1A Improving Safety and Quality of Care Across the Care Continuum for Patients with Dementia — A Study of the TOP 5 Communication Tool

Virginia Armour, Anne Axam, Erin Gilmore, Mei Chan, Fiona Hasnip, John Dobrohotoff, Maureen Strudwick, Rebecca Reeve, Changhao Hou, Rosalie Viney, Karen Luxford

1 Clinical Excellence Commission, NSW; 2 Central Coast Local Health District, Mental Health Service for Older People, NSW; 3 Central Coast Local Health District, Carer Support, NSW; 4 Centre for Health Economics Research and Evaluation, University of Technology Sydney

1B Reciprocal Accountability: A Mystery at the Heart of Indigenous and Government Relations in Primary Care

1B.1 Reciprocal Accountability: A Mystery at the Heart of Indigenous and Government Relations in Primary Health Care

Judith Dwyer
Flinders University

1B.2 Accountability for Whānau Ora Outcomes: Beyond Hierarchical Understandings of Accountability to a More Holistic Approach

Amohia Boulton
Whakauae Research Services

1B.3 Paradigms at Odds: Reciprocal Accountability for First Nations Health in British Columbia (Highly commended abstract overall)

Josée G. Lavoie, Lloy Wylie
1 University of Manitoba; 2 Western University

1B.4 Principles for a System of Reciprocal Accountability in Australian Aboriginal Health

Judith Dwyer, Tim Tenbensen, Angelita Martin, Kim O’Donnell, Josée G. Lavoie, Amohia Boulton, Patrick Sullivan
1 School of Medicine, Flinders University; 2 Faculty of Medical and Health Sciences, University of Auckland; 3 Faculty of Medicine, Manitoba University; 4 Whakauae Research Services; 5 Nulungu Research Institute, Notre Dame University

1B.5 Reciprocal Accountability and Fiduciary Duty: Accountability Frameworks and the Federal Responsibility for Indigenous Health in Canada

Derek Kornelsen, Josée G. Lavoie, Judith Dwyer
1 Faculty of Health Sciences, University of Manitoba; 2 School of Medicine, Flinders University

1B.6 Trust in the Funding and Accountability Relationship Between Aboriginal Community Controlled Health Organisations and Government Departments

Kim O’Donnell
Lowitja Institute & Flinders University

1C Measuring the Influence of Regularity of GP Contact on Diabetic Potentially Preventable Hospitalisations

1C.1 Measuring the Influence of Regularity of GP Contact on Diabetic Potentially Preventable Hospitalisations Using Commonwealth-State Person-Level Linked Data: Methods and Initial Findings

Jane Hall
CHERE, University of Technology Sydney

1C.2 Identifying a Population at Risk of Diabetes Using 45 and UP and WA Administrative Data

Chunzhou Mu, Milica Kecmanovic, Rachael Moorin, David Youens
1 Centre for Health Economics Research and Evaluation, University of Technology Sydney; 2 Faculty of Health Sciences, Curtin University
1C.3 The Impact of Regular GP Visits on Diabetic Potentially Preventable Hospitalisations: Initial Findings

David Youens\(^1\), Serena Yu\(^2\), Kees van Gool\(^3\), Jane Hall\(^2\), Rachael Moorin\(^1,3\)

\(^1\)Health Policy and Management, School of Public Health, Curtin University, Perth; \(^2\)Centre for Health Economics Research and Evaluation, University of Technology Sydney; \(^3\)Centre for Health Services Research, School of Population Health, University of Western Australia

1C.4 The Effect of Regular GP Contact on Potentially Preventable Hospitalisation in NSW: Developing and Testing a Second Generation of the Regularity Metric

Serena Yu\(^1\), David Youens\(^2\), Kees van Gool\(^1\), Rachael Moorin\(^2,3\), Jane Hall\(^2\)

\(^1\)Centre for Health Economics Research and Evaluation, University of Technology Sydney; \(^2\)Centre for Health Services Research, School of Population Health, University of Western Australia; \(^3\)Health Policy and Management; School of Public Health, Curtin University, Perth

1C.5 The Utility of Historical Electoral Roll Records and Their Effect on the Association of Regularity of GP Contact and Potentially Preventable Diabetic Hospitalisations

Rachael Moorin\(^1,2\), David Youens\(^1\), Serena Yu\(^3\), Kees van Gool\(^3\), Jane Hall\(^2\)

\(^1\)Health Policy and Management, School of Public Health, Curtin University, Perth; \(^2\)Centre for Health Services Research, School of Population Health, University of Western Australia; \(^3\)Centre for Health Economics Research and Evaluation, University of Technology Sydney

2A Hospital Use

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2A.1 The Impact of Community Palliative Care on Hospital Use and Place of Death in Western Australia

Rachael Moorin\(^1,2\), David Youens\(^1,2\), Joanna Smith\(^1\), Gill Lewin\(^1,2\)

\(^1\)Silver Chain Nursing Association; \(^2\)Curtin University

2A.2 Prevalence of Selected Low Value Services in New South Wales Public Hospitals

Tim Badgery-Parker\(^1,2\), Sallie-Anne Pearson\(^3\), Adam Elshaug\(^1,2\)

\(^1\)Menzies Centre for Health Policy, University of Sydney; \(^2\)Capital Markets Cooperative Research Centre; \(^3\)Faculty of Pharmacy and School of Public Health, University of Sydney

2A.3 Reasons for and Timeliness Measures of Emergency Department Visits for People with Cancer in New South Wales: A Population-Based Study (Highly commended abstract overall)

Huei-Yang Chen\(^1\), Ariana Dobrovic\(^1\), Sadaf Marashi-Pour\(^1\), Kim Sutherland\(^1\), Jean-Frédéric Lévesque\(^1,2\)

\(^1\)Bureau of Health Information, NSW; \(^2\)Centre for Primary Care and Equity, University of New South Wales

2A.4 Visualising Linked Health Data to Explore Service Use Around Preventable Hospitalisations

Michael O. Falster\(^1\), Louisa R. Jorm\(^1\), Alastair H. Leyland\(^2\)

\(^1\)Centre for Big Data Research in Health, University of New South Wales; \(^2\)MRC/CSO Social and Public Health Sciences Unit, University of Glasgow

2A.5 Using Aggregate Targets of Emergency Department Timeliness: Impact on Performance Monitoring

Lilian Daly, Jean-Frédéric Lévesque, Jill Kaldor, Carolyn Fredericks, Jason Boyd

Bureau of Health Information

2A.6 Using Medical Informatics to Translate Evidence into Bedside Quality Improvements

Kristina Weeks, Laura Vail

Johns Hopkins University

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Grant Russell\(^1\), M.F. Harris\(^2\), Nigel Stocks\(^3\), Teng Liaw\(^2\), Jenny Advocat\(^1\), Kirsty Rawlings\(^3\), Nilakshi Gunatillaka\(^1\), Simone Champion\(^3\), Amy Prince\(^2\), IMPACT Team

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1University of New South Wales; 2Bureau of Health Information; 3Monash University; 4La Trobe University; 5McGill University; 6Université de Sherbrooke; 7University of Lausanne

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1McGill University; 2Monash University; 3Bureau of Health Information; 4Alberta Centre for Child, Family & Community Research; 5Université de Sherbrooke; 6St-Mary’s Research Center; 7La Trobe University; 8Centre Hospitalier Universitaire de Lausanne

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1McGill University; 2Monash University; 3Bruyère Research Institute; 4St-Mary’s Research Center; 5University of New South Wales; 6Bureau of Health Information; 7La Trobe University; 8Alberta Centre for Child, Family & Community Research; 9University of Adelaide

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¹Healthy Mothers Healthy Families Research Group, Murdoch Childrens Research Institute; ²Aboriginal Families Study

Sarah MacLean¹, Rebecca Ritte¹, Alister Thorpe¹, Shaun Ewen², Kerry Arabena¹
¹Indigenous Health Equity Unit, Melbourne School of Population and Global Health, University of Melbourne; ²Melbourne Poche Centre for Indigenous Health, University of Melbourne

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¹Wuchopperen Health Service; ²Wellbeing Study Team (authors shown in alphabetical order); ³Wirraka Maya Health Service Aboriginal Corporation; ⁴Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute; ⁵Nunkuwarrin Yunti Inc; ⁶Maari Ma Health Aboriginal Corporation; ⁷Tharawal Aboriginal Corporation; ⁸Danila Dilba Medical Service; ⁹Baker IDI Heart & Diabetes Institute; ¹⁰Winninga Nimmityjah Aboriginal Health Service

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1National Institute for Stroke and Applied Neurosciences Auckland University of Technology; 2Department of Biostatistics and Epidemiology, Auckland University of Technology; 3School of Social Sciences, Humanities and Arts, University of California Merced; 4Health and Disability Intelligence, New Zealand Ministry of Health; 5School of Population Health, University of Auckland; 6School of Psychology, University of Auckland; 7Health and Rehabilitation Research Institute, Auckland University of Technology; 8School of Psychology, University of Waikato; 9Department of Primary Health Care & General Practice, University of Otago

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1Jack Brockhoff Child Health and Wellbeing Program, Melbourne School of Population and Global Health, University of Melbourne; 2Melbourne School of Psychological Sciences, University of Melbourne; 3Department of Social Work, University of Melbourne; 4School of Psychology, University of New South Wales; 5Centre for Transformative Innovation, Swinburne University of Technology; 6Australian Centre for Posttraumatic Mental Health and Department of Psychiatry, University of Melbourne; 7Disaster Recovery Consultant; 8Southgate Institute for Health, Society and Equity, and School of Medicine, Flinders University; 9Prevention and Population Health Branch, Department of Health and Human Services; 10Office of the Deputy Vice-Chancellor (Education), University of Sydney
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1Melbourne School of Population and Global Health, University of Melbourne; 2School of Public Health and Community Medicine, University of New South Wales; 3Department of General Practice, University of Melbourne; 4Kirby Institute, University of New South Wales

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¹Deakin Health Economics, Deakin University, Melbourne; ²Centre for Health Economics, Monash University, Melbourne; ³Flinders Centre for Clinical Change & Health Care Research, Flinders University, Adelaide

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1Monash University, Clayton; 2Monash Health, Clayton; 3Western Health Service, Footscray; 4Department of Health and Human Services, Melbourne; 5Melbourne Health, Melbourne

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¹Wardliparinga Aboriginal Research Unit, South Australian Health and Medical Research Institute, Adelaide; ²Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; ³Joanna Briggs Institute, Faculty of Health Sciences, University of Adelaide; ⁴School of Public Health, Faculty of Health Sciences, University of Adelaide

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¹University of New South Wales; ²University of Ottawa; ³McGill University; ⁴NSW Bureau of Health Information; ⁵La Trobe University; ⁶Monash University; ⁷Alberta Centre for Child, Family & Community Research; ⁸University of Adelaide

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⁴National Stroke Foundation, Sydney; ⁵Queensland Statewide Stroke Clinical Network, Brisbane;
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1Jack Brockhoff Child Health and Wellbeing Program, Centre for Health Equity, School of Population and Global Health, University of Melbourne; 2Department of Developmental Medicine, Royal Children’s Hospital, Melbourne; 3Developmental Disability and Rehabilitation Research, Murdoch Childrens Research Institute; 4Department of Paediatrics, University of Melbourne; 5Quality, Innovation and Safeguards, Yooralla; 6Centre for Developmental Disability Health Victoria, Monash University, Melbourne; 7Deakin Health Economics, Deakin University, Melbourne; 8Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne

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The Extra Resource Burden of In-Hospital Falls: A Cost of Fall Study

Renata T. Morello1, Anna Barker1, Jennifer J. Watts2, T. Haines3, Silva Zavarsek4, Keith D. Hill5, Caroline A. Brand1,6, Catherine Sherrington7, Rory Wolfe1, Megan A. Bohensky2, Johannes U. Stoelwinder1

1Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Victoria; 2Deakin Health Economics Population Health Strategic Research Centre, Deakin University, Victoria; 3Physiotherapy Department, Monash University and Allied Health Research Unit, Monash Health, Monash University, Victoria; 4Centre for Health Economics, Monash Business School, Monash University, Victoria; 5School of Physiotherapy and Exercise Science, Curtin University, Western Australia; 6Melbourne Epi Centre, Royal Melbourne Hospital, University of Melbourne, Victoria; 7George Institute for Global Health, Sydney Medical School, University of Sydney, New South Wales

Does Higher Bed Occupancy Rate (BOR) Affect the In-Hospital and 30-Day Mortality Rate?

Yan Sun1, George Gunapal Pradeep Paul1, Bee Hoon Heng1, Kelvin Bryan Tan2

1Health Services & Outcomes Research, National Healthcare Group; 2Policy Research & Economics Office, Ministry of Health

Characteristics of Indigenous Primary Health Care Models of Service Delivery

Stephen Hartfield1,2,3, Carol Davy2, Zachary Munro2, Alexa McArthur4, Alex Brown2, Ngiare Brown2,5

1National Aboriginal Community Control Health Organisation; 2Wardliparinga Aboriginal Research Unit, South Australian Health and Medical Research Institute, and Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; 3School of Public Health, Faculty of Health Sciences, University of Adelaide; 4Joanna Briggs Institute, Faculty of Health Sciences, University of Adelaide, and Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; 5Faculty of Education and Graduate School of Medicine, University of Wollongong

Is Funder Reporting Undermining Service Delivery? Compliance Requirements for Aboriginal Community Controlled Health Organisations in Victoria

Kate Silburn1, Alister Thorpe2, Yola Frank-Gray3, Louise Carey3, Graeme Fletcher3, Rumbalara Aboriginal Cooperative Ltd

1La Trobe University; 2University of Melbourne; 3Victorian Aboriginal Community Controlled Health Organisation

Characteristics and Value of Aboriginal Community Controlled Health Organisations Primary Health Care

Judith Streak Gomersall1, Edoardo Aromataris2, Alex Brown3, Judith Dwyer3, Drew Carter4, Kim O’Donnell3,5, Karla Canuto2, Kootsy Canuto2, Matthew Stephenson1, Odette Gibson2

1Joanna Briggs Institute, Faculty of Health Sciences, University of Adelaide, and Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; 2Wardliparinga Aboriginal Research Unit, South Australian Health and Medical Research Institute, Adelaide, and Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; 3Health Care Management, School of Medicine, Flinders University, Adelaide; 4School of Public Health, Faculty of Health Sciences, University of Adelaide; 5School of Medicine, Faculty of Health Sciences, University of Adelaide

Mapping Aboriginal Patient Journeys — Working Together to Identify Gaps and Improve Health Outcomes

Janet Kelly1,2, Judith Dwyer1, Tamera Mackean1, Kim O’Donnell1

1Flinders University; 2University of Adelaide

Engagement in a Maximally-Assisted Therapy Programme Positively Association with Optimal Adherence to Antiretroviral Therapy Among Indigenous People Who Use Illicit Drugs in a Canadian Setting

Brittany Barker1,2, Evan Wood1,3, Thomas Kent1,3, Huiru Dong1, Robert Hogg4, Silvia Guillemi5, Julio Montaner1,3, M.-J. Milloy1,3

1BC Centre for Excellence in HIV/AIDS, St. Paul’s Hospital; 2Interdisciplinary Studies Graduate Program, University of British Columbia; 3Division of AIDS, Department of Medicine, University of British Columbia; 4Faculty of Health Sciences, Simon Fraser University

Multimorbidity in Aboriginal and Non-Aboriginal People in NSW and its Impact on Mortality

Deborah Randall, Sanja Lujic, Louisa R. Jorm

Centre for Big Data Research in Health, University of New South Wales
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Judy Lowthian, Rosemary McGinnes, Caroline A. Brand, Anna Barker, Peter A. Cameron
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Josée G. Lavoie, Amanda Ward
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Kristina Weeks, Tiffany Callender, J. Matthew Austin
Johns Hopkins University

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Amanda Neil, Andrew J. Palmer, Tracy Richardson, Kristy Sanderson, Meghan Mann-Leonard, Mark Nelson
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Neonia Panko, Jacqueline Cumming, Greg Martin
Health Services Research Centre, School of Government, Victoria University of Wellington
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Angela Todd, Amanda Ampt, Maree Porter, Jillian Patterson, Christine Roberts
Kolling Institute, University of Sydney

P59 What is the Prevalence of Antenatal Risk Factors Affecting Child Development in Australian Women?

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P60 A Population Analysis of Self-Management and Health Related Quality of Life for Chronic Musculoskeletal Conditions

Elizabeth Hoon
University of Adelaide

P61 A Cultural Competence Organisational Review for Community Health Services

Mandy Truong1, Lisa Gibbs1, Veronika PradeF, Michal Morris3, Pauline Gwatirisa3, Maryanne Tadic2, Andrea de Silva4,5, Martin Hall6, Dana Young1, Elisha Riggs7, Hanny Calache4,5,8, Mark Gussy9, Richard Watt9, Iqbal Gondal10,11, Elizabeth Waters1
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P62 The Factors Influencing Antibiotic Prescribing in a Rural Hospital Emergency Department with No On-Site Infectious Disease Support

Girish Swaminathan
Bega Valley Health Service

P63 Identifying Women for a Nurse Home Visiting Service: The Feasibility and Utility of Antenatal Risk Factor Screening

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P65 Workplace Culture and Health Care Reform: Front Line Workers Carrying the Weight of Policy Shifts

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Improving Safety and Quality of Care Across the Care Continuum for Patients with Dementia — A Study of the TOP 5 Communication Tool

Virginia Armour1, Anne Axam1, Erin Gilmore1, Mei Chan1, Fiona Hasnip1, John Dobrohotoff1, Maureen Strudwick2, Rebecca Reeve2, Changhao Hou3, Rosalie Viney4, Karen Luxford1

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OBJECTIVES
This two part study investigated the impact of a clinician-carer communication strategy (TOP 5) on i) hospitalised patients with dementia and ii) use in transfers of care between hospital services and local referral linkages.

METHODS
The study involved 21 hospitals and a subset of 10 hospitals with referral linkages for transfers of care. Surveys were conducted with clinicians and carers about perceptions and experiences. Implementation process, use in transfers of care and costs were explored through surveys of staff. Time series analysis was conducted on incident-reported falls, usage of non-regular anti-psychotics and one-to-one nursing.

LESSONS LEARNED
Following implementation over 12 months, clinicians and carers reported high levels of acceptability and perceived benefits for patients. Clinicians rated confidence in caring for patients with dementia as significantly higher after the introduction of TOP 5. Average cost of TOP 5 interview was $20 AUD. Improvements were also found in key patient safety indicators with an overall decrease of 36% in patient falls including one hospital with a matched control ward exhibiting an average of 6.85 fewer falls incidents per month in the intervention ward compared to the matched control ward (B=6.85, p<0.05). Preliminary results regarding transitions indicate ongoing use of personalised strategies for care across services and continuing implications for safety and quality.

Reciprocal Accountability: A Mystery at the Heart of Indigenous and Government Relations in Primary Care

Judith Dywer
Flinders University

OBJECTIVES
This symposium addresses a critical challenge in the relationships between Indigenous health care providers and governments in Canada, New Zealand and Australia — the search for meaningful and manageable accountability arrangements. For governments, persistent inequalities in the health outcomes of Indigenous peoples fit the profile of an unstructured policy problem, and in response they have imposed requirements for contracting, performance and accountability that have been shaped for other contexts, with some reforms currently underway. Community-based NGOs deliver primary health care for Indigenous communities, and also function as the base for advocacy for health rights and priorities.

METHODS
In this symposium, research and analysis of different discourses and field-work data from each of the three countries will be presented, outlining shared and separate contexts, perspectives and strategies towards both theorising and operationalising the concept of reciprocal accountability.

LESSONS LEARNED
Reciprocal accountability has foundations in Indigenous worldviews, and in political, policy and public administration fields. It provides a suitable framework for deriving improved accountability arrangements focused higher up the causal chain from health service activities to health outcomes than can be accommodated in New Public Management methods.

IMPLICATIONS
The development of practices of reciprocal accountability will require a rethinking of the relationship between Indigenous NGOs and governments, with a stronger focus on performance in government, and on community accountability by NGOs.

Accountability for Whānau Ora Outcomes: Beyond Hierarchical Understandings of Accountability to a More Holistic Approach

Amohia Boulton
Whakauae Research Services

OBJECTIVES
The measurement of Whānau Ora (family wellbeing) outcomes represents "a significant shift in the performance monitoring, reporting and accountability mindset"; characterised as being away from a functional accountability arrangement, towards an arrangement that is more relational in nature (Williams &Taylor, 2013, p569). This paper discusses the development of an outcomes framework aimed at measuring the multiplicity of Whānau Ora goals; those of government, of Iwi (tribes) and of whānau (families).

METHODS
Critical analysis of accountability literature and direct participant observation of the development of the emergent Whānau Ora Outcomes Framework. The author is a Whānau Ora Technical Advisor, providing advice to the Iwi Leaders of the Whānau Ora Partnership Group; a joint Crown/Iwi entity charged with supporting the new accountability and institutional arrangements for Whānau Ora.

LESSONS LEARNED
Iwi leaders have recently voiced the desire to ensure the Whānau Ora Outcomes Framework takes cognizance of the needs and desires of whānau Māori, in addition to the Crown’s imperative for efficiency and economy articulating some founding principles. A more consultative approach to the development of an accountability framework that meets the needs of all stakeholders is required.

IMPLICATIONS
The Whānau Ora Outcomes framework represents a key component of the overall Whānau Ora policy. Ensuring a robust accountability framework that can both accommodate the needs of Iwi and Crown (as Treaty partners) and deliver performance.

Paradigms at Odds: Reciprocal Accountability for First Nations Health in British Columbia (Highly commended abstract overall)

José G. Lavoie1, Lloy Wylie2
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OBJECTIVES
In October 2013, the First Nations Health Authority (FNHA) took over the responsibility of funding and/or providing health services to all British Columbia First Nation communities (N=170, $3.88M, 300 employees) from the First Nations and Inuit Health Branch of Health Canada. A key component of the agreement was a commitment to “new roles and relationships. . . based on respect and Reciprocal Accountability”, yet its principles were not defined. This presentation explores the paradigms at work that are shaping the development of a common understanding of reciprocal accountability in the context of this transfer.

METHODS
We conducted a detailed analysis of documents, as well as interviews
with key participants in the transfer process, and engaged stakeholders in a policy round table discussion exploring reciprocal accountability.

LESSONS LEARNED

Transferring structures that were based on a federal accountability paradigm of nested relationships between departments (Finance, Treasury Board, etc.) and third party accountability creates challenges. Commitments to the FNHA sit outside of this framework AND include but also extend beyond the traditional contractual principal-agent relationship. FNHA is also accountable to BC First Nations, yet not in the same relationship as a band council to community. This creates a vacuum where the details of reciprocal accountability have yet to be fully articulated.

IMPLICATIONS

While challenging, this transfer of responsibility creates opportunities to reframe federal-First Nations accountability relationships, and to overcome regulatory challenges associated with a principal-agent framework. This transfer is paving the way for health self-governance for First Nations across Canada, and Indigenous communities beyond.

Principles for a System of Reciprocal Accountability in Australian Aboriginal Health

Judith Dwyer 1, Tim Tenbensel2, Angelita Martins1, Kim O’Donnell 1, Josée G. Lavoie2, Amohia Boulton4, Patrick Sullivan5

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OBJECTIVES

Accountability is a ‘golden concept’, universally agreed to be a good thing. While it is clear that health services for Indigenous communities are accountable to governments for their use of funding, there is a sense in which Indigenous community organisations also represent their communities as a particular class of citizens, who can hold government to account. These two accountability relationships are in tension. Reciprocal accountability is a concept in search of a method for redefining the accountability relationship in these circumstances, with broader potential applicability in third sector-government relations.

METHODS

We conducted comparative case-studies of primary health care system reform in Australia’s Northern Territory and North Queensland, at jurisdiction and regional level. Governments and the Aboriginal Community Controlled Health Organisation sector pursued policies to transfer primary health care services for Aboriginal communities from health departments to the sector, with limited success. Concerns about accountability, and their force as a barrier to reform, were examined through interviews and document review.

LESSONS LEARNED

While participants in the reforms recognised the limitations of current accountability regimes, they lacked confidence that alternatives would work. Strong barriers included technical capacity and systemic racism. A statement of design principles for reciprocal accountability in this context has been derived from analysis of the barriers to reform.

IMPLICATIONS

A new approach to accountability must work for government and the sector, and requires untangling of the relationships of both providers and funders to the communities they seek to serve.

Reciprocal Accountability and Fiduciary Duty: Accountability Frameworks and the Federal Responsibility for Indigenous Health in Canada

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OBJECTIVES

There is growing recognition among public servants, Indigenous organisations, and scholars in Canada, Australia, and New Zealand that the delivery of effective and responsive health care to Indigenous communities is best served by a shift from classical New Public Management accountability models to models that reflect reciprocal accountability. However, despite some common thinking about future directions, greater conceptual clarity is needed in order to develop workable frameworks that reflect both Indigenous and Western conceptions of reciprocal accountability.

METHODS

This paper brings together two bodies of literature that have, until now, developed along largely parallel paths — the literature addressing the need for a reciprocal accountability framework in Indigenous health care; and the literature examining Canada’s fiduciary obligation to Indigenous peoples. An analysis of the fiduciary relationship also entails a consideration of Indigenous perspectives on a legitimate relationship with the state.

LESSONS LEARNED

The fiduciary framing offers clarity on the nature of the entities involved in the accountability relationship (Indigenous peoples are citizens of Indigenous nations possessing unique Aboriginal and Treaty rights) and the unique processes and mechanisms of accountability that are implied by a federal fiduciary obligation.

IMPLICATIONS

A consideration of the fiduciary relationship offers an understanding of reciprocal accountability that takes into account Indigenous interpretations of the concept. While the foundations are different in Australia and New Zealand, it is likely that the conceptions of reciprocal accountability derived in Canada may resonate in these countries as well.

Trust in the Funding and Accountability Relationship Between Aboriginal Community Controlled Health Organisations and Government Departments

Kim O’Donnell

Lowiita Institute & Flinders University

OBJECTIVES

The importance of building strong working relationships between government departments and Aboriginal Community Controlled health Organisations is written into Aboriginal health policies. However, there is a lack of national strategic direction to support engagement with First Peoples’ leaders and organisations. The relationship is assumed to occur in the ‘top down’ processes of accountability, funding and activity reporting to government.

METHODS

This study investigated the funding relationship between management of an Aboriginal Community Controlled Health Organisation and government staff who manage the funding contracts, based on document review, and interview analysis; their perceptions of trust and accountability in their work with each other and whether trust is perceived as enabling more effective working relationships, and the barriers they face in negotiating and maintaining these relationships.

LESSONS LEARNED

A lack of trust was found in the funding relationship, along with goodwill to improve the relationship. Distrust is perpetuated when there is a lack of agreed understanding about the purpose of ACCHOs. Current contractual arrangements are founded on distrust underpinned by the Australian ‘inconvenient truth’— we are a colonised nation and the legacy lives on. However, many people refuse to admit or fully explore this continuing reality. As a result, working in Aboriginal and Torres Strait Islander health is fraught with challenges we ALL need to address.

IMPLICATIONS

By understanding the causes of (dis)trust, tensions and barriers in the funding and accountability relationship, ACCHOs and government departments may find realistic ways to engage for agreed accountability, governance and community participation goals.
**ImPLICATIONS**

This paper identifies the strengths and weaknesses of using person level data in identifying an at risk diabetes population using both 45 and UP and WA administrative data. These limitations need to be considered when analysing health care patterns and outcomes among diabetes patients.

**The Impact of Regular GP Visits on Diabetic Potentially Preventable Hospitalisations: Initial Findings**

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1Health Policy and Management, School of Public Health, Curtin University, Perth; 2Centre for Health Economics Research and Evaluation, University of Technology Sydney; 3Centre for Health Services Research, School of Population Health, University of Western Australia

**OBJECTIVES**

Potentially preventable hospitalisations (PPHs) place a substantial burden on the Australian health system, with the AIHW reporting 212,000 PPHs for diabetes alone in 2005/06. Timely and effective primary care may reduce the risk of acute episodes and subsequent hospitalisation among those with chronic diseases. The Medicare Enhanced Primary Care program, introduced to improve the quality and accessibility of healthcare provided by GPs to Australians with chronic disease, has been shown to improve quality of GP access. The aim of our study is to ascertain whether more regular GP access reduces diabetes PPHs.

**METHODS**

Whole of population longitudinal study using linked hospital, mortality, and Medicare data. Regularity of GP access is determined through calculating the variance in the number of days between GP visits in each year. Regular GP contact is taken to indicate planned, proactive primary care. Multilevel modelling techniques will determine the relationship between regularity of GP access and diabetic PPHs in the population at risk of diabetes.

**LESSONS LEARNED**

This paper will report results on the relationship between regular, proactive GP contact and diabetes PPHs in the population at risk of diabetes. Socio-demographic, geo-spatial and access factors which influence regularity of GP access, which drive PPHs and which modify the effect of regularity on PPHs will be presented.

**IMPLICATIONS**

Findings from this study will provide important evidence concerning strategies to reduce PPHs in relation to diabetes, which will be of interest to policy-makers wishing to reduce unnecessary hospitalisations.

**The Effect of Regular GP Contact on Potentially Preventable Hospitalisation in NSW: Developing and Testing a Second Generation of the Regularity Metric**

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**OBJECTIVES**

High quality primary care is associated with better management of diabetes which, in turn, should lead to better health and reduced likelihood of complications. This paper will contribute to the limited evidence on measuring the relationship between high quality primary care and a reduction in hospitalisations. In particular, it examines one aspect of continuity of care relating to the regularity by which diabetes patients visit their GP.

**METHODS**

We use the NSW 45 and Up data to examine the relationship between regular GP visits and diabetes outcomes such as hospitalisations. The paper utilises linked survey and administrative datasets to undertake panel data analysis.

**LESSONS LEARNED**

The paper will report the results on the relationship between GP...
The Utility of Historical Electoral Roll Records and Their Effect on the Association of Regularity of GP Contact and Potentially Preventable Diabetic Hospitalisations

Rachael Moorin 1,2, David Youens 1, Serena Yu 3, Kees van Gool 3, Sadaf Marashi-Pour 1, Kim Pearson 3, Sallie-Anne Pearson 3, Adam Elshaug 1,2

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OBJECTIVES
Correctly ascertaining person-time at risk is paramount to studies of health services research and relies on the ability to track the status of individuals throughout the study. Administrative data cannot contain this information on where study subjects live in the time between episodes of health service use. This study evaluated the utility of historical electoral roll data to better ascertain person-time at risk.

METHODS
The association between regularity of GP contact and potentially preventable hospitalisations (PPHs) in WA was modelled using person-level linked data where the time at risk for both the exposure (regularity of GP contact) and outcome (PPHs) was assumed to be constant throughout the follow up until death. The analysis was then repeated incorporating historical (longitudinal) electoral roll data. These data were partitioned follow up time according to location of residence within the State to better characterise access and socio-economic status and included removal (out-of-state/country migration) and re-enrolment records.

LESSONS LEARNED
Accurate ascertainment of person-time at risk is important particularly when it varies differentially across exposure groups or covariates. Historical electoral roll data allows better specification of person-time and also provides longitudinal information on geographic location facilitating the inclusion of accessibility and socio-economic status longitudinally.

IMPLICATIONS
Currently cross-sectional electoral roll data are available to researchers in WA solely for the purposes of identifying and characterising a cohort at baseline. However these data are longitudinal and contain important information that improve analyses. Information on their utility is important so as to leverage their availability from the Electoral Commission.

LESSONS LEARNED
This study showed that patterns of hospital and ED use in the last 12 months of life differ between those who do and do not utilise community palliative care in terms of volume of use, type of use and cost. The groups had similar numbers of admissions, but those who accessed community palliative care had fewer bed days and a lower cumulated cost associated with those admissions. The greatest differences were recorded in terms of emergency admissions. The service was also associated with a three-fold increase in the odds of death occurring out of hospital.

IMPLICATIONS
This study presents evidence for the utility of community palliative care that will be helpful for other services contemplating the implementation of similar models. It also provides evidence for the palliative care community regarding resource utilisation and the determinants that drive both hospital and community care resource use.

Prevalence of Selected Low Value Services in New South Wales Public Hospitals

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1Menzies Centre for Health Policy, University of Sydney; 2Capital Markets Cooperative Research Centre; 3Faculty of Pharmacy and School of Public Health, University of Sydney

OBJECTIVES
Low value care comprises interventions that have no or little net benefit for patients. Many low value services have been identified through the various Choosing Wisely lists in the United States, Canada, and Australia. However, the extent of low value care in Australia is not known. Our objective was to use administrative data to measure the prevalence of selected low value services in NSW hospitals.

METHODS
Diagnosis and procedure codes and other information needed to identify low value use of selected interventions were used to extract records relating to low value services (vertebroplasty for osteoporotic vertebral fracture; arthroscopic surgery for knee osteoarthritis; and endoscopic retrograde cholangiopancreatography [ERCP] for acute gallstone pancreatitis without cholangitis) from the NSW Health Information Exchange data warehouse in the period 1 July 2010 to 30 June 2015.

LESSONS LEARNED
Use of some low value services can be identified from hospital administrative data. Vertebroplasty is rare in NSW hospitals, and decreased from 26 episodes in 2010–11 to 6 in 2014–15. Episodes involving knee arthroscopy decreased from 745 in 2010–11 to 491 in 2014–15, and ERCP episodes decreased from 119 to 78.

IMPLICATIONS
This work provides the first application of this new method, estimating prevalence of low value services in an Australian hospital system. Directly measuring these services with administrative data will allow monitoring and targeting of incentives to reduce low value care. We will outline a broader program of work in this area, applying this method at a broad scale to quantify waste in Australian hospitals.

Reasons for and Timeliness Measures of Emergency Department Visits for People with Cancer in New South Wales: A Population-Based Study (Highly commended abstract overall)

Huei-Yen Chen 1, Ariana Dobrovic 1, Sadaf Marashi-Pour 1, Kim Sutherland 1, Jean-Frédéric Lévesque 1,2

1Bureau of Health Information, NSW; 2Centre for Primary Care and Equity, University of New South Wales

OBJECTIVES
This study examined reasons why people with cancer visited a NSW emergency department (ED) and how quickly they were treated and departed.

METHODS
A retrospective cohort study linked data from cancer registry (2006–2009) and EDs (2005–2010). The reason for visits, defined as the principal diagnosis at presentation and coded in SNOMED-CT, ICD-9-CM and old ICD-10-AM versions, were mapped to ICD-10-AM.
V6 and then grouped accordingly. Median time from presentation to treatment and the proportion of patients leaving the ED within four hours were examined for different cancer types and compared with results for all ED visits.

LESSONS LEARNED
Between 2006–2009, there were 141,461 people diagnosed with cancer in NSW. Half of this cohort (53%) visited an ED at least once. A total of 193,472 emergency ED visits were made. Fewer than 4% of these visits were attributed specifically to cancer. The reasons for ED visits were diverse but symptoms relating to circulatory, respiratory and digestive systems were most common. People with respiratory, colorectal and lymphohaematopoietic cancers visited an ED more frequently than those with other cancers. Using all emergency ED visits as a comparator, people with cancer were triaged to more urgent categories, and were more likely to be admitted to hospital (58% vs. 27%).

IMPLICATIONS
This study used a tool to map diagnoses from different clinical coding systems in NSW EDs based on ICD-10-AM V6. Timeliness measures for ED visits made by people with cancer inform efforts to understand their needs and improve care.

Visualising Linked Health Data to Explore Service Use Around Preventable Hospitalisations

Michael O. Falster¹, Louisa R. Jorm¹, Alastair H. Leyland²
¹Centre for Big Data Research in Health, University of New South Wales; ²MRC/CSO Social and Public Health Sciences Unit, University of Glasgow

OBJECTIVES
Preventable hospitalisations, considered to be avoidable through timely and effective access to primary care, are used internationally as an indicator of health system performance. Much research has investigated their associations with measures of health workforce, but it remains unclear how they relate to actual use of health services. This study explored patterns of service use around the time of preventable hospitalisations.

METHODS
Linked data on hospital admissions, general practitioner (GP) visits, and other health events for 268,850 participants in the 45 and Up Study, Australia, were used to create visual representations of health service use. For each participant, each health event was plotted against time, with different coloured dots, lines, and panels representing each type of event. Various visualisations were explored, by patient characteristics, and displayed over calendar year or centred on admission date.

LESSONS LEARNED
The visualisations were a powerful way of synthesising information from thousands of patients across multiple datasets. GP visits clustered in the lead up to, and following, preventable hospitalisations, while many patients died soon after the hospitalisation. The visualisations did not show evidence of limited access to primary care, instead that people with preventable hospitalisations tended to have higher levels of engagement with all components of the healthcare system.

IMPLICATIONS
Preventable hospitalisations might be better used as a tool for identifying sicker patients for managed care programs, or a measure of the availability of community-based options for chronic and complex care and end-of-life care, rather than as an indicator of access to primary care.

Using Aggregate Targets of Emergency Department Timeliness: Impact on Performance Monitoring

Lilian Daly, Jean-Frédéric Lévesque, Jill Kaldor, Carolyn Frederickks, Jason Boyd
Bureau of Health Information

OBJECTIVES
Emergency department (ED) targets are widely used to assess performance. These targets seldom assess performance for specific cohorts. The aim of this presentation is to assess the sensitivity of aggregate measures in capturing variation in performance and improvement over time.

METHODS
BHI analysed data from over three million ED presentations to NSW public hospitals for the January to March period over the past five years (2010 to 2015). Data drawn from the NSW Emergency Department Data Collection were used to compare hospital performance for the percentage of patients leaving ED within four hours at the aggregate level, and stratified by modes of separation across hospital peer groups and time.

LESSONS LEARNED
Improvement achieved at a state level over the past five years in the percentage of patients leaving ED within four hours is unevenly distributed across NSW hospitals and patient groups. Most of the improvement was observed across the larger A1 and B hospital peer groups, which gained 17 and 12 percentage point increases in performance against this measure. Overall, patients treated and admitted to hospital had a larger increase in the percentage leaving within four hours than those treated and discharged (21 versus 10 percentage point increase for patients treated and discharged). Change from ED hospital cohort also affects performance results over time.

IMPLICATIONS
Using aggregate measures of ED timeliness without stratifying for peer group or discharge type does not sufficiently capture performance variation. Setting targets for specific patient groups is required to address the complexity of ED care.

Using Medical Informatics to Translate Evidence into Bedside Quality Improvements

Kristina Weeks, Laura Vail
Johns Hopkins University

OBJECTIVES
Despite the many advances of modern healthcare, researchers struggle to convert clinical evidence into widespread practice, and many quality improvement (QI) projects fail to deliver intended benefits. This work describes how two frameworks, Informatics Stacks (IS) and Translating Research into Practice (TRiPS), combine to inform large-scale QI projects across more than 300 hospitals in the US to reduce surgical site infections (SSI), ventilator associated events (VAE), and empower bedside clinicians to monitor and improve clinical performance.

METHODS
This study describes the conceptual frameworks of IS and TRiPS used to build an electronic platform which provides evidence-based content and accessible data outputs to bedside clinicians. The IS instructs the design and development of information technology instruments (electronic platforms), which integrates scientific evidence and user input, context, and workflows. The TRiPS model draws from implementation science to distill rigorous evidence into formats that engage and educate clinicians and guides the execution and evaluation of QI programs.

LESSONS LEARNED
Medical informatics offers promise for providing strategies to capture, store, and retrieve information and knowledge to healthcare practitioners trying to provide safe, evidence-based care. The combined use of these proven conceptual frameworks to create electronic platforms can facilitate knowledge translation and desired changes in provider behaviors. Ultimately, providers can more readily access content and their data in the prevention of infections with less lag time.

IMPLICATIONS
This study partners these two proven frameworks from medical informatics and implementation science to illustrate how to create clinically relevant platforms to deliver scalable, scientifically sound QI interventions.
LESSONS LEARNED

While both countries face issues with regards to access to PHC, the specific dimensions of access where inequity is present varies. Australia performs better overall with regards to access, but affordability remains an issue compared to Canada. In contrast, Canada faces challenges related to appropriateness of PHC. In both countries, advancing age is associated with better access across most dimensions, while people living with mental health problems, especially when compounded by physical co-morbidity, confront higher barriers to access. The impact of low socioeconomic status is present across many dimensions of access in Canada but is limited to affordability in Australia.

IMPLICATIONS

Understanding the specific characteristics associated to barriers to PHC and the dimensions of access where disparities are present can guide policy. Barriers to access to PHC in Australia and Canada reveal remaining disparities in these two universal systems.

Comparing Australia-Canada System Performance on Access and Equity: A Canadian Commentary

Jeanne Haggerty1, Grant Russell2, Jean-Frédéric Lévesque3, Cathie Scott4, Erin Strumpf1, Mylaine Breton5, Sarah Descôteaux6, Lisa Corscadden3, Virginia Lewis7, Nicolas Senn8, Riki Lane2, IMPACT Team

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OBJECTIVES

Canada and Australia have many similarities. Both are members of the Commonwealth, have federal democratic political systems and health care principally funded by the public purse. Each has struggled to provide accessible, equitable primary health care, especially to vulnerable individuals. This symposium will highlight recent evidence that provides insight into the Australian-Canadian differences in cost-related access, timeliness and equity.

METHODS

A brief history of the establishment of the universal healthcare system in Canada reveals that the publicly-funded universal system is limited to principally to medical services provided in hospitals and by physicians. Results from a wide variety of studies shed further light on the issues of access and equity. The Commonwealth Fund surveys suggest that recent reforms may have begun to yield better performance.

LESSONS LEARNED

The areas of healthcare that publicly funded explain some of the differences in the performance of cost-related access and timeliness of care between Australia and Canada. The Canadian system functions as designed, and is also experiencing some of the unanticipated effects of compromises that were made with organized medicine to establish a universal health system. Additional factors such as physician supply and the epidemiologic transition explain the observed differences in performance.

IMPLICATIONS

Canada system design leads to good cost-related access for medically necessary services, but improvement is needed for comprehensive care. Canada has much to learn from Australia about timeliness of care. Both countries need to remain vigilant to inequities for vulnerable populations.

Comparing Australia-Canada System Performance on Access and Equity: Learning Across Systems

Jeanne Haggerty1, Grant Russell2, Simone Dahrrough3, Sarah Descôteaux4, M.F. Harris5, Jennifer Hester6, Jean-Frédéric Lévesque6, Virginia Lewis7, Cathie Scott8, Nigel Stocks9, IMPACT Team

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OBJECTIVES

The Commonwealth Fund has conducted international health system surveys in 11 countries since 1998. This 90-minute symposium will compare Australian and Canadian performance with respect to
cost-related access and timeliness, with a focus on equity for vulnerable populations. The goal of the session is to provide insight on how the health system structure accounts for the observed performance and to suggest avenues in the system that can improve access, especially for vulnerable populations.

METHODS
The symposium consists of three presentations, with time for questions and discussion. The first speaker (Jean-Frédéric Lévesque) presents the comparative performance based on Commonwealth Fund International Health Policy Survey 2013 and 2014, including a detailed secondary analysis of differences by vulnerable groups. The second speaker (Grant Russell) provides more Australian detail, including results emerging from access needs analyses in New South Wales, Melbourne and Adelaide in the context of a research program to implement organizational innovations to improve primary health care access for vulnerable populations. The third speaker (Jeannie Haggerty) describes briefly the Canadian health system, with independent findings that corroborate and explain the results.

LESSONS LEARNED
Australia ranks 6/11 and Canada 11/11 on timeliness of care, but for cost related access Australia 9/11 and Canada 5/11. Independent studies provide some nuance to these results but mostly corroborate the findings. Changes over time are observed in response to reforms to improve access to care in each country.

IMPLICATIONS
The comparative performance is conditioned by the design and history of the respective health care systems, but improvements are possible and each country can learn from the other to better address the needs of vulnerable populations.

An Exploration of the Framing of Rheumatic Fever for Māori in Aotearoa, New Zealand

Hannah Burgess, Anneka Anderson, Elana Curtis
Te Kupenga Hauora Māori, University of Auckland

OBJECTIVES
This research aimed to gather a comprehensive understanding of how rheumatic fever for Māori is currently understood and framed in Aotearoa (New Zealand). A further objective was to establish how the framing of attributed causes, prevention and management of rheumatic fever drives current health policies and practice.

METHODS
This research applied a Kaupapa Māori research methodology. The study undertook a critical literature review of peer reviewed journal articles, grey literature and health policy documents that describe the causes, prevention and management of rheumatic fever in Aotearoa. The articles were identified through seven electronic databases and additional search engines using the search terms “rheumatic fever, Māori, indigenous, prevention, treatment, healthcare, intervention”.

LESSONS LEARNED
Current framings of rheumatic fever in Aotearoa take a surface level (or proximate), victim-blaming approach to rheumatic fever, ignoring structural drivers of inequities such as racism, privilege and colonisation. Current framing also fails to take into account indigenous experiences and world views. The proximal framing of rheumatic fever has influenced treatment and prevention policies and practices by narrowing their focus to factors that cannot address the root causes of the disease and therefore maintain current inequities of rheumatic fever.

IMPLICATIONS
In order to address indigenous health inequities, there needs to be a shift in framing to focus on key structural causes of health inequities that takes into account indigenous experiences and world views. This shift can lead to health system innovations that support more appropriate and relevant interventions for Māori residing in New Zealand.

Objectives
The study applied a qualitative kaupapa Māori research design that included participant observations, whānau interviews and individual, semi-structured interviews with 10 whānau (36 participants) who resided in Northland at the time of the research.

LESSONS LEARNED
AFR impacted on financial status, employment and education of whānau resulting in whānau experiencing significant emotional, social and economic stressors. Pathways to reducing these stressors included the presence of whānau support, good rapport, communication and continuity of care with healthcare professionals. Within the primary care setting, inadequate throat swabbing and/or antibiotic prescribing in conjunction with experiences of health service-related discrimination were barriers to improving AFR outcomes for whānau.

IMPLICATIONS
We suggest that health services need to employ an integrated support service for AFR prevention and care that promotes youth and whanau centered approaches. We recommend implementation and regular evaluation of cultural safety training and greater emphasis on whakawhanaugatanga/rapport building between health practitioners and clients across the health sector. Finally, we recommend a review of sore throat management and utilisation of sore throat guidelines within Northland's primary health care services.

Improving Access to Antenatal Care for Aboriginal Women in South Australia: Findings from the Aboriginal Families Study

Stephanie Brown, Donna Weetra, AFS Collaborative Group
Healthy Mothers Healthy Families Research Group, Murdoch Childrens Research Institute; Aboriginal Families Study

OBJECTIVES
To investigate the views and experiences of Aboriginal women having a baby in South Australia, and compare the experiences of women attending Aboriginal Family Birthing Program services with those of women attending standard public models of antenatal care.

METHODS
Population-based study of 344 women giving birth to an Aboriginal baby in South Australia between July 2011–June 2013 conducted in partnership with the Aboriginal Health Council of South Australia. Women living in metropolitan, regional and remote communities in South Australia completed a structured questionnaire with an Aboriginal research interviewer when their baby was 4–12 months old.

LESSONS LEARNED
79% of mothers accessed antenatal care in the first trimester of pregnancy, and 90% attended a minimum of 5 or more visits. Compared to women attending mainstream regional services for pregnancy care, women attending the Aboriginal Family Birthing Program (AFBP) services were more likely to access antenatal care in the first trimester (Adj OR 2.5, 1.0–6.3) and markedly more likely to attend a minimum of 5 visits (Adj OR 4.3, 1.2–15.1). Women attending metropolitan AFBP services were also more likely to attend a minimum of 5 visits (Adj OR 12.2, 1.6–80.8).

IMPLICATIONS
Scaling up of culturally responsive Aboriginal Family Birthing Program services in urban and regional areas of South Australia is changing the way that Aboriginal families engage with antenatal care. This is likely to translate into better outcomes for Aboriginal families over time.
This paper shows that programs that include components which support
the expression of cultural identity. Articles published in English up until
December 2013 were included. The cultural intervention component
of the included studies was assessed by the Indigenous researchers on
the team.

LESSONS LEARNED
Thirteen papers describing 12 studies were identified. The studies
included one randomized control trial (RCT), one cluster RCT and two
studies with non-randomised controls. Other papers that were also
included reported on case series or a series of cross-sectional studies.
Outcomes associated with interventions enabling the expression of
cultural identity reported include diet (n=3), physical activity (n=4),
birthing (n = 2) and emotional wellbeing (n = 3). A diverse range
of strategies were utilized to support Indigenous people to express
cultural identity. It is impossible to be certain of the effects of
the cultural components as all the interventions except one involved
multiple components, usually including conventional medical or health
promotion interventions. Nonetheless, all excluding one of the
interventions reviewed were associated with significant improvements
(either statistically or for the community concerned) in health or wellbeing
measures.

IMPLICATIONS
This paper shows that programs that include components which support
people to express cultural identity can be associated with positive health
and wellbeing outcomes.

Evaluating Primary Healthcare: Including the Voices of
Aboriginal and Torres Strait Islander Peoples

Tirjema Ahmat1,2, Gary Brahim3,2, Alex Brown4,2, Carol Davy4,2, Anna Dowling4,2, Shaun Jacobson5,2, Tanja Kelly5,2, Kaylene
Kemp6,2, Elaine Kite4,2, Fiona Mitchell4,2, Tina Newman7,2, Margaret
O’Brien8,2, Jason Pitt8,2, Bernadette Rickards8,2, Kesha Roesch9,2, Christine Saddler10,2, Leda Sivak4,2, Maida Stewart9,2, Tiana
Thomases1,2

1Wuchopperen Health Service; 2Wellbeing Study Team (authors
shown in alphabetical order); 3Wirraka Maya Health Service
Aboriginal Corporation; 4Wardliparinga Aboriginal Research Unit,
South Australian Health and Medical Research Institute; 5Nunkuwarrin
Yunti Inc; 6Maari Ma Health Aboriginal Corporation; 7Tharawal Aboriginal
Corporation; 8Danila Dilba Medical Service; 9Baker IDI Heart & Diabetes
Institute; 10Winnunga Nimmitjah Aboriginal Health Service

OBJECTIVES
Evaluating the quality of primary healthcare is useful for a number of
reasons including identifying practices which may need to be improved
in order to increase acceptability. Yet important elements found to increase
acceptability of services for Aboriginal and Torres Strait Islander people,
such as cultural safety and strong relationships between healthcare
practitioners and patients, are notoriously difficult to measure.

METHODS
A team of researchers, including thirteen experienced Aboriginal
healthcare professionals, came together to develop a Wellbeing
Framework which identifies values and principles that are important
for improving the acceptability of services as well as quality of care
and health outcomes for Aboriginal and Torres Strait Islander peoples
living with chronic conditions. Using a participatory action approach,
this study actively engaged people with local knowledge to ensure that
the Framework was developed by and for Aboriginal people.

LESSONS LEARNED
While traditional evaluations are often imposed by professionals who are
concerned with measuring standards and performance, the Wellbeing
Framework outlines core values, elements and principles as defined
by Aboriginal and Torres Strait Islander peoples. Importantly, the
Framework also includes practical examples of how the principles could
be applied in cases where improvement is warranted.

IMPLICATIONS
Current health service thinking highlights the need to recognise the
importance of clients and professional stakeholders. Utilising the
Wellbeing Framework to measure the extent to which services are
incorporating the type of values and principles that are considered by
Aboriginal and Torres Strait Islander peoples to be important will ensure
that both voices are heard.

