



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2019 Academic General Practice & Primary Care Research Symposium

**Waikato Management School
20-22 September 2019**



Abstracts

Saturday 21st September

1. The invisible reality of informal Māori caregivers of elderly whānau members.

Edgar Te Piere Warahi Wallace (Doctoral Candidate)

James Henare

University of Auckland

Also referred to as the shadow workforce, shadow economy, shadow activities, the hidden economy and more specifically, the OECD¹-term non-observed economy.

Exploring the expectations of Māori protocols and customs (tikanga) that guide Māori responsibility to care for their kaumātua. This includes understanding how whānau negotiate government health services to enable kaumātua to age well, and the impact on whānau when that is onerous and time-consuming. It is partly informed by my own ten-year experience as a whānau caregiver for my mother who had Alzheimer's.

Examine the value created within the social, health and financial sectors that the wider caregiving community contributes to New Zealand and to the government. For example, from an economic viewpoint, it was estimated that in 2013, informal caregivers saved the New Zealand government \$10.8 billion and for comparative purposes, the savings in 2015 to Australia was \$60.3 billion and to the United Kingdom, £132 billion. Sadly, the efforts of informal caregivers while representing a success to neoliberal policies, are not acknowledged.

Address the question of whether Māori carers have rights as caregivers and how those rights may be interpreted in NZ and international law. The objective is to empower Māori carers with mana (dignity, respect) by removing the negative impacts of being invisible and unpaid in a world referred to as the shadow workforce.

¹ The Organisation for Economic Co-operation and Development

2. Hā Ora: Reflecting on a Kaupapa Māori community engaged co-design approach to lung cancer research.

Jacque Kidd, Shemana Cassim, Anna Rolleston, Rawiri Keenan, Janette Ngaheu, Ross Lawrenson

University of Waikato

Lung cancer survival in Aotearoa is poor, particularly for Māori, as it is typically diagnosed at a late stage once a patient has presented with symptoms. Late diagnosis can occur due to barriers relating to access to services, relationships between patients and General Practitioners (GPs) and awareness of lung cancer symptoms and treatment. Māori have an incidence of lung cancer that is 3-4 times that of non-Māori, in the Midland Cancer Region of Aotearoa. In this region, 27% of patients identify as being Māori. Our study aimed to explore the barriers to early diagnosis for rural Māori communities in this region. The study used a Kaupapa Māori methodological approach to co-design. The team worked with 4 rural communities in the Midland Region. Hui were carried out with Māori whānau and/or community members affected by cancer to identify local barriers and enablers to diagnosis. This presentation will discuss the process of engaging with these communities, and the overall lessons learned. A key issue highlighted is the length of time that the community engagement process takes, in order to get participants into a space where they are ready to engage in, and contribute to the co-design process.

3. The Emoqol 100, an ultra ultra-brief case-finding tool for assessment of mood: a pragmatic diagnostic accuracy audit.

Bruce Arroll, Connor Francis Mulcahy, Vicki Mount

University of Auckland

Objective

To assess the diagnostic accuracy for low mood of a single verbally administered question on emotional quality of life (Emoqol 100) in patients with symptoms of distress in an ambulatory care setting.

Methods

Retrospective audit of consecutive consultations.

Participants

Eligible patients were consecutive patients seen by one of the authors over 13 months and who had both a PHQ-9 inventory assessment and an Emoqol 100 recorded at the same consultation. The index test is the verbally asked Emoqol 100 which is the patient's emotional quality of life now, with 100 being perfect emotional health and 0 being worst imaginable. The reference standard is the PHQ-9 test for mood which was written on a piece of paper.

Results

102 patients were seen during the study period of which 76 met the eligibility criteria for this audit and there were 215 test results for them. For a cut point of <50 on the Emoqol 100 and the PHQ-9 \geq 12 the sensitivity was 53% (95% CI 45-61) and the specificity was 92% (95% CI 86-98). The likelihood ratio positive for these figures was 6.8 95%CI (3.1-14.9) and the likelihood ratio negative was 0.5 95% CI (0.42-0.62). The positive predictive value was 92% and the negative predictive value was 52%. The likelihood ratio for a cut point of <40 on the Emoqol was 9.5 (95% CI (3.1 to 29.4).

