Australian National University

APHCRI Evaluation Project Report 2013

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A C K N O W L E D G E M E N T S

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The project's objectives

The broad objective of this project was to create an evaluation strategy for APHCRI, focused on the use of knowledge transfer and exchange in APHCRI research and dissemination, research capacity building and knowledge brokering.

The dual purpose of institutional evaluation is to provide data for summative reporting and for formative use in continuous quality enhancement. Creating an institutional evaluation strategy where there has not previously been one means identifying the institute's summative reporting needs and its capacity for formative uses of evaluative data.

APHCRI's reporting needs focus on its ability to: strengthen the knowledge base of primary health care by conducting and supporting research; to facilitate the uptake of research evidence in primary health care policy and practice; to enhance research capacity in primary health care through strategic partnerships with other relevant national and international groups. The evaluation strategy needed to provide a process for capturing, and turning to advantage, data relating to the whole of APHCRI's infrastructure support for primary health care research.

METHODS

The project began with an environmental scan and a literature survey and review.

The purpose of the scan and literature review was to find out what would be subject to evaluation, and how best to evaluate it. The literature review focused on knowledge transfer and exchange, research capacity building, knowledge production and dissemination and knowledge brokering.

The scan produced a quantitative profile of APHCRI which is reported below (pp 7-12).

The literature review enabled the project to focus on two target areas: "research capacity building" and "impact", understood as "APHCRI's contribution to change in primary health care research and the uptake and use of research findings". APHCRI's impact was seen as a difficult-to-measure product of at least 8 interrelated factors (listed below), each of which was significantly complex in its own right. The literature review also revealed a number of "conceptual frameworks" for evaluating impact. Many of these "conceptual frameworks" focused on the key indicators each framework would use when gathering data for summative reporting purposes. Discussions of these frameworks seldom addressed the issue of how an evaluation using the framework might be conducted, or how the data gathered might be used to achieve improvements.

The scan and the literature review together produced two key questions: What to evaluate and how to evaluate it? Answers to these questions are outlined below.

What to evaluate

- Research Capacity Building at the individual and group levels
- Impact, as facilitated or otherwise affected by,
  - relationships and communication
  - knowledge transfer
  - knowledge exchange
  - knowledge translation
  - policy relevance

- stakeholder relevance
- utility
- uptake and use

How to evaluate

The project proposes an evaluation process framed by a slightly modified version of the Buxton and Hanney [1, 2, 3,4, 5, 6] Payback Framework.

Individual evaluations

Individual evaluations will be made:

- Using survey questionnaires in APHCRI-hosted Workshops, DoHA-hosted "Conversations with APHCRI in DoHA" and other "networking and learning events", followed by selective post-event interviews to monitor the lasting effects of these events.
- Drawing data from researcher reports
- Conducting face-to-face and telephone interviews to broaden and deepen understanding of issues raised by survey feedback and researchers' reports.
- Research where data cannot be derived from the three methods listed above.

Individual APHCRI evaluations will not be conducted with the single intention making a measurement. They will all be conducted with an eye to understanding whether and why the measurement made this time differs from measurements made in the past, and with the intent of using what's discovered in a continuous quality enhancement cycle led by APHCRI Management.

The Payback Framework

The framework supports an evaluation process that would:

a) address

- issue identification
- project specification
- stakeholder input to project specification
- stakeholder engagement in research process
- knowledge transfer and exchange (KTE) skill development and use
- knowledge production
- knowledge dissemination
- knowledge uptake and use, and
- final outcomes

b) provide measurements of APHCRI's impact (mapped contribution, achieved effect, acknowledged influence) in

- Australian primary health care research
- Australian primary health care policy, and

- Australian primary health care practice.

c) provide measurements of APHCRI's support for primary healthcare research, and turn them to advantage through a continuous quality improvement cycle which would

- focus on APHCRI's support for high quality knowledge production, transfer and exchange
- be driven by regular scheduled discussions between APHCRI management and APHCRI's evaluation team about evaluation findings, and actions that need to taken in light of those findings.

An account of the framework is offered toward the end of this report. An account of the practical application of tools and procedures related to the framework is to be found in the accompanying document: The APHCRI Evaluation Handbook.

The project was supported by an interview program: 42 interviews were recorded. During the project evaluations were conducted of 23 events: 18 "Conversations with APHCRI in DoHA" and 5 APHCRI Workshops.

The Literature

The literature is prolific. It is all about defining and fostering working relationships and effective communication. The most important relationships are between the researcher and the stakeholder. The communication is best if it is in plain English at both ends of the relationship, and if its purpose is to facilitate co-operation in the tasks of generating new knowledge and putting it to good use.

In the literature, reference to knowledge transfer and knowledge exchange tend to overlap. This is not without reason. Effective exchange frequently depends on prior, equally effective transfer; but the overlap frequently shows up as a confusion between the two. The perception that transfer is a one-way interaction and exchange is a two-way interaction is not uniformly shared.

APHCRI-hosted workshops will continue to address the issues of knowledge transfer and exchange. In light of evaluations conducted during 2012-13, and in light of contributions made to the literature by such authors as Ward, House and Hamer [7], and Bernhardt, Mays and Kreuter [8], future workshops may begin to explore one-way, two-way, multidirectional, media, and social media modes.

Intent, in light of readings: APHCRI evaluations will seek information about APHCRI's support for heightening Knowledge Transfer and Knowledge Exchange skills, and about APHCRI researchers' approaches to communication with a variety of audiences, correspondents and stakeholders. Data gathered will be tabled for discussion.

A clearer distinction is usually made in the literature between the transfer and exchange process and the translation process. Translation is intended to cause research findings to stimulate changes in human behaviour, or in the precepts that guide human behaviour. In APHCRI's case this amounts to changes in policy, or in stated policy directions; changes in primary health care service provision; changes in primary health care research targets; changes in what is identifiable as stakeholder relevance, and changes in the reasons anyone might have for taking up and using research findings.

Effective translation, however, is not easy to achieve, and if it is achieved it is difficult to claim credit for it. Parker and Davies [9] put it simply: "it is difficult to establish causal links between research findings and changes in policy or practice". Kothari, Birch and Charles [10] indicate why the causal links, if there are any, are difficult to establish: "Studies exploring the determinants of the utilization of research findings have generally been undertaken in the absence of a guiding unified, tested and accepted conceptual framework." Spaapen and van Drooge [11, 12], allowing that impacts do occur, indicate that measuring them constitutes yet another problem: "Social impact of research is difficult to measure. Attribution problems arise because of the often long time-lag between research and a particular impact, and because impacts are the consequences of multiple causes. Furthermore there is a lack of robust measuring instruments." Duryea [13], acknowledging the difficulties, alludes to the different kinds of reward a successful researcher might be granted: "Research impact is defined within the RQF [Australian Research Quality Framework] as the beneficial application of research to achieve social, economic, environmental and/or cultural outcomes. This is not to be confused with impact in the academic domain, which is seen more as an indicator of the intrinsic quality of the research on scholarly or academic measures". The difficulty of achieving the desired impact on policy is such that, for some researchers on some occasions, the only achievable impact appears to be the impact their publications can have on their academic career and reputation.

Intent in light of readings: APHCRI evaluations will seek information about APHCRI-ANU and APHCRI Network researchers' approaches to, and success with, Knowledge Translation. Data gathered will be tabled for discussion.

TRENDS IN COMMUNICATION: DIFFUSION, DISSEMINATION, "BRIDGING THE GAP", AND INTEGRATED KNOWLEDGE TRANSLATION

Two facts about the literature stand out. While many articles contain statements about the extreme difficulty of causing, let alone measuring, the impact of primary health care research on primary health care policy or practice, many more offer ways of measuring or assessing that impact. Some, like the UK Economic and Social Research Council papers [14, 15] and the PHCRIS Research Project Reports [16, 17, 18, 19], address the issue broadly and consider the changes in behaviour it would take for the knowledgeable uptake, absorption and utilization of research findings to be more common.

The literature embodies – and recent contributions to the literature freely comment on – the historical development of conceptual models of research transfer, from the early diffusion model through the dissemination model [20, 21, 22,] and the bridge-building "two communities" model [8, 23, 24, 25, 26, 27,28] to the currently favoured models which focus on interaction [10, 11, 12] integration [29, 30] and contribution mapping [31, 32, 33].

Lomas [20] speaks of diffusion as "a passive concept. Light diffuses from a source ... Those who receive diffused messages were likely already open to and seeking out the message. They were active seekers in the face of a passive flow of information". Dissemination, by contrast, "is a more active concept. It not only implies a more aggressive flow of information from the source ... but it also implies targeting and tailoring the information for the intended audience".

Lomas also speaks of "implementation" without which, the goal of dissemination might seem to be nothing more than to increase awareness, "implementation involves identifying and assisting in overcoming the barriers to the use of knowledge obtained from a tailored message".

Kothari, Birch and Charles [10] observe that the Diffusion model failed to recognise the incremental nature of policymaking and program development, as well as the other environmental constraints faced by users". The Dissemination model was seen as "unidirectional", with users' input seldom being incorporated into the research process, and little attention being given to the receptivity of policymakers to disseminated research findings". Their take on "implementation", or "uptake and use" reflects Lomas'.

The "two communities" model gave rise to numerous attempts to "bridge the gap" by means of a common language; but a cultural divide between researcher and research end-user continues to bedevil their relationship. Avenier and Bartunek [27] refer to it as an "unfortunately labelled 'rigor-relevance gap'," which reflects a kind of status-vanity difference "between knowledge considered scientific and knowledge considered relevant for practice". Others see it as more than an issue of speaking style. Caplan [23] for example, sees the "two communities" as a way of thinking that hinders the development of shared concepts of the instrumental and conceptual utilisation of new knowledge. Whichever way it goes, Parker's [34] (2010) observation still appears to hold, "There is a heavy reliance on 'traditional' academic approaches to dissemination" which often makes it hard for the non-academic audience to receive and assimilate what's being said.

The productive interaction-oriented model, the integrated knowledge translation (IKT) model and the contribution mapping models share a perception. Like all before them they see:

> ... a curious disconnect between the production of new research knowledge and its implementation in health care practice or policy. At worst, we find researchers disinterested in the real-world issues of knowledge users, and unwilling to communicate with them, and users dismissive of the ability of researchers to provide them with useful information on which to base policy or practice decisions.

They also see interaction (particularly between researcher and engaged stakeholders) and integration (especially of academic and social drives) as offering potential solutions to the curious disconnect. Proponents of the IKT model, Kitson and Bisby' [29], speak of current social and cultural changes facilitating a shift away from the traditional "research Mode 1" to the more flexible "research Mode 2". Mode 2 is characterised by Health Research Funding Agent-funding, and appropriately evaluated collaborations between researchers and research end-users, in research project design, knowledge production, knowledge valuing, and knowledge utilisation.

Three things may make it appropriate for APHCRI to consider this scenario:

- IKT flavoured activity happens of its own accord, without needing or causing radical shifts between research modes, where-ever primary health care researchers work in the field with, for example, indigenous groups, vulnerable consumers, obesity sufferers, refugees.
- APHRI's Intervention Research in Chronic Disease CRE submitted an Integrated Knowledge Translation and Exchange Plan with its Summary Report in January of 2013.
- Even the involuntary or partial adoption of IKT ideas warrants investment in evaluation and research in order to learn whether, for whom, and under what circumstances IKT programs, structures, frameworks and theories can be made to work, and to ensure that knowledge generated by them is socially and scientifically robust.

The contribution mapping models give rise to the idea that the interaction and integration described above facilitate what Meagher et al [35] identify as a smoother flow of knowledge, expertise and influence between researcher and engaged stakeholder which, in turn, helps research findings to be assimilated (taken up and used) without encountering the curious disconnect.

