

Engaging communities for future health:

The Anticipatory Care Action Learning Project

FINAL REPORT

**ANTICIPATORY
CARE PROJECT**

ACTION
LEARNING TO
IMPROVE HEALTH
IN TASMANIAN
COMMUNITIES



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Glossary

We use several acronyms in the report. They are listed here, alphabetically.

AC	Anticipatory care
ACCHO	Aboriginal Community Controlled Health Organisation
CC	Connecting Care (Ulverstone and 7315 postcode AC project)
CCWG	The Healthy Tasmania Chronic Conditions Working Group
CLD	Causal loop diagram
DoH	(Tasmanian) Department of Health
FHOCM	Flinders Island Health Organisation Coordination Meeting (community members and service providers)
H2H	Help to Health (Clarence AC project)
LAG	Local advisory group
OCOC	Our Community Our Care (Launceston AC project)
OHOF	Our Health Our Future (Flinders Island AC project)
PHT	Primary Health Tasmania
PPH	Potentially preventable hospitalisations
PSO	Project Support Officer – employed by the local lead organisations and working with them and with the UTAS team
SDoH	Social determinants of health

The Report

Anticipatory Care at a whole of population level is concerned with reducing inequities through identification of geographic areas and/or specific target groups that are most at risk of preventable serious ill-health and/or deterioration of existing conditions. Key elements include screening, the provision of care pathways and appropriate interventions with monitoring and follow up. It could also potentially include assessment of preventative health needs across communities and at all levels of government to inform the development and implementation of plans to address identified needs.[1]

Vignette. When anticipatory care isn't working—Anne's story

Anne is in her forties and has recently been moved into the community by Housing Tasmania. She's come from a social housing estate in another part of the state, with her partner and children. This isn't the first move she's made; her whole life has been lived in insecure housing around the state. It means she knows very few people here in her new place. She is also affected by some physical impairments, and doesn't have a driver's licence, or a car. *"I can't go on the bus in wintertime with sick kids—it's a 10 minute walk to get to the bus in the rain. There's hardly any bus shelters when you do get to the stop. If my kids are sick, I have to pay for a taxi and most of the time I just don't have that money"*. Despite her impairments, she hadn't heard of the NDIS and so was not being supported. When told about the NDIS, she was a bit nervous—filling in forms and telling people about your circumstances is an uncomfortable space for her. Anne can't read or write. She quietly said she had left school without these skills.

Because she is new in this community, she hasn't got a regular GP. She *"can't afford it. Most of them don't bulk bill anymore. ... Couldn't get into [local clinic] because they weren't taking new patients. Didn't bulk bill if they did take new patients."* She's also worried that, as has happened many times before, the doctor will ask lots of questions, that make her feel ashamed, in order to decide whether to bulk bill her. All these reasons mean she is much more likely to just go straight to the local hospital, where at least she knows she, or the kids, will eventually be seen.

The other problem is that one of her kids is *"acting up"*. Like her, he has been affected by trauma: they both witnessed a violent crime. Now, *"my son's behaviour is getting out of control. He's not learning. He's behind with his spelling, writing, ... That's his self-worth going down the toilet. And that is a bad thing, because his mental health is affected by his perception of his own worth. So that mental health is deteriorating. He's got anger control issues, impulse control issues, ..."*. Other people told us that *"... so many of the women [...] can't leave the house, they're scared to leave the house with their child because their child is so off the show. And they're isolated, [this situation is] very, very isolating"*.

What is anticipatory care

Anticipatory care identifies who is at risk of developing an illness and works to keep people well. Anticipatory care is not a reactive system, but one that “anticipates health needs before they arise and that delivers continuous, integrated, preventive care with the patient as partner” [5]. In the UK, anticipatory care programs have been managed through (medical) general practice, and combine “a population approach with long term productive relationships, between patients and professionals who know and trust each other, and who are guided by evidence and audit” [3]. Effective anticipatory care may reduce the use of expensive health and social services [6, 7].