Discussion

This is the first accuracy estimation of the Emoqol 100 and it appears to have a high specificity which means when it is positive (<50) it is a good estimate of a high PHQ-9 i.e. a mood issue probably exists. The test will be very useful for busy primary care clinicians as it takes less than 15 seconds to verbally administer.

Registration. This is an audit and done retrospectively and hence has not been registered. Key words: depression, primary health care, clinical audit, sensitivity and specificity

4. Optimal medication therapy in Indigenous Populations: A Case Study of Gout in Māori.

*Leanne Te Karu Ngāti Rangī/Muaūpoko PhD Candidate
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The overarching topic of this thesis ultimately aims to investigate how access to medicines, prescription of evidenced base drug therapy and administration of medicines by Māori/to Māori be optimised.

The contribution will be through research using a case study of gout and investigating how gout medication therapy for Māori can be optimised?

This presentation will present a component of the mixed method approach involving:

1. Development and implementation of a decision support tool, for providers to improve prescribing of medicines for gout for Māori.
2. Developing a multi-level care approach that aims to empower people to self-manage gout
3. Conducting interviews at organisation/provider level and at patient/ whanau level identifying the barriers and enablers to the implementation of 'best practice management.
4. Investigate the perspective of prescribers on what constitutes 'optimal prescribing' and how to achieve this

5. Undergraduate medical students and uncertainty – into the unknown.

Ciara Lee, Katherine Hall, Megan Anakin, Ralph Pinnock

*Department of General Practice and Rural Health
University of Otago, Dunedin*

Objectives:

Learning to work in the presence of uncertainty is a crucial aspect of medical practice, affecting students' wellbeing, career choices, and attitudes towards patients. Transitioning from structured education to clinical environments, medical students enter a world that is increasingly uncertain and can lack the skills to navigate it. We do not know what sources of uncertainty medical students at the University of Otago identify in their learning environments, nor how effectively they feel able to deal with situations of uncertainty.

Methods:

Phase one of my PhD explored student perceptions of uncertainty using a novel mixed-methods questionnaire. Questionnaire items were developed following a review of the literature and consideration of three main domains of uncertainty; sources, responses and personal factors.

Following a pilot study, a questionnaire consisting of 29 self-efficacy items and two free-text questions was distributed to University of Otago medical students from February to May 2019. Participants rated these

items and in two free text questions, participants were asked to identify sources of uncertainty in a clinical vignette and sources from their own medical education.

Results:

206 second year, 183 fourth year, and 109 sixth year medical students in Dunedin, Christchurch and Wellington completed the questionnaire. Cronbach's alpha for the quantitative items was 0.93. A factor analysis is being performed on the quantitative responses and the qualitative responses are currently being analysed using reflexive thematic analysis.

This presentation will discuss the findings. How efficacious do medical students feel to respond to situations of uncertainty in their learning environments? What sources of uncertainty have University of Otago medical students identified at different stages of their clinical training?

Conclusions:

Questionnaire findings will be used to develop a pilot intervention to empower medical students to navigate uncertainty in their learning environments. Ideas for the design of this intervention will be proposed and discussion welcomed.

6. Improving access to health care for people with severe Chronic Obstructive Pulmonary Disease in Southern New Zealand: qualitative study of the views of health professional stakeholders and patients.

Tim Stokes, Emma Tumilty, Anna Tiatia Fa'atoese Latu, Fiona Doolan-Noble, Jo Baxter, Kathryn McAuley, Debbie Hannah Simon Donlevy, Jack Dummer

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Dunedin*

Objectives

Chronic obstructive pulmonary disease (COPD) is a common chronic disease with significant morbidity and mortality in those with severe disease and places a large burden on the New Zealand (NZ) health system. Inequalities are marked, particularly for Māori. We undertook a mixed-methods implementation research study which aimed to determine the barriers and enablers to the provision of accessible high quality COPD care.

Methods

Semi-structured interviews were undertaken with 11 health professional stakeholders and 23 patients with severe COPD in NZ's lower south island. The descriptive categories developed from the patient and stakeholder interviews were organised into themes informed by a conceptual framework for access to health care (Levesque et al. 2013).