Balancing International Experiences and Local
Contexts in Indigenous Health (Highly commended
abstract by an ECR)

Angeline S. Ferdinand
Centre for Health Policy, School of Population and Global Health,
University of Melbourne

OBJECTIVES
Indigenous community-controlled health services have been developed
in the Americas, Australia and New Zealand to increase health care
coverage, accessibility and appropriateness for Indigenous communities.
However, despite being founded on similar principles, these systems
manifest in unique ways, being influenced by local, national and political
contexts. The current research aims to understand opportunities
and constraints for Australian hospitals in drawing lessons from the
Latin American experience in order to improve the provision of
culturally appropriate and safe hospital-based health care to Indigenous
Australians.

METHODS
The research combines case studies of Indigenous
community-controlled hospital-based services in Latin America
and interviews with Australian practitioners and policymakers. The case
studies aim to understand the influence of community control on wider
hospital practices while the interviews serve to guide analysis regarding
the suitability of strategies employed in these models for adoption within
Australia.

LESSONS LEARNED
In recent decades, there has been an increasing push towards
comparative health services research. Given contextual similarities in
Indigenous health, there is scope to learn from what has and has not
worked well in other countries. However, Indigenous health practice also
needs to be based in local context. There is therefore a need to balance
examples provided from overseas with local knowledge and experience.

IMPLICATIONS
Ensuring that lessons learned from overseas are balanced with practical
considerations for local implementation necessitates strong ties between
research and practice in the area of comparative Indigenous health
research, with the views of practitioners and policy makers playing a
central role.

2D Economics
14:00 – 15:30 Monday 7 December 2015, Room 103

How Good is it Really? An Evaluation of New
Zealand’s Population-Based Funding Formula

Erin Penno1, Robin Gauld1, Paul Hansen2, Andrew Gray3

1Centre for Health Systems, Department of Preventive and Social
Medicine, Dunedin School of Medicine, University of Otago; 2Department
of Economics, University of Otago; 3Department
of Preventive and Social Medicine, Dunedin School of Medicine, University
of Otago

OBJECTIVES
To evaluate the ability of New Zealand’s population-based funding
formula (PBFF), which is used to distribute funding between District
Health Boards (DHBs), and alternative models, which incorporate richer
demographic and clinical data, to explain current expenditure and
to predict expenditure into the future.
IMPLICATIONS
Interpreting these results is challenging due to potential circularity of funding and expenditure at the DHB level. However, results at an individual level suggest incorporating clinical data in funding models may offer a more equitable method of allocating scarce resources between DHBs.

LESSONS LEARNED
Preliminary modelling indicates that demographics-based models, including the model approximating the PBFF, perform poorly at an individual level, explaining less than 5% of variation in future expenditure. Richer demographic data appear to offer minimal improvement while incorporating clinical information substantially improves predictive power. At a DHB level, the predictive power of all models is significantly higher, as expected. However, models which incorporate clinical data appear to offer little improvement in predictive power at the DHB level over existing demographics-based models.

LESSONS LEARNED
The use of contract negotiations between the state and elected national representatives of general practice to design a pay for performance scheme was key to achieving greater scope, speed of implementation and improved health outcomes in England than in New Zealand. Policymakers were able to engage with general practitioners and to access practice data more effectively in England than in New Zealand. This, together with other features such as the amount of income dependent on performance, drove greater uptake of the scheme by general practitioners and better outcomes for patients in England.

IMPLICATIONS
Effective engagement between health funders and general practitioners to jointly design pay for performance schemes can assist primary health care services to achieve improved population health outcomes.

Casemix Based Peer Clustering
Michael Hart, Shima Ghassem Pour, Federico Girosi
University of Western Sydney & Capital Markets CRC

OBJECTIVES
We consider the problem of clustering hospitals based on their case-mix distributions. Hospitals belong to the same cluster if they offer the same mix of services and have similar demand for those services. The cluster labels can be used to control for case-mix in hospital level analyses.

METHODS
We obtained distributions of the 770 AR-DRGv7.0 for 148 de-identified private and public hospitals. The distance between two hospitals was defined as the mean square error between the two corresponding DRG distributions. The clustering algorithm of choice was Partitioning Around Medoids (PAM). The optimal number of clusters was found by minimizing the Dunn validation index subject to the constraint that no cluster contains less than 3 hospitals, in order to avoid creating clusters of isolated outliers.

LESSONS LEARNED
The algorithm found 7 clusters, that is 7 groups of hospitals, with similar case-mix. Some clusters were easily interpretable and were defined by being dominated by a narrow set of DRGs (psychiatric, neonatal, rehabilitation). Other clusters corresponded to hospitals that offered a broad set of services, but that differed significantly on the frequency of relatively few groups of DRGs. The 7 groups explained approximately 80% of the variance of length of stay across hospitals.

IMPLICATIONS
Clustering hospital DRG distributions produces highly stable hospital level variables that are driven purely by case-mix, easy to compute and with good predicting power. This offers an alternative to measures, such as the AIHW peer groups, which are based on a variety of variables in addition to case-mix.

Improving Population-Based Health Through Pay for Performance
Verna Smith1, Jacqueline Cumming2
1Institute of Safety Compensation & Recovery Research, Monash University; 2Victoria University of Wellington

OBJECTIVES
Health funders use pay for performance schemes to increase their influence over the quality of health care and achieve improved population-based health outcomes. Understanding the factors that affect the process of design, scope, speed of implementation and outcomes of these schemes will assist health funders to design more effective schemes.

METHODS
In a most similar systems comparative case study design, two pay for performance schemes implemented between 2001–7 in the general practice sub systems of England’s and New Zealand’s health system were studied. Qualitative methods involving interviews with proximate policymakers, documentary analysis and literature review were utilised. A comparative framework for policymaking analysis, adapting John Kingdon’s Multiple Streams Framework, was applied to establish drivers for scheme differences in process, scope and speed of implementation.

LESSONS LEARNED
We considered the problem of clustering hospitals based on their case-mix distributions. Hospitals belong to the same cluster if they offer the same mix of services and have similar demand for those services. The cluster labels can be used to control for case-mix in hospital level analyses.

METHODS
An incidence-based cost of illness model was developed using data from the Brain Injury Outcomes New Zealand in the Community (BIONIC) study. Details of TBI-related resource use during the first 12 months after injury were obtained for 725 cases using resource utilisation information from participant surveys and medical records. Total costs are presented in NZ dollars year 2010 value.

METHODS
Routine case collection from 2005/6 to 2009/10 were merged with population estimates derived from Census data to obtain an estimated population of both users and non-users of health services with associated costs. Regression analyses were used to evaluate demographics- and clinical data-based models in terms of their ability to predict both concurrent and prospective health care expenditure for both individuals and DHBs. A variety of model performance measures including R2 and mean absolute prediction error were used.

LESSONS LEARNED
Preliminary modelling indicates that demographics-based models, including the model approximating the PBFF, perform poorly at an individual level, explaining less than 5% of variation in future expenditure. Richer demographic data appear to offer minimal improvement while incorporating clinical information substantially improves predictive power. At a DHB level, the predictive power of all models is significantly higher, as expected. However, models which incorporate clinical data appear to offer little improvement in predictive power at the DHB level over existing demographics-based models.

IMPLICATIONS
Clustering hospital DRG distributions produces highly stable hospital level variables that are driven purely by case-mix, easy to compute and with good predicting power. This offers an alternative to measures, such as the AIHW peer groups, which are based on a variety of variables in addition to case-mix.

LESSONS LEARNED
The results suggest that there is an urgent need to develop effective interventions to prevent both mild and moderate severe TBI.

METHODS
Routine case collection from 2005/6 to 2009/10 were merged with population estimates derived from Census data to obtain an estimated population of both users and non-users of health services with associated costs. Regression analyses were used to evaluate demographics- and clinical data-based models in terms of their ability to predict both concurrent and prospective health care expenditure for both individuals and DHBs. A variety of model performance measures including R2 and mean absolute prediction error were used.

LESSONS LEARNED
Preliminary modelling indicates that demographics-based models, including the model approximating the PBFF, perform poorly at an individual level, explaining less than 5% of variation in future expenditure. Richer demographic data appear to offer minimal improvement while incorporating clinical information substantially improves predictive power. At a DHB level, the predictive power of all models is significantly higher, as expected. However, models which incorporate clinical data appear to offer little improvement in predictive power at the DHB level over existing demographics-based models.

IMPLICATIONS
Clustering hospital DRG distributions produces highly stable hospital level variables that are driven purely by case-mix, easy to compute and with good predicting power. This offers an alternative to measures, such as the AIHW peer groups, which are based on a variety of variables in addition to case-mix.
OBJECTIVES
Best-practice pricing describes an approach to purchasing healthcare services for a specific procedure or intervention at a price that reflects best-practice care. This project aimed to augment the current national activity-based funding pricing approach based on the average cost of care by adding a safety and quality aspect to pricing. In addition, the project examined the utility of providing timely and relevant data to clinicians alongside pricing incentives.

With advice from clinicians and consumers, three national agencies have identified a target cohort and designed a model for pricing best-practice hip-fracture care in Australian public hospital services.

METHODS
Domestic and international consultations, review of literature and analyses of national data.

LESSONS LEARNED
Local and international examples may inform a national approach. Two states have implemented a pricing scheme; however, outcomes are not available. Internationally, the English hip fracture best practice tariff has resulted in a reduction in hip fracture mortality. Clearly defining best-practice care, eligibility and availability of clinical information were essential to achieving these outcomes.

An Australian approach should target a condition with clearly defined best-practice care that is high volume and cost in order to test the feasibility of introducing national best-practice pricing. It is also important to assemble clinical experts and consumers to inform the model development and implementation.

IMPLICATIONS
Sufficient lead time is required for stakeholders to prepare for implementation and for administrators to support the collection of reliable information on the quality of care delivered to enable benchmarking and to determine eligibility for funding.

LESSONS LEARNED
Two percent of all ambulance transfers were taken to an A&M facility (2,967 patients) with the majority being successfully managed in primary care settings (88%). Transfer rates to A&Ms plateaued over this time. While overall stakeholders viewed SJTI as being successful, the majority agreed it had not reached its potential. Factors influencing performance included lack of additional funding for the initiative; lack of awareness about the initiative; A&M and St John capacity and capability; concerns about patient safety; confidence of ambulance staff; and patient choice.

IMPLICATIONS
Given appropriate funding and support there is significant potential for the ambulance service to help integrate primary and secondary care ensuring patients get the right care at the right time in the right place in the health system.

Hospital Nurse Attraction and Retention: A Review of Hospital Workplace Design Characteristics (Highly commended abstract overall)

Lucio Naccarella
University of Melbourne

OBJECTIVES
Hospital nursing staff attraction and retention are significant issues, particularly as a nursing workforce shortage exists. This paper reviews literature on workplace design which may contribute to improve nursing staff attraction and retention. The research is funded by a Commonwealth Department of Industry Research Connections grant to HASELL (architectural design firm) to work in partnership with the University of Melbourne.

METHODS
A literature search was undertaken in March 2015 of databases: Web of Science; SCOPUS; MEDLINE; CINAHLPlus; ProQuest Central. Key words: “nurs* AND "hospital environments" were supplemented by: “hospital facility design”, "recruitment"; "attraction"; and "retention". Reference lists and key journals were scanned. A realist literature review approach was used to identify a Context-Mechanism-Outcomes (CMO) configuration to explain how hospital workplace design can improve nursing attraction, retention and performance.

LESSONS LEARNED
From one-hundred sixty articles retrieved, twenty-two were reviewed.
Hospital workplace design characteristics that can improve nursing staff attraction and retention included: peer line of sight, patient visibility; walking distances; storage space; outdoor spaces; temperature, lighting, air quality, acoustics; and work processes/technology. A list of CMO configurations were generated to explain the role hospital workplace design in improving nursing staff attraction and retention.

**IMPLICATIONS**

The identified hospital workplace design characteristics and CMO configurations are informing focus group discussions with hospital nursing managers and hospital ward clinical nurses, to generate practice-based evidence about good hospital workplace design principles to improve nursing staff attraction and retention. The generated evidence will inform the development of a hospital workplace design specification by HASELL.

**Beyond Bushfires: Learnings for Disaster Resilience and Recovery Services**

**OBJECTIVES**

Building understanding of recovery risk and protective factors helps to guide development and delivery of disaster support services. Beyond Bushfires is a five-year study led by University of Melbourne in partnership with academic, community, government, emergency, and health service provider partners. The study explores medium to long-term impacts of the Victorian 2009 bushfires on individuals and communities.

**METHODS**

The communities selected for this study had bushfire experiences ranging from low to high impact. The study measured mental health, wellbeing and social connections, provides insights into the interplay of individual and relationships. Age, sex and living circumstances influenced how the disaster and its aftermath were experienced. This means that interventions must be tailored to the different responses household/family members had to their bushfire experience. Close emotional ties, social networks and involvement in local community groups and organisations all contribute to recovery. These findings are being translated into decision making tools for service providers and government partners.

**LESSONS LEARNED**

An overview of disaster study results show the disaster experience had a prolonged impact on mental health and wellbeing, as did subsequent disruptions such as changed accommodation, employment, health and relationships. Age, sex and living circumstances influenced how the disaster and its aftermath were experienced. This model was initially applied to South Australia as a whole and has now been applied to Western Australia with the addition of the ability to separately model need and supply under a range of scenarios at both the urban and regional levels.

**IMPLICATIONS**

Whilst the variety of work undertaken by GP proceduralists has been associated with enhanced professional satisfaction and rural retention, newer generation GPs increasingly prefer an improved work-life balance. Longer hours of work may deter younger doctors from pursuing careers in procedural rural practice and this may jeopardise future supply of these critically important services, especially in smaller and more remote locations.

**Tailored to Suit: Adapting a Needs-Based Model to Estimate the Future GP Requirements for Western Australia**

**OBJECTIVES**

To adapt a previously developed need based approach to planning the health workforce requirements for GPs. This model was initially applied to South Australia as a whole and has now been applied to Western Australia with the addition of the ability to separately model need and supply under a range of scenarios at both the urban and regional levels.

**METHODS**

The model is based on work initially undertaken in Canada and consists of other workforce planning approaches by using need as a determinant of demand for health care services. Supply projections are based on a cohort-based transition model with prevalence and incidence data used to construct a measure of illness in the population. Other models rely on utilisation based determinants of demand which are not necessarily reflective of need but rather reflect existing patterns of provision and use of health services.

**LESSONS LEARNED**

The modelling indicated that a significant shortage of GPs was projected for WA by 2033 but with separate modelling of urban and regional locations indicating that the shortages would be located in urban WA rather than rural WA. Scenario modelling also indicated a diverse level of sensitivity to particular assumptions around population, need and workforce configuration across regional and urban locations.

**IMPLICATIONS**

Strategies and policies designed to ensure need for health services
Although Some of My Best Friends Are City Folks…
Methodological Strategies to Generate Rural/Remote Relevant Research Evidence to Support Health Service Decision-Making
Josée G. Lavoie, Sabrina Wong, Alan Katz, Amanda Ward, Wanda Phillips-Beck, Stephanie Sinclair
University of Manitoba

OBJECTIVES
Health services research has to date focused on urban research, or aggregated data geographically to counter the limitations of small sample sizes, thereby obliterating rural and remote-relevant findings. As a result, the evidence generated remains largely urban-centric. This presentation discusses the use and importance of rural and remote-centric methods in generating evidence to inform rural and remote healthcare policies and decision-making.

METHODS
We present evidence generated from two large rural and remote focused health services studies, namely the Closing the Gap study (Lavoie, PI, Ward, Co-Pi; British Columbia First Nations) and the Innovation in community based primary healthcare supporting transformation in the health of First Nations and rural/remote Manitoba communities (Katz, PI, Lavoie Co-Pi; rural and remote Manitoba communities). Both studies used hospitalization for ambulatory care sensitive conditions to identify trends in primary healthcare needs in rural and remote communities. We used GEE modeling to identify communities with similar characteristics, aggregated data across time, and used 5 year rolling samples to attenuate the impact of small sample size.

LESSONS LEARNED
Our methodological innovations allowed for the generation of community and policy relevant findings that can be used to transform rural and remote primary healthcare settings, and signal areas where investments might yield the most benefits.

IMPLICATIONS
Rural and remote health service research is a worthwhile field of inquiry, especially in Canada and Australia. Dependence on urban-centric evidence is likely to yield underperforming solutions in these settings, and potentially result in higher than necessary healthcare costs.

Targeting Outreach: The Influence of Australia’s Rural Outreach Policy
Belinda O’Sullivan1,2, Johannes U. Stoelwinder3, Matthew McGrail1,2
1School of Rural Health, Monash University; 2Centre for Research Excellence in Medical Workforce Dynamics, University of Melbourne and Monash University; 3Department of Epidemiology and Preventive Medicine, Monash University

OBJECTIVES
To explore whether structured rural outreach policy, by comprehensively subsidising specialist doctors for costs of outreach-related travel according to priority areas of care, influences the distribution of targeted services into more remote locations.

METHODS
We used cross-sectional data for 575 specialist doctors travelling to provide a rural outreach service in 2014, through the Medicine in Australia: Balancing Employment and Life (MABEL) survey. The primary outcome was specialists receiving subsidies for their main outreach service from the Rural Health Outreach Fund (RHOF), via another source, or neither. Multinomial regression models were used. Covariates included: time travelled (<1, 1 to 3 or 4+ hours); location (inner regional versus outer regional/remote); outreach service regularity (<monthly or monthly+); and intention to continue for 5+ years. Specialists targeted under the RHOF policy included general medicine, general surgery, obstetrics and gynaecology, ophthalmology, otolaryngology, paediatrics and psychiatry.

LESSONS LEARNED
Around half of all specialists received some subsidies; 19% (n=110) from the RHOF and 27% (n=154) through another source. Subsidies of any type were related to specialists travelling for longer and visiting more outer regional/remote locations, compared with non-subsidised specialists. The RHOF also supported targeted specialists, who maintained service regularity, and reported similar intention to continue.

IMPLICATIONS
Subsidies of any type are likely to play an important role in promoting longer travel and services in more remote locations, relative to allowing specialists to fund themselves. However, a structured policy with comprehensive subsidies plays an additional role of targeting specialists working in priority areas, providing regular, ongoing services.

“Yeah, Why Not?” — Evaluating the Acceptability of Chlamydia Testing in General Practice to Young People Living in Rural Australia
A. Vaisey 1, Anna Yeung2, Amie Bingham 1, Meredith Temple-Smith3, Rebecca Guy4, A. Wood 1, E. Smyth1, Rebecca Lorch4, M. King 1, B. Ford4, Jane Hocking 1
1Melbourne School of Population and Global Health, University of Melbourne; 2School of Public Health and Community Medicine, University of New South Wales; 3Department of General Practice, University of Melbourne; 4Kirby Institute, University of New South Wales

OBJECTIVES
Annual chlamydia testing is recommended for women and men aged 16–29 years, but questions remain about rural young people’s willingness to be tested in their local area. We investigated the acceptability of chlamydia testing in general practice for young adults living in rural Australia.

METHODS
Quantitative and qualitative data were collected as part of the Australian Chlamydia Control Effectiveness Pilot (ACCEPt). Patients aged 16–29 attending 150 participating clinics were asked to complete a questionnaire and provide a specimen for chlamydia testing (4284 participants; response rate = 70%), and semi-structured interviews were conducted with 21 patients.

LESSONS LEARNED
Over 80% of participants were consulting a local general practitioner (GP) and over 80% were attending for a non-sexual health reason. Most respondents (86%; 80% males versus 88% females, p <.01) were willing to have another chlamydia test in 12 months and 91% (86% males versus 93% females, p<.01) found reminders to have another test in 12 months acceptable. Interview participants favoured being offered the test as an opportunity rather than a mandate, and supported being offered the test in a non-sexual health consultation. Perceived cost of the test was seen as a potential barrier.

IMPLICATIONS
Young people in rural areas will agree to a chlamydia test if offered by their local GP, even if they are attending for a non-sexual health reason. Interventions need to support GPs to offer testing in non-sexual health consultations and ensure young patients know they are eligible for routine testing.
the Urgent After-Hours Primary Health Care: Survey of General Practice. The survey was undertaken between 7 May 2015 and 5 June 2015 and consisted of a series of questions comprised of 5-point Likert items and open text responses.

LESSONS LEARNED
Telephone triage was considered to have a role in supporting work-life balance; ensuring sustainable after-hours care; and reducing burden of after-hours care in general practice, including in metropolitan areas. Satisfaction with after-hours telephone triage in Tasmania decreased after the introduction of Healthdirect Australia as the ‘gatekeeper’ on 1 July 2013. Dissatisfaction was particularly noted among General Practice Principals, not one of whom who specified a preference for the post-July 2013 service. The cause for some of this dissatisfaction can be attributed to concerns pertaining to accessibility, supportiveness and appropriate referral back to practice doctors.

IMPLICATIONS
The GP Assist service is considered of value in the Tasmanian context; arguably a proxy for rural Australia. Consequent to the Jackson Review funding for the national general practitioner based triage service After-Hours GP Helpline was ceased in the 2015 Federal Budget. Our results indicate that this decision may have unfair implications for rural Australia.

Prolonged ED Access Block Impacts on Patient Outcomes in a Large Regional Hospital
Phoebe Griffin1,2, Jim Stankovich1, Kerry Leonard2, Helena Nicholson2, Leigh Kinsman2,3, Kerryn Butler-Henderson4, Greg Peterson1, Duncan Cooke2, Alasdair MacDonald2
1Health Services Innovation Tasmania, Faculty of Health, University of Tasmania; 2Launceston General Hospital; 3School of Health Sciences, University of Tasmania; 4Tasmanian School of Business and Economics, University of Tasmania

OBJECTIVES
Studies in large Australian metropolitan hospitals have demonstrated that medical patients experiencing access block (staying more than 8 hours in ED) have longer lengths of stay (LOS) in hospital as inpatients. We sought to replicate this association in a large regional hospital where: the complexity and acuity of presentations is high relative to the size of the hospital; ambulance bypass is not possible; and a large number of patients experience prolonged ED access block (>24 hours in ED).

METHODS
We performed a retrospective data analysis of all (9449) medical patient admissions via the emergency department between October 2012 and September 2014. Multivariate linear regression was used to model log(LOS) as a function of access block, with adjustment for factors including age, sex, diagnosis related group (DRG), and presence/absence of Charlson comorbidities.

LESSONS LEARNED
Compared to patients spending less than 8 hours in ED, moderate access block (time in ED between 8 and 24 hours) was associated with a modest 5.0% increase of adjusted LOS as an inpatient (p=0.02; 95% confidence interval 0.9%–8.2%). However, adjusted LOS was 48% longer for the 32% of patients who experienced prolonged access block of more than 24 hours (p<10^-6; 95% CI 42%–55%).

IMPLICATIONS
Despite concerted efforts to improve patient flow, increasing demand and finite resourcing suggest that a small cohort of patients are likely to continue to experience prolonged access block. Strategies should therefore be developed to mitigate the impact of access block on patient outcomes.

The Importance of Rural Vocational Training to Rural Medical Workforce Supply
Matthew McGrail1,2, Deborah Russell1,2,3
1Monash University; 2Centre for Research Excellence in Medical Workforce Dynamics; 3Centre of Research Excellence in Rural and Remote Primary Health Care

OBJECTIVES
To investigate the association between vocational training location and early-career practice location of Australian doctors, mediated by rural origin.

METHODS
Data are drawn from Waves 1–7 (2008–2014) of the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal panel study. Included respondents are those who both complete their vocational training within the MABEL study and are observed in at least one post-vocational training practice location. Respondents are separated by whether they are general practitioners (GPs) or other specialists, whether they have a childhood rural origin, and by the length of observation (1–5 years) practising post their vocational training.

LESSONS LEARNED
There are very strong associations between completing training in a rural location and early-career rural practice. Two years post training 71% of GPs and 76% of specialists who trained rurally were also practising in a rural location, with 54% of GPs in the same location. In contrast, 11% and 10% of urban-trained GPs and specialists were practising rurally. Moreover, sustained rural practice (4–5 years) is more likely for rurally-trained rural-origin doctors (GPs 85% and specialists 100%), compared to rurally-trained but urban-origin doctors (GPs 55% and specialists 73%).

IMPLICATIONS
This study provides evidence of the combined positive effect of rural vocational training and practitioner rural-origin on rural medical workforce supply. These results suggest continuation of Australia’s policy that at least 50% of GP vocational training positions are located rurally; moreover, specialist training colleges should strive to provide increased opportunities for specialists to undertake training in rural locations.

2G Use of Evidence
14:00 – 15:30 Monday 7 December 2015, Room 108
How Can Policy Makers Best Prepare for an Evaluation and Engage with Evaluation Researchers?
Carmen Huckel Schneider1,2, Andrew Milt1,2, Gabriel Moore1,2
1Sax Institute, Sydney; 2University of Sydney; 3New South Wales Ministry of Health

OBJECTIVES
Policy makers face barriers at various points of the evaluation process; but particularly at the stages of preparing to commission evaluations and establishing relationships with evaluation researchers. We sought to identify conditions for, and characteristics of, good preparation for an evaluation.

METHODS
We analysed data from a series of 17 interviews with senior policy makers (n=9) and evaluation researchers (n=8) in which policymakers were asked to reflect on their experiences of evaluation in their agencies, and evaluation researchers were asked about their experiences of evaluating health policies and programs for government agencies. Interview transcripts were coded using NVivo and thematically analysed to identify common themes.

LESSONS LEARNED
Four overarching themes of good evaluation preparation emerged relating to 1) funding, 2) time management, 3) role and responsibilities and 4) developing an evaluation brief. Key aspects of a good evaluation brief included clarity of scope, deliverables and research questions; each requiring an understanding of evaluation methodologies and implementation. The value of external advisors in formulating the brief was also raised. Eight models for engagement with evaluation researchers were identified, ranging from competitive tender processes to long-term agency funded centres and researcher-initiated partnerships. Barriers to sustaining good relationships included separation between evaluation researchers and program sites, staff turnover at policy agencies, and resistance to negative evaluation outcomes.

IMPLICATIONS
As evaluation of policies and programs becomes increasingly expected and mandated in Australia, policy makers may benefit from mentoring, training, tools and access to external advisors to prepare for quality evaluation and facilitate strong relationships with evaluation researchers.
Validity of Routinely Collected Data in Reporting Falls in Hospital in Western Sydney Local Health District
Lieu Thi Thuy Trinh, Helen M. Achat, Hassan Assareh
Epidemiology, Executive Medical Services, Western Sydney Local Health District

OBJECTIVES
To examine the validity of the two routinely collected datasets, the Incident Information Management System (IIMS) and the Health Information Exchange (HIE) in reporting falls in hospital.

METHODS
IIMS records that contained words indicating a fall (e.g. “fall”, “fell”, “slip”, or “trip”) were examined to determine falls. Records that contained words suggesting places outside of hospital (e.g. “home”, “house”, “address”) were examined to exclude falls outside of hospital.

Falls in hospital in HIE data were determined using ICD-10-AM codes W00-W19 and “condition_onset_flag”=1 (in hospital). If “condition_onset_flag”=9 (not recorded), ICD-10-AM code for place of occurrence of Y92.22 (Health service area) immediately following the ICD-10-AM code for fall was used. A set of explicit criteria was applied to exclude records that pertained to new inpatient episodes as a consequence of falls that were previously reported.

IIMS and HIE data were linked using Medical Record Number. Characteristics of falls that require treatment in hospital (recorded in HIE) but were not captured by IIMS were determined using logistic regression.

LESSONS LEARNED
Between January 2010 and December 2014, 8,647 falls in hospital were recorded in IIMS. In HIE, 2,169 falls in hospital were recorded. When linked together, the number of falls in hospital recorded in both dataset was 9,338. IIMS captured 93% and HIE only captured 23% of these falls.

Of the falls recorded in HIE, 677 (31%) were not recorded in IIMS. These falls were more likely to be subsequent falls (47.1% vs. 29.7% for first fall, OR=3.17, p<0.001) and falls by female patients (34.8% vs. 28.2% for male patients, OR=1.43, p<0.001). Falls that were less likely to be recorded in HIE only were falls from Blacktown hospital (26.9% compared to 34.5% in Westmead hospital, OR=0.66, p<0.001), by patients who were older than 65 years, had length of stay longer than one week or received allied health intervention.

IMPLICATIONS
IIMS captured the vast majority of falls in hospital but failed to report one third of falls that were severe enough to require treatment in hospital. Efforts to address this issue should be focused on the identified factors.

ACKNOWLEDGEMENTS
The authors would like to thank Ms. Jowmee Kwong for assistance in extracting the HIE data and for useful explanations, Dr. Neil Hime for his comments on the draft and Dr. Yogendra Narayan for his support and advice.

The Australian Burden of Disease Study: An Important Resource for Health Service Planning and Supporting Policy
Lynelle Moon, Michelle Gourley, Miriam Lum
Australian Institute of Health and Welfare

OBJECTIVES
The current Australian Burden of Disease Study is updating burden of disease estimates for Australia, including indigenous and subnational estimates. A key objective of the study is to set up a system that enables efficient ongoing updates and analysis.

METHODS
We use the updated global approach to estimating Disability Adjusted Life Years, which quantifies both the fatal and non-fatal impacts of diseases and injuries, and estimates the proportion caused by various risk factors. We have adapted these methods for the Australian context, including the use of detailed Australian data such as health service and population health data.

LESSONS LEARNED
We have published estimates of the fatal burden for both the national and Indigenous populations. Analysis of the non-fatal burden and attribution to risk factors is well underway. This work has highlighted the importance of transparency to enable full application of the results, and the sensitivity of using various models and data sources.

IMPLICATIONS
While it has been a significant amount of work to update the Australian estimator, a system has been established to enable streamlined updates into the future. There are a wide range of potential uses of the full results from this study. The non-fatal burden estimates will provide detailed information that will support health service planning, particularly in responding to the increased burden associated with chronic disease. There is also significant potential for extension analyses, including scenario modelling of various policy options and relating it to disease expenditure data.

Improving Health Service Delivery Through Innovative Research Approaches
Alana Hulme Chambers 1, Arno Parolini 1,2
1School of Population Health, University of Adelaide; 2Parenting Research Centre

OBJECTIVES
Understanding wicked problems, such as improving the sexual health and wellbeing of rural young people, demand innovative approaches if progress is to be made towards improved health outcomes. This presentation will describe the use of mixed-methods research approach regarding three different sexual health service delivery models operating in regional Victoria. The presentation will discuss the value of the research approach and its contribution to identification of intangible underlying structures and processes operating within each model, and the implications of this knowledge.

METHODS
The research project, currently underway, is using a convergent parallel research design as a means of utilising different methodological approaches within a pragmatic epistemological worldview. Research methods include individual interviews, surveys, and social network analysis. The aim is to create synergies through integration of various data sources which will deepen the understanding of each sexual health service delivery model.

LESSONS LEARNED
Quantitative and qualitative research can be useful as singular methodological paradigms. However, researchers from different methodological standpoints, working together, can result in a deeper understanding of complex health service delivery issues. Increased dialogue and collaboration between researchers who have different research skill sets may illuminate new opportunities for understanding these types of issues. By building on strengths from different methodological approaches and disciplines, we intend to enable identification of structural and procedural components of health service delivery models that may not be addressed by a single-methodology approach.

IMPLICATIONS
Rigid methodological perspectives need to be revised if progress is to be made in research that assists in addressing complex health issues.

Coverage with Evidence Generation on the Medicare Benefits Schedule: Intracytoplasmic Sperm Injection as a Case Study
Clarabelle Pham 1, Ben Mol 2, Robert J. Norman 3, Jonathan Karnon 1
1School of Population Health, University of Adelaide; 2Robinson Research Institute, University of Adelaide; 3Fertility SA

OBJECTIVES
The MBS Review Taskforce aims to review services listed on the MBS to align with contemporary clinical evidence and improve education and compliance around MBS items. Intracytoplasmic sperm injection (ICSI), used during assisted reproduction, is an example of a service where effectiveness for its original indication (severe male factor infertility) has been established but its use has transferred to other indications of unknown effectiveness (mild male and unexplained infertility). Using ICSI as a case study, we critique alternative options for the implementation of coverage with evidence generation for services with limited or uncertain evidence.

METHODS
Alternative national and international decision options were identified
and applied in theory to the funding of ICSI on the MBS to consider and address implementation issues.

LESSONS LEARNED
In Australia and New Zealand, 68% (25,407) of fresh IVF cycles in 2012 used ICSI while male factor infertility was reported in only 38% (14,038). The largest increase in ICSI use was observed in couples with unexplained infertility costing Medicare an annual $6.4 million. Potential options to inform the value of ICSI across indications include linking coverage to evidence generation with only in research (where ICSI coverage is only available to patients involved in research), and only with research (a managed entry scheme where ICSI coverage is conditioned upon the collection of additional evidence).

IMPLICATIONS
Options to maintain funding whilst generating new evidence require buy-in from clinicians and patients to support robust study designs, to usefully inform decisions around the de-listing of services on the MBS.

Potential Pitfalls in Defining Prescription Opioid Misuse Using Routinely Collected Dispensing Data: ‘Doctor Shopping’ or Standard Care? (Winner, the best abstract by an ECR)

Bianca Blanch
Pharmacoepidemiology and Pharmaceutical Research Group, Faculty of Pharmacy, University of Sydney

GO

OBJECTIVES

Opioid use and opioid-related harms are increasing in Australia. ‘Doctor shopping’, accessing multiple prescribers within a defined time period, is the most common metric used to identify potential opioid misuse in dispensing claims. We investigate prescriber access patterns for opioids and statins (a medicine with no known abuse potential) in a 12-month period, the purpose of which is to establish an appropriate ‘doctor shopping’ threshold for prescribed opioids that may be indicative of misuse.

METHODS

We analysed the dispensing claims of adult concessional beneficiaries with ≥1 statin or opioid dispensings in 2013.

LESSONS LEARNED

We identified 130651 opioid users and 157911 statin users who were predominantly female (57–59%) with a median age of 66–73. 99% of statin users accessed 1–3 prescribers compared to 93% of opioid users. The proportion of opioid users accessing ≥5 prescribers was 18.5 times higher than statin users and they obtained 15.4% of all opioid dispensings in 2013.

IMPLICATIONS

The US Food and Drug Administration have called for increased post-marketing surveillance to measure opioid misuse in routine data collections. In our recent systematic review the most commonly used measures of misuse was ≥3 or ≥5 prescribers in 12 months. Our benchmarking analysis demonstrates that a threshold of ≥3 prescribers may measure routine medicine access as well as misuse, whereas ≥5 prescribers is likely to identify access patterns above the norms. However, this latter threshold may include individuals who are not misusers. Further research is warranted to address the accuracy of these measures before they are used as population surveillance tools.

2H General Practice

14:00 – 15:30 Monday 7 December 2015, Room 107

Does the Quality of General Practitioners Affect the Use of Emergency Department? Evidence from an Australian Survey

Chun Yee Wong, Jane Hall
Centre for Health Economics Research and Evaluation, University of Technology Sydney

H1A

OBJECTIVES

To examine whether the quality of General Practitioner (GP) is associated with the use Emergency Department (ED). Demand for ED has increased considerably in recent years. Many studies have investigated the impacts of demographic factors and the accessibility of GP services on the demand for ED. However, the effect of the quality of GP on the use of ED has not been examined previously.

METHODS

We collected the data from an online survey on Australians aged 16 years or older. The survey questions included whether patient has visited ED in the last 12 months, patient perceptions of the quality of GP services, and patient demographics. We also included the GP density in our analysis. Probit model was deployed to examine the effects of those factors on visiting ED.

LESSONS LEARNED

We find that patients who have high quality GPs are associated with lower probability of visiting ED. Young, senior, and low household income people tended to have a higher probability to attend ED, while gender and marital status did not have significant effect on the ED visit. The density of GPs appears to have a negative effect on using ED in outer regional areas.

IMPLICATIONS

The results indicate that high quality GP care has a significant negative effect on ED attendance. Our finding suggests that besides the accessibility of primary care services, the quality of primary care should also be taken into account when considering future adjustments to health policy in response to the increase in demand for ED.

How Important Are GP and Practice Characteristics in Determining Patient Waiting Time for Appointment and Consultation Length?

Mai Pham, Ian S. McRae
Australian National University

2G.2

OBJECTIVES

How long patients must wait for an appointment with a GP, and the duration of consultations with GPs, are determined by needs of the patients, characteristics of the GPs, and the nature of the market in which the consultation takes place. This study explores the relationship between characteristics of GPs and their practices with waiting times and consultations lengths.

METHODS

Pooled data from six waves of the Medicine in Australia: Balancing Employment and Life (MABEL) survey is used providing more than 11,000 observations. Log linear regression modelling is applied to examine the waiting time for a GP appointment with a particular doctor and GP consultation length for full time and part time GPs.

LESSONS LEARNED

Full time GPs with higher average fees for a standard consultation have longer patient waiting time and longer consultations. Non-medical income does not appear to link with waiting and consultation times. Medical income is negatively associated with both consultation length and waiting time but causal effects cannot be identified as causality could operate in either direction. GPs in areas of low socio-economic status have longer patient waiting times and shorter consultation length than their colleagues in more advantaged areas.

IMPLICATIONS

Understanding GP and practice characteristics relation to patient waiting time and consultation length is essential for planning GP services in terms of access and quality. While both GP and practice characteristics are associated with these outcomes, the largest effects remain the socio-economic status of the areas in which the GPs work.

General Practice Reception Processes: A Neglected Aspect of Care

Pat Neuwelt1, Robin Kearns2, Kyle Eggleton1
1School of Population Health, University of Auckland; 2School of Environment, University of Auckland

2H.3

OBJECTIVES

This paper presents selected findings from a Health Research Council funded project on the acceptability of general practice reception processes in New Zealand. The acceptability of primary care to patients includes their pre-clinical experience of making and waiting for appointments. Patient satisfaction surveys fail to do justice to the complexity of patient-receptionist interactions and patient experiences
of waiting for care. Such surveys also fail to capture the voices of those who are ‘on the margins’, due to social and material disadvantage.

**METHODS**
The study used qualitative participatory methods to explore the views of receptionists, patients who they find ‘problematic’, and practice managers on the role of receptionists and waiting spaces in the acceptability of care. Focus groups and individual interviews were carried out in Auckland and Whangarei, a regional centre in Northland, New Zealand between 2013 and 2015.

**LESSONS LEARNED**
Reception processes create a range of barriers to accessing general practice, as highlighted by both patients and receptionists in this study. The role of the receptionist in offering hospitality and care has been undervalued in primary care. The care provided by receptionists is particularly significant to patients from the most marginalised groups who have intersecting material disadvantage and high health need, and in particular to indigenous peoples such as Māori.

**IMPLICATIONS**
If more equitable access to primary care is to be achieved, reception processes need to be addressed in service delivery for those groups most marginalised by health care institutions.

**Nursing Scope of Practice and Autonomy: Improving Quality Outcomes for Patients in Australian General Practice**

*Jane Desborough*, *Michelle Banfield*, *Jane Mills*, *Rosemary Korda*, *Nasser Bagheri*, *Christine Phillips*

1 Australian Primary Health Care Research Institute, Research School of Population Health, Australian National University; 2 National Institute for Mental Health Research, Research School of Population Health, Australian National University; 3 College of Health Care Sciences, James Cook University, Townsville; 4 National Centre for Population Health, Research School of Population Health, Australian National University; 5 Australian National University Medical School, Australian National University

**OBJECTIVES**
The aim of this study was to examine the relationship between general practice nurse profession at a policy, practice and research level.

**METHODS**
A concurrent mixed methods design was used. For the quantitative component we conducted a cross-sectional survey of 678 patient consultations with nurses in 21 general practices in the Australian Capital Territory. Using multilevel mixed effect modelling we examined the association between general practice and nurse consultation characteristics and patient satisfaction and enablement. For the qualitative component we used a grounded theory approach to gain insight into general practice and nurse consultation structures and processes influencing these quality outcomes.

**LESSONS LEARNED**
Practices where nurses were supported to work with broad scopes of practice accompanied by high levels of autonomy had adopted team-based, interprofessional models of care. Patients attending these practices reported significantly higher levels of both satisfaction and enablement than patients attending practices where nurses worked with narrow scopes of practice and low levels of autonomy.

**IMPLICATIONS**
These findings provide the first evidence of an association between nursing scope of practice and autonomy and these key quality patient outcomes. They highlight the value of team-based, interprofessional models of care, essential for optimum implementation of general practice nursing roles. The addition of mechanisms that support extended team care management to the Practice Nurse Incentive Program would enhance the capacity for nurses to work to their full potential in all general practices.

**Evaluation of a General Practice Support and Advisory Service Pilot**

*Lucio Naccarella*

University of Melbourne

**OBJECTIVES**
In 2014/15 the Australian Primary Health Care Nurses Association (APNA) was funded to develop and pilot a General Practice Support and Advisory Service (‘Pilot’). The ‘Pilot’ involved recruitment of six Nursing Advisors to enhance the ability of six recruited general practice clinics to employ nurses and/or optimise the role of nursing. A support system was also developed (i.e., skill building workshop; teleconference, mentorship service; planning resources; and reporting templates). The University of Melbourne was commissioned by APNA to evaluate what makes the ‘Pilot’ work, for whom and under what circumstance?

**METHODS**
A formative participatory realist evaluation approach was used. Qualitative semi-structured interviews were conducted with Nursing Advisors; general practice clinic staff and with Mentorship service providers.

**LESSONS LEARNED**
Twenty interviews were conducted including: Nursing Advisors (n=12); Practice-Managers (n=4); Practice Nurses (n=2) and Mentorship service providers (n=2). The ‘Pilot’ has contributed to optimising the role of general practice nursing as demonstrated by: increased awareness and clarity about general practice nursing roles and scope of practice; improved clinical culture and systems (billing, management, human resource, recall and reminder systems); improved practice teamwork; and increased clinic practice management capacity. A core set of enablers and barriers to the implementation of the ‘Pilot’ emerged at the individual, organisational and system level.

**IMPLICATIONS**
Key recommendations for the future design, implementation and sustainability of a General Practice Support and Advisory Service are presented with implications for APNA, primary health care, and for the general practice nurse profession at a policy, practice and research level.

**Changes in Functional Ability in Later Life: Associations with Clinician and Practice Characteristics**

*Leah Palapar*, *Ngaire Kerse*, *Thomas Lumley*, *Lauren Wilkinson-Meyers*

University of Auckland

**OBJECTIVES**
Studies linking clinician and practice characteristics to health care variations are largely focused on clinical activity and procedures. Less is known on how these are associated with patient outcomes. This paper will examine how these factors relate to changes in functional ability of older people within an 18-month and 36-month period.

**METHODS**
Data from the Brief Risk Identification of Geriatric Health Tool trial was analysed using multilevel techniques (Npatient=3,755 NGP=125 Nnurse=60). Clinician and practice characteristics were added to a three-level model with 18-month and 36-month Nottingham Extended Activities of Daily Living (NEADL) score as the dependent variable and patient characteristics as covariates.

**LESSONS LEARNED**
Only a small proportion of the total variation in 18-month and 36-month NEADL scores lies between GPs and practices (1.3% and 2.2%, respectively). Patients of GPs who were partners or associates of the practice had lower 18-month NEADL scores compared to patients of salaried GPs, but had higher scores compared to patients of locums and solo practitioners (joint significance z=8.99 p=0.0294). Patients of practices that had a larger proportion of patients aged 75 and above had significantly higher 36-month NEADL scores (z=2.02 p=0.0430). Patients of practices in more deprived areas had significantly lower scores at 18 months (z=2.15 p=0.0310) and 36 months (z=2.10 p=0.036).

**IMPLICATIONS**
The findings suggest that the negative impact of particular GP positions is not sustained over time; in contrast, this effect was persistent for area deprivation. However, the amount of variation explained at GP and
practice levels suggests that statistically significant associations may not be clinically important.

### 3A Equity

**16:00–17:30 Monday 7 December 2015, Room 104**

**Assessing Local Governments’ Role in Health Equity: The Sunset Diagram**

Geoffrey Browne, Melanie Davern, Billie Giles-Corti

McCaughhey VicHealth Community Wellbeing Unit, University of Melbourne

**OBJECTIVES**

Victorian local governments are required by legislation to develop evidence-based Municipal Public Health and Wellbeing Plans (MPHWPs) that incorporate State-level health planning priorities and that address the social determinants of health. To date there has been no evaluation of these requirements. This paper describes the application and results of a novel method for rapid assessment of councils’ performance against these requirements.

**METHODS**

Deductive content analysis was used to categorise all actions in 14 Victorian local government MPHWPs according to State priorities, social determinants of health policy areas, and for how far ‘upstream’ in a social determinants framework they are directed. Actions were then mapped against a version of Dahlgren and Whitehead’s social determinants of health framework.

**LESSONS LEARNED**

Of over 1000 actions identified, fewer than half directly addressed a state priority. However, a significant number of actions addressed policy areas known to be broader determinants of health. In particular, there was a marked focus on leisure and culture, and on building social cohesion through changes to living and working conditions. Furthermore there was a clear emphasis on addressing the diverse upstream ‘causes of the causes’ of health, rather than health promotion behaviour change programs.

**IMPLICATIONS**

The results indicate that councils are ‘punching above their weight’ to address health and wellbeing via their social determinants. This paper provides a snapshot of how local government is translating research into actions, and also how it understands its efficacy and responsibility to address health’s social determinants.

**Hospitalisation for Chronic Ambulatory Care Sensitive Conditions Amongst Indigenous and Non-Indigenous Australians: A Cross-Sectional Analysis of Linked Data**

David Banham1,2, Tenglong Chen1,3

1University of Adelaide; 2SAHMRI; 3Griffith University

**OBJECTIVES**

Hospitalisation for chronic ambulatory care sensitive conditions (ACSCs) are an indicator of the availability and effectiveness of primary and community health care. Indigenous Australians experience excessively high ACSC rates, particularly in South Australia. Stratifying analyses by Indigenous status, this paper:

- Enumerates people admitted to South Australian public hospitals with chronic ACSCs and the frequency of admissions experienced;
- Examines ACSC rates and total length of stay across levels of disadvantage in Urban, Regional and Remote settings.

**METHODS**

Statistically linked, public hospitalisations in SA were categorised using AIHW definitions for ACSCs. The main outcome measures are crude and age-adjusted rates of chronic ACSCs and length of stay by regional attributes, specifically, level of disadvantage and remoteness.

**LESSONS LEARNED**

Crude rates of individuals admitted for ACSCs were 50% higher among Indigenous people than non-Indigenous. Variations within both populations are further pronounced. In particular, ACSC rates by remoteness and disadvantage levels increase more rapidly among Indigenous people with added evidence of a synergy between the two factors. Indigenous people were also more likely to experience multiple ACSC hospitalisations and commensurately longer total lengths of stay.

**IMPLICATIONS**

These results provide evidence of systematically increased risk of hospitalisation on the basis of area disadvantage, remoteness and Indigenous status. Efforts to address the rate and effects of these potentially avoidable hospitalisations will benefit from targeting specific population segments. Routine regional reporting will help monitor progress in meeting the underlying population health needs with earlier, lower cost interventions.

**Visualising Absent Groups in Healthcare: The Case of Diversity and Disability in Australia**

Harshil Robertson1, Nick Nicholas2, Maria Katrivesis3, Joanne Travaglia1

1University of New South Wales; 2Demographer’s Workshop; 3Independent

**OBJECTIVES**

Recent evidence shows that a number of groups are largely missing from disability research in Australia. Women, Aboriginal and Torres Strait Islanders and people from culturally diverse backgrounds (CALD) are systematically underrepresented both as participants of studies into disability and therefore in the body of knowledge which constitutes that field. The absence of these groups from the research agenda inhibits the capacity to improve health systems responses to rapidly growing segments of Australian society.

**METHODS**

Utilising data from the 2009 and 2012 Disability, Ageing and Carers Survey, we constructed a disability prevalence model for major CALD communities in Australia. Combined with the 2011 Australian Census, we constructed a probabilistic spatial model of disability prevalence and included a range of projections for the next 20 years. The results have been mapped in a geographic information system (GIS) and visualized to permit various forms of inquiry and visualization.

**LESSONS LEARNED**

The result is an attempt to make excluded groups more visible and to compensate for gaps in current health research. The model indicates an unequal distribution of groups and communities across the state, providing information and direction for a more targeted approach to both generalist and specialist service design and delivery.

**IMPLICATIONS**

We present these findings both as data about existing gaps in population research, and as a method for health services planning which can account for marginal and missing groups in the disability-health nexus. This is an issue in the health services research and new approaches can resolve information gaps.

**Incidence, Patterns and Sequelae of Primary Care Access a Cohort of Ex-Prisoners**

Megan Carroll1, Anna Kemp-Casey2, Georgina Sutherland1, Stuart A. Kinner1,2,3

1Melbourne School of Population and Global Health, University of Melbourne; 2Centre for Health Services Research, School of Population Health, University of Western Australia; 3Griffith Criminology Institute and Menzies Health Institute Queensland, Griffith University; 4School of Medicine, University of Queensland

**OBJECTIVES**

We present findings both as data about existing gaps in population research, and as a method for health services planning which can account for marginal and missing groups in the disability-health nexus. This is an issue in the health services research and new approaches can resolve information gaps.

**METHODS**

We present these findings both as data about existing gaps in population research, and as a method for health services planning which can account for marginal and missing groups in the disability-health nexus. This is an issue in the health services research and new approaches can resolve information gaps.
diagnostic tests and 42% prescription medications. Within the cohort, those with poorer health or a history of risky behaviour had higher rates of primary care use. While the association between healthcare and other social determinants of health are hard to separate, those with moderate Primary care use have better rates of employment and housing post-release than those who have little to no access and those whose high access may be more likely associated with complex health needs.

**IMPLICATIONS**

Primary care is an important part of improving post-release health and lifestyle quality of ex-prisoners. However, rather than focussing solely on access, interventions should also aim to increase quality of care, although further studies are required to determine how best to achieve this.

### Assessing the Contribution of Multi-Site Interventions Towards Social Change in Public Health

**Ruth Aston** 1, Janet Clinton 1, Jon Quach 1,2

1Centre for Program Evaluation, University of Melbourne; 2Murdoch Childrens Research Institute

**OBJECTIVES**

Interventions that aim to take action on the social determinants of health (SDOH), are often complex (multi-site, multi-disciplinary, multi-input, multi-output) and can involve multiple areas of action, such as policy and community development. For example, the prevention of atherosclerotic cardiovascular disease (ASCVD) requires multiple health services, delivered across the community to tertiary care sectors. Given the complex nature of such interventions, understanding how their implementation leads to changes in ASCVD disease states remains a limitation to measuring intervention effectiveness. Therefore, this study aims to develop measurable criteria for the implementation of community-based ASCVD interventions taking action on the SDOH.

**METHODS**

A meta-analysis of community-based, multi-component interventions to reduce exposure to ASCVD risk among adults (>18 years). In particular, effect size in reducing ASCVD risk factors will be examined according to factors associated with the intervention's design and implementation. Through this process, we will develop criteria for the appropriate design and implementation of complex interventions aiming to take action on the SDOH.

**LESSONS LEARNED**

There is much diversity in opinion and reporting of outcomes, making collating the evidence base to combine all information in this area challenging. Therefore, it is important to draw on the knowledge from experts and stakeholders from multiple disciplines to inform and guide research in this field.