All variations on knowledge transfer, knowledge exchange, knowledge translation, gap-bridging, integrated knowledge translation, diffusion, dissemination, stakeholder engagement, stakeholder participation may be made viable. The APHCRI research community has a sufficient array of temperaments and skills for each researcher to find his or her way through the knowledge production, knowledge dissemination and knowledge uptake and use steeple chase.

Intent in light of readings: APHCRI evaluations will seek data and create case studies relating to successful practice across all communication models. Evaluation findings and case studies will be tabled for discussion.

THE LOMAS THEORY: WHY RESEARCH IS NOT TAKEN UP AND USED

The principal difficulties faced by an evaluator of the impact of research on primary health care policy or practice do not lie in which transfer model was used. They lie in the fact that, if an impact occurs at all, it may happen well after dissemination, and well after the research findings in question have been absorbed among the impact's other factors. For these and other reasons, if an impact occurs at all, it is seldom witnessed, and even more seldom reported on. Discovering these impacts, on policy, practice or community knowledge, or discovering why expected impacts do not occur, is beyond the normal reach of an evaluator. It requires a fully funded research project whose findings would inevitably be taken up and used by the evaluator who would attend on the research project as a participating stakeholder.

A research project team charged with this responsibility might profitably be briefed to test Lomas' concept of what helps uptake and use to happen and why it happens so seldom.

Looking to create "a framework for understanding the context of decision making" Lomas [36] encourages his reader to think of research and policy as processes not products, and to understand that decision making is not an event. He suggests that a process-oriented way of thinking would enable the researcher to see that:

> ... early and ongoing involvement of relevant decision makers in the conceptualization and conduct of a study is the best predictor of its utilization. Similarly, research centres with ongoing linkages to and an accepted role in a specific jurisdiction's or organization's decision making, have greater influence than those without such links.

While this suggests Lomas to have been an intuitive early adopter of the interactive model, his motive is not to persuade his reader in that direction. His contention is that the researcher with research findings to shed light on one of the most important impediments to uptake and use – the researcher's lack of understanding of "the institutional structure for decision making" – in particular,

> ... its design, those who officially and unofficially have a voice, the history and nature of the interest groupings, the distribution of responsibility and accountability, the implicit and explicit rules of conduct ... Into this structure go the outputs of two other domains – the values in which decisions are immersed and the information upon which a decision is based and justified.

A third complication is that

> Values . . . emerge from a complex interaction of interests with beliefs and ideologies . . . Interests change readily with context and are altered with each new policy decision. Ideologies declare a person's or an organization's view of how the world ought to work. They are hard if not impossible to change. Beliefs are sandwiched between interests and ideology. They are our knowledge of how we think the world actually does work, arrived at on the basis of whatever has persuaded us from the bombardment of information we receive ... Beliefs, therefore, [being amenable to change based on persuasive research] are the main target of research findings

The final complication occurs when information is brought into the decision making process. "*Information* ... comprises more than research". It comprises alternative "evidence", anecdotes, personal experiences, propaganda and information purveyed from other sources such as think tanks, interest groups and the media which purveyors translate into "common knowledge".

> It is this "common knowledge", only partly representing health researchers' labours, that serves as both the input to the institutional structure for decision making and as a persuasive force acting on beliefs embedded in values.

The outcome is frequently a "sensible" rather than a "rational" decision whereby the research findings are ignored and a decision based on something quite other is made. Lomas concludes:

> Researchers who ignore the distinction between rational and sensible decisions i.e., fail to acknowledge the influence of these political and institutional factors, are restricting themselves to a very limited niche in the decision-making world.

Wiseman [26] echoes Lomas' point:

> Many academic researchers cling tenaciously to the belief that empirical evidence and the scientific method are – or should be the primary driver of

> policy decisions. Some continue to be shocked and disturbed by the extent to which calculations about political risks and benefits can and do trump evidence obtained from carefully constructed methodologically robust research.

Holmes, Scarrow and Schellenberg [37] re-enforce it:

> Challenges exist in fulfilling expectations that research evidence results in beneficial impacts for society.

Much of the literature that explores ways of measuring the impact of research on policy (or on the improvement of primary health care delivery with or without the aid of policy) is based on the assumption that beneficial impacts do occur and are there to be measured. Much of the literature of Knowledge Transfer, Exchange and Translation is based on the belief that skills in these areas will help to ensure the achievement of beneficial impacts.

Intent in light of readings: APHCRI evaluations will focus on

- the development of Knowledge Transfer, Exchange and Translation skills
- the frequency, and the causes and effects of uptake and use, and the measurement of beneficial outcomes
- the work done to ensure APHCRI researchers understand the institutional structures for decision making to which their research findings will be exposed.

Evaluation findings will be tabled for discussion.

WEB 2.0

Lomas [36] makes another suggestion regarding ways of perceiving the relationship between research and the end-user, “Research is not a retail store”. Bernhardt, Mays and Kreuter [8], celebrating the communication break-through provided by Web 2.0, put an alternate case,

> From a marketing perspective, increasing prospective end users’ understanding and valuation of a product is critical to cultivating demand for the product. Informed consumers will search for a desired product more effectively and efficiently than uninformed consumers. However, consumers also respond negatively when a desired product is not easily available to them ... Consequently, dissemination of evidence-based programs and services requires a balanced approach that strives to increase demand for research products among intended end users (i.e., clinicians, health care consumers, policymakers) and also seeks to make these products easily accessible when, where, and how they are needed by end-users.

Their argument stems from an acute awareness of the wide-spread and growing effects, on networking, of information and communication technology. But however it may be taken, its central sentiment sounds familiar,

> Creating and linking social networks of researchers and practitioners with multidirectional information flow can build stronger partnerships for dissemination. Analyzing social media data about targeted practitioner end users’ behaviours and practices online can inform strategies for increasing practitioner demand for evidence-based programs and for ensuring easy access to research products.

In short, free flow and exchange of information between researchers and end users during the research process anticipates formal dissemination and facilitates fluid uptake and use of research findings. The benefits of a free flow and exchange of information between

researchers and end users may be magnified by the astute use of current social and communication media.

Intent in light of readings: APHCRI evaluations will focus on APHCRI researchers' ability to judge the usefulness of social and communication media in networking and the sharing of research findings, and to act effectively on their judgement. Evaluation findings will be tabled for discussion.

THE SCAN: LOOKING FOR STANDARD PRACTICE

The scan was intended partly to create a profile of APHCRI's standard practices and regular achievements. It was also intended to identify what might contribute to the sense of impact the evaluation process was expected to capture.

The scan was completed by the end of the first quarter of 2013. It is proposed that, for the sake of a cyclical continuity from that date, an annual audit of the aspects of APHCRI's work scanned in the first quarter of 2013 be conducted during the first quarter of each succeeding year. The objective of each successive scan thereafter would be to

- monitor the evaluated object's tendency to maintain, to rise above or to fall below its baseline measures
- identify causal factors of stability, or changes upward or downward
- formulate appropriate action for APHCRI to take with respect to the detected causal factors.

Standard Practice: Research capacity building – direct and indirect

Bates, et al [38] speak of research capacity building as "a poorly defined and understood concept". Their literature search revealed a number of generic definitions. One fits APHCRI's situation well, "For health research, the goal of building capacity is ... to improve the ability to conduct research, to use results effectively, and to promote demand for research". They found no tools for developing, and no models for evaluating health research capacity building, but "the literature review was helpful for identifying ineffective capacity building strategies, such as "bolting on" capacity building to research projects". In the end, Bates et al chose a model,

> that had been developed for institutionalising quality assurance (QA) because it focused on defining, measuring, and improving quality. This mirrors the process required for capacity building in health research: defining the institutional systems needed to support research, enumerating existing and missing resources, and improving research support by addressing identified gaps".

It is proposed that these "requirements" be included in future evaluations of APHCRI's research capacity building activities.

APHCRI's Annual Report for 2010 indicates that APHCRI's commitment to building research capacity, represents approximately 54% of its second-round four-year budget.

Evidence of research capacity development at the individual level involves the reported employment of full time PhD students and postdoctoral fellows, and the systematic skill and knowledge development of all early career researchers. At the time of the scan there were,

- 18 full time PhD students in place, (27.2% of the 66 researchers employed in CREs) with an expectation of four more being employed during 2013

- 14 postdoctoral fellows in place (21.2% of the 66 researchers employed in CREs) with an expectation of three more being employed during 2013
- one indigenous research fellow in place, (1.5% of the 66 researchers employed in CREs) with an expectation of three more being employed during 2013

In total 50% of the researchers working in CREs at that time were early career researchers being assisted in their career.

Evidence of research capacity building at a national level involves,

- increases, over time, in the number of researchers employed in primary health care research, and the number who had re-engaged one or more times after their first engagement
- generating links with, and exchanges between, Australian and international primary health care researchers of comparable standing.

A list was drawn up by APHCRI's Administration Support Officer of researchers who had engaged with "Stream" research in the decade between 2003 and the first quarter of 2013: 324 researchers had been employed in that time; 68 had re-engaged. Of the 68

- 41 re-engaged twice
- 11 re-engaged three times
- six re-engaged four times
- one re-engaged five times
- two re-engaged six times
- three re-engaged seven times
- two re-engaged eight times
- one re-engaged 10 times.

The numbers are not significant in their own right, but their implication is that there has developed a community of researchers whose active engagement in Australian primary health care has been supported by APHCRI funding.

Figures drawn from a publications list covering research productivity 2003-2012, and drawn up by APHCRI's Research Development Officer in the first quarter of 2013, indicated that at least,

- 453 researchers had been brought into, or supported in, Australian primary health care research by APHCRI funds between 2003 and early 2013.
- 224 of them contributed to APHCRI ANU's publication output, 63 of them as lead authors
    - 38 of them authored one article, 25 of them having stayed long enough (as APHCRI staff members) to author more than one article
        - 9 authored 2
        - 8 authored 3
        - 1 authored 4
        - 1 authored 5
        - 2 authored 6
        - 1 authored 7
        - 1 authored 8

        - 1 authored 11, and
        - 1 authored 12
- 229 contributed to APHCRI Network's publication output, 56 of them as lead authors
    - 37 of them authored one article
    - 19 stayed long enough or re-engaged often enough to author more than one article
    - 10 authored two
    - four authored three
    - three authored four
    - one authored five, and
    - one authored six.

Again, the numbers are not significant in their own right but they indicate the existence of a body of Australian primary health care researchers whose scholarly productivity has been supported by APHCRI.

Between 2003 and the time the publications list was drawn up research conducted by the 453 researchers had produced,

- 80 completed project reports in APHCRI's preferred 1:3:25 format
- one book
- five book chapters
- at least 229 peer-reviewed journal publications, and
- a wide variety of materials designed for use in the dissemination of APHCRI research findings.

Output from APHCRI ANU began in 2003. Output from APHCRI Network researchers began in 2005. By 2007 there were indications that an upward productivity curve had begun (see Table 1 below). Primary Health Care research is a young branch of health research. This upward productivity curve may be taken to indicate the beginnings of growth in the strength or number of the primary health research community APHCRI is helping to build. However, my scan did not reveal any indication of an exchange of information within APHCRI, or between APHCRI and its funded research teams, about methods of capacity building. It has not yet become a standard practice for examples of early career researchers being lead authors to be reported on.

