illness (p<0.001), the mental health domain of quality of life (p<0.001), concerns about medication (p=0.001), and global satisfaction with medication (p<0.001). Consumers also reported an increase in medication adherence (p=0.005). This goal-oriented, flexible and individualised community pharmacy medication support service improved mental health consumer outcomes across various measures. Further research into the cost-effectiveness and sustainability of such a service is warranted with future plans to conduct a cluster randomised controlled trial.

10C: The Drug and Alcohol Withdrawal Network: exploring client experience, effectiveness and cost of an innovative, home-based service.

Cameron Wright2, Jacqueline Davis1, Richard Norman2, Richard Varhol3, Elizabeth Wilson-Taylor3, Suzanne Robinson2, Justin Dorigo3
1Health Systems and Health Economics, School of Public Health, Curtin University; 2Curtin University; 3St John of God Health Care

Background: The Drug and Alcohol Withdrawal Network (DAWN) is a home-based, nurse-led service based in Perth, Western Australia.

Methods: We analysed time to treatment initiation, time to relapse, changes in drug use frequency and direct service costs for clients enrolled after 1 July 2011 and discharged before 30 June 2016. Perceptions of important program attributes were assessed through semi-structured interviews with ten clients.

Results: Over the study period, 1,819 clients (54% male, mean age 37 years) were enrolled, with 2,067 care episodes. During 2015-16, the median time from phone triage to face-to-face assessment or discharge/transfer was six days. While most first-episode clients (52%) listed alcohol as the primary drug of concern, the proportion listing methamphetamine increased from 4% in 2011-12, to 23% in 2015-16. Median time to relapse was 284 days (n=195). There was a 52 times greater odds
(95% confidence interval 30.7 – 89.1) of withdrawal detoxification clients (n=717 episodes) using the primary drug of concern less frequently than ‘most days’ at discharge, compared to enrolment. Five year direct costs were ~$4.8 million. Clients valued the person-centred holistic approach to care, including linking with other health providers. Barriers included low awareness of the program, and difficulties finding an appropriate support person.

Conclusions: The DAWN presents a person-centred service and is valued by clients. In 2015-16, an average stay of 14 days for inpatient detoxification cost ~$20,000 ($1,429 per day). The DAWN home-based detoxification model presents a relatively less expensive treatment option, albeit with different eligibility criteria between care types.

10D: Primary mental health care for serious mental illness: the role of general practice
Michelle Banfield1, Jennie Walker1, Christopher Harrison2
1Australian National University; 2University of Sydney

Background: Australians with serious mental illness describe the healthcare system as inadequate and identify improving service quality and access as high priorities for research. This study aimed to explore service access and navigation experiences for people with chronic mental and physical illness in Australian general practice.

Method: Bettering the Evaluation And Care of Health (BEACH) data from 2000-2016 were used to measure the management rate of schizophrenia, bipolar disorder, depression, anxiety and type II diabetes (T2DM) at general practice encounters. The use of referrals and specific MBS items in the management of these problems was also examined.

Results: Depression had the highest management rate, 3.4-4.43 per 100 encounters across the study period. T2DM increased from 2.52 to 4.01. Bipolar disorder and schizophrenia were relatively uncommon (maximum of 0.35 and 0.5 respectively) and rates remained stable across the time period. Between 2006 and 2016, the use of GP Mental Health Care Plans increased from 2.9% to 18.7% of encounters with depression/anxiety and from 2.2% to 11.4% at encounters with schizophrenia and bipolar disorder, while chronic disease management items at T2DM encounters increased from 3.6 to 11.5%. Referrals to allied health professionals also increased over the decade.

Conclusion: Management rates of schizophrenia and bipolar disorder in general practice are low, and depression and anxiety are significantly more likely to receive referrals and planning for multidisciplinary care. Given consumers’ reports of inadequate care for serious mental illness, this suggests a need to review how primary health care may better meet this group’s needs.

10E: Are public sector mental health services meeting the needs of consumers?
Lila Vrklevski1,2, Dr Kathy Eljiz3, Professor David Greenfield2
1Sydney Local Health District, 2Australian Institute of Health Service Management, University of Tasmania

Introduction: Consumers of public sector mental health services are a complex and challenging cohort. These consumers require assistance in psychiatric, psychological, relationships, accommodation, social, employment, and legal domains. The study aim was to investigate the challenges of a regional mental health service in meeting the needs of consumers.

Methods: Semi-structured interviews were conducted with staff of a regional mental health service in New South Wales, Australia. Purposive sampling was used to recruit participants. Ethics approval was gained from the participating health and university institutions. Staff from nursing, occupational
therapy, psychiatry, psychology and social work were interviewed. The interviews were taped, transcribed and content analysis was undertaken.

Results: All professional groups were unanimous in stating their role was to deliver appropriate care. Participants thought better role clarity between the professional groups could be achieved with more understanding and use of discipline specific skills. Participants stated the service was meeting consumer needs across three domains; psychiatric intervention, accommodation and legal. Participants identified that needs across medical and social dimensions were not being met, including: psychological and psychosocial interventions; assistance in building relationships; basic health/medical needs; and, employment. Participants explained future services needed to offer more holistic mental health care provided by professionals with discipline specific skills and focus.

Conclusion: Mental health professionals need skills and abilities that are varied, flexible and adaptable. Role overlap is beneficial and enables a shared understanding but too far and it limits the ability to address the full range of consumer needs.

10F: A volunteer-run dental rescue service for homeless youth
Nicole Stormon1, Phil Smith2, Annemaree Callander3, Professor Pauline Ford1
1University of Queensland; 2Brisbane Youth Service

Background: The relationship between homelessness and ill health is complex with many risk factors for homelessness also risk factors for poor oral health. To overcome barriers to accessing dental care, previous studies have recommended integrating dental care within homeless support services. This study aimed to evaluate a volunteer-led dental rescue service run for a week, four times a year within a Brisbane community youth service.

Methods: Participants were clients of Brisbane Youth Service, who attended the dental rescue service in October 2016, February, May and August 2017. A questionnaire collected demographic information, self-assessment of oral health and an evaluation of their experiences.

Results: In the first two dental rescue weeks, sixty-one clients received dental services and participated in its evaluation. Compared to the general Australian population, this group had higher proportions of Indigenous Australians, current daily smokers, eligibility for public dental care and unemployment. Cost was the greatest reported barrier to accessing dental care. Half (53%) of participants who pre-booked an appointment failed to attend. Each appointment cost approximately $9 to run and the total estimated value of the services delivered in the 2 rescue weeks was $26,000.