**IMPLICATIONS**

Delineating the relationship between intervention design, implementation, and effectiveness will further our ability to accurately measure the long term benefits of complex interventions beyond disease state alone. This will inform decisions about resource allocation to be made.

### Early GP Contact and Health Service Utilisation in a Large Sample of Recently Released Ex-Prisoners in Australia: A Prospective Cohort Study

**Jesse Young** 1,2,3, Diane Arnold-Reed 2,4, David Preen 2, Max Bulsara 2,3, Nick Lennox 6, Stuart A. Kinner 1,7,8

1Melbourne School of Population and Global Health, University of Melbourne; 2Centre for Health Services Research, School of Population Health, University of Western Australia; 3National Drug Research Institute, Curtin University; 4General Practice and Primary Health Care Research, School of Medicine, University of Notre Dame Australia; 5Institute for Health Research, University of Notre Dame Australia; 6Queensland Centre for Intellectual and Developmental Disability, School of Medicine, University of Queensland, Mater Misericordiae Health; 7School of Medicine, University of Queensland; 8Griffith Criminology Institute and Menzies Health Institute Queensland, Griffith University

**OBJECTIVES**

To describe the association between general practitioner (GP) contact within one month of prison release and health service utilisation in the six months following release.

METHODS

Face-to-face, baseline interviews were conducted in a sample of prisoners (N=1325) within six weeks of expected release from seven prisons in Queensland, Australia from 2008-2010, with telephone follow-up interviews 1, 3 and 6 months post-release. Adjusted time-to-event hazard rates for hospital, mental health, alcohol and other drug (AOD), and subsequent GP service utilisation assessed as multiple failure time-interval data. Associations were assessed using a multivariate Andersen-Gill model, controlling for a range of other factors.

**LESSONS LEARNED**

GP contact prevalence within one month of follow-up was 46.5%. One-month GP contact was positively associated with hospital (Adjusted Hazard Ratio(AHR)=2.07; 95%CI:1.39–3.09), mental health (AHR=1.65; 95%CI:1.24–2.19), AOD (AHR=1.48; 95%CI:1.15–1.90) and subsequent GP service utilisation (AHR=1.47; 95%CI:1.26–1.72) over six-months of follow-up. In participants who reoffended during follow-up, there was no significant association between one-month GP contact and other health service utilisation, whereas we observed significant positive associations for ex-prisoners who stayed in the community.

**IMPLICATIONS**

Engagement with GP services soon after prison release increases health service utilisation during the critical community transition period, where ex-prisoners are at highest risk of poor health outcomes. Policy reform facilitating early post-release GP service contact may be an effective and practical way to improve ex-prisoner healthcare integration in the community. For ex-prisoners at high risk of return to custody, further case management and/or more comprehensive healthcare planning and intervention is likely necessary.

3B Outcomes Measurement

16:00 – 17:30 Monday 7 December 2015, Room 103

### Establishing Activity and Cost at the Patient Level — Experience with Advanced Heart Failure and Ventricular Assist Device Therapy

**Rosalyn Prichard** 1, Stephen Goodall 2, Philip Newton 3, Louise Kershaw 1, Patricia Davidson 4, Christopher Hayward 1

1St Vincent's Hospital Sydney; 2University of Technology Sydney (CHER); 3University of Technology Sydney (CCCC); 4Johns Hopkins University, Baltimore

**OBJECTIVES**

With a limited supply of donor hearts, ventricular assist devices (VADs) provide an alternative therapeutic approach in end-stage heart failure. However uptake has been restricted because of high device costs and uncertain cost-effectiveness. This study aims to describe and compare resource use associated with advanced heart failure treatment.

**METHODS**

We compare 3 groups of patients; 1 year prior to transplant (Pre HTX), prior to VAD implant (PreVAD) and 1 year post implant (VAD). A ‘bottom up’ approach was used based on institutional data for a cohort of 81 patients listed for heart transplant in New South Wales between 2009 and 2012. Clinician interviews were used to verify, and apply a time value to, medical and nursing activities.

**LESSONS LEARNED**

Excluding the cost of the pump ($100,000), medical, nursing and pathology activity are drivers of increased post VAD cost. Cost per patient vary significantly

- **Costs for 12 months pre transplant averaged $21,916 (±$21,658) n=56**
- **Costs for 12 months pre VAD implant averaged $73,380 (±$58,156) n=25**
- **Costs, including VAD implant, and the 12 months post implant averaged $310,818 (±$107,173) n=25**

Left ventricular function and functional status were significantly worse in the Pre VAD group. In addition, much of the activity in the Pre HTX group occurred at other NSW hospitals. Linked administrative data analysis is being undertaken to capture this cost.

**IMPLICATIONS**

Wide variation in the cost of care reflects differences in outcomes for VAD patients. Standardising care delivery and determining cost effectiveness
Data Mining for Evaluation of Healthcare Quality in the End-of-Life Care in New Zealand

Nikolai Minko, Richard Hamblin, Catherine Gerard
Health Quality and Safety Commission New Zealand

OBJECTIVES
To investigate the use of national administrative data to describe provision of the range of diagnostic, treatment and supportive care in primary, inpatient and outpatient settings to people in their last year of life.

METHODS
The New Zealand residential population aged 65 and over at 1/01/2007 were tracked through inpatient, outpatient, laboratory, pharmacy, aged care and mortality datasets over six years between 2007 and 2012. All datasets were linked together by patients’ encrypted unique national health index. The inpatient data collection appeared the most difficult one to track patients through as it also contains outpatient and aged care events. Those events were identified and filtered out by applying a casemix filter, by linking to the aged residential care data at a patient level and by linking healthcare facility certificates at facility level.

LESSONS LEARNED
589,000 people met the inclusion criteria and received healthcare services at least once during this period. Inpatient services were provided to 395,000 people (67%) with 1.6 million admissions with average length of stay (ALOS) of 11.9 days. After filtering by services received, 72% of admissions remained as inpatient with ALOS 4.7, 10% were relocated into aged care with ALOS = 90.7 and the remaining 18% were filtered as outpatient. Of the 453 healthcare facilities listed in inpatient data, 314 (69%) facilities provided only aged care.

IMPLICATIONS
These improved data are being used for further detailed analysis of end-of-life healthcare in New Zealand. This will inform the Health Quality and Safety Commission’s programme to evaluate and improve measures of quality and safety in New Zealand.

Patient Reported Outcome Measures Provide Complementary Data to Patient Reported Experience Measures

Diane Hindmarsh, Jason Boyd, Katinka Moran, Clare Aitken, Anna Do
Bureau of Health Information

OBJECTIVES
The NSW Bureau of Health Information collects and reports on the experiences of patients in NSW public hospitals. In 2014, questions were introduced into several of the surveys which aimed at assessing the outcome of interaction with the health service. The responses to these Patient Reported Outcome Measures (PROMs) were assessed for their association with Patient Reported Experience Measures (PREMs).

METHODS
BHI analysed survey responses from 12 months of data for a random sample of patients admitted to major to medium sized hospitals. Survey data were weighted to the appropriate patient population and the outcome questions were analysed using the Surveyfreq procedure in SAS. Associations were investigated using Spearman’s correlation.

LESSONS LEARNED
77% of respondents said the care and treatment received helped them and the majority reported the problem they went to hospital for was much better (72%). The proportion reporting difficulties or inability to carry out their normal daily activities dropped from 38% in the week before admission, to 26% about one month after discharge. Continued difficulties with activities of daily living were associated with having a complication or problem and having a delay in discharge. The Spearman correlation between the PROMs and patient experience measure of overall care varied from 0.12 to 0.20.

IMPLICATIONS
This study highlights that PROMs and PREMs do not correlate strongly and therefore provide complementary assessment of healthcare measurable from the patient perspectives and should therefore be used in conjunction in patient surveys.

Which QALY Measures Should We Use? The Comparison of Health Related Quality of Life Measures, Subjective Wellbeing Scales and Severity Scales in People with Depression

Catherine Minalogopoulos, Jeff Richardson, Gang Chen, Angelo Iezzi, Munir Khan
1Deakin Health Economics, Deakin University, Melbourne; 2Centre for Health Economics, Monash University, Melbourne; 3Flinders Centre for Clinical Change & Health Care Research, Flinders University, Adelaide

BACKGROUND
Economic evaluations of mental health interventions are preferred by many health economists and policy makers when they employ generic outcomes such as Quality-Adjusted Life-Years (QALYs). However the available utility-instruments used to measure QALYs are not comparable since, amongst other things, they measure different quality of life (QoL) domains. The first aim of the current study is to compare the sensitivity of five commonly used utility-instruments (AQoL-8D, EQ-5D-5L, SF-6D, HUI3, 15D), two disease specific depression outcome measures (DASS21 and the K10), three subjective wellbeing measures and one capability measure (the ICECAP). The second aim investigates which utility instrument domains are most sensitive to changes in the disease specific questionnaires and the subjective wellbeing measures.

METHODS
Individual data from 917 adults with self-report depression collected as part of the International Multi-Instrument Comparison Survey are used in the analyses. The MIC survey included respondents from Australia, UK, USA, Canada, Norway and Germany. Descriptive techniques are used to assess the first aim and regression techniques will be used to assess the second aim.

RESULTS
All the utility-instruments discriminated between the levels of severity measured by the K10 and the DASS21. The AQoL-8D had the highest correlation with the K10 and DASS21 (e.g. the pearson correlation coefficient was 0.734 with the K10). The sensitivity of the QoL domains of the utility-instruments to the K10, DASS21 and the subjective wellbeing scales will be presented as these analyses are currently being completed.

CONCLUSIONS
The results of this study have demonstrated that all the utility-instruments discriminate well between the severity levels of the K10 and DASS21. The value of assessing which utility-instrument QoL domains are most sensitive to changes in routinely used outcome measures and subjective wellbeing is that decisions regarding which utility-instrument should be used for intervention research in depression can be better informed.

Broadening the Scope of Economic Evaluation in Perinatal Depression: Implications for Cost-Effectiveness and Equity

Jemimah Ride
Centre for Health Economics, Monash University

OBJECTIVES
Arguments for increased investment in perinatal mental health often rely on the downstream associations of perinatal mental health problems to demonstrate the impact of these disorders, and yet many economic evaluations in this area use a less than two year time horizon and examine only the women’s own wellbeing outcomes. This paper examines the implications of extending economic evaluations in perinatal depression to incorporate these downstream factors.

METHODS
Two decision analytic models are developed, using data from the literature: The first uses a 12 month time horizon and focusses only on women’s payoffs; the second uses a lifetime horizon and incorporates women’s and children’s payoffs (the corollaries of perinatal depression in the children of affected women such as behavioural, cognitive and health problems). Comparison is made between the incremental cost-effectiveness ratio and probability of cost-effectiveness estimated by each model for specified treatment effects.

LESSONS LEARNED
The comparison of results from the two models addresses the question of whether including these extensions would change the conclusions of economic evaluations in perinatal depression.
**IMPLICATIONS**

Along with the potential for differing conclusions of economic evaluations in perinatal depression, the ethical and equity implications are also examined; for instance, should we have a higher willingness to pay for treatment of depression among perinatal women than among women without children? Family members’ outcomes may be considered relevant in perinatal depression, but how can we compare such findings to evaluations in other areas of health where the scope is limited to the patient themselves?

**3C Symposium: Data Linkage**

16:00—17:30 Monday 7 December 2015, Room 102

**Data Linkage and Australian Health Services Research: Progress, Challenges and Opportunities**

**Philip Clarke**
Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne

**OBJECTIVES**

To explore the use of administrative health data linkage for health services research in Australia and to translate findings to improve our health care system.

**METHODS**

This symposium will involve three inter-related papers:

1. A systematic review of the published use of linked hospital data in Australia, which will provide insights into its comparative growth over time in different State jurisdictions;
2. Case studies of the use of Australian linked administrative for health economic and health services research including insights into disease based costing; understanding disease progression and survival; determinants of disability and related claims by veterans; insights into use of health care and pharmaceuticals by different socio-economic groups;
3. A major hospital CEO’s perspective on why data linkage and health services research is essential to better manage population health and create opportunities to improve the quality of care across the entire patient journey.

**LESSONS LEARNED**

While data linkage is potentially a highly valuable resource for health services research, its use in Australia is very uneven. Often health services research studies utilizing linked data are one-offs and there has been no systematic attempt to develop a joint research agenda with service providers to improve resource allocation and patient care.

**IMPLICATIONS**

To make full use of linked data, substantial reforms are required to improve access and to support more health services research.

**The Growth of Linked Hospital Data Use in Australia: A Systematic Review**

**Michelle Tew, Kim Dalziel, Dennis Petrie, Philip Clarke**
University of Melbourne

**OBJECTIVES**

To describe the use of hospital data linkage for research purposes in Australia.

**METHODS**

A systematic review was performed using PRISMA checklist. Databases were searched using key terms for linkage and hospital. All journal articles available until December 2014 using individual patient-level data linked with hospital records were included. Information on publication year, state(s) involved, type of data-linkage, disease area and study purpose were extracted.

**LESSONS LEARNED**

A surge of publications utilizing hospital data linkage is observed in the last 15 years. Of 625 total articles, 319 (51%) were from WA and 203 (33%) from NSW with NSW making significant contributions since 2011. Linkage to state hospital databases (56%) was the most common linkage employed. Only 8% of hospital data linkage was to non-hospital databases. The most common research areas were on factors influencing health status or health services (19%), circulatory diseases (15%) and injury and external causes (14%). 73% of publications were epidemiological with only a small proportion focusing on costs, informing policy or validation.

**What Can Data Linkage Do for Us? : Case Studies of How Linked Data Can be Used to Better Understand Aspects of the Australian Health Care System**

**Philip Clarke¹, Alison Hayes²**
¹University of Melbourne; ²University of Sydney

**OBJECTIVES**

To illustrate how linked administrative data can be used to: (i) estimate costs and outcomes of chronic diseases such as diabetes; (ii) the long-term impact on veterans of military deployment; (iii) socio-economic related use of medical and pharmaceutical care.

**METHODS**

Three large linked administrative data sets will be used as case studies. Firstly information on hospital services and primary health-care services on 70,340 people with diabetes in Western Australia for a period of up to ten years (1990 to 2000). Regression methods were used to estimate disease specific costs for people with diabetes and survival analysis was used to estimate mortality following a range of diabetes-related complications (e.g. myocardial infarction). Secondly, data linkage was undertaken on cohort 60,228 of Australian Vietnam Veterans to look at their disability claims over a 50 year period. Rates of claims were estimated and regression methods used to understand associations between war-related service and propensity for a war-related disability. Finally, clinical and patient reported information were linked to Medicare and Pharmaceutical Benefits Scheme data for 2600 people attending a GP and used to measure inequalities in access to care.

**LESSONS LEARNED**

Data linkage is a powerful tool to understand aspects of the Australian health care system, particularly for chronic diseases such as diabetes and for groups such as war-veterans when disabilities such as PTSD take many years to emerge.

**IMPLICATIONS**

There is a need to expand data linkage and make it widely available to maximize the value of health services research in Australia.
The Expensive First Years of Life: Healthcare Utilisation and Costs from Birth to Age 5 in a Low Socio-Economic Region of Sydney

Alison Hayes¹, Mario D’Souza¹,², Anna Chevalier¹, Li Ming Wen², Louise Baur¹, ³, Stephen Jan¹
¹School of Public Health, University of Sydney, NSW; ²Sydney South West Local Health District, Sydney NSW; ³The Children’s Hospital at Westmead Clinical School, University of Sydney, NSW; ⁴George Institute for International Health, Sydney, NSW

OBJECTIVES
Little is known on patterns of healthcare utilization and costs among pre-school children nor the relative contribution of primary, secondary and tertiary healthcare to total healthcare costs. The aim of this study was to describe health funder and out-of-pocket costs of all health care utilization from birth to 5 years in a cohort of healthy infants in a low SES area of Sydney.

METHODS
Retrospective longitudinal analysis of total healthcare costs of a cohort of children over the first 5 years of life. Participants were 350 infants recruited to a randomised controlled trial who had complete linkage to Medicare and Pharmaceutical Benefits Schedule administrative data, emergency department and hospital records.

LESSONS LEARNED
The mean (95%CI) cost of birth was $5440 (2900, 7979), and included a small number of very high cost births. Beyond birth, the mean (sd) total healthcare costs to age 5 (funder perspective) were $5560 (4900) and out-of-pocket costs were $255 (295) per child. The mean (sd) healthcare costs per child under 5 years were: hospitalisations $1965 (3059); primary care $1746 (844); emergency $1088 (1258); secondary care $450 (549); medicines $83 (298); tests and diagnostics $229 (290); procedures $37 (113). While primary care and hospitalisations had similar mean costs over 5 years, primary care accounted for 86% of all encounters with the health system and hospitalisations only 1.5%.

IMPLICATIONS
Primary care remains the major form of healthcare for young children, with high coverage and low cost per consult. Maintenance of primary care services is essential to avoid other forms of higher cost care.

Data Linkage in Australia: A View from the Coal-Face

Gareth Goodier
Melbourne Health

OBJECTIVES
To review from the perspective of a major service provider the potential benefits of enhancing data linkage and identify opportunities for expanded health services research.

METHODS
Improving data linkages and creating better access to this patient health outcome data is essential to better manage population health and create opportunities to improve the quality of care across the entire patient journey (from the acute setting to the community). Data linkage combined with appropriate health services research would facilitate: (i) greater access to information that would enable the development of targeted initiatives aimed at achieving measureable improvements in patient outcomes and the quality of services; (ii) a better understanding of factors influencing health service usage trends and the impact of various interventions to manage patient conditions; (iii) the creation of opportunities to better manage patients in the community and proactively prevent admissions/readmissions; (iv) enable more appropriate usage of health resources.

LESSONS LEARNED
While linkage of hospital data has great potential to improve both resource allocation and patient care, there are still significant barriers to the effective use of this information, particularly of cross-jurisdiction data linkage. Not having access to linked data clearly creates inefficiencies between services and may adversely affect the patient experience in the health care system.

IMPLICATIONS
Linking hospital administrative data, and developing a framework to enable this to be achieved across the care continuum and investing in health services research to fully utilise this resource represents an ongoing challenge for services providers in the Australian health care system.

What is the Effectiveness of Weekend Allied Health Services on Acute Medical and Surgical Wards for Reducing Length of Stay, Readmissions and Adverse Events in Hospital? Results of Two Randomised Trials

T. Haines¹,², Deb Mitchell², K. Bowles¹, K. May², D. Markham², T. Chiu³, K. Philip³, Lisa O’Brien¹, S. Plumb⁵, M. Sarkies², M. Ghaly³, G. Jul⁵, Fiona McDermott¹,², Elizabeth Skinner³
¹Monash University, Clayton; ²Monash Health, Clayton; ³Western Health Service, Footscray; ⁴Department of Health and Human Services, Melbourne; ⁵Melbourne Health, Melbourne

OBJECTIVES
To understand the effectiveness of weekend allied health services on acute medical and surgical wards for reducing length of stay, readmissions and adverse events in hospital.

METHODS
Two stepped-wedge randomised controlled trials were conducted. The first was a disinvestment (roll-in) stepped wedge of the existing model of service, while the second was a conventional (roll-out) stepped wedge of a new, stakeholder-driven model. Admissions to 12 acute medical and surgical wards across two metropolitan teaching hospitals in Melbourne, Victoria over a 14 month period across 2014/2015 participated. The interventions were the existing weekend allied health services (inclusive of physiotherapy and occupational therapy at both sites, with speech pathology, dietetics and social work at one site), and a new, stakeholder-driven model of weekend service designed to be tailored to the individual needs of wards in the trial. Both were compared to a “no service” control. Patient adverse events were collected using routine administrative data collection systems combined with daily ward visits and hand-over note reviews. Length of stay and readmissions within 28 days were captured using administrative data collection systems.

LESSONS LEARNED
The two trials have been completed in April 2015 with over 13,000 patients involved. Interim safety analyses have demonstrated no adverse impact of removing the current weekend allied health service on patient length of stay, readmission or adverse event outcomes (all multi-level, generalised linear models p-values >0.05).

IMPLICATIONS
Removal of existing weekend allied health services from acute medical and surgical wards did not affect patient flow or safety outcomes.

Advantages and Challenges of Providing Weekend Allied Health Services on Acute Medical and Surgical Wards: The Managers’ Perspective

Deb Mitchell¹,², Lisa O’Brien², Anne Baroell², Fiona McDermott², Elizabeth Skinner², T. Haines¹,²
¹Monash Health; ²Monash University; ³Western Health

OBJECTIVES
Health services face competing demands to provide high quality care, seven day per week, while also minimising service delivery costs. Providing care on weekends is problematic. Some staff are reluctant to work on weekends and industrial agreements in different countries dictate that rates of pay are higher for work done on weekends. Monash Health spent more than $1 million on weekend allied health (AH) services in 2012–3 despite a lack of evidence showing these services on acute medical and surgical wards result in better patient outcomes. There may also be unanticipated inefficiencies in providing these services, such as staff training, recruitment, retention and supervision.

METHODS
We interviewed AH managers and senior clinicians at two health services who provide weekend services and asked what they saw as the advantages and disadvantages of providing such a service. Interviews were analysed using a qualitative framework approach.

LESSONS LEARNED
Twenty-two AH managers and senior clinicians participated in this study.

3D Allied Health

16:00 – 17:30 Monday 7 December 2015, Room 101
Managers perceived the services could add value by reducing patient length of stay and adverse incident rates, and improve quality of care. Participants reported a number of challenges in providing services on the weekend. These included the challenge of providing an efficient service at times when other services are not being available and the time taken to train weekend staff.

**IMPLICATIONS**

The cost of providing weekend AH services is significant, and this must be considered when deciding if resource allocation delivers return on investment.

**Additional Saturday Rehabilitation Improves Functional Independence and Quality of Life in Inpatient Rehabilitation**

*Casey Peiris*, 1, 2, *Nora Shields*, 1, *Natasha Brusco*, 1, 3, *Jennifer J. Watts*, 4, *Nicholas Taylor* 1, 2

1La Trobe University; 2Eastern Health; 3Cabrini Health; 4Deakin University

**OBJECTIVES**

To determine whether providing additional weekend allied health therapy during inpatient rehabilitation affects patient health outcomes.

**METHODS**

Multi-centre randomised controlled trial with 996 adults admitted to rehabilitation for any orthopaedic, neurological or other disabling condition. Control group participants received usual care Monday to Friday physiotherapy and occupational therapy. Intervention group participants received Monday to Saturday physiotherapy and occupational therapy. The primary outcomes were functional independence (FIM), health-related quality of life (EuroQOL) and patient length of stay (days). Outcomes were assessed on admission, discharge and 6 and 12 months post discharge.

**LESSONS LEARNED**

Intervention group participants had higher functional independence (mean difference 2.3, 95%CI 0.5 to 4.1) and health-related quality of life (mean difference 0.04, 95%CI 0.01 to 0.07) on discharge and may have had a shorter length of stay by 2 days (95%CI 0 to 4). Intervention group participants were 17% more likely to have achieved a clinically significant change in functional independence (risk ratio 1.17, 95%CI 1.03 to 1.34) and 18% more likely to have achieved a clinically significant change in health-related quality of life (risk ratio 1.18, 95%CI 1.04 to 1.34) on discharge compared to the control group. There was some maintenance of effect for functional independence and health-related quality of life at 6 months but not at 12 months.

**IMPLICATIONS**

Providing additional Saturday physiotherapy and occupational therapy improved functional independence and health-related quality of life and may have reduced length of stay for patients receiving inpatient rehabilitation.

**Are Weekend Inpatient Rehabilitation Services Value for Money? An Economic Analysis**

*Natasha Brusco*, 1, 2, 3, *Jennifer J. Watts*, 4, *Nora Shields*, 1, 4, *Nicholas Taylor*, 1, 5

1La Trobe University; 2Cabrini Health; 3Deakin University; 4Northern Health; 5Eastern Health

**OBJECTIVES**

To determine if it is cost effective to provide additional Saturday inpatient rehabilitation.

**METHODS**

Cost effectiveness analyses alongside a single-blinded randomized controlled trial (n=996) with a 30-day, 6 and 12 months follow up. Participants were admitted to two publicly funded inpatient rehabilitation facilities. The control group received usual care rehabilitation from Monday to Friday and the intervention group received usual care plus additional Saturday rehabilitation. Incremental cost effectiveness ratios were reported as cost per quality adjusted life year (QALY) gained and for a minimal clinical important difference (MCID) in functional independence.

**LESSONS LEARNED**

From admission to 30-days following discharge there was a mean difference in cost of AUD$1,673 (95% CI -271 to 3,618) in favour of the intervention group. In this same period the incremental cost utility ratio found a saving of AUD$41,825 (95% CI -2,817 to 74,620) per QALY gained for the intervention group and the incremental cost effectiveness ratio found a saving of AUD$16,003 (95% CI -3,074 to 87,361) in achieving a MCID in functional independence for the intervention group. From admission to 6 months there was a significant difference in cost favouring the intervention group (MD AUD$6,445; 95% CI 3,368 to 9,522; p<0.04) and from admission to 12 months there was a non-significant difference in cost favouring the intervention group (MD AUD$6,325; 95% CI -4,081 to 16,730; p=0.23), with no cost shift into the community.

**IMPLICATIONS**

Providing additional Saturday rehabilitation is cost effective with a high degree of certainty.

**A Study of Rehabilitation Patient Flow and Potential for Improvements**

*Peter W. New*, 1, 2, 3, *Peter A. Cameron*, 1, *John H. Olver*, 3, *Johannes U. Stoelwinder* 1

1Department of Epidemiology and Preventive Medicine, Monash University; 2Rehabilitation and Aged Care Services, Department of Medicine, Monash Health; 3Epworth-Monash Rehabilitation Medicine Unit, Southern Medical School, Monash University

**OBJECTIVES**

Measure time taken for key processes in the patient journey from acute hospital admission through to rehabilitation admission. Assess the prevalence and reasons for barriers to discharge from inpatient rehabilitation, as well as the resulting additional days in hospital.

**METHODS**

Open cohort study of 360 patients (females = 186, 51.7%; mean age = 58.4 years) admitted into two inpatient rehabilitation units in Melbourne over an 8-month and a 10-month period in 2008.

**LESSONS LEARNED**

There was a median of 7 days (interquartile range [IQR] 4–13) from acute hospital admission till referral for rehabilitation, a median of 1 (IQR 0–1) day from referral till assessment, a median of 0 (IQR 0–2) days from assessment till deemed ready for transfer and a median of 1 (IQR 0–3) day from ready till admission into rehabilitation. Overall, patients spent 12.0% (804/6682) of their acute hospital admission waiting for a rehabilitation bed. Fifty-nine (16.4%) patients had a barrier to discharge from rehabilitation. The most frequent causes of discharge barriers were patients being non-weight bearing after lower limb fracture, family deliberations about discharge planning, waiting for home modifications and waiting for accommodation. Over the study period, 21.0% (3152/14976) of all bed-days were occupied by patients deemed to have a discharge barrier.

**IMPLICATIONS**

There are opportunities to improve the efficiency of key processes in the acute hospital journey for patients subsequently admitted to inpatient rehabilitation. Barriers to discharge from inpatient rehabilitation are common and substantial, and they represent an important opportunity for improvement.

**A Population Based Analysis of the Impact of a Provincial Quality Improvement Program on Primary Health Care in Ontario, Canada (Highly commended abstract overall)**


1Queen's University; 2Institute for Clinical Evaluative Sciences; 3Western University; 4University of Toronto

**OBJECTIVES**

To assess the impact of quality improvement program for primary care practices in Ontario, Canada, on diabetes quality of care, colorectal cancer screening and health systems use.
METHODS
Secondary analysis of comprehensive linked Administrative Data (physician billings, ER and hospital use, lab and imaging ordering, public funded drugs, provider database, primary care enrollment, census, vital statistics). Patients of participating physicians (N=78,192) compared to controls (N=1,661,152) in a similar model of care. Outcomes assessed include AIC test ordering, eye exams, diabetes specific visits, medication use, cancer screening completion, ER visits, ACSC hospitalizations, hospital readmissions, continuity of care and specialist visits.

LESSONS LEARNED
For diabetes and colorectal screening outcomes both groups improved over time. These were greater in the intervention group compared to controls. Differences were modest in absolute value but were statistically and clinically significant. For example AIC ordering up to date increase of 10% vs 5% p=0.006, colorectal screening up to date increase of 9.4% vs 5.4%, p<0.001. There were no clinically significant differences in health systems use (ER visits, ACSC hospitalizations, specialty visits or continuity of care) between the groups.

IMPLICATIONS
Broad based quality improvement initiatives can improve the quality of care in primary health care practices. While the impacts are modest in size, at a population level this can translate into improvement in care for large numbers of patients. The changes were greatest for measures that are primarily under control of the practice. The access component of the QI collaboratives did not result in any changes in health systems use.

A Real-Time Approach to Improving Primary Healthcare Implementation: Accounting for Complexity Through Developmental Planning and Evaluation

Cathie Scott1, Virginia Lewis2, William Miller3, Grant Russell4, Jeannie Haggerty5, Simone Dahrouge6, M.F. Harris7, IMPACT Team

1Alberta Centre for Child, Family & Community Research; 2La Trobe University; 3Lehigh Valley Health Network and University of South Florida Morsani College of Medicine; 4Monash University; 5McGill University; 6Bruyère Research Institute; 7University of New South Wales

OBJECTIVES
To share lessons learned from application of a developmental evaluation approach to the work of six local innovation partnerships (LIPs) in Canada and Australia. The LIPs bring together researchers, policy advisors, health services, clinicians, and community members in each region to identify local access needs and co-design an intervention to address the needs.

METHODS
The developmental approach applies overlapping phases of planning, implementing and evaluating. This approach is explicitly designed to guide complex interventions where it is not possible to anticipate all inputs, activities and outputs that will be required to achieve desired outcomes. Characteristics of this approach include:

- Embedding an evaluation role within the program while maintaining independent critical thinking;
- Designing the evaluation to support real-time learning and decision-making about what to add, change, discontinue, or further develop;
- Ensuring that development and evaluation are mutually reinforcing;
- Ensuring that data collection, analysis & implementation are ongoing;
- Producing context-specific understandings to inform implementation.

LESSONS LEARNED
Through this presentation we will share what we have learned about the practical aspects of applying this innovative approach to planning and evaluation within complex primary healthcare contexts across six settings in two countries. We will also share early examples of the benefits of real-time learning for design and implementation of interventions.

IMPLICATIONS
This non-traditional approach to planning and evaluation is essential to guide complex interventions that are responsive to uncertain and changing contexts. Building capacity for a developmental approach to planning and evaluation is required to sustain long-term improvements in primary care access for vulnerable populations.

Safety on the Line — Development and Implementation of a Quality Improvement Model for a Nurse and GP Helpline Using Simulated Patients

Rosemary McKenzie1, Gary L. Freed1, Matthew J. Spittal2

1Centre for Health Policy, Melbourne School of Population Health, University of Melbourne; 2Centre for Mental Health, Melbourne School of Population Health, University of Melbourne

OBJECTIVES
Simulated patients have been used to evaluate safety, appropriateness and communication of telephone triage and advice services (TTAS), which operate in many countries to manage demand for and improve access to health services. A quality improvement model based on the simulated patient method has been developed and recently implemented in Australia’s nurse and after hours GP helpline. This study piloted the use of the quality improvement model.

METHODS
The model has five elements: random selection of a subset of commonly presenting case scenarios with an uncommon level of acuity in some scenarios; an annual cycle of simulated patient calls presenting the scenarios; clinical and communications assessment using outcomes ascribed by a multidisciplinary Clinical Advisory Panel and clinical communication standards; rapid feedback to the service provider on strengths, weaknesses and gaps, and provision of professional development and reflective practice opportunities for helpline clinicians. Between March and June 2015 simulated patients presenting five clinical scenarios made 250 calls to the healthdirect and after hours GP helpline service.

LESSONS LEARNED
Strengths and weaknesses of Australian primary care TTAS can be identified and quantified using a quality improvement model based on simulated patient clinical testing of the service. The results of the pilot implementation of the model will provide insights into both the clinical appropriateness of advice delivered by telephone clinicians and the communications skills of the clinicians.

IMPLICATIONS
A quality improvement model using simulated patients is expected to improve the safety and appropriateness of telephone health advice offered to Australian consumers.

Continuous Quality Improvement in Primary Care: What Evidence do We Need to Better Inform the Use of the Methods in Practice?

Sue Brennan1, Marjie Bosch1, Joanne McKenzie1, Heathie Buchan2, Sally Green7

1School of Public Health and Preventive Medicine, Monash University; 2Australian Commission on Safety and Quality in Health Care, Sydney

OBJECTIVES
Continuous quality improvement (CQI) methods are widely advocated for improving service delivery and implementing new models of care. We aim to (i) examine what is known about the effectiveness of CQI in primary care, and (ii) identify a framework for informing the design of evaluations intended to address gaps in existing knowledge about how best to implement and use CQI.

METHODS
This paper draws together findings from two linked systematic reviews. The first review synthesised theory and empirical research to identify a framework of factors thought to influence the outcomes of CQI. The second review examined the effects of CQI on professional performance, patient outcomes and systems change. The evidence arising from this review was mapped to the framework to identify gaps in the existing research.

LESSONS LEARNED
Review and analysis of more than 170 papers contributed to a framework of factors identified as important for understanding the processes and outcomes of CQI. The resulting Informing Quality Improvement Research (InQuIRe) framework groups factors into four domains (the CQI process, implementation approaches, enabling context, outcomes). Review and mapping of evidence from studies evaluating the effects of CQI showed...
sparse evidence about the influence of the CQI process and contextual factors on outcomes, and limited consideration of systems change.

IMPLICATIONS
Addressing unanswered questions about how best to implement and use CQI will require evaluations that examine the interplay between CQI process, context, and outcomes. The InQuIRe framework provides a tool intended to support the design of such evaluations.

The Benefits of Public Reporting of Hospital Performance: Does it Deliver What Consumers Want?
Margaret Kelaher
Centre for Health Policy, University of Melbourne

OBJECTIVES
Despite its promise public performance reporting has had little impact on improving quality of care for consumers. In this study we examine consumer advocates, purchasers and providers' understanding of public performance reporting and how it contributes to quality of care. The aim of the study is to improve the impact of public performance reporting on quality of care.

METHODS
We conducted 41 semi-structured interviews nationally. The aim of the study was to examine differences in perceptions of the aims, implementation and impact public performance reporting. Data was transcribed and themes were analysed using NVivo.

LESSONS LEARNED
The study revealed that consumers, providers and purchasers share similar perceptions of the goals of public performance reporting. However they have very different views about the extent to which current public performance reporting is likely to meet the needs of consumers. Overall the views of all respondents highlighted the need to better target publically reported information to inform the actions of the intended audience.

IMPLICATIONS
While consumers are supportive of public performance reporting current iterations are unlikely to influence either public perceptions of health services or consumer choice. Developing fit for purpose reporting is likely to improve the extent to which public performance reporting will improve quality of care.

3F Consumer & Community Engagement
16:00 – 17:30 Monday 7 December 2015, Room 107

Putting Our Values and Principles into Practice: “What Does It All Mean?”
Donna Weetra 1, Roxanne Miller 1, Rikki Wilson 1, Stephanie Brown 1, AFS Collaborative Group 2
1Healthy Mothers Healthy Families Research Group, Murdoch Children’s Research Institute; 2Aboriginal Families Study

OBJECTIVES
The Aboriginal Families Study was developed paying attention to methodology that respects and strengthens Aboriginal culture and communities. The purpose of this paper is to reflect on what that meant in practice, from the perspective of the Aboriginal fieldwork team.

METHODS
Women living in metropolitan, regional and remote communities in South Australia completed a structured questionnaire with an AFS Collaborative Group 2
1University of New South Wales; 2University of Ottawa; 3McGill University; 4NSW Bureau of Health Information; 5La Trobe University; 6Monash University; 7Alberta Centre for Child, Family & Community Research; 8University of Adelaide

LESSONS LEARNED
Our questions address all phases of the research process and are underpinned by four key principles — ethical practices, acknowledgement of Indigenous knowledge systems, reciprocity between researchers and communities, and the empowerment of Aboriginal and Torres Strait Islander peoples.

IMPLICATIONS
This appraisal tool will assist all who undertake and review research with Aboriginal and Torres Strait Islander peoples to assess the quality, appropriateness and ethical acceptability of research outputs. The tool will also help to ensure that systematic reviews can inform health practice and policy and improve health outcomes for Aboriginal and Torres Strait Islander peoples.

Engaging Local Organisations and Stakeholders Developing Interventions to Improve Access for Vulnerable Groups to Primary Health Care
Maree F. Harris 1,2, Christine Casaer 3, Danielle Watson 4, Suzette Giardina 5, Michael Atkinson 6, Jessica Creagh 7, Tamara Weekes 8, Jonathan Tattersall 9
1Wardliparinga Aboriginal Research Unit, South Australian Health and Medical Research Institute, Adelaide; 2Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; 3Joanna Briggs Institute, Faculty of Health Sciences, University of Adelaide; 4School of Public Health, Faculty of Health Sciences, University of Adelaide

OBJECTIVES
To describe the role of local primary health care organisations (PHCOs) in the development of health system interventions to improve access to primary health care for vulnerable groups as part of the Canadian-Australian IMPACT study.

METHODS
Participatory action research examining the engagement and role
LESSES LEARNED

- PHCOs were ready to engage and commit to agreed priorities (both in identifying vulnerable groups and types of intervention). However this was challenged by recent structural and policy change in both Australia and Canada.
- A strong focus on approachability of services emerged in all localities (especially in relation to navigation and information) which enables vulnerable people to identify what services exist, how they can be reached and how they may impact on their health.
- Local needs and opportunities varied in different localities giving rise to a range of strategies focused on: self-management; outreach from one location to another; engagement or enrolment with a primary care service or provider; navigation or referral to specialised or non-health services.

IMPLICATIONS

This demonstrates the value of a structured approach to creating a productive relationship between researcher and local organisations so that the needs of both are met. This has implications for the role of primary care organisations in planning and commissioning better access to primary health care for vulnerable groups.

Involving Consumers in Service Development: Using Discourse Analysis to Understand What Works to Enhance Consumer Agency

Sarah Pollock
Mind Australia

OBJECTIVES

This presentation explores the value of discourse analysis as a research method for understanding how power operates in participatory approaches to service evaluation and development, and the possibilities it offers for more inclusive practice.

METHODS

The research draws on a project undertaken in a large social care provider in Melbourne, across three diverse service settings (disability; homelessness; aged care). The project brought together consumers, families, service delivery staff, managers and personnel from government departments to evaluate current delivery and identity priorities for service development.

Following the completion of the project, participants were invited to be interviewed about their experiences. Using a Foucauldian framework, a method of discourse analysis was developed to examine the micro-politics of the participatory process, and applied to the interview data and other project texts.

LESSONS LEARNED

The research found the participatory process was effective in giving service users and families a say in service development. The research provides an empirical demonstration of how the arrangements of the process made available more agentic subject positions for service users and families. Discourse analysis proved an effective method for revealing the ways in which power operated in the service setting to limit/enhance service user agency.

IMPLICATIONS

The research has implications for research and for organisations. It identified practical and realistic ways in which organisations can become more inclusive. It has also demonstrated the utility of discourse analysis as a means of understanding ways in which power delimits consumer agency, and how inclusive processes can give people greater control.

What Research Questions Matter to Australian Paediatricians? National Delphi Study

Kate Hughes 1, Alisha Gulenc 1,2, Margie Danchin 1,2,3, Gary L. Freed 1,2,3, Daryll Eron 1,2,3, Melissa Wake 1,2,3, Harriet Hiscock 1,2,3
1Centre for Community Child Health, Royal Children’s Hospital, Parkville; 2Murdoch Childrens Research Institute, Parkville; 3Department of Paediatrics, University of Melbourne, Parkville; 4Child Health Evaluation and Research (CHEAR) Unit, University of Michigan, Ann Arbor

OBJECTIVES

Most paediatric research is conducted in tertiary or public health settings, but most care takes place in outpatient settings (private practice, outpatients, community centres). The Australian Paediatric Research Network (APRN) is a practice-based network aiming to foster research to benefit outcomes in these settings. In 2007, an inaugural Delphi study helped the APRN set its research priorities for the following 5 years. Here, we report on the APRN’s second Delphi study that will shape its future research to 2018.

METHODS

APRN members (n=448) were invited to take part in a two-stage email Delphi survey. In stage 1 (July 2014) they were asked “Thinking about your clinical practice, what is/are the most important research question(s) which need addressing?” 189 responses were collated into 23 answerable questions. In stage 2 (May-July 2015), members rated the importance of each question to their practice using a 5-point Likert-type scale (1= not important, 5= very important/essential). Scores were averaged to generate a list of research priorities from most to least important.

LESSONS LEARNED

Paediatricians prioritised management and long term outcomes for common chronic conditions including autism, obesity and asthma. Health service research questions, including benefits and costs of telehealth and models of shared care, also rated highly.

IMPLICATIONS

Australian paediatricians prioritise research into common, challenging conditions with high burden of disease, and are evolving to reflect changing epidemiology. These questions could not be easily answered by traditional research methods, highlighting the importance of engaging this sector to drive and participate in research.

Private General Paediatric Care Availability in Melbourne

Marina Kunin, Amy Allen, Caroline Nicolas, Gary L. Freed
Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne

OBJECTIVES

The objective was to determine actual availability of private general paediatric appointments in the Melbourne metropolitan area for children with common non-urgent chronic illnesses and the out-of-pocket cost of such care to the patient.

METHODS

The project utilised an audit methodology, also known as a ‘secret shopper’ method. Telephone calls were made to a random sample of 47 private paediatric clinics. A trained research assistant posed as the parent of a child, requesting the first available appointment with a specific paediatrician. Tailored scenarios were developed with a focus on the assessment of non-urgent chronic diseases. The research assistant also enquired as to the charge for attending an appointment. Total charges and net charges after the Medicare rebate were collected.

LESSONS LEARNED

Of the clinics with an available appointment (79%, n=37), 38% (n=14) had waiting periods that exceeded one month. Cost of paediatric consultations varied across the Melbourne metropolitan area. Five of the clinics contacted bulk-billed for the consultation, all of them situated in the North and North-West suburbs of Melbourne. In the fee-paying clinics in this area, maximum out-of-pocket cost for the patient ranged from $AUD40 to $AUD160, with average cost $AUD104. In the South
and South-East, maximum out-of-pocket cost ranged from $AUD70 to $AUD222, with average cost $AUD136.

**IMPLICATIONS**

Private paediatric care availability in the Melbourne metropolitan area is highly variable. As there is no system for private insurance cover for outpatient specialist visits, all charges above the Medicare rebate are out-of-pocket. The out-of-pocket cost of private paediatric outpatient care may present a potential economic barrier for some Melburnians.

**Cost-Effectiveness of a Community Delivered Infant Sleep Intervention**

Sopany Saing, Bonny Parkinson, Jody Church, Stephen Goodall

Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney

**OBJECTIVES**

Infant sleep problems can cause postnatal depression and can be a burden on health care resource use. The aim of the study is to evaluate the cost effectiveness of a community delivered infant sleep intervention aimed at reducing infant sleep problems in infants aged 7 months and postnatal depressive symptoms in women in Melbourne, Australia.

**METHODS**

A decision analytic model was used to synthesise data from a variety of sources. Efficacy was based on a published randomised cluster trial. Edinburgh Postnatal Depression Scale (EPDS) scores were measured and mapped to published utility scores. Healthcare resource use and costs were based on published data. Cost effectiveness was measured in terms of the incremental cost per QALY (quality adjusted life year) gained.

**LESSONS LEARNED**

The trial found that the intervention group had statistically significant improvements in mean EPDS at 4 and 16 months follow-up. Modelled results suggest that an infant sleep intervention is cost effective, and under certain assumptions was cost-saving compared to usual care. The main drivers of the model included the use and cost of early parenting centres and training costs.

**IMPLICATIONS**

Community delivered infant sleep interventions are likely to be cost-effective and there are potential cost savings from reduced use of residential stays in early parenting centres. As the funding mechanism for maternal and child health (MCH) services varies across States, further research is required on the applicability of these results prior to the widespread implementation of this program.

**How Reliable Are Extended Midwifery Services (EMS) in Tracking Morbidity in Late Preterm Infants (born 34 weeks to 36 Weeks 6 Days Gestation (LPI)), Discharged to the Community?**

Sunday Pam 1,2, Ann Kynaston 3,4, Alan Sive 5, Gwenda Chapman 2, Bushra Nasir 6, Srinivas Kondalsamy-Chennakesavan 6

1 Rockhampton Hospital, Rockhampton; 2 University of Queensland Rural Clinical School, Rockhampton; 3 Lady Cilento Children’s Hospital, South Brisbane; 4 University of Queensland School of Medicine, Brisbane; 5 Royal Children’s Hospital, Brisbane (retired); 6 University of Queensland Rural Clinical School, Toowoomba

**OBJECTIVES**

The study aimed at assessing the role of the Extended Midwifery Service (EMS) of the Rockhampton Hospital, in identifying common morbidities in Late Preterm Infants (LPI), discharged into the community.

**METHODS**

The study received institutional ethical approval. The locally administered EMS database, detailing occasion at service by the midwives, was sourced for the study period January 2010 to December 2012.

**LESSONS LEARNED**

Of the 4113 infants born at the Rockhampton Hospital, only 244 (5.96%) were LPI. The EMS Rockhampton was responsible for the Universal Postnatal Contact Service for 2630 infants during the period with 144 (5.48%) being LPI. There were 51 infants re-hospitalised in the immediate neonatal period. Out of these, 4 (7.84%) were LPI, admitted due to neonatal jaundice, weight loss, or hypothermia. Logistic regression showed that the risk for post-birth re-hospitalization of all infants was higher if delivery was by forceps (OR 4.674, p=0.042) or caesarean section (OR 1.787, p=0.048) and increasing number of home visits by EMS (OR 1.498, p<0.001). The odds for re-hospitalization was, however, less with increasing parity (OR 0.708, p=0.040). The same analysis could not be applied to LPI alone due to small numbers.

**IMPLICATIONS**

The EMS data, despite small numbers, showed that the proportion of LPI re-hospitalized in the neonatal period was greater than at birth, implying higher morbidity of LPI. The EMS, suitably modified, can be a useful service to track and manage LPI who are often thought to be ‘almost mature’ yet have significantly more morbidity than full term infants.

**Evaluation of Secondary Prevention for Rheumatic Heart Disease in Fiji and Implications for Screening Policy**

Daniel Engelman 1,2,3, Andrew C. Steer 1,2,3

1 Royal Children’s Hospital Melbourne; 2 Centre for International Child Health, Department of Paediatrics, University of Melbourne; 3 Group A Streptococcal Research, Murdoch Childrens Research Institute

**OBJECTIVES**

Rheumatic heart disease (RHD) is a public health priority in Fiji, causing morbidity and mortality at considerable expense. In an attempt to improve disease control, 15,000 children were screened for RHD since 2005, resulting in >800 diagnosed cases. Screening can only be effective if appropriate secondary prevention measures are implemented for detected cases. Therefore we aimed to evaluate the secondary prevention program, including the adherence to secondary antibiotic prophylaxis for the cohort of young people diagnosed through screening.

**METHODS**

A register of patients diagnosed through screening was collated. Benzathine penicillin prophylaxis records were collected from 65 health facilities nationally for a 36 month period (2012–2014). Injection data for patients diagnosed through screening were compared with the number of injections recommended for the period of observation. Adherence was categorised as complete (>95% of recommended injection) or incomplete (0%, >0–50%, >50–80% and >80%). Broader aspects of secondary prevention were appraised using the Australian RHD management guidelines.

**LESSONS LEARNED**

The adherence to secondary prophylaxis is suboptimal to improve disease outcomes of patients detected through screening. Regional variation was observed. Adherence in the Central Division was particularly poor: 80% of patients received no injections, 16% received 0–50%; 4% received 50–80%. No patients received more than 80% of recommended injections.

**IMPLICATIONS**

Secondary prevention for RHD in Fiji is currently inadequate to improve disease outcomes. Innovative health system strengthening of secondary prevention should be the priority of the RHD control program. Further case detection through screening is not recommended until adherence is improved.

**Trends in Paediatric Practice in Australia 2008–2013: A National Audit from the Australian Paediatric Research Network**

Harriet Hiscock 1,2,3, Margie Danchin 1,2,3, Alisha Gulenc 1,2, Stephen Heaps 2, Daryl Elton 1,2,3, Gary L. Freed 3,4, Prescilla Perera 1,2, Melissa Wake 1,2,3

1 Centre for Community Child Health, Royal Children’s Hospital, Parkville 3052; 2 Murdoch Childrens Research Institute, Parkville 3052; 3 Department of Paediatrics, University of Melbourne, Parkville 3052; 4 Child Health Evaluation and Research (CHEAR) Unit, University of Michigan, Ann Arbor, MI

**OBJECTIVES**

There is increasing concern in adult medicine that some patients are being over diagnosed and over treated. Whether this is true for children is unclear. We aimed to document change in diagnostic and management practices of Australian paediatricians from 2008 to 2013.

**METHODS**

Prospective national audit of paediatricians’ practice in private rooms,
community health centres and hospital outpatient clinics. Paediatricians who are members of the Australian Paediatric Research Network completed brief standardised data collection over a 2-week period. Outcomes included diagnoses made, consultation duration, proportion of consultations with medication prescribed and pathology and imaging ordered. Hierarchical linear modelling, clustered at the paediatrician level, investigated practice change over time. Rates of imaging and pathology ordered per consultation were calculated.

LESSONS LEARNED
180 (48%) paediatricians collected data on 7102 consultations. As in 2008, the majority of 2013 consultations were for developmental and behavioural problems, but the proportion of consultations including such conditions was higher in 2013 (eg. autism spectrum disorder (ASD) 56% versus 39%, p=0.002). Consultation duration changed little. Medication prescribing increased significantly for ASD, anxiety, sleep disturbance, behaviour, constipation, asthma and learning difficulties. There was no change in pathology or imaging rates.

IMPLICATIONS
Australian paediatricians are seeing more developmental and behavioural problems and prescribing medication more often. Further research is required to determine whether these practices are appropriate or whether they represent over-diagnosis and treatment. Factors such as increased family and practitioner awareness of conditions and difficulties in accessing non-pharmacological therapies may also play a role.

4B Governance in Primary Care
Old Wine in New Bottles? Australia’s Primary Health Networks and Commissioning
Helen Dickinson
Melbourne School of Government and School of Social and Political Sciences, University of Melbourne

OBJECTIVES
The re-organisation of the Australian health system has seen Primary Health Networks (PHNs) replace Medicare Locals. PHNs have been charged with; increasing the efficiency and effectiveness of services, with a particular focus on those at risk of poor health outcomes; and improving the coordination of care so that individuals receive the right care, in the right place, at the right time. PHNs are purely commissioning bodies for clinical services, except in the case of market failure. Commissioning is a rather new concept in Australia and it is not yet entirely clear what commissioning will entail and how it will operate in practice in Australia.

This research investigates PHNs understanding of commissioning, what it should achieve in its locality, and the challenges and opportunities of this process. We consider how these perspectives compare to one another and to the broader international literature on commissioning and what this suggests in terms of the future development of this agenda.

METHODS
The study encompasses two components: 1) a review of international evidence on the impact and effectiveness of commissioning in health; and 2) adopts a qualitative methodology drawing on semi-structured interviews with key stakeholder groups (including commissioners; policy makers and providers).