Table 1: APHCRI ANU and APHCRI Network article and book publication rates

	APHCRI ANU	**APHCRI Network**	**Total**
Up to April 2013	10	5	15
2012	21 + 1 book chapter	27	48 + 1 book chapter
2011	26	10	36
2010	25 + 1 book + 2 book chapters	11	36 + 1 book + 2 book chapters
2009	13+ 2 book chapters	9	24+ 2 book chapters
2008	13	17	30

	APHCRI ANU	APHCRI Network	Total
2007	9	6	15
2006	6	0	6
2005	4	5	9
2004	8		8
2003	4		4
Totals	139 + 1 book + 5 book chapters	90	229 + 1 book + 5 book chapters

Symul [(39)] focuses on an issue that APHCRI is no doubt familiar with, the viability of comprehensive research capacity building in the absence of clear career paths for early- or mid-career researchers employed in short term contracts. Symul uses the descriptive terms "apprentice", "colleague", "master" and "member of the elite" instead of "early-career", "mid-career" and "advanced". The almost medieval connotations of that terminology spell out the difficulty: the longer, more continuous form of capacity building implicit in the idea of a career path from apprentice to master and beyond is not available when the career path doesn't exist. When there is no clear career path, the focus shortens to publications and citations rather than on "using results effectively, and promoting a demand for research". It is Symul's contention that short term contracts often lead to unfinished unpublished research and do not leave room for long-term projects. In APHCRI's situation, it is possible that the Symul's contention explains a phenomenon that was also revealed by the breakdown of numbers relating to the 453 researchers mentioned above.

- 224 of the 453 contributed to APHCRI ANU's publication output
    - 63 of them were listed as lead authors
    - 161 only contributed as co-authors, and of that 161,
    - 111 (69%) only got to co-author one paper.
- 229 of the 453 contributed to APHCRI Network's publication output
    - 56 of them were listed as lead authors
    - 173 only contributed as co-authors, and of that 173
    - 122 (70%) only got to co-author one paper.

APHCRI encourages research team leaders to include their early-career ("apprentice") researchers in as many aspects of the research process as possible in the time available – including the drafting of papers. It is possible (it was mentioned as a possibility in one of the interviews conducted during the Scan) that the number of researchers who repeatedly re-engage in primary health care research is a less important factor in the evaluation of research capacity development than the number of realised intentions to ensure a short term researcher a co-author's experience. Either way, the absence of a clear, long term career path may also be a factor in the preference career researchers sometimes have for making the push (for publications and citations) rather than provoking the pull (the user's appetite for research).

Standard practice – publishing

APHCRI's publications record indicated a standard practice relating to the publication of research articles. The most consistent acceptance of APHCRI research papers over time was provided by four publishers. They published 43% of APHCRI's recorded research output,

- BioMedCentral 36 articles, 2008-April 2013

- Medical Journal of Australia 34 articles, 2004-April 2013
- Australian Journal of Primary Health 19 articles, 2007-April 2013
- Australian Family Physician 10 articles, 2004-April 2013

Acceptance of a further 9% was provided more recently by,

- Australian Health Review 10 articles, 2009-April 2013
- Australian Journal of Rural Health 10 articles, 2010-April 2013

Of the remaining articles,

- 53 (23%) were accepted by a total of 19 publishers each of which had accepted two, three or four articles by April 2013
- 57 (25%) were accepted by a further selection of 57 publishers each of which had accepted one article for publication by April 2013.

This pattern was taken as an indication that APHCRI had established a stable, secure relationship with an appropriate set of journal publishers, and enjoyed a degree of flexibility in finding further journal publishers whose themes more precisely matched APHCRI researchers' designated topics.

Standard Practice – Workshops, "Conversations with APHCRI in DoHA," and other networking and learning events

APHCRI provides workshops for CREs, Stream researchers and stakeholders. The workshops are open to early-career, mid-career and advanced researchers as well as stakeholders. They target research capacity building, especially with respect to the use of knowledge transfer and knowledge exchange communication skills. They are evaluated by survey questionnaires. The questionnaires are tailored to capture participant responses to key aspects of the workshop topic. Each workshop elicits a record of the ratio of early- and mid-career researchers, advanced researchers, and stakeholders in attendance, enabling evaluators to identify differences in the ratings provided by each group. All questionnaires target the following key metrics,

- opportunities provided in events for researchers at all levels, and stakeholders, to get to know each other and discuss topics of mutual interest over and above the set topics
- the stimulation of thinking on the topic being addressed
- the event's impact on breadth or clarity of knowledge on the topic being discussed
- the applicability of the workshop's content to the participants' work
- the participants' confidence in their capacity to apply the workshop's contents
- the appropriateness of time dedicated to each part of the workshop

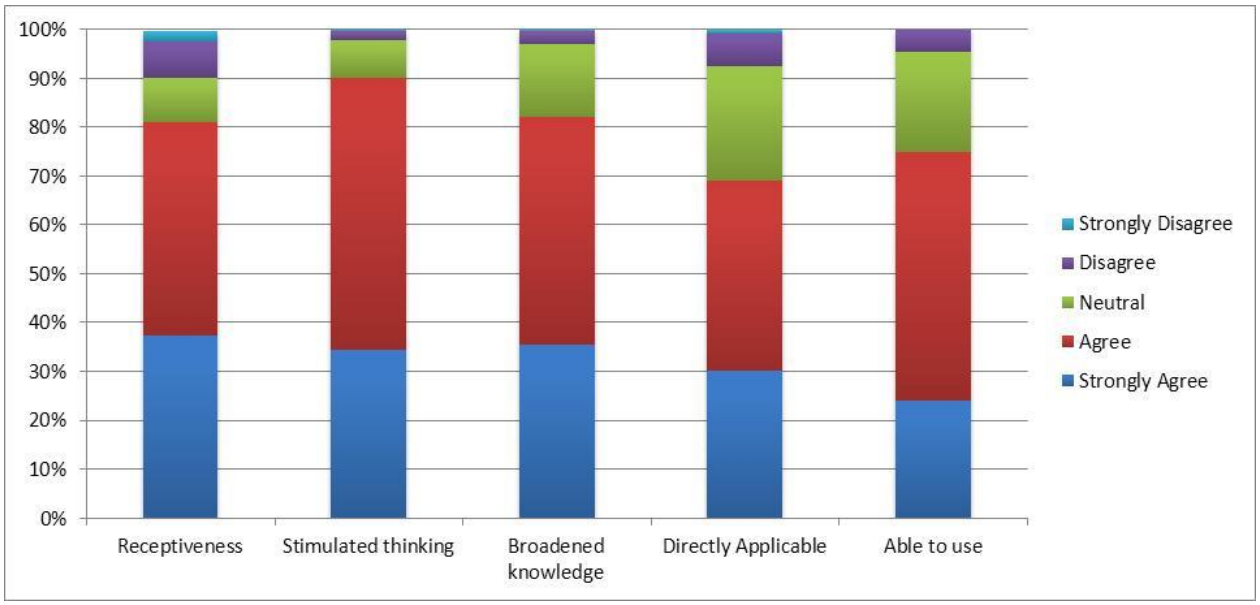
The expectation, with respect to each item in the questionnaire, is a rating of 3.8 or above on the questionnaire's five-point approve-disapprove scale. This equates to a 76% approval on an "approve-disapprove" scale of any length. In keeping with the evaluation system that has evolved during this project, causal factors for surpassing or not reaching this expectation are sought and used in guidance for improvement. At the outset of the project, the "3.8 or above" rating stood as an expectation. All of the five workshops held during 2012-13 were evaluated with this expectation as an indicator of value. The "3.8 or above" measure was met or surpassed with sufficient consistency in the five evaluated workshops for it to be considered an achievable metric. Data gathered from future workshops may establish the "3.8 or above" measure as a confirmed base-line.

Through the agency of the PHCRED Liaison Officer, opportunities are provided for APHCRI funded researchers to present their research findings directly to a DoHA audience. Fifteen of these events ("Conversations with APHCRI in DoHA') were evaluated in 2012 and are reported here as a baseline.

The Conversations in APHCRI series were evaluated with three core metrics:

- Receptiveness – whether departmental staff who attended the "Conversation" had previously used research (last 12 months)
- Effectiveness of Knowledge Translation and Exchange - whether departmental staff who attended the "Conversation" felt that it had stimulated their thinking and broadened their knowledge, and
- Applicability of research - whether departmental staff who attended the "Conversation" perceived that they would be able to use knowledge gained and if the knowledge was directly applicable to their job.

Figure 1: Conversations 2012 – Outcomes of the evaluations



In the 15 Conversation evaluated in 2012 against the "Effectiveness of Knowledge Translation & Exchange" metrics overall 90% of the 271 respondents either agreed or strongly agreed with the statement that the presentation had stimulated their thinking. Similarly 80% agreed or strongly agreed that they had broadened their knowledge by their attendance. In the "Applicability of research" metrics around 70% agreed or strongly agreed that the presentations were directly applicable to their work and they would be able to use the knowledge that they contained. This positive result was probably related to the general receptiveness of the audience most of whom (80%) had used research in the last year.

Both of APHCRI's fellowship programs – the International Visiting Fellow program and the Travelling Fellow and International Training Network program – give rise to presentations, workshops and seminars which prove popular. Unfortunately there has been no consistent evaluation of these events, so there is no pre-established baseline for future evaluations. The evaluation of these events will be like the evaluations of APHCRI-hosted workshops. It will be necessary to create a baseline, indicating the number of questionnaire items that regularly meet the "3.8 or higher" expectation, and the number of events where every questionnaire item meets that expectation.

Standard Practice – Stakeholders

APHCRI's files contain several lists of stakeholders. A compilation of these lists is to be found below, in Appendix D: Australian partners, stakeholders and other organisations with a history of interaction with APHCRI. The list is divided into six sections,

1. Key partners (two entries: The Commonwealth Department of Health and Ageing (DoHA), and the Primary Health Care Research Information Service (PHCRIS)).
2. University related organisations (centres, departments, schools) (22 entries).
3. Organisations associated historically with Divisions of General Practice (and which may now be refocusing on Medicare Locals) (14 entries).
4. Professional organisations with specific areas of interest (32 entries)
5. Government departments (10 entries).
6. Organisations on whose committees or boards APHCRI has (or has recently had) membership (19 entries).

It is inappropriate to think of these lists as representing a united or constant community of interest. They do indicate the breadth and depth of APHCRI's "stakeholder resource".

Each group, and each member of each group, has a unique stake in the Primary Health Care Research, Evaluation and Development (PHCRED) Initiative, now in its third phase. Each stake has its own weight and significance in the organisation named.

The weight or significance of any stake may vary as APHCRI's research themes coincide with or move away from an individual stakeholder's principal areas of interest.

The university-related organisations benefit directly from the APHCRI funding program. They provide researchers, and communicate with APHCRI through agreed reporting procedures and by participating in APHCRI-hosted workshops and DoHA-hosted "Conversations with APHCRI in DoHA".

Stakeholders in categories 3, 4 and 5 (above) are called on for input to pre-project issue identification and project specification. Where appropriate, they are invited to attend APHCRI-hosted workshops and to engage with or assist research teams as participants, informants, advisory group members, or participants in the dissemination process.

The inclusion of organisations in category 6 indicate a recognition by APHCRI and the other parties of the importance of ongoing interaction between them.

Interviews

Interviews were with

- members of the APHCRI Research Advisory Board (RAB)
- past and present APHCRI ANU researching staff members
- past and present CRE and Stream researchers
- DoHA Policymakers, and
- other stakeholders.

Questions were shaped to gather information that would be helpful in creating APHCRI's evaluation process.

For interviewees who were close to APHCRI, the themes were,

- relationship and communication
- push and pull
- knowledge creation
- knowledge dissemination and sharing
- the impact / influence / effects / documented end-use / shelf life of APHCRI research, and
- researchers' self-evaluation criteria.

For policy makers and other stakeholders the theme was

- relationship and communication; knowledge sharing; and impact.

The conversations were semi structured. They often took their own course. The tone of the conversations was consistently cheerful and cooperative. Together, they comprehensively covered the categories of action identified by the project's conceptual framework as instrumental in achieving impact a) in the academic world and b) in the world of policy, health and broader economic gains. Attempts to carry the conversation toward health and broader economic gains usually brought to the surface reasons for talking of something else.

The recordings and transcripts contain a great deal of information. What follows will be a representative summary of major views and perceptions.

