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Consumer and community engagement in successful grants

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UniSA Research Office (URO)
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Acknowledgement of Country

We respectfully acknowledge the Traditional Owners of the land and waters on which we meet today – the Kaurna People – and acknowledge their continued spiritual and physical connection to these lands. We would like to pay our respects to Elders past, present, and emerging, and extend that respect to First Nations people here today.

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Criteria across all grants

- ✓ Priority – Why?
- ✓ Method – How?
- ✓ Team – Who?

- Meaningful consumer or community engagement can and should be embedded into all aspects of grant criteria

- Examples from two successful grant applications illustrating how to operationalise consumer and community engagement via aims and objectives, methods, budget, and plans

Successful grant examples

- A. 2022 MRFF Effective Treatments and Therapies: *Small Steps towards personalised dementia prevention* - Dr Ashleigh Smith
- B. 2022 MRFF Quality, Safety and Effectiveness of Medicine Use and Medicine Intervention by Pharmacists: *Establishing the PHARMA-Care quality monitoring program in aged care homes* - Dr Janet Sluggett
- Available via URO's Successful Grant Library
- See also: Consumer engagement resources – Learning - on URO's MRFF website

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Priority - A

Synopsis

Dementia has the unenviable claim as Australia's second leading cause of death. With no treatment breakthroughs, the number of people living with dementia will increase from 472,000 to 1.1 million Australians by 2058. Individual modifiable risks, including physical inactivity, could prevent up to 40% of late life dementia.

We will genuinely collaborate with older adults (priority population), and partner with local councils and aged care providers to co-design a personalised intervention called Small Steps. We will then embed this intervention into our already developed My Best Day smart phone application and finally we will evaluate its feasibility in older adults most at risk of dementia.

Our Small Steps intervention will support older adults at risk of dementia to make healthier choices about physical activity, whilst also giving them the flexibility to keep constant the lifestyle behaviours they cannot, or would prefer not to change (like an unavoidable commute or looking after grandchildren).

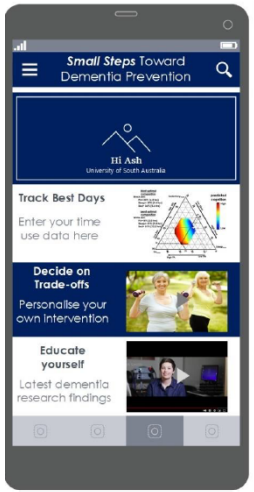
Our study comprehensively addresses the Stream 2 objectives of the 2022 Effective Treatments and Therapies grant opportunity in the following ways: (1) We have established key community partners in local councils and aged care providers and we will co-design the personalised Small Steps intervention with the older adult priority population, (2) we will then validate our approach in older adults most at risk of dementia and finally, (3) working with our project partners (local council and aged care) we will rapidly disseminate our research findings to people who most need it.

A. Project impact

Our study *"Small Steps* towards personalised dementia prevention" comprehensively addresses the **Stream 2** objectives by **conducting implementation research** with **older adults** to validate our personalised dementia prevention intervention and support early adoption.

Primary aim: To co-design, implement and evaluate a personalised, technology-assisted physical activity intervention called *Small Steps,* which promotes positive behaviour changes to reduce dementia risk factors.

Our research shows only 19% of the Australian public have a good understanding of dementia and its risk factors (4). We have identified that people need 1) access to evidence-based information about modifiable risk factors (like physical inactivity) that contribute to the development of dementia and 2) individualised support to help them make healthier choices regarding dementia risk factors, but also the flexibility to keep constant the lifestyle behaviours they cannot, or prefer not to, change (like an unavoidable commute or looking after grandchildren).



To address this knowledge gap, **we will combine evidence-based dementia prevention advice with an individualised behaviour-change intervention co-created with our established community, primary care and service provider partners.** In doing so, we will address the following study aims:

Aim 1: Co-design the *Small Steps* intervention and extend the existing *My Best Day* smartphone application with this new functionality to promote lifestyle behaviour change (see Figure 1).

Aim 2: Partner with local councils and service providers (with AIs Di Venuto and Rosso, Onkaparinga Council and ACH Group) to implement *Small Steps* in adults at risk of dementia.

Aim 3: Evaluate implementation success using measures of behaviour change (time spent in physical activity), recruitment, retention, acceptability, barriers to feasibility, safety and enjoyment and disseminate our findings broadly.

Figure 1 *Small Steps* will be embedded into our already developed **My Best Day** smartphone APP (left). Older adults will be supported to personalise interventions based on preference and individual health needs. Intervention supports will be personalised and findings disseminated back to users.