Lessons learned

Health professional stakeholders identified barriers to providing access to health services, in particular: availability (e.g., limited geographical availability of pulmonary rehabilitation), affordability (e.g., co-payment charge for seeing a general practitioner) and appropriateness (a shared model of care across primary and secondary care was needed to facilitate better delivery of key interventions such as pulmonary rehabilitation). Māori stakeholders highlighted the importance of communication and relationships and the role of whānau for support. Patients' accounts showed variable ability to access services through having a limited understanding of what COPD is, a limited knowledge of services they could access, being unable to attend pulmonary rehabilitation and incurring direct and indirect costs.

Implications

The use of a conceptual framework for access to health care allows demonstration of how both stakeholder and patient perspectives interact along the pathway of COPD care.

7. Interim results from a survey of the use of cannabis for medicinal and therapeutic purposes by New Zealanders in 2019.

Geoff Noller, PhD (lead); Tony Farrell, MBChB, FRNZCGP, FACHAM; Shane Le Brun

*Department of General Practice and Rural Health,
University of Otago, Dunedin*

Background

Recent Ministry of Health data suggests that 42% of the 400,000 New Zealanders considered their previous-year perceived cannabis use was for medicinal or therapeutic purposes. Conditions potentially benefitting include some forms of epilepsy, e.g. Dravet Syndrome, where the cannabinoid CBD has been associated with seizure reduction (Porter & Jacobson, 2013); nausea/vomiting associated with chemotherapy (Machado Rocha et al, 2008); and pain, including fibromyalgia (Seely et al., 2011).

Aim

The current study aims to survey New Zealanders' use of cannabis as a medicine, where this is either formally prescribed as a pharmaceutical product or 'natural' or 'raw' cannabis, in any form (e.g. flowers, edible, oil, tincture).

Method

Data collection is primarily via an online questionnaire, based on a recently published Australian survey (Lintzeris et al, 2018). A target of 2,000 respondents has been set, with data collection running from May to July 2019. The survey covers respondents' use of cannabis-based medicines, including health condition/s the medicine is used for, dosage, form of cannabis medicine (i.e. pharmaceutical or other), efficacy, adverse events, interactions with health professionals, legal experiences. A second wave of data collection will involve clinical interviews in combination with the online questionnaire, for 20 patients at a single medical clinic.

Interim results

At the time of abstract submission (mid-June), the online survey had been active for six-weeks, with 1899 responses. Early trends have included:

demographics (females 54%; median age 36.5 years; ethnicity NZ Euro 85%, Māori 18.5%; 56% employed at least part-time; 20% receiving some level of disability or health-related benefit)

medical care: 87% reported having a regular GP; 46% reported visiting a specialist at least one a year; those NOT advising their health professional about their use of medicinal cannabis included, 38% (GP), 57% (specialists), 62% (nurses); patients reported the following being either supportive or very supportive of their use: GPs (34%); specialists (22%); nurses (20%); upon advising their health professional about their use, 38% received no advice at all; however, upon telling their health professional about their use, 13% of patients were assisted to gain a prescription for legal access.

medical indications: multiple indications for the use of cannabis were identified, including: depression/anxiety (65%); chronic back pain (41%), other chronic pain (36%), arthritis (21%), CRPS (6%); migraine (25%); persistent nausea (24%); endometriosis (12%); IBD (12%).

8. Cannabis-based medicinal products and the role of the doctor: should we be cautious or cautiously optimistic?

Irene Braithwaite, Giles Newton-Howes, Karen Oldfield, Alex Semprini.

Medical Research Institute, Wellington

With rapidly changing legislation designed to improve access to cannabis-based medicinal products, we assess the obligations of the law and professional bodies on the proposed prescribers of these products. We argue that the current legal and professional obligations may limit prescribing practices despite legislative change, and that without the usual licensing processes of Medsafe being applied to these products, prescribers and their professional bodies must engage in the process of change to ensure short- and long-term patient safety and to maintain professional standards.

Sunday 22nd September

9. Developing Integrated Care models in New Zealand: A Rapid Scoping Review.

Gagan Gurung, Tim Stokes, Robin Gauld, Carol Atmore
Department of General Practice and Rural Health,
University of Otago, Dunedin

The problem

Achieving integrated care is a continuous focus of health reform in New Zealand (NZ) and is a core aspect of the NZ Health Strategy. Aligned with these priorities and policies, local health systems across NZ have been implementing different care models to integrate care across primary, community and secondary care. One of such initiatives is the Community Health Hub (CHH), and there are other integrated care models in ambulatory/outpatient settings. Reviews of integrated care between traditional community, primary and secondary/specialist services conducted internationally are available, but there is an absence of consolidated and systematically reviewed literature in this area in the NZ context. Drawing on literature from NZ and overseas, this review identified models of integrated care in ambulatory care settings, the effectiveness of such models, and key implementation issues and lessons learnt.