Anticipatory care involves health services and individuals [8], but the risk of developing a chronic illness is also produced by the social determinants of health [9], the “material, social, political, and cultural conditions that shape our lives and our behaviors” [10]. Julian Tudor Hart, regarded as one of the two founders of anticipatory care [3, 11-13], noted the problem of treating a patient but then sending them home to the conditions that had caused their illness. This link between social (and economic) factors and health is central to anticipatory care and is conceptualised in the social determinants of health.

Background

Chronic illness is a major cause of ill-health and avoidable hospitalisations in Tasmania, and this burden is not evenly distributed. Chronic disease is linked with the social determinants of health: risk is reduced when people have reliable access to economic resources, secure and good quality housing, good diet, hygiene, health services, social networks and education.

We need to reduce the risks for chronic illness and find better ways to manage existing conditions to keep people well. The Anticipatory Care (AC) Action Learning Project explored whether building a more effective local anticipatory care system could start to address this problem, in four Tasmanian sites.

People living in the project sites have higher rates of chronic illness, and potentially preventable hospitalisations than Tasmanians overall. They also have higher rates of risk factors for chronic illness; across the sites, these risk factors include experiences of trauma, smoking, substance misuse, overweight or obesity, and insufficient physical activity.

This report documents the project’s aims, processes, activities, and findings. There are many more learnings in this project than can be captured in this short report; the UTAS Full Report provides that information. There is also detail in the UTAS Local Site Reports and Policy Briefs, and in the reports prepared by the four site teams.

The social determinants of health

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries. [2]

Project aims

The Tasmanian Department of Health (DoH) received funding from the Australian Government to conduct research to better understand and learn from communities about different ways anticipatory care happens and what works well and why. Between late 2018 and June 2020, the Department and the University of Tasmania worked with four Tasmanian communities to apply an action learning approach to anticipatory care to:

- Increase our knowledge and understanding of how anticipatory care occurs in different communities
- Better understand the enablers and barriers to anticipatory care experienced by communities
- Increase our knowledge and understanding about how communities and health services can work together to engage ‘at risk’ Tasmanians in primary and preventative health care, including assessment and management of their health needs.

(Anticipatory Care, Project Guidelines, 2018)

The project aims were operationalised through four research questions, outlined below. Figure 1 illustrates the relationship between the project aims and the research questions.

The research questions (RQs) for the AC project are:

Mapping anticipatory care:	What does anticipatory care look like in each community? What are the shared elements, and what are not? What is working, and who is it working for? What is not working, or who is not benefiting?
Opportunities for enhancing AC:	What elements in the existing system can be influenced (and are they within the capacities of local actors)? What gets in the way?
Actions and outcomes:	What actions are the sites implementing? What changes have the actions resulted in—what differences can be seen at individual, organisation, service, and community levels?

In keeping with the broad scope of the project, the DoH also wanted to gain a better understanding of the roles of different agencies in anticipatory care. Hence, there is an additional research question in each site:

Help to Health	What is the role of Local Government in Anticipatory Care, and can it be strengthened? (Clarence)
Our Community Our Care	What is the role of Neighbourhood Houses in Anticipatory Care, and can this be strengthened? (Launceston’s Northern Suburbs)
Connecting Care	What role can a GP clinic play in Anticipatory Care, and can it be strengthened? (Ulverstone and the 7315 postcode area)
Our Health Our Future RQ	How does anticipatory care look and function in an isolated and under-resourced community? (Flinders Island)