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Priority - B

Improving medicines use in RACFs is a public priority. It is the most common reason for complaints to the Aged Care Quality and Safety Commission and it was the focus of one-third of all public submissions to the Royal Commission.[1, 11] Close engagement with ROSA's Consumer Advisory Committee has been a consistent feature of our work in line with the first key principle of the *National Strategy for Quality Use of Medicines,* which recognises the primacy of consumers.[15] Our proposal has similarly been shaped with input from this committee, which will continue across the co-design of our quality framework, evaluation, national plan, and consumer summaries with consumer representatives Ms Sheppeard (ROSA Consumer, former RACF physiotherapist) and Ms Quirke (aged care nurse) (**Appendix B**). Residents and family will be invited to participate in interviews and workshops to ascertain their needs and preferences for onsite pharmacists work models and QUM indicators, and provide input into the national quality framework.

The steering group and overall research team will receive advice and feedback from the PHARMA-Care Project Advisory Group and the PHARMA-Care Consumer Advisory group. The project advisory group will meet twice per year and include representatives from our 13 project partner organisations, along with other key stakeholders. The consumer advisory group will be chaired by CI Corlis (an experienced aged care executive and registered nurse with expertise in driving strong collaboration between aged care providers, consumers, and researchers). and will include two experienced consumer representatives with professional experience working in RACFs and lived experience as informal carers for family members living with dementia.

Specific project objectives will be overseen by objective-specific working groups comprising selected CIs who will contribute to that objective along with other relevant members of the project team. CIA Sluggett will meet with the research staff employed on the project each week. PhD candidates will meet with their supervisors on a weekly basis initially.

Throughout our project, we will maintain strong links and regular interaction with the Registry of Senior Australians (ROSA) Consumer and Community Advisory Committee. By drawing on existing ROSA infrastructure, we will benefit from regular insights provided by ROSA's Steering Committee (established in 2017) and ROSA's Consumer and Community Advisory Committee, and we will benefit from ROSA's experiences with effective engagement between researchers, consumers, and aged care providers.

This four-year project will generate new evidence, including:

a) Understanding of stakeholder needs/perspectives to improve pharmacist interventions.

It is crucial to understand stakeholder needs/perspectives relating to pharmacists' activities, integration within the aged care team, and the use of quality indicators as part of the new onsite pharmacist model of care.

Expected outcomes: We will ascertain the common elements of onsite pharmacist services in RACFs that stakeholders consider to be important, key metrics for monitoring service quality and QUM, and barriers and enablers to the use of QUM indicators in RACFs.

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Method - A

Consumer and community engagement
To directly shape and help facilitate the rapid translation of knowledge gained, the project will be guided by an end-user advisory group. Based on our previous experience in co-design, this group will be composed of 6 older adults and 6 primary health professionals recruited from our existing networks. The group will meet quarterly and oversee all aspects of the project.

Phase 1: Co-design the *Small Steps* intervention (12 months)
With our previous funding we have developed a prototype of the *My Best Day* app (Figure 1) in consultation with community stakeholders. This prototype allows older adults to enter information around their current life. If funded here, we will continue the co-design process by sharing the prototype with the community, allowing iterative design steps to meet the needs of end users and inform our bespoke *Small Steps* intervention (See Figure 3).

Groups of Allied Health Professionals (recruited from ACH Group), Care workers (recruited from ACH Group) and older adults (Recruited from Council partners) will be invited to co-design the *Small Steps* intervention in Phase 1. Using an iterative co-design process, a range of evidence-based resources that can be delivered through the app to support behaviour change will be co-designed and added to the app. For example, if a participant needed to increase physical activity but not modify sleep, personalised resources would be made available to help them make evidenced-based trade-offs with other types of negotiable behaviours (i.e., TV viewing or passive transport).

A series of 10 three-hour workshops (one per month for 10 months) will be conducted to identify the key priorities and refine the features of the intervention. Attendees will include representative stakeholders from allied health, aged care and local council.

Between the workshops, software developers (supervised by CI R Smith) will make iterative changes to the *Small Steps* technology interface. Once a *Small Steps* intervention prototype is available within the *My Best Day* tool, we will conduct usability testing by recruiting 10 members of the public. We will assess ease of use, accessibility and functionality via observations of tool use and interviewing participants. Further refinements to the intervention and/or the app interface will be made iteratively, as required.

Phase 2: To evaluate the success of *Small Steps* (24 months)

Study overview: Using a holistic time-use intervention approach, our team will for the first time, characterise the effect of an evidenced-based intervention on changes in time-use behaviour. We will partner with local council areas and service providers to implement a community-delivered intervention. Our partners will be crucial for intervention success and will provide facilities for assessments to occur, and links to already established healthy ageing programs, community groups and transport facilities to support participants with mobility and accessibility issues.

