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APHCRI RESEARCH STREAMS
EVIDENCE INFORMING THE FUTURE OF
AUSTRALIAN PRIMARY HEALTH CARE

ANU College of
[Medicine, Biology
& Environment](#)

CONTENTS

**APHCRI Research
Streams: Evidence
informing the future
of Australian primary
health care**

The Australian Primary Health
Care Research Institute

2015

Foreword	2
Coordination and the vulnerable consumer	4
The relationship between sub-acute and primary care	18
Integrated Primary Care Centres	30

FOREWORD

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

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

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

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

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

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

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



A handwritten signature in black ink, appearing to read 'Terry Findlay'.

Associate Professor Terry Findlay
Head of Programs



COORDINATION AND THE VULNERABLE CONSUMER

APHCRI awarded funding for six projects under the Coordination and the Vulnerable Consumer Health Care Research Stream.

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

All of these projects are now completed. Reports from each project are available on the APHCRI website.



PARTNERSHIPS IN CARE: ATTRIBUTES OF SUCCESSFUL CARE COORDINATION MODELS WHICH IMPROVE HEALTHCARE NETWORKS FOR PEOPLE WITH INTELLECTUAL DISABILITY

Chief Investigator: Associate Professor Lucie Walters

Based at: Rural Clinical School, Flinders University, SA

This study identified key attributes of successful care coordination models in order to improve health outcomes for people with an intellectual disability in rural Australia.

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

The study showed that in order to improve the health outcomes of people with an intellectual disability in rural areas, there must be sustainable, long-term models of care coordination. Care coordinators should be situated in local primary health care organisations and must act as trusted navigators for clients. This study also proposed benchmarks for health outcomes for people living with an intellectual disability and explored the feasibility of measuring these against local and practice population data to help enforce health care service accountability.



THE IMPACT OF EQUITY FOCUSED HEALTH IMPACT ASSESSMENTS (EFHIA) ON LOCAL PLANNING FOR AFTER HOURS CARE TO BETTER MEET THE NEEDS OF VULNERABLE POPULATIONS

Chief Investigator: Dr Elizabeth Harris

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

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

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

This study developed methodologies to assist Medicare Locals / Primary Health Networks in the consideration of access and equity issues in planning and development. These methodologies include EFHIAs and using an equity lens or equity audits.



OVERCOMING BARRIERS FOR TRANSITIONING VULNERABLE CLIENTS FROM TARGETED PROGRAMS TO MAINSTREAM PRIMARY CARE

Chief Investigator: Associate Professor Virginia Lewis

Based at: Australian Institute for Primary Care & Ageing, La Trobe University,
VIC

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

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

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



Y HEALTH-STAYING DEADLY

Chief Investigator: Dr Annapurna Nori

Based at: Watto Purrinna Aboriginal Health Services, SA

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

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

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



COORDINATED PRIMARY HEALTH CARE FOR REFUGEES: A BEST PRACTICE FRAMEWORK FOR AUSTRALIA

Chief Investigator: Professor Grant Russell

Based at: Southern Academic Primary Care Research Unit, School of Primary Health Care, Monash University, VIC

This project reviewed international evidence and conducted new research into developing a framework for the delivery of accessible and coordinated primary health care to refugees.

Australia permanently resettles over 20 000 refugees each year. The complex social, physical and mental health problems faced by refugees require high quality, accessible and coordinated primary health care.

Our work highlighted how easy it is for refugees to "fall through the cracks" between the many services charged with easing their transition into a new country.

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



THE SPRINT PROJECT: PRIMARY HEALTH CARE SERVICES BETTER MEETING THE HEALTH NEEDS OF ABORIGINAL AUSTRALIANS TRANSITIONING FROM PRISON TO THE COMMUNITY

Chief Investigator: Dr Jane Lloyd

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

The SPRINT project involved a partnership between the
University of New South Wales, the Aboriginal Medical Service

Western Sydney, the University of Western Sydney and the
University of Technology Sydney. The project looked at the
primary health care needs of Aboriginal Australians as they
transition from custody back into the community.

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



Through conducting systematic literature reviews, linked dataset analysis and qualitative interviews, this study found there is inadequate continuity of comprehensive health care in the context of Aboriginal inmates' complex needs and significant emotional distress and anxiety. This contributes to the higher risk of injury and illness experienced by Aboriginal former inmates post release, and to the institutionalisation of Aboriginal people within and outside the criminal justice system. To ensure continuity of health care in custody and post-release, policy makers need to develop relevant governance and infrastructure to support effective "throughcare" programs for Indigenous people. This may include expanding the duty of care of corrective services or supporting community agencies to run transition programs for Indigenous people, enabling the use of Medicare items for Indigenous people in custody, and involving community service providers and family members in the development of individual discharge plans.



THE RELATIONSHIP BETWEEN SUBACUTE AND PRIMARY CARE

APHCRI is funding five projects under the Relationship Between Sub-Acute and Primary Care Research Stream. This Research Stream uses aged care and/or mental health care as examples to:

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

These projects are all funded for the period from March 2014 to April 2015. Further information is available on the APHCRI website.