Statements of appreciation regarding APHCRI and its contribution to primary health care research are not suppressed. More than one interviewee voiced this sentiment,

> I guess I just want to again underscore my appreciation of APHCRI. I have been around long enough where I saw the genesis and was involved to a small extent, in the difficult birth of APHCRI. I think they have done a fantastic job in terms of generating and enabling primary health care research in this country.

Concern that I understand their perception of APHCRI was typically voiced in this way,

> I think it is very young in this country; primary health care research has not been around very long. To say after five or ten years that it hasn't generated much is really a bit young I think.

One interview linked APHCRI's short history to the likelihood of APHCRI-funded research being capable yet, of translation into health sector cost savings,

> The set tone was, 'Let's get one thing straight. We're not having a primary health care policy'. That was the old government and here we are ten years

> later and we've got the primary health care policy where there is still a genuine sense of belief that if we can get those upstream determinants sort of right we might save money downstream.

The greater concern, however, was with APHCRI's vulnerability:

> The primary health care research community in Australia is small and I think it is extremely vulnerable ... I don't think overall we are anywhere near a stage of maturity where the group can sustain itself on mainstream funding that is available outside of APHCRI ... To reach maturity may take decades and we're certainly not there yet.

It was suggested that "A networked approach to linking policy with practice and the community is important" as a way of more securely contextualising APHCRI's position and role. Many APHCRI-funded research programs are being lived out in the field. The interviewee who made the suggestion above, acknowledged the appeal of the horizon-broadening, eye-opening work of creating, or finding and tapping into, supportive professional, industrial and social networks, and making them work for the sake of the project. He then went on to describe the position and role of the APHCRI-funded researcher, and by inference, the role of APHCRI itself, like this, "I think that the fire in the belly from the people who work in the area is sustaining, but it's also a bit of a challenge, and I think our job is sometimes to temper that enthusiasm into reality and to link it with the data".

The intensity of the networking experiences some field-based or rural-and-remote oriented research teams have, and the sense that what they were doing was generating and implementing health sector gains right there on the spot, made the thought of breaking away from it all to help formulate government policy on the matter seem retrogressive.

Lasting impressions of the interview program include an awareness that APHCRI-funded researchers' teams are far more than "APHCRI-funded", typically, they are very widely and imaginatively networked, which means APHCRI is, too, by implication.

The difference between the experience of primary health care and NHMRC researchers was referred to on a number of occasion, sometimes to explain why there are so many more NHMRC researchers than primary health care researchers, but always to spell out that those who chose to be primary health care researchers knew exactly what they were letting themselves in for,

> So NHMRC funds you to do some research and says, 'Okay here is some money. Go and do your research and tell us what publications come out of it. APHCRI says, 'Here is some money. Go and do some policy relevant research. We will help you with the knowledge exchange component of it and we want to know, not only what research you've done, what papers you've published, but how that has informed policy in practice in this country.

As an NHMRC researcher "There is more latitude to do what you want to do as opposed to framing your work in a way that is likely to help the policy people".

The point was made, however, that helping the policy people was not always top priority with primary health care researchers.

When the conversation moved to dissemination, uptake and use and the prospect of having an impact on primary health care policy or practice much of the discussion focused on impediments,

> We aren't funded for the really meaningful multi-level dissemination that potentially makes a difference.

The question of diversifying their modes of dissemination was also raised,

> For a lot of people, once the article is published, the consideration is done. It has only really been recently that you translated into one hundred and forty

> characters for Twitter and a Croakey blog and a media release and maybe in fact rewrite the article simplistically for releases to organisations and for presentations so that you try and summarise in a PowerPoint slide what is clearly a complex sort of formula, your outcome or something like that. I think researchers struggle with that sort of thing.

The formality of presentational dissemination made some interviewees turn to the continuous flow of information as a preferred alternative. The theme was: the responsibility of the researcher to maintain meaningful dialogue,

> I regard it more as an ongoing dialogue that influences, where the researchers talking to policy makers influence their thinking about policy and the policy makers engaging in dialogue with the researchers influence the research. I don't see it as a finite process, 'Okay we've done our presentation, we've done our job and we can go onto the next research project'. I see it as an ongoing dialogue. In terms of the researcher's responsibility, I think we have a responsibility to engage with the policy makers in a meaningful way but at the end of the day we have no control over what they do with the information that comes out of the exchange.

The view was also voiced that disseminating for impact was not something academic researchers were good at,

> It's the sort of thing that I think the marketing group within the faculty, which is quite successful, could well be additionally involved in. The sad reality is that the business of research means that you have to go from one to the other, one project to the next project ... But it's interesting that we will often blame the researcher for not doing it well, but we are not trained that well at doing it and we certainly aren't resourced to do it ... I think researchers are learning ... I saw a gradual evolution of understanding of that from the research community, but within our own world, which is generally going to be the world of universities, many of them are purely interested in academic output, purely interested in citations and what sort of journal, and I think that this raises the much broader question about how do you value the impact of research ... I would hope that we can have impact on policy, but there are a hell of a lot of reasons why, pushing us to actually not do that.
>
> I have tried at times to have say, a panel of stakeholders for lots of different project. What I have found is that it is ineffective. You actually need it built in to every project ... it is really important to engage them throughout

The issue of Push and Pull was always met like this:

> I don't think there is a huge pull from federal or state policy makers, but the agenda has been set and so the push is probably stronger,

As on past occasions, the differences between push and pull was attributed to an absence of developed relationships and understandings between researchers and policy makers.

> I think a big gap at the moment is that many researchers don't understand the policy process, many policy makers don't understand what's involved in conducting research, and neither party can afford the time or energy to do anything about it, even if they wanted to. Or maybe it's a test case for where there's a will there's a way. But probably both think and probably with some sort of justice, that their own work is important and – what? – fulfilling, so doing something about it just doesn't rate.
>
> I think one of the best ways of increasing this awareness of each other's' way of being is actually having exchanges or internships or opportunities where policy people visit researchers at their research sites and see what is going

> on and how they do things. Similarly, where researchers are obligated to go and spend some time in policy places to see how things are done. I think a lot of us are tacit learners in a busy society and that sort of immersion often opens eyes.

Interviewees from DoHA acknowledged an awareness of this perceived imbalance, but gave no indication of a future change. Researchers often voiced a feeling that there was a distance between them and their DoHA stakeholders. This was also acknowledged by DoHA interviewees. The work of the PHCRED Liaison Officer was referred to with respect and gratitude in these parts of the interview program. The "Conversations with APHCRI in DoHA" organized by the Liaison Officer were referred to as opportunities for the distance to be reduced, and the recent emergence of small-group Policy Round Table exchanges was spoken of as a welcome addition to the opportunities for researchers and policy workers to meet as collaborators. The impediments to further or more frequent interactions between APHCRI–funded researchers and their DoHA colleagues, expressed in terms of work requirements and circumstances, were spoken of as "not having changed much".

The voice of other stakeholders maybe represented with one quote that represents much that was said in interview with advocacy and support groups,

> We like coming to the workshops. It's nice to be invited. And we do get to meet some people, but it's not quite the right venue for us. I mean what we do isn't always like what the workshops are about. And we don't always agree with what's said in the workshops, but at least we are accepted as colleagues. The trouble is we aren't used as colleagues. What we would like is for your lot to come to us now and then. The researchers. And the APHCRI lot. To talk directly with us about how we can help each other.

THE QUESTION OF IMPACT AND ITS EVALUATION

The project uses the Payback Framework. The Payback Framework is focused on impact.

An impact is understood to be something that makes an observable difference.

Payback is understood as a return on investment. The project is concerned with three kinds of investment: the government's investment in APHCRI, APHCRI's investment in primary health care research, and stakeholders' investment in the uptake and use of APHCRI-funded research findings.

Early payback is measured in terms of observable differences in research capacity, targeted knowledge production, and the uptake and use of research findings attributable in whole or in part to APHCRI's funding program and infrastructure support. The "final outcome" payback comes later, when primary health care research begins to have an impact on health, health care processes, equity, costs and broader economic benefits.

Every evaluation conducted by an APHCRI evaluation team is to be considered part of an ongoing impact study.

THE EVALUATION'S CONCEPTUAL FRAMEWORK.

A full account of the "Payback Framework for health research evaluation" may be found in Buxton and Hanney [1,3], Cave, Hanney, Henkel and Cogan [2]; Hanney [4], Buxton [5], and Donovan and Hanney [6].

An evaluation of the Payback Framework may be found in Kalucy et al [40].

Kitson [41] observes that a conceptual framework or model "is not expected to be used in any practical way to guide actions. Rather it is a mental representation of the many elements that need to be considered". The Payback Framework has been selected because the elements it focuses on, and the relationship between those elements it perceives as normal (see Figure 2) comfortably match the priorities in APHCRI's infrastructure support for primary health care research.

Hanney [4] speaks of categories and subcategories rather than elements. In his (2005) account of the framework he says,

> The multi-dimensional categorisation of payback consists of 5 main categories and key sub-categories:
>
> a) Knowledge production
> b) Research targeting, capacity building and absorption
> c) Informing policy and product development
> d) Health and health sector benefits
> - health gain
> - cost savings
> - improvements in processes of health care
> - equity
> e) Broader economic benefits
> - benefits for commercial developments
> - healthy workforce
>
> Each can be considered in turn, with various sub-categories explored and possible approaches to measurement described.

The six stages in the standard depiction of the Framework's terrain (see Figure 2) makes it possible to identify a number of sub-categories that are implicit in categories a) and b) (Knowledge Production and Research Targeting). These sub categories are topic/issue identification, project specification, inputs to research, and the commissioning of research. Capacity building and absorption may be considered as tightly tied into, or clearly separate from, knowledge production. All are infused with concerns for communication (Knowledge Transfer, Knowledge Exchange, and Knowledge Translation) and for the relationships good communication make possible.

The payback being sought in this project comes from impact in,

- categories a) and b) (the academic realm)
- categories c), d) and e) (the realm of policy, and health and economic gains.

A major challenge in this project was to identify the impediments APHCRI funded research encounters in being

- taken up and used in category c), and
- turned to advantage in categories d) and e).

Minor modifications needed to be made to the standard depiction of the framework to make its match with circumstances in APHCRI more visible.

The three-step modification is illustrated in Figure 2. A one-page picture of how the proposed evaluation process relates to the modified framework is to be found in Figure 3.

The following five pages outline who would do what to make the evaluation work within a) the framework and b) the prevailing circumstances in APHCRI. I have couched that text on those pages in the present tense ("who does what" instead of "who would do what") so that

the Handbook can be put to use straight away if APHCRI decides to accept the proposed evaluation process and set it in motion.

WHO DOES WHAT?

The proposed evaluation process is intended to be owned and run by APHCRI personnel, for,

- internal use in monitoring and, where possible, enhancing its practices
- external use in public reporting.

In normal circumstances responsibilities for evaluation practice are shared by or among a combination of the following personnel,

- An evaluation coordinator (part time, with research and evaluation background)
- the PHCRED Liaison Officer (with respect to Workshops and "Conversations"), and
- up to two APHCRI ANU researchers prepared, on occasion, to perform specific research tasks on request.

Leadership

APHCRI Management includes "evaluation" as a standing item in management meeting agendas. Evaluation activity and data is reported on in management meetings. It is discussed with respect to action that might be taken in its light. The discussions are noted. Responsibility for action is allocated. The data is filed by Management but remains accessible to evaluation team members.

An audit is carried out at the end of the first quarter of each year, focusing on:

- the number of APHCRI-funded research publications in peer-reviewed journals
- the number of researchers brought into and supported in primary health care by APHCRI funds
- the number of early career researchers with PhD scholarships funded
- the number of early or mid-career researchers with Post-doc fellowships funded
- the rate of uptake and use of APHCRI-funded research findings
- other, as required by APHCRI Management.