We will recruit older adults most at risk of dementia (older population, low physical activity levels, lower socio-economic status areas). Participants will be assessed face-to-face by trained research staff at study Enrolment, and completion of the Introduction, Implementation and Maintenance Stages. The trial will involve comprehensive assessments including detailed demographics, anthropometry and time-use assessments.

Recruitment: Infrastructure for recruitment and follow-up is already in place at the UniSA, Clinical Trials Facility. This includes a centrally funded Clinical Trials Manager who will coordinate participant clinic appointments and process participant reimbursement payments. We have a proven track record of recruiting older adults at risk of dementia, including successfully recruiting 448 older adults for the NHMRC funded ACTIVate study between August 2020 and Dec 2021 (GNT1171313). Recruitment will also be assisted by our partners at ACH, The Onkaparinga Council, and contacts within the Office of Ageing Well. Randomisation to the intervention group (*Small Steps*) or the control group (generic health advice) will employ permuted blocks to ensure differences in the planned ratio of control and intervention recruitment does not exceed two (using a block size of eight for unequal allocation ratio of 3:1, see power analysis section).

Dissemination (3 months): We will work collaboratively with local council stakeholders, the consumer and community engagement group and Animate Your Science to ensure rapid dissemination of research findings to the broader community. A detailed dissemination plan will be developed within the first quarter of the grant and executed throughout each phase of the study. Our experience tells us that the target population are high users of social media (including Facebook), radio (including local talk back radio) and prefer pamphlet style infographic dissemination. Upon study completion we will work with Onkaparinga Council and ACH Group to co-create a social media campaign that could be disseminated through targeted Facebook adverts encouraging older adults to take control of their own dementia risk using the *Small Steps* approach. By partnering with Radio Adelaide, we will disseminate the findings of the study through our already developed Podcast series (Re-imagining ageing, **CIs A Smith** and **Wade**). Re-imagining was co-produced with CI's **A Smith** and **Wade** and Radio Adelaide in 2021 and is already available on all major streaming services including (iHeartRadio, Spotify, Google Podcasts and Soundcloud). We have an established listener base across 9 different countries and have already disseminated 7 episodes covering all aspects of healthy and active ageing (500 unique listeners over past 6 months).

Method - B

METHODOLOGY

Our detailed project plan (attached) outlines our methodological approach. The PHARMA-Care project activities will be guided by the Monash Partners Learning Health System conceptual framework, which supports an integrated team of care providers, researchers, data analysts, consumers/community members and other stakeholders to work together to harness the power of routinely collected health care data to provide new insights into care delivery to optimise health outcomes. This framework is particularly relevant to the Australian RACF setting, where there are numerous ongoing changes in care delivery requirements and increasing use of electronic systems to support patient care, in response to the Royal Commission into Aged Care Quality and Safety and resulting national aged care reforms. In accord, our mixed methods approach includes qualitative work to understand stakeholder needs and preferences, a systematic review and document analysis to synthesise existing evidence, and a consensus-based approach to identifying suitable objective, resident-focused quality indicators and developing a national quality framework. After developing and evaluating the quality indicators using established pharmacoepidemiological techniques using three population-based data sources (i.e., data from ROSA, Ward Medication Management, and Medi-Map) and via pharmacist audit (if required), the indicators will be implemented and evaluated in RACFs using an existing framework for implementation research. Health economic analyses will be undertaken to examine facility-level variation in indicator incidence and related health system costs, and to determine the cost of implementing PHARMA-Care nationally. The final output will be a co-designed national dissemination and translation plan that will guide the implementation of routine monitoring of the quality and outcomes of pharmacist services and QUM throughout all Australian RACFs. These activities will be supported by regular stakeholder engagement via activities with 13 project partners, the project advisory group, and workshops to ensure the final PHARMA-Care quality monitoring program meets the needs of end users.

The steering group and overall research team will receive feedback from the PHARMA-Care Project Advisory Group and the PHARMA-Care Consumer Advisory Group. The project advisory group will meet twice per year to advise on the refinement of project outputs and will include representatives from our 13 partner organisations, along with other stakeholders (i.e., Emeritus Prof Lloyd Sansom, Prof. Julie Ratcliffe, Associate Prof. Craig Whitehead, Ms. Michelle Hogan, **Appendix B**). The consumer advisory group will be chaired by CI Corlis and includes experienced consumer representatives with professional experience in RACFs and lived experience as informal carers for family members living with dementia (Ms. Sheppeard and Ms Quirke, **Appendix B**). Discussions with our consumer representatives while forming the PHARMA-Care project plan identified the need to explore potential quality indicators relating to appropriate use of specific medicines (e.g., psychotropics, opioids, anticoagulants), provision of education to residents and family members, and uptake of pharmacist recommendations by aged care teams as important to residents and family members. Each postdoctoral researcher employed on the project will be

partnered with one of our consumer representatives or a member of the ROSA Consumer and Community Advisory Committee to meet and discuss the project at two-monthly intervals to embed consumer perspectives throughout the project. We have successfully utilised this model for our other ROSA studies to ensure consumer perspectives are truly embedded within our projects.