LESSONS LEARNED
Preliminary findings from the literature suggest that when applied to healthcare commissioning is challenging, and that focus on the more technical aspects around contracting and procurement should not distract from the relational elements that also need to be firmly embedded in commissioning activity. The study is ongoing and results from component two will be available at the conference.

New Directions for Australian Primary Health Care:
Lessons from US Health Reforms
Paul Burgess 1,2
1Department of Health, Northern Territory Government; 2MacColl Center for Health Care Innovation, Group Health Research Institute, Seattle

OBJECTIVES
In the US, the Affordable Care Act (Obama-care) has greatly improved access by expanding health insurance and reforming primary care — incentivising adoption of the Patient Centred Medical Home (PCMH). Beyond access however, there is limited consensus on how to address health inequalities. Our objective was to identify how high-performing health care organisations, extending upon the PCMH, were progressing health equity.

METHODS
Multiple case study of four high-performing organisations serving vulnerable populations and achieving the triple aim; better care, better population health and lower costs. Four contextually diverse sites were chosen on the advice of industry experts and leading health services researchers. Site visits were supplemented with 62 semi-structured interviews (114 respondents) and documentary analysis.

LESSONS LEARNED
Success was achieved by building an integrated and accountable community of care around primary care — markedly expanding the roles and functions of the primary care team, providing technical assistance for health improvement, intentional relationship building, fostering community and stakeholder linkages — all underpinned by rigorous data and analytics for organisational learning. In these health systems, patients experienced transformational care through empowerment, problem solving and advocacy. While these health systems were developed to serve vulnerable populations, they portend the future of population-focussed and data-driven primary health care in the US and beyond in the 21st century.

IMPLICATIONS
For Australia, these four successful PCMH-based systems provide key learnings for primary health care reorientation and payment reform. The population-level capabilities and functions developed in these systems are also instructive for Australia’s revamped Primary Health Networks.

Improving Access to Integrated Primary Health Care:
Lessons from the Field
Bernadette Ward 1, Riki Lane 2, Catherine Spooner 3, Grant Russell 2, Julie McDonald 3, Gawaine Powell Davies 3, Rachael Kearns 3, Sarah Dennis 4, Jeff Fuller 5, Christine Walker 6
1School of Rural Health, Monash University; 2School of Primary Health Care, Monash University; 3Centre for Primary Health Care and Equity, University of New South Wales; 4Faculty of Health Sciences, University of Sydney; 5School of Nursing and Midwifery, Flinders University; 6Chronic Illness Alliance

OBJECTIVES
Numerous jurisdictions have realised the importance of comprehensive and coordinated primary health care, particularly for vulnerable and under-served groups and people with complex and chronic health care needs. Both the federal government (through GP Super Clinics) and a number of states have introduced new models of primary care delivery (known as integrated primary health care centres (IPHCCs)). We aimed to describe and identify the factors that influence approaches to optimise access to IIPHCCs.

METHODS
A multi-method comparative case study design was used. A sample of six IIPHCCs (three in NSW, three in Victoria) was drawn from GP Super Clinics, HealthOne, Community Health and traditional general practices. Data collection included semi-structured interviews, document analysis, surveys and practice based non-participant observation.

LESSONS LEARNED
Approaches to optimising access (availability, accommodation, approachability, affordability, acceptability and appropriateness) to services varied between and within the IPHCC models. These approaches were shaped and influenced by context and practice organisational factors. Context factors included national and regional factors such as contractual arrangements, supply of primary care services relative to need and bulk-billing relative to GP supply. Internal IPHCC factors such as governance arrangements, vision, leadership and practice systems impacted upon access outcomes.

IMPLICATIONS
There is a range of policy-amenable interventions that can be implemented to improve access to IIPHCCs. This presentation will outline how these interventions can be supported and implemented by policymakers and health service leaders alike.
Reshaping Community Health Services in Victoria: Drivers of Recent Voluntary Mergers
Véronique Roussy, Charles Livingstone
Monash University

AB.4

OBJECTIVES
To describe the drivers and desired outcomes from two recent voluntary mergers in the Victorian community health sector, which led to the creation of large, regional-size and community-governed primary health care organisations.

METHODS
Qualitative exploratory research project, using 26 semi-structured interviews with key informants related to two community health mergers that occurred in 2014 in the state of Victoria, Australia. Key informants included pre-merger and post-merger CEOs, selected executive management team members, and external stakeholders from a peak body, regional government offices and Primary Care Partnerships. The two studied organisations cover primarily urban and outer urban areas of Melbourne. Interview transcripts were thematically analysed.

LESSONS LEARNED
Becoming bigger through the act of merging was seen by studied organisations to be the best way to respond to mounting external pressures that threatened the ongoing survival and success of Victorian community health services. Such pressures included a diminishing sense of obtaining funding and a generally unsupportive policy environment. Desired outcomes related to creating the capacity to thrive, not only survive, and position services to be able to continue providing quality services to disadvantaged communities, which may otherwise “fall through the gaps”.

IMPLICATIONS
Large mergers are changing the face of community health services in Victoria, creating an even more diverse sector than before, and shifting the dynamics. The ability of these large organisations to remain true to core values of localism, community participation and health equity remains to be seen.

Integrated Primary/Secondary Health Care Governance: We Have the Evidence, Do We Have the Practice?
Caroline Nicholson¹,², Claire Jackson¹, Julie Hepworth³, John Marley⁴
¹University of Queensland, Brisbane; ²Mater Health Services, South Brisbane; ³Queensland University of Technology, Brisbane

AB.5

OBJECTIVES
There is an identified need for more robust and high-quality evidence to inform decisions about how to develop and deliver integrated primary/secondary health care. Researchers and policy-makers need to work together with practitioners to develop, evaluate and implement effective approaches. For the goals of health reform to be realised primary and secondary care must work together to achieve co-ordinated and integrated healthcare services. This study investigates the perceptions of board members and CEOs currently working in meso-level organisations on how the elements of a health care system capable of supporting effective integrated primary/secondary are being used, or could be in the future.

METHODS
This study presents the results of an exploratory case study design using semi-structured interviews and contextual evidence.

LESSONS LEARNED
The ten elements linked to successful primary/secondary health care integration; a population focus; shared clinical priorities; joint planning; using data as a quality improvement tool across the continuum; innovation; effective change management; an appropriately trained workforce; integrated information communication systems; incentives; and, patient engagement, are all supported in the case studies. While the current reform environment has made some progress in some elements, others remain ad-hoc or non-existent.

IMPLICATIONS
To apply important evidence to health care policy, and maximise reform success, we must review current governance frameworks to address the gaps identified in this paper. Whilst challenging to bring historically disparate partners together into formal agreements, they are essential to creating the scalable ‘business rules’ and a sustainable environment required to achieving new care models.

Australia’s National Health Program Initiatives: An Ontological Mapping
Ghassan Beydoun¹, Linda Dawson¹, Arkalgud Ramaprasad¹,², Thant Syn¹, Khin Than Win¹
¹University of Wollongong; ²University of Illinois at Chicago; ³Texas A&M International University

AB.6

OBJECTIVES
Australia has a large number of health program initiatives whose comprehensive assessment will help refine and redefine priorities by highlighting areas of emphasis, under-emphasis, and non-emphasis. The objectives of our research are to: (a) systematically map all the programs onto an ontological framework, and (b) systemically analyze their relative emphases at different levels of granularity.

METHODS
We mapped all the health program initiatives onto an ontology with five dimensions, namely: (a) Program-scope, (b) Program-focus, (c) Outcomes, (d) Type of care, and (e) Population served. Each dimension is expanded into a taxonomy of its constituent elements. Each combination of elements from the five dimensions is a possible policy initiative component. There are 30,030 possible components encapsulated in the ontology. It includes, for example: (a) National financial policies on accessibility of preventive care for family, and (b) Local-urban regulatory policies on cost of palliative care for individual-aged.

Four of the authors mapped all of Australia’s health programs on to the ontology. Visualizations of the data are used to highlight the relative emphases in the program initiatives.

LESSONS LEARNED
The dominant emphasis of the program initiatives is: [National] [educational, personnel-physician, information] policies/programs on [accessibility, quality] of [preventive, wellness] care for the [community]. However, although (a) information is emphasized technology is not; and (b) accessibility and quality are emphasized cost, satisfaction, and quality is not.

IMPLICATIONS
The ontology and the results of the mapping can help systematically reassess and redirect the relative emphases of the programs from a systemic perspective.

4C Indigenous HSR
13:30 – 15:00 Tuesday 8 December 2015, Room 104

Amał N. Trivedi¹, Allan J. Pollack², Helena Britt², Christopher Harrison², Graeme Miller², Margaret Kehler³
¹Brown University; ²University of Sydney; ³University of Melbourne

AB.7

OBJECTIVES
We examined prescribing of lipid-lowering medications during general practitioner (GP) encounters with Indigenous and with non-Indigenous Australians from 2001–2013.

METHODS
Using national data from the Bettering the Evaluation and Care of Health program, we conducted an observational time-trend study of 9584 primary care encounters with Indigenous patients and 750,079 encounters with non-Indigenous patients.

LESSONS LEARNED
The age-sex standardized proportion of encounters that resulted in at least one lipid-lowering prescription was 5.5% (95% CI: 4.7–6.3) among Indigenous patients and 4.6% (4.5–4.7) among non-Indigenous patients. Among encounters with Indigenous patients, the proportion recording any lipid-lowering prescription significantly increased from 4.1% during 2001–2005 to 6.4% during 2009–2013 (P=0.013 for trend). Among non-Indigenous encounters, the proportion recording any lipid-lowering prescription significantly increased from 3.8% during 2001–2005 to 5.2%...
We observed substantial increases from 2001–2013 in lipid-lowering medications and reducing cardiovascular risk for Indigenous patients, suggesting some measure of success in lipid-lowering medications for Indigenous patients compared with non-Indigenous patients. Providers were more likely to prescribe medications for Indigenous and non-Indigenous patients seen in non-remote areas (64.5–65.8) for non-Indigenous encounters.

**Cultural Safety in Hospitals in Australia: Messages from the Practice of Aboriginal Hospital Liaison Officers and Social Workers**

Liz Orr, Helen Bhadts

1University of Melbourne Indigenous Eye Health, Indigenous Health Equity Unit, La Trobe University School of Social Policy and Social Work and Lowitja Institute PhD Scholarship; 2Frankston Hospital, Peninsula Health, Social Work

Creating cultural safety for Aboriginal people in hospitals in Australia is an implicit aim of Aboriginal health policy. The Australian Health Ministers’ Advisory Council (AHMAC) Cultural Respect Framework for Aboriginal and Torres Strait Islander Health (2004–2009) outlines an approach for all government jurisdictions, departments and funded services to create cultural respect, which is a prerequisite to cultural safety. The cultural respect framework aimed to influence corporate health governance, organizational management and the delivery of services in the Australian health care system. Increasing the Indigenous workforce and changing the culture of hospitals are additional elements in strategies to build cultural safety for Aboriginal people in the Australian health system.

Stories of practice from Aboriginal Hospital Liaison Officers (AHLOs) and Social Workers (SWs) provide anecdotal evidence about the translation of cultural respect into practice in hospitals. We will respectfully share messages for ‘good practice’ from our work with Aboriginal patients/families and communities and highlights the challenges and rewards of AHLOs and SWs working together in hospitals. Drawing on the findings of one of the authors PhD research, we propose that Aboriginal and non-Aboriginal people working together as allies can not only improve the journey of Aboriginal people in hospitals but potentially create change from the ground up in hospital systems.

Ideas for continuing professional education of social workers and pathways for Aboriginal workers into higher education health courses will also be discussed with attendees at the presentation.

**REFERENCES**


**Effect of Drug Copayment Reductions on Preventable Hospitalizations Among Indigenous Australians: Australia’s Closing the Gap PBS Copayment Incentive (Winner, the best abstract overall)**

Amal N. Trivedi, Margaret Kelaher

1Brown University; 2University of Melbourne

**OBJECTIVES**

In July 2010, the Australian government implemented the Closing the Gap PBS Copayment Incentive, which reduced monthly drug copayments for Indigenous persons in non-remote areas to $5.40 or free, depending on household income. We evaluated the impact of the PBS copayment reductions on disparities in rates of preventable hospitalizations.

**METHODS**

Using hospital, pharmacy, and Census data, we conducted a quasi-experimental study assessing rates of admissions for diabetes, asthma, COPD, hypertension, heart failure, and cardiovascular events among Indigenous and non-Indigenous Australians from 2009 to 2011. We compared pre and post-policy changes in areas of high uptake of the PBS Incentive (>22% of all Indigenous persons registered) and low uptake (<22% registered). We derived confidence intervals using the Fay-Feuer method. As a falsification test, we repeated the analyses for admissions for acute conditions. The study population included 1.7 million persons (41,000 Indigenous) age 15 and older in 16 urban and regional regions in Australia.

**LESSONS LEARNED**

A targeted effort to reduce drug copayments for Indigenous Australians with chronic disease was associated with marked declines in hospitalization rates for ACS conditions, with reductions exclusively observed in areas with high uptake of the incentive and for chronic conditions amenable to drug therapy. The reductions appear plausible given the magnitude of the copayment reduction, the number of Indigenous Australians who registered for the incentive, and prior literature on hospital offsets from enhanced drug coverage.

**IMPlications**

Reducing out-of-pocket costs for prescription drugs may be a powerful strategy to reduce ethnic disparities in chronic disease outcomes.

**Identifying Bereavement-Related Grief and Loss Supports and Service Gaps in Aboriginal Communities**

Ngara Keeeler, Merridy Malin, Margaret Cargo

1Aboriginal Health Council of South Australia; 2University of South Australia

**OBJECTIVES**

The mortality rate for Aboriginal and Torres Strait people is 1.9 times higher than for non-Indigenous Australians resulting in multiple premature deaths and Aboriginal people in constant bereavement. This beyondblue funded project investigated perceptions of the prevalence and impact of grief and loss within South Australian Aboriginal communities identifying perceived effective bereavement supports, the gaps and barriers to effectiveness.

**METHODS**

The project was governed by a research team and Aboriginal Advisory Group of strategically placed community members, practitioners and managers that guided the project and lobbied for its findings to inform policy and practice.

Semi-structured and structured interviews were conducted with 134 respondents (82% being Aboriginal and 66% being female) in 19 geographic regions of the state. Interviewees ranged from CEOs, Elders, community members, and various health practitioners specialising in social and emotional wellbeing (SEWB) and mental health. Interviews were digitally recorded, transcribed and analysed thematically.

**LESSONS LEARNED**

The high prevalence of death results in Aboriginal people constantly facing the heavy burden of emotional, organisational, financial and legal demands which currently characterise funeral preparations and their aftermaths. Bereavement was addressed opportunistically within a broad range of existing programs including counselling teams, substance misuse and Elders groups.

20 programs which successfully engaged with Aboriginal people were identified and characterised, as were appropriate pathways to healing.

**IMPLICATIONS**

This unique project has been well received by community-controlled and government health sectors. The 32 recommendations, which are continuing to be implemented, relate to short-term funding priorities, workforce development policy, information dissemination, and community engagement, in a challenging political environment.
Service Satisfaction of Aboriginal Children Accessing a New Oral Health Service in Northern NSW, Australia
Michelle Irving1,2, Kylie Gwynn1,2, Blake Angell1,4, Anthony Blinkhorn2
1 Poche Centre for Indigenous Health, University of Sydney; 2 Faculty of Dentistry, University of Sydney; 3 Faculty of Health Sciences, University of Sydney; 4 George Institute for Global Health, University of Sydney

OBJECTIVES
In Australia, the oral health of Indigenous children is poorer than non-Indigenous children. A community-led oral health service was implemented, using a community development approach, for Northern NSW Aboriginal communities in 2014. This study aimed to determine: The extent of reported dental problems, oral health knowledge, attitudes and behavior, accessibility of oral health services, satisfaction and cultural sensitivity of the service, for the children of these communities.

METHODS
A survey of the children who access this service was conducted between June 2014 and December 2014. The questionnaire was interviewer assisted.

LESSONS LEARNED
A total of 48 Aboriginal children aged 4–14 (or parents of), provided responses to the survey. All agreed that healthy teeth were important, but most thought oral disease leading to extraction was normal. High levels of oral pain were reported and access to preventive care measures was low. Access to the new dental health service was reported as ‘easy’. All respondents reported approval of their dental treatment, within the new service, and that their Aboriginal heritage was respected by the oral health team.

IMPLICATIONS
The new community-led oral health service to Northern NSW Aboriginal communities is a well utilised, respected and very much needed. Community education is needed to combat the current inverse views on the normalcy of oral disease. Development of targeted, community-led health promotion programs is required to facilitate and encourage better oral health practices for the Aboriginal children in these communities.

Strengthening Cardiovascular Disease Prevention in Remote Indigenous Communities in Australia’s Northern Territory
Paul Burgess1,2, Gary Sinclair1, Mark Ramjan1, Patrick Coffey1, Christine Connors1, Leonie Katekar1
1 Department of Health, Northern Territory Government; 2 Northern Territory Clinical School, Flinders University

OBJECTIVES
In 2012 the Northern Territory Department of Health commenced the Chronic Conditions Management Model (CCMM) — strengthening cardiovascular disease prevention in remote Indigenous communities. Interventions included providing regular functional reporting and decision support to frontline primary health care teams. Our objective in this paper is to describe the outcomes associated with the implementation of the CCMM during the first three years of its operation.

METHODS
Longitudinal (3 monthly) clinical audits of cardiac prevention services between 2012 and 2014. Our primary outcome was population coverage of cardiovascular risk assessment for Indigenous clients aged 20 and older. Secondary outcomes for those identified at high risk were (i) assessment of modifiable cardiac risk factors, (ii) prescription of risk lowering medications, and (iii) the proportion of high risk clients achieving clinical targets for risk reduction.

LESSONS LEARNED
As of August 2014, 7266 clients have had their cardiovascular risk assessed, improving population coverage from 23% in mid June 2012 to 58.5%. For 2566 high risk clients, 1728 (67%) and 1416 (55%) were prescribed blood pressure and lipid lowering therapy and for those clinically re-assessed, 1366 (57%) and 989 (40%) were achieving clinical targets for risk reduction for blood pressure and lipids respectively.

IMPLICATIONS
Functional reporting and decision support was associated with improvement in cardiovascular risk assessment coverage and a sustained proportion of high risk clients achieving clinical targets for cardiovascular risk reduction. Further intervention-based research is required to close the gap between identification of risk and risk reduction.

4D A Symposium on Using Economics Data as Part of an Implementation Strategy
13:30 – 15:00 Tuesday 8 December 2015, Room 103
Economic Evaluation of Optimal Prevention and Treatment of Chronic Wounds in Australia
Rosana Norman1,2, Qinglu Cheng1, Nicholas Graves1
1 Australian Centre for Health Services Innovation (AusHSI), Institute of Health and Biomedical Innovation, Queensland University of Technology; 2 Wound Management Innovation Cooperative Research Centre

OBJECTIVES
In addition to the impact on quality of life, chronic wounds also impose an economic burden, both on the health system and on affected individuals. The aim of this study was to conduct economic modelling to reveal the social and economic benefits of optimal prevention and treatment of chronic wounds in Australia.

METHODS
State-based models were developed to estimate the change in costs and health benefits from a decision to implement nationally an optimal care pathway for chronic wounds compared with routine health services. Optimal care was defined according to national evidence-based guidelines for the prevention and treatment of chronic wounds. Transition probabilities and model assumptions were based on Australian data and augmented with international literature if not available. The main outcome measures included incidence, recurrence, time to healing, amputations, deaths, costs of health care utilisation and quality-adjusted life years.

LESSONS LEARNED
The additional costs of optimal services for the prevention and treatment of chronic wounds can be offset by the reduced service use and health care costs of improved healing of wounds, lower recurrence rates, and wounds prevented and amputations avoided.

IMPLICATIONS
This work will inform decisions on allocation of health-care resources and provide the evidence to recommend changes to the current funding and reimbursement structures leading to more efficient use of health resources and improved patient outcomes in Australia.

Using Economics Data as Part of an Implementation Strategy
Nicholas Graves
Queensland University of Technology

A failure to use economics when implementing changes to health services can lead to poor outcomes for society. In particular a situation where scarce resources are used for services that deliver no health returns, or health returns at very high marginal cost. At worst resources are used up and patients are harmed. The first 15 minutes will be giving some examples of these. Nicholas Graves will present this section. Many health services decision makers have a good sense of the potential economic loss or gain from a decision they are considering. But they struggle to convert their intuition into a clear ‘statement of the problem’ or ‘research question’. The next part of the symposium will be about the different ways decision makers express the economic problem at hand. Kate Halton will present this section.

Greg Merlo will present a discrete choice experiment on how decision makers view and use cost-effectiveness data. This shows the different attributes of cost-effectiveness information and how they are valued by health services administrators.

There will be three shorter talks on applied health services research that use economic data and arguments to make an improvement to health services. Rosana Norman will submit an abstract on improving prevention and treatment for chronic wounds. Katie Page will submit an abstract on the economics of the national hand hygiene programme. Qinglu Cheng will submit an abstract on diagnosing patients with unspecified chest pain quickly to save time and costs in the ED.

The discussion will be led by Nicholas Graves and structured to address: why poor decisions get made; how non expert decision makers...
conceptualise economic questions; what decision makers want from economic studies; lessons from the field and some likely barriers to implementation.

The Change to Costs and Length of Stay of Using the Brisbane Accelerated ChEst Pain Protocol
Qinglu Cheng1, Louise Cullen2, Jaimi Greenslade2, William A. Parsons2, Adrian Barnett1, Nicholas Graves1, Katharina Merollini1
1Queensland University of Technology; 2Royal Brisbane and Women's Hospital

OBJECTIVES
This study sought to compare the Brisbane Accelerated Chest pain (BACH) protocol and the National Heart Foundation and Cardiac Society of Australia and New Zealand Guidelines in terms of costs and length of stay associated with managing patients who presented to an Australian emergency department (ED) with symptoms of possible acute coronary syndrome (ACS).

METHODS
Prospectively collected data on ED patients presenting with suspected ACS from Royal Brisbane and Women's Hospital over two different periods was used. Information on patient disposition, length of stay and costs incurred was extracted from hospital administration records. A decision tree model was built to compare expected costs and length of stay between traditional assessment approach and the BACH approach. A probabilistic sensitivity was conducted to account for uncertainty in the information used in the model.

LESSONS LEARNED
The BACH protocol enabled a large proportion of non-high risk patients to be assessed rapidly for ACS and discharged from ED within 4 hours. A reduction in expected cost and length of stay in hospital was achieved using BACH approach compared to current guideline-based traditional assessment approach. Results from sensitivity analysis suggested that BACH approach has a high probability of being both cost- and time-saving. The BACH protocol was also safe as no one managed by BACH approach died within 30 days after discharge.

IMPLICATIONS
The BACH protocol may be a cost-effective process for the assessment of ED patients with possible ACS and help emergency departments meet the National Emergency Access Target.

Stakeholder Preferences for Economic Evaluation as a Service: A Discrete Choice Experiment
Gregory Merlo1, Kate Halton1, Nicholas Graves1, Julie Ratcliffe2, Katie Page1
1Australian Centre for Health Services Innovation (AusHSI), Queensland University of Technology, Brisbane; 2Flinders Clinical Effectiveness, Flinders University

OBJECTIVES
Economic evaluation is used infrequently and irregularly in healthcare decision-making. The current literature on the challenges to using economic evaluation in healthcare decision-making does not consider which factors are most relevant and what trade-offs are possible. This is the first study to value stakeholder preferences for economic evaluation as a service.

METHODS
Preferences of stakeholders — defined as healthcare professionals, managers, administrators, and researchers — were measured using a discrete choice experiment. Attributes were identified through a literature review and represent features that alter the usefulness, quality, or credibility of an economic evaluation. The questionnaire was conducted online using an orthogonal fractional factorial design and analysed through conditional logit regression.

LESSONS LEARNED
There were 94 responses. Regression analysis revealed significant preferences for the quality of clinical evidence, quality of economic modelling, communication, applicability (relevance to decision making context), and having no conflicts of interest. Preferences for reporting equity were not significant. Stakeholders were willing to wait over a year for a good quality economic evaluation — one having high methodological quality, with good communication, and no conflicts of interest.

IMPLICATIONS
There is a clear preference for a good quality economic evaluation that is specifically applicable and communicated well by an independent researcher. Methodological rigour is important to stakeholders, but does not solely determine the value of an economic evaluation. These findings provide guidance for how to improve the usefulness of economic evaluations in healthcare decision-making.

Economics of the National Hand Hygiene Initiative: Costing Approaches and Recommendations
Katie Page, Adrian Barnett, Nicholas Graves
Queensland University of Technology

OBJECTIVES
The objective of this study was to estimate, with measured uncertainty, the annual health services cost of running the National Hand Hygiene Program (NHHI).

METHODS
A health services perspective was adopted and data were collected from the 50 largest public hospitals in Australia that implemented the initiative, covering all states and territories. The costs of HHA, the costs to the state-level infection-prevention groups, the costs incurred by each hospital, and the costs for additional alcohol-based hand rub are all included. A discussion of the various methods used to elicit these data is provided.

LESSONS LEARNED
Retrospective collection of costing data is sometimes difficult and subject to a range of biases often resulting in uncertainty. In such situations it is essential to have good methods to capture this uncertainty so that one can assess its impact on subsequent cost effectiveness decisions. Using a range of methods to capture different costing data is recommended based on the data's likely overall impact. The most costly part of the NHHI was the time staff dedicated to its implementation; therefore accurately costing this aspect was of paramount importance. The findings from this study will be used to address the policy-relevant question of whether the NHHI is cost-effective.

IMPLICATIONS
Good estimates of the total costs of this programme are fundamental to understanding the cost-effectiveness of implementing the NHHI. This paper reports transparent costing methods, and the results include their uncertainty. Other large scale health and safety initiatives would benefit from a similar rigorous, transparent approach.
of incorporating empirical estimates of opportunity cost in the decision-making process. There was variation in preferences for, and perceived feasibility of alternative potential approaches to estimating opportunity costs. It was also noted that decision-making requires flexibility to allow for the fact that any measure of opportunity cost cannot capture all relevant effects.

**IMPLICATIONS**

Robust, empirical estimates of opportunity cost would be welcomed by decision makers, and could increase the use of cost-effectiveness data to inform health care funding decisions. Decision makers are comfortable with uncertainty around a mean estimate of opportunity cost, but open and intuitive applied methods. Cross validation, using alternative approaches would improve confidence in the relevance of empirically estimated opportunity costs.

**Does Knowledge Brokering Improve the Quality of Rapid Review Proposals?**

*Gabriel Moore* 1,2, *Sally Redman* 1, *Cate D’Este* 3, *Steve R. Makkar* 1, *Tari Turner* 4

1Sax Institute; 2University of Sydney; 3Australian National University; 4Monash University

**OBJECTIVES**

Rapid reviews are a relatively new tool for assisting policy makers to access research in shortened timeframes. Policymakers initially draft a rapid review proposal, in which they specify the purpose, questions, scope, methods, and reporting format of the review. Policymakers then have a 1-hr session with a knowledge broker who helps redraft the proposal. We aimed to evaluate whether knowledge brokering improved the clarity of rapid review proposals, from the perspective of potential reviewers.

**METHODS**

Thirty reviewers were allocated four proposals — two before (pre) and two after (post) knowledge brokering, randomly ordered, from 60 reviews, ensuring no reviewer received a pre and post knowledge brokering proposal from the same review. On a six point scale, reviewers rated six dimensions: the clarity of the review’s purpose, review questions, scope, method, and reporting format, and their overall confidence in meeting policymakers’ needs based on the proposal. The data were analysed using cross-classified multilevel modelling to test whether the knowledge brokering process improved scores on the six dimensions above.

**LESSONS LEARNED**

There were significant pre-to-post increases on all six dimensions, suggesting that knowledge brokering improved the quality of review proposals.

**IMPLICATIONS**

The study suggests that using knowledge brokering in one-off, brief interventions, may be an effective strategy for policy agencies wishing to commission rapid reviews, and for the researchers who will undertake them. It also suggests that, at relatively low cost, policy and program agencies are more likely to receive a timely, relevant and tailored review for use in policy processes.

**Engaging with Evidence: Key Findings from the Process Evaluation of a Research Utilisation Intervention in Six Australian Health Policy Agencies**


1Sax Institute; 2Australasian Cochrane Centre; 3Centre for Values, Ethics and the Law in Medicine (VELIM), University of Sydney; 4School of Medicine, University of Western Sydney; 5Faculty of Health Sciences, University of Sydney

**OBJECTIVES**

Supporting Policy in health with Research: an Intervention Trial (SPIRIT) tested the effects of a year-long multicomponent intervention designed to increase the capacity of health policy agencies to use research. Six Sydney-based agencies participated. The mixed method process evaluation focused on: (a) how the intervention was implemented (including fidelity assessment), (b) how people participated in and perceived the intervention, and (c) the contexts that mediated this relationship.

**METHODS**

Data collection included direct observation and coding of intervention activities; purposively sampled semi-structured interviews; participant feedback forms; and consultations with the intervention designers, implementers and providers. Analysis focused on Framework Analysis and the development of schematic comparative case studies.

**LESSONS LEARNED**

Marked variation between the intervention sites in how people engaged with SPIRIT was mediated by a complex interplay of factors including: perceptions of the alignment between intervention and organisational goals (underpinned by differing conceptualisations of ‘evidence’ and its role in policy practices), intervention flexibility and how adaptations were negotiated, provider delivery approaches, communication strategies, the attitudes and activities of locally nominated champions, and the burden of data collection.

**IMPLICATIONS**

Findings suggest that, like practitioners, health policymakers want ownership of the goals, methods and form of workplace interventions. Interventions similar to SPIRIT are more likely to be perceived as relevant and useful if they are rooted local practices and priorities, have a flexible and collaborative study design, use policymakers’ expertise as core content, limit data collections points and develop a tailored communication strategy.

**Senior and Middle Managers’ Views on Investment and Disinvestment Decision-Making by Acute Health Care Services: A Qualitative Study**

*Elizabeth McInnes* 1, *Rosemary Phillips* 1, *Janet Hiller* 2,3, *Gill Harvey* 3

1Australian Catholic University; 2Swinburne Institute of Technology; 3University of Adelaide

**OBJECTIVES**

Expenditure on medical and surgical consumables by Australian public acute care services totalled over four billion dollars ($4,004,625) in 2013–2014 [1]. There is evidence of waste and inappropriate use: products that are not cost-effective consume valuable hospital resources, result in limited patient benefit and may become entrenched in practice. Little is known about how acute care services make decisions about investment (purchasing) and disinvestment (ceasing or withdrawing products). The aim of this qualitative study was to investigate how acute care services make decisions about investment and disinvestment in relation to health care consumables.

**METHODS**

Interviews were conducted with 20 participants from three metropolitan acute care teaching hospitals (one private and two public). A purposive sampling approach was used to recruit senior and middle managers with a role in investment and disinvestment decisions. Interviews were transcribed verbatim to produce transcripts of narrative text for thematic analysis.

**LESSONS LEARNED**

Investment processes were reported to be underpinned by structured, systematic decisions. However, product selection was frequently based on clinician preference and experience, contractual obligations, presentations from industry representatives and ‘who’s got the loudest voice’, rather than on research evidence. Disinvestment was poorly understood and conceptualised as a euphemism for cost-cutting and disempowerment and was reported to occur in an ad hoc and unsystematic manner.

**IMPLICATIONS**

Acute care services may benefit from guidelines for robust evidence-based investment and disinvestment decision-making that promote improved patient outcomes, the optimisation of limited health care resources and ensure that clinically and cost-effective consumables are selected.

**REFERENCES**

The Development of the Organisational Research Access Culture and Learning (ORACLe) Measure to Assess Organisational Capacity to Support Evidence-Informed Health Policymaking

Steve R. Makkar1, Tari Turner2, Anna Williamson1, Jordan Louviere3, Sally Reddan1, Sally Green4, Sue Brennan4

1 Sax Institute; 2 World Vision Australia; 3 Institute for Choice, University of South Australia; 4 School of Public Health and Preventive Medicine, Monash University

BACKGROUND

Measures of organisations’ research use capacity are needed to assess current capacity, identify opportunities for improving research use, and examine the impact of capacity-building interventions. Our aim was to develop a comprehensive measure of organisations’ capacity to support research use in policymaking, entitled ORACLe.

METHODS

We firstly reviewed the available literature to identify key domains of organisational tools that may facilitate research use by staff. We interviewed senior policymakers to verify the practical relevance of these domains. This information was used to generate an interview schedule that focused on seven key domains of organisational capacity. A Discrete Choice Experiment (DCE) was undertaken using an expert sample to establish the relative importance of these domains. This data was used to produce a scoring system for ORACLe.

LESSONS LEARNED

The ORACLe interview was developed that addressed seven domains of organisational capacity: (i) documented policymaking processes; (ii) leadership and (iii) staff training; (iv) research resources; and systems to (v) generate research, (vi) undertake evaluations, and (vii) strengthen relationships with researchers. Analysis of the DCE data revealed that experts placed the greatest importance on domains (ii), (iii), and (iv). This data was used to generate a scoring system that calculated total ORACLe scores based on the relative importance of the seven domains.

IMPLICATIONS

We developed a comprehensive, context-appropriate system of measuring and scoring an organisations’ capacity to support research use in policymaking. ORACLe data can be used by organisations keen to increase their use of evidence to identify areas for further development.

An Online Tool to Help Policymakers Better Engage with Research: Web CIPHER

Steve R. Makkar, Frances Gilham, Anna Williamson, Kellie Bisset
Sax Institute

OBJECTIVES

Because of the growing need to develop innovations that help policymakers better engage with research, we established Web CIPHER; an online portal with multiple sections including Research Updates, Hot topics, Blogs from trusted public health figures, a Community Bulletin Board, Multimedia section, and Research Portal. The aim of this study was to examine website usage, and determine which sections were key drivers of usage.

METHODS

Google Analytics was used to gather usage data during a 16-month period. Analysis was restricted to Web CIPHER members from policy agencies. We examined a range of usage statistics and performed analyses of variance to compare usage between sections. Repeated measures analyses were undertaken to examine whether a weekly reminder email improved site usage.

LESSONS LEARNED

During the measurement period, 223 policymakers from over 30 organisations joined Web CIPHER. Users viewed 8 posts on average per visit, and stayed on the site for approximately 4 minutes. The bounce rate was less than 6 percent. The Blogs and Community section received more unique views than all other sections. Blogs relating to improving policymakers’ skills in applying research to policy were particularly popular. Finally, the email reminder had a positive effect on improving usage, particularly for research-related posts.

IMPLICATIONS

The popularity of the Blogs section indicates that users are keen to hear about the views of trusted figures in public health. The findings suggest that blogs combined with email alerts provide an effective strategy for disseminating the latest research to policymakers through an online web portal.

4F Symposium on Stroke

13:30 – 15:00 Tuesday 8 December 2015, Room 101

Overview of Stroke Initiatives for Improving the Quality of Hospital Care

Dominique Cadilhac1,2, Helen Dewey3, Rohan Grimley4, K. Hill5, Sandy Middleton6, Natasha A. Lannin7, Nadine Andrew1, M. Kilkenny1,2, Brenda Grabbsch2, Tharshanath Thayabaranathan1, Enna Salama2, Helen Brangan3, Amanda Thrift1, Vijaya Sundararajan8, Craig Anderson9, Geoff Donnan2, Erin Lator2
Stroke123 Investigators, ASC Data & Quality Working Group10

1 School of Clinical Sciences, Monash University; 2 Florey Institute of Neuroscience and Mental Health; 3 Eastern Health Clinical School, Monash University; 4 Queensland Health; 5 National Stroke Foundation; 6 Australian Catholic University; 7 La Trobe University; 8 Melbourne Medical School, University of Melbourne; 9 George Institute for Global Health; 10 Australian Stroke Coalition

OBJECTIVES

In June 2015, national standards for acute stroke care were launched in recognition that variable patient access to evidence-based care results in worse outcomes. This symposium will present an overview of the innovative and collaborative work that has laid important foundations for systematically and efficiently monitoring and enhancing the quality of stroke care in Australian hospitals.

METHODS

The Stroke123 partnership project is closely linked to activities of the Australian Stroke Clinical Registry (~52 hospitals in Australia) for monitoring clinical care and patient outcomes among all eligible admissions. The registry and complementary national audit data (more detailed on a subset of patients) have been used in Stroke123 as part of a quality improvement program developed by the Stroke Foundation, known as StrokeLink within Queensland. Other efforts to maximise the registry data have involved processes to achieve state-based and cross-jurisdictional data linkage. Policy initiatives, including those by the Australian Stroke Coalition and Queensland Health, have further supported these efforts.

LESSONS LEARNED

Better systems of collecting and presenting data were needed to inform facilitated quality improvement programs. Complex interactions between quality improvement activity, policy initiatives and health system changes required assessment of the context of care to understand the impacts of various drivers of improving quality. Sharing health data from different organisations was worthwhile.

IMPLICATIONS

Focussed collaboration has positioned the stroke community as a leader in the field of quality improvement and implementation science providing a sustainable infrastructure and advancements for on-going progress in reducing the burden of stroke.
Efforts to Improve National Data Collection for Stroke in Australia


1National Stroke Foundation, Melbourne, VIC; 2Florey Institute of Neuroscience and Mental Health, Heidelberg, VIC; 3Stroke & Ageing Research Centre, School of Clinical Sciences at Monash Health, Monash University, Clayton, VIC; 4Statewide Stroke Clinical Network, Queensland Health, Brisbane, Queensland; 5Priority Research Centre for Translational Neurosciences Mental Health Research, University of Newcastle and Hunter Research Institute, Newcastle, NSW; 6Faculty of Medicine, The University of New South Wales, Sydney and St Vincent’s Hospital, Darlinghurst, NSW; 7Nursing Research Institute, St Vincent’s Health Australia (Sydney) and Australian Catholic University, VIC; 8Faculty of Health Sciences, La Trobe University, Melbourne, VIC; 9Eastern Health Clinical School, Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne, VIC; 10Australian Stroke Coalition

OBJECTIVES
Data collection for monitoring stroke care in hospitals is complicated by clinicians often using multiple systems to collect the same variables on the same patients. Creating a single, yet flexible, data collection system was proposed to avoid inefficiencies, and encourage greater participation in national data collection programs.

METHODS
In 2013, the Australian Stroke Coalition agreed to focus efforts on improving the sustainability of data collection for quality monitoring in Australia and established the Data and Quality Working Group. The data custodians from major stroke care quality programs (n=3) and research projects (n=5) were invited to work with the National Stroke Foundation (NSF) to design a unified web-based system for monitoring stroke care. Sub-committees were established to focus on: governance; a comprehensive national data dictionary to ensure standardisation of variables; webtool features and functionality; policies and procedures; communication; and funding strategies. Staged transition of the programs is planned since governance clearances differ.

LESSONS LEARNED
Agreement to support data collection within a single webtool infrastructure, known as the Australian Stroke Data Tool, was achieved across all existing national program data custodians: NSF Audit; Australian Stroke Clinical Registry; repurposing data collection programs e.g. SITS, imaging database (INSPIRE); and some state-based programs e.g. Victorian Stroke Telemedicine Program, New South Wales Stroke Clinical Audit Program.

IMPLICATIONS
Through shared vision, good will and collaboration, a unified system of standardised national data collection, responsive to the needs of multiple partner programs, has been developed. The potential uses and value of this tool will be substantial.

Performance Benchmarking for Acute Stroke Care in Australian Hospitals

Nadine Andrew1, Rohan Grimley2, M. Kilkenney1,3, K. Hill4, Sandy Middleton5, Dominique Cadilhac2,3, Stroke123 Investigators

1School of Clinical Sciences at Monash Health, Monash University; 2Queensland Health; 3Florey Institute of Neuroscience and Mental Health; 4National Stroke Foundation; 5Australian Catholic University and St Vincent’s Hospital

OBJECTIVES
Performance benchmarking can help improve hospital care and identify sites in need of assistance. We aimed to test the utility of a performance benchmarking method, based on the Australia Benchmark of Care (ABC™), for the Australian healthcare system, using stroke as a case study.

METHODS
We report data for 8 nationally endorsed stroke performance indicators from the Australian Stroke Clinical Registry (AuSCR), restricted to 20 Queensland hospitals from January 2012 to December 2013 (hospital sample size: 45 to 314 cases). An Adjusted Performance Fraction (APF) score was calculated [(n adherence+1)/(N eligible+2)] for each indicator and the mean top APF scores for hospitals that represented at least 15% of the sample was the benchmark. Results were compared to current methods i.e. state averages and adherence [(n adherence/N eligible)] of top ranked hospitals and used in a multifaceted quality improvement program.

LESSONS LEARNED
Comparisons between the APF method, top performer adherence and mean adherence varied from 9% (intravenous thrombolysis: top performer 17% versus APF 18% versus mean 8%) to 53% (discharge care plan: top performer 98% versus APF 82% versus mean 45%). Large improvements (19% to 82% for discharge care plan) were achieved at some sites following the quality improvement intervention. The APF benchmark was acceptable to researchers and clinicians for identifying hospitals appropriate for quality improvement interventions and setting performance targets.

IMPLICATIONS
The APF method provided a realistic target to encourage motivation to improve performance that was often more achievable than a benchmark based on a single top performing hospital.

Financial Incentives to Increase Access to Evidence Based Care in Queensland Public Hospitals

Rohan Grimley1,2, Patrick Derhy1, Sarah Kuhle1, K. Hill3, Dominique Cadilhac2,3, Greg Cadigan4, Jane Partridge5

1Clinical Access and Redesign Unit, Queensland Department of Health; 2Sunshine Coast Clinical School, University of Queensland; 3National Stroke Foundation; 4School of Clinical Sciences at Monash Health, Monash University; 5Florey Institute of Neuroscience and Mental Health; 6Health Commissioning Queensland, Queensland Department of Health

OBJECTIVES
Stroke units (SU) provide better outcomes for patients with stroke related to greater delivery of evidence-based care. It remains unclear whether financial incentives aimed to stimulate improved access to stroke unit care are effective.

METHODS
A time-limited financial incentive scheme was collaboratively devised by the purchaser and a state-wide stroke clinical network for Queensland Public Hospitals in 2011/12. Implementation was led by the network with initial start-up incentives paid on network approval of business plans (2012). Subsequent payments were for achievement of incremental performance targets captured using new reporting codes. Network endorsement using review of processes against national guidelines and submission of clinical performance data was required for payment. Feedback on performance was integrated in network activities and the Stroke Foundation StrokeLink program.

LESSONS LEARNED
11 new SU were established. Access to SU care rose from 38.7% (12 months prior to incentive) to 77.4% (third and final 12 months of incentives) across all Qld public hospitals; and from 58.0% to 85.0% in sites with existing SU. Average acute episode length of stay dropped from 6.3 to 5.4 days, and subacute from 20.8 to 17.8 days (subacute) with corresponding decrease in costs. Involvement of the clinical network in the planning and implementation phase, start up incentives, and use of progressive and achievable targets, appeared to be key contributors to success.

IMPLICATIONS
Financial incentives can be useful to stimulate improved efficiency and access to evidence based healthcare when designed and integrated with clinical effector groups. Integration of systematic quality improvement monitoring is possible.
Effects of a Comprehensive Package of Monitoring and Quality Improvement to Reduce Gaps in Clinical Practice for Acute Stroke Care: Experience from the Stroke123 Project

M. Kilkenny1,2, Rohan Grimley3, Nadine Andrew1, K. Hill4, Helen Branagan5, Brenda Grabesch5, Enna Salama4, Natasha A. Lannin5, Sandy Middleton5, Dominique Cadilhac1,2, Stroke123 Investigators
1School of Clinical Sciences at Monash Health, Monash University; 2Florey Institute of Neuroscience and Mental Health; 3Queensland Health; 4National Stroke Foundation; 5Alfred Clinical School, Faculty of Health Sciences, La Trobe University; 6Nursing Research Institute, Australian Catholic University and St Vincent’s Hospital

OBJECTIVES
Stroke is a leading cause of disease burden. In 2011, a National Health and Medical Research Council partnership grant was awarded for Stroke123 to establish integrated methods of monitoring and improving hospital care. The primary hypothesis was that use of comprehensive performance data, coupled with an evidence-based quality improvement program, would be more effective than ‘usual practice’ for changing clinical practice and achieving better patient outcomes.

METHODS
Multicentre, controlled before-and-after design undertaken in Queensland hospitals. Patient-level Australian Stroke Clinical Registry (AuSCR) data integrated with (i) National Stroke Foundation (NSF) audit data and (ii) death registry data were provided to clinicians as part of the NSF facilitated StrokeLink quality improvement program supplemented by State Clinical Network programs. Changes in hospital adherence to 8 nationally endorsed stroke performance indicators from pre-program (2013) data to post-StrokeLink (2015) data are compared.

LESSONS LEARNED
20 Queensland hospitals participated (3,623 pre-program episodes of care; 2015 final data pending). Pre-program: 74% (range: 35%–100%) of patients were admitted to a stroke unit; 8% (range: 0–16%) with ischaemic stroke received tPA; 68% (range: 51%–86%) were prescribed antihypertensive medication at discharge; and 42–% (range: 0–94%) received a discharge care plan. Interim analyses for hospitals that completed StrokeLink workshops by mid-2014 (n=10) showed significant improvements for 5/8 clinical indicators e.g. stroke unit care: 11% increase, discharge care planning: 29% increase.

IMPLICATIONS
This evidence-based practice implementation intervention study will provide important findings for informing future efforts to improve stroke care and patient outcomes, and is transplantable to other conditions.

Understanding the Benefits of External Support Provided to Public Hospitals for Quality Improvement Activities in Acute Stroke - A Sub Study of Stroke123
Tharshanah Thayabaranathan1, Nadine Andrew1, Helen Branagan2, Enna Salama3, Brenda Grabesch4, K. Hill4, Greg Cadigan5, Rohan Grimley5,6, Sandy Middleton5, Dominique Cadilhac1,3
1School of Clinical Sciences at Monash Health, Monash University, Melbourne; 2National Stroke Foundation, Brisbane; 3Stroke Division, Florey Institute of Neuroscience and Mental Health, Melbourne; 4National Stroke Foundation, Sydney; 5Queensland Statewide Stroke Clinical Network, Brisbane; 6Department of Neurology, Nambour General Hospital, Nambour; 7Nursing Research Institute, St Vincent’s Health Australia (Sydney) and Australian Catholic University

OBJECTIVES
There are several state-based and national quality improvement (QI) initiatives designed to support Australian hospitals in closing the gap between evidence and clinical practice in stroke care, although little is known about the influence of external support. The aim was to investigate the association between the amount and type of external support provided by hospitals participating in the Stroke123 Queensland sub-study, and the extent to which a QI plan was implemented.

METHODS
Participating hospitals (n=20) were given external support for QI activities by staff from the Australian Stroke Clinical Registry (AuSCR), StrokeLink program (National Stroke Foundation), and Queensland Statewide Stroke Clinical Network. Program Managers submitted data using a standardised template on: the number of contacts; type of support; and frequency of hospitals reviewing their AuSCR data. Descriptive statistics are presented using data from May 2013 – May 2015.

LESSONS LEARNED
The most common externally supported activities included: educational outreach (66%); interprofessional collaboration (61%); and audit and feedback (10%). Face-to-face contacts ranged from 4–19/site and telephone contacts 4–22/site. Most (95%) hospital staff reported accessing their AuSCR data for QI monitoring. Hospitals that developed action plans (AP) for 4 or more indicators (n=12) tended to have more face-to-face contact time with support managers (median [Q1,Q3]: AP 24 hours [16,28] vs no AP 20 hours [14,28], p=0.41) and more email contact (median [Q1,Q3]: 30 times [20,40]) vs no AP (median [Q1,Q3]: 23 times [19,29], p=0.52).

IMPLICATIONS
Providing external support may facilitate development of action plans for hospital-based QI activities. Further research is needed.

4G Models of Care
13:30 – 15:00 Tuesday 8 December 2015, Room 108
Connecting Practice, Research and Policy to Improve Refugee Health Outcomes
Donata Sackey1, Margaret Kay1,2, Caroline Nicholson1,2, Paula Peterson1
1Mater UQ Centre for Primary Health Care Innovation; 2Discipline of General Practice, University of Queensland

OBJECTIVES
Refugee Health-Access Better Care (RH-ABC) is an innovative model of care developed to enhance the delivery of primary health care to people of refugee background. With a robust foundation informed by research, strong engagement with local refugee communities and partnerships with organisations providing services to refugees it has enabled the model to grow in a responsive manner to improve the health outcomes for refugees.

METHODS
Clinical data and qualitative research (health provider focus groups and peer led refugee community research) informed the development of RH-ABC. Evaluation of RH-ABC uses mixed methodology and focuses on access, quality of care and care coordination. Data collected (from stakeholders, health providers, and refugees) feeds directly into this dynamic model to strengthen care delivery.

LESSONS LEARNED
RH-ABC is an example of translational health service research in action where research and practice intersect there is: opportunity for policy innovation, capacity building in primary care and development of a sustainable model based on multiple stakeholder needs. Strong inclusive partnerships are critical to the success of this model and require a common vision. Incorporating feedback is essential for the model to be responsive to the dynamics of refugee health and strong communication pathways are essential. Flexibility is a strength of primary health care that affords resilience to this model.

IMPLICATIONS
Further evaluation of RH-ABC will identify gaps enabling the extension of this model. The understandings from the experience with RH-ABC will help inform the development of refugee health and wellbeing policy within Queensland giving hope for broader opportunities for health promotion and health service development. This model facilitates translational research capacity in primary care.

Integrating Care for Chronic Mental Ill-Health: Organizational Change and Outcomes, the Partners in Recovery Western Sydney Study
James A. Gillespie1,2, Jennifer Smith-Merry1,2, Nicola Hancock3, Ivy Yen1,3
1School of Public Health, University of Sydney; 2Menzies Centre for Health Policy, University of Sydney; 3Faculty of Health Sciences, University of Sydney

OBJECTIVES
People experiencing severe and complex mental ill-health face major problems navigating fragmented systems of care. This study evaluates
an attempt to integrate services to build recovery-oriented, client focused approaches to care. Partners in Recovery is a nationally funded, locally implemented program using new funding arrangements to improve system responses. Previously competing service providers are linked to improve coordination of clinical and other support needs. The paper assesses organizational change, and the development of new methods of working with clients.

METHODS
This prospective mixed method evaluation focuses on two local PIR sites in the western Sydney region. We look at relationships between: 1) the political and policy context of PIR, 2) new forms of system integration 3) changes in service delivery and processes and 4) recovery based outcomes for individual consumers. This paper explores the difficult conceptual and methodological issues raised in evaluating complex interventions in mental health.

LESSONS LEARNED
The recovery-orientation of PIR starts from individual client needs. This requires a new set of work practices, engaging with clients and building new networks to meet their needs. New models of service commissioning have faced extra hurdles of service gaps — both of information and availability. Centrally imposed administrative changes and short-term program funding have provided major challenges.

IMPLICATIONS
The findings have relevance beyond PIR. Programs such as the National Disability Insurance Scheme require new models of service commissioning. The lessons of PIR need to be absorbed to develop an adequate national response to acute and continuing mental health illness.