The approach

Design: Systematic structured rapid review of published and grey literature from 2000.

Setting: Ambulatory settings.

Participants: Patients receiving a healthcare service and service providers delivering services in primary and community care or in the transition of care from hospital to primary/community care.

Findings

A total of 36 articles were included to summarise international and NZ based evidence. Internationally, the most common models of integrated care found were: transfer, relocation, and liaison/joint working. In NZ, the most common models of integrated care between primary and secondary care were: integrated family health centre, health pathways, telehealth, transfer of care, shifted outreach, consultation-liaison, and localities model.

The international literature showed that transferring of care from hospitals to community and other

integrated models of care between primary-specialist interface increased access and convenience for patients. However, there was no sufficient evidence of clinical and economic outcomes. Relocation model increased equity and cost-effective if located in rural areas. Telemedicine may increase equity and useful for rural and remote areas. Co-location provides opportunities for better coordinated and integrated care, but it does not automatically lead to such improvements in practice.

Key outcomes reported by NZ based literature were improved communication, coordination and sharing of information between primary and specialist care providers, improved equity and accessibility, reduced waiting time, reduced hospital presentations, and improved skills of the primary care workforce. Key implementation issues were: no viable and sustainable funding for the model of care, lack of infrastructure/IT system, lack of confidence, trust and communication between providers, increased workload and time, and knowledge and skills gap to perform new roles/tasks.

The NZ literature highlighted the need of an appropriate location for services, committed leadership, development of a governance group representing different providers groups, strong communication mechanism, new workforce skills, and overall change management to facilitate a new way of working.

Implications

The review provides an overview of key components of the integrated care models in ambulatory settings and identifies some common elements across the models of care. The findings will be informative to design and implement an integrated ambulatory care model such as CHH in the local health system.

10. From research to impact – how do we get there? (update of study in progress).

Maria Larcombe, Prof Tim Stokes, Dr Michele Coleman, Prof Richard Cannon

Department of General Practice and Rural Health,
University of Otago, Dunedin

Objectives

The objective of this study is to investigate the pathway to achieving research impact for individual or groups of researchers in the University Of Otago Division Of Health Sciences. Research impact is the benefit that research has in the world – namely social, health and wellbeing, environmental, economic and

policy impacts. Research impact is integral to the research landscape as all research should be aiming to make a difference, and researchers at all stages of their careers and undertaking different types of research can articulate and plan their impact to make their research more likely to have impact. Research impact is currently a 'hot topic' in New Zealand, with increasing calls for researchers to be able show their pathway to impact in grant funding applications, so that the 'return on investment' into research is able to be articulated.

Methods

Eight case studies have been produced, one from each school in the Division, with two from the School of Biomedical Sciences (to account for the large number of biomedical researchers in the Division). Each case study consists of semi-structured qualitative interviews with the principal investigator, co-researchers and stakeholders of the research. A documentary review has also been completed to provide evidence of impacts that have taken place. Coding has been done using a thematic analysis approach with a logic model framework.

Results

Study participants emphasise the need for identifying and engaging early with stakeholders, including the community, industry and potential collaborators. A wide variety of dissemination methods have been utilised, for example utilising the media and producing industry reports, as well as traditional academic publication. Impact is person-lead, with principal investigators and research teams often being high-functioning in creating cultures of collaboration and forward-thinking. Finally, research impact is built on high-quality science. Individual case studies have taken different pathways to impact depending on research goals, with some particularly focusing on policy changes, scientific impact or commercialisation.

Conclusions

This case study approach to research impact is providing useful and important insights into the research impact pathway.

11. The Fear Reduction Exercised Early (FREE) approach to management of low back pain in general practice: a pragmatic cluster-randomised controlled trial.