KEY ACTIVITIES

This pharmacist-led, multidisciplinary project will develop, validate, implement, cost, and disseminate a new national quality monitoring program to support pharmacists and aged care teams to improve QUM and the consistency of pharmacist-related care for residents of RACFs. We will:

1. Explore key stakeholder needs and preferences for pharmacist services delivered to residents of RACFs and resident-focused QUM indicators for a national monitoring program.

Stakeholder needs and preferences will be explored via focus groups and semi-structured interviews with: i) pharmacists, including onsite, accredited, community, and hospital pharmacists, ii) residents/family, iii) RACF staff, including nurses, carers, quality teams, and medication advisory committee members, iv) general medical practitioners (GPs) and v) policy makers.

3. Develop and disseminate an evidence-based national quality framework for the comprehensive delivery of pharmacist services to residents of RACFs.

A consensus-based process will be used to obtain agreement on appropriateness of key care domains and related quality indicators identified in the preceding activity. Using these results, together with the information on stakeholder needs and preferences obtained above, a national quality framework that describes the top priorities for pharmacist care and QUM in RACFs, aligned with quality indicators and key monitoring recommendations will be developed and disseminated for national implementation.

6. Develop a national dissemination and implementation plan for successful program scaling.

Our project team and partners will co-create a national implementation plan with costings to guide translation of the PHARMA-Care quality monitoring program into policy and practice. Dedicated time has been allocated within the project period to conduct dissemination and translation activities with our project partners.

Our proposal leverages a critical window of opportunity to equip aged care teams with the framework and data urgently needed to improve the safe and effective use of medicines in RACFs. Onsite and community pharmacists, aged care providers, GPs and policy makers will be able to use the robust knowledge generated from this project to reduce medicines induced harm, improve resident health and wellbeing, and enable finite resources to be directed to high-value care.

Team - A

Co-design and translation: **CIE Laver**, CIA/CIB on two NHMRC funded national translational research projects which demonstrated the ability to improve the quality of care for people with dementia (116 pubs, 4104 cites, $8.8 M). She has a strong reputation for genuine collaboration with patients and members of the public, having co-ordinated two citizen's juries and the first NHMRC-approved Clinical Practice Guidelines for Dementia. **CIJ Rogers** (10 pubs, 175 cites, $75K) has specific expertise in co-designing lifestyle interventions with study participants.

Software and smart phone technology development: **CIG R Smith** has extensive experience with the design and development of interactive systems and user interface design methodologies that wil support our *Small Steps* app (32 pubs, 1433 cites, $3.5M). His research on novel interaction devices and sensing technologies for immersive systems has captured IP through four granted US patents.

Over the past 5-years we have regularly implemented our research within local council programs and evaluated the outcomes. In 2020, we co-developed and evaluated a bespoke suite of evidence-based wellbeing materials that could be implemented across different community groups and upscaled broadly with **Onkaparinga City Council (collaboration: Di Venuto)**. In 2021, we evaluated a council delivered Daily Moves activity program designed to link older adults with healthcare, sporting and exercise providers to enhance physical activity with **Unley City Council**. Leveraging the availability of the "My Best Day" tool prototype this important and timely study will build on these established collaborations by co-designing, implementing and evaluating the feasibility of a personalised time-use intervention called *Small Steps*.

therapy researcher in dementia care in Australia, despite her early career status. CI Laver has established herself as a researcher with a reputation for genuine collaboration with patients and members of the public. A/Prof Laver's track record is strong and follows an upwards trajectory;

Community engagement leading to information about the preferences of patients and members of the public (via coordination of two citizen's juries).

Community engagement and participation: Co-created, implemented and evaluated a dementia education intervention in primary school (2x publications) and co-created well-being materials for older adults with Onkaparinga City Council.

Community engagement and participation: Media: The Conversation (12 articles, 2M readers); New Philosopher (4 articles); Australasian Science (regular column to 2016). Prof Olds appears regularly on TV, radio and in print media (approx. 50 interviews p.a.).

Community engagement and participation: 5 media releases in the last year picked up by 254 media outlets, potentially reaching a community audience of 3.21 M. Invited lead of the World Health Organization policy brief on Physical Activity (Health Promoting Schools initiative, 2022).