Conclusion: This dental rescue service is feasible and sustainable due to its integration into an existing homeless youth service, low running costs, acceptability to clients and interest by dental practitioners to volunteer. It provides a useful model which could be scaled up and implemented in other regions.

Results of a full year of the dental clinic will be completed August 2017.
3.15PM – 4.15PM: PLENARY SESSION

BUILDING SYSTEM CAPACITY FOR HEALTH SERVICES IMPROVEMENTS
Session Chair: Jane Hall, Director of Strategy for the Centre and Professor of Health Economics, UTS Business School

Federal policies and a national strategy for building health services research will be presented; and how might this fit with the ‘nuts and bolts’ of running a health services research group from within a health service.

Health Services Research and New Zealand’s first Health Research Strategy: new opportunities?
Professor Tim Stokes
Elaine Gurr Professor of General Practice in the Department of General Practice and Rural Health (DSM) and Co-Director of the Centre for Health Systems and Technology, University of Otago, part-time GP

June 2017 saw the publication of NZ’s first ever health research strategy. This short plenary presentation will outline its key strategic priorities and consider the opportunities it provides for growing HSR in NZ.

The Medical Research Future Fund building health service and system research impact
Professor Ian Frazer
University of Queensland, Chair of the Australian Medical Research Advisory Board
Ms Erica Kneipp
Assistant Secretary Health and Medical Research, Commonwealth Department of Health

The Medical Research Future Fund (MRFF) is set to double Australia’s investment in health and medical research. The MRFF will provide a complementary source of research funding alongside the National Health and Medical Research Council and the Biomedical Translation Fund. For the first time, research in Australia is recognised as a key pillar supporting the health system. This is a good time for research, translation and commercialisation with the health of Australians, the health system and the economy at the forefront. This session will provide background to the MRFF including consideration of the Australian Medical Research and Innovation Strategy 2016-2021, which among many things identifies health service and system research as a strategic platform for advancement. First and forthcoming disbursements from the MRFF will also be discussed.
4.15PM – 5.15PM: PLENARY SESSION

GOVERNMENT REGULATION AND REFORM FOR HEALTH SERVICES
Session Chair: Wayne Adams, HCF

How useful is government intervention to improve the value of the health spend? What does the private sector think of current reform?

MBS Review

Professor Adam Elshaug
HCF Research Foundation Professorial Research Fellow and Co-Director, Menzies Centre for Health Policy (MCHP), The University of Sydney

In April 2015, then Minister of Health and Sport Sussan Ley announced a programme of work to deliver a ‘Healthier Medicare’ and announced that a Medicare Benefits Schedule (MBS) Review Taskforce would be established. This is one of the largest fee-for-service reviews ever undertaken around the world, with the Taskforce considering how the more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. To date, the Taskforce has consulted with more than 440 clinicians, consumers and health system experts, with the formation of 18 clinical committees and 48 working groups. To date over 80 recommended changes to the schedule have been made to government and the majority of these have been accepted. Much more is planned. This presentation will give an overview of the process, the challenges, the recommendations, and where the Review is heading.

Regulatory reforms in private healthcare

Dr Bennie Ng
General Manager – Partnerships and Strategy, Healthscope

The Commonwealth Government has policy responsibilities in the funding and design of the Australian public and private health care system through the National Health Reform Agreement and direct regulations. The purpose of the presentation is to focus on private healthcare system and review the progress of private health insurance reforms since it first announced by the Government in October 2015. The Government is concerned by the affordability, value, complexity of private health insurance and out-of-pocket costs experienced by consumers. Key policies changes are expected to address prostheses pricing, design of insurance products and inequity of private patients in public hospitals.
STANDARD POSTERS: THURSDAY

REACH: Reviewing equitable access to healthcare outcomes out of hours and at the weekend
**Anthony Bell**, Metro North Hospital and Health Service (MNHHS), University of Queensland (UQ)

Functional Decline in Elderly with Chronic Obstructive Pulmonary Disease: Community to Long Term Care?
**Babajide Onademuren**, School of Health Sciences University of Canterbury Christchurch New Zealand

Discharge planning processes for older persons: A comparison of two hospitals and best practice in Australia
**Cassandra Ranatunga**, Centre for Applied Health Economics, School of Medicine, Griffith University

Rates of 30-day Readmission and Mortality Following an Acute Myocardial Infarction across Australia and New Zealand
**Clementine Labrosciano**, University of Adelaide

Readmission and Mortality Rates following Heart Failure Hospitalisations across Australia and New Zealand
**Clementine Labrosciano**, University of Adelaide

The Observing Recurrent Incidence of Adverse Outcomes following HospitalisationS (ORION) Study: Towards Nationwide Reporting of Outcomes of Hospital-Based Cardiovascular Care Using Existing National Data Infrastructure
**Clementine Labrosciano**, University of Adelaide

An Australian Dashboard for Disability and Ageing: Visualising the Community to Acute Care Demand Spectrum
**Hamish Robertson**, University of Technology Sydney

Harm free care among ischaemic stroke patients
**Huei-Yang (Tom) Chen**, Bureau of Health Information

Overuse of CTPA in patients with suspected pulmonary thromboembolism
**Ian Scott**, Director of Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital, Brisbane

Identification of hospitals with excess falls in hospital in New South Wales
**Jacob Humphries**, Bureau of Health Information, NSW Ministry of Health

Predictive Risk Modelling under Different Data Access Scenarios: Who is identified as High-Risk and for How Long?
**Jacob Humphries**, Bureau of Health Information, NSW Ministry of Health

Health economic modelling of interventions with resource constraints: a comparative analysis
**Kim-Huong Nguyen**, Griffith University
Cost-effectiveness analysis of fetal RHD genotyping of RhD negative pregnant women for targeted versus universal anti-D therapy in Australia

Louisa Gordon, QIMR Berghofer Medical Research Institute

Chronic disease patients with and without mental illness: learning for balancing between acute and primary care from a retrospective analysis in Tasmania, Australia

Nazlee Siddiqui, University of Tasmania

Investigating hospital level variation in risk standardised 30-day mortality for congestive heart failure: what is the impact of disease progression?