JOIN THE CONVERSATION: EVALUATING THE EFFECTIVENESS OF EXPERIENCED BASED CO-DESIGN IN IMPROVING THE CLIENT EXPERIENCE OF MENTAL HEALTH TRANSITION ACROSS HEALTH SECTOR INTERFACES

Chief Investigator: Ms Kathryn Cranwell

Based at: College of Health and Biomedicine, Victoria University, VIC

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

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

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



ENHANCING HEALTH SYSTEM INTERFACES: A STUDY OF EXPERIENCES OF SUB-ACUTE CARE PATIENTS, THEIR CARERS & PROVIDERS

Chief Investigator: Dr Edward Strivens

Based at: Cairns and Hinterland Hospital and Health Service, QLD

This project is using a qualitative methodology to examine the journey by older people presenting at emergency departments who are referred to the Geriatric Evaluation and Management (GEM) service and discharged to the community. It is examining service experience, needs and access to services from the perspective of patients, carers and service providers.

The GEM model of care is a national policy direction for multidisciplinary, coordinated care of older patients with multiple conditions and complex health care needs who present at the

Integration and coordination of the patients' journey across transitions in care is the key issue for patients, their carers and primary care teams alike.

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

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



Dr Strivens and the team

IMPROVING THE 'NETWORK PLANNING AND MANAGEMENT' OF INTEGRATED PRIMARY MENTAL HEALTH CARE FOR OLDER PEOPLE IN RURAL REGIONS

Chief Investigator: Professor Jeffrey Fuller

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

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

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

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

A well networked range of local services can help carers get the necessary care for their older relatives with mental health issues.



Professor Fuller and the team

FUNCTIONAL DECLINE IN COMMUNITY-DWELLING OLDER PEOPLE AND THE MEDICARE 75+ HEALTH ASSESSMENTS

Chief Investigator: Professor Karen Grimmer

Based at: School of Health Sciences, University of South Australia, SA

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

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

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



REDIRECT: REDUCING OLDER PATIENTS' AVOIDABLE PRESENTATIONS FOR EMERGENCY CARE TREATMENT

Chief Investigator: Professor Danielle Mazza

Based at: Department of General Practice, Monash University, VIC

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

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

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

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



INTEGRATED PRIMARY CARE CENTRES

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

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

These projects are all funded for the period from April 2014 to October 2015. Further information is available on the APHCRI website.



ANALYSIS OF THE SUPPORTS AND HINDRANCES TO THE INTEGRATION OF CO-LOCATED SERVICES IN MULTIPLE MODELS OF PRIMARY HEALTH CARE DELIVERY

Chief Investigator: Professor Nigel Stocks

Based at: Discipline of General Practice, University of Adelaide, SA

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

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

The six participating case study sites in South Australia all provide integrated multidisciplinary approaches to patient care. This project is exploring how integration is operationalised within these different service sites, as well as examining extent of integration with other levels of care external to the case sites. A research framework is being used to investigate a comprehensive range of components, including methods and supports for integration, patient experience of integration and the tools used, and a mixed method research approach is being used to closely examine how service integration is supported or confounded in the different models.



EMERGING MODELS OF INTEGRATED PRIMARY HEALTH CARE CENTRES: THEIR IMPACT ON ACCESS AND INTEGRATION OF CARE AND CONTRIBUTING FACTORS

Chief Investigator: Dr Julie McDonald

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

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

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

Case study methodology is being used to describe the approaches (systems, arrangements and organisational routines) that IPHCs use to maximise access and integration of care, with a particular focus on people with chronic conditions as an identifiable group for whom access and integration are of particular importance. This involves site visits to undertake interviews, reviews of documents and administrative data, and staff surveys.



PRINCIPLES AND PRACTICE OF PRIMARY HEALTH CARE INTEGRATION: LEARNING AND UP-SCALING RESULTS FROM A REGIONAL GP SUPERCLINIC

Chief Investigator: Professor Susan Nancarrow

Based at: School of Health and Human Sciences, Southern Cross University,
NSW

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

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

This case study of the Lismore GP Super Clinic is exploring how primary care services are integrated at the patient, service and system level. It is looking at patient referral networks and referral pathways (service-level integrations) and how the Super Clinic is integrated with the wider regional community (systems-level integration), to assess how far these networks spread and their density with regard to populations with particular demographic characteristics. Based on the findings, from both qualitative (thematic analysis of the narratives) and network analysis, an integration 'model' will be developed.



INTEGRATING CARE: ORGANISATIONAL PROCESS, PATIENT-CENTRED OUTCOME OR BOTH? LEARNING FROM FIRST GENERATION INTEGRATED PRIMARY HEALTH CARE CENTRES

Chief Investigator: Associate Professor Kirsty Douglas

Based at: Medical School, Australian National University, ACT

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

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

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



E-HEALTH INITIATIVES AND HEALTH CARE INTEGRATION IN GP SUPER CLINICS

Chief Investigator: Professor Siaw-Teng Liaw

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

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

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

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