Community engagement and participation: The Conversation (1 article; >100,000 views), co-creator of the podcast series 'Reimagining Ageing'. Interviewed by national and international news (The Times UK, Nine News Australia, ABC Radio) and lifestyle (Bottom Line, Your Life Choices) media. Presented at national community forums including the Australian Association of Gerontology's 'Lifestyle and Healthy Brain Ageing' Seminar (2019), and the Nutrition Society of Australia's 'Impact of Nutrition on Cognition and Mental Health' Seminar in Geelong (2020, expenses covered).

Community engagement and participation: Researcher chair of the Flinders Health and Medical Research Institute Consumer Advisory Board. Multiple applications of deliberative engagement techniques in research.

Key community engagement

- 2020: co-designing a wellbeing program for older adults with the City of Onkaparinga.
- 2018: running an intergenerational dementia education program with the City of Unley.
- 2015-2021: SA Brain Bee Co-coordinator.

Community engagement and participation: With extensive experience working with consumers, CI Corlis set up a large successful engagement program called Turn up your Voice for >3000 people receiving aged care services, this was replicated by several other agencies.

STAKEHOLDER AND END USER ENGAGEMENT

Improving medicines use in RACFs is a public priority. It is the most frequent reason for complaints to the Aged Care Quality and Safety Commission. Close engagement with the ROSA's Consumer and Community Advisory Committee has been a consistent feature of our work, in line with the first key principle of Australia's National Strategy for Quality Use of Medicines: the primacy of consumers. Our PHARMA-Care proposal has similarly been shaped with input from this key ROSA governance committee, which will continue across the co-design of our quality framework, evaluation, national plan, and plain language summaries with our PHARMA-Care Consumer Advisory Group. Residents and family members will be invited to participate in interviews and workshops throughout the project to ascertain their needs and preferences for onsite pharmacist work models and QUM indicators in RACFs.

End-user engagement has been prioritised across all stages of this cutting-edge project to ensure the broader community engages with and adopts the PHARMA-Care program. Our 13 project partner organisations have been carefully chosen to complement existing initiatives and with our multiple end-users in mind to support meaningful translation: pharmacists, nurses, GPs, aged care providers, industry, and the Aged Care Quality and Safety Commission. CI Sluggett and Emeritus Professor Lloyd Sansom (member of our PHARMA-Care Project Advisory Group, and former Senior Advisor to the Australian Government Department of Health) discussed aspects of this project with the Department of Health Pharmacy Programs team (who administer funded programs) in early 2022 and we will invite a representative from that team to join our project advisory group at commencement. Health Translation SA (an NHMRC-accredited Research Translation Centre at SAHMRI) will review policy briefs and assist with dissemination of our fully costed national implementation plan to drive national scaling and rapid translation of outcomes into policy and practice.

Team - B

Consumer Advisory Group	
Ms Megan Corlis (Chair)	Academic Liaison for Aged Care, University of South Australia. Director, Aged Care & Research, Australian Nursing and Midwifery Federation (SA Branch).
Ms Anna Sheppeard	Consumer advisor with lived experience caring for a family member living with dementia, and former physiotherapist in an aged care facility. Member of the Registry of Senior Australians (ROSA) Consumer and Community Advisory Group.
Ms Lyntara Quirke	Consumer advisor with lived experience caring for family members living with dementia and special interest in quality use of medicines. Registered nurse with considerable experience practicing in residential aged care settings.

Community engagement and participation: CI Caughey leads ROSA's Consumer and Community Engagement, which is SAHMRI's exemplar for community engagement. CI Caughey is a Non-Executive Director of Life Care Aged Care Services (2021-). CI Caughey received SAHMRI's Research Translation award in 2020 (Individual) and 2019 (ROSA team).

Community engagement and participation: CI Khadka regularly communicates his research to the public. For example, he has delivered 3 radio interviews, 4 public lectures, and multiple training workshops. CI Khadka co-authored an article on ageing for The Conversation with >25,000 reads.

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Budget - A

Other Research Costs Summary

Other Research Costs Summary						
Item	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Consumer and community engagement group	$600	$600	$600			$1,800
Activity trackers (Axivity AX3)	$0	$2,400	$0			$2,400
Recruitment - Advertising	$1,000	$1,000	$0			$2,000
Transcription costs - Kate Laver	$10,000	$0	$0			$10,000
Co-design workshops	$21,000	$0	$0			$21,000
Software development	$30,000	$10,000	$10,000			$50,000
Participant reimbursement	$4,000	$5,100	$5,100			$14,200
CANTAB	$0	$4,099	$0			$4,099
Dissemination - Animate Your Science	$0	$0	$5,000			$5,000
	$66,600	$23,199	$20,700			$110,499