Sadaf Marashi Pour, Bureau of Health Information

Hospital variations in all-cause emergency department visits within 28 days after discharge for people hospitalised with cancer in New South Wales: a population-based study

Sadaf Marashi Pour, Bureau of Health Information

Why are high cost devices treated differently compared to high cost drugs? The case of ventricular assist devices

Sopany Saing, University of Technology Sydney, CHERE
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FRIDAY 3 NOVEMBER

8:30AM – 9:45AM: PLENARY SESSION

KEYNOTE ADDRESS
Session Chair: Gillian Harvey, Professorial Research Fellow, The University of Adelaide

Evidence for using participatory/co-production approaches to improve research uptake
Professor Ian Graham
Professor, School of Epidemiology and Public Health & the School of Nursing, University of Ottawa
Senior Scientist, Clinical Epidemiology Program, Ottawa Hospital Research Institute, and Honorary Professor at Deakin University, Melbourne Australia

There is growing interest in participatory and co-production approaches to research by research funders, charities, governments and the public. Because of the expectation that these approaches produce research findings that are more relevant, useful, and applied and therefore have greater impact, research funders are considering these approaches an important strategy for mobilizing research findings. In Canada, the term integrated knowledge Translation (IKT) is used to refer to collaborative research that involves researchers (traditionally seen as ‘research producers’) and knowledge-users (traditionally seen as ‘research consumers’) working together as partners through the research process.

This session will present results from an evaluation of the Canadian Institutes of Health Research IKT funding opportunities that reveal IKT projects produce similar academic outputs and training of HQP as more traditional researcher-driven projects but involve more dissemination activities.

Working together to improve care of older inpatients: Eat Walk Engage
Adjunct Professor Alison Mudge
Physician, Internal Medicine and Aged Care; Health & Medical Research Fellow, RBWH

As hospitals care for increasing numbers of older and frail patients, the evidence developed in specialist geriatric services to reduce hospital-acquired complications must be applied more broadly across the hospital. Dr Mudge will discuss the Eat Walk Engage program, developed to implement good geriatric principles into general wards, using the i-PARIHS implementation framework. She will describe how redesign has been driven at ward level by bringing teams together, assessing local context for barriers and strengths, using the consumer voice to inform change, and adapting solutions to local resources. She will discuss learnings from 11 wards where the program has been implemented, and discuss some of the challenges in spreading and sustaining complex interventions in acute care.
9:45AM – 10:45AM: PLENARY SESSION

INCREASING INDIGENOUS VOICES AND CULTURAL VALUES IN HEALTH RESEARCH
Session Chair: Josée G. Lavoie, University of Manitoba

**Discussing the elephant in the room: research impact in Aboriginal and Torres Strait Islander Australian health research**

**Associate Professor Roxanne Bainbridge**
Director, Centre of Indigenous Health Equity Research (CIHER)

A perennial question in Indigenous research discourse is whether the abundance of research conducted, purportedly to improve health, is justified and benefits Indigenous people in ways that are meaningful and valued by them. Different research stakeholders have different conceptions of the value and nature of research, its conduct, what it should achieve and the kinds of impact expected.

The purpose of this presentation is to open a frank conversation about the value of health research to Indigenous Australian populations and to stimulate ways of thinking about potential resolutions to the lack of progress made in the Indigenous research impact debate. The research impact debate must take account of the various standards of accountability (to whom), impact priorities (for whom), positive and negative impacts, and biases that operate in describing and measuring impact.

As a point of departure to improving impact and reaching mutually beneficial outcomes for researchers and partners in Indigenous health research, we need to routinise the assessment of impact from outset of research as one of the standards toward which we work.

**Decolonising interventions**

**Dr Rawiri (David) Jansen**
Clinical Director, National Hauora Coalition

My provocation will be that we must prepare for systematic improvement in health equity for Maori, that is to restore health equity for Maori. Health inequities are avoidable inequalities in health between groups of people. Health inequities are unnecessary and avoidable, unjust and unfair. We have better evidence now than ever before to inform us and we have a remarkable opportunity. In 23 years Aotearoa will reflect on the two hundred years since the signing of the Treaty, and health equity will be a key indicator of our nation’s journey. Health interventions that are informed by the research on decolonising approaches are required and will be discussed referencing current programmes of action led by the National Hauora Coalition.
11.15AM – 12.45PM: CONCURRENT SESSION

SYMPOSIUM 7: DISINVESTING FROM LOW-VALUE CARE: IF YOU CAN’T MEASURE IT YOU CAN’T MANAGE IT

Session Chair: Adam Elshaug, CF Research Foundation Professorial Research Fellow and Co-Director, Menzies Centre for Health Policy (MCHP), The University of Sydney

Due to the international movement, Choosing Wisely (and in Australia the RACP’s ‘EVOLVE’ initiative), thousands of doctors have banded together to specify low-value medical interventions. Yet when asked how often these practices occur, they cannot say as measurement of the scale and scope of the problem has been lacking. That is until now. A comprehensive measurement program has been underway for the past two years led out of the Menzies Centre for Health Policy (USyd) and Centre for Big Data Research in Health (UNSW). We have estimated the proportion of patients receiving, as well as number of low-value services rendered, including costs, from (i) a sample of private health insurance (PHI) beneficiaries; (ii) NSW public hospital attendees, and (iii) those prescribed pharmaceuticals within the hospital environment, and from the pharmaceutical benefits scheme (PBS).

We are also leading an international collaborative comparing estimates between countries. This will be the first forum where all the measurement results will be presented together. Professors Adam Elshaug and Sallie Pearson will moderate the session. Adam is the Co-Director, Menzies Centre for Health Policy, School of Public Health and Sallie heads the Medicines Policy Research Unit at the Centre for Big Data Research in Health, UNSW.

Measuring low value care from the private payer perspective
Kelsey Chalmers1,2, Sallie-Anne Pearson1,3, Adam G Elshaug1
1School of Public Health, Menzies Centre for Health Policy, University of Sydney, Sydney, NSW, Australia; 2Health Market Quality, Capital Markets CRC Ltd, Sydney, NSW, Australia; 3Medicines Policy Research Unit, Centre for Big Data Research in Health, University of New South Wales, Sydney, NSW, Australia

Almost half of Australians hold private health insurance, and over 75% of elective procedures in 2014-15 took place in private hospitals. Low-value care in the private sector may be one contributing factor to increasing medical costs and out-of-pocket expenses for patients. This presentation will provide a technical perspective and present results on measuring low-value care in a data set of private health insurance claims. Kelsey is a PhD student two years into her project, with a background in statistics and data science.

