



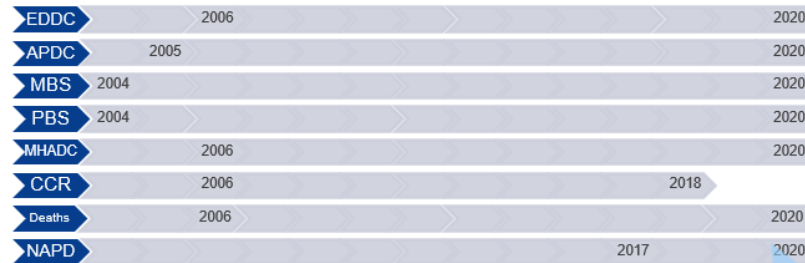
# CES Primary and Community Health Cohort/Linkage Resource

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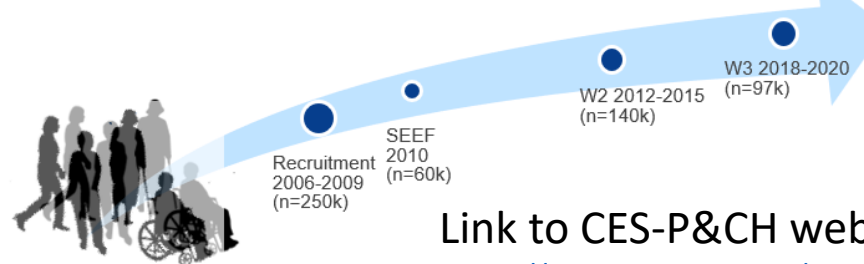
- **Cohort:** over 250k NSW residents (45 and Up Study); 30,645 in CES (20,337 in SES and 10,308 in Sydney)
- **Resource:** 10 datasets; over 172.7 mil records in NSW and 20.7 mil recodes for CES; 2006 onwards.



## Longitudinal data within the resource

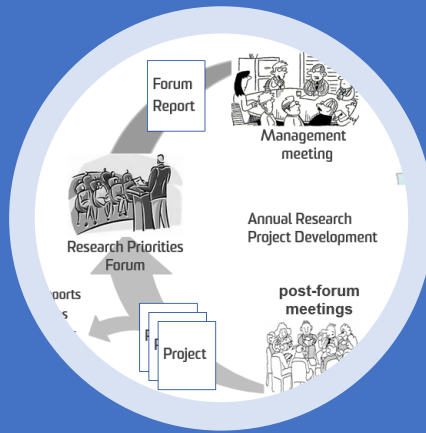


Modified from figure in Bureau of Health Information. Data Matters – Linking data to unlock information. The use of linked data in healthcare performance assessment. Sydney (NSW). 2015; BHI



Link to CES-P&CH web page:

<https://cphce.unsw.edu.au/research/health-system-integration-and-primary-health-care-development/central-and-eastern-sydney>



# CES-P&CH major stages and summary of research








Phase 1 projects:  
Integrated care;  
GP follow-up after hospitalisation

Phase 2 projects:  
loneliness, predictors of service use in older people, reducing preventable hospitalisations, health of carers, weight and ageing






Phase 3: Workplan developed from research priority annual forums (2021 projects: transition hospital to home, diabetes and CVD, telehealth)



# Summary of Research: Previous Research Projects

Research Projects		Evidence	Application
	<b>Impact of care plans on health outcomes</b>	<ul style="list-style-type: none"> <li>Well-targeted towards those with chronic and complex care needs</li> <li>Physiotherapy appear to reduce hospitalisations</li> </ul>	<ul style="list-style-type: none"> <li>Targeting services to need</li> <li>Evidence for expanding number of allied health services per year</li> </ul>
	<b>Impact of GP follow-up after hospitalisation on re-admissions</b>	<ul style="list-style-type: none"> <li>Difference between high and low GP users</li> <li>30% reduction in 12-month re-hospitalisation</li> </ul>	<ul style="list-style-type: none"> <li>More liaison pre/post hospitalization</li> <li>Explore other Innovative models of care</li> </ul>
	<b>Association between social isolation and health service use</b>	<ul style="list-style-type: none"> <li>No difference in high service</li> <li>No difference in mortality</li> <li>2020 understanding loneliness</li> </ul>	<ul style="list-style-type: none"> <li>Understand perceptions</li> <li>Impact over time</li> <li>Impact of COVID</li> </ul>
	<b>Predictors for high service use in older people</b>	<ul style="list-style-type: none"> <li>High services use (except for ED) based on the ability to pay</li> <li>ED use higher as age</li> <li>ED use predictor of mortality</li> </ul>	<ul style="list-style-type: none"> <li>Understand differences between perceptions and reality</li> <li>Exploring options to meet service needs</li> </ul>
	<b>Health of Carers</b>	<ul style="list-style-type: none"> <li>12% carers at any time (although only 5% carers full 5 years others transition in and out of carer role)</li> <li>Mortality lower in those coping well</li> <li>Exploring difference <math>\leq 10</math>hrs v <math>&gt; 10</math>hr</li> </ul>	<ul style="list-style-type: none"> <li>Identifying carers and needs of during routine care</li> <li>Providing support for people transitioning in and out of carer role</li> </ul>

# Summary of Research: Current Research Projects

Research Projects	Questions/exploring	Findings	
	<p><b>Weight and Ageing</b></p>	<ul style="list-style-type: none"> <li>Examine impact of primary care initiatives on weight loss in those with BMI of 30-40</li> <li>Examine impact of risk factors/mobility/medications on weight gain (healthy weight or overweight to obese)</li> </ul>	<ul style="list-style-type: none"> <li>Mod PHC factors assoc with weight gain were: current smoker, physical limitations, TCA, high psych distress, psychiatric med use and high BP.</li> </ul>
	<p><b>PHC to reduce PPH and ED visits</b></p>	<ul style="list-style-type: none"> <li>Do people from CaLD backgrounds have more non-urgent emergency department visits</li> <li>Assessing inequalities in all-cause mortality with cardiovascular disease</li> </ul>	<ul style="list-style-type: none"> <li>Overall similar to Aust born;</li> <li>recent arrivals less likely</li> <li>Higher in most disadvantaged</li> </ul>
	<p><b>Telehealth</b></p>	<ul style="list-style-type: none"> <li>Use</li> <li>Satisfaction</li> <li>Change in service use (MBS 2019 v 2020)</li> </ul>	<ul style="list-style-type: none"> <li>44-48% of participants had used telehealth</li> <li>57% reported that it was as good as in-person visit</li> </ul>
	<p><b>Transition hospital to community (including NAP)</b></p>	<ul style="list-style-type: none"> <li>Characteristics of</li> <li>Relationship between seeing a GP/Attending OPD after hospital discharge and rehospitalisation</li> </ul>	<ul style="list-style-type: none"> <li>Understanding NAP data</li> </ul>
	<p><b>Diabetes and CVD – Service use Lumos</b></p>	<ul style="list-style-type: none"> <li>What are the patterns of service use</li> <li>Do treatment patterns, disease progression and milestones differ for GP care vs hospital care</li> </ul>	<ul style="list-style-type: none"> <li>Understanding Lumos data</li> </ul>



# CES Research Priorities Webinar