Other Research Costs	
Item	Justification
Consumer and community engagement group	The project will be guided by an end-user advisory group who will meet every 6 months. The advisory group will involve clinicians, older adults, representatives from local council and knowledge translation experts. We will reimburse advisory group members for their travel costs associated with the meeting (6 people x $50 x 2 meetings per year = $600 per year).
Activity trackers (Axivity AX3)	To objectively measure time use we budget for 10 activity trackers. Ten units (1 per 7 participants) @ $220 ea. and 2x charging cradles ($99.95 ea.) will be needed.
Recruitment - Advertising	Experience shows us that we can recruit using Facebook. We budget for 6 targeted Facebook adverts for 2 weeks per advert (~$300 per advert). Total = $2000.
Transcription costs - Kate Laver	To cover the costs of transcription and development of key themes during the co-design phase (Year 1) we budget $10,000.
Co-design workshops	Co-design of the Small Steps intervention will occur in Year 1. Our Partners (ACH Group and Onkaparinga) will provide key staff to participate in 10 x 3 hour co-design workshops, plus up to 4 other staff (per workshop). We budget for a total of 312 hours across the life of the project to enable staff the flexibility to join the workshops, to assist with coordination and recruitment for Phase 2 and to provide reflections, liaison and internal coordination of the evaluation.
Software development	Infrastructure for the My Best Day tool is already available. We request funding for the incorporation of the Small Steps Intervention into My Best Day. We budget for $5,000 of software development to occur between each of the co-design workshops 4 - 10. In Years 2 and 3, we budget for $10,000 of software development to repair any bugs that may arise.
Participant reimbursement	Older adults in Phase 1 will be reimbursed for their time @ $50 per workshop. 8 older adults will be required to attend 10 co-design workshops. 8 Older adults x 10 workshops = $4000 (Year 1). Participants will be reimbursed for the cost of attending the face to face visit in Phase 2 ($50 per visit, to cover travel and parking) total $150 per participant. For 68 participants this will cost $10,200. This will be split across years 2 and 3.
CANTAB	CANTAB assessment will enable sensitive secondary assessment of cognitive domains most affected by dementia. For Phase 2, we will need one CANTAB assessment per participant at study enrollment and one assessment at end of the implementation phase. Total CANTAB assessments is 68 x 2 = 136. A 250 test administration license for unlimited devices is $3370. To administer the assessments we will need one tablet device (IPad) $729.
Dissemination - Animate Your Science	To facilitate fast dissemination of the research findings to the general public we will collaborate with Animate your Science to generate an info-graphic and social media campaign.

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Budget - B

CI travel to Canberra for dissemination and translation activities	0	0	0	0	3,380	3,380
TOTAL	0	6,100	0	6,100	3,380	15,580
Equipment						
SURE access	0	0	13,200	10,800	0	24,000
TOTAL	0	0	13,200	10,800	0	24,000
Other						
Interviews/focus groups and validation workshop	0	21,000	0	0	0	21,000
Expert Consultations	0	21,000	0	0	0	21,000
Workshop costs	0	2,250	0	0	2,250	4,500
Data provision and assistance from Medi-Map	0	10,000	15,000	0	0	25,000
Data provision by Ward Medication Management	0	1,875	0	0	0	1,875
Data collection by pharmacists	0	0	18,000	0	0	18,000
Training sessions for aged care facility staff	0	0	0	19,200	0	19,200
Interviews/focus groups	0	0	0	5,700	0	5,700
General medical practitioner (GP) engagement costs	0	600	600	600	600	2,400
Consumer engagement costs	1,566	3,132	3,132	3,132	1,566	12,528
PHARMA-Care logo	2,000	0	0	0	0	2,000
Production and dissemination of national framework and national plan	0	0	5,000	0	5,000	10,000
TOTAL	3,566	59,857	41,732	28,632	9,416	143,203
TOTAL REQUESTED	**103,256**	**303,571**	**474,379**	**508,362**	**109,525**	**1,499,093**

OTHER RESEARCH COSTS: Other funds requested ($143,203) encompass reimbursement for consumer representatives, RACF staff, and interview and expert panel participants, and reimbursement for data provision from Medi-Map and WardMM. Two workshops will facilitate stakeholder input into the national quality framework (year 2) and the national dissemination and translation plan (year 4). These expenditures are essential to ensure involvement of key stakeholders throughout the research program, from co-design to the successful translation into practice and policy.

PARTNER CONTRIBUTIONS

A wide range of partners will contribute to PHARMA-Care, reflecting the need and wide-ranging support for a national quality monitoring program for QUM and pharmacist practice in RACFs. Our 13 confirmed partners include organisations representing pharmacists, GPs, nurses and care workers, aged care providers, industry providers, and the Aged Care Quality and Safety Commission. These partners will aid with recruitment of interview and expert panel participants, contribute to workshops, and participate in the project advisory group that will monitor the relevance of project outcomes and assist with translation activities. These contributions will ensure our project is truly embedded within a learning health system, and that our final product is a nationally scalable quality monitoring system. In-kind contributions, namely through the provision of expertise, will be made by chief investigators and project advisory group members. The total estimated value of our in-kind partner contributions is $607,545.