Exploring variation in low value care in the NSW public hospital system
Tim Badgery-Parker1,2, Sallie-Anne Pearson1,3, Adam G Elshaug1
1School of Public Health, Menzies Centre for Health Policy, University of Sydney, Sydney, NSW, Australia; 2Health Market Quality, Capital Markets CRC Ltd, Sydney, NSW, Australia; 3Medicines Policy Research Unit, Centre for Big Data Research in Health, University of New South Wales, Sydney, NSW, Australia

One priority of NSW Health is to deliver better value care. An important aspect of delivering better value care is to understand how much and where low-value care occurs, to inform efforts to redirect care to better value alternatives. This presentation will quantify low-value care in NSW public hospitals, with a focus on variation between hospitals in the proportion of low-value care provided.
Tim is a PhD student two years into his project. His background is in biostatistics, working in cancer epidemiology and health service research.

**Quantifying low-value prescribing using dispensing claims data**

Jonathan Brett, Nicholas A Buckley, Helga Zoega, Adam G Elshaug, Sallie-Anne Pearson

1School of Public Health, Menzies Centre for Health Policy, University of Sydney, Sydney, NSW, Australia; 2Medicines Policy Research Unit, Centre for Big Data Research in Health, University of New South Wales, Sydney, NSW, Australia; 3Clinical Pharmacology, Sydney Medical School, University of Sydney, Sydney, NSW; 4Centre of Public Health Sciences, Faculty of Medicine, University of Iceland, Reykjavik, Iceland

To date the majority of the focus of measuring low-value care in routinely collected data has been on tests and procedures. However, prescribing practices constitute around a quarter of all Choosing Wisely practices internationally. This presentation will discuss a framework to measure prescribing practices in national longitudinal routinely collected medicines data. Three examples will be discussed to illustrate the quantification process and some of the challenges encountered. Jonathan is in the second year of his PhD candidature and is a medical specialist in clinical pharmacology and addiction medicine.

**Measuring the impact of a social movement: insights from Choosing Wisely Australia**

Vanessa Simpson, Rachel Holbrook, Leanne Atkins, Robyn Lindner

1NPS MedicineWise, Sydney, NSW

Our ability to measure low-value care is a critical step in supporting implementation and, ultimately, measurement of the impact of initiatives like Choosing Wisely that seek to affect a culture shift around the delivery of low-value care. Insights into Australian perspectives of low-value care will be presented as well as an overview of current activities and opportunities to leverage the Choosing Wisely Australia initiative to drive implementation of activities to support reduction of low-value care.

**The ‘ABDCE’ approach to minimising low value care**

Ian Scott

1Princess Alexandra Hospital, Brisbane, QLD, Australia; University of Queensland, Brisbane, QLD

Audit and feedback to clinicians of reliable, timely and accurate utilisation data that involves benchmarking with peers has been shown to be effective in changing clinical practice. Combining performance feedback with decision support, appropriate use criteria and clinician education can reduce low-value care. Examples of these interventions in consultant physician practice will be presented. Ian is a senior consultant general physician and clinical epidemiologist in a large tertiary hospital and is a lead clinician with the RACP EVOLVE program.
ORAL POSTERS (3): IMPROVING HEALTH OUTCOMES
Session Chair: Katherine Harding, La Trobe University, Eastern Health

Facilitation in action: case example from implementing “The SIMPLE Approach”
Adrienne Young, Royal Brisbane and Women’s Hospital; Queensland University of Technology

Building collaboration between emergency medicine and community care through a research support network
Amy Sweeney, Emergency Medicine Foundation and Gold Coast University Hospital

Rurality and family structure in Whānau Pakari: a multidisciplinary obesity intervention programme for children and adolescents
Cervantée Wild, Liggins Institute, University of Auckland

Variation in Risk Standardised Mortality following Isolated Coronary Artery Bypass Grafting Surgery Among Hospitals in Australia and New Zealand
Clementine Labrosciano, University of Adelaide

Identifying strategies to improve uptake of evidence-based guidelines in cancer services: a national cross-sectional survey of health professionals’ awareness and perceived suitability of implementation strategies.
Elizabeth Fradgley, University of Newcastle

Social preferences and acceptability of standard and behavioural economic inspired policies designed to reduce and prevent obesity
Emily Lancsar, CHE, Monash

The Consolidated Framework for Implementation Research Adapted for Economic Evidence (CFIR-EE)
Gregory Merlo, AusHSI, Queensland University of Technology

The Burden of Vascular Access Devices Used in Public Hospitals in Queensland
Haitham Tuffaha, Griffith University

Family-led rehabilitation post stroke in India- a process evaluation of a RCT
Huei Ming Liu, The George Institute for Global Health

Reducing rates of inappropriate knee arthroscopy through clinical leadership: evidence from New South Wales
Huei-Yang (Tom) Chen, Bureau of Health Information

Critical appraisal skills facilitates translation to practice for clinical dietitians
Ingrid Hickman, Princess Alexandra Hospital and Mater Research Institute – University of Queensland

Why place is a determinant of poor health outcomes and should guide funding investment in primary care services
Jacqueline Davis, Curtin University
Promoting Research Opportunities in Allied Health: A systematic process for evaluating and improving research capacity, culture and engagement.

Janine Matus, Gold Coast Health

Within Trial Cost-Utility Analysis of Disease Management Program for Patients with Atrial Fibrillation: results from the SAFETY Trial

Joshua Byrnes, Centre for Applied Health Economics, Griffith University

Big Outcomes: integrating an oral health wellness program into a nurse-led refugee health service

Leeanne Schmidt, Metro South Hospital And Health Service

Evaluation of allied health led primary contact services: Interim results at 1 year

Michelle Stute, Metro North Hospital & Health Service

The use of an ‘acclimatisation’ heatwave measure to compare temperature-related demand for emergency dept. services in Australia, The Netherlands, Botswana, the USA and Pakistan

Naomi van der Linden, CHERE, University of Technology Sydney

Can statistical cure models inform cancer health service planning? A population-based study from Western Australia.