Implementing Integrated Models of Care for Older Adults: The Importance of Context
Toni Ashton1, Tim Tenbensel1, iCOACH Research Project Team2
1University of Auckland; 2Universities of Auckland and Toronto

OBJECTIVES
Many countries are turning their attention to the need to develop integrated models of care for older adults with complex health and social needs. This study — which is part of a wider New Zealand - Canada collaboration — aims to understand how the wider structural, political, economic and cultural context affects implementation of these models of care.

METHODS
Semi-structured interviews were undertaken with key informants who have some knowledge of the policy environment that has shaped the development of three new models of health and social care in Northland, Waikato and Canterbury. Key informants included senior managers of district health boards (DHBs), primary health organisations (PHOs), and service providers; members of Whānau Ora regional collectives; senior bureaucrats; and politicians. Interview questions focussed on the institutional, political, social, cultural and economic factors that have enabled or inhibited the implementation of our three case study models of care.

LESSONS LEARNED
Factors which enabled the development of integrated models of care for older adults included: all players share a single vision; an ability and willingness to use funding creatively; independent oversight; and a commitment to the Treaty of Waitangi. Inhibitors included: constraints on information sharing; siloed funding; the need for excessive documentation; and short-term contracts.

IMPLICATIONS
Innovative models of care are sometimes implemented in spite of, rather than because of, their policy context. Addressing some of the contextual barriers to the implementation of new models of care should assist the scaling up and/or transferability of successful models to other jurisdictions.

Cross-Sectoral Integration: Lessons from the Evaluation of a Successful Collaboration
Virginia Lewis, Jenny Macmillan, Geraldine Marsh, Kate Silburn, Vanessa White
La Trobe University

OBJECTIVES
In July 2012, a large acute health service, two community health centres and the primary care network in Melbourne’s inner North West formed an innovative partnership, committing to work together to improve patient care, outcomes and pathways to ensure patients receive the right care, at the right time in the right setting. The Inner North West Melbourne Health Collaborative (INWMHC) is governed through a multi-layered structure, including a strategic-level CEO group, an operational-level senior managers’ group and multi-partner project management and implementation groups.

METHODS
Using a mixed methods design, the evaluation was based on a program logic framework that represents the interrelated activities of the INWMHC and the collective impacts of its work.

LESSONS LEARNED
Survey data and key stakeholder interviews administered repeatedly over a period of two and a half years demonstrated the five dimensions of collaboration described by Thomson et al. (2007) were strong. As they enter their fourth year of collaboration, partners need to actively manage the potential conflict between meeting and balancing the needs and expectations of the collaborative at the same time as those of each individual organisation.

IMPLICATIONS
Through strong governance and adherence to principles of partnering and collaboration, the INWMHC demonstrates how integration of health care at the local system level can be supported and enhanced by mechanisms at the meso (collaborative) and micro (partner organisation) level. The challenge in the next phase is to determine processes by which the outcomes of projects can be translated into widespread system reform.

Three Years in to Coordinated Care: The View from Oregon
Lisa Angus1, Sarah Bartelmann2, Lori Coyner2, Chris DeMars2, Jeanene Smith2
1Australian-American Health Policy Fellow (2015–16); 2Oregon Health Authority

OBJECTIVES
In 2012, Oregon launched Coordinated Care Organizations (CCOs) to provide physical, behavioral, and oral health care to Medicaid beneficiaries. CCOs are required to adopt multiple new approaches to care delivery. They are governed by a partnership among health care providers, community members, and the entities bearing financial risk; have an integrated budget with limits on cost growth; and are accountable for health outcomes of the population they serve.

METHODS
Claims data, beneficiary surveys, CCO transformation plans and other reported data are used to monitor & publicly communicate CCOs' quality of care and financial performance. Qualitative data about the process of transformation has been collected via interviews and learning collaborative sessions.

LESSONS LEARNED
Compared to a 2011 baseline, CCOs have achieved a 22% reduction in emergency department visits, a 27% decrease in hospitalizations for complications of diabetes, and a 56% increase in likelihood of having a “primary care home.” Per-member per-month spending has decreased by 14% for inpatient hospital services and increased by 19% for primary care. Other metrics, such as follow-up after hospitalization for mental illness, do not show progress and performance on all measures varies by CCO. CCOs report significant efforts around transformation of primary care and integration of physical & behavioral health services but less progress to date on moving away from fee-for-service payments or addressing disparities.

IMPLICATIONS
Carefully designed, locally-tailored health system transformation can improve quality while holding down costs but demands substantial effort and commitment from all participants.
The Influence of Context and Organisational Factors on the Level of Integration in Primary Health Care Co-Location Models

Julie McDonald, Rachael Kearns
1Centre for Primary Health Care and Equity, University of New South Wales; 2School of Nursing and Midwifery, Flinders University

OBJECTIVES
To describe arrangements for optimising integration in co-located models of PHC and identify contextual and organisational influences.

METHODS
A multiple methods comparative case study of six co-location models. These included policy initiatives (GP Superclinics, HealthOne Centres), a NGO Community Health Service and a traditional GP practice. Data collection included semi-structured interviews, document analysis, surveys and non-participant observation.

LESSONS LEARNED
The level of integration between GPs and practice nurses (PNs) could be described as ‘coordination’, whereas integration between GPs and other co-located services/professionals rarely went beyond a lower level of ‘linkage’. GPs and PNs worked together as teams for patients with chronic conditions with nurse roles in assessments, care planning, care coordination and care provision. Roles of other co-located services in relation to GPs was more circumscribed and focused on care provision, with little input into care planning or reviews. Factors that differentiated the cases in the level of integration included their context and organisational arrangements. Local history and vision, plus regional and broader health system influences were major contextual factors. These interacted with organisational features including the types of co-located services, team structures, culture and relationships, and information and communication systems.

IMPLICATIONS
Better integration of allied health services can be supported by initiatives at three levels: macro (financial incentives that enable their participation in care planning and case conferences), meso (role of PHNs in supporting multidisciplinary practice teams and interdisciplinary working), and micro levels (multidisciplinary team structures and agreements on inter-professional and inter-disciplinary collaboration and service delivery).

From Delivery to Data: Findings from a Patient Satisfaction Survey Among Birthing Women Attending Urban and Regional Hospitals

Maree Porter, Angela Todd, Margaret Lum
Kolling Institute, University of Sydney

OBJECTIVES
Across Australia, health policies and health services promote the importance of delivering patient-centred care as a key strategy for improving the quality and safety of care. This study uses feedback from a patient satisfaction survey to explore the extent to which hospitals are meeting the needs of one of the largest and most diverse patient groups: women giving birth.

METHODS
A Framework approach was used to analyse qualitative data from a cohort survey of women giving birth in seven public NSW maternity units in 2013. Responses from 915 women were entered into Nvivo for indexing and coding to identify emerging themes.

LESSONS LEARNED
The women in this cohort displayed significant diversity in patient profile and care needs. Positive and negative experiences and outcomes were reported. Comments from women seeking infant feeding support, and women needing post-surgical care following caesarean section suggest wide differences in how well health services were responding to their needs, and thus delivering patient-centred care. Of concern, some care experiences resulted in women making choices at the expense of their own health or that of their baby.

The disconnection between patients’ expressed care needs and the care they experience reflects the disconnection between the intent of patient-centred care policy and its implementation in practice. What patients say they want and need should inform the care they receive. However, health services often lack the flexibility and resources needed to fully accommodate the wide range of women’s circumstances and care needs.

What Influences the Choice of GP? Evidence from a Discrete Choice Experiment in Australia and New Zealand

Stephen Goodall, Patricia Kenny, Chunzhou Mu, Jacqueline Cumming
1University of Technology Sydney; 2Victoria University of Wellington

OBJECTIVES
This study uses a Discrete Choice Experiment (DCE) to investigate preferences for GP consultations in Australia and New Zealand (NZ) and to determine if preferences differ by health problem.

METHODS
Participants were asked to consider 3 non-urgent health problems of different severity, and to complete 5 choice sets for each health problem (15 in total). The experiment included 9 attributes with each choice set offering a choice between 2 hypothetical GP consultations. The survey was completed online by 2005 adults (NZ=1000, Australia=1005). A generalised multinomial logit (G-MNL) model was used for estimation.

LESSONS LEARNED
There was a strong emphasis on quality (‘good communication’, ‘thorough examination’, and ‘involvement with treatment decisions’). Cost had the largest impact on the choice of a GP consultation, followed by continuity of provider and access. This was the case across all 3 health problems. The impact of cost on the probability of choosing a GP visit was greater in Australia than NZ, while the willingness-to-pay for improved quality was higher in NZ. For both countries, there was greater emphasis on the continuity and quality of care attributes when the presenting health condition was more severe.

RELEVANCE TO POLICY
This is the first study that compares population preferences for GP consultations between Australia and NZ, two geographically adjacent countries but with distinct primary health care systems. Our results suggest that the GP consultation choice will differ depending on the health problem and that NZ residents are less cost sensitive than Australian residents.

Assessment and Diagnosis Experiences of Lung Cancer Patients in Auckland

Rob McNeill, Lisa Walton, Matine Harwood, Jeffrey Garrett
1University of Auckland; 2Counties Manukau District Health Board

OBJECTIVES
Previous research has shown that people with lung cancer in New Zealand are often diagnosed at more advanced stages of illness than in other comparable countries. This research aimed to explore the experiences of lung cancer patients in the Auckland region of New Zealand and this paper focuses on the assessment and diagnosis related findings.

METHODS
A postal survey was sent to all lung cancer patients and their family, who had been diagnosed in two District Health Boards within the Northern Cancer Region Network over a two year period. A subsample of the survey participants then took part in a focus group or interview. Both the survey and the focus groups/interviews explored experiences around service access, information quality, relationships with staff, and coordination of care.

LESSONS LEARNED
Overall patients and family expressed a high degree of satisfaction with cancer services. A significant minority, however, experienced issues in a number of areas relating to their assessment and diagnosis. These included slow referral by primary care physicians for diagnostic tests, difficulty arranging diagnostic tests, lack of understandable information about their diagnosis, lack of preparation for the diagnosis, and an
over-reliance on the internet as a source of information about their diagnosis.

**IMPLICATIONS**

Many areas of service improvement have been identified and some of these are currently being worked through by the services involved. Further areas of research, particularly around the timeliness of diagnostic tests and the communication of diagnostic information are needed to better understand the needs of patients.

**Experiencing Obesity, Seeking Support in General Practice**

Jodi Gray1,2, Elizabeth Hoon1

1University of Adelaide; 2Centre for Obesity Management and Prevention Research Excellence in Primary Health Care (COMPaRe-PHC)

**OBJECTIVES**

The Counterweight Program is an evidence based weight management program delivered by practices nurses within general practice. Originally implemented in the UK, Counterweight has been piloted in South Australia. While evaluations often focus on weight change alone, patient experience may be much broader and include experiences related to wellbeing, empowerment, self-esteem, knowledge or lifestyle change. We sought to understand the experiences of patients participating in the pilot study.

**METHODS**

Across three general practices, 61 patients participated in the pilot study of the Counterweight Program. Following program delivery, the experiences and insights of participating patients were collected using in-depth, semi-structured interviews. Thematic analysis was used to identify key themes around the history of their weight and weight management, the experience of living with obesity and their experience of the Counterweight Program.

**LESSONS LEARNED**

Prominent concepts in the literature on the lived experiences of obesity include critiques of biomedical discourses on weight and resistance to stigmatised identities. While useful, these tend to oversimplify the complexity of the lived experience of obesity, where people struggle to negotiate internalised understandings of weight, health and appearance. In this study, the Counterweight Program acted as a tool, providing guidance towards health promoting behaviours and realistic weight management in a context where patients were comfortable.

**IMPLICATIONS**

Obesity is a chronic, relapsing condition, and weight management is complex. The ongoing contact and established relationship with general practice provides an opportunity to intervene and provide weight management support to obese patients.

**Carers — The ‘Hidden’ Health Workforce**

Louise Freijser, Arnie Bingham, Tom Lawrence, Peter Brooks

Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne

**BACKGROUND**

Australia currently has around 2.5 million ‘carers’ and half a million ‘volunteers’ contributing to our health and social welfare system. Carers provide the majority of care that is provided in the community. However, the gap between supply and demand for carers is predicted to widen significantly over the next few decades according to the Productivity Commission Report on Ageing 2011.

**AIM**

This study reports a literature review exploring the delivery of care by carers and volunteers and their expertise, capabilities and qualifications followed by a series of semi-structured interviews with carers and organisations to address gaps in our understanding of the role of carers in delivering care. These interviews also addressed the resources, training and structures required to better support carers to perform these roles.

**RESULTS**

The literature review identified a series of factors that influence carers and the care they provide. These included: the type and stage of the condition of the care recipient; the relationship between carer and recipient; family dynamics; location of care delivery; health literacy and the health of the carer. Financial factors were also of significant importance. Interviews with carers and care organisations highlighted a number of important issues such as: information on the health conditions; knowledge of the health system and resources available; financial management; legal rights; and self-care. An important issue that was raised was that many carers felt ignored by health professionals and their role in the delivery of care was often not acknowledged or supported.

Recommendations based on these data could be incorporated into new guidelines developed for supporting and training carers. The findings of the study also emphasise the importance of all health professional education and training in recognising the key role that carers play as part of the health care ‘team’, particularly in the aged care and disability sectors. Organisations accrediting health professional programs should ensure that all health professionals understand and support the role that carers play as part of that ‘team’.

**Invisibility of Older People as Consumers Working in Partnership with Health Providers**

Anna Gregory, Shayle Mackintosh, Carol Grech, Wendy Bastalich

University of South Australia

**OBJECTIVES**

The purpose of this study was to gain depth of insight into quality of health care, to address persistent problems with quality of care for older people who need support to live at home. An emergent objective was to explore how roles of older people in health systems affect quality of health care.

**METHODS**

An interpretive descriptive approach was adopted to analyse data collected through semi-structured interviews with 26 participants from three groups: older people, carers and key informants. Interviews explored how quality of health care for older people is experienced and perceived, and how quality of health care might be improved. Secondary review of qualitative data addressed emergent questions about how older people are placed in health care, and how the roles of older people might affect quality of health care.

**LESSONS LEARNED**

A central finding was that older people who need support to live at home are invisible as active partners engaged in shaping health care delivery, to health providers, policy-makers and researchers. Older people are visible as recipients of care, but are not yet placed at the centre of health care as partners in care. Partnership infers consumers being treated on an equal basis, being involved in decision-making and making contributions which impact upon health systems.

**IMPLICATIONS**

Invisibility of older people as partners in health care leads to missed opportunities to address persistent problems with quality of health care, through lack of engagement with older people as consumers working in partnership with health providers.

5A Child Health

Parental Use of the Victorian Nurse-On-Call Service Prior to Attending the Emergency Department for Lower Urgency Conditions

Erin Turbitt, Gary L. Freed

Health Systems and Workforce Unit, Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne

**OBJECTIVES**

The Victorian Nurse-On-Call (NOC) service has been in use for over eight years, though little research has been conducted investigating the service. This study aimed to explore whether parents in Victoria presenting with their child to the emergency department (ED) for lower urgency conditions use the NOC prior to ED arrival and whether the advice given influences their decision to attend the ED.

**METHODS**

A survey study of 1150 parents attending one of four EDs in Victoria, Australia for their child’s lower urgency condition. Frequency and
to date has been effective for universal use, the authors developed the Social Attention and Communication Study (SACS) for the early identification of ASD within Victoria’s Maternal and Child Health (MCH) system. The SACS was found to be the most accurate and sensitive method for the identification of ASD in infants and toddlers worldwide. The objectives of the current study were to replicate and improve the results of the SACS by using the SACS-Revised.

METHODS
125 Victorian MCH nurses were trained on the SACS-R for use at their 12–24 month consultations. All children identified “at risk” for ASD were referred for developmental assessments every 6 months until 2 years, and followed-up at 3.5 years to confirm diagnoses. 13,779 children have been monitored thus far, with 232 children identified “at risk” for ASD (1.68% referral rate). 169 children have been assessed, with 138 children meeting criteria for ASD (81.7% accuracy/ascertainment rate).

LESSONS LEARNED
These preliminary results confirm that developmental surveillance using the SACS-R, and not screening, is the most useful way of identifying very young children with ASD. Updated results to December 2015 will be presented at the conference.

IMPLICATIONS
Developmental surveillance for ASD during children’s routine health checks is the most accurate, and cost and time effective, way of identifying very young children at risk for ASD.

Supporting Parents' Mental Health and Wellbeing in Children’s Disability Services: Parent Perceptions of Need
Kim-Michelle Gilson 1, Elise Davis 1, Dana Young 1, Lisa Gibbs 1, Dinah S. Reddihough 2,3,4, Elizabeth Waters 1, Jeffrey Chan 5, Katrina Williams 2,3,4, Jane Tracy 6, Rachael McDonald 7, Rob Carter 8, John Reynolds 9, Utsana Tomnukayakul 6, Jennifer Morgan 10, Sean Spence 1
1Jack Brockhoff Child Health and Wellbeing Program, Centre for Health Equity, School of Population and Global Health, University of Melbourne; 2Department of Developmental Disability Research, Murdoch Childrens Research Institute, Melbourne; 3Developmental Disability and Rehabilitation Research, Murdoch Childrens Research Institute; 4Department of Paediatrics, University of Melbourne; 5Quality, Innovation and Safeguards, Yooralla; 6Centre for Developmental Disability Health Victoria, Monash University, Melbourne; 7Deakin Health Economics, Deakin University, Melbourne; 8Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne

OBJECTIVES
Parents of children with a disability experience multiple challenges, which can impact on their mental health and wellbeing. This study will describe parents’ perceptions of important service components for better supporting their mental health. The data was gathered as part of a partnership project between Yooralla and the University of Melbourne that aims to develop a new model of care that prioritises not only the health and wellbeing of children with a disability but the health and wellbeing of their families.

METHODS
Sixteen parents participated in qualitative interviews to provide their own experiences in accessing support and services, the challenges they have faced and ways that disability services could be improved to promote the health and wellbeing of children and their families. Transcripts were analysed using a grounded theory approach.

LESSONS LEARNED
Despite family-centred care approaches underpinning most disability service frameworks, parents voiced their frustration at the lack of support for their own wellbeing. Parents felt greater recognition was needed for their capacity as carers and their family as having unique needs. To sustain their mental health, parents described the need for quality support groups, new mothers mentoring programs, relationship counselling, availability of crisis and emergency contacts, family wellbeing seminars, holiday programs and flexible respite to enable parental employment.

IMPLICATIONS
Findings indicate that disability services operating within the new funding context of the National Disability Insurance Scheme need to consider how to address parents' wellbeing, in addition to catering for their child’s needs. These results inform these considerations.
The Experience of Accessing Child Disability Services: Parents' Perspectives

Dana Young 1, Elise Davis 1, Kim-Michelle Gilson 1, Lisa Gibbs 1, Dinah S. Reddihough 2,3,4, Elizabeth Waters 1, Jeffrey Chan 2, Katrina Williams 2,3,5, Jane Tracy 2, Rachel McDonald 2, Rob Carter 2, John Rodelo 2, Utsana Tommukayakul 2, Jennifer Morgan 2, Sean Spence 2, Jack Brockhoff Child Health and Wellbeing Program, Centre for Health Equity, School of Population and Global Health, University of Melbourne; 2Department of Developmental Medicine, Royal Children’s Hospital, Melbourne; 3Developmental Disability and Rehabilitation Research, Murdoch Childrens Research Institute; 4Department of Paediatrics, University of Melbourne; 5Quality, Innovation and Safeguards, Yooralla; 6Centre for Developmental Disability Health Victoria, Monash University, Melbourne; 7Deakin Health Economics, Deakin University, Melbourne; 8Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne

5B Outcomes: Acute Care

5B.3 OBJECTIVES

A new partnership has been formed between Yooralla and the University of Melbourne to develop and evaluate a cost effective model of care focussing on the health and wellbeing of children and their families. The first stage of developing the model involves qualitative interviews with parents of children with a disability to find out their experiences of accessing services.

METHODS

A qualitative study was conducted involving 16 parents of children with a disability. Parents were asked what good health and wellbeing means for their family, how disability services currently support their family’s wellbeing, any difficulties they face in accessing disability services and what they would like from a service provider to support their child’s health, function and wellbeing as well as their own wellbeing in the future. Transcripts were analysed using a grounded theory approach.

LESSONSlearneD

Analysis of the qualitative interviews demonstrated that parents feel they need to battle, fight and beg for services and feel grateful and lucky when they receive them. Parents feel isolated, experience much anxiety about the future and feel conflicted about best use of funds.

IMPLICATIONS

Parents need more support in applying for funding, accessing information and supporting their own and their families’ health and wellbeing. This research will provide insight into the services and supports required to promote health and wellbeing of children with a disability and their family, and will inform organisational redesign within the context of the new National Disability Insurance Scheme (NDIS) at a major Victorian disability service.

Parent Perspectives on General Practice Referrals to General Paediatricians

Marina Kumin 1, Erin Turbitt 1, Sarah A. Gafforini 1, Lena A. Sanci 2, Neil Spike 2, Gary L. Freed 1

1Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne; 2Department of General Practice, University of Melbourne

5A.3 OBJECTIVES

The objective was to understand parental perspectives on multiple aspects of the referral process from primary to secondary (general paediatric) care, including their beliefs regarding the role of primary care for their child, their desire for referral and their preferred method of follow-up care.

METHODS

Self-administered survey of 211 parents presenting with their child at general paediatric outpatient clinics of the Royal Children’s and Monash Children’s hospitals. Parents waiting with their child for a consultation were asked to complete the survey on an iPad using REDCap software toolset. The sample consisted of both new (N=101) and review (N=110) patients.

LESSONS LEARNED

More than half of new patients waited over three months for an appointment. Fewer than half of parents (44%) reported they were “completely confident” in their GP to provide general care for their child while 50% were “fairly confident”. Parents had less confidence in their GP to provide the follow-up care for the concern prompting the referral (31% “completely confident”; 42% “fairly confident”). Forty five percent would prefer a general paediatrician as their first choice for follow up care. Approximately one-fifth of the parents reported they were the first to suggest the referral to a GP. Close to one-third of parents preferred to consult with a paediatrician rather than a GP for any health concern.

IMPLICATIONS

Accessibility of outpatient general paediatric care may be limited by long waiting periods for an initial consultation. Request for referral to secondary care may be influenced by parental desires as well as their confidence in primary care provided by GPs.
collapsing transfers into a single unit of analysis. Risk standardised readmission ratio (RSRR) was calculated as the ratio of the observed to the expected number of returns to acute care at a given hospital, by developing and validating seven NSW-level prediction models using Fine and Gray competing risk regression. Funnel plots with 95% and 99.8% control limits based on Poisson distribution identified outliers.

LESSONS LEARNED
Sensitivity was enhanced by the use of linked data (23%–32% more returns to acute care across the seven conditions / procedures). The unadjusted rate of return to acute care ranged from 9% for total hip replacement to 25% for heart failure. The number of hospitals with an RSRR higher than expected ranged from 4 for ischaemic stroke (8.5%) and hip fracture surgery (9.5%) to 8 for pneumonia (10.3%). Higher than expected RSRRs were recorded in hospitals of different sizes (peer groups A-C), settings and regions. Most hospitals (73%) had all RSRRs as expected, or lower.

IMPLICATIONS
The RSRR method compares a hospital’s results given its case mix with an average NSW hospital with the same case mix. In NSW, this method is a screening tool, identifying areas of excellence and of potential improvement.

Unplanned Early Return to the Emergency Department by Older Patients — The Safe Elderly Emergency Department Discharge Project
Judy Lowthian 1, Lahn Straney 1, Caroline A. Brand 1,2, Anna Barker 1, de Villiers Smith 3, Harvey Newnham 3, Peter Hunter 3, Cathie Smith 3, Peter A. Cameron 1,3
1Monash University; 2University of Melbourne; 3Alfred Health

OBJECTIVES
To determine factors associated with early Emergency Department (ED) re-presentation by older patients.

METHODS
Prospective cohort study of community-dwelling patients aged ≥65 years who were discharged from a metropolitan ED, 31/7/2012 to 30/11/2013. Patients were interviewed in ED including comprehensive assessment of cognitive and functional status, and mood. The primary outcome was unplanned ED re-presentation. Multiple logistic regression identified characteristics associated with return within 30 days.

LESSONS LEARNED
Of 959 patients, median age 77 years, 140 patients (14.6%) returned within 30 days, including 22 patients (2.3%) on ≥2 occasions; and 75 patients (7.8%) within 7 days. Logistic regression identified COPD (OR 1.78 95%CI 1.02 to 3.11), moderate cognitive impairment (OR 2.07 95%CI 1.09 to 3.90), previous ED visit (OR 2.11 95%CI 1.43 to 3.12), and ATS 4 (OR 2.34 95%CI 1.10 to 4.99) to be independently associated with early unplanned return; and older age ≥85 years associated with reduced risk of revisit (OR 0.81 95%CI 0.70 to 0.93).

IMPLICATIONS
There continues to be a high return rate by older patients. Previously identified risk factors including older age, living alone, functional dependence or poly-pharmacy, were not associated with early return in this cohort. It is not clear if these inconsistencies represent a change in patient case-mix or strategies implemented to reduce re-attendance. It is timely for further research to systematically examine all the system and patient factors that impact outcomes and health care delivery after discharge.

Diagnoses and Timing of Returns to Acute Care (readmissions) Following Hospitalisation for Five Clinical Conditions and Two Elective Surgical Procedures, NSW Public Hospitals, July 2009 – June 2012
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1Bureau of Health Information; 2Centre for Primary Health Care and Equity, University of New South Wales

OBJECTIVES
To examine the diagnostic and temporal patterns associated with patients returning to acute care following discharge from NSW public hospitals.

METHODS
The return to acute care measure used linked data, and identifies patients who return to acute care within 30 days (acute myocardial infarction, ischaemic stroke, heart failure, pneumonia, hip fracture surgery) or 60 days (total hip and total knee replacement) following either discharge home or transfer to a non-acute setting. Reasons for return to acute care were explored. Patients who returned to acute care were stratified into four diagnostic categories: same principal diagnosis, related to the principal diagnosis, potentially related to hospital care (including complications and management of comorbidity) and ‘other’.

LESSONS LEARNED
Up to 82% of returns to acute care were potentially related to the index hospitalisation. The proportion of patients returning to acute care with the same diagnosis was 6% for fractured hip with surgery, 14% for acute myocardial infarction, 19% for ischaemic stroke and pneumonia and 37% for heart failure. Patients admitted for stroke were most likely to return to acute care with a condition potentially related to hospital care (43%). Almost half (46%) of patients discharged from acute care following knee replacement (TKR), and 38% following hip replacement, returned with orthopaedic complications. Temporal patterns also varied -14% of TKR and 20% of AMI returns to acute care occurred within three days.

IMPLICATIONS
Comprehensive information about timing and diagnoses associated with returns to acute care will guide strategies and initiatives to reduce rates of unplanned readmission, and improve patient care.

The Extra Resource Burden of In-Hospital Falls: A Cost of Fall Study
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OBJECTIVES
To quantify the additional length of stay (LOS) and hospitalisation costs associated with in-hospital falls and fall-related injuries to acute hospitals within Australia.

METHODS
A multi-site prospective cohort study conducted in the control wards of a falls prevention trial, involving all admissions to 12 acute medical and surgical wards from six hospitals in Australia. In-hospital falls data were prospectively collected over a 15 month period (2011–2013), from medical record review, daily verbal reports from ward Nurse Unit Manager and triangulated with incident reporting and administrative data. Clinical costing data linked for three of the six participating hospitals to calculate patient level costs. Average additional LOS and hospitalisation costs attributable to in-hospital falls and fall-related injuries were examined using multivariate linear regression models, with standard errors calculated using a bootstrap approach.

LESSONS LEARNED
After adjustment for age, gender, admission type and comorbidity, patients who had an in-hospital fall experienced an eight day longer LOS (95% CI: 5.8, 10.4, p<0.001) and an additional AUD$6,669 in hospitalisation costs (95% CI: 3,888, 9,450, p<0.001), compared to those without a fall recorded. Compared with those who fell without injury, patients with a fall-related injury experienced a four day longer LOS (95% CI: 1.8, 6.6, p<0.001) with some evidence of additional hospitalisation costs by an average AUD$4,727 (95% CI: -568, 10,022, p=0.080).

IMPLICATIONS
Patients who experience an in-hospital fall have a significantly longer hospital stay and higher costs. Our findings highlight that falls prevention programs in the acute hospital setting need to focus not only on the minimisation of harm from a fall, but the prevention of all falls.
Does Higher Bed Occupancy Rate (BOR) Affect the In-Hospital and 30-Day Mortality Rate?

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1Health Services & Outcomes Research, National Healthcare Group; 2Policy Research & Economics Office, Ministry of Health

OBJECTIVES
High bed occupancy rate (BOR) has been found to be associated with reduced patient comfort, privacy, productivity and higher hospital mortality. This study aims to explore the association between BOR and mortality in Singapore.

METHODS
This is a multicenter retrospective time series study of patients admitted from three acute hospitals in Singapore. Data on hospital admission from year 2008–2013 were extracted from hospital databases, these included: hospital admission date, daily hospital BOR, daily bed waiting time (BWT), daily emergency department (ED) admission rate and hospital mortality rates. The primary outcomes of interest were: in-hospital and 30-day mortality rates. Generalized linear regression was applied to study association between the mortality rates and their associated factors respectively.

LESSONS LEARNED
The average in-hospital mortality rate ranged from 1.4–4.0%; while the 30-day mortality rate ranged from 2.4–5.0%. The association between BOR and hospital mortality rates varied with hospital. The mortality rates in three hospitals were significantly associated with time, day of week, public holiday, BOR and 95th percentile BWT. Unlike elsewhere, in Singapore higher BOR at the hospital was not associated with higher mortality. Strong weekend and public holiday effect on hospital mortality rates were observed in this study. Patients admitted to hospital on the dates with longer BWT had higher risk of death.

IMPLICATIONS
This is the first study on association between BOR and hospital mortality in Singapore. Further research is needed to explore the reasons behind the strong weekend/public holiday effect. Reducing BWT at ED may help reduce the mortality.

Characteristics of Indigenous Primary Health Care Models of Service Delivery

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OBJECTIVES
Indigenous primary health services have been addressing the gap in life expectancy between Indigenous and non-Indigenous people for some time now. In addition to treating and managing the health of Indigenous peoples, these services often incorporate unique features such as focusing on a more holistic definition of health and an acknowledgement of the importance of upholding people’s connectedness with families, communities, Country, culture and spirituality. Our objective was to identify the characteristics, value and principles of that underpin Indigenous primary healthcare models of service delivery.

METHODS
We conducted a scoping review of the international literature. Databases were searched for commercial and grey literature. Four reviewers were involved in the appraising of studies and charting of data. A unique feature of the methods employed was the use of QSR International’s NVivo 10 software to thematically analyse the extracted findings.

LESSONS LEARNED
A number of characteristics, values and principles of Indigenous primary health care models of service delivery were identified which covered the themes of culture, governance and leadership, funding, workforce and infrastructure.

IMPLICATIONS
Findings from the review will inform the development of a best practice service delivery framework for Aboriginal primary healthcare services. This framework could then be used to support Aboriginal primary healthcare services to not only evaluate but also advocate for the unique services they provide.

Is Funder Reporting Undermining Service Delivery?

Compliance Requirements for Aboriginal Community Controlled Health Organisations in Victoria

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1La Trobe University; 2University of Melbourne; 3Victorian Aboriginal Community Controlled Health Organisation

OBJECTIVES
Large Aboriginal community controlled health organisations in Victoria provide extensive health, wellbeing and community services and obtain funding from many sources. This study was initiated to document the cost of meeting compliance requirements of such organisations in Victoria in order to create an evidence base for advocacy purposes.

METHODS
Rumbalara Aboriginal Cooperative Ltd was chosen as a case study site. Compliance requirements were documented and interviews conducted with senior managers about processes for reporting against these requirements. Data to support a costing study could not be collected due to the additional workload it would create.

LESSONS LEARNED
For the 2012/13 financial year Rumbalara Aboriginal Cooperative had 62 funding agreements with 12 agencies for which they submitted 428 reports. The organisational complexities associated with meeting these reporting requirements were significant. Examples include having to: maintain multiple data bases; report to multiple funders for some programs; and report the same data for different purposes. This creates significant organisational risk and does not enable analysis of de-identified data in ways that are useful for service planning. Accountability for expenditure of public funds was found to be procedural (focused on activity) rather than substantial (focused on outcomes) and vertical (rule oriented) rather than horizontal (relational).

IMPLICATIONS
Getting the balance and direction of accountability right is a crucial part of ensuring organisations can achieve their objectives. The current arrangements potentially undermine the delivery of holistic, integrated and coordinated models of care.

Characteristics and Value of Aboriginal Community Controlled Health Organisations Primary Health Care

Judith Streak Gomersall1, Edoardo Aromataris1, Alex Brown2, Judith Dwyer3, Drew Carter4, Kim O’Donnell3,5, Karla Canuto2, Kootsy Canuto2, Matthew Stephenson1, Odette Gibson2
1Joanna Briggs Institute, Faculty of Health Sciences, University of Adelaide, and Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; 2Wardiparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute, Adelaide, and Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange; 3Health Care Management, School of Medicine, Flinders University, Adelaide; 4School of Public Health, Faculty of Health Sciences, University of Adelaide; 5School of Medicine, Faculty of Health Sciences, University of Adelaide

OBJECTIVES
To describe and assess the unique characteristics and value of primary health care (PHC) delivered by Aboriginal Community Controlled Health Organisations (ACCCHOs) for Aboriginal and Torres Strait Islander people in Australia.

METHODS
A systematic review of qualitative evidence including grey literature published 1971–2015. The review questions were: How do patients, their family members and PHC providers’ experience/perceive: a) the characteristics and meaningfulness of PHC provided by ACCCHOs; and
b) the differences between the characteristics and meaningfulness of PHC provided by ACCHOs and other PHC providers? Two reviewers appraised studies. Aboriginal and Torres Strait Islander reviewers and sector experts with cultural and contextual knowledge were involved in each review step. Meta-aggregation was used to synthesise findings.

LESSONS LEARNED
Eighteen studies offering rich findings were identified. Qualitative research on the review topic has increased rapidly since 2004. The findings shed light on the provision of culturally appropriate comprehensive care for Aboriginal and Torres Strait Islander people by ACCHOs and how their services promote empowerment, social inclusion and access to PHC with limited resources. The findings show key common characteristics of ACCCHOs and differences.

IMPLICATIONS
Further supporting and strengthening ACCHOs to sustainably deliver comprehensive PHC services with unique characteristics that meet the complex physical and social health needs of Aboriginal and Torres Strait Islander people is a priority. More high quality qualitative research on PHC in ACCHO settings is needed to understand their contribution and resource needs. Measuring effects on social determinants of health is important in quantitative research assessing ACCCHOs contribution.

Mapping Aboriginal Patient Journeys — Working Together to Identify Gaps and Improve Health Outcomes
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1 Flinders University; 2 University of Adelaide

OBJECTIVES
To develop a set of patient journey mapping tools that could be used for quality improvement and education, to enable staff, patients and health care organisations to identify the barriers and enablers to equitable and responsive care.

METHODS
Staff, patients and family members, researchers, educators, students, managers and policy makers worked together to modify, test and adapt a set of patient journey mapping tools. Individual journeys were mapped from multiple perspectives, highlighting patient needs, health system responses and transition points. These individual journey experiences were then compared to guidelines and standards, enabling staff to identify gaps and measures for improvement.

LESSONS LEARNED
Health care is delivered in specialised segments, but mostly succeeds or fails as a package. Tracking patient experiences, or journeys, through the system is an effective way to evaluate how and why the package works—or doesn’t. Mapping patient journeys from multiple perspectives enables issues to be identified and addressed effectively “like a root cause analysis, but proactive”.

IMPLICATIONS
This study enabled better understanding of complex patient journeys for Aboriginal people and produced practical tools that highlight the critical segments and gaps. The tools help identify what support is needed and what needs to be done to improve coordination, communication, collaboration and cultural safety. Better patient journeys will deliver better health outcomes for Aboriginal people.

Engagement in a Maximally-Assisted Therapy Programme Positively Association with Optimal Adherence to Antiretroviral Therapy Among Indigenous People Who Use Illicit Drugs in a Canadian Setting
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OBJECTIVES
Indigenous peoples throughout the world experience a disproportionate burden of HIV infection and there is an urgent need to improve HIV/AIDS treatment outcomes. Maximally-assisted therapy (MAT) co-locates health services, including antiretroviral therapy (ART) dispensation, to support individuals with a history of addiction and homelessness. We sought to longitudinally evaluate the relationship between engagement in a MAT programme and achievement of optimal ART adherence among Indigenous individuals who use illicit drugs.

METHODS
Using data from the AIDS Care Cohort to Evaluate Exposure to Survival Services (ACCESS), a community-recruited cohort of HIV-positive illicit drug users in Vancouver, Canada. Longitudinal cohort data was confidentially linked to comprehensive HIV clinical monitoring records and ART dispensation records. We included all six-month observation periods with ≥1 day of ART dispensation in the previous 180 days. Using generalized mixed-effects models, we estimated the effect of engagement in a MAT programme on the likelihood of achieving >95% adherence to ART.

LESSONS LEARNED
Between December 2005 to May 2014, 321 HIV-positive Indigenous people who had ≥1 day of ART dispensation were included in these analyses. At baseline, 67% of participants in MAT achieved ≥95% adherence compared to 50% not in MAT (p=0.076). In multivariable analysis, engagement in MAT was independently associated with optimal adherence to ART (Adjusted Odds Ratio [AOR]=5.23; 95% confidence interval [CI]: 3.07–8.91), after controlling for factors including drug use, addiction treatment, and homelessness.

IMPLICATIONS
These findings provide evidence that MAT is an effective intervention to promote optimal adherence for Indigenous people living with HIV/AIDS.

Multimorbidity in Aboriginal and Non-Aboriginal People in NSW and its Impact on Mortality
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OBJECTIVES
To examine multimorbidity and its impact on mortality for Aboriginal and non-Aboriginal people in New South Wales (NSW), Australia.

METHODS
NSW hospital and deaths data were linked from March 2003–March 2014. All NSW residents alive at 1 March 2013, and admitted to NSW hospitals March 2003–March 2013, were included (n=5,704,498). The Elixhauser Comorbidity Index (30 conditions) was used to count cumulative morbidities between 2003 and 2013. The rate of multimorbidity (two or more conditions) was analysed using Poisson regression and the rate of mortality in the following year was analysed using Cox proportional hazards regression.

LESSONS LEARNED
In the 10-year follow-up period, 36.8% of Aboriginal people had at least one morbidity, and 18.9% had two or more, compared with 27.3% and 12.6% of non-Aboriginal people, respectively. The prevalence of multimorbidity increased with age, to 57.6% and 35.8%, respectively, in Aboriginal and non-Aboriginal people aged over 65 years. After adjusting for age and sex, Aboriginal people had 2.99 (2.95–3.03) times the rate of multimorbidity as non-Aboriginal people, and 2.78 (2.58–2.99) times the hazard of mortality within a year as non-Aboriginal people. Accounting for multimorbidity reduced this hazard ratio to 1.56 (1.45–1.68), but Aboriginal people were still more likely than non-Aboriginal people of the same age, sex and multimorbidity level to die within a year.

IMPLICATIONS
The prevalence of multimorbidity challenges the single-disease treatment approach. Given the impact of multimorbidity on mortality, and the high level of multimorbidity for Aboriginal people, a person-centred, rather than disease-oriented, approach is needed.
Cardiovascular Disease Risk at the Netherlands and Australian Communities: Using General Practitioners’ Clinical Data and Spatial Analysis Methods

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OBJECTIVES

This research compares cardiovascular disease (CVD) risk from Dutch and Australian general practitioners’ (GP) clinical records, assesses spatial variations of CVD risk at the community level and examines correlations of CVD risk with socio-economic status and lifestyles.

METHODS

The probability of developing absolute CVD risk over the next 5 and 10 years were estimated using 8,879 and 18,837 patients’ records from the Dutch and Australian GP data based on the Framingham risk equation. The individual risk scores were aggregated at the community level to highlight hotspots of CVD risk across the communities. Furthermore, we assessed the relationship between community level CVD risk and lifestyle information and socio-economic status, using ring maps and Pearson’s correlation analysis.

LESSONS LEARNED

CVD risk and lifestyles vary across the Australian and Dutch communities. Furthermore, communities with high CVD risk had low socio-economic status and poor lifestyles. There were considerable spatial variations of CVD risk across the Australian and Dutch communities. The method suggests an innovative way to explore hotspots of CVD risk in the communities.

IMPLICATIONS

GP practice clinical data, as real life information, are unique sources for the prediction of CVD risk score at individual and community levels. This study suggests a geo-spatial method to estimate the prevalence of CVD risk at different geographical scales using GP practice data. Fine-grained maps of CVD risk could be used by clinicians and policymakers to geographically target preventative interventions at the right place for the right people.

智能手机健康生活方式项目对年轻人：TX2BFIT™的效用

Margaret Allman-Farinelli 1, Stephanie Partridge 1, Kevin McGeechan 1, Kate Balestracci 1, Phyllayrth Phongsvan 1, Lana Hebden 1, Annette Wong 1, Elizabeth Denney-Wilson 2, M.F. Harris 3, Adrian Bauman 1

1 University of Sydney; 2 University of Technology Sydney; 3 University of New South Wales

OBJECTIVES

This study assessed efficacy and maintenance of a 12-week TX2BFIT™, a personalized healthy lifestyle program for prevention of weight gain and evaluated feasibility of recruitment from general practices (GPs).

METHODS

A randomised controlled trial of 18 to 35-year-olds who had BMI of 23 to 31.9 kg/m² (n=250) was conducted, and details of the recruitment process were collected. The intervention arm received the TX2BFIT™ that included individually-tailored motivational text messages, emails, telephone support, nutrition booklet and website resources. The control arm received one phone-call, dietary and physical activity guidelines sheet and four related texts. Participants were followed for a further six months to assess maintenance. During this time, intervention arm received two booster coaching calls and monthly texts and emails. The outcomes included weight change, changes in fruit and vegetable consumption, intakes of sugar-sweetened beverages (SSB) and energy-dense take-away foods, and physical activity. Outcomes were assessed at baseline, 12-weeks and six months from program end.

LESSONS LEARNED

TX2BFIT™ was efficacious but recruitment was challenging, and GPs contributed only 27% of the sample. Intervention participants lost 2.2 kg (95% CI 0.8–3.6), ate more vegetables and fewer takeaways and SSB and were more physically active compared with controls. Six months after program delivery further weight loss resulted with maintenance of behaviours.

IMPLICATIONS

The individually-tailored TX2BFIT intervention is effective and could be scaled up to support weight management among young adults in primary health care. However, as <30% of participants could be recruited from GPs it suggests barriers other than access need to be addressed.

Pearly Whites, a Dental Outreach Service in Residential Aged Care Facilities

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North Richmond Community Health Limited

OBJECTIVES

To improve residential aged care facility (RACF) staff oral health knowledge and RACF client oral health status.

METHODS

The guiding principles were health promotion, minimal intervention, dentistry and health equity. The program rationale was: (A) Increasing RACF staff knowledge and capacity will result in better client oral health outcomes and (B) Integration of outreach service with RACF administration ensures program sustainability, continued care and appropriate referral pathways for oral healthcare. RACFs in the Inner Northwest Melbourne Medicare local area were invited to participate. Informed consent was obtained before proceeding with client treatment or collecting evaluation information. Data collection tools included: Oral Health Assessment Tool (Chalmers 2005) and a staff pre-post knowledge survey. Client demographics, oral hygiene habits and medical history were also collected. Data were analysed using STATA 13.

LESSONS LEARNED

Across RACFs a 20% increase in RACF staff oral health knowledge was noted post the oral health workshop, with increases in knowledge per RACF ranging from 10% to 31%. Mean RACF client oral health assessment scores were lower than 5, which is closer to the good oral health side of the scale. A 20% improvement in client oral health means scores (across RACFS) were observed at follow-up.

IMPLICATIONS

Preliminary results are encouraging and provide sufficient evidence for program continuation and expansion to a more robust study design to explore causation. In-depth analysis is being conducted to understand what works, for whom and in what contexts. This evaluation will help establish best practice models of oral healthcare for elderly in residential care.

Effectiveness of Knowing the People Approach on Case Managers of Mental Health Teams: Findings of a Longitudinal Study from Canterbury, New Zealand

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School of Health Sciences, University of Canterbury

OBJECTIVES

This study tested the effectiveness of a service development tool —"Knowing the People Planning" (KPP) for management of mental health clients in the Canterbury District Health Board (CDHB), New Zealand.

METHODS

A longitudinal study was conducted in the CDHB mental health services and data were obtained from 341 case managers who managed clients with long term mental health disorders, under the care of the Community Mental Health Teams (CMHTs), in Christchurch. The managers at the North, South, East and West CMHTs were invited to participate in the study. The West CMHT managers were provided with KPP (N=83) while the other teams continued with usual care (N = 258). The intervention period was staggered over different time points, and The Health of the Nation Outcome Scale (HoNOS) data were collected every three months over a three-year period to investigate mental health outcomes. The data were analysed using RM-ANOVA, and GEE in SPSS.
LESSONS LEARNED
The intervention group showed increase of reporting of client symptoms in the first three months following the intervention commencement period. Scaled scores for reporting of the client symptom scores were notably higher in the intervention group for depression (standardised beta = 1.86 (95% CI: 1.22, 2.49), and the HONOS 12-item summative scores (standardised beta = 2.24, 95% CI: 0.86, 3.63).

IMPLICATIONS
Immediately following KPP implementation, case managers reported increased scores for client symptoms. This implies that KPP can reinforce observations among the mental health care managers and can be used as a monitoring tool in the community mental care setting.

Translating Clinical Trial Research Outcomes to Improve Venous Leg Ulcer Healing in the Community
Carolina Weller, Anna Barker, Jan Darby, T. Haines, Martin Underwood, Stephanie Ward, John McNeil
1Monash University; 2RMIT; 3Warwick University

OBJECTIVES
Almost 400,000 Australians suffer from venous leg ulceration costing over $3 billion/year. The burden of disease is expected to rise with an ageing population and growing diabetes and obesity epidemics. Best practice care involves compression therapy to aid venous return. Our compression clinical trial results have been translated to clinical practice but have found many remain unhealed due to inflammatory response. The objective was to determine whether aspirin as an adjunct to compression improves time to healing.

METHODS
The ASPirin in Venous Leg Ulcer (ASPIVLU) study, a double blind placebo controlled RCT. 268 participants from Australian wound clinics and primary care settings will be recruited. We will report time to healing, recurrence rates, quality of life, wound pain, biomarkers of inflammation and platelet activation, adverse events, and medication adherence.

LESSONS LEARNED
Aspirin is a widely used drug that has several actions potentially capable of influencing the progression of healing by suppression of inflammation to promote ulcer healing. Data suggest that aspirin (300mg daily) may speed healing rates. Improving healing rates in an ageing population with chronic venous insufficiency is a high priority. Aspirin is an affordable medication whose use is unlikely to be limited by income or insurance status.

IMPLICATIONS
ASPIVLU will likely have a significant impact on medical care world-wide because the ageing of the Australian populations will progressively increase the numbers for whom these results are applicable.

The Roadmap to Close the Gap for Vision: Evidence, Planning and Implementation for Improved Indigenous Eye Health Outcomes
Mitchell Anjou, Uma Jatkar, Emma Stanford, Hugh Taylor
Indigenous Eye Health, University of Melbourne

OBJECTIVES
The Roadmap to Close the Gap for Vision (2012) is a sector-agreed policy reform framework with 42 recommendations spanning a whole-of-system approach to eliminate disparities in Indigenous eye health. The Roadmap was built from an evidence base including a national survey of the prevalence of eye conditions and investigations of the barriers and enablers for successful eye care.

METHODS
National activity has been advanced through peak bodies, professional associations, governments, non-government organisations and universities. Roadmap regional approaches currently exist in twelve areas, representing over 35% of Australia’s Indigenous population. Regional stakeholders include Aboriginal Health Services, eye specialists and health authorities. An annual progress report is published.

LESSONS LEARNED
Progress has been made to increase services, improve efficiencies and support better Indigenous patient engagement with the eye care system. Five of the 42 Roadmap recommendations are complete, but there remains much work to be done. Despite considerable high-level advocacy, a national oversight function is yet to be established and jurisdictional oversight varies across the country. Eye health indicators have been agreed and efforts to eliminate cost as a barrier have been partially successful. Eye health workforce capacity has been increased and efforts to improve data sharing and the coordination of care are being realised.

IMPLICATIONS
The Roadmap provides example of evidence, planning and implementation leading to improved Indigenous eye health outcomes. The template used for eye care has high relevance for integrating care between primary care, specialist and hospital services for both Indigenous and non-Indigenous Australians.

5E Research Translation: Implementation
15:30 – 17:00 Tuesday 8 December 2015, Room 102

Translating Knowledge into Practice: Training for Community Service Providers Who Work with People Living with Dementia
Grace O’Sullivan, Clare Hocking, Kathryn McPherson
Auckland University of Technology

OBJECTIVES
To develop, deliver, and evaluate training that will equip service providers, who deliver care and support to people who live with mild to moderate dementia in the community, with up to date knowledge designed to dispel disabling myths about dementia.

METHODS
This exploratory qualitative study involved an interdisciplinary, inter-university team working in collaboration to develop an evidence based resource for use in the delivery of dementia specific training. Participants, who were recruited from three organizations that are publicly funded to provide care services in the community included management staff, care workers, and clients. Data on the acceptability and support for the training were gathered from organizational staff through focus group discussions. Clients engaged in individual interviews to consider the perceived outcomes. Using a conventional qualitative approach, transcribed data were analysed to generate open codes which were clustered into themes and sub-themes addressing the content, delivery and value of the training.

LESSONS LEARNED
Organizational staff valued up-to-date knowledge that was reinforced with ‘real life’ stories grounded in practice. Clients welcomed the strengths based approach which encouraged person-centred care. Conversely, the findings indicate that contractual obligations and communication deficits between health care institutions, affect the translation of knowledge into practice and ultimately, this impacts on the quality of service provision.

IMPLICATIONS
Community care staff’s capacity to implement new knowledge and understanding is dependent on the health policies which underpin practice.

What’s Going on Here? Factors Influencing the Implementation of a Hospital Nutrition Intervention
Jorja Collins, Catherine E. Huggins, Judi Porter, Claire Palermo
1Department of Nutrition and Dietetics Monash University; 2Dietetics Department Eastern Health

OBJECTIVES
Discrepancy between planned and actual delivery of interventions in healthcare can affect outcomes for recipients. Discrepancy may, in part, result from reliance on staff to adapt their work practices for intervention implementation. This study aimed to explore from the perspective of hospital foodservice staff, their experiences delivering a nutrition intervention to address inadequate intake of patients and the factors affecting its implementation.

METHODS
A process evaluation using qualitative description was undertaken. A purposive sample of foodservice staff who delivered the intervention
(n=15) participated in focus groups and semi-structured interviews. Factors influencing staff’s capability, opportunity and motivation to provide the intervention were explored. Data were analysed using content (sub-themes) and thematic analysis (themes) by two independent researchers underpinned by theories of behaviour change.