Evaluation of events: (APHCRI-hosted Workshops, DoHA-hosted "Conversations")

Evaluation as a part of the event

Evaluation is treated as an integral part of APHCRI-hosted Workshops, DoHA-hosted "Conversations with APHCRI in DoHA" and all other events in which researchers, policy makers and other stakeholders interact. This means the progressive or summative completion of the survey questionnaire is woven into the event design and into the program of the event itself, not simply tagged on at the end where it risks cursory compliance or dismissal.

Evaluation after the event

Workshops and "Conversations" are to be evaluated by selective post-event interviews as well as by in-event survey questionnaires. Interviews are intended to gather evidence of an event's lasting effects.

Workshops and "Conversations" have a common theme

APHCRI-hosted workshops are focused (entirely or in part) on the development of knowledge transfer and exchange skills (KTE).

DoHA-hosted "Conversations" are designed for the exercise of those skills.

The relationship between Workshop and "Conversation" is not unlike the relationship between research dissemination and uptake and use: the second sheds light on the relevance and utility of the first.

Collaboration: APHCRI evaluation team members and the PHCRED Liaison Officer

There are advantages in combining the designing of an event with the designing of its evaluation. It helps the aims of an event align with the objectives of the organisation's "evaluation for continuous quality improvement" process.

Evaluation is collaborative. Responsibility for the event is shared. Data from the event is shared and discussed by event designers and evaluators. Discussion of method, data and application of data in continuous improvement is essential if the continuous improvement cycle is to be complete.

It has become standard practice for the PHCRED Liaison Officer to be the principal designer of DoHA-hosted "Conversations" and their evaluations, and to share the data. The design and evaluation of Workshops has been ad hoc and experimental, but the data has been shared.

It is in APHCRI's interest, and in the interests of the PHCRED Liaison Officer, for the designing and evaluation of Workshops and "Conversations" to be shared, and for the APHCRI evaluation team members and the PHCRED Liaison Officer to collaborate in the design of these events and their evaluation. It is equally in their interests to collaborate in subsequent discussions of event design, evaluation method, evaluation data and its application in the continuous improvement of,

- the communication of research findings – Knowledge Transfer and Exchange (KTE)
- the uptake and use of research findings – Knowledge Translation (KTr).

Responsibility for conducting post-event interviews is distributed: PHCRED Liaison Officer interviews selected participants in "Conversations"; APHCRI evaluation team members conduct interviews with selected Workshop participants. But the data is shared and discussed by all evaluators – again, for the sake of joint continuous improvement of KTE and uptake and use.

Evaluation of knowledge production, dissemination, uptake and use

Survey questionnaires are seldom used in these evaluations. Conducting interviews, drawing data from researchers' reports, and research are more common. Research is called for where interviews and researcher reports do not or cannot provide the required data.

The researcher normally seeks the hard-to-get data in records and documents relating to changes in policy direction, service delivery, or community understanding over time. Research is also called for to track uptake and use of research findings after the researcher responsible for those findings has gone in pursuit of the next fund and the next research project.

Other specific pieces of research are sometimes called for to ensure APHCRI is fully and accurately informed about,

- the number of publications stemming from APHCRI-funded research, including those that do not acknowledge APHCRI's help
- the number of active primary health care researchers it funds

- the contributions made within CREs to individual primary health care research capacity building.

Responsibility for these pieces of research is shared between the collaborating APHCRI evaluation team members and occasionally one or two others where specific skills and experience is required.

PROCESS

Quantitative and qualitative data is gathered by,

1. Survey Questionnaires (Evaluation coordinator and PHCRED Liaison Officer)

- Survey Questionnaires are used to evaluate events which are
  - APHCRI-hosted workshops dedicated (entirely or in part) to the development of Knowledge Transfer and Knowledge Exchange skills
  - DoHA-hosted "Conversations with APHCRI in DoHA" dedicated (entirely or in part) to the exercise Knowledge Transfer and Knowledge Exchange skills
  - prepared by APHCRI staff and/or the PHCRED Liaison Officer

Between 20 and 30 of these events may be expected to occur throughout the year.

2. Drawing data from standard Researcher Reports (Evaluation coordinator)

- Researcher reports are used as a principal source of data that relates to research capacity building, knowledge production and knowledge dissemination.

3. Face-to-face and telephone interviews (Evaluation coordinator)

- interviews with researchers are used for an in-depth understanding of:
  - issues raised through the standard reporting process
  - after effects and lasting influences of surveyed Workshop or "Conversation"
- interviews with policy makers and other stakeholders are used for in-depth understanding of
  - after effects and lasting influences of surveyed Workshop or "Conversation"
  - up-take and use of research findings in policy
  - uptake and use of research findings in practice.

4. Research (APHCRI ANU researchers with Evaluation coordinator)

- Standard research processes are used whenever data proves difficult to get using survey questionnaires, the standard researcher reporting processes, or interviews. This is most likely to happen,
  - with respect to the uptake and use of research findings in policy or by direct adoption before or without regard to policy
  - in tracking down fugitive publications which should (but don't) acknowledge APHCRI support.

WHAT IS APHCRI LOOKING FOR?

1. In short, APHCRI is looking for

> data that indicates maintenance of, or deviation upwards or downwards from, standards set by data gathered on previous occasions, and

> causal factors for the maintenance or change.

2. In slightly more depth, APHCRI is looking for evidence of its performance against its own list of performance indicators. This list is to be found in Appendix A.

3. It is looking for the day when it has sufficient depth of data in hand to establish, for public reporting, solid APHCRI metrics for

> the number of researchers brought into and/or sustained in Australian Primary Health Care research attributable to APHCRI funding

> the number of early career researchers with PhD scholarships funded

> the number of early or mid-career researchers with Post Doc fellowships funded

> the number of articles published in peer-reviewed journals

> the number of citations of articles published in peer-reviewed journals

> the rate of uptake and use of APHCRI-funded research findings

4. Finally, it is looking for ways to capture not just the rate, but the consequences of policy uptake and use, and the direct adoption of research findings that occurs before, or without regard to the creation of policy. Evaluation of these consequences will provide an understanding of the capacity APHCRI's-funded research has for generating what the Payback Framework calls "health and health sector benefits", and "broader economic benefits".

The final outcomes

Hanney [(5)] says: "The final outcomes are the health and broader economic benefits ... These are increasingly seen as being the ultimate goal of health research funding".

APHCRI does not have a record of achievements in this area. As indicated elsewhere in this report, achievements in this area are notoriously difficult to achieve.

There is a tendency to shy away from the task of evaluating the broader benefits that research can give rise to. It is considered too hard. Hanney is not very encouraging. Evaluating health and broader economic benefits is difficult, but "whilst their precise estimate in practice often remains difficult it is possible to make progress in some examples". His one suggestion is to monitor behavioural change.

> For the research findings incorporated into secondary outputs to result in final outcomes there usually has to be some behavioural change by practitioners, and/or the public ... Sometimes the adoption comes as a direct result of the primary outputs, as when clinicians ... decide to implement research findings even prior to the development of policies such as clinical guidelines. Either way, it is important to try to establish the adoption or take-up rates and to explore how far the behavioural change can be attributed to the specific research findings, as opposed to other factors.

APHCRI's slight modifications to Buxton and Hanney's Payback Framework do not counter Hanney's (2005) observations. If APHCRI is to go beyond the mechanical counting of occasions in which it meets the standards set by itself against its own performance indicators it will need to do as Hanney suggests:

> to try to establish the adoption or take-up rates and to explore how far the behavioural change can be attributed to the specific research findings, as opposed to other factors.

The next section of this Handbook maps the evaluation process described above against the stages in the Payback Framework. The minor modifications made to fit the framework to APHCRI's circumstances are incorporated in the diagram used. They do not alter the sequence of stages in any way.

The relatively mechanical evaluation process described above enables APHCRI to report against

- researcher-stakeholder relationship gains
- communication-skill gains
- scholarship gains
- research-capacity gains.

It is not difficult to see how the evaluation of these gains map against the framework's Stages 1-3, and "Interface B". When it comes to mapping an evaluation process against Stages 4 & 5 – to enable APHCRI to report against "health and health sector gains" and "broader economic gains", or even to see if it can report against these things – research becomes the dominant means of gathering data.

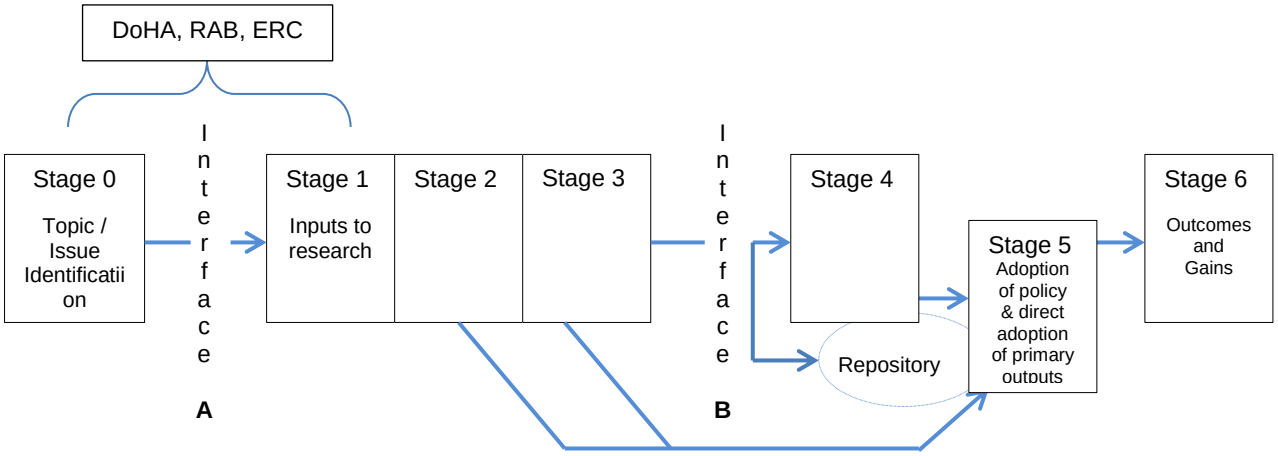
Evaluation of APHCRI's contribution to "health and health sector gains" and "broader economic gains" needs to be supported by a full scale, ongoing research program, involving,

- interaction between researchers, policy makers, and the stakeholders responsible for the direct adoption of research findings, (see "Zone 3")
- analysis over time of records and publications relating to policy, practice and other behavioural changes attributable in some measure to APHCRI-funded primary health care research findings.

..

Evaluation activity mapped against the Framework

ZONE 1



Evaluation activity in Zone 1

Zone 1 evaluation activity focuses on the creation of a research project and the beginning of the researcher-stakeholder relationship, the commissioning of research, and the transfer of responsibility from DoHA, RAB and Expert Review Committee (ERC) to the commissioned researcher.

Stage 0

Stage 0 is not a contained stretch of time but includes all the time it takes for ideas about change and improvement to coalesce into a suggestion for action. Stage 0 begins to look like a stage in a process when the suggestion for action begins to get a voice.