Rachael Moorin, Health Systems and Health Economics, School of Public Health, Curtin University

Meeting outpatient wait time targets: A new approach to planning

Tracy Comans, Metro North Hospital and Health Service; Griffith University

SYMPOSIUM 8: PHARMACY ROLES IN AUSTRALIA AND NEW ZEALAND: FULFILLING THE POTENTIAL

Session Chair: Jackie Cumming, Research Centre, Faculty of Health, Victoria University of Wellington

Ageing populations and growing numbers of people with long-term conditions continue to increase demand for health services. The associated pressure on the health workforce means it is vital the best use is made of all health practitioners’ skills. Community pharmacies are the most accessible primary health care service and pharmacists are a highly trained and skilled workforce not currently being used to their full potential. Pharmacists are therefore well positioned to contribute to improvements in population and personal health and a reduction in health disparities by expanding roles in both individual care and population health arenas. Internationally, changes are occurring in community pharmacy models of care and funding to enable optimal use of pharmacists’ skills.

This symposium will explore changes underway in pharmacy services on both sides of the Tasman. Changes include a range of cognitive service initiatives (e.g. de-regulated medicine supply, screening and prescribing), moving beyond more traditional dispensing and medicines advice roles towards more pro-active service delivery especially for people with long-term conditions. We will explore the key factors that support or provide barriers to expanding pharmacy services, consider how they can best be integrated with other health care, and the evidence to support their wider health benefit.
Exploring the development and impact of changes in community pharmacy services in New Zealand

Dr Caroline Morris¹, Dr Janet McDonald¹, Professor Jackie Cumming¹, Dr Ausaga Faasalele Tanuvasa¹, Dr Lynne Russell¹, Dr Kirsten Smiler¹, Dr Jonathan Kennedy², Ms Eileen McKinlay²
¹ Health Services Research Centre, Faculty of Health, Victoria University of Wellington; ² Department of Primary Health Care & General Practice, University of Otago, Wellington

New Zealand recently produced a Pharmacy Action Plan which builds on other developments in pharmacy services, focuses on people-centred care and aims to optimise the use of the pharmacy workforce. This research explores how changes in community pharmacy services in NZ are anticipated to influence health and health service outcomes, using a ‘realist evaluation’ methodology to identify the contexts in which success is occurring (or being hindered) and the mechanisms by which change is being achieved. We will discuss findings from an initial round of key informant interviews and what they signal about the future of community pharmacy in NZ.

Increased access and enhanced clinical services via medication reclassification in New Zealand

Associate Professor Rhiannon Braund¹, Dr Natalie Gauld, Honorary Research Fellow²
¹ School of Pharmacy, University of Otago; ² Department of General Practice and Primary Health Care, University of Auckland

Within New Zealand, medication reclassification to increase patient access to timely medication has been increasing. This has many advantages to patients and health care providers, and reduces the burden on general practitioners and the wider health care system.

Recently trimethoprim and sildenafil have been reclassified from a “prescription only” medication, to “pharmacist only” when provided by an accredited pharmacist for specific patient groups. The rationale for these changes will be discussed and the results of local studies investigating the impact of these changes on pharmacist practice and the reported feedback from stakeholders including patients and general practitioners.

Building evidence for the role of pharmacy in prevention and screening – the Pharmacy Diabetes Screening Trial

Professor Ines Krass², Dr Kevin McNamara¹, Dr Bernadette Mitchell², Dr Vincent Versace³, Dr Sophy Shih¹, Professor Robert Carter¹, Dr Mohammadreza Mohebbi⁴, Ms Peta Trinder¹, Frances Wilson²
¹ Deakin University Centre for Population Health Research, Faculty of Health, Deakin University; ² University of Sydney; ³ Deakin Rural Health, Deakin University ⁴ Faculty of Health, Deakin University

This presentation will describe the design and implementation of a clustered RCT investigating a public health role for community pharmacy in secondary prevention. The health services trial focuses on determining the most effective of three approaches to screening for undiagnosed type 2 diabetes and pre-diabetes through community pharmacies. Those indicated for further investigation based on clinical algorithms, are referred to their GPs and followed up by pharmacists. The preparatory stages of the trial involved assembly of an expert panel of diverse stakeholders in diabetes, development of online training and assessment, bespoke supporting software, and a systematic recruitment and credentialing process.
Evolving population health requirements and a health workforce unable to service demand requires resetting the balance for health workforce operation. The pharmacist prescriber role offers one means of redesigning the health workforce. In New Zealand, pharmacist prescriber training uptake and deployment has not met policy makers’ expectations. This research evaluates pharmacist prescriber role development in policy circles and within primary health care. This presentation discusses the influence of factors along this pathway on the success of pharmacist prescriber development. It then outlines the applicability of lessons learnt from developing New Zealand nurse practitioner roles and examines areas of future research.

**ORAL PRESENTATIONS (11): INTEGRATED CARE**

Session Chair: Roman Kislov, The University of Manchester

11A: Ensuring high-quality, integrated care experiences for patients with acute abdominal pain across the acute care delivery chain

**Rebecca Feo**¹, Frank Donnelly²

¹Adelaide Nursing School, The University of Adelaide; ²The University of Adelaide

Acute abdominal pain (AAP) is one of the most common presenting conditions in acute care. However, little is known about the ways in which patients with AAP experience fundamental care and how their fundamental needs (e.g., communication, nutrition, pain management, dignity, respect etc.) are managed from presentation to post-discharge. Filling this gap in knowledge is imperative given the documented failures in fundamental care globally and the tendency for AAP patients to have highly variable care pathways involving several clinicians from different specialties. To ensure safe, quality care for this patient group, it is crucial to understand how they experience fundamental care across the acute care delivery chain. This study involved repeated interviews with 10 adult AAP patients at a large Australian public hospital, seeking to understand their experiences in the Emergency Department and surgical ward and one week post-discharge. The interviews (n=28), analysed thematically, demonstrated variable experiences, with patients reporting positive and negative aspects of care within the same hospital stay.

Patients typically reported effective and timely pain management and positive, humorous interactions with nurses, but identified issues with the discharge process (e.g., not knowing what to eat once home) and communication (e.g., not being involved or informed and a lack of dignity and respect). The results are discussed in light of the increasing imperative to improve fundamental care delivery in acute care. We also consider how improving care experiences for AAP patients will ensure better integrated and co-ordinated care delivery in hospital and once patients return home.
Background: HealthPathways (HP) is an electronic database of pathways for patient management between primary and secondary care accessible through an online portal, developed in the Canterbury Region of New Zealand (NZ) in 2008. It is seen as an important way of achieving health care integration and there has been rapid adoption of HP and similar systems across both NZ and Australia. In 2013 HP was adopted by the NZ Southern Health Region.