LESSONS LEARNED

Five key themes (and 15 sub-themes) were identified. Aspects of the foodservice environment and patients’ resistance were barriers to prescribed implementation and perceived sustainability of the intervention. Teamwork, problem solving, leadership and job satisfaction among staff were enablers. There was opportunity to optimise training and feedback. Foodservice staff’s knowledge, beliefs and perceptions of diet, health and their job role had the potential to influence their behaviours and decision making.

IMPLICATIONS

Addressing the challenges of time, the foodservice structure, patients’ resistance, gaps in knowledge and misconceptions of foodservice staff may enhance similar nutrition interventions in the future. More broadly, considering the interacting factors that influence behaviour change of healthcare staff is necessary in clinical practice and research studies to enhance fidelity, feasibility and sustainability of interventions.

Infant Colic in the Emergency Department; a Mixed Methods Study to Understand Factors Influencing Clinician’s Practice

James McGann1,2, Valerie Sung2, Denise O’Connor3, Jaqueline Manohar2, Franz Babl4, Harriet Hiscock2

1 University of Melbourne; 2 Murdoch Childrens Research Institute; 3 Monash University; 4 Royal Children’s Hospital

OBJECTIVES

The aim of this study is to apply an established theory-based approach, the Theoretical Domains Framework (TDF), to identify clinician reported barriers and enablers to managing infant colic in the emergency department (ED). We specifically focused on two guideline-recommended behaviours — explaining normal crying and limiting anti-reflux medication use.

METHODS

We conducted TDF guided, semi-structured focus group discussions from March until May 2015 with doctors from different training levels working at The Royal Children’s Hospital ED to explore factors affecting current practice. We conducted content and thematic analysis to identify TDF domains relevant to each guideline-recommended behaviour.

LESSONS LEARNED

A total of 25 doctors (7 consultants, 4 fellows, 14 registrars) participated in 5 focus groups, stratified by seniority levels where possible. Several key domains acted as barriers and enablers to desired behaviours. Domains that considerably impacted on explaining normal crying included the view that it reassured parents and prevented representation (theoretical domain of ‘Belief about consequences’) and time restriction (‘Environment and resources’). For limiting anti-reflux medication use, parents requesting the medication (‘Social influence’) and the clinician’s desire to avoid disrupting the parents’ relationship with the practitioner who prescribed the medication (‘Belief about consequences’).

CONCLUSIONS

Using the TDF, we identified key factors that served as barriers and enablers to best practice management of infant colic in the emergency department. These factors present theoretically based targets for future interventions.

The Integrated-PARIHS Framework: Facilitating a Theoretically-Informed Approach to Research Translation

Gill Harvey, Alison Kitson
University of Adelaide

OBJECTIVES

Successful translation of research into clinical practice and healthcare delivery remains a challenge. The Promoting Action on Research Implementation in Health Services (PARIHS) framework was first published in 1998 [1] and proposed that successful implementation resulted from a complex interplay between the evidence to be implemented, the context of implementation and the way in which the process was facilitated. Since 1998, the framework has been applied across a range of countries and healthcare settings, mostly commonly as a heuristic device to plan and evaluate implementation projects.

METHODS

Building on published critiques of PARIHS, areas for further refining the framework were identified, namely to: articulate the theories underpinning PARIHS; more clearly acknowledge the role of the actors involved in translation; and be more explicit about how to operationalise PARIHS. Linking theory, concepts and an operational model of facilitation has resulted in the development of the integrated-PARIHS or i-PARIHS framework [2].

LESSONS LEARNED

The i-PARIHS framework defines successful implementation (of research) as the facilitation of an innovation with individual and collective recipients in their local, organisational and health system context.

IMPLICATIONS

The main differences from the previous PARIHS framework are that facilitation is positioned as the active ingredient in implementation. A continuum for developing novice, experienced and expert facilitators is proposed. The concept of evidence is broadened to one that draws on wider theories of innovation. Recipients are acknowledged as key actors within the implementation process and both inner and outer context are recognised to exert an influence on the translation process.

REFERENCES


Key Factors for Successful Implementation and Uptake of eMMS — A Pharmacy Perspective

Elin C. Lehnborn1, Melissa T. Baysari2,3, Johanna I. Westbrook3

1 Faculty of Pharmacy, University of Sydney; 2 Department of Clinical Pharmacology and Toxicology, St Vincent’s Hospital; 3 Centre for Health Systems and Safety Research, Macquarie University

OBJECTIVES

To explore Australian hospital pharmacists’ perceived barriers and facilitators to successful implementation of electronic medication management systems (eMMS).

METHODS

Twelve pharmacists with experience using eMMS participated in a semi-structured interview in person or over the telephone. Two researchers independently coded each transcript, and compared and discussed themes to further develop a coding frame.

LESSONS LEARNED

Pharmacists reported that some eMMS features (e.g. automatic annotation of medication orders) allowed work to be performed more efficiently than when using paper charts, but in other cases, the design of the eMMS (e.g. lack of integration with other hospital systems) led to new tasks being created for pharmacists. Pharmacists varied in their views on the impact of eMMS on patient safety. More legible medication orders and a reduction in transcribing tasks were often cited as benefits of eMMS, regardless of the eMMS used. However, pharmacists also identified particular system features in some eMMS that compromised patient safety. For example, a ‘safety’ feature (warfarin had to be ordered daily following INR review) in one eMMS was thought to lead to doctors forgetting to order warfarin, putting patients at risk of adverse outcomes. The responsiveness of support staff to modify and improve the eMMS once implemented had a great impact on pharmacists’ satisfaction with the system.

IMPLICATIONS

Carefully choosing a system that is interoperable with other hospital systems, intuitive to use, and that can be easily modified with local support were key factors identified by pharmacists for successful implementation and uptake of eMMS.
This symposium introduces a framework that can be used to characterise arrangements for knowledge organisations in performance measurement and reporting efforts. It then draws on this framework to explore differences across three contexts within Australia: the Bureau of Health Information which is a board-governed organisation operating at arm’s-length from the NSW Ministry of Health; the Department of Health and Human Services which fulfils the functions of health performance measurement and reporting at the national level, and the National Health Performance Authority which is a board-governed statutory authority operating in accordance with the National Health Reform Agreement between the Commonwealth, states and territories. A panel discussion will follow involving an international expert discussant and a question and answer session.

LESSONS LEARNED
Within health jurisdictions, knowledge organisations are configured differently in response to key tensions or questions including how to: (1) balance stability, capitalise upon embedded knowledge and expertise, with encouraging change in response to shifting circumstances; (2) determine the appropriate mix of levers of change to be utilised; (3) balance the need to be integrated into the healthcare system with the need for independence and the credibility that brings.

IMPLICATIONS
Critical analysis of different configurations for performance measurement and reporting reveals potential for inter-jurisdictional learning and innovation in performance management and reporting efforts.

Health System Improvement in Australia: Knowledge Organisations as Enablers
Jean-Frédéric Lévesque 1,2, Kim Sutherland 1, Lisa Corscadden 1, Christopher Papadopoulos 1
1Bureau of Health Information; 2Centre for Primary Health Care and Equity, University of New South Wales

OBJECTIVES
Across healthcare systems, there is consensus on the need for independent and impartial assessment of performance. There are various ways assessment enables change. The aim of this presentation is to describe and explore different levers that promote and support improvement of performance in healthcare systems.

METHODS
Synthesis of reports and academic papers that describe performance reporting organisations’ functions and levers for change.

LESSONS LEARNED
Eight levers were identified from the literature, spanning internal and external influences, and emergent and planned change. Providing awareness of performance is a (1) cognitive lever for change. Seeing how well others are doing can encourage emulation through a (2) mimetic lever. Programs or policies based on providing (3) supportive ideas and resourcing or (4) formative feedback facilitate emergent change. Professional associations and accreditation bodies provide (5) normative standards and assessment that can encourage providers or organisations to change. Ministries and private funders can use (6) coercive, managerial levers that provide external incentives and disincentives to force change. Finally, external pressures exercise either (7) competitive or (8) structural levers.

IMPLICATIONS
Data, information and knowledge are increasingly crucial to support service delivery, redesign of clinical models, and consolidation of organisational structures to respond to changing population needs. Some of the levers are internal to providers or managers, meaning individuals are enabled to act on problems with emergent, or bottom-up change processes. Other levers are external, securing change through planned, or top-down, processes, often to address more sensitive or difficult issues. Multimodal approaches have the biggest impact.

The Bureau of Health Information in NSW: Providing Accountability and Informing Efforts to Improve at the Interface of Patients, the Public, Clinicians, Policymakers and Managers
Kim Sutherland 1, Christopher Papadopoulos 1, Jean-Frédéric Lévesque 1,2
1Bureau of Health Information; 2Centre for Primary Health Care and Equity, University of New South Wales

OBJECTIVES
To explore different approaches to performance measurement and reporting with particular reference to how the Bureau of Health Information (BHI) reconciles its dual objectives of providing accountability and informing efforts to improve healthcare in NSW.

METHODS
Given the wide range of options for knowledge management functions
and organisations in healthcare systems, BHI's structure, governance, mandate and strategic direction are mapped. Relative strengths and challenges associated with this arrangement are identified and explored. Various approaches to leveraging performance measurement and reporting for accountability and quality improvement purposes are compared.

LESSONS LEARNED
There is a range of different knowledge organisations in NSW, each with different but sometimes overlapping roles and functions. As a ‘pillar’ of the NSW healthcare system, BHI operates in a negotiated space at the intersection of patients, the public, clinicians, managers, researchers and policymakers. This fosters both collaboration and competition and has resulted in an integrated framework for accountability and quality improvement across the NSW healthcare system.

IMPLICATIONS
Providing accountability and supporting efforts to improve healthcare are widely held objectives. The relative strengths and benefits that can flow from a small knowledge organisation which is both connected to, but separate from, healthcare administrators and local providers can inform approaches used by knowledge organisations in other contexts and jurisdictions.

Improving Measurement and Measuring Improvement: Monitoring the Performance of Public Health Services in Victoria

Aaron Doty, Paul Dolan
Victorian Department of Health and Human Services

OBJECTIVES
To describe the key features of Victoria’s health service performance monitoring framework, the challenges facing it and the way it is evolving.

METHODS
The key features of the Victorian health service performance monitoring framework are described, in the context of the environment that has shaped them — particularly the relatively long history of public health systems managed by independent boards and funded through casemix arrangements. Formed in this milieu, the framework has come to centre on a performance assessment score based on an annual performance contract (the statement of priorities) signed between the government and individual health services. The score is used to determine the level of earned autonomy applied to health services.

LESSONS LEARNED
The performance monitoring framework has evolved with the healthcare system, responding to government priorities and changing thinking about the measurement of hospital performance. In particular, the framework has changed to focus more on outcomes, patient experience and contextual factors in performance (including leadership and culture) that drive and sustain performance.

As well as building on these directions, the framework needs to find ways to help drive continuous performance improvement across the healthcare system while improving its ability to detect and respond to performance problems.

IMPLICATIONS
The Victorian framework provides an example of responsive regulation of the healthcare system. This arrangement is beneficial in that it fosters the intersection of patients, the public, clinicians, managers, researchers and policymakers. This fosters both collaboration and competition and has resulted in an integrated framework for accountability and quality improvement across the NSW healthcare system.

LESSONS LEARNED
There is a range of different knowledge organisations in NSW, each with different but sometimes overlapping roles and functions. As a ‘pillar’ of the NSW healthcare system, BHI operates in a negotiated space at the intersection of patients, the public, clinicians, managers, researchers and policymakers. This fosters both collaboration and competition and has resulted in an integrated framework for accountability and quality improvement across the NSW healthcare system.

IMPLICATIONS
Providing accountability and supporting efforts to improve healthcare are widely held objectives. The relative strengths and benefits that can flow from a small knowledge organisation which is both connected to, but separate from, healthcare administrators and local providers can inform approaches used by knowledge organisations in other contexts and jurisdictions.

5G Changing Practice

15:30 – 17:00 Tuesday 8 December 2015, Room 108

Prevention and Early Intervention for Perinatal Mental Health: An Evaluation of Outcomes for Women who give Birth in Australia

Nicole Reilly 1, Deborah Loxton 2, Peta Fordier 2, Sheree Harris 2, Catherine Chojenta 2, Jeanette Milgrom 3, Marie-Paule Austin 1

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OBJECTIVES
Clinical practice guidelines now recommend that women be asked about their past or current mental health as a routine component of maternity care. The purpose of this research was to examine the clinical effectiveness of this prevention and early intervention approach to perinatal mental health using data from women who had recently given birth in Australia.

METHODS
A sub-sample of women (N=1804) from the Australian Longitudinal Study on Women’s Health (ALSWH) Young Cohort participated in the study.

LESSONS LEARNED
Results showed that asking women about current mental health is not only a good practice approach but does not seem to inflate referral rates, and that health professionals appropriately taking into account risk factors such as past history will initiate referrals. Subsequent analyses demonstrated that this line of enquiry is associated with help seeking throughout the perinatal period, in particular when women are also referred for additional follow-up or management, as required. The most consistent predictors of maternal mental health and parenting outcomes across the first two years following birth were overall social support, significant stressors in the 12 months prior to survey completion and delayed help seeking.

IMPLICATIONS
This research provides an important contribution to the ongoing debate relating to the clinical efficacy of depression ‘screening’ or psychosocial assessment during pregnancy and the postpartum. The clinical and resource implications of these findings for the primary health care sector should be considered prior to the implementation of future routine perinatal depression screening or psychosocial assessment programs.

Reflections on the Experiences of a National Organisation Dedicated to Public Reporting on Hospital and Primary Care: An Australian Experience

Diane Watson
National Health Performance Authority

OBJECTIVES
Discuss performance measurement and public reporting from the perspective of the National Health Performance Authority (NHPA) and to critique the strengths and limitations of its operating environment and approach to assessing and reporting on health performance.

METHODS
A critique of NHPA’s operating environment; its strategic directions and tactics for achieving them; the nature of its performance reports; and the ways in which it optimises the positive impact of its public reports was conducted to provide nation-wide insights into health performance measurement and quality improvement.

LESSONS LEARNED
NHPA operates within the context of its legislation and intergovernmental agreements between the Commonwealth, states and territories and reports within the context of a nationally agreed framework and list of indicators. NHPA has used a number of tactics effectively including: prospectively defining the audience and purposes of reports to optimise report content, design and impact; engaging with key stakeholders to identify high-priority information needs for its reports; magnifying the effects of reports by focusing on a single topic where performance indicators are grouped as themes; and liaising closely with the media to more effectively communicate important health-related messages to the public, facilitating improvement in hospitals and primary care.

IMPLICATIONS
The experiences of NHPA suggest that when specific strategies and tactics are employed a health performance and reporting organisation can quickly become a credible and trusted source of locally relevant health performance information and an influential agent for effecting positive change in relation to hospitals and primary care.
Evaluating Practice Change in an Acute Health Setting: Capturing Complexity

Virginia Lewis, Vanessa White
La Trobe University

OBJECTIVES

The Australian Government’s National Reform Programme, A World’s Best Practice Approach to Organ and Tissue Donation for Transplantation includes a number of different elements which are intended to contribute — ultimately and in combination — to a national system for organ and tissue donation that maximises the potential number of donated organs and leads to successful outcomes for transplant recipients. Evaluating the reform programme requires an approach that recognises its complex multi-layered nature and acknowledges the difficulties of attribution of change to specific activities because of the dynamic context in which organ and tissue donation takes place.

METHODS

A program logic or theory-based approach was used to develop a framework for the evaluation in consultation with the OTA. The framework guided identification of indicators required to explore and explain the process and experience of organ donation requesting, recognising individual, organisational and community-level factors. Based on the program logic, relevant indicators and methods for data collection were identified and implemented in 15 participating hospitals.

LESSONS LEARNED

The evaluation framework provided a useful structure within which to determine the key indicator domains that would be relevant to capture the complex and dynamic way the intended collaborating requesting model for organ donation requesting was being implemented in each site. The indicators and methods used to assess the pilot can be used for routine monitoring and continuous quality improvement.

IMPLICATIONS

When seeking to intervene strategically at multiple points in complex systems, theory-based approaches to evaluation offer benefits that are not present through other paradigms or approaches.

Leading and Managing Changes in the Rapidly Changing Healthcare Environment — Are Health Service Managers Ready for Such Challenge?

Zhanming Liang1, Peter Howard1, Sandra Leggat1, David Briggs2, Godfrey Issourd4, Janny Madden4, Nicola North5
1La Trobe University; 2University of New England; 3University of Auckland; 4Flinders University; 5University of Auckland

OBJECTIVES

The competence of health service managers (HSM) is important to the successful implementation of health reform agendas. The presentation will discuss whether middle level managers from Victorian hospitals and community health services (CHS) are competent in leading and managing change and areas of improvement are required to improve their competence. The presentation will also discuss the importance of using an evidence-based competency assessment process to identify the competency gaps and training and development needs of the health service management workforce.

METHODS

The MCAP Competency Assessment Tool consisting of 360° subjective and case study-based objective assessments was used to assess the competence of middle level HSM from Victorian CHS and hospitals in leading and managing change in their roles between 2012 and 2014.

LESSONS LEARNED

The 360° Subjective Assessment indicates that middle level HSM are competent in leading and managing changes. However, more than half of the CHS managers failed to fully demonstrate their competence in the objective assessment confirming the existence of areas requiring significant improvement and the value of subjective and objective measures of managerial competence.

IMPLICATIONS

Training and development is required to improve the competence of middle level HSM in leading and managing change — an essential requirement for being a manager working in rapidly changing healthcare environments. The need for improvement is greater amongst managers working in the CHS. An evidence-based assessment process is critical to confirming the competency gaps and setting the overall directions of training and development for HSM.

Factors Affecting Implementation of Perinatal Mental Health Screening in Women of Refugee Background

Nishani Nithianandan 1, Melanie Gibson-Heilm 1, Christine East 1,2, Kylie Gray1, Jacqui McBride2, Jacqueline Boyle1
1Monash University; 2Monash Health

OBJECTIVES

To investigate barriers and enablers to implementing evidence based, nationally recommended perinatal mental health screening for women of refugee background.

METHODS

Semi-structured interviews with a broad range of stakeholders (n = 28): midwives, obstetricians, nurses, refugee health experts, interpreters, and women of refugee background from diverse ethnic groups (n = 9).

LESSONS LEARNED

All participants perceived perinatal mental health screening in this cohort to be necessary and pregnancy was commonly recognised as an opportune time for screening. Common themes across all groups included the trade-off between prompt screening and building rapport, continuity of care, timely mental health care and women perceiving follow up care as useful. All community representatives discussed loss of social support as a significant stressor and the importance of on-site female interpreters, trust, empathy, and peer support. Barriers identified by health professionals included time and training constraints and availability of interpreters and mental health services. Whilst most participants felt the Edinburgh Postnatal Depression Scale was appropriate, some health professionals expressed doubts about the cross-cultural understanding of, and communication of, key concepts. Multiple enablers to implementation were proposed: normalising screening, privacy, simple referral pathways and clear communication of pathways, feedback mechanisms, support for staff, and both women and staff developing a sense of ownership.

IMPLICATIONS

Perinatal mental health screening is perceived as necessary by both health professionals and consumers. The findings presented here are critical to informing the appropriate and sustainable implementation of a robust screening and management program for women of refugee background.

Effect of Change in Coding Rules on Incidents and Variations of Non-Recorded Diabetes Condition in NSW Hospital Administrative Datasets

Hassan Assareh, Helen M. Achat, Veth M. Guevarra, Joanne M. Stubbs, Neil Hime, Kim Hill
Epidemiology, Executive Medical Services, Western Sydney Local Health District

OBJECTIVES

During 2008–2011 Australian Coding Standards mandated a causal relationship between diabetes and inpatient care as a criterion for recording diabetes as a morbidity. We examined the associated effect on recording diabetes and related inter-hospital variations.

METHODS

Using NSW linked inpatient datasets, we identified and followed all adult inpatients with diabetes to NSW public hospitals during 2004–2013. An index admission was identified for each diabetic. Subsequent admissions without a diabetes code were classified as discrepancies. Poisson mixed models were employed to derive adjusted incidence rates (IR), rate ratios (IRR) and quantify inter-hospital variation.

LESSONS LEARNED

Diabetes condition was not recorded in 20.7% of all admissions for patients with diabetes (494,433 admissions for 102,150 patients). Discrepancy rates were four times greater during the ‘changed rules period’ (2008–2011) compared to the pre- or post-change periods (IR=32.5% vs. 8.4% in 2004–2007, 6.9% in 2012–2013). Inter-hospital variation was also higher; the discrepancy rate gap between hospitals with the highest and lowest rates doubled compared to the other periods (median IRR=1.50 vs. 1.24 and 1.27). The inter-hospital variation
of discrepancies decreased during the change period (27%), while discrepancy rates continued to rise (50%). Case mix explained a smaller proportion of the variation in the change period of the variable compared to the other periods (46% vs. 59% and 53%), leaving hospitals-specific practices more responsible for the observed differences.

**IMPLICATIONS**

Difficulties associated with communication are thought to contribute to pressures. A collaborative approach using cycles of improvement has seen success despite a complex environment including an initiative to engage accredited interpreters in labour. Driven by evidence, leadership and supporting champions were critical to ‘doing things differently’ in this universal health platform. A number of PDSA cycles have resulted in scaling up the initiative with lessons learnt about the challenges of sustaining best practice care. An after hours general practitioner (GP) helpline was established as a supplementary service to existing 24-hour nurse-staffed TTAS in Australia. This qualitative study explored the perceptions of professional identity and role, motivations and contributions to the health system of GPs employed on the afterhours GP helpline in 2011–2013.

**METHODS**

The study took a phenomenographic approach seeking to understand the essence of being a telephone GP, probing professional identity while also exploring role characteristics and tensions. Twelve GPs, or 15% of the helpline GP workforce participated in in-depth semi structured interviews.

**LESSONS LEARNED**

The helpline GPs experienced both personal and professional benefits and believed they were strengthening patient care and the Australian health system. However the role required a re-alignment of conventional practice that challenged professional autonomy, the Dr-patient relationship and commitment to continuity of care. There was a strong collegial bond amongst the helpline GPs which facilitated the maintenance of professional autonomy and the emergence of a new generalist primary care identity as telehealth innovators.

**IMPLICATIONS**

Despite the absence of two features of primary care generalism — comprehensiveness of practice and continuity of care — GPs identify new generalist skills in a helpline role. The establishment of an after hours GP helpline in Australia has provided the platform for an emerging primary care generalist role as a telephone-based GP.

**Limitations Experienced by GPs and Nurses Relating to Health Literacy and Obesity Management in Primary Health Services**

**OBJECTIVES**

To identify issues reported by general practitioners (GPs) and practice nurses (PNs) in the assessment and management of patients with obesity and low health literacy in their practice.

**METHODS**

A cluster randomised trial with twenty general practices in low socioeconomic areas (10 each in Sydney and Adelaide). Participants (37 GPs and 24 PNs) self-completed a validated questionnaire on their assessment and management of obese patients and attitudes to health literacy.

**LESSONS LEARNED**

Neither GPs nor PNs reported usually assessing patients’ level of health literacy, using a range of recommended communication techniques (or assisting patients with low health literacy to access community-based programs). While most participants reported frequently assessing patient risk factors and providing brief advice, they reported less frequently working with patients to set goals or refer them to other services. They reported barriers to patient referral such as the availability of affordable and appropriate services. Factors reported as impacting GP and PN capacity to treat obesity were lack of patient interest in preventive care and their own lack of time.

**IMPLICATIONS**

GPs and PNs can have significant roles in assessing and providing weight management education and advice. Our findings, however, suggest they fail to tailor their approach to the needs of patients with low health literacy. They tended to conflate their patients’ lack of understanding (due to low health literacy) with lack of motivation. Combined with infrequent referral, this means that patients with obesity and low health literacy tend not to be advised of effective options that are available.
"It Opened My Eyes" — Examining the Impact of the Australian Chlamydia Control Effectiveness Pilot (ACCEPt) on the Chlamydia Testing Practices of General Practitioners

Highly commended abstract by an ECR

Anna Yeung1, Jane Hocking2, A. Vaisey2, Rebecca Lorch3, Rebecca Guy3, Christopher K. Fairley4, Kirsty Smith5, John Immie6, Basil Donovan5,7, Jane Gunn6, Meredith Temple-Smith6

ACCEPt Consortium

1 School of Public Health and Community Medicine, University of New South Wales; 2Centre for Epidemiology and Biostatistics, Melbourne School of Population and Global Health, University of Melbourne; 3Kirby Institute, University of New South Wales; 4Melbourne Sexual Health Centre; 5Central Clinical School, Monash University; 6UCL Centre for Sexual Health and HIV Research, University College London; 7Sydney Sexual Health Centre; 8General Practice and Primary Health Care Academic Centre, University of Melbourne

OBJECTIVES

Chlamydia testing rates remain low in Australian general practice, despite dramatic increases in notifications and recommendations that young people be tested annually. ACCEPt is a randomised controlled trial to evaluate the impact of a chlamydia testing intervention on chlamydia prevalence. The intervention included regular feedback, visual reminders, computer alerts, support for recall systems and incentive payments. To assess the acceptability of ACCEPt, GPs were interviewed to investigate changes in their chlamydia management practices.

METHODS

Semi-structured interviews were conducted with purposively sampled GPs prior to randomization (baseline) and after one year in the intervention (midpoint) until saturation was reached. Data were analysed thematically to examine the effectiveness of the ACCEPt intervention and issues around implementing a complex intervention into practice.

LESSONS LEARNED

A total of 44 GPs at baseline and 24 GPs at midpoint were interviewed. The ACCEPt intervention facilitated GPs’ comfort and ease in offering a test, and was associated with a shift in practice from symptom-based testing to age-based testing. Many GPs highlighted that feedback was a major driver of increased testing. The intervention was gradually implemented through increasing awareness and engagement with the project. However, not all GPs were able to utilize all of the intervention components because of limitations in clinic structure, like the expenses associated with a recall system. Logistical issues, such as remembering to offer a test, were overcome with practical facilitators like computer alerts.

IMPLICATIONS

GPs reported that the ACCEPt intervention has been effective at increasing testing in general practice.

Barriers and Enablers to Effective Falls Prevention in Acute Hospitals

Anna Barker1, Jason Talevski1, Mari Botti2, Patricia M. Livingston3, Sandy Brauer3, Fiona Landgren4, Caroline A. Brand1, Renata T. Morello1, Mayer Melham1, Zhao-Chen Bian1

1Monash University; 2Deakin University; 3University of Queensland; 4Project Health Melbourne

OBJECTIVES

The aim of this study was to assess nurse and senior management perceptions of barriers to, and enablers of, effective falls prevention in acute public hospitals to inform the implementation of a nurse led falls prevention program — the 6-PACK program.

METHODS

A mixed-methods study including 24 acute wards from six Australian hospitals was conducted (2). Data was obtained via medical records, incident reporting and practice audits (n=37,737); focus groups (n=12 with 96 nurses); interviews (n=24); and surveys (n=420).

LESSONS LEARNED

Audits and bed-side observation revealed variable falls prevention practice across wards. Falls commonly occurred in relation to toileting (35% of falls), from the bed (38% of falls) and in confused patients (38% of falls). Barriers to effective falls prevention identified in focus groups and interviews included a lack of time, skills, effective strategies, and resources. Patient complexity and a belief that falls were inevitable were also identified as barriers. Enablers included face-to-face education; leadership; and use of audit, reminders, feedback and benchmarking.

IMPLICATIONS

This study provides new information on the perceived barriers and enablers to effective falls prevention practices within the acute hospital setting. These results inform that future implementation of falls prevention programs include the promotion of executive and ward leadership; on-ward face-to-face education and improved access to falls prevention resources.

Re-Commissioning Mental Health Community Support Services and Community-Based Alcohol and Other Drug Treatment Services in Victoria

Kate Silburn, Virginia Lewis

La Trobe University

OBJECTIVES

Significant reform has been undertaken in two important sectors in Victoria — mental health community support services and community-based alcohol and other drugs treatment services. These reforms (labelled ‘recommissioning’) have resulted in new regionalised system configurations in which there are central intake and assessment providers and a limited number of service providers. This paper will explore some of the lessons learnt from these reform processes with a focus on the resultant outcomes for both service providers and six months post reform.

METHODS

Semi-structured interviews were undertaken with 23 CEOs and senior managers. Interviews were analysed by theme, documented and sent to participants for checking prior to finalising the work.

LESSONS LEARNED

There are significant challenges to introducing reform in complex systems. ‘Recommissioning’, is seen as one mechanism for achieving enhanced quality and efficiency in human service systems. A range of lessons about commissioning were identified, including those associated with: introducing ‘one size fits all’ models across a state; using competitive tendering as a mechanism for achieving human service system reform; and the consequences of limited attention to process in system re-design.

IMPLICATIONS

If large scale systems reform is to be successful, service provider experience and expertise needs to be actively engaged to facilitate excellence. The criteria underpinning procurement processes need to be consistent with achieving the desired outcomes and transition periods need to be well prepared for and carefully managed.

Stories of Excitement and Frustration — Interprofessional Collaborative Practice in Primary Health Care

Andrew Lynch, Nicola North, John Parsons

University of Auckland

OBJECTIVES

Health care systems around the world increasingly emphasise interprofessional collaborative practice (ICP), particularly in the primary health sector. However, considerations of ICP are confounded by differences in definitions and understandings of the primary concepts. This study explores the ways that different professionals in primary health care understand ICP.

METHODS

Semi-structured interviews were conducted with a range of professionals working in primary health care in the Northland, Waikato and Canterbury regions of New Zealand. Utilising a critical hermeneutics lens, different understandings of ICP were explored.

LESSONS LEARNED

It has been argued that profession specific cultures (and role socialisation), interfere with the ability to work collaboratively with other professions. Key excerpts from research stories will be used which illustrate challenges to these ideas and show:
• Personal experiences of culture and collaboration that professionals carry, impact on their experiences of, and hopes for, collaboration with others.
• Engagement in individual and collective reflective practices has a strong relationship with ICP.
• Establishing long-term professional relationships in an environment of respect and trust seems fundamental to meaningful ICP.
• ICP can include the following: working with other professionals within, and/or outside of, your own organisation; intersecting work across the primary and secondary sectors; working with clients, their families, and their communities.

IMPLICATIONS
Implementation of meaningful ICP requires the following: a significant shift in the professional education of our health care workforce; a recognition by organisations of the time needed to invest in relationship building; utilisation of processes of individual and collective reflection by professionals.

The Transformation of First Nations Health Governance in British Columbia, Canada: Implications for Regional Co-Decision Making in Health Services (Highly commended abstract by an ECR)

Lloy Wylie
Western University

OBJECTIVES
This study is a partnership between researchers and the First Nations Health Authority, which examined co-decision making between FNHA and existing regional health authority partners, which continue to deliver health services in BC. This symposium addresses three main aspects of this transition: the transformation of governance; the impact of an Indigenous wellness approach; and the opportunities for improved health services through coordination.

METHODS
Qualitative key-informant interviews and a policy dialogue workshop were held in 2014 with participants from local health authorities, FNHA and other government stakeholders; all have played a key role in the transformation of governance for First Nations Health Care in BC.

LESSONS LEARNED
The development of new political partnerships have been built on long-term engagement and trust. This has allowed for sharing perspectives on health and wellness to inform health services planning. The relationship between higher level leadership is not yet fully developed in the regional levels, although this is starting through the creation of regional partnership accords and service level coordination.

IMPLICATIONS
New partnerships and self-governance arrangements in Indigenous health creates the opportunity for more appropriate health services for Indigenous peoples, including the focus on wellness through action on the determinants of health. This panel discusses the principles of partnership that have facilitated the transformation of health governance, and the opportunities and challenges for the cross-jurisdictional co-ordination of health and wellness services to improve the health of Indigenous peoples.

Cross-Jurisdictional Co-Operation in First Nations Health Services Delivery (Highly commended abstract by an ECR)

Lloy Wylie
1, Josée G. Lavoie2, Danielle Alcock3
1Western University; 2Faculty of Medicine, University of Manitoba; 3Public Health, Anthropology, Western University

OBJECTIVES
This presentation will examine the opportunities and challenges in the co-ordination of cross-jurisdictional health services under the new model of First Nations health governance in British Columbia. Drawing on the experience of health service providers working in regions across BC, structural challenges to effective coordination are discussed, and innovative service partnerships between health authorities and First Nations’ run services are explored.

METHODS
Qualitative key-informant interviews and a policy dialogue workshop were held in 2014 with participants from local health authorities, FNHA and other government stakeholders; all have played a key role in the transformation of governance for First Nations Health Care in BC. This presentation is based on the coded data that discusses the opportunities and challenges in the coordination of delivery of health services for First Nations in different regions of British Columbia.

LESSONS LEARNED
The high level political agreements have created the space for regional partnerships in health services delivery for Indigenous peoples. At the same time, the relationships established at the provincial level have not yet been developed in the regions, with partnerships and trust among health authority and First Nations staff emerging at an uneven pace.

IMPLICATIONS
Effective coordination of health services delivery can address the barriers in service access faced by Indigenous peoples. Strong partnerships among care providers in First Nations organizations with mainstream health services can increase the understanding of health needs in specific communities. These partnerships across jurisdictions provides an opportunity for providing more culturally safe and appropriate care for Indigenous peoples.

Wellness Based Indigenous Health Promising Practices: Using Culturally Appropriate Indicators as a Way to Measure Indigenous Wellness

Danielle Alcock1, Lloy Wylie1, Brittany Bingham2
1Western University; 2Simon Fraser University

OBJECTIVES
The development of the FNHA presents an opportunity for an Indigenous perspective to shape the debate about population health and wellness. First Nations control of health services allows for integrating local knowledge to ensure culturally safe care. This presentation will discuss the impact of a wellness approach to ensure that the determinants of health, i.e. housing and community development, are part of the measure of Indigenous wellness.

METHODS
Qualitative key-informant interviews and a policy dialogue workshop were held in 2014 with participants from local health authorities, FNHA and other government stakeholders; all have played a key role in the transformation of governance for First Nations Health Care in BC. This presentation is based on the coded data that discusses perspectives of wellness.

LESSONS LEARNED
Participants have indicated that using culturally appropriate indicators as a way to measure Indigenous wellness can be used to assess if services, programs and policies are meeting Indigenous community needs. Implementing a First Nations wellness perspective into the health care system is an important commitment of this work and solidifying the role of traditional healers into service delivery.

IMPLICATIONS
Existing strategies in BC First Nations health services use cultural/traditional Indigenous practices to promoting Indigenous wellness and address health disparities. This approach to holistic wellness can inform the discussion about sustainable health care, with an emphasis on population health and wellness strategies, can create a model for the rest of the country.

The Transformation of First Nations Health Governance in BC

John O’Neil1, Brittany Bingham1, Josée G. Lavoie2
1Faculty of Health Sciences, Simon Fraser University; 2Faculty of Medicine, University of Manitoba

OBJECTIVES
First Nations health governance in British Columbia (BC), Canada has
undergone a historic transformation with the transfer or operations from the federal government to the new First Nations Health Authority (FNHA). A Tripartite Framework agreement guided this transformation and established the formalized partnerships between: FNHA, the provincial government and the regional health authorities.

**METHODS**
Qualitative key-informant interviews and a policy dialogue workshop were held in 2014 with participants from local health authorities, FNHA and other government stakeholders; all have played a key role in the transformation of governance for First Nations Health Care in BC. This paper focuses on the qualitative data that discussed the principles of partnerships, and the ways that the new governance agreements have changed accountabilities and cross-jurisdictional collaboration.

**LESSONS LEARNED**
Key findings highlighted the importance of relationship development and commitment between partners. Building lasting partnerships takes time and effective communication is key. Participants also indicated that an increased understanding of reciprocal accountability and developing mechanisms to ensure accountability for regional partners is important.

**IMPLICATIONS**
Ongoing partnerships and co-decision making will have its challenges and successes. It is important to continue building on these existing partnerships through the development and commitment to regional partnership accords. The partnership accords allow partners to come to a consensus as well as continue building trust, have clear expectations and good communication. Telling the story of this historic transformation and its successes and challenges has implications for Indigenous health globally.

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**6B Outcomes Pharmaceutical Services & Policy**

08:30 – 10:00 Wednesday 9 December 2015, Room 104

**How Do Medication Policies Guide Nursing Practice? A Comparison of Medication Policies Across Seven Victorian Health Services**

*Mariann Fossum, Tracey Bucknall, Lee Hughes, Elizabeth Manias, Paul Bennett, Trisha Dunning, Alison Hutchinson, Julie Considine, Mari Botti, Maxine M. Duke*

Deakin University, School of Nursing and Midwifery

**OBJECTIVES**
The objectives were to review and compare the content of medication management policies across seven Victorian health services to consider whether the policies contained requisite and consistent information to guide the medication management of nursing staff in acute health services.

**METHODS**
Medication management policies for administration of medications were obtained from six public health services and one private health service in Victoria. Policy content was extracted and reviewed for 14 predefined coding categories. Coding categories were based on the relevant medication management literature and legislation. Analysis focused on policy content including the health service requirements and regulations governing nursing practice.

**LESSONS LEARNED**
Medication management policies are developed to assist health professionals to safely treat patients; however, concurrent activities and interruptions increase the risk of medication errors. This policy analysis identified some areas of standardisation in staff authorisation, controlled medications and poisons, labeling injections and infusions, patient self-administration, documentation, and management of medication errors. However considerable variation in medication management policies was evident across Victorian health services in policies related to medications that require single- and double-checking, and the individuals involved in checking procedures; procedures for nurse-initiated medications; administration rights; telephone orders; and competencies required to check medications.

**IMPLICATIONS**
High level of complexity and lack of intra-jurisdictional concordance between health services may lead to increase the potential for nurses to administer medications outside policy guidelines of a particular health care organisation. A standardised medication management policy would facilitate institutional benchmarking for error and inform the development of effective guidelines.

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**A Multifaceted Approach to Improve Medication Management When Patients are Fasting or Nil by Mouth**

*The-Phung To 1, David Story 2, Melodie Heland 3, Patricia Bruce 4, Catherine D’Alterio 4, Andrew Hardidge 5*

1 Pharmacy Department, Austin Health; 2 Anaesthesia, Perioperative and Pain Medicine Unit, Melbourne Medical School, University of Melbourne; 3 Surgical Clinical Service Unit, Austin Health; 4 Consumer Representative, Austin Health; 5 Orthopaedic Surgery, Austin Health

**OBJECTIVES**
Confusion about managing medications when patients are fasting or nil by mouth affects patient safety. We aimed to use a multifaceted approach to improve the management of medications when patients are fasting or nil by mouth.

**METHODS**
A process that simplified and standardised medication administration instructions and included use of decision aids, champions, opinion leaders and audit/feedback, was rolled out on a surgical ward. Interventions focussed on distinguishing fasting from nil by mouth — all medications should be given unless advised when a patient is fasting whereas nothing should be given orally if nil by mouth (different route of administration should be sought). Decision aids were colour-coded using the traffic light system (i.e. red/do not give, amber/check before giving, green/give). Data were collected from 20 consecutive, preoperative, non-elective, orthopaedic surgery patients, per month, 8 months pre- and post-intervention. Logistic regression was used to compare inappropriate medication omission pre- and post-intervention.

**LESSONS LEARNED**
Inappropriate medication omissions decreased from 35% (260/748) pre- to 9% (73/817, OR 0.18, p<0.0001, post-intervention). There was also a decrease in patients with one or more inappropriate omissions (67%, pre- compared with 28%, OR 0.20, p<0.0001, post-intervention). These results suggest that the multifaceted approach, which included simplification, standardisation and use of decision aids, was associated with an improvement in the management of medications in the study population.

**IMPLICATIONS**
The multifaceted approach appeared to be important to the change in practice seen. Further studies are required to determine whether this approach is effective in a wider population.

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**Is There a Difference in Characteristics of Consumers Who Cease or Reduce Their Medication? A Review of Statin Medication Dispensing Pre and Post a PBS Co-Payment Increase (Highly commended abstract overall)**

*Karla Seaman 1,2, Anna Kemp-Casey 2, David Preen 2, Caroline Bulsara 3, Max Bulsara 4*

1 School of Health Sciences, University of Notre Dame Australia; 2 Centre for Health Services Research, University of Western Australia; 3 School of Nursing and Midwifery, University of Notre Dame Australia; 4 Institute for Health Research, University of Notre Dame Australia

**OBJECTIVES**
To examine differences between consumers who ceased, reduced, or continued statins following a 21% consumer co-payments increase in January 2005.

**METHODS**
We analysed individual-level Pharmaceutical Benefits Scheme (PBS) claims for individuals in Western Australia with ≥3 statins dispensed in 2004. Numbers of scripts dispensed during this period were compared to 2005, with statin dispensing categorised as: i) reducing (<20% decrease in amount dispensed), ii) ceasing (no record of a statin dispensed in 2005), or iii) continuing (<80% change). Demographic characteristics and prior medication use were ascertained from PBS records and mortality data were used to censor for death. Multivariate logistic regression determined the difference in characteristics between groups.
LESSONS LEARNED
Both cessation and reduction of statins were more common for females (OR=1.23, 95% CI=1.18–1.29), those with higher RxRisk scores (OR=1.03, 95% CI=1.02–1.04), and aged >50 years. People ceasing statins were more likely to be concessional beneficiaries (OR=1.34, 95% CI=1.25–1.43), live outside of Perth and be newly-initiated on statins (OR=2.62, 95% CI=2.48–2.77). Reducers were more likely to be general beneficiaries (OR=1.09, 95% CI=1.06–1.13) with prior statin dispensing history (OR=1.20, 95% CI=1.15–1.24).

IMPLICATIONS
The results indicate that large increases in co-payments affect medicine use by females, younger adults and those with existing co-morbidities. While reduction in use of essential medicines is concerning; it is particularly alarming that concessional beneficiaries, people in regional/rural areas and the newly-initiated were most likely to cease therapy following the 21% co-payment increase. Policy makers should be aware that cost increases can differentially impact the population.

The Cardiovascular Polypill: Does Increasing the Quality Use of Medicines Save Money?
Tracey-Lea Laba1, Stephen Jan1, Alison Hayes2, Anushka Patel1, Anthony Rodgers1, KGAP and PEAK Study Investigators
1 George Institute for Global Health, Sydney; 2 School of Public Health, University of Sydney

OBJECTIVES
Australia’s National Medicine Policy (NMP) seeks to improve health through the availability and quality use of safe, effective and cost-effective medicines. Yet for cardiovascular disease (CVD), while many such medicines are available, large treatment gaps and medicine non-adherence suggest that the NMP’s objectives are not being met. The CVD 4-in-1 polypill is a novel strategy that improves the quality use of CVD medicines and health outcomes by changing patient and prescriber behaviour through simplifying treatment regimens. While expected to reduce costs compared with current practice, very little prospectively collected data supporting this claim exists. This study sought to compare the ‘real-world’ costs of a CVD polypill against usual care among Australians with established CVD or at high estimated cardiovascular risk.

METHODS
A ‘within-trial’ cost analysis from the Australian health system perspective of polypill-based care versus usual care using data from the pragmatic randomised controlled trial Kanyini Guidelines Adherence to Polypill (Kanyini GAP) and linked health service and medication data. The primary outcome, estimated with generalised linear models, was mean annual health service and pharmaceutical expenditure, per patient.

RESULTS
Statistically significantly lower mean annual pharmaceutical expenditure of $989 (95% CI 648 to 1331) per patient in the polypill arm (P<0.001, adjusted, excluding polypill cost). No significant differences in annual non-hospital health service expenditure ($40, 95% CI -202 to 281 per patient).

IMPLICATIONS
Although the CVD polypill has the potential to produce significant cost savings to health systems while improving the quality use of CVD medicines, translation into practice remains a challenge.

What Consumers Think, Do and Say About Antibiotic Use
Elaine Lum1, Katie Page1, Lisa Nissen1, Jenny Doust2, Nicholas Graves1
1 Queensland University of Technology; 2 Bond University

OBJECTIVES
The objectives of this study were to investigate (1) the attitudes and behaviours of Australian consumers in antibiotic use, and (2) their understanding of antibiotic resistance.

METHODS
Semi-structured interviews were conducted with consumers in May/June 2015. Convenience sampling was used to recruit consumers between 18–54 years old. Thirty-two consumers were interviewed. Transcripts were analysed to identify themes.

CONCLUSIONS
If the TPPA is successfully prosecuted it will contribute to adverse health outcomes by limiting policies governing and rationalising the use of medications, and reducing access to affordable medicines. This calls for patent law that prioritises the public interest, and for public institutions and decision making processes that are independent and free from pharmaceutical industry influence.
OBJECTIVES

Primary health care research in Alberta, Canada is carried out through multiple networks. Our team wanted to describe the emerging role of the Alberta Primary Health Care Research Network (APHCRN) in quality improvement (QI), translation of research into practice, and identifying research priorities in primary health care.

METHODS

We gathered information from the published literature, stakeholder dialogue, and monthly network meetings to identify primary health care research priorities in the province of Alberta. Participants at the stakeholder dialogue included clinician researchers and health policy decision makers. At the dialogue participants deliberated on primary health care research priorities that were presented to them. We adopted Wenger’s notion of Communities of Practice (CoP) where knowledge is regarded as a social enterprise at the center of member interactions.

LESSONS LEARNED

The Alberta Primary Health Care Research Network (APHCRN) aims to support primary care research, knowledge translation and exchange, and scale-up of evidence-based solutions to pressing issues and challenges facing the primary health care system and providers in Alberta, Canada. The APHCRN aims to clarify the difficulty of applying study findings to everyday care as an inappropriate disconnect between discovery and implementation, research and practice. Participatory models are emerging in which stakeholders agree on their goals; and apply their collective knowledge, skills, and resources to accomplish these goals.

IMPLICATIONS

Research Networks are learning communities, proving grounds for evidence-based solutions to pressing system issues and challenges, and engines for improvement of primary health care delivery systems in Western Canada.

Reducing the Research Policy/Practice Gap: A Collaborative Initiative

Jonathan Karonn, 1, Ellen McIntyre, 2, Carol Davy, 3, Christina Hagger, 2, Julie Marker 4

1 University of Adelaide; 2 Flinders University; 3 South Australian Health and Medical Research Institute; 4 Cancer Voices

OBJECTIVES

During the 8th HSRAANZ Conference, researchers voiced the need to learn more about effective research exchange strategies to increase the relevance of their research for policy and practice. A South Australian based collaboration set out to develop, implement and evaluate an initiative to address this need.

METHODS

Three widely promoted public interactive panel discussions addressed the challenges of translating research into policy and practice from researcher, policy maker and community perspectives, respectively.

REFERENCES


Screening for Rheumatic Heart Disease in the Pacific: Translating Research into Policy (Highly commended abstract by an ECR)

Daniel Engelman, 1,2,3, Andrew C. Steer1,2,3

1 Royal Children’s Hospital Melbourne; 2 Centre for International Child Health, Department of Paediatrics, University of Melbourne; 3 Group A Streptococcal Research, Murdoch Childrens Research Institute

OBJECTIVES

Rheumatic heart disease (RHD) continues to be one of the major causes of morbidity and mortality for children and young people in the Pacific. Population-based screening for RHD has been recommended by the WHO as an important strategy for disease control, and several Pacific Island nations have expressed an intention to establish screening. We aimed to evaluate the evidence for rheumatic heart disease screening, in order to develop appropriate policy recommendations for the Pacific.

METHODS

A relevant set of review criteria were developed from screening program theory, incorporating methods and criteria used by the United Kingdom National Screening Committee, Australian framework and the World Health Organization. Published and grey literature was searched for relevant evidence, including primary data and expert commentary. The evidence was evaluated, collated and appraised against the screening criteria.

LESSONS LEARNED

Despite an increase in evidence regarding RHD screening over the last decade, particularly regarding the use of echocardiography, considerable gaps remain for many essential screening criteria. Critical gaps include the natural history of latent disease without intervention, effectiveness of available treatments to improve long-term outcomes, capacity of health systems to effectively manage identified cases, best screening test strategy and cost-effectiveness.

IMPLICATIONS

Based on the available evidence, population-based screening in resource-limited settings in the Pacific is not currently justified. Further innovation in screening methods and operational research are required before this strategy could be recommended for disease control.

Rainbow Standards — Developing LGBTI-Inclusive Practice in Health Care Delivery

Philoitena Horsley, William Leonard, Sunil Patel

Gay and Lesbian Health Victoria, Australian Research Centre in Sex, Health and Society, La Trobe University

OBJECTIVES

To promote national standards of LGBTI-inclusive practice to health and human services in order to improve health outcomes for lesbian, gay, bisexual, transgender and intersex (LGBTI) people.
OBJECTIVES
The Teeth Tales research study (2006–2014) aimed to address increased risk of early childhood caries for children from migrant/refugee families. It was underpinned by a culturally competent, participatory approach. The final exploratory trial phase (2012–2014) aimed to establish a model for feasible health promotion, for culturally diverse local government areas in Australia.

METHODS
The trial included families with children (1–4yrs), self-identified as Iraqi, Lebanese or Pakistani background, residing in metropolitan Melbourne. Dental screenings were provided to 667 children as part of recruitment and follow-up. The intervention comprised peer educator-led community oral health education sessions, attended by 151 (52.4%) intervention families. Partner organisations participated in a Cultural Competency Organisational Review (CORE) to reorient dental health and family services.

LESSONS LEARNED
Significant differences in Debris Index (OR=0.44 (0.22, 0.88)) and Modified Gingival Index (OR=0.34 (0.19, 0.61)) indicated improved child oral hygiene in the intervention group. An increased proportion of intervention parents, compared to the comparison group reported they had been shown how to brush their child’s teeth (OR=2.65 (1.49, 4.69)). No significant difference was found in other knowledge or behaviour outcome measures. Costs of recruitment activities and intervention delivery averaged $709 per family in the intervention group. Partner organisations introduced changes in policy/procedures to improve cultural competence. The study also resulted in changed oral health policies, service delivery, and client resources for community health, cultural, and government partners.

IMPLICATIONS
Teeth Tales is a promising model for promoting child oral health in culturally diverse communities, requiring further development to maximise participation.

Design, Development and Implementation of the First Australian Based Horizon Scanning Program
Amanda K. Sampson1, Andra Morrison2, Andrew Dzuba2, Fiona Chomley3, Clarissa Martin1, Samantha Barker1
1 Institute of Safety, Compensation & Recovery Research; 2 Canadian Agency for Drugs & Technologies in Health; 3 Transport Accident Commission

OBJECTIVES
Health care horizon scanning (HS) programs are routinely employed internationally to inform health service research prioritisation, financial or operational planning, the diffusion of technologies and provision of information to policymakers, purchasers and health care providers. HS programs are designed to specifically address the needs of the constituencies and sectors in which they operate. We aimed to design, develop and implement the first Australian based HS program to 1) identify, filter and prioritise new and emerging health technologies, 2) assess and/or predict their impact on health, society and the health care system and 3) inform decision makers.

METHODS
The Institute for Safety, Compensation and Recovery Research partnered with HS experts from the Canadian Agency for Drugs and Technology in Health (CADTH) to design, implement and evaluate a seven phase horizon scanning methodology.

LESSONS LEARNED
The evaluation report highlighted the strengths of the methodological design, implementation and the 23 products delivered. We identified a delay between identification and availability of new technologies on the Australian market and the time required for health care decision makers to act and respond to the HS information. Therefore, we anticipate that the impact of the technologies identified and products produced will take between two to four years to be realised.