Interface A

Typically, once a suggestion gets a voice it begins to be talked about, challenged, critiqued, reworked and refined by people who might take the action and people who might be affected by it. Interface A, in the context of Australian Primary Health Care research, serves

- to gather and consider input from all interested parties, including policy makers, researchers, consumers, service providers and any other parties who might be involved in or potentially threatened or benefited by recommendations
- to come up with a project, and establish project specifications
- to clarify criteria for the commissioning of research
- to commission research

Responsibility for this process rests primarily with:

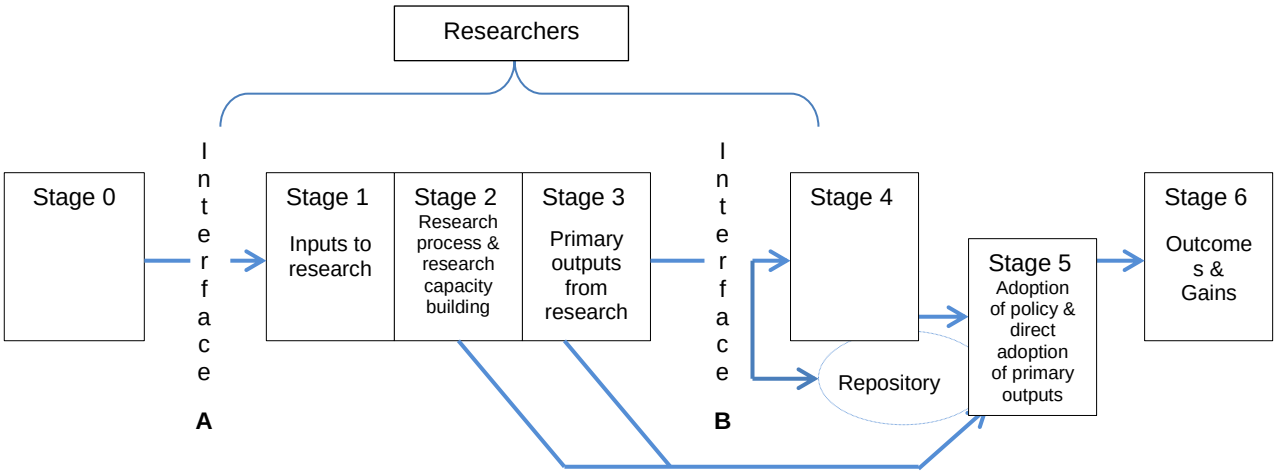
- The Commonwealth Department of Health and Ageing (DoHA)
- APHCRI's Research Advisory Board (RAB) and
- APHCRI's Expert Research Committee (ERC).

The actions taken by DoHA, RAB and ERC are not within the evaluation teams' purview.

Stage 1

Flow-on effects of Interface A, felt by the commissioned researcher in Stage 1, are within the evaluation team's purview.

ZONE 2



Evaluation in Zone 2

Zone 2 evaluation focuses on research capacity building, knowledge production, knowledge dissemination and the further development of the researcher-stakeholder relationship.

Stage 1

The key activity in the usually brief Stage 1 focuses on

- the development of a research plan and the incorporation into it of considerations that will ensure
  - policy relevance, stakeholder relevance and utility in the research findings, and
  - a measure of uptake and use of research-findings

Stage 2

Stage 2 evaluations focus on six topics,

1. Communication: APHCRI-hosted Workshops on diverse topics, including interpersonal, print-based, or electronic media aided knowledge transfer and exchange (KTE) (**engagement with**, and **impact of**)
2. Communication: DoHA-hosted "Conversations with APHCRI in DoHA" (**engagement with**, and **impact of**)

Where-ever possible these events are attended by member(s) of the evaluation team. The events themselves are evaluated using in-event survey questionnaires and selective post-event follow-up interviews focused on the events' lasting effects.

3. Research capacity building (**engagement with**, and **impact of**)
4. Stakeholder engagement (**engagement with**, and **impact of**)
5. Knowledge production (**engagement with**, and **impact of**)
6. Knowledge dissemination **(engagement with** ...)

The impact of dissemination (measured in terms of uptake and use) is to be found in Zone 3. Discovering it involves a change of evaluation method.)

Stage 3: Primary outputs of research

"Primary outputs from research" means "research findings and their articulation". The "articulation" of research findings takes many forms, each of which is an indicator of engagement with knowledge dissemination. Evaluation of these is optional rather than priority.

- (optional) indicators of engagement with dissemination include, for example,
  - Number and evaluated quality of oral presentations
  - Number and evaluated quality of power point displays, posters, etc
  - Number of media releases
  - Number of grey literature items
  - Usage of blogs
  - Usage of social media and range of social media used

Quantitative data relating to such indicators may be found in researchers' reports, but they are more likely to be found by evaluation-team research.

Interface B: Dissemination and Reporting

Three distinct kinds of communication occur in Interface B:

1. structured academic presentations (symposia, seminars), sometimes characterised by a focus on researcher credentials and research methodologies, and usually followed by Q and A sessions.
2. presentations and round-table discussions usually involving one or two researchers from one research project, and a gathering of policy makers and stakeholders with an interest in the research being discussed. These discussions seldom need an account of researcher credentials or research methodology. They tend to focus on research findings, their policy-relevance, stakeholder-relevance, utility, and possible immediate or longer-term uptake and use.

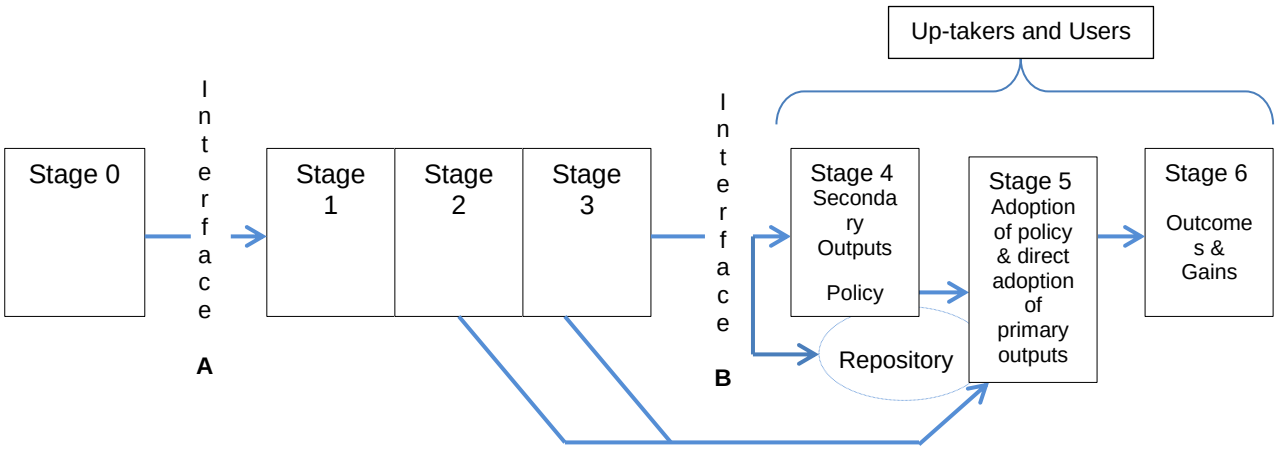
1 & 2 above occur in "Conversations with APHCRI in DoHA". These events are evaluated by in-event survey questionnaire and selective follow-up interviews to discover lasting effects.

1. two-way flows of information between researchers and interested stakeholders, during Stages 2 and 3, enabling direct, considered adoption of research processes and primary outputs before, or without regard to, the development of policy.

This kind of continuous communication, and the direct application of research findings it can give rise to, are represented in the diagram at the head of this section by the angled lines running from Stage 2 & Stage 3 to Stage 5. Quantitative and qualitative data relating to this practice is provided by self-reporting by those involved or by evaluation team research and interview.

Researchers and stakeholders can begin engaging in dissemination and reporting activities from the moment they become certain that they have "findings" to talk about.

ZONE 3



Evaluation in Zone 3

A second transfer of responsibility occurs in Zone 3. Researchers, who have fulfilled their obligations in knowledge production, knowledge dissemination and Interface B discussions about the relevance and utility of their research findings, move on to the next funding round and the next research project. In doing so they relinquish further responsibility for uptake or use, and the evaluators need to find other dependable sources of uptake and use data.

Decisions about uptake and use in policy (Stage 4) become the responsibility of policy makers – sometimes with the help of a researcher who has accepted a position as advisor in, or contributor to, the policy development and implementation process.

Decisions to take up and use research findings in direct adoption (Stage 5) become the responsibility of the interested stakeholder – sometimes with the help of a researcher who has accepted a position as advisor or technical work party member in the adoption.

There is little hope of policy makers or direct adopters self-reporting on their uptake and use of research findings. They are usually combining information from too many other sources to identify clearly the bits of research they have taken up and made use of – and the sense of being in a collaborative relationship with APHCRI tends to fade when the researcher they have been working with starts looking for the next fund and the next project.

Capturing and measuring uptakes and uses of research in this context is very difficult. It is a lot easier if there is a researcher working in the uptake-and-use team who can report back on what's being taken up, and what uses its being put to. Lacking that aid, the evaluation team needs to track down the uptakes and uses through interviews and investigative research.

Stage 6: Aided by a comprehensive research program, evaluators create and (over time) accumulate a body of evidence to illustrate the "health and health sector benefits" and the "broader economic benefits" derived from the uptake and use of APHCRI-funded research findings.

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Appendix A: APHCRI's Priority Indicators for external reporting

Research capacity building

- Number of active Primary Health Care researchers in Australia attributable to APHCRI funding
- Number of PhD candidates funded
- Number of Post-Doc Fellowships funded
- Number of lead authorships by early career researchers

Communication (KTE)

- Evaluations of KTE workshops provided to primary health care researchers and research users
- Evaluations of KTE use in 'Conversations with APHCRI in DoHA' and other linkage and exchange events

Knowledge production (relevance, utility and stakeholder engagement)

- Information flow between researchers and stakeholders (including policy makers) throughout the research process.
- Researcher proactivity in seeking stakeholders input
- Stakeholder encouraged to participate in knowledge production (as observer, informant, sounding board, steering committee member etc.
- Clear expression of stakeholder relevance, policy relevance and utility in presentations or discussions of research findings

Knowledge dissemination

- Number of scheduled "Conversations with APHCRI in DoHA" provided
- Number of articles in peer-reviewed journals
- Number of accessible 1:3:25 summary reports of research findings and implications for policy
- Number of alternative personal, print, or electronic media modes of dissemination used by researchers
- The placement of APHCRI-funded research publications in the ANU digital collections repository
- Records of access made to materials in the repository

Knowledge uptake and use

- Citations of APHCRI-funded research findings in government documents
- Citations of APHCRI-funded research findings in official published documents other than government documents
- Self-reports by policy-makers and adopting stakeholders on uptake and use of research findings (feedback loop required)
- Changes in policy direction attributable to APHCRI funded research findings and brought to light by APHCRI research
- Changes in Understanding and Awareness brought to light by APHCRI research

- Tracking and reporting on longer-term uptake and use in policy and in direct adoption of research findings by stakeholders

Collaborations and partnerships

- Number of existing collaborations and partnerships with like-minded Australian academic and professional organisations
- Number of meetings between PHCRIS and APHCRI personnel focusing on joint enhancement of services provided
- Number of existing collaborations and partnerships (local, national, international)
- Maintenance or increase of number of collaborations and partnerships (local, national, international).

Appendix B: Data sought from APHCRI-hosted Workshops and DoHA-hosted "Conversations"

- The ratio of researchers to stakeholders in attendance
- Ratings of opportunities provided in events for researchers and stakeholders to get to know each other and discuss topics of mutual interest over and above the set topics
- Ratings of the stimulation of thinking on the topic being addressed
- Ratings of the event's impact on breadth or clarity of knowledge on the topic being discussed
- Ratings, by participants in APHCRI-hosted workshops, of
  - the applicability of workshop content to daily work
  - their capacity to apply it
- Ratings of DoHA-hosted conversation attendees' receptiveness of research
- Ratings, by participants' in DoHA-hosted "conversations", of
  - applicability of research findings to policy
  - their capacity to apply it

Appendix C: Indicators of engagement and impact for internal (formative) use

Communication (KTE)

- Indicators of engagement
  - Promotion of Researcher-Research User Relationship
  - Provision, to PHC research producers & users, of workshops that focus on KTE
- Indicators of impact
  - Ratings and free-form feedback from workshop participants on the effectiveness of workshops in enhancing knowledge transfer and exchange skills
  - Ratings and free-form feedback for presenters in 'Conversations with APHCRI in DoHA' (and other KTE events involving researchers and research-users) on the effectiveness of communication in those events.