Aims: To explore the process of implementation of HP using relevant implementation science theory.

Methods: A qualitative interview study with a range of stakeholders drawn from across the NZ Southern Health Region who were either involved in the process of implementing HP or who were intended end-users of HP. Interviews were conducted with 10 participants and were analysed using the Consolidated Framework for Implementation Research (CFIR).

Results: The implementation of HP was challenging and did not adequately take account of key elements of all the five major domains of the CFIR (intervention characteristics, outer setting, inner setting, characteristics of the individuals involved, and the process of implementation). Two key findings were the lack of shared recognition of a need for HP in both primary and secondary care and a lack of relationship building between the two groups.

Conclusion: The use of implementation science theory (CFIR) has furthered our understanding of the factors needed for the successful implementation of a complex health programme (HP) in the NZ health system.

Integrated care initiatives are often fluid and evolving. Emphasising how different providers are reacting and reasoning, a realist evaluation of a locality based integrated care initiative reveals the complex web of incentives that need to be negotiated.

Background: In order to strengthen the role of primary care and improve the integration of care, Counties Manukau Health grouped local providers into 4 geographical localities.

Methods: Using the explanatory power of the realist evaluative approach (Pawson and Tilley 1997), theories concerning the new behaviours that would be adopted by providers were tested in interviews with stakeholders in 2012 and 2015, and via an online survey of general practices and local care organisations.

Results: Between 2012 and 2015, the Localities initiative shifted from an emphasis on four new local networks charged with reshaping services across a local population to four new networks operating as an “enabler of integration”. In light of this shift, providers made sense of the changes by testing whether they improved their knowledge around who to contact to arrange care for individual patients.
Conclusions: The Localities initiative evolved to focus most on strengthening local relationships. Local care organisations already saw their role as an advocate and co-ordinator for their clients, so were most influenced by changes that deepened connections that supported that role. General practices also saw their role as advocates and coordinators for their patients, but were struggling with how to balance their time across all the potential connections and relationships they might need.

11D: Effective management of non-communicable diseases in Ghana: the case of hypertension and diabetes mellitus

Mark Owusu¹
¹University of Canterbury

Although interest in non-communicable disease research in Africa in general and Ghana, in particular, is increasing, the real burden of hypertension and diabetes and the policy response to these conditions have not yet received the necessary attention. Overemphasis of research on malaria and HIV/AIDS control means that few studies have addressed the increasing incidence of diabetes and hypertension; with epidemiological studies largely focusing on the prevalence of these conditions in pockets of population segments. With evidence on policy interventions for controlling hypertension and diabetes generally emanating from High-Income Countries, more studies are needed from Low-and-Middle-Income Country settings to inform policy and practice.

This study focuses on establishing the burden of hypertension and diabetes mellitus in Ghana and explores the perspectives of relevant stakeholders on how they understand and are responding to the challenge of hypertension and diabetes mellitus in Ghana. Using a pragmatic policy approach, this paper presents a progress report on the analysis of data from the Global Burden of Disease database and routine hospital data from the Ghana Health Service using Joinpoint tools; as well as key informant interview data from relevant stakeholders in the Ghanaian health system. Considering the fact that countries in sub-Saharan Africa share many social, economic and political characteristics, it is expected that this study will have useful lessons for hypertension and diabetes policy and practice beyond Ghana.

11E: Expanding the space for equity-oriented health care: policy requirements

Josée G. Lavoie¹, Colleen Varcoe², Nadine Wathen³, Annette Browne²
¹University of Manitoba; ²University of British Columbia; ³University of Western Ontario

NGOs play a crucial role within health care systems in fostering equity, acting both as direct providers of services and as sentinels of social justice. In a study of an intervention to promote equity in primary healthcare, we enlisted 4 diverse primary healthcare clinics with mandates to serve highly marginalized populations. All of these clinics operated under the auspices of NGOs, and as such have a tenuous relationship financially and socially to other parts of the healthcare system.

This paper demonstrates what is required at the level of policy to expand capacity for equity within the healthcare system in general, including enhancing the role of NGOs as sentinels of equity. As part of our study we examined the clinics’ policy and funding contexts, and identified the ways in which their capacities to promote equity were constrained.

Our analysis highlighted five key mechanisms that created these constrained conditions: the funnelling of complex patients from other parts of the health care system, the use of indicators not matched to an equity mandate, the patterns of funding and distribution of physicians, the marginal position of NGOs, and the limited availability of capital funding. Expanding the space for equity-
oriented healthcare requires carving a clearer space for the NGO sector within national healthcare system, clearer mandate that match access to funding.

Although this analysis is based on a study within a high income country, given the populations served by these clinics, we argue that the implications have applicability to low and middle income countries.


Lynette Cusack¹, Dr Tim Schultz¹, Prof Jon Karnon¹, Meredith Hobbs², Bronwen Klaer², Julianne Bruening²
¹The University of Adelaide; ²Northern Adelaide Health Network; ³Lyell McEwin Hospital, Womens and Childrens Division

The Australian Institute of Health and Welfare indicate that in Australia in 2011 95,894 women gave birth by caesarean section. Caesarean section rates increased from eighteen percent in 1991 to thirty two percent in 2011. Given the high and increasing rate of elective caesarean sections (ECS) an alternative pathway for safe transition of maternity care from hospital to home, for women and their babies 24 hours after a ECS was undertaken in the Women’s and Children’s Division of a large metropolitan hospital in South Australia. The alternative pathway titled ‘Enhanced Recovery Elective Caesarean’ (EREC) was initiated based on evidence from literature that identified key aspects of safe practice for this model of care. EREC included inclusion criteria, antenatal preparation and postnatal home visits.

This mixed methods study used an economic evaluation analysis, case note review and patient interviews to evaluate the new model in 3 phases. The three phases comprised: (i) Identification and analysis of economic data (resource use and costs) pre and post introduction of EREC; (ii) assessment comparison of readmissions and emergency department visit rates and reasons for readmissions for both women and neonates pre and post introduction of EREC; (iii) interviews with women about their experience of an earlier discharge 24 hours after an ECS.

The outcomes of this research provides evidence on whether EREC is a cost effective, safe intervention, which is also acceptable to women and their family. The results will be presented at the conference.