IMPLICATIONS
Access to information on new and emerging health technologies, treatments and services allows health care decision makers to anticipate, prepare and better address existing and emerging health challenges. A local HS program ensures that Australian based long term healthcare strategies are informed by a better understand of future contexts.
less pronounced when considering actual scheme paid days. Longer time until first return to work was associated with pre-injury use of antithrombotic drugs and troponin CK/myoglobin testing. Longer duration of allied health service use such as physiotherapy was also associated with pre-injury use of antithrombotic drugs. Persistent pain after the injury was associated with pre-injury use of lipid modifiers and antithrombotic drugs, prescription opioid analgesics, and X-rays of the extremities.

**IMPLICATIONS**

These results suggest that cardiovascular disease pre-injury is associated with longer time until recovery from work-related injury. After further verification in a prospective study, this information can be used to help identify injured workers who would most benefit from early interventions to aid recovery, and to better understand service needs of injured workers with comorbidity.

### The Interactive Role of Pre-Injury Mental Health and Related Risk Factors on Post-Traumatic Stress Disorder Symptoms Following Road Trauma: Insights from Data Linkage of Transport Accident Commission Claims and Medicare Records

Sara Liu1, Roderick J. McClure2, Janneke Berecki-Gisolf1

1Monash Injury Research Institute (MIRI), Monash University; 2National Centre for Injury Prevention and Control, U.S. CDC

**OBJECTIVES**

It is well documented that psychological health can be compromised following traumatic experiences, such as transport crashes. Symptoms associated with depression, anxiety and post-traumatic stress disorder (PTSD) are commonly observed. However, despite this well-established relationship, specific predictors that contribute to this trajectory are yet to be fully understood. The present study aims to explore pre-injury mental health as a risk factor for the onset of post-injury PTSD symptoms. More specifically, this research attempts to understand how personal (age, gender), injury-related (injury severity, fault attribution) and socio-environmental (socioeconomic status / occupation, return-to-work status) risk factors may interact with pre-injury mental health, to influence PTSD presentation following road trauma.

**METHODS**

The study utilised a de-identified linkage dataset comprising Pharmaceutical Benefits Scheme, Medicare Benefits Scheme, and Victorian Transport Accident Commission compensation data. Pre- and post-injury mental health issues were identified based on the use of mental health services and psychotropic medication. Therefore the study is limited to treated mental health symptoms only. A total of 734 participants were included in a series of regression analyses to examine a combination of different risk factors on PTSD outcomes.

**LESSONS LEARNED**

Pre-injury mental health issues present as a significant risk factor for compromised psychological health following transport-related injury. The outcomes examining combined risk factors on PTSD will be discussed in detail.

**IMPLICATIONS**

The results of this study have significant implications for early detection and intervention of those most at risk of mental health related symptoms following road trauma.

### Impact of Pre-Injury Health Service Utilisation on Recovery from Work-Related Injuries: Insights from Data Linkage of WorkSafe Victoria Claims and Hospital Records

Behrooz Hassani-Mahmoedi1, Janneke Berecki-Gisolf2

1Institute for Safety, Compensation and Recovery Research, Monash University; 2Monash Injury Research Institute, Monash University

**OBJECTIVES**

Following a workplace injury or disease, workers may be eligible to receive compensation for lost time and recovery expenses via WorkSafe. There is substantial variation in the recovery process after a compensable work injury. Injury severity, work and worker related information collected at the start of a compensation claim cannot predict the claim duration or service use patterns: seemingly mild injuries can result in long-term work disability and health service use. These may be driven partly by the claimants’ prior mental and physical health. The objective of this study was to investigate likely relations between pre-existing conditions and dynamics of workplace injury recovery.

**METHODS**

A cohort of workers’ compensation claims that started in 2008/2009 were linked to hospital admissions and emergency department records predating the injury by eight years, via collaboration of WorkSafe with the Victorian Data Linkage Unit. This is the first linkage of this type in Australia.

**LESSONS LEARNED**

The presentation will report on the results of analysing these data investigating the impact of pre-injury physical and mental health and health service use on primary and secondary claim outcomes. Outcomes are defined as claim duration, claim cost and health service use, persistent pain, secondary mental health, lawyer involvement and litigation, and repeat claims.

**IMPLICATIONS**

This study will provide WorkSafe with practicable knowledge of risk profiles for adverse primary, secondary and long-term outcomes of injury, which will help in the development of preventive measures.

### The Influence of Social Support on Healthcare Service Use Following Transport-Related Musculoskeletal Injury: Insights from Data Linkage of TAC claims and Client Outcome Survey

Khic-Houy Prang, Janneke Berecki-Gisolf, Sharon Newman

Monash Injury Research Institute, Monash University

**OBJECTIVES**

Limited research has examined the mechanisms through which social support influences healthcare service use (HSU) among people with musculoskeletal injury sustained in a transport accident. This research examines the direct effects, mediating effects and effect modification of social support on HSU.

**METHODS**

The study design was secondary data analysis. The data involved cross-sectional surveys of compensated transport accident victims in Victoria 2010 and 2011, linked to compensation claims and payment records. Analyses included (i) regressions to model HSU (direct effect), (ii) the KHB method to assess social support as a mediator of predisposing/need factors and HSU (mediation effect), and (iii) interactions to assess social support as a modifier between predisposing/need factors and HSU (effect modifier).

**LESSONS LEARNED**

Results of the direct analyses showed that support from family and friends was associated with lower HSU. No mediation effects were identified for family or friends’ support on the uptake of allied and mental HSU. Family support was found to modify the association between socio-economic indexes for areas and mental HSU. In the group with no social support, the odds of mental HSU in the advantaged group was lower than the odds of mental HSU in the disadvantaged group.

**IMPLICATIONS**

Supportive relationships might substitute for formal treatment or perhaps delay treatment seeking. Existing social networks need to be protected, strengthened and mobilised as potential channels to provide health education and encourage health service uptake.
Opportunities for Cumulative Learning and Implementation of Innovations in Delivery of Primary Health Care (PHC) Services: What Can be Learned from Canada's 12 PHC Teams?


1University of British Columbia; 2Universite de Montreal; 3University of Manitoba; 4University of Toronto; 5McMaster University; 6Queen's University; 7University of Ottawa; 8University of Alberta; 9Memorial University of Newfoundland; 10Western University; 11Universite de Sherbrooke

OBJECTIVES

Twelve cross-jurisdictional community-based primary health care (PHC) research teams have been formed across Canada, 2 of which work with Australia or New Zealand partners. The teams were challenged to generate evidence over and above any knowledge that could be developed within each team. We report here on the challenges and opportunities identified in the process of establishing a mutually acceptable set of measures and common approaches to data collection.

METHODS

We created a working group representing each of the 12 teams, the Canadian Institutes for Health Research (CIHR) and the Canadian Institute for Health Information. Through an iterative process we identified a set of common dimensions, indicators, and measures. Specific efforts focused on incorporating feedback on the measures from teams' First Nation and Inuit partners. Team specific logic models were created as a lens for examining and synthesizing the diverse evidence base that is emerging from this initiative.

LESSONS LEARNED

A requirement for some of each teams’ funding was cross-team collaboration. Attention to group process and utilizing all expertise (e.g., funders, researchers, First Nation partners) resulted in a mutually acceptable set of measures and common approach to data collection. Intentional embedding of common objectives, measures and analytic strategies provide a unique opportunity for generation of new knowledge.

IMPLICATIONS

Cross-team work creates a repository of provider and patient experiences and patient reported outcome measures within the context of PHC. This work provides the largest pan-Canadian opportunity for cross-jurisdictional learning and new knowledge of the impact and outcomes of PHC delivery.

A Better Oral Health in Home Care Model: Service Delivery Quality Improvement

Adrienne Lewis1,2

1South Australian Dental Service; 2School of Nursing, University of Adelaide

OBJECTIVES

To assess the process and client oral health outcomes of implementing a Better Oral Health in Home Care Model into home care service delivery.

METHODS

The PARIHS framework (Promoting Action on Research Implementation in Health Services) provided evidence based implementation strategies with which to introduce the Model. Client oral health outcomes were measured by pre and post implementation questionnaires taking into consideration oral hygiene behaviours and dental treatment results.

LESSONS LEARNED

As demonstrated by positive improvements in client’s oral health the Model’s processes of oral health assessment, oral health care planning, assistance with daily oral care and dental referral provide home care organisations with quality improvement strategies which support Home Care Standards. As such the Model and its accompanying educational resources provide a structure for improving home care organisational and workforce oral health capacity. Recognised as key enablers, home care workers were encouraged to adopt a ‘think and link’ rather than ‘task and time’ approach to service delivery not only in relation to oral health but to an older person’s holistic care and wellbeing. Given the predicted demands for more complex home care this approach coupled with investment in staff education has significant benefits for home care providers.

IMPLICATIONS

In order to build ongoing organisational and workforce oral health capacity as well as improve older people’s access to dental care, sustainable systems change requires consideration of micro, meso and macro level perspectives and ultimately requires inter-sectorial leadership and collaboration involving the aged care, dental and vocational/ health education sectors.

Are Waiting Lists Really Inevitable in Ambulatory Services? A Mixed-Methods Study

Katherine Harding1,2, Nicholas Taylor1,2, Nicole Robertson2

1La Trobe University; 2Eastern Health

OBJECTIVES

Long waiting lists for care are common in sub-acute ambulatory and community health services. Previous studies have suggested that waiting times may not always be the inevitable result of too much demand for available supply, but can also be due to factors related service design. The aim of this study was identify features of ambulatory services that are associated with long waiting times.

METHODS

A mixed methods approach combining analysis of routinely collected service data with qualitative semi-structured interviews with health service managers.

LESSONS LEARNED

Services within a single large metropolitan health network that provided assessment and/or treatment over a series of face to face appointments (n=14) were included in the study. The sample included 8 allied health outpatient services and 6 multi-disciplinary specialist clinics seeing more than 4,000 patients each year. All services used a waiting list to manage referrals. Waiting times varied from a mean of 24 to 162 days for a first appointment. The majority of managers perceived a high demand and insufficient resources to be the major cause of long waiting times. However, other themes emerged including high failure to attend rates, inconsistent review practices and diversion of resources to multi-stage triage and booking processes that suggested other factors also contribute.

IMPLICATIONS

Waiting times for ambulatory services are often assumed to be due to excessive demand for available resources. However, the findings of this study provide evidence of contributing factors that could be addressed through service redesign interventions in order to reduce waiting time.

An Evaluation of the Hospital at Night Team Nursing Model of Care

Janet Weir-Phylait1, Martin Keogh1, Kethly Fallon1, Joshua Stuart1, Mariann Fossum1,2, Nicky Hewitt1,2, Tracey Bucknall1,2

1Alfred Health; 2Deakin University, School of Nursing and Midwifery

OBJECTIVES

This study investigated nurses’ perceptions of the Hospital at Night (H@NT) after-hours nursing model of care and the effect on nurses’ decision-making and organisational workflow.

METHODS

The H@NT model of care is an after-hours support team designed to assist nurses across the hospital during nightly fluctuations in workload demands related to patient acuity, admissions and behaviours of concern. It was implemented in a major metropolitan hospital in Melbourne in October 2013 and evaluated a year after implementation. Five focus groups were conducted with 34 nurses from the H@NT and 14 hospital wards. Transcribed interviews were analysed using thematic analysis.

LESSONS LEARNED

Changes in models of care across a health service requires careful planning and early engagement with multiple stakeholders, both internal and external to the organisation. Identification of potential barriers and enablers, targeted strategies for communicating the objectives and processes of the H@NT model, and an evaluation framework are critical.
to understand the intended and unintended consequences of system change as it evolves.

IMPLICATIONS
Hospital environments are complex adaptive systems that have many inter-related and inter-dependent elements that can significantly impact on patients, clinicians, workflow processes and organisational management. The H@NT responds quickly to the after-hours needs of the organisation, offering critical and timely support at the individual, unit and organisational level. It has contributed to improved patient safety and enhanced management after-hours. An evaluation of organisation-wide models of care longitudinally enables greater understanding of the effect as models mature and are embedded into the system.

The Beacon Model: A Lower-Cost Alternative for Patients with Complex Chronic Disease
Bharat Vaikuntam 1, Samantha Hollingworth 2, Luke Connelly 1, Maria Donald 1, Anthony Russell 1, Claire Jackson 1
1School of Medicine, University of Queensland; 2School of Pharmacy, University of Queensland

OBJECTIVES
The Beacon model offers an alternative for patients with complex type 2 diabetes whereby they receive care through a community-based clinic where GPs with a special interest and advanced training in diabetes work alongside an endocrinologist and diabetes educator. Our objective is to compare the costs of the Beacon model with the usual approach of patients being treated as outpatients at a tertiary hospital.

METHODS
An economic evaluation was conducted in parallel with a non-inferiority RCT. We measured costs at one hospital site (H1) and the three Beacon sites (S1, S2, S3). Unit costs were calculated using information from accounting data, time and motion studies (TMS) and interviews with clinic managers. We measured staffing profiles, administrative and other shared costs, as well as the number of patients treated at each clinic.

LESSONS LEARNED
The total cost per clinic for H1 was $16,522, compared to $5,424 at S1, $4,961 at S2 and $4,760 at S3. The cost per patient attendance was highest at the hospital at $806, the corresponding cost at the Beacon sites was $374, $340 and $661 respectively. The Beacons are optimally designed to operate for 4 hours with 14 patients per clinic. At S3 the optimal patient numbers were not reached accounting for the higher cost per patient. Nursing staff constituted the highest proportion of costs ranging from 44% to 31%.

IMPLICATIONS
The Beacon model of care is cheaper to deliver than usual care. These data can be used to inform future models of care for those with chronic diseases.

Experiencing Integration in Primary Health Care: A Pilot Study
Michelle Banfield 1, Anne Parkinson 2, Paresh Dawda 3
1National Institute for Mental Health Research, The Australian National University; 2Australian Primary Health Care Research Institute, The Australian National University; 3Ochre Health

OBJECTIVES
There is little available Australian information regarding consumer and provider experiences of primary health care integration. This study aimed to pilot the exploration of consumer and provider perceptions, expectations and experience of integration in primary health care.

METHODS
The study focused on one large urban integrated primary health care centre, established under the GP Super Clinic program. Twenty consumers with chronic illness and 10 practice staff, including GPs, allied health professionals and practice support staff were interviewed. The semi-structured protocol explored their perspectives on, and understanding of, integrated primary health care. A thematic analysis of interview transcripts was conducted.

LESSONS LEARNED
Not all consumers were familiar with the terminology of integrated primary health care, but understood and valued key features nonetheless. These included access to multidisciplinary teams of primary health care professionals, assistance to organise and coordinate multiple appointments and the co-location of pharmacy, pathology and radiology facilities.

Providers valued access to shared patient information and colleagues with expertise in multiple areas. In addition to formalised methods of shared communication, providers highly valued opportunistic “corridor conversations”. Practice support staff were able to coordinate patient appointments in a timelier manner.

Consumers and providers both valued the continuity of care offered at the centre, particularly the relationship continuity supported by designated substitutes within the centre for doctors on leave.

IMPLICATIONS
Integration using a co-location model can improve the primary health care experience both for consumers and providers. Informal collaboration is as important as formalised structures for sharing care.

6F Health of Older People
08:30 – 10:00 Wednesday 9 December 2015, Room 107

Do Senior Australians with More Complex Chronic Conditions Get Better Coordinated Care?
M. Motizul Islam 1, Ian S. McRae 1, Laurann Yen 1, Anne Parkinson 1, Nasser Baghni 2, Michelle Banfield 2, Jose M. Valderas 3
1Australian Primary Health Care Research Institute, Australian National University; 2ANU Centre for Mental Health Research, Australian National University; 3Health Services & Policy Research Group, University of Oxford

OBJECTIVES
Patients with chronic conditions, and particularly those with multiple and complex conditions, are likely to have better health outcomes if their care is well coordinated. However, this relationship is under-researched. This study examines the relationship between the total number of chronic conditions, specific chronic conditions, and clusters of chronic conditions and the level of care coordination patients receive.

METHODS
Using a national survey, data were collected from 2,540 senior Australians. Disease clusters were identified using cluster analysis and using clinical expert opinion. A composite index of care coordination was also developed using seven questions that addressed the communication and management domains of care coordination. A set of Tobit regressions was used to identify significant factors of coordination.

LESSONS LEARNED
The median score of 1,821 patients who responded to at least four coordination questions was 76.2 (range 0–100). Coordination increases with the total number of diseases up to a point and then decreases. Among patients with only one chronic disease those with osteoporosis or heart disease reported the highest level of coordination and those with chronic pain reported the lowest level of coordination. In adjusted model diabetes was strongly associated with better coordination. Patients in the “mental health” or “asthma-COPD” cluster were more likely to report high levels of coordination than those in other clusters.

IMPLICATIONS
For most people at least some elements of coordination were in place. Patients with a single chronic disease such as chronic pain seem to be less well served. Disease clusters offer only limited information.

The 45 and Up Study as a Platform for Health Services and Policy Relevant Research
Mark Bartlett, Margo Barr, Robert Wells
Sax Institute

OBJECTIVES
To describe the value of research infrastructure such as the 45 and Up Study in supporting health services and policy relevant research and provide examples of research enabled by the Study.

METHODS
The 45 and Up Study provides large-scale, open-source research infrastructure. More than 267,000 NSW residents aged 45 years and over were recruited to the Study and provided information on their health, lifestyle and demographic characteristics, as well as consent...
to link this data with other administrative data collections and to be contacted for sub-studies. Participants are re-contacted periodically.

Features of the 45 and Up Study which make it a valuable resource to enable health services and policy relevant research will be described and contemporaneous examples of policy agency-directed research will be provided.

LESSONS LEARNED

The 45 and Up Study’s wide range of self-reported health, lifestyle, demographic, health and family history data, along with the ability to link the survey data to state and national administrative datasets means the Study is a valuable source of information to enable health services and policy relevant research.

IMPLICATIONS

Combining a readily accessible research infrastructure such as the 45 and Up Study with intimate involvement of policy agencies in the research process means the ‘right’ policy question is more likely to be answerable in a timely fashion.

Mapping the Aged Society: A Cartographic Approach to Population Ageing and Health Service Demand

Hamish Robertson1, Nick Nicholas2, Andrew Georgiou3, Andrew Hayen1, Joanne Travaglia1

1University of New South Wales; 2Demographer’s Workshop; 3Macquarie University

OBJECTIVES

Population ageing is a global phenomenon. Government rhetoric at all levels has raised ageing as a major concern. The implications for health systems are considerable as Australia’s ageing population will not peak until 2050. Understanding where and how ageing will affect health service demand and provision is a growing priority.

METHODS

This approach utilises a combination of system dynamics, geographic information systems and data visualization software to provide model that links ageing and the demerits to health system infrastructure. Different scenarios can be modelled in the SD software, the outcomes mapped against infrastructure and the results visualized in Tableau.

LESSONS LEARNED

Spatial visualisation offers a variety of benefits to health systems research, design and delivery. It capitalises on current and emerging data technologies to provide a platform for engaging with population health problems as they progress over time. This means questions can be raised prior to the implementation of responses and service issues addressed such as over or under supply of specific resources.

IMPLICATIONS

This presentation explores the use of spatial science methods to analyse and visualize the inevitable consequences of population ageing in Australia. This approach is about mapping spatially and conceptually, the aged society that population ageing will produce by the middle of this century. Mapping the gaps between what we are experiencing now and what the future will produce makes the complexity of ageing accessible in new and innovative ways.

Impact of Caregiving on Informal Carers of Older People in Advanced Age

Htein Linn Aung, Richard Edlin, Laura Wilkinson-Meyers, Ngaire Kerse
University of Auckland

OBJECTIVES

Demographic change is increasing pressures on health systems. Informal carers take on an increasing proportion of this burden, especially those caring for older adults. Research suggests possible adverse effects of caregiving on caregivers’ physical and mental health.

This study assessed the impact of informal caregiving on the quality of life (QOL) of informal carers.

METHODS

The Life and Living in Advance Age (LILACS) study started in 2010 to identify the predictors of successful advanced ageing. In Wave 4, QOL of carers was measured with EQ-SD; and positive and negative effects of caregiving were assessed using COPE Index. EQ-SD and COPE scores (Negative Impact (NI), Positive Value (PV), and Quality of Support (QOS)) were compared across different demographic and caregiving characteristics. Hierarchical regression analysis will be conducted to predict the independent associations between caregiving factors and QOL of carers.

LESSONS LEARNED

Most of the variables attributed signiﬁcant differences in COPE scores especially NI score. Significant determinants of EQ-SD were age, helping with food shopping, organizing affairs, being informed about general and healthcare needs of care recipients, and confidence to access support services. EQ-SD was also significantly correlated with NI (negatively) and PV (Positively). Further regression analysis will explore the independent association with QOL, and relative contribution of each group of variables.

IMPLICATIONS

Assistance for caregivers can be better targeted by identifying what matters most for them; including both positive and negative aspects of caring.

Evaluating Transitional Care for People with Dementia Discharged Home from Hospital

Ashley Kable1, Dimity Pond1,2, Carolyn Hullick3, Anne Duggan3, Lynette Chenoweth4
1Faculty of Health, University of Newcastle; 2Division of General Practice and Priority Research Centre for Gender, Health and Ageing, University of Newcastle, Hunter Medical Research Institute; 3Clinical Governance Unit, Hunter New England Health; 4Centre for Healthy Brain Ageing, Faculty of Medicine, University of New South Wales

OBJECTIVES

This study was conducted to evaluate the discharge process for people with Dementia who are discharged home.

METHODS

Discharge documentation of people with Dementia was evaluated using a purpose developed audit instrument. Eligibility criteria included patients who were discharged home during a six month period. Seventy three patients were recruited from surgical wards (17), medical wards (35) and short stay units (21).

LESSONS LEARNED

Medical discharge summaries were complete for 65 discharges and most contained required information. Three mandatory items were documented in all discharge summaries: diagnosis, estimated date of discharge and allergies. Other mandatory items were less frequently documented: Confusion risk was assessed for 48%, falls and pressure injury risk assessments (56%) and documentation of seven day supply of medication provided on discharge (65%). Short stay units had signiﬁcantly less documentation of these items in the discharge summary. Many other items were routinely documented in most discharge summaries however documentation was notably low for provision of contact information for patient support groups and advanced care planning.

IMPLICATIONS

These results indicate that some aspects of the discharge process were not done consistently for all patients, and some patients were potentially more vulnerable due to inadequate information being provided to their general practitioner for ongoing management. The provision of medications and risk assessment for people with Dementia, were aspects of this process that present opportunities for improvement. The lack of contact information for patient support groups and advanced care planning is a clinically significant concern for people with Dementia.

Variation in the Use of Primary Care Services for Diabetes Management According to Country of Birth and Geography Among Older Australians

Duong Thuy Tran1, Louisa R. Jorm1,2, Alyx Havard1,2, M.F. Harris3, Elizabeth Comino3
1Centre for Big Data Research in Health, University of New South Wales; 2Centre for Health Research, University of Western Sydney; 3Centre for Primary Health Care and Equity, University of New South Wales

OBJECTIVES

To investigate variation in the use of Medicare-funded services for type 2 diabetes management according to country of birth and geography among older overseas-born Australians.
The Cost-Effectiveness of Identifying and Treating Malnutrition in Hospitals: A Systematic Review of the Last 10 Years of Research

Hannah Mitchell¹, Judi Porter¹,²

¹Eastern Health; ²Monash University

OBJECTIVES
Malnutrition has significant economic and clinical consequences. This systematic review aimed to inform clinical practice through establishing the cost-effectiveness of identifying and treating malnutrition in the hospital setting.

METHODS
This review was conducted with guidance from the PRISMA statement, with the review protocol registered with PROSPERO. Nutritional care and healthcare costs were considered by the search strategy. The focus of the review was hospitalised adults with, or at risk of malnutrition, with original research to identify or treat malnutrition through usual care considered for inclusion. Four electronic databases were searched systematically, supplemented by an internet search. Date limits were applied from 2003 to 2013. The methodological quality of the included studies was assessed by both authors using the Consensus on Health Economic Criteria (CHEC).

LESSONS LEARNED
There was an absence of high quality cost-effectiveness studies in this field evidenced by only five eligible studies. Positive findings from a clinical and economic perspective were reported in all studies, all concluding that the intervention modelled or tested was more cost effective than the control. However, direct comparisons were challenging due to the lack of heterogeneity between outcomes, settings and populations.

IMPLICATIONS
Given our resource constrained environment, the management of malnutrition in hospitals needs to be planned and administered with consideration of cost-effectiveness in addition to robust clinical evidence. This review has highlighted the dearth of health economics research which supports the inclusion of economic considerations as a routine part of future research.

Canada and Australia Joining Hands to Improve Access to Primary Health Care for Vulnerable Populations: The Innovative Models Promoting Access-to-Care Transformation Initiative

Jeannie Haggerty¹, Grant Russell², Simone Dahrouge³, Sarah Descôteaux⁴, M.F. Harris⁵, Jennifer Hester⁶, Jean-Frédéric Lévesque⁶, Virginia Lewis⁷, Cathie Scott⁸, Nigel Stocks⁹, IMPACT Team

¹McGill University; ²Monash University; ³Bruyère Research Institute; ⁴St-Mary’s Research Center; ⁵University of New South Wales; ⁶Bureau of Health Information; ⁷La Trobe University; ⁸Alberta Centre for Child, Family & Community Research; ⁹University of Adelaide

OBJECTIVES
Started in 2014, the IMPACT initiative is a five year participatory research program that aims to develop and implement evidence-based and regionally-tailored models of care that enhance access to community based primary health care (PHC) for vulnerable populations.

METHODS
Local researcher/decision-maker/ community partnerships in each region identify local access needs and co-design an intervention to address the needs. An international team of researchers provide overarching evidence to inform the process, using a variety of mixed methods including scoping reviews, social media, systematic and realist review and trials of innovations.

LESSONS LEARNED
• Adapting the program locally has been far more extensive and nuanced than originally conceptualized.
• Much more time and effort was required for community consultations in order to develop local partnerships and support deliberation.
• The research inputs surrounding the local partnership process

METHODS
Multivariable multilevel analysis of Medicare claims linked to the 45 and Up Study baseline questionnaire for 640 participants born in Italy, Greece, Vietnam, Lebanon, China, India and the Philippines and 12,444 Australia-born participants with type 2 diabetes, living in 195 statistical local areas in NSW. Study outcomes included ≥6 general practitioner (GP) claims, and ≥1 claim for specialist, optometrist, allied health professional (AHP), diabetes Practice Incentive Payment (PIP), GP Management Plan/Team Care Arrangement (GPMP/TCA), Hba1c, cholesterol and micro-albuminuria testing.

LESSONS LEARNED
Compared to Australia-born participants, Vietnamese- and China-born people had less AHP claims (odds ratio [OR] 0.14, 95% CI 0.05–0.43, and OR 0.40, 95% CI 0.18–0.87, respectively). Italy-born participants had less PIP (OR 0.60, 95% CI 0.39–0.92) and micro-albuminuria claims (OR 0.65, 95% CI 0.47–0.89), and Philippines-born participants had lower claims for specialist services (OR 0.59, 95% CI 0.38–0.91). Compared to Australia-born participants, claims for the following services were more likely among those born in Greece and China (GP), Vietnam (optometrist) and India (micro-albuminuria). Significant geographic variation was observed for all outcomes, with the greatest variations in claims for AHP (9.3%, median odds ratio [MOR] 1.74, 95% credible interval [CrI] 1.60–2.01), PIP (7.8%, MOR 1.65, 95% CrI 1.55–1.83), and GPMP/TCA items (6.6%, MOR 1.58, 95% CrI 1.49–1.73).

IMPLICATIONS
Different intervention programs for geographical areas, identified cultural groups and their providers are warranted to improve disparities in diabetes care.

Burden of Traumatic Brain Injury in New Zealand: Incidence, Prevalence and Disability-Adjusted Life Years

Braden Te Ao¹,², Martin Tobias³, Shanthi Ameratunga³, Kathryn McPherson⁴, Alice Theadom¹, Anthony Dowell⁶, Nicola Starkey⁷, Kelly Jones¹, Suzanne Barker-Collo⁸, Paul Brown⁹, Valery Feigin¹, BIONIC Study Group

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OBJECTIVES
To estimate the incidence, prevalence and disability adjusted life years (DALY) for traumatic brain injury (TBI) in New Zealand (NZ) in 2010.

METHODS
A multi-state life table model was constructed using inputs for first-ever in a lifetime TBI incidence and severity distribution from the Brain Injury Outcomes New Zealand in the Community (BIONIC) study, TBI mortality data from the NZ Ministry of Health’s Mortality Collection, and population data from Statistics New Zealand. The modelled estimate of prevalence was combined with the disability weights for TBI (by stage, and severity level) from the Global Burden of Disease 2010 study to obtain estimates of health loss (DALYs) for TBI.

LESSONS LEARNED
Approximately 11,300 first-ever incident traumatic brain injuries occurred in NZ in 2010, with 527,000 New Zealanders estimated to have ever experienced a TBI (prevalent cases). The estimated 20,300 DALYs attributable to TBI accounted for 27% of total injury related health loss and 2.4% of DALYs from all causes. Of the total TBI attributable DALYs 71% resulted from fatal injuries. However, nonfatal outcomes still accounted for a substantial share of the burden (29%) with mild TBI making the greater contribution of non-fatal outcomes (56%).

IMPLICATIONS
The burden of TBI in NZ is substantial and mild TBI contribute to major part of nonfatal outcomes.
generate a commonalities across regions that enhance cross-partnership learning while maintaining local specificity. These inputs include a common conceptual framework, a typology of innovations, intervention logic modelling, and co-design principles.

- Health reforms in Canada and Australia have affected the development of the research program creating uncertainty in some local partnerships and at the same time creating new opportunities for the program.

IMPLICATIONS
IMPLICIT will generate new policy and program options for improving access to care by vulnerable population groups adapted to context. We also expect to create sustainable, local, national and international communities of practice able to produce innovative solutions to healthcare intractable access barriers to appropriate PHC for vulnerable populations.

Working Together: A Collaborative Approach to Population Based Health Services Research with First Nations in Ontario, Canada

Michael Green 1,2, Jennifer Walker 3,2, Kristen Jacklin 4, Carmen Jones 5, Eliot Frymine 1, Baiju Shah 2,6, Rahim Moineddinn 2,6
1Queen’s University; 2Institute for Clinical Evaluative Sciences; 3Nippising University; 4Northern Ontario School of Medicine; 5Chiefs of Ontario; 6University of Toronto

OBJECTIVES
To describe a program of research to assess the impact of diabetes and diabetes related health service delivery and policies on outcomes for First Nations people residing in Ontario, Canada, and to translate the findings into changes in policy and practice through a integrated knowledge transfer process that engages multiple stakeholders.

METHODS
A collaborative approach was used to identify the research questions, establish collaborative governance and management structures and develop a successful research funding proposal. The proposed program of research includes secondary analysis of comprehensive linked Administrative Data (physician billings, ER and hospital use, lab and imaging ordering, public funded drugs, provider database, primary care enrollment, census, vital statistics) and a strong complementary qualitative component. Both policy stakeholder and patient advisory committees will help guide the work of the research team, which includes First Nations stakeholders as co-investigators.

LESSONS LEARNED
We will present an overview of the components of this research program, which includes a comprehensive report on the epidemiology of diabetes in First Nations people in Ontario, a report on access to care, a series of focused population based policy analyses (for example: impact of limitations on funding for diabetes test strips, policies on reimbursement for medical related travel), and in depth case studies in selected communities. An integrated knowledge broker position located at the office of the primary partner (Chiefs of Ontario), will play a key role in the knowledge translation activities.

IMPLICATIONS
High quality population based research that has the potential to have an impact on policy for First Nations people is possible only in the context of a partnership with First Nations organizations at the level most appropriate for the nature and scope of the research being undertaken.

The Potential Effects of Pausing Indexation of Private Health Insurance and Medicare Rebates by the Federal Government of Australia: A Review of status quo Debates

Vincent Pagiwa, Simon Barraclough
La Trobe University

OBJECTIVES
The Federal government of Australia announced a pause on rebates for healthcare for four years and the Australian Medical Association and health economists expressed their formal opposition to the new policy. The goal of this status quo review was to identify the potential effects that will result from pausing indexation of private health insurance and Medicare rebates.

METHODS
We searched and extracted articles published on Medical Journal of Australia and Australian Medical Association publications from 26 November 2014 to 31 May 2015. We did a wider inclusive criteria to accommodate for both research articles, insight papers and opinion articles. The results obtained were synthesized and interpreted qualitatively.

LESSONS LEARNED
Almost every article reviewed supported the view that pausing rebates for healthcare will have a negative impact. The rebates pause will affect bulk-billing by general practitioners and the remaining charges will be passed on to the patients, giving a rise to out-of-pocket payments. The capacity of individuals to access primary services will be reduced leading to advanced diseases and high cost of hospitalization. Insurance premiums will rise to compensate for high hospital charges. The reform will also discourage medical students to enter into general practice.

IMPLICATIONS
The findings of this study were in support to the contention that a pause on rebates is not pro poor. Since demand for healthcare is inelastic, the charges for general practitioners visits will be regressive. It is evident that a feasibility study is needed to examine the long-term practicability of this reform.

Recruiting Older People for Research in Diverse Rural Australian Communities

Turi Berg 1, Rachel Winterton 1, Maree Petersen 2, Jeni Warburton 1, 3
1La Trobe University, Wodonga; 2University of Queensland, St Lucia

OBJECTIVES
To explore the challenges and strategies involved in the recruitment of diverse older people living in varied rural Australian communities for a study on wellness in later life.

METHODS
A community saturation method was utilized to recruit adults aged 65 years or older within six rural case study communities across Victoria and Queensland. To achieve the project aims, a diversity of participants was required in relation to age, health status and location. This required employing specific strategies to engage older adults who were less well or isolated.

LESSONS LEARNED
Key challenges included the ability of researchers to access hard to reach, remote populations, ensuring that the healthy community active populations were not over-represented, and the different recruitment strategies required across rural communities and regions. While strategies were devised to address many of these challenges, the time and resources requirements were much greater than anticipated and did not necessarily fit with research funding timelines.

IMPLICATIONS
Rural populations are ageing more rapidly than urban areas. In this context, addressing the health needs of older rural residents, who already face significant barriers to health care access, will become even more important. Understanding the challenges to engaging this diverse group in research, and developing strategies to addressing these challenges is important to build a representative evidence-base to guide policy decisions, but also to assist in the promotion and delivery of health and social services to this population. Policy-makers need to understand these experiences of those living in rural communities to enable delivery of more appropriate services and supports, thus ensuring better health outcomes.

Multiple Electronic Patient Records Rather than One — Disciplinary Differences in Integrated Primary Health Care Centres

Riki Lane 1, Grant Russell 1, Jane Taggart 2, Rachael Kearns 2, Oliver Frank 3, Siaw-Teng Liaw 2
1Monash University; 2University of New South Wales; 3University of Adelaide

OBJECTIVES
Australia has varied primary care practice models that aim to deliver integrated care, often within multidisciplinary settings. We aimed to identify key information system factors facilitating provision of integrated care in Australian integrated primary care models.

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METHODS
Mixed methods case study design using an ethnographic approach, complemented by staff surveys. Setting: Seven multidisciplinary primary care centres in three Australian States. Models vary by funding (salaried – fee for service); governance (government – private); extent of co-location (single – distributed). Participants: GPs, practice nurses, allied health professionals (AHPs), administrative and managerial staff.

LESSONS LEARNED
Although clinician information systems influenced integrated care, recording needs varied between disciplines. Provider groups were wedded to discipline specific systems. Most centres prioritised an appointment and clinical record system for GP/nurses. A second system aligned with hospital systems usually existed for some AHPs and medical specialists. Other private health practitioners used further systems. Access by different practitioners to one another's systems varied greatly across and within centres. In one centre, all clinicians shared one system: elsewhere, mental health practitioners' records varied greatly across and within centres. In one centre, some AHPs could read and write into the core GP/nurse system. For other centre/provider combinations, only appointment details were accessible. Co-location of AHPs with GP/nurses built relationships and multidisciplinary teamwork through enhanced feedback on patient referrals and opportunities for informal verbal communication.

IMPLICATIONS
Current patient record systems lag requirements for integration. While “workarounds” allow existing systems to inefficiently facilitate multidisciplinary care, well-designed integrated or shared record systems are needed.

Building an Australasian Paramedicine Research Agenda: Expanding Horizons Through Leadership and Inclusion

Peter O'Meara 1, Brian Maguire 2, Paul Jennings 3, Paul Simpson 4
1La Trobe University; 2Central Queensland University; 3Monash University; 4University of Western Sydney

OBJECTIVES
To draw on international experiences to identify and recommend the best methodological approach that should be employed to develop an Australasian paramedicine research agenda.

METHODS
A search and critical appraisal process was employed to produce an overview of the literature related to the development of paramedicine research agendas throughout the world. These approaches were further reviewed to account for the Australasian paramedicine context where there is substantially more paramedicine research capacity than most other regions of the world.

LESSONS LEARNED
A mixed methods approach should be used to develop an inclusive Australasian Paramedicine Research Agenda, capturing the views and interests of a wide range of expert stakeholders through multiple data collection strategies including interviews, roundtable discussions and an online Delphi consensus survey. Success will depend on ensuring a representative sample of expert stakeholders, fostering an open and collaborative roundtable discussion, and adhering to a predefined approach to measure consensus on each topic. This research agenda would assess the progress of paramedicine research in Australia and New Zealand; map the research capacity of the paramedicine discipline, paramedic services, universities and professional organisations; identify current strengths and opportunities; make recommendations to capitalise on opportunities; and identify research priorities.

IMPLICATIONS
It is time for paramedic researchers and industry leaders to use a multidisciplinary process of inquiry to develop an Australasian Paramedicine Research Agenda that will provide a framework for the development of a culture of open evaluation, innovation and improvement.

Family Knowledge of Patients’ Organ and Tissue Donation Wishes Affects Consent Rate

Vanessa White, Virginia Lewis
La Trobe University

OBJECTIVES
The Australian Government’s National Reform Programme, A World’s Best Practice Approach to Organ and Tissue Donation for Transplantation includes training for health professionals conducting family donation conversations (FDC) as one of its key elements. The Organ and Tissue Authority (OTA) commissioned an evaluation of the National Pilot of Models for Requesting Donation. Using selected data from the evaluation of the National Pilot, the impact of family knowledge of patients’ organ and tissue donation wishes on consent to donate is explored.

METHODS
Fifteen Australian hospitals participated in data collection from April 2013 to April 2015. Nominated staff completed a summary record of the donation requesting process, including whether the family were aware of the patient’s wishes and the final donation decision. Approximately 200 FDCs were held.

LESSONS LEARNED
Families may be aware of patient wishes through prior discussions between patient and family members or by being informed by health professionals that the patient had registered on the Australian Organ Donor Register. Data revealed that, in most cases, the patient's wishes were not registered on the Australian Organ Donor Register (61% of cases where register was checked). In almost two-thirds of cases (64%), the family said they knew the wishes of the patient. Consent rates were much higher where the patient's wishes were known (79% compared with 32% when wishes were not known).

IMPLICATIONS
These findings suggest public education and awareness strategies encouraging individuals to discuss their organ donation wishes with family members may have a positive impact on consent rates.

A Collaborative Approach to Requesting Supports Good Practice and Increases Consent Rates: Results of a National Pilot of Organ Donation Requesting Models in Australia

Virginia Lewis, Vanessa White
La Trobe University

OBJECTIVES
The Australian Government’s National Reform Programme, A World’s Best Practice Approach to Organ and Tissue Donation for Transplantation includes training for health professionals conducting family donation conversations (FDC) as one of its key elements. The Organ and Tissue Authority, commissioned an evaluation of the National Pilot of Models for Requesting Donation.

METHODS
Fifteen Australian hospitals participated in data collection from April 2013 to April 2015. Nominated staff completed a summary record of the organ and tissue donation (OTD) requesting process, and staff participating in each OTD requesting conversations were invited to complete a survey. Approximately 200 FDCs were held.

LESSONS LEARNED
FDC requesting practice was generally consistent with the intent of the “Collaborating Requesting Model” (CRM):

- In 87% of cases there were 3 meetings held (discussion of death, team planning meeting & FDC)
- In 72% of cases there was a gap between the meeting about death and the FDC

In many cases, qualitative data provided suggested there had been appropriate flexibility in implementation of CRM.

In 81% of cases there was at least one FDC trained requestor present. Conversations led by an FDC-trained requestor had significantly higher consent rates than conversations led by staff not FDC trained (70% compared with 47%). Nearly all staff involved in the FDCs reported they were comfortable with their role, and agreed that the family felt supported by the staff during the conversation.
IMPLICATIONS

Results suggest that the CRM for organ OTD requesting practice is an acceptable and effective model to be considered for adoption nationally.

NSW Patient Survey: Who is Responding Online, and do the Results Really Differ?

Diane Hindmarsh, Jason Boyd, Katinka Moran, Clare Aitken, Anna Do

OBJECTIVES

The Bureau of Health Information collects and reports on the experiences of patients in NSW public hospitals. While survey delivery is principally postal, respondents also have the opportunity to complete it online. BHI undertook analysis to determine who was most likely to respond online and whether their ratings of hospital care differed compared to the paper format.

METHODS

We analysed the profiles of more than 100,000 survey respondents across six NSW surveys; the Adult Admitted, the Emergency Department (2013 and 2014 cohorts) and the 2014 Children’s and Young Patient Surveys. Statistical testing was used to identify which demographic groups were most and least likely to use the online response option and whether there was an effect of survey mode on overall rating of care, after accounting for differences in the other demographic variables.

LESSONS LEARNED

The proportion responding online nearly doubled in both Admitted (from 9% to 19%) and Emergency Department surveys (from 19% to 30%) between 2013 and 2014. Younger, better educated respondents, people responding on behalf of the patient and those who usually speak a language other than English were more likely to respond online. While the results for online respondents are generally less favourable, once the effect of the demographic variables are taken into account the results are not statistically different.

IMPLICATIONS

Results for online respondents can be included with paper-based survey results without separate adjustment as their results are similar to respondents of the demographic profile.

“How Do I Manage It?” Evaluating the Chlamydia Partner Notification Attitudes and Practices of Australian General Practitioners

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OBJECTIVES

Partner notification (PN) is an integral component of chlamydia control, and the majority of cases of chlamydia are diagnosed in general practice. We investigated the chlamydia PN attitudes and practices of Australian general practitioners (GPs) participating in the Australian Chlamydia Control Effectiveness Pilot, a randomised controlled trial of a general practice-based chlamydia testing intervention.

METHODS

Chlamydia PN attitudes and practices of participating GPs were examined at recruitment to ACCEPt using a questionnaire and semi-structured interviews. 649 GPs (382 male, 267 female) completed questionnaires (response rate = 65%) and 44 GPs were interviewed.

LESSONS LEARNED

All questionnaire respondents (99.5%) usually or always encouraged patients to notify partners after a chlamydia diagnosis. Less than two thirds of GPs (59.4%) reported offering to notify partners on behalf of patients. More than half (59.5%) had requested assistance with chlamydia PN from government health departments, and some interview participants believed it was the responsibility of health departments. Many interview participants felt that managing PN was time-consuming, and some didn’t view chlamydia PN as crucial compared to “more serious” STIs. 43.8% of GPs reported using patient-delivered partner therapy (PDPT) for chlamydia at least occasionally.

IMPLICATIONS

Many GPs are using PDPT at least occasionally, suggesting that it is an acceptable practice in chlamydia control despite the fact that medico-legal barriers exist in most Australian jurisdictions. Incorrect assumptions that health departments routinely undertake PN for chlamydia suggest that GPs require additional training and clarification of their own role in chlamydia PN.

Reducing Admissions for Patients at Risk of Readmission: Lessons from an Evaluation of a Complex Health Intervention

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OBJECTIVES

This study aimed to evaluate the effectiveness of a telephone health coaching and support service provided to members of a private health insurance fund — Telephonic Complex Care Program (TCCP) — on hospital use and associated costs.

METHODS

A case-control pre-post study design was employed using propensity score matching. Private health fund members (n=273) who participated in the TCCP between April and December 2012 (cases) were matched (1:1) to members who had not previously been enrolled in the program or other disease management programs offered by the insurer (n=273). Eligible members were community-dwelling, aged >65 years and had two or more hospital admissions in the 12 months prior to program enrolment. Pre-program variables that estimated the propensity score included: participant demographics, diagnoses and prior hospital use (in the 12 months prior to program enrolment). TCCP participants received one-on-one telephone support, personalised care-plan and referral to community based services. Control participants continued to access usual healthcare services.

LESSONS LEARNED

Findings from this evaluation suggest that participation in the TCCP did not result in reductions in hospital utilisation claims or total benefits paid in the 12 months following program enrolment. However, program characteristics and level of implementation may have impacted on its effectiveness. Evaluations of complex health interventions, such as TCCP, present a number of challenges, which should be considered.

IMPLICATIONS

There remains limited evidence to support the effectiveness of telephone coaching to reduce hospital utilisation of participants with a range of long-term conditions or complex care needs. Comprehensive evaluations of complex health interventions is essential to understanding the effectiveness of programs.

Jumping into the Deep-End: Results from a Pilot Impact Evaluation of a Community-Based Aquatic Exercise Program

Anna Barker1, Jason Talevski1, Renata T. Morello1, Genevieve Nolan1, Renee De Silva2, Andrew Briggs2,3

1Monash University; 2Arthritis and Osteoporosis Victoria; 3Curtin University

OBJECTIVES

To evaluate changes in pain, stiffness, physical function and quality of life in adults with musculoskeletal conditions attending ‘Waves’ aquatic exercise classes.

METHODS

A quasi-experimental pilot study with 12-week follow-up was conducted in 109 adults (mean age, 65.2y; range, 24–93y) with musculoskeletal conditions. The intervention group (n=67) underwent 11 peer-led, 45 minute, weekly aquatic exercise classes over the 12 week follow-up period. Control group participants were not participating in Waves or other formal exercise (n=42). Main outcome measures included the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) and EuroQol five dimensions survey (EQ-5D). Satisfaction with Waves classes also measured.
LESSONS LEARNED
While scores for all WOMAC subscales demonstrated an improvement in the Waves participants, the change did not reach statistical significance. Both groups reported some improvements in EQ-5D domains; however these did not reach statistical significance. There was no change in utility scores over the follow-up period. EQ-5D overall health state scores improved significantly over follow-up for the Waves group (mean change: 5.40%, 95% CI: 1.38% to 9.43%; p<0.05). High levels of satisfaction with classes were reported by Waves participants.

IMPLICATIONS
Peer-led aquatic exercise classes may improve overall health and physical function for people with musculoskeletal conditions. The diversity is likely to have limited the power to detect significant changes in outcomes. Larger studies are needed to confirm effects and explore the long term cost benefits.

Is Pilates a Feasible Form of Exercise to Decrease Falls Risk in Older Community-Dwelling People? A Pilot Randomised Controlled Trial
Anna Barker¹, Jason Talevski¹, Renata T. Morello¹, Megan A. Bohensky², Caroline A. Brand¹,², Peter A. Cameron¹
¹Monash University; ²University of Melbourne
P17, Poster

OBJECTIVES
Evidence suggests well-designed exercise programs can improve balance and falls risk in older people; however there has been poor uptake of these programs. Participation in exercise can be improved by investigating alternative exercise programs. This study aimed to explore the feasibility and acceptability of a Pilates intervention in older people.

METHODS
Fifty-three community-dwelling people aged ≥60yrs with high falls risk were randomly allocated to a Pilates intervention (n=22) or standard care control group (n=31). The intervention was a 1 hour tailored Pilates class, performed 2 times per week for 12 weeks. The main outcome measure was feasibility, which included: adherence (% of classes attended); safety (adverse events); acceptability of intervention (participant perceptions survey); and efficacy of the intervention (falls; standing balance; lower limb strength; and flexibility) measured at baseline, 12 and 24-weeks.

LESSONS LEARNED
The attendance rate of the Pilates intervention was high (90%) and utility scores over the follow-up period. EQ-5D overall health state scores improved significantly over follow-up for the Waves group (mean change: 5.40%, 95% CI: 1.38% to 9.43%; p<0.05). High levels of satisfaction with classes were reported by Waves participants.

IMPLICATIONS
Overall, participants described wanting the same standard of care non-disabled people want from their family doctor with the main difference being that many are not receiving it. Without better clinical education and ongoing support of front line primary care professionals, our health system will leave those with greatest need behind.

Gaining Clinicians Views to Inform the Next Victorian State Government Cancer Plan
Esther Sadek¹, Rachel Whiffin¹, Nicola Quin²
¹Clinical Network, Cancer Council Victoria; ²Strategy and Support, Cancer Council Victoria
P19, Poster

OBJECTIVES
The Victorian Government is required to develop a four-yearly Cancer Plan by October 2016. This plan is pivotal to reducing the impact of cancer on Victorians and is of great interest to cancer clinicians. Cancer Council Victoria’s Clinical Network (CCVCN) aims to improve the capacity of the Victorian oncology sector through education, research, and using the clinical voice to advocate for improvements in cancer policy. CCVCN undertook consultations with cancer clinicians to identify their priorities for cancer and assist the Victorian Government in the process of developing the next cancer plan.

METHODS
Seven consultation sessions were conducted in early 2015 across Melbourne. A total of 157 clinical professionals from metropolitan and regional Victoria attended the sessions or completed an online survey and included specialists from surgery, radiotherapy, medical oncology, and other multidisciplinary specialisations. From this process, priorities to improve cancer care and outcomes across Victoria were identified.

LESSONS LEARNED
A range of new and emerging issues were identified that span the continuum of cancer care. The overarching consensus from consultations was that it is critical the Cancer Plan be underpinned by a strong vision and deliver a responsive, innovative cancer system. It was also clear clinicians want to be involved in the development, implementation and evaluation of this policy and expressed support for the Victorian Government in this endeavour.

IMPLICATIONS
The report will be used to engage relevant officials in the Department of Health and Human Services in the development of Victoria’s next Cancer Plan.

The Impacts of Public Reporting of Hospital Performance on Quality of Care
Margaret Kelaher
Centre for Health Policy, University of Melbourne
P20, Poster

OBJECTIVES
Public performance reporting is much heralded as an innovation to improve quality of care. This study aims to explore the processes via which public performance reporting influences quality care.

METHODS
We conducted a systematic review of all studies, which examined interventions that used public performance reporting, and outcomes associated with quality of care. Databases searched included EBMR (Ovid), EMBASE (Ovid), MEDLINE (Ovid) and Psychnfo (Ovid). The study revealed 2120 studies. Abstracts were screened by two independent reviewers. Any inconsistencies were then reviewed by a third. The same process was applied to the final review of the papers.
LESSONS LEARNED

The study revealed that there was some evidence of positive impacts of public performance reporting on quality of care. However, despite considerable number reviews, of varying quality, there was a relative dearth of primary research. Most of the research was atheoretical. This suggests that careful consideration of the methods via which public performance reporting will impact on quality of care and the agents who will initiate this action.

IMPLICATIONS

There is considerable capacity to improve the impact of public performance reporting on quality of care through better targeting of the information provided and the audiences to whom it is provided.

Closing the Gap in the Grampians: Improving Eye Health Services

Uma Jatkar, Mitchell Anjou, Hugh Taylor

Indigenous Eye Health, University of Melbourne

OBJECTIVES

Real progress has been made in the Grampians region of Victoria to improve eye health services to Indigenous people. The Grampians provides an excellent case study of data sharing and analysis that not only highlights gaps in eye health services for Indigenous people, but also has resulted in tangible service improvements in the region.