Ben Darlow, James Stanley, Sarah Dean, Haxby Abbott, Sue Garrett, Ross Wilson, Fiona Mathieson, Tony Dowell

Department of Primary Health Care and General Practice, University of Otago, Wellington

Background/Aims/Objectives:

Low back pain (LBP) is the world's most disabling condition. Effective and cost-effective primary care treatments are required to reduce this burden. The Fear Reduction Exercised Early (FREE) approach to LBP was developed to empower and support GPs to manage LBP.

Methods

A pragmatic, cluster-randomised controlled trial with process evaluation and parallel economic evaluation was conducted. Eight general practices were randomly assigned to intervention (4 practices; 34 GPs) or control group (4 practices; 29 GPs). Adults presenting to these GPs with low back pain as their primary complaint were recruited. GPs in intervention practices were trained in the FREE approach and patients presenting to these practices received care based on the FREE approach. GPs in control practices did not receive specific training for this study and patients presenting to these practices received usual care. Primary outcome was change from baseline in patient participant disability measured with the Roland Morris Disability Questionnaire (RMDQ) score at 6 months. Secondary patient outcomes included pain, satisfaction, and psychosocial indices. GP outcomes included attitudes, knowledge, confidence and GP LBP management behaviour.

Results

140 eligible patients presented to intervention practices (126 enrolled) and 110 eligible patients presented to control practices (100 enrolled). At 6 months, the groups did not significantly differ on the primary outcome (adjusted mean RMDQ score difference 0.57, 95%CI -0.64 to 1.78; $p = 0.354$) or secondary patient outcomes. Intervention group GPs had clinically meaningful improvements in attitudes, knowledge, and confidence compared to control group GPs. Intervention group GP LBP management behaviour became more guideline concordant than the control group. In cost-effectiveness, the intervention dominated control with lower costs and higher QALY gains.

Conclusions

Findings from this study suggest that the FREE approach improves GP concordance with low back pain guideline recommendations but does not improve patient recovery outcomes compared with usual care. The FREE approach may reduce unnecessary health care use and produce economic benefits.

12. Evaluation of the Piki Pilot: Integrated Therapies for 18-25 Year Olds.

A Dowell, M. Stubbe, S. Gordon, F. Mathieson, J. Hilder, S. Garrett, R. Tester, D. Fedchuk, T. Gardiner, J. Stanley

Department of Primary Health Care and General Practice, University of Otago, Wellington

This paper presents initial findings from an ongoing evaluation of Piki, a pilot initiative in the Wellington region that aims to improve access to integrated mental health support for young people experiencing mild to moderate mental health and substance use issues. The Piki pilot was launched in March 2019 building on an existing platform of primary mental health activity. It provides free counselling with trained therapists to young people, and also offers digital support through the use of a mobile health application (Melon), and access to peer support (Peerzone). Piki aims to break down barriers to accessing services by offering self-referral opportunities for this group through the www.piki.org.nz website in addition to existing referral pathways. Other innovative aspects of the pilot include co-design with service users and between multiple partners engaged in the project, and the integration of an evaluation methodology to allow feedback and 'course corrections' at multiple time points during the project timeframe.

13. Exploring health professionals' perceptions of a new advanced physiotherapy scope of practice in New Zealand; understanding barriers and enablers to implementation in primary health care.

Gill Stotter, Eileen McKinlay, Ben Darlow

Department Primary Health Care & General Practice, University of Otago, Wellington

Background/Aims/Objectives

In New Zealand, nearly all physiotherapists currently practice under a single General Scope of practice (there

are also nine registered Physiotherapy Specialists). Formally recognising physiotherapists who have advanced skills and expertise may make health care more efficient and accessible. These physiotherapists could provide clinical expertise and lead development and delivery of new models of healthcare.

The Physiotherapy Board of New Zealand has developed an Advanced Practice Physiotherapy (APP) scope of practice and competency framework for consultation. This scope sits between the General Scope and the Specialist Scope. Advanced Practice Physiotherapists (APP's) are broadly defined as physiotherapists who have the clinical skills and experience to address and manage complex presentations. A clear definition of advanced practice physiotherapy and a good understanding of this role would support successful implementation of the new scope.

This qualitative study explores health professionals' perceptions of a proposed APP definition and scope of practice in relation to musculoskeletal management in primary health care in NZ.