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Risk management plan

E. Overall Value and Risk of your project
E1: Risk Management Plan

Risk theme	Risk	How risk is mitigated / managed
People	Recruitment: There is a risk that we will not be able to recruit the required participants for the intervention study.	Low Risk (1) Established relationships with community and council partners (2) Provisions in the budget for recruitment via social media. (3) CI Smith has successfully recruited 224 older adults for the ACTIVate trial between 2020-2021. We have in place a full-time clinical trials manager who is experienced and will contact all participants for the study and book them in/send reminders
	Stakeholders: Low engagement.	Low Risk (1) We already have established working relationships with stakeholders through previous grants. (2) We have included budget for key stakeholders to be a part of the design process (3) Monthly meetings with stakeholders and advisory team

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MRFF Measures of Success

F. MRFF measures of success statement

Measure of success	How the project will contribute towards the measure of success	Description of outcome or result against which the contribution will be evaluated
Increased focus of research on areas of unmet need.	There are no evidenced based dementia prevention tools that incorporate a holistic, lifestyle approach, representing a critical unmet need.	Development of a freely available tool *My Best Day* embedded with a personally tailored, bespoke intervention, *Small Steps*. Transparent publication of the Co-design process. Dissemination will occur through infographics, podcasts, social media campaigns and through liaising with professional organisations with whom we already have established relationships Dementia Australia, SA Health (Office for Ageing Well, local community groups).
New health technologies are embedded in health practice	Dementia prevention requires a holistic approach, which is also scalable. Our *Small Steps* intervention directly addresses this critical knowledge gap through co-designing health technologies that will be embedded within community and the health practice.	Transparent publication feasibility and acceptability of the Small Steps intervention including barriers and facilitators of the intervention. Future opportunity to link in with the digital health CRC which is based in Adelaide will be sought.
Community engages with and adopts new technologies and treatments	*Small Steps* is a first of its kind interactive technology-delivered dementia prevention tool. The tool will be co-designed with older adults, local councils and primary health professionals. The co-design approach will maximise uptake and adoption of the technology broadly for dementia prevention.	Transparent publication feasibility and acceptability of the Small Steps intervention including barriers and facilitators of the intervention. Iterative feedback of the new technology through stake holder (Consumer and community advisory group) and partner engagement (Lui DiVenuto, Onkaparinga City Council and Dr Edoardo Rosso, ACH Group).

MRFF measures of success statement

Measure of success	How the project will contribute towards the measure of success	Description of outcome or result against which the contribution will be evaluated
Increased focus of research on areas of unmet need	PHARMA-Care focuses on older people in residential aged care facilities (RACFs) where the evidence base is limited and are often excluded from research. We will determine user needs (Obj. 1) & provide critical new baseline data on quality use of medicines (Obj. 4) and the cost of unwarranted variation in medicines-related care (Obj. 5).	We will develop a national quality framework and national implementation plan, together with research papers, reports for aged care teams and translation materials, to embed PHARMA-Care into usual clinical practice to improve quality use of medicines, pharmacist interventions, and resident health outcomes.
New health technologies are embedded in health practice	We will develop, validate, implement, and disseminate a new evidence-based system to improve the safety and quality of medicines-related care in RACFs. It will enable health professionals and RACFs to efficiently benchmark their performance, prioritise areas for improvement, to improve resident health and wellbeing.	We will work with end-users to determine feasibility, acceptability, and usability of PHARMA-Care in RACFs. Pharmacists and RACFs will have access to indicator results. In conjunction with project partners, a fully costed national plan to facilitate implementation in all Australian RACFs will be developed and disseminated.
Research community has greater capacity and capability to undertake translational research	Our multidisciplinary team includes EMCR and senior-career clinician researchers. We will recruit EMCRs and 2 PhD candidates to increase researcher capacity. Team members will contribute to meetings, mentoring, and co-authoring publications and reports to facilitate sharing of expertise. We will be supported by a project advisory group that includes key stakeholder groups. We will work with project partners and RACFs to implement, evaluate, and translate project findings.	Working closely with Health Translation SA will increase our capability to undertake translational research using the learning health system conceptual framework. This collaborative project bringing together pharmacists/clinicians, aged care industry, peak bodies, policy makers, and the community will promote meaningful exchange of ideas, and provide researchers with feedback on the PHARMA-Care outcomes and refine their end-user engagement skills.
The community engages with and adopts new technologies and treatments	Two consumer representatives with expertise/interests in dementia, aged care and quality use of medicines will provide input during the project. ROSA's Consumer & Community Advisory Committee will also be involved in the project. Residents, family, and RACF staff will be involved in developing the quality framework (Obj. 1 and 3), co-design of intervention materials, implementation in RACFs (Obj. 4), developing the national plan, and dissemination and translation activities to promote awareness and support of PHARMA-Care (Obj. 6).	Direct input into the project design and conduct will be provided by consumers and stakeholders (e.g., aged care providers, policy makers) through advisory group membership, regular one-on-one discussions between consumer representatives and postdoctoral researchers, contributions to interviews and workshops, review of consumer plain language summaries, and review and endorsement of i) the national quality framework and ii) the national dissemination and translation plan.