METHODS

The Roadmap to Close the Gap for Vision is an evidence-based, sector-supported framework of 42 recommendations to improve Indigenous eye health. The Roadmap is being implemented across 12 regions in Australia, covering an estimated 35% of the Indigenous population. In Victoria, the Roadmap underpins eye health projects being implemented in four regions under the statewide policy Koolin Bait: Strategic Directions for Aboriginal Health 2013–2022.

LESSONS LEARNED

The Grampians has seen system improvements and increased services for Indigenous health. Crucial has been the collaboration among stakeholders in undertaking significant clinical redesign to develop new, enhanced models of care. The aim of this study is to present the development and progress of AHP led models of care within MNHHS.

IMPLICATIONS

Specific strategies proposed to overcome resistance and enhance progress include medical school-based and community-based initiatives, and working partnership models between medical schools and indigenous community stakeholders.

The Development And implementation of Ten Allied Health Specialist Outpatient Clinics

Tracy Comans 1, 2, Michelle Stute 1, Marita Plunkett 3, Merrilyn Banks 3, Simon Finnigan 3, Maree Raymer 2, Peter Buttrum 3

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BACKGROUND

The Metro North Hospital and Health Service (MNHHS) located in Brisbane had around 50,000 people on specialist outpatient waitlists in 2013. Innovative, feasible models were required to achieve MNHHS’s goal of a 50% reduction in waiting lists within a 12 month period. Allied Health Practitioners (AHPs) are able to screen and manage patients on ENT, orthopaedic, plastic surgery, gynaecology, urology and neurosurgery outpatient waiting lists. In developing the models of care, AHPs worked closely with relevant stakeholders engaged to quickly respond to organisational priorities and funding opportunities. The process followed has ensured strong stakeholder support for these models. Financial data including cost and revenue projections has been weak or missing from allied health submissions to date and this model offers a reporting and research framework that may assist others to demonstrate the value of AHP led services.

RESULTS

The new models were operationalised in March 2014. A database has been constructed to collect outcomes including throughput, waiting times, clinical outcomes, health care utilisation, discharge outcome and adverse events. This data will be reported on six monthly intervals to relevant stakeholders to ensure the services are meeting MNHHS objectives.

DISCUSSIONS

This project highlights the need to have proposals drafted and stakeholders engaged to quickly respond to organisational priorities and funding opportunities. The process followed has ensured strong stakeholder support for these models. Financial data including cost and revenue projections has been weak or missing from allied health submissions to date and this model offers a reporting and research framework that may assist others to demonstrate the value of AHP led services.
Institutional Ethnography as a Decolonizing Method of Inquiry for Health Institutions
Melody Morton Ninomiya
Li Ka Shing Knowledge Institute, St. Michael’s Hospital

OBJECTIVES
This study aimed to make visible how health supports and services are organized and coordinated around children diagnosed with fetal alcohol spectrum disorder in a rural Indigenous community in eastern Canada.

METHODS
Institutional ethnography was used for this community-based study as a decolonizing method of inquiry. Institutional ethnography is an empirical method that frequently employs qualitative methods to map how everyday lived experiences of a particular group are organized by institutional policies and processes.

LESSONS LEARNED
I argue that when institutional ethnography is used to facilitate community-based research and knowledge translation (KT), decolonizing research is made possible. At the heart of decolonizing community-based research and knowledge translation (KT), I argue that when institutional ethnography is used to facilitate community-based research and knowledge translation (KT), decolonizing research is made possible. Further, I suggest that this method of inquiry is well positioned to facilitate both strategic and community-driven knowledge translation.

IMPLICATIONS
This study offers new and exciting advances to the field of decolonizing research and knowledge translation (KT). Moreover, I suggest that decolonizing research is made possible. At the heart of decolonizing research is the concept of decolonizing research as a decolonizing method of inquiry. Institutional ethnography is an empirical method that frequently employs qualitative methods to map how everyday lived experiences of a particular group are organized by institutional policies and processes.

Evaluating the HealthPathways Programme: A Collaboration Between Research, Policy and Practice
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1Curtin University; 2Barwon Health; 3Deakin University; 4WA Primary Health Alliance; 5Western Victoria Primary Health Network

OBJECTIVES
Substantial efforts have been undertaken in both Perth and Barwon to develop, promote and implement the HealthPathways programme (HPW), to shape system reform and aid General Practitioners, with the ultimate goal of improving healthcare outcomes across the entire healthcare spectrum. HPW, an online health information portal consisting of localised clinical pathways assisting with patient referrals to appropriate services. This study provides evidence on early development and implementation of HPW with the aim of shaping future research policy and practice.

METHODS
Mixed-methods evaluation designs have been used to explore development and early implementation of HPW across Perth and Barwon regions. Methods include: interviews and focus groups with key stakeholder groups; analysis of usage using google analytics and surveys of GPs.

LESSONS LEARNED
Perth have over 92 developed and localised clinical pathways while Barwon, have 120 localised clinical pathways. Early findings suggest that conceptually there is a lot of interest and enthusiasm around HPW. The system is talking, with many positive examples of HPW being a catalyst for primary and secondary care coming together over a shared interest. An identified challenge has centred on GP uptake and lack of confidence in HPW and issues with accessing technology.

IMPLICATIONS
HPW has great potential, but there needs to be a focus on collective leadership that encompasses clinicians, managers and individuals across and within organizations. Currently the research teams are working with healthcare providers to develop best practice approaches to long-term outcome measurements, primarily aimed at secondary care demand management.

Measuring Safety Climate in Acute Australian Hospitals
Sze-Ee Soh1,2, Anna Barker1, Renata T. Morello3, Megan Dalton1,3, Caroline A. Brand1
1Monash University; 2Alfred Health; 3Central Queensland University

OBJECTIVES
This study aims to quantify safety climate in Australian acute hospitals and to further validate a widely used safety climate tool, the Safety Attitudes Questionnaire (SAQ).

METHODS
The SAQ was administered to 420 nurses from 24 acute medical and surgical wards in six hospitals across Australia as part of a larger falls prevention trial — the 6-PACK project. The SAQ assesses six-safety related climate domains including teamwork climate, job satisfaction, perceptions of management, safety climate, working conditions and stress recognition. Descriptive statistics were used to profile safety climate across wards and Rasch analysis was used to assess the internal construct validity and reliability of the SAQ.

IMPLICATIONS
Measuring patient safety climate can provide hospitals with important insights about the safety culture of organisational units. Whilst there was general support for the reliability of the SAQ as a measure of safety climate, further refinement of the tool is warranted in order to assist in designing targeted patient safety initiatives.

Evaluation of an Oncology Multidisciplinary Team Service
Kylie Museth
Translational Cancer Research Centre, Sydney West Cancer Network

BACKGROUND
Multidisciplinary Teams (MDTs) have been well established in the Western Sydney Local Health District (WSLHD) and Nepean Blue Mountains Local Health District (NBMLHD) for several years. At present there are over 20 MDTs across two sites and with the impending Blacktown Cancer Care Centre being finalised in 2016, this number of MDTs will increase. Therefore this is a prime time to look towards further developing these teams into more than a clinical meeting or multidisciplinary clinic, but to move towards a tumour specific multidisciplinary service.

OBJECTIVES
To assess the performance status of current MDTs in order to streamline all teams in functionality, adherence to mandatory KPIs and contribution to best-evidence-based patient care delivery. Implementation of QI strategies such as possible restructure of the support model both administrative and care coordination; incorporating IT infrastructure to provide wireless access for the purpose of entering live data into patient notes during MDT meetings, and initiating local research development from MDTs. These changes will foster the concept of the next phase in multidisciplinary care: from a clinical meeting into a multidisciplinary service, which would include initiating change management to develop and implement a tumour specific program with a keen focus on patient pathways from entry of service to exit/survivorship.

METHODS
Baseline data has been collected from a sample size of 12 MDTs across the two LHDs. This data has been analysed using the Likert scale methodology measuring compliance against 46 identified indicators, and resulting in an evaluation of the performance status of these teams. The results will be process mapped to identify gaps and indicator non-compliance in order to develop interventions aimed at increasing compliance; improvement in service delivery and initiate integrating translational cancer research (T3) into MDTs to foster local research initiatives.
LESSONS LEARNED
The preliminary data shows the majority of teams are compliant with the 46 indicators; importance/higher rating was given to core and non-core membership, regularity of meetings, collection of basic data and utilisation of best-evidence-based protocols. Gap analysis of criteria for performance status has identified high and low functioning MDTs, as well as gaps in service provision. From this data, several initial interventions have been implemented with success and sub-projects have been instigated to further develop more significant interventions and future planning.

IMPLICATIONS
Further development and planning is required to standardise all MDTs to a level of acceptable compliance with the view to move forward into a tumour service. Several components of multidisciplinary care may need to be re-modelled to allow access for all tumour streams, such as the care coordination program and administrative support. A concurrent research study with Sydney West Translational Cancer Research Centre members is currently being undertaken to integrate translational T3 cancer research into MDTs.

Developing a Model and Scale for Measurement of Healthcare Service Quality: The Patient Perspective
Ingy Shafei1, Ahmed Taher2, Jan Auke Walburg3

OBJECTIVES
The role of service quality in healthcare is paramount for success. Considerable attention in literature has been given to optimal measurement of healthcare service quality (HSQ). In this study, our objective was to develop a model and scale for effective measurement of HSQ for obstetrics patients and gain a deeper understanding of what patients’ value in the service delivery process.

METHODS
A qualitative phase through in-depth interviews with experts and patients as well as a quantitative phase through surveys with 384 patients were undertaken. Data was analysed using statistical tools including coefficient (Cronbach) alpha, composite reliability, factor analysis, logistic regression analysis and discriminate analysis.

LESSONS LEARNED
A model of 8 constructs (hospital premises and employees, doctor medical service, nursing medical service, diagnostic medical service, admission, discharge, rooms/housekeeping, meals) and 17 subcontracts (physician reliability, physician assurance, physician interaction, physician competence, nursing tangibles, nursing reliability, nursing assurance, nursing interaction, nursing responsiveness, diagnostic service competence, diagnostic service reliability, hospital premises and employees tangibles, admission responsiveness, admission knowledge and courtesy, meals tangibles, rooms tangibles and housekeeping courtesy, discharge knowledge and courtesy) that have a significant effect on HSQ was developed. Weighted SERVPERF was identified as the best measure among several alternative measures (SERVQUAL, Weighted SERVQUAL, SERVPERF, Weighted SERVPERF).

IMPLICATIONS
The current research is unique in its conclusions on measuring HSQ and provides a comprehensive model and valid and reliable scale. This enables identifying areas of HSQ shortfalls and acting to improve the service delivery process thus enhancing satisfaction, loyalty and repeat patronage.

What Matters to People in Managing Their Health: Exploring Perspectives of Those Who Do Not Discuss Their Musculoskeletal Conditions with Their GP
Elizabeth Hoon
University of Adelaide

OBJECTIVES
This study’s objective is to gain an in depth understanding of the processes underpinning people’s lack of engagement with their GP in managing bone and joint problems (BJP) with the aim of informing pathways to care, including support services delivered by Arthritis SA.

METHODS
Respondents in a large population health survey (n=1307) who self-reported having a current BJP were asked how they engaged with their GP to manage their condition (14% indicated no discussion with their GP). In-depth qualitative interviews (n=20) were conducted with those who indicated no discussion and agreed to reconnect. This study is informed by theoretical literature on cumulative patient complexity (Shippee et al).

LESSONS LEARNED
This qualitative inquiry unpacks processes tied to balancing workload demands (related and unrelated to health) and capacities (abilities, resources, priorities) in managing BJP. Preliminary analysis indicates at least two distinct themes; one where poor health is combined the workload of living with multiple comorbidities and prioritizing other more pressing concerns. The other theme so far explored, is where the balance of workloads and capacities emphasize the maintenance of usual activities and mobility, and resistance to identifying BJP as a health problem.

IMPLICATIONS
The community-based support and self-management programs delivered by Arthritis SA require multiple approaches address a range of needs, including; support for people who have high workload demands in managing BJP in conjunction with co morbidities, and early preventative support for those endeavouring to persevere everyday activities without constructing BJP as a limiting health problem.

Using a World Café Community Forum to Explore Preferences of Seniors About Seeking and Receiving Falls Prevention Health-Related Information
L. Khong1, Caroline Bulsara1, K. Hill2, A.M. Hill1

OBJECTIVES
To address the gap in understanding of what is considered as “appealing” falls prevention information for people aged 60 and over.

METHODS
Falls in older adults are a major problem in Australia, they account for about $648.2 million in hospitalisation costs annually and an estimated one third of community-dwelling older adults over the age of 65 fall at least once per year. Despite strong evidence for effective falls prevention strategies, there is poor translation of these strategies from research to clinical practice, resulting in less than optimal uptake and adherence by older adults. This study completed a community forum using the World Café approach. A convenience sampling of community-dwelling older adults 60 years and over were invited to participate in the community forum within a metropolitan setting. Five topics in consultation with community groups were defined for the forum discussion.

LESSONS LEARNED
Overall, 80 adults attended the forum. The age range was about 65–75 years. Key themes from the forum included empowering oneself and not ‘being a burden’, education and self-management along with community awareness, appropriate delivery of information rather than ‘talking down’ to the person. Strategies and recommendations will be discussed.

IMPLICATIONS
The collective forum group reframed key issues and re-examining current practices are crucial to optimise falls prevention for the growing older population in the future.

Preferences for Food Irradiation Labelling
Stephen Goodall1, Elena Meshcheriakova1, Rosalie Viney1, Richard Norman2

OBJECTIVES
In Australia labelling of irradiated food is mandatory, however the government is currently considering a voluntary option to encourage broader uptake by producers. This study explores consumer attitudes towards food labels, examines preferences for irradiated foods and the value of the irradiation label.

METHODS
An online discrete choice experiment (DCE) was used. Responders were asked to choose between two food products based on irradiation label
status; irradiated, not irradiated, or no label (with varying probabilities that the product is irradiated). Other attributes included price, country of origin, shelf-life, availability, and probability of illness. To test for heterogeneity between food types, three food products were considered (fresh fruit, tropical fruit and meat). Using information specific vignettes, we also tested the role of education. The analysis was conducted using generalised multinomial logit models to account for scale and preference heterogeneity.

LESSONS LEARNED
On line surveys were completed by 1000 respondents. Awareness of the food irradiation process and labelling was low. Consumers prefer lower priced and locally produced products. For some, irradiation labels provide essential information, with clear preference for non-irradiated products. Consumers are more accepting of irradiated foods when additional information regarding the irradiation process and alternative food processing techniques is provided, thus demonstrating a clear role for education.

IMPLICATIONS
Despite food irradiation being a safe process, many consumers value the food irradiation label. If the current mandatory labelling policy is to be relaxed, education has an important role in consumer acceptance.

Beyond Crystal Ball Gazing: Estimating the Future South Australian GP Workforce Requirements Using a Needs-Based Approach
Caroline Laurence, Troy Heywood, Jonathan Karmn
School of Public Health, University of Adelaide
P33, Poster

OBJECTIVES
The aims of this study were to: develop a needs-based planning model to estimate the future GP requirements for South Australia from 2013 to 2033; and assess the impact of policy, workforce and population changes on these estimations.

METHODS
A needs-based simulation model was built which determined the supply and level of services required based on the health of the population and allowed the modelling of the effects of various policy and workforce scenarios. The main outcome measure was the number of full-time equivalent GPs required for South Australia from 2013 to 2033.

LESSONS LEARNED
The baseline scenario estimated an excess of 225 FTE GPs (95% CI -64, 375). A small surplus was estimated for 2033 under the increased GP visits scenario (95% CI -282, 132) and 194 FTE GPs with the IMG scenario (95% CI -431, 37). A small surplus (450 FTE GPs, 95% CI 217, 656) of GPs was estimated for 2033 for the scenarios based on projected changes in illness in the population (450 FTE GPs, 95% CI 217, 656) and substituting a proportion of GP consultations with practice nurses (8 FTE GPs, 95% CI -64, 375).

IMPLICATIONS
The model developed allows policy makers and planners to assess the likely impact of various policy options on future GP workforce estimates. Increasing demand for GP services and a reduction in the reliance of IMGs to fill workforce shortages have important consequences on the future GP workforce requirements.

How Can e- Help? The Potential for Electronic Job Aids to Close the Mental Health Treatment Gap in Low- and Middle-Income Countries
Huw Jarvis
University of Melbourne
P34, Poster

OBJECTIVES
Mental, neurological and substance use disorders make up approximately 14% of the global burden of disease. Most of this burden is in low- and middle-income countries, where three-quarters of people with these disorders do not receive care — what the World Health Organisation calls the treatment gap. This study investigates the potential role of electronic job aids in non-specialist settings to close the mental health treatment gap.

METHODS
The current study is a literature review of electronic job aids used in primary health care, with a particular emphasis on their advantages and limitations in mental health care in low- and middle-income countries. The study was supplemented by consultation with clinicians and health informatics experts to inform the examples given.

LESSONS LEARNED
Electronic tools are already used widely in primary care settings, but in mental health care they are more often developed for use by patients to improve doctor-patient shared decision making or to overcome barriers of access caused by geographical remoteness. Fewer have been developed for use in mental health care to support clinical decision making or training of non-specialists.

IMPLICATIONS
There is potential for electronic job aids to play an important role in closing the mental health treatment gap in low- and middle-income countries. Increased use of electronic job aids in non-specialist settings may also contribute to a greater understanding of workforce roles in other health care settings.

Prostate Cancer Research: From Lab Bench to Bedside. A Prospective from the Trenches
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1 Garvan Institute of Medical Research/Kinghorn Cancer Centre; 2 Chris O’Brien Lifehouse; 3 St Vincent’s Prostate Cancer Centre
P35, Poster

OBJECTIVES
The Australian Prostate Cancer Research Centre — New South Wales (APCRC-NSW) was established to change prostate cancer clinical practice with novel approaches to improve patient outcomes. It uses the resources of a clinical database and a cancer tissue biobank to achieve this aim.

METHODS
In 1994, the Garvan Institute of Medical Research and St Vincent’s Hospital, Sydney established a prostate cancer database and a tissue repository. Over 13,000 men have since consented to have their clinical data collected and their tissue samples stored. This has allowed researchers access to long-term follow-up data to evaluate treatment plans and tissue samples to compare pathology with outcomes.

LESSONS LEARNED
Over the years, the database and the biobank have been fundamental to significant scientific and clinical discoveries. These have been progressively translated into the clinical setting. The discovery of the role that Microphage Inhibitory Cytokine (MIC-1) has in predicting response to Docetaxel chemotherapy may lead to a more individualised approach to drug therapy. The use of magnetic resonance imaging (MRI) for men on active surveillance can reduce the need for invasive annual biopsies. These are examples of the research that the APCRC-NSW conducts to change clinical practice.

IMPLICATIONS
The management of cancer is dependent on knowing its cellular and morphological characteristics and pairing this with clinical outcomes. The APCRC-NSW has at its hand an extensive database and tissue repository capable of evaluating a range of research questions. It has published extensively and has champions to continue to promote its findings into the clinical setting.

A ‘Head-to-Head’ Comparison of the EQ-5D-5L and AQoL-8D Multi-Attribute Utility Instruments in Patients Who Have Undergone Bariatric Surgery
Julie A. Campbell, Andrew J. Palmer, Alison Venn, Melanie Sharan, Petr Olahal, Amanda Neil
Menzies Institute for Medical Research, University of Tasmania
P36, Poster

OBJECTIVES
Given the detrimental impact of morbid obesity on psychosocial health, the targeting of physical health by the EQ-5D and psychosocial health by the AQoL-8D, compare the performance of the EQ-5D-5L and AQoL-8D in assessing the utility of patients who have undergone bariatric surgery.

METHODS
Utilities for post-surgical private-sector patients (n=33) were assessed using the EQ-5D-5L and AQoL-8D. Discriminatory attributes were investigated in relation to floor (worst health) and ceiling effects (perfect health).
LESSONS LEARNED
Mean EQ-5D-5L utility value was 0.84 (0.15) and median 0.84 (IQR: 0.75–1.00). Mean AQoL-8D utility value was 0.76 (0.17) and median 0.81 (IQR: 0.63–0.88). Spearman’s rank was r=0.68 (p<0.001) however Bland-Altman analysis revealed fundamental differences. Neither instrument gave rise to floor effects. However, a ceiling effect was observed with the EQ-5D-5L, 36% of participants obtaining a utility value of 1.00 (perfect health). These same participants obtained a mean utility value of 0.87 on the AQoL-8D, primarily driven by a low score on the mental super-dimension (0.52).

IMPLICATIONS
Before selecting a generic MAUI, researchers should fully understand the instruments’ descriptive/classification systems and the innate sensitivities of the MAUI in their context. Improved psychosocial health status is increasingly identified as an important outcome for bariatric surgery patients. Given the relative importance of the psychosocial health in this population, the choice of MAUI may be crucial. The AQoL-8D precludes capturing psychosocial aspects of bariatric surgery patients’ quality-of-life. We recommend the AQoL-8D as a preferred MAUI for bariatric surgery patients given their complex physical and psychosocial needs.

Joint Prediction of Chronic Conditions Onset: Comparing Multivariate Probit with Multiclass Support Vector Machines
Shima Ghassem Pour, Federico Girosi
University of Western Sydney & Capital Market CRC

OBJECTIVES
We consider the problem of building accurate models that can predict, in the short term (2–3 years), the onset of one or more specific chronic conditions at individual level.

METHODS
We consider 5 chronic conditions: heart disease, stroke, diabetes, hypertension and cancer and build two different models that predict all possible combinations of these conditions. Covariates for the models include standard demographic/socio-economic variables, risk factors and the presence of the chronic conditions at baseline. The first model is the multivariate probit, chosen because it allows to model correlated outcome variables. The second model is the Multiclass Support Vector Machine (MSVM), a leading predictive method in machine learning, specifically designed to take advantage of correlated outcomes. We use data from the Social, Economic, and Environmental Factors (SEEF) study, a follow up to the 45 and Up study survey, that allows to observe 80,000 individuals in NSW, over age 45, twice over a period of two to four years.

LESSONS LEARNED
MSVM captured the correlations across chronic conditions much better than multivariate probits. While the specificity of the two methods are comparable, the sensitivity of MSVM is about 10 percentage points better than the one of multivariate probits. Since sensitivities are in general low, this translates in a large relative improvement, of approximately 30%.

IMPLICATIONS
Researchers in the field of comorbidities, that requires studying joint distributions of events, would greatly benefit from using MSVM rather multivariate probits, especially since R packages for MSVM are widely available and easy to use.

Exploring Parking Provisions for Patients Attending Victorian Cancer Treatment Centers
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OBJECTIVES
This study sought to explore:
1. the nature and extent of parking issues and costs incurred by people receiving cancer treatment in Victoria;
2. the availability of concessions; and
3. whether there are particular factors that impact affordable parking at treatment centres.

METHODS
Relevant staff members from all treatment facilities (n=53) were approached to participate in a structured telephone questionnaire consisting of fixed and open-ended questions regarding parking provisions at and around their centre.

LESSONS LEARNED
The questionnaire response rate (n=53; 100%) suggests high staff engagement. Parking was reported as a known patient problem by 85% of staff surveyed. Most frequently reported issues were cost (55%), insufficient spaces (43%) and time-limited parking (39%). Ninety-one percent of centres provided onsite parking. Of these, 77% charged a fee and 25% did not offer subsidies or discounts to cancer patients. Only 23% of treatment centres provided dedicated spaces for cancer patients. Many centres did not systematically inform patients about parking or subsidy schemes.

The average daily maximum to park was $19.88 (range: $3.00–$50.00), which equates to over $1100 in one year for a patient receiving ‘standard’ treatment.

IMPLICATIONS
Inconvenience and cost of parking are unwanted by patients and often uncertain and unexpected.

Establishment of a consistent and accessible approach to parking with clear eligibility criteria for discounts and subsidies may significantly reduce the impact of parking on cancer patients. One method of achieving this may be to assign responsibility for informing patients about parking to a specific person or role.

Assessing the Impact of Ventricular Assist Device Implantation on Hospitalisation Rates in Advanced Heart Failure Using Linked Administrative Data
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OBJECTIVES
Ventricular assist devices (VADs) are used to rescue advanced heart failure (AHF) patients at risk of dying, as a bridge to heart transplantation (HTX). The use of VAD therapy is increasing and the cost implications need exploring.

Hospitalisation drives cost and linked administrative data allows comparative assessments of rates to be undertaken. We compared length of stay (LOS) before and after VAD implant, and before heart transplantation.

METHODS
77 patients were included (52 AHF and 25 VAD). NSW Linked administrative data was obtained and we analysed LOS, as well as clinical data, in the year prior to, and post VAD implantation and prior to HTX.

LESSONS LEARNED
• The Pre VAD group (N=25) was significantly sicker over a number of clinical indicators, and spent longer hospitalised than the Pre HTX group (Median (IQR) 50 (38–73) vs 19 (5–37) days per patient, p<0.001)
• 9/25 VAD patients required reconditioning for a median of 22 (11–47) days in rehabilitation, with significant clinical improvement prior to first discharge.
• Admissions occurring after first discharge compared with Pre VAD data, show a reduction in (LOS) (Median 17 (6.5–51.5) vs=0.02)
• In the 8/25 patients who were supported on VAD pump for more than a year prior to transplant, the median total LOS in the year before HTX was only 6.5 days (1–35).

IMPLICATIONS
Patients requiring VAD as a bridge to transplant are critically ill and their care is complex. Length of stay post VAD varies widely but this therapy is associated with clinical improvement as well as a reduced hospitalisation once reconditioning has occurred.
Application of Risk-Standardised Outcome Ratios in Different Performance Measures

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OBJECTIVES
To describe the application of a core method, the risk-standardised outcome ratio, in the development of different performance measures, including mortality, return to acute care (readmission), and utilisation of emergency departments following hospital discharge.

METHODS
Risk-standardised outcome ratios provide a method of indirect standardisation that examines hospital performance in terms of (observed outcomes) / (expected outcomes). Expected outcomes were generated by statistical models using the NSW patient population's characteristics. Models were tailored to the outcome of interest. For mortality, prediction models based on random intercept logistic regression were used, while for readmissions and ED visits, time-to-event, competing risk regression models were used. Across all applications, ratios >1.0 indicate higher than expected outcomes and ratios <1.0 indicate lower than expected outcomes. However, ratios close to 1.0 are not deemed to be significant; and funnel plots used to identify outliers.

LESSONS LEARNED
The method proved to be sensitive to identifying outlier hospitals across risk-standardised ratios <1.0 indicate lower than expected outcomes. However, ratios close to 1.0 are not deemed to be significant; and funnel plots used to identify outliers.

Retention of Midwives in Remote Areas of Indonesia: A Success Case Study from West Nusa Tenggara

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OBJECTIVES
Retention is a major issue for developed and under developed countries. Retaining qualified midwives closer to communities or villages, particularly remote areas, is not a simple task. Thus, the objective of this research is to explore the supporting and inhibiting factors that need to be addressed in order to improve retention of midwives in the remote areas of Indonesia.

METHODS
The Success Case Method (SCM) used considers 'What is working well?' before focusing on 'what are we worried about?'. This approach allows the researcher to identify key success factors from the best performing case in order to obtain a better future. West Nusa Tenggara Barat was chosen as the success case area because it is categorised as an underdeveloped region with a sustainable high coverage of midwives for the past three years, from 2011 – 2013.

LESSONS LEARNED
Many factors contribute to the success of retention strategies, but how these factors operate and interact is not yet well understood in Indonesian context. Having midwives in remote areas of Indonesia depends on two interconnected aspects: first, the factors that influence midwives to work and stay in remote areas; and second, the extent to which the policies of the Government of Indonesia respond to and facilitate factors that influence the retention of midwives in remote areas of Indonesia.

IMPLICATIONS
Policy-makers need to consider a broad range of motivational determinants which could potentially improve programmes and policies in recruiting and retaining health workers in rural and remote areas of Indonesia. Significant challenges remain and these will be outlined along with suggestions for ways of tackling them.

The Potential Impact of a Financial Incentive on GP Prescribing and Patient Use of Inhaled Corticosteroids

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OBJECTIVES
Guidelines recommend use of low-dose inhaled corticosteroids (ICS) preventer inhalers for most patients with asthma, with higher-cost combination ICS/long-acting β2-agonist (LABA) only recommended if good asthma control is not achieved. However, most preventer prescribing in Australia is for ICS/LABA. This qualitative study examined: factors that influenced patients’ purchase and use of preventers; and the feasibility and acceptability to patients and GPs of financial incentives to encourage the use of ICS inhalers.

METHODS
Semi-structured telephone and face-to-face interviews were conducted with a purposive sample of patients with asthma/carers (n=45) and GPs (n=15). Data were analysed to identify themes and intersections between themes.

LESSONS LEARNED
Patients did not regard themselves as primary decision-makers about preventer use, as GPs played a crucial ‘gatekeeper’ role for prescriptions. GPs reported poor access to information about medication costs and seldom initiated discussions of costs with patients. Effectiveness of preventer class medicines was the stated priority for patients and GPs. Cost was important to users of multiple medicines and low income-earners, but this tended not to override the priority of effectiveness. Consequently, the notion of financial incentives was met with suspicion.

Determinants of Birth Interval Among Women in Reproductive Age Group in Ethiopia

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OBJECTIVES
This study was intended to identify determinants of birth spacing among child bearing age group women in Ethiopia.

METHODS
Secondary data analysis of 10482 reproductive age women included in the 2011 Ethiopian Demography and Health Survey of 2011 was conducted. Survival analysis using Kaplan Meier survival curve and Cox proportional hazards model was done from April to June 2014. Data on women having at least one live birth were considered.

LESSONS LEARNED
The median birth interval was 34 months. After adjustment for potential confounders, mothers having no education (AHR=1.67; 95% CI: 1.32, 2.12), being rural residence (AHR=1.13; 95% CI: 1.03, 1.25), sex of head of house hold being male (AHR=1.20; 95% CI: 1.13, 1.27), mothers who were poorest (AHR=1.28; 95% CI: 1.15, 1.39), poorer (AHR=1.22; 95% CI: 1.10, 1.36) and middle income (AHR=1.15; 95% CI: 1.04, 1.27) by their wealth status were associated with increased risk of short birth interval.

IMPLICATIONS
The implications of the findings were that the health and wealth status of households at the time of birth were associated with the birth interval. Therefore, the birth interval of a child was influenced by the wealth status of the household at the time of birth.
The impact of existing cost incentives on GP prescribing could be enhanced by improving their awareness of costs of asthma preventers to patients. This could improve the quality of exchanges between patients and GPs and may encourage patients to accept ICS-only inhalers. Patients and GPs require evidence and reassurance from reliable sources about the effectiveness of lower cost preventer medicines.

Audit of Gross Decay Treatment in Young Children Under General Anaesthetic

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OBJECTIVES
In Australia, dental caries is one of the most prevalent diseases affecting children. For more severe cases a dental general anaesthetic (GA) is required.

METHODS
A retrospective analysis of clinical records for all patients aged up to 10 years who attended Barwon Health (Geelong, Victoria, Australia) for a dental GA from 2010–2012 was performed.

LESSONS LEARNED
There were 236 separate events in 234 children, with 223 new cases and 11 that had already received a dental GA prior to the study period. The average age of patients at their dental GA procedure was 6.3±2.0 years. Prior to the GA, the average dmft/DMFT was 8 (6–12) (median, interquartile range). The length of time from referral to GA increased significantly from 166.4 days (SD 108.1), 164.3 days (SD 98.9) to 225.4 days (SD 129.5) in 2010, 2011 and 2012, respectively. Follow up review appointments after GA appointment was attended by 10.8%, 37.3% and 36.0% of patients, respectively across the same years.

IMPLICATIONS
Following the findings of long waiting times for GA procedures for children with severe dental caries, and the low rate of attendance for post-GA reviews, a change in dental process is urgently needed.

Limited Evidence is Available to Inform Public Oral Health Care Services for Indigenous Australians in Victoria

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OBJECTIVES
Indigenous people have priority access to public dental services in Victoria due to their high dental needs. To ensure public oral health services continue to meet the needs of indigenous community members in Victoria, we sought to review the evidence base related to oral health in Indigenous adults and children in Australia and examine trends in disease prevalence over time.

METHODS
We systematically searched for peer-reviewed articles (published 1971–2014) reporting oral health disease prevalence and/or experience (clinical caries or periodontal indices) in a general sample of Indigenous people. Data was extracted from each study and synthesised by jurisdiction and sample demographics.

LESSONS LEARNED
Suitable studies of Indigenous children (n=32) and adults (n=18) were identified, however the evidence base was found to be extremely limited and primarily related to Indigenous people living in rural or remote locations. There was very little data on Indigenous people living in metropolitan areas, and no data published on Indigenous people in Victoria. Trend analysis was also not possible due to the small number of studies, and variations in the collection and reporting of data. Further, while risk factors for oral disease are well known there was extremely limited analysis of the relationships between the established risk factors and oral disease.
the sampling period (March 2014), 20% of outpatients attended multiple clinics. Following review of three distinct data periods, the completeness, consistency and overall quality of the WebNAP data were found to be poor.

IMPLICATIONS

While some degree of the mismatch is expected due to patients attending multiple clinics, mismatch seems disproportionately large in this study. Although WebNAP data quality is poorer than other sampling frames used, some mismatch may result from patient confusion on specialty definitions or inconsistently applied definitions in WebNAP. Changes in survey methodology are required to facilitate specialty-level reporting. Ultimately, trusting the patient-reported source of outpatient care should be warranted.

Human Papillomavirus (HPV) Self-Sample Testing: Interventions with/for Northern Canadian Women

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BACKGROUND

Cervical cancer (CC) is the fourth most commonly diagnosed cancer among women internationally [1] and the third most common cancer in younger Canadian women [20–49]. Indigenous women living in high-income countries have higher rates of late stage CC and mortality than non-Indigenous women [2]. In Canada, historically Aboriginal women have had higher late stage CC rates, particularly women living in challenging northern geographies with limited access to health services. High-risk HPV infections are a necessary cause of cancer of the cervix [3]. A self-collection modality for cervical screening has been demonstrated to be acceptable by women who face barriers to screening and are under- or un-screened [4–6].

OBJECTIVES

An HPV Self-Sample North (HPV-SSN) working group was established in 2014 with funding from the Canadian Institute of Health Research with the objective of developing a collaborative research program to advance the science and address inequities in HPV and CC prevention for women in northern and rural Canadian communities.

METHODS

Findings will be presented from working group meetings attended by researchers, provincial cancer agency policy-makers, health care providers, First Nations advocacy representatives, and First Nations program coordinators from British Columbia, Ontario, and Manitoba.

LESSONS LEARNED PLUS IMPLICATIONS

Key themes that emerged from the meetings included: a need to address the limited access to culturally relevant awareness materials about HPV, CC, and screening; a lack of trauma informed training and care among health care providers; a need for more strengths-based, as opposed to deficit-, research and care; and new ways of knowing (e.g., arts-based methods), and integrating new technologies such as HPV testing of self-collected samples.

REFERENCES


Discharging Older Patients from the Emergency Department Effectively: Systematic Review and Meta-Analysis

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OBJECTIVES

A decline in health state and re-attendance are common in people aged ≥65 years following emergency department (ED) discharge. Discharge models have been implemented to support safe community transition. This review examined ED community transition strategies (ED-CTS) and evaluated their effectiveness.

METHODS

A systematic review and meta-analysis using multiple data-bases up to December 2013 was conducted. We assessed eligibility, methodological quality, risk of bias and extracted published data; then conducted random effects meta-analyses. Outcomes were unplanned ED re-presentation or hospitalisation, functional decline, nursing-care home admission and mortality.

LESSONS LEARNED

Five experimental and four observational studies were identified for qualitative synthesis. ED-CTS included geriatric assessment with referral for post-discharge community-based assistance, with differences apparent in components and delivery methods. Four studies were included in meta-analysis. Compared with usual care, the evidence indicates no appreciable benefit for ED-CTS for unplanned ED re-attendance up to 30 days (OR 1.32, 95% Confidence Interval (CI) 0.99–1.76; N=1389), unplanned hospital admission up to 30 days (OR 0.90, 95% CI 0.70–1.16; N=1389), or mortality up to 18 months (OR 1.04, 95% CI 0.83–1.29; N=1794). Variability between studies precluded analysis of the impact of ED-CTS on functional decline and nursing-care home admission.

IMPLICATIONS

There is limited high quality data to guide confident recommendations about optimal ED community transition strategies, highlighting a need to encourage better integration of researchers and clinicians in the design and evaluation process; and increased reporting, including appropriate robust evaluation of efficacy and effectiveness of these innovative models of care.

Can a Nursing-Centric Primary Healthcare System Deliver on Health Outcomes in Rural and Remote Communities?

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OBJECTIVES

Sustainability challenges as well as on-going issues with diseconomies of scale create challenges to the provision of responsive primary healthcare services in rural and remote communities. This presentation reports on findings from the BC Closing the Gap study, which assessed the performance of rural and remote primary healthcare services.

METHODS

We used hospitalization for ambulatory care sensitive conditions to identify trends in primary healthcare needs in rural and remote communities. We used GEE modeling to identify communities with similar characteristics, aggregated data across time, and used 5 year rolling samples to attenuate the impact of small sample size.

LESSONS LEARNED

Our results show that communities served by a nursing centric model of care which includes some level of primary care (nursing stations) show a strong association between rates of hospitalization for ACSC and premature mortality rate. The strength of association is particularly noticeable for all ACSC conditions and chronic conditions suggesting that the models of care in communities served by nursing stations is sufficient to ensure a lower premature mortality rate from ACSC and comparable to urban centres.
IMPLICATIONS
These results suggest that the nursing station model of care, where prevention and primary care are delivered by nurses with an expanded scope of practice, can potentially meet the primary healthcare needs of BC First Nations, in so far as helping to prevent premature mortality. These findings are important for the design and delivery of primary healthcare services in rural and remote communities.

Organizing Hospital Infrastructures to Identify and Address Disparities in Quality of Care
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OBJECTIVES
Many hospitals do not yet publicly share performance across different sociodemographic variables. This study describes how a 1000 bed, US-based academic medical center created an infrastructure to support the collection, acquisition, and data reporting of quality metrics by race and gender.

METHODS
The study team engaged hospital leadership to support the exploration of disparities in care. Two publicly reported quality metrics reported by the Johns Hopkins Hospital were selected: core measures and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). We identified roles within the hospital tasked with collecting and reporting the two metrics to government agencies and stratified 2010–2013 aggregated data by race and gender. Results were presented through the organizational structures to the quality and safety committees and then to the health system patient safety and quality board of trustees. The study informed the creation of an organizational infrastructure map of roles and processes involved in the collection, reporting and analysis. Results presented at all organizational levels include: differences in response rates by race for HCAHPS (43% White, 18% Black), differences in 9 of the 11 HCAHPS domains (P<.001), and differences across all domains by gender (P=.01).

LESSONS LEARNED
Healthcare system reforms and updates in electronic systems and reporting along with strong support from hospital leadership (Senior VP of Quality and Safety) made data accessible for analysis. Moreover, the use of standardized metrics enables broad comparison of performance across the organization.

IMPLICATIONS
Creating structures and roles within Quality Departments is an effective means to explore disparities in care.

Tasmanian General Practice’s Satisfaction with the Tasmanian General Practice After-Hours Incentive Funding Mechanism 2014–15
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OBJECTIVES
Evaluate the success of the Tasmanian After-Hours Incentive Funding Model 2014–15 in addressing the concerns of Tasmanian general practice in regards to lack of fairness and bias in the 1998–2013 Practice Incentive Payment (PIP) funding model.

METHODS
All 159 Tasmanian general practices were approached for inclusion, with a General Practice Principal and the Practice Manager asked to complete the Urgent After-Hours Primary Health Care Survey. General Practice. The Survey sought to assess satisfaction, experience and opinions of the Model using 5-point Likert items and open text responses. The survey was undertaken between 7 May 2015 and 5 June 2015.

LESSONS LEARNED
The Model encompassed fundamental change but was associated with high levels of satisfaction overall and across its individual elements:

- After-hours clinics;
- On-call care to mobile patients; and
- On-call care to patients in residential aged care facilities (RACFs).

The highest levels of satisfaction arose with respect to the inclusion of the RACF component, the least, after-hours clinics. Thirteen new practices subscribed to the Tasmania Medicare Local’s After Hours Practice Funding Scheme indicating acceptability. There was greater preference for the Model compared to the earlier PIP mechanism.

IMPLICATIONS
This study likely provides the only opportunity to evaluate an innovative Model for after-hours incentive funding given re-introduction of national funding through the PIP scheme. Such information was considered of ongoing importance in the Jackson Review. The adoption of a specific RACF component could be valuable in the wider Australian context given difficulties in ensuring after-hours service provision in this setting.

The Impact of the New Zealand Transient Ischaemic Attack Guidelines (2008) on Clinical Services and Practice in the Central Wellington Region
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OBJECTIVES
This study examined the impact of the New Zealand Transient Ischaemic Attack (TIA) Guidelines on clinical services and practice in the central Wellington region over the last 6 years. The guidelines were released in 2008 with the intention to improve public awareness of TIA symptoms; GPs’ awareness of TIA as a medical emergency and pathways development to improve management of TIA patients.

METHODS
Mixed methods research was applied to assess the extent of uptake of the guidelines and their impact on primary and secondary care in the central Wellington region. A quantitative survey was conducted among primary care physicians and nurses, secondary care specialists, emergency department doctors and nurses, and TIA clinics’ healthcare professionals. Quantitative data analysis was performed using descriptive statistics. On the base of the findings of the quantitative analysis second part of the research employed qualitative cross-sectional interviews with healthcare professionals in the primary and secondary care. Qualitative data was evaluated using NVIVO.

LESSONS LEARNED
TIA clinics establishment influenced development of local TIA pathways between primary and secondary care; encouraged guidelines’ recommendations uptake in primary care; improved quality of care for TIA patients. TIA clinics development initiated education processes for local GPs about TIA as a medical emergency. Guidelines dissemination and uptake within primary care settings remains a challenge. More than half of the survey respondents indicated that they were unaware of the NZ TIA Guidelines (2008) existence.

IMPLICATIONS
More research is needed on guidelines development with the focus on uptake strategies for wider range of healthcare practitioners. Nurses and registrars who are mainly triaging and assessing patients in primary care and emergency departments should be aware of the guidelines recommendations.

Using Data to Inform the Delivery of Care: Patients’ Assessments of Care over an Extended Period
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OBJECTIVES
Patient satisfaction surveys commonly indicate relatively high levels of satisfaction with hospital care. However, the needs of patients who receive care over some months may change, and the degree to which the care provided meets those needs may wax and wane. Maternity patients usually receive care over 6–7 months, comprising the antenatal, birth and postnatal periods. This study explored how maternity patients rated their care over these periods, and what factors in the care environment predicted higher or lower ratings of care.

METHODS
All women who gave birth in seven public maternity units in NSW between 1 May and 31 July 2013 were invited to complete a postal survey
What is the Prevalence of Antenatal Risk Factors Affecting Child Development in Australian Women?

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METHODS
Cross sectional risk factor survey of 5,613 women attending public antenatal clinics of secondary hospitals located in outer metropolitan and regional areas of Tasmania and Victoria. Data collection took place from April 2013 to August 2014. Survey design was based on review of current child development literature and a small pilot study.

LESSONS LEARNED
Women in this cohort (N=5613) were on average 29.0 years of age and 26.9 weeks gestation. Approximately 78.2% of the cohort lived in the lowest three SEIFA quintiles on the area based relative index of disadvantage (SEIFA 2011), the most social and economically disadvantaged. The three most prevalent risk factors included poor self-rated health (38.9%), low maternal education (33.2%) and young maternal age less than 23 years (13.1%), all proportions higher than the general population. Most women were exposed to at least one risk factor (68.5%), with 21.5% exposed to ≥3 risk factors. There was a high degree of co-occurrence between risk factors.

IMPLICATIONS
Existing universal health platforms offer the opportunity to enhance support during the perinatal period. Surveys such as ours highlight the level of socio-economic and psychosocial risk in pregnancy. A number of these factors can potentially be addressed through policy and practitioner effort that is more focused on identifying vulnerable pregnant women, with the aim of providing early intervention to improve child development outcomes.

A Population Analysis of Self-management and Health Related Quality of Life for Chronic Musculoskeletal Conditions

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University of Adelaide

OBJECTIVES
Taking a population perspective rather than being reliant on a clinical population or sample of convenience this study assesses associations between self-management behaviours and health-related quality of life for people with chronic musculoskeletal conditions.

METHODS
A Computer Assisted Telephone Interview (2012) was conducted with 885 respondents aged 15 years and over who indicated still having a musculoskeletal condition reported in a 2010 health census study undertaken in Port Lincoln, Australia. Analysis used variables related to severity of musculoskeletal problems, self-management activities, demographic, socioeconomic and quality of life. Analyses using generalized linear regression (cumulatively adjusted for age, sex, education, marital status, smoking, comorbidities, and pain) and ordered logistic regression examined associations between use of a range of self-management activities and quality of life.

LESSONS LEARNED
Exercise (63%) and diet (19%) were the most commonly reported self-management activities used to manage musculoskeletal conditions. 24% reported not using any specific self-management activities. Involvement in self-management showed no association with quality of life, with and without adjustment for confounders. Diet had a negative association with quality of life as did use of formal support (self-management course or community group support).

IMPLICATIONS
Taking a population perspective, this study raises questions about the impact of self-management activities on quality of life for people with chronic musculoskeletal conditions in real world settings. It highlights the need to consider more proactive intermediary models to support and direct change in self-care and effective use of resources, earlier in the disease continuum.

A Cultural Competence Organisational Review for Community Health Services

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OBJECTIVES
To describe the development of a cultural competence assessment, intervention and evaluation tool called the Cultural Competence Organisational Review (CORe) and its implementation in three community health sector organisations.

METHODS
The CORe tool consists of both qualitative and quantitative methods to assess the quality and appropriateness of an organisation’s current practices and policies in relation to its services to culturally and linguistically diverse (CALD) clients and communities. Baseline and follow up staff surveys and document audits were conducted at each participating organisation. Process data was collected through regular partner and committee meetings. Organisational documentation was used to monitor the implementation of CORe within the organisations and whether the intervention was being implemented as intended.

LESSONS LEARNED
Organisations that were able to embed actions to improve organisational cultural competence within broader organisational plans increase the likelihood of sustainable changes to policies, procedures and practice within the organisation. Implementation of the CORe provided organisations with a platform for measuring existing staff capacity, raising staff awareness of the value and importance of cultural competence, as well as opportunity to display leadership and support for improving service delivery to CALD groups.

IMPLICATIONS
A process and tool for assessing organisational cultural competence is presented that can be utilised and adapted by organisations within the community health and social services sector. The CORe also provides an opportunity for regular monitoring and review as the staff survey and document review can be repeated at subsequent time points in order to monitor and evaluate organisational change.
The Factors Influencing Antibiotic Prescribing in a Rural Hospital Emergency Department with No On-Site Infectious Disease Support

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OBJECTIVES
Overuse of antibiotics is associated with the emergence of multi-drug resistant organisms. Implementing effective strategies to improve antimicrobial prescribing is often challenging in rural hospitals. This study aimed to evaluate and understand antibiotic prescribing practices in a rural hospital emergency department (ED).

METHODS
Quantitative component — Cohort method, retrospectively audited 200 ED antibiotic prescriptions and assessed for appropriateness against Therapeutic Guidelines.


LESSONS LEARNED
The audit revealed that 31% of antibiotics prescribed in the ED were inappropriate. Logistic regression analysis confirmed the choice of antibiotic as the only variable that significantly influenced inappropriate antibiotic prescribing (IAP). Ceftriaxone was the only antibiotic that predicts IAP with a p value < 0.001.

Interviews identified prescribing culture, lack of awareness of hospital guidelines and organisational constraints after-hours are the main factors that influenced IAP.

Participants (doctors) recommended strategies such as education, restricting antibiotic availability and developing consensus-based guidelines as way to improve prescribing.

This study found that broad-spectrum antibiotics, primarily ceftriaxone, are still widely overprescribed. Improving knowledge and guideline familiarity alone is not sufficient; prescribing culture needs to be changed to improve antibiotic prescribing. Co-ordinated multidisciplinary approach along with other strategies such as restricting availability of antibiotics is required to reduce the rate of IAP.

IMPLICATIONS
The study gave insight into prescribing practices in a rural hospital ED, which was largely unexplored. This information will help to target interventions that could lead to practice improvement.

Identifying Women for a Nurse Home Visiting Service: The Feasibility and Utility of Antenatal Risk Factor Screening

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OBJECTIVES
Determine the feasibility and utility of an antenatal risk factor survey delivered in public settings.

METHODS
Design & Setting: Study-designed survey data linked with clinician-collected risk factors. Participants: Pregnant women attending antenatal clinics at two Victorian hospitals. Measures: (a) Survey: age, social support, health, education, employment, and proxy poverty measures. (b) Clinician-collected data: smoking, substance abuse, social support, domestic violence and mental health problems. Analyses: Feasibility was assessed through survey completion. Each of 10 survey items were dichotomised into risk versus no risk. A count of survey risk factors co-occurring with clinician-collected risk factors assessed utility.

LESSONS LEARNED
166/186 (89%) of eligible women completed the survey and 139/166 (84%) consented to linkage with clinician-collected data. This high response and zero missing data demonstrated feasibility. Of women with both survey and clinician-collected data, 92/139 (66%) had ≥ 1 survey risk factors and 30/139 (22%) had ≥ 3, and 36/139 (26%) had at least one clinician-collected risk factor. A survey risk factor count of ≥ 2 identified 38% of all women screened: 61% of whom had clinician-collected risk and 30% who did not.

IMPLICATIONS
This survey provides a simple and rapid method for gathering antenatal risk data in a public setting, albeit identifying a higher proportion of women with risk factors than clinician-collected data. It has the potential to be a useful tool to enable health platforms to better respond to and support pregnant women based on antenatal risk for poorer maternal and child outcomes.

Workplace Culture and Health Care Reform: Front Line Workers Carrying the Weight of Policy Shifts

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OBJECTIVES
To examine what health care policy reform means to and for front line workers in primary and secondary care.

METHODS
A mixed method evaluative framework was employed for two evaluation studies. The qualitative component of the studies involved site visits and face to face semi-structured interviews (n=88) at five geographically distinct locations. The quantitative component involved a survey of patients (n=433), staff (4233) and analysis of routine data. The analysis of qualitative data was informed by the Consolidated Framework for Intervention Research (CFIR).

LESSONS LEARNED
This paper draws on the qualitative component of two evaluation studies and explores how health care policy reform is experienced by front line staff and the role workplace culture plays in facilitating or inhibiting policy interventions. Insufficient attention to the work loads of front line staff and understandings of how they prioritise workplace demands can undermine the success of policy/practice interventions. Externally driven interventions (policy and practice) are substantially challenged by institutional politics and workplace culture and require support not just from those in senior positions but also those in front line roles.

IMPLICATIONS
It is necessary to ensure that the institutional culture is responsive to reform/intervention, to understand the intervention characteristics, outer and inner setting realities, the characteristics of individuals and the process — the latter which should be informed by the content and context analysis.
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