Research capacity building (RCB)

- Indicators of engagement
  - Resources dedicated to RCB
  - Evidence of organised programs of RCB activities in CREs
- Indicators of impact
  - Number of active Primary Health Care researchers in Australia attributable to APHCRI funding
  - The ratio of early career, mid-career and advanced researcher in research teams and CREs
  - Number of PhD candidates funded
  - Number of Post-Doc Fellowships funded
  - Number of lead authorships by early career researchers

Stakeholder participation in knowledge production

- Indicators of **engagement** in the promotion of stakeholder participation in research
  - Researcher proactivity in seeking stakeholders input
  - The presence or absence (in Stage 1) of a plan of action for stakeholder engagement in commissioned research
  - Balance between researcher push and research end-user pull is monitored
- Indicators of **impact** of stakeholder engagement
  - Maintenance of stakeholder relevance and utility of research as considerations throughout the knowledge production process
  - Clear expression of stakeholder relevance and utility in presentation of research findings
  - Number of stakeholders accepting an invitation to engage in the research (as observer, informant, subject, steering committee or advisory board member etc.)
  - Number of stakeholders still participating in the research (as observer, informant, subject, steering committee or advisory board member, or collaborating disseminator of research findings etc.,) in late stages of knowledge production

- Balance between researcher push and research end-user pull is maintained at previous level or strengthened
- *See also 'Indicators of instrumental impact' and 'indicators of conceptual impact' below*

Knowledge production

- Indicators of **engagement**
  - Number of articles in peer-reviewed journals
  - Number of accessible 1:3:25 summary reports of research findings and implications for policy
- Indicators of **impact** among fellow researchers
  - Number of citations in peer-reviewed journals
  - Consistency in the acceptance of APCRI-funded research papers by BioMedCentral, The Medical Journal of Australia and The Australian Journal of Primary Health
  - Extension of the number of journals consistently accepting APHCRI-funded

Knowledge dissemination

- Indicators of **engagement**
  - Number of scheduled "Conversations with APHCRI in DoHA" provided
  - Number of alternative personal, print, or electronic media modes of dissemination used by researchers
  - The creation of the proposed digital collection of APHCRI-funded research publications, and its placement in ANU's free-access digital collections repository
- Indicators of **impact**
  - *See Uptake and Use*

Uptake and Use

(See Stages 4 and 5 in APHCRI's modified version of the Payback Framework)

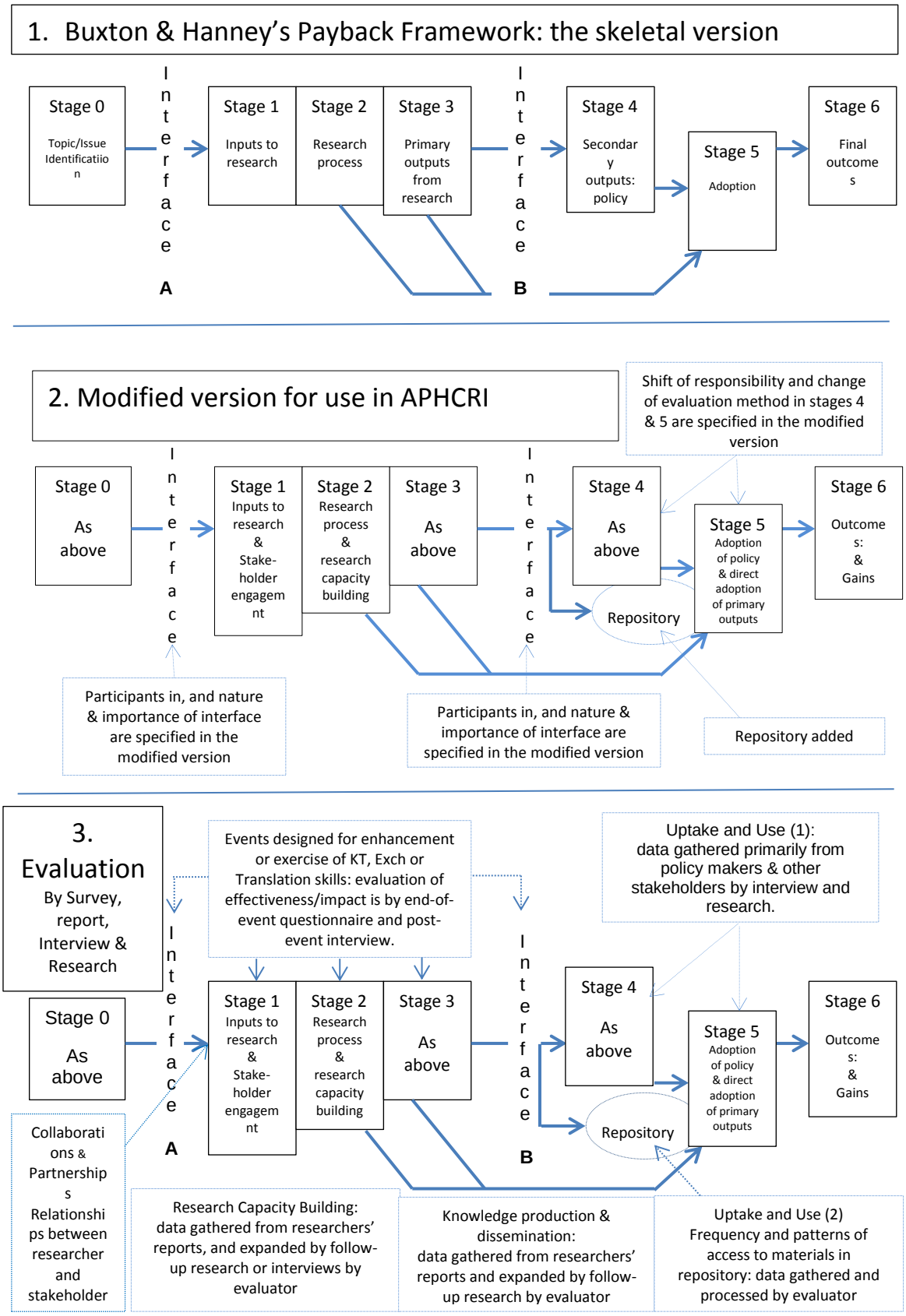
- Indicators of **engagement**
  - Self-reporting by policy-makers and adopting stakeholders on uptake and use of research findings (feedback loop required)
  - Frequency of uptake and use in policy, and identification of the research finding(s) taken up and used
  - Frequency of uptake and use in direct adoption, and identification of the research finding(s)taken up and used
- Indicators of **impact** in policy and decision making
  - Number of citations of APHCRI-funded research findings in government documents
  - Number of citations of APHCRI-funded research findings in official published documents other than government documents
  - Number of detectable changes in policy direction attributable to APHCRI-funded research findings and brought to light by APHCRI research
  - Number of detectable changes in community understanding and awareness attributable to APHCRI-funded research and brought to light by APHCRI research

- Number of researchers acknowledging their use of APHCRI-funded research to sharpen the targeting of their own research.

> Indicators of **impact** in direct adoption of research findings by stakeholders

- Number of direct adoptions by primary health care consumers, service providers, and NGOs
- Frequency of access to research papers in the repository
- Patterns of access to research papers in the repository
- Number of downloads from the repository
- Number of references to or recommendations of the repository in journals, papers, and other official and recorded communications between researchers.

Appendix D: Figure 2 – Three-step Modification of the Payback Framework



Appendix E: Figure 3 – A one page map of APHCRI's Evaluation Process

For use in the Evaluation of APHCRI's Impact

Communication – Knowledge Transfer and Exchange (KTE)
High quality KTE is required from Stage 0 to Interface B

Principal Data Sources:
Participants' ratings of:

a. APHCRI-hosted workshops on topics including interpersonal, print-based, or electronic-media-aided knowledge transfer and exchange between researcher and research end-user.
b. DoHA-hosted "conversations" in which knowledge transfer and exchange skills are exercised to facilitate uptake and use.

Method
Survey Questionnaires in the event and
follow-up interviews on the event's lasting effects

Measure:
All items: 3.8 or above on a 5-point scale (76% positive on any negative-positive scale used)

- Ratio of researchers to stakeholders in attendance
- Ratings of opportunities provided in events for researchers and stakeholders to get to know each other and discuss topics of mutual interest over and above the set topics
- Ratings of the stimulation of thinking on the topic being addressed
- Ratings of the event's impact on breadth or clarity of knowledge on the topic being discussed
- Ratings, by participants in APHCRI-hosted workshops, of
  - the applicability of workshop content to daily work
  - their capacity to apply it
- Ratings of DoHA-hosted conversation attendees' receptiveness of research
- Ratings, by participants' in DoHA-hosted "conversations", of
  - applicability of research findings to policy
  - their capacity to apply it

NOTE 1: "Conversations" tend to occur when the researcher is in Stage 3 or Interface B. Workshops may be scheduled at times when research attendees are at different points in the research process between Interface A and Interface B.

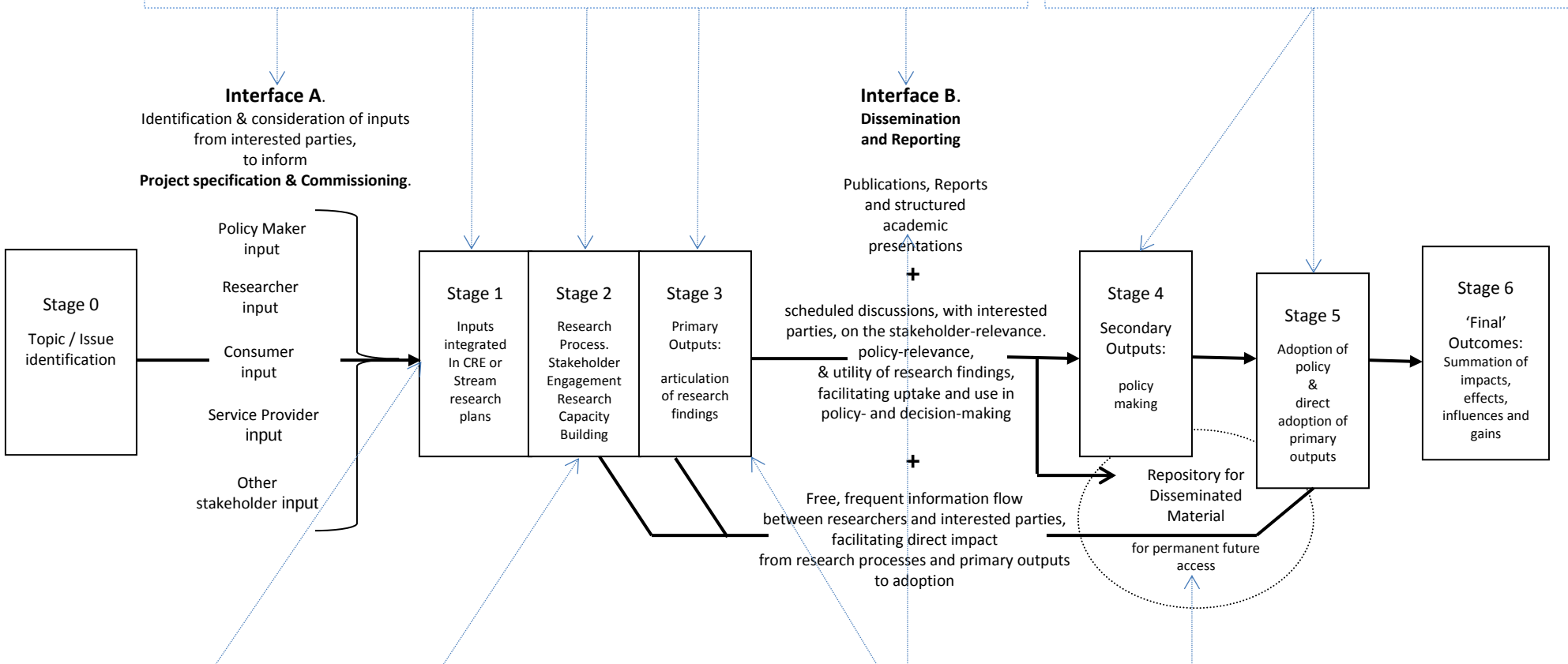
Knowledge Uptake and Use
(Post Interface B):

Principal Data Source:
Policy makers, adopting stakeholders, researchers with positions in technical working parties or advisory groups attached to policy making or Stakeholder Adoption, primary health care workers affected by the application of research findings

Method
Interviews and research, conducted within one-yea of Interface B

Measure
Identifiable achievements in the research sector, and identifiable gains and benefits in the health sector, or in the broader economy as reflected in

- Number and kinds of detectable uptakes and uses of APHCRI-funded research
- Number of researchers using APHCRI-funded research to sharpen the targeting or set the target of their own research
- Number of citations of APHCRI-funded research in government publications
- Number of citations of APHCRI-funded research in non-government publications
- Number of detectable changes in policy direction attributable to APHCRI-funded research
- Number of detectable changes in community understanding and awareness attributable to APHCRI-funded research
- Number of detectable changes in primary health care service provision attributable to APHCRI-funded research
- Number of detectable changes in the economy attributable to APHCRI-funded research.