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Meaningful and authentic engagement

- Consumer and community engagement should be built over time
- Both project examples leveraged pre-existing relationships with their different consumer and community groups
- Building relationships takes time, trust, openness

Our unique and strategic partnerships directly align with the Preventative and Public health Research Initiative. A critical strength of our project is leveraging already established partnerships with local councils (AI Di Venuto) and service providers (AI Rosso). This will ensure a truly co-designed *Small Steps* product by collaborating with older adults, councils, and health care professionals working at the forefront of dementia prevention and care (ACH Group).

We have commenced community consultation. Led by CI Laver's team (Flinders), our interviews with 19 older adults (14 women) and 5 Health Professionals between Sept and Dec 2021 revealed they would use a technology delivered *Small Steps* intervention administered through the *My Best Day* app (number of older adults responding positively = 16). *"...I think, it would be a really well accessed app"* (older adult). Other participants highlighted the need for primary care and allied health dissemination *"... I think the greatest driver would be your GP"* (older adult). Health professionals interviewed so far, shared similar positive comments about the tool describing the need for support and accountability for users *"...you need that either one-on-one or group support where they can check in, and be slightly accountable, or have that personal feedback"* (publication in preparation).

Issue identified	Feasibility description
Technical feasibility	
Strengths	Strengths of our project design include: • The utilisation of a robust mixed methods approach to develop, validate, implement, cost, and disseminate a national quality monitoring program, that includes qualitative research, systematic review and document analysis, consensus-based decision making, pharmacoepidemiological studies using population-based data sources, implementation research, economic analysis, and dissemination and translation activities. • The use of national, routinely collected linked health data and electronic medicines administration chart data to evaluate the PHARMA-Care quality indicators will minimise the burden of manual data collection for pharmacists and aged care providers, enable quality indictors to be risk-adjusted to facilitate comparisons across sites, and minimise the risk of bias that can arise with self-reporting of indicator results. • End-user and consumer engagement has been prioritised across all stages of this innovative project, with dedicated time for interactions and feedback from consumer representatives and our project advisory group built into the project design. Our project plan includes dedicated time and resources to contribute to the development of a fully costed national dissemination and translation plan to assist future program scaling, and to participate in effective translation activities with our project partners to facilitate sustainability for the future.
Achievability of planned recruitment targets	Our planned recruitment targets are realistic, achievable and will provide sufficient sample size to achieve our project objectives. • For Objective 1, we plan to interview up to 60 stakeholders to understand their needs and perspectives. We have secured support from Eldercare to facilitate invitations to their residents, family members and staff, which demonstrates the feasibility of this activity, and we will recruit other aged care provider organisations to be involved to obtain a representative sample of views. • For Objective 3, we plan to include 25 Australian experts in our Delphi round, which is in keeping with the sample sizes of previous consensus-based studies conducted by CIs Peterson and Hibbert to reach expert agreement on quality indicators. • For Objective 4, our population-based data sources will include Medi-Map (which captures data for >10,000 residents annually), data collected by WardMM pharmacists (which provide care for ~30,000 RACF beds annually) and ROSA (which captures data for all 240,000 residents of aged care facilities nationally). Hence our analyses will be sufficiently powered and generalisable to aged care facilities nationally. • For Objective 4, we will implement the quality indicators with 20 aged care facilities (from up to five aged care provider organisations) which will provide sufficient sample size to explore feasibility, acceptability, and utility. We have secured support from project partner Eldercare (who maintain eleven aged care facilities in South Australia), which demonstrates the feasibility of this activity, and we will recruit other aged care provider organisations to be involved to obtain a representative sample of views.

Final thoughts

- Engagement connects research to real-life experiences, grounding the work
- “Nothing about us without us”
- Meaningful, genuine, and well-supported engagement positively impacts research
- Public funding should demonstrate its value through community involvement
- Advocates can mentor and speak alongside researchers, benefiting early-career researchers
- Involving consumers and communities enhances grant writing, ensuring clear and relatable language is used

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Thank you!