Methods

The study used a qualitative Interpretative Description methodology with an iterative study design. Participants were primary care musculoskeletal physiotherapists or health professionals who work with primary care musculoskeletal physiotherapists, including GP's, medical specialists and ACC case managers. Participants were recruited purposefully with maximum variation sampling used to strategically select a variety of professional backgrounds and contexts. New participants were identified to offer different perspectives as analysis progressed. Face to face, semi-structured interviews were conducted with fourteen participants. Interview schedules with open questions explored participants' perceptions related to the APP role, the potential of the APP to enhance the management of musculoskeletal conditions in primary healthcare, and potential challenges and facilitators for implementation of the role into practice. A proposed definition for Advanced Physiotherapy Practice in NZ was developed from the international literature and used to generate discussion during the interviews.

Audio-recorded interviews of 40 to 60 minutes duration were transcribed verbatim. Data collection and analysis occurred concurrently. Each transcript was read and reread by one researcher (GS) to identify interesting or important data and generate initial codes. The software package NVivo was used to organise and

manage the data. Data from each transcript was coded into categories within NVivo. Critical review of the data by all researchers was conducted after the third and sixth interviews to discuss data interpretation and propose emerging themes. Subsequent manuscripts were coded into these themes.

Results

Fourteen interviews will have been conducted before the research weekend involving physiotherapists (6), GP's (4), orthopaedic surgeon (1), sports physician (1) and ACC case managers (2). Data analysis is progressing and emergent themes will be presented for discussion.

14. Toi Ora Research Network: A Bay of Plenty participatory Practice Based Research Network (PBRN).

Emily Gill

University of Auckland

Background and Motivation

Flourishing descendants of Toi, with improved health and wellbeing outcomes for tangata whenua and all people living in Te Moana ā Toi, is the vision for the Bay of Plenty (BOP) that has been approved by the BOPDHB board. Te Toi Ahorangi Maori Health Strategy directs how to achieve this vision and includes the goal of a Toi Ora research agenda as part of the establishment of a Toi Ora Centre of Excellence so that evidence supports implementation. An essential component of this strategy is to facilitate tangata whenua led development. Therefore, Kaupapa Māori (KM) approaches are the best and most appropriate choice for all research activities in the BOP because this will produce the highest quality and most generalizable and influential evidence. A regional Practise Based Research Network (PBRN) guided by KM methods will contribute to Te Toi Ahorangi strategy as another demonstration of the partnership between the Crown and Māori that is represented as Te Waka o Toi.

Learning Objectives

- Attendees will be able to describe the role of Kaupapa Māori approaches in research to address health equity.
- Attendees will be familiar with how a regional research network is being established in New Zealand, across a range of diverse populations.
- Attendees will be able to describe current challenges with establishing such a network.
- In partnership with the audience, the essential

components of a rigorous research network will be explored.

15. Should we have a trial of iFOBT in low risk patients with lower GI symptoms?

Ross Lawrenson, Ben Hudson

University of Waikato

Background

Colorectal cancer is the most commonly registered major cancer in New Zealand with over 3000 cases per year. High proportion of New Zealand patients are diagnosed at late stage. In NZ only 3% of cases are diagnosed through screening while in Australia only 4.3% of colonoscopies were undertaken following bowel screening. Thus most colonoscopies are undertaken in symptomatic patients. Immunochemical faecal blood tests (iFOBT) are not recommended outside of an approved screening programme in New Zealand although FOBT kits may be purchased at pharmacies. In the Waikato in a three year period general practitioners referred 20648 patients to Gen Surg/Gastro-enterology of whom 16973 (82.2%) were accepted. 7331 had record of CRC related symptoms and in total 428 (2.0%) had an underlying CRC. Of 16973 patients accepted by the service 6432 had a colonoscopy (36.8%) and 356/6432 (5.5%) had a CRC. Controversially in 2015 NICE noted that when investigating lower bowel symptoms, testing for occult blood in faeces should be undertaken where there is a low risk of colorectal cancer. NICE DG 20 in 2017 concluded there was sufficient evidence to advocate triage of symptomatic patients using a cut off of 10µg Hb /g faeces (50ng Hb/mL) and that use of iFOBT may have potential to reduce the need for referral to colonoscopy by up to 80%. It is suggested that we should consider a multicentre New Zealand trial of iFOBT in patients with symptoms relevant to the lower GI tract.

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