ORAL PRESENTATIONS (12): ACCESS TO SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Session Chair: Kirsten Smiler, Victoria University of Wellington

12A: Engaging stakeholders to inform system-level action for wide-scale improvement in quality of Aboriginal and Torres Strait Islander primary care

Veronica Matthews¹, Jodie Bailie¹, Alison Laycock², Ross Bailie¹
¹The University of Sydney, University Centre for Rural Health - North Coast; ²Menzies School of Health Research, Charles Darwin University

Background: There is wide variation in delivery of recommended primary care to Indigenous communities across maternal and child, preventive, chronic illness and mental health care.

Aim: To gather stakeholder data-informed views of the priority evidence-practice gaps categorised by how care is delivered (eg clinical measurements, brief interventions, follow-up of abnormal
findings) and perceptions of corresponding barriers to provide insight into higher system changes required to achieve wide-scale improvements.

Methods: We shared data collected as part of a large-scale continuous quality improvement project in Indigenous primary health settings with service providers, policy-makers and researchers. We undertook qualitative assessment of stakeholder feedback on gaps and barriers in care and conducted Pareto analysis to identify key system issues as they apply to different care processes, enabling them to be targeted by tailored interventions.

Results: Priority evidence-practice gaps were associated most commonly with the following care processes: follow-up of abnormal findings and provision of brief interventions. Perceived barriers to addressing gaps included both health system and staff attributes. Key issues identified were: effective recruitment and retention of appropriately qualified and trained staff; availability and use of clinical information systems; good clinical leadership and management support; and community engagement and mobilisation for health.

Conclusion: Findings identify areas of focus for development of barrier-driven, tailored interventions to improve holistic primary health delivery on a broad-scale. They reinforce the importance of system-level action to improve health centre performance and health outcomes, and of developing strategies to address system-wide challenges that can be adapted to local contexts.

12B: Evaluation of Aboriginal and Torres Strait Islander health services, policy and programs: Moving towards a health equity perspective
Angeline Ferdinand1, Margaret Kelaher1, Joann Luke1, Daniel Chamravi1
1University of Melbourne

Effective evaluation is essential to ensuring that the policies and programs delivered to Aboriginal and Torres Strait Islander people reflect best practice. Not only is evaluation crucial to increasing evidence by providing positive exemplars, it also serves to identify and ameliorate or avoid unintended negative consequences of policies, programs or practices. However, increasing health equity through the practice of evaluation is rarely an explicitly stated goal of evaluation.

The incorporation of Aboriginal and Torres Strait Islander perspectives in evaluation is imperative to reframe evaluation in order to reflect the priorities and expectations that Aboriginal and Torres Strait Islander communities have regarding the policies, programs and services that affect their health. This necessitates research conduct in evaluation that has at its centre strong partnerships with Aboriginal and Torres Strait Islander communities. Quality governance structures within programs, policies and services, including accountability mechanisms and decision-making processes must therefore be central to the evaluation framework.

The current paper describes the development of a coherent framework that guides the evaluation of policies, programs and services to improve the health of Aboriginal and Torres Strait Islander people. The approach incorporates the work of Pratt and Loff’s Research for Health Justice framework (Pratt and Loff 2012) to orient research conduct in the evaluation of Aboriginal and Torres Strait Islander health policy, programs and services towards a health equity perspective, focusing on the involvement of local stakeholders in priority setting, community benefits before and after the research, capacity-building and research partnerships.
**12C: Knowledge Translation (KT) support for clinicians: Development and introduction of a new role within Community, Indigenous and Subacute Services (CISS)**

Sally Eames¹, Hayley Middleton¹

¹Community, Indigenous and Subacute Services (CISS), Metro North, HHS

What: Over 2016-17, resource redistribution allowed a Project Lead (guided by Steering Committee) to develop a Knowledge Translation (KT) support role within a community, Indigenous and subacute public health service. Drawing on EBP, KT and implementation literature, we used stakeholder consultation, benchmarking and a staff survey to identify current state and needs for evidence-based practice (EBP) and KT support. Interactions with Library, Systems Improvement and Innovation were defined, allowing the Clinical Evidence Development Officer (CEDO) role to be integrated into business as usual and recruited to in May 2017.

Why: The need to support clinicians to implement evidence into their everyday practice is clear from research-practice gaps and barriers to implementation identified in the literature. We want to build staff capacity to implement evidence into their everyday practice to ensure sustainability, as well as ensure the strategies that staff use to translate evidence into everyday practice, are themselves evidence-based.

Thus far: Stakeholder consultation and the staff survey identified facilitators and barriers. The following strategies are planned to address the identified local barriers: education, consultations, project facilitation and organisational supports.

Impact: We anticipate that the role will increase staff capacity to complete EBP and KT activities, which in turn will allow for: increased consistency of the provision of best practice care; positive client and staff experiences, and improved client outcomes. We anticipate evaluation of the role over its first 2 years (using action research) will allow refinement and responsivity in an evolving public health system, and contribute to implementation science literature.

**12D: Social and emotional wellbeing screening for Aboriginal and Torres Strait Islanders within primary health care: a series of missed opportunities**

Erika Langham¹, Veronica Matthews¹, Janya McCalman¹, Roxanne Bainbridge¹, Barbara Nattabi³, Irina Kinchin¹, Ross Bailie²

¹CQUniversity; ²University Centre for Rural Health; ³West Australian Centre for Rural Health

Social and emotional wellbeing (SEWB) is a critical determinant of health outcomes for Indigenous Australians. The present study examined the extent to which primary healthcare services (PHS) undertake SEWB screening and management of Aboriginal and Torres Strait Islander clients, and the variation in SEWB screening and management across Indigenous PHS. Cross-sectional analysis between 2012–2014 of 3407 Indigenous client records from a non-representative sample of 100 PHSs in four Australian states/territory was undertaken to examine variation in the documentation of: 1) SEWB screening using identified measurement instruments, 2) concern regarding SEWB, 3) actions in response to concern, and 4) follow up actions. Binary logistic regression was used to determine the factors associated with screening. The largest variation in SEWB screening occurred at the state/territory level. Variation was also related to PHS characteristics. For the clients where SEWB concern was noted, missed opportunities were identified in both referral and follow up.

Our findings suggest that the lack of a clear model or set of guidelines on best practice for screening for social and emotional wellbeing in Indigenous health may contribute to the wide variation in SEWB service provision. There is a need for the development of national best practice guidelines for SEWB screening and management, accompanied by dedicated SEWB funding and training for health
service providers as well as ongoing monitoring of adherence with the guidelines. Further research on barriers to screening and follow up actions is also warranted.