Collaboration and Partnership

…between DoHA reps, other stakeholders, RAB and ERC members
&
The commissioned research leaders.

Principal Data Source:
The commissioned research leaders
Method
Interview
Measures
Presence or absence of plan of action.

Inheritance or no inheritance from DoHA, RAB, ERC of a list of the project's key stakeholders and/or an indication of the stakeholder inputs that were most influential in shaping the project's specifications.

Research Capacity Building

Principal Data Source
Researchers' Reports
Method
Data gathered from researchers' reports and expanded by follow-up research by evaluators
Measure
Maintenance, increase or decrease in

- the number Primary Health Care researchers in Australia attributable to APHCRI funding.
- the percentage of these researchers who engage in APHCRI-funded research more than once
- the frequency of Primary Health Care researchers' re-engagement with APHCRI-funded research
- the number of PhD scholarships funded
- the number of Post-doc fellowships funded
- the ratio of early-career, mid-career and advanced researchers in research teams & centres
- evidence of organised programs of RCB activity in CREs

Knowledge Production & Dissemination

Principal Data Source:
Researchers' Reports
Method
Data gathered from researchers' reports and expanded by follow-up research by evaluators
Measure
Maintenance, increase or decrease in

- the volume of APHCRI-funded research output, including number of peer-reviewed publications.
- the quality of APHCRI-funded research output, as attested to by citations and recorded acknowledgements by policy-makers and stakeholders of policy relevance, stakeholder relevance and utility of research findings
- consistency in the use of APHCRI's favoured mainstream publishers

Knowledge Uptake and Use (following access to repository)

Principal Data Source:
Repository of Disseminated Materials
Methods
Usage of repository monitored, and data gathered and analysed by evaluators. Interviews with frequent users to discover the rate of uptake and use of materials in the repository.
Measure
Maintenance, increase or decrease in

- number of identified sources of 'hits on' or 'access made to' materials in the repository
- frequency of access to materials in the repository
- patterns of access to materials in the repository
- rate of uptake and use of materials in the repository

Appendix F: Australian partners, stakeholders and other organisations with a history of interaction with APHCRI

Principal Partners

- Commonwealth Department of Health and Ageing (DoHA)
- Primary Health Care Research Information Service (PHCRIS)

University-related organisations

- Centre for General Practice Integration Studies (CGPIS), in the School of public Health & Community Medicine, UNSW
- Centre for Health Economics Research and Evaluation (CHERE), UTS
- Medicine in Australia: Balancing Employment and Life (MABEL), University of Melbourne
- Palliative and Supportive Services, Flinders University
- The ANU Medical School, ANU
- The Centre for Health Economics, Monash University
- The Centre for Mental Health Research, ANU
- The Centre for Remote Health, Flinders University
- The Centre for Rural and Remote Area Health, University of South Queensland
- The Child Health Promotion Research Unit, Edith Cowan University
- The Department of General Practice, the University of Melbourne
- The Department of General Practice, University of Adelaide
- The Department of Rural Health, Northern Rivers University
- The Indigenous Health Interest Group, ANU College of Medicine, Biology and Environment
- The Mater Centre for Integrated Health Care and General Practice, University of Queensland
- The Menzies School of Health Research
- The Primary Mental Health Care Australian Resources Centre, Flinders University
- The Public Health Information Development Unit, University of Adelaide
- The School of Population Health, University of Queensland
- The School of Public Health and Community Medicine, UNSW
- The School of Primary Health Care, Monash University

Organisations associated with Divisions of General Practice and (possibly) Medicare Locals

- ACT Division of General Practice Policy and Program Development, Canberra
- Alliance of NSW Divisions, Sydney
- Australian Divisions of General Practice (ADGP), Manuka, ACT

- Australian General Practice Network (AGPN), Manuka, ACT
- Australian Healthcare and Hospitals Association (AHHA), Deakin, ACT
- Australian Medicare Local Alliance (AMLA)
- General Practice and Primary Health Care (GPPHC), Darwin
- General Practice Victoria (GPV), Melbourne
- General Practice Education and Training, (GPET)
- General Practice Registrars Australian Ltd (GPRA), Wembley, WA
- Queensland Divisions of General Practice, Brisbane
- SA Divisions of General Practice, Wayville, SA
- Tasmanian General Practice Divisions (Rural Workforce Support), Newstead, Tasmania
- Western Australia General Practice Network, Bentley, WA

Professional organisations with specific areas of interest

- Allied Health Professionals Australia (AHPA)
- Australian College of Rural and Remote Medicine (ACRRM), Brisbane
- Australian Commission on Safety and Quality in Health Care (ACSQHC), Sydney
- Australian Indigenous Doctors Association (AIDA), Manuka, ACT
- Australian Medical Association (AMA), Kingston, ACT
- Australian Nursing Federation (ANF), Phillip, ACT
- Australian Practice Nurses Association (APNA), Melbourne
- Cancer Australia (CA), Dickson, ACT
- Central Australian Aboriginal Congress (CAAC), Alice Springs
- College of Nursing (CN), Burwood, Victoria
- Consumers' Health Forum (CHF), Manuka, ACT
- Cooperative Research Centre for Aboriginal Health (CRCAH), Casuarina, NT
- Health Care Consumers' Association of the ACT (HCCA), Hackett, ACT
- Health Disability and Aged Care Gippsland Region (HDAC), Traralgon, Victoria
- Health Workforce Queensland (HWQ), Brisbane
- Indigenous Allied Health Australia (IAHA), Deakin West, ACT
- National Aboriginal Community Controlled Health Organisation (NACCHO), Braddon, ACT
- National Allied Health Advisory Committee (NAHAC), Adelaide
- National Health and Medical Research Council (NHMRC), ANU
- National Institute of Clinical Studies (NICS), Melbourne
- National Primary Health Care Partners (NPHCP)
- NSW Rural Doctors' Network (NSWRDN), Newcastle

- Palliative Care Australia (PCA), Deakin West, ACT
- Primary Health Insurance Administrative Council (PHIAC), Kingston, ACT
- Royal Australian College of General Practitioners (RACGP), South Melbourne
- Royal College of Nursing Australia (RCNA), Deakin West, ACT
- Rural Doctors Workforce Agency (RDWA), Wayville, SA
- Rural Doctors Association of Australia (RDA), Kingston, ACT
- Rural Workforce Agency of Victoria (RWA), Melbourne
- Services for Australian Rural and Remote Allied Health (SARRAH), Deakin, ACT
- Telethon Institute for Child Health Research, Subiaco, WA
- Western Australia Centre for Rural and Remote Medicine (WACRRM), Nedlands, WA

Government Departments

- ACT Department of Health, Canberra
- Commonwealth Department of Health and Ageing (DoHA), Canberra
- New South Wales Department of Health, North Sydney
- Northern Territory Department of Health & Community Services, Casuarina, NT
- Queensland Department of Health, Brisbane
- South Australian Department for Families and Community, Adelaide
- South Australian Department of Health, Adelaide
- Tasmanian Department of Health and Human Services, Hobart
- Victoria Department of Human Services, Melbourne
- Western Australian Department of Health, Perth.

APHCRI's current or recent committee participation

- ACT Primary Health and Chronic Disease Strategy Committee
- Evaluation Sub-committee, Medicare Services Advisory Committee, DoHA
- National Mental Health Consumer Reference Group
- Health Care Consumers' Association of the ACT Executive Committee
- beyondblue blueVoices consumer and carer reference group
- Reconciliation Action planning sub-committee, ANU College of Medicine, Biology and Environment, ANU
- Australian Institute of Policy and Science Board
- Menzies Centre for Health Policy Advisory Board
- Menzies School of Health Research - Darwin Board
- PHC RIS Advisory Committee
- The John Curtin School of Medical Research Foundation - Board
- The Sax Institute - Board

- Medicine in Australia: Balancing Employment and Life (MABEL) - Advisory Group
- MAGNET Steering Committee
- PHCRIS Steering Committee
- Australian Healthcare and Hospitals Association (AHHA) National Council
- Primary Health Care Advisory Board
- Deeble Institute Board

Appendix G: Interview informants

Ms Sue ANDREWS	Health Care Consumers Association (HCCA)
Dr Nasser BAGHERI	APHCRI ANU
Dr Michelle BANFIELD	APHCRI ANU
Prof Emily BANKS	APHCRI Network
Ms Julie BATES	C'wealth Department of Health and Ageing (DoHA)
Mr Mark BOOTH	C'wealth Department of Health and Ageing (DoHA)
Mr Chris CARLILE	C'wealth Department of Health and Ageing (DoHA)
Ms Mier CHAN	APHCRI ANU
Ms Darlene COX	Health Care Consumers Association (HCCA)
Dr Len CROCOMBE	APHCRI Network
Ms Jane DESBOROUGH	APHCRI ANU
Prof James DUNBAR	APHCRI Network
Dr Karen GARDNER	APHCRI ANU
Ms Michelle GRYBAITIS	Australian Medical Association (AMA)
Prof Jane GUNN	APHCRI Network
Prof Jane HALL	APHCRI Network
Prof Mark HARRIS	APHCRI Network
Emeritus Prof John HUMPHREYS	RAB member and APHCRI Network
Prof Clare JACKSON	APHCRI Network
Dr Tina JANAMIAN	APHCRI Network – Project Manager
Ms Tanisha JOWSEY	APHCRI ANU
Mr Paul KONINGS	APHCRI ANU – 2 interviews
Ms Lisa LAVEY	APHCRI Network – Project Manager
Dr Jane LLOYD	APHCRI Network
Prof John MARLEY	RAB Chair
Prof Robyn McDERMOTT	APHCRI Network
Mr Patrick McGOWAN	Health Care Consumers Association (HCCA)
Dr Ian McRAE	APHCRI ANU – 2 interviews
Dr Soumya MAZUMDAR	APHCRI ANU
Ms Roxanne MISSINGHAM	ANU Librarian (Chief Scholarly Information Officer – Repository/Digital Collections)
Mr Doug MONCUR	Repository/Metadata manager ANU
Ms Megan MORRIS	C'wealth Department of Health and Ageing (DoHA)
Mr Martin MULLANE	Australian Medical Association (AMA)
Dr Lucio NACCARELLA	APHCRI Network
Ms Hope PEISLEY	C'wealth Department of Health and Ageing (DoHA)
Dr Sharon PONNIAH	APHCRI Network
Prof Grant RUSSELL	APHCRI Network
Dr Lesley RUSSELL	APHCRI ANU
Dr Ginny SARGENT	APHCRI ANU
Dr Catherine SPOONER	APHCRI Network
Prof John WAKEMAN	APHCRI Network
Prof Lucy K WALTERS	APHCRI Network

Ms Laurann YEN APHCRI ANU – two interviews