12E: Long-term trends in supply and sustainability of the health workforce in remote Aboriginal communities in the Northern Territory of Australia

Deborah Russell1, Yuejen Zhao2, Steve Guthridge1, Mark Ramjan3, Michael Jones1, John Humphreys1, Tim Carey1, John Wakerman1
1Monash Rural Health

Background: Longstanding health workforce supply problems in remote Northern Territory Aboriginal communities jeopardise primary care delivery and increase potentially preventable hospitalisations. This research describes temporal changes in workforce supply in government-operated clinics during a period of substantially increased funding.

Methods: Descriptive and Markov-switching dynamic regression analysis of NT Government Department of Health payroll and financial data for 54 remote clinics, 2004-2015. Main outcome measures: number of unique employees/year; average annual headcounts; average full-time equivalent (FTE) positions; agency employed nurse FTE estimates; high and low supply state estimates.

Results: Overall, workforce supply increased between 2004 and 2015, especially administrative and logistic positions. Supply of nurses and Aboriginal Health Practitioners (AHPs) increased from 2.6 to 3.2 full-time equivalents (FTE) per clinic, though supply of AHPs declined after 2010. Each year almost twice as many individual employees are required for each nurse or AHP FTE position. Following funding increases, some exemplary clinics doubled their nursing and AHP workforce and achieved stability of supply, however most increased to a much smaller extent or not at all. Most health clinics demonstrated a “fading” of supply following an initial increase, and frequent cycling periods of higher and lower staffing levels.

Conclusions: Overall increases in workforce supply in remote NT communities between 2004 and 2015 have been affected by continuing very high turnover of nurses and AHPs, compounded by recent declines in AHP supply. Despite substantial increases in resourcing, an imperative remains to develop more robust health service models which better support supply of resident health staff.

12F: An evaluation framework for the Apunipima Workforce Exchange Program

Stephanie Panchision1, Annette Panzera1, Skye Williams2, Dr Mark Wenitong3
1Catholic Health Australia; 2Australian Catholic University; 3Apunipima Cape York Health Council, James Cook University

Background: The Apunipima Workforce Exchange Program is the result of a partnership between Apunipima Cape York Health Council and Catholic Health Australia. This partnership aims to:
- Provide backfill and additional clinical workforce that otherwise would not be in the Apunipima budget;
- Provide a cultural and educational opportunity for CHA member organisation employees, in an effort to Close the Gap in these communities.

The first of these placements occurred in November 2016.

Aims: To use this pilot exchange as a source of data to develop an evaluation framework for the project.
To use this evaluation framework for planning of current and future priorities for resources.
To reduce health inequalities attributed to the lack of appropriate evaluation for programs.

Methods: Conduct a review of existing literature on evaluation frameworks, particularly in the area of Aboriginal and Torres Strait Islander health. Using participatory action research in the form of semi-structured interviews informed by Yarning and Dadirri practices, interview:
- 2 Allied Health professionals who spent one week in Kowinyama, Cape York in November 2016;
- 2 local Aboriginal Health Workers in Kowanyama to get their feedback on the effectiveness of these clinical placements.

Using the literature review and informed clinical responses develop an evaluation framework for future workforce exchanges.

Anticipated impact: The establishment of an evaluation framework based on the experiences of the community and participants of the program to build a sustainable, culturally responsive health workforce in Aboriginal Community Controlled Health Services.

1:45PM – 2:00PM: PLENARY SESSION

ORAL POSTER PRESENTATION AWARDS

2:00PM – 3:30M: PLENARY SESSION

SHARK TANK
Session Chair: Dr David Rosengren, Deputy Executive Director Operations, Metro North Hospital and Health Service, Emergency Physician, Royal Brisbane and Women’s Hospital, Chair Queensland Clinical Senate.

Four groups will pitch for a possible ‘investment’ in their health services innovation or intervention, with our Sharks jumping in with financial support or opting out at any time. The groups will state their case for how much money they need, what they’ll do with it, and why the Sharks should invest. Following each pitch, the Sharks will have plenty of time to ask challenging questions as they decide to opt out, or pursue the investment opportunity.

Sharks:
Amanda Dines
Executive Director, The Royal Brisbane Women’s Hospital
Fionnagh Dougan
Chief Executive, Children’s Health Queensland
Mark Tucker-Evans
Chief Executive, Council on the Ageing (COTA) Queensland
Erica Kneipp
Assistant Secretary Health and Medical Research, Commonwealth Department of Health
STANDARD POSTERS: FRIDAY

The role of academic health centres in contributing to equitable health systems: A systematic review and the case of the Tropical Australian Academic Health Centre

Alexandra Edelman, James Cook University

Encouraging the use of non-pharmacological strategies in the management of dementia

Anna Moffatt, UniSA

Does an education program increase the knowledge, confidence and skills of Primary Health Care Nurses about dementia diagnosis and management in general practice

Anne Parkinson, The Australian National University

DEM Medicine Wise

Anthony Bell, Royal Brisbane and Women's Hospital (RBWH), University of Queensland School of Medicine

A randomised stepped-wedge trial to implement systematic distress screening and structured care for callers using Cancer Councils' telephone services: the START study protocol

Elizabeth Fradgley, University of Newcastle

Quantifying the evidence-practice gap in distress screening and management for cancer patients: a national audit of supportive care in Australian cancer services

Elizabeth Fradgley, University of Newcastle

Are we 'Choosing Wisely'? 

Jessica Toleman, Royal Brisbane and Women's Hospital (RBWH)

Achieving Quadruple Aim goals through clinical networks: a systematic review

Massimiliano Panella, University of Eastern Piedmont

Embedding a socio-behavioral framework in community based rehabilitation: Evaluation of a staff training and service change program

Michelle Currin, Community Adult Rehabilitation, Service Metro South Health Service

Streamlining clinical practice in an Australian community rehabilitation service using The Calderdale Framework

Michelle Currin, Community Adult Rehabilitation, Service Metro South Health Service

Are we undertreating? An audit of occupational therapy intervention techniques used for people with dementia

Miia Rahja, Flinders University and Cognitive Decline Partnership Centre (CDPC)

Economic evaluations of occupational therapy for people with cognitive and/or functional decline: A systematic review

Miia Rahja, Flinders University and Cognitive Decline Partnership Centre (CDPC)
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