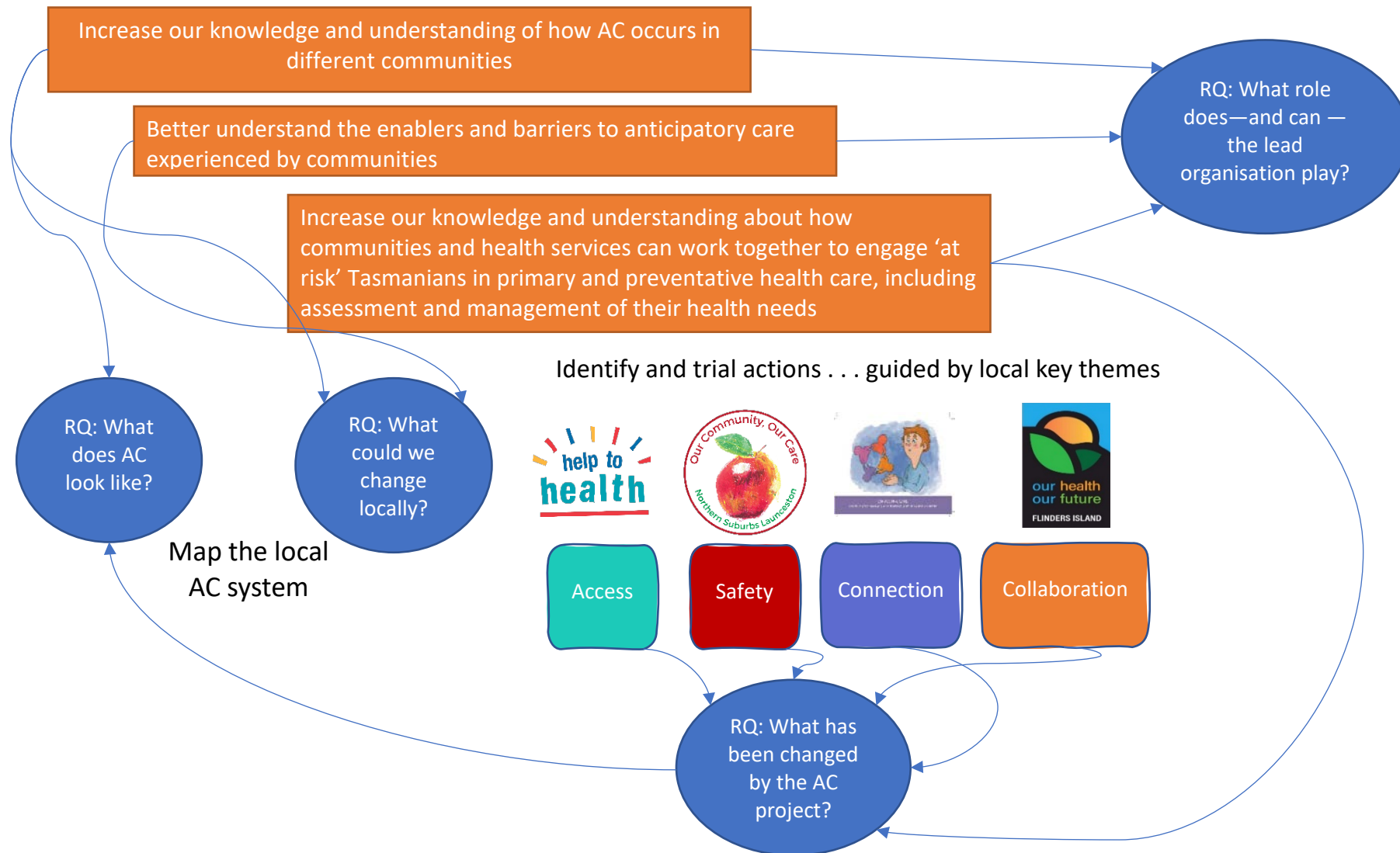


Figure 1: Operationalising the project aims

Who was involved—The project sites and lead agencies

The project was a collaboration between the Department of Health's Chronic Conditions Working Group (CCWG), the University of Tasmania, the Sax Institute and project teams in four participating communities (Figure 2 shows the roles played by the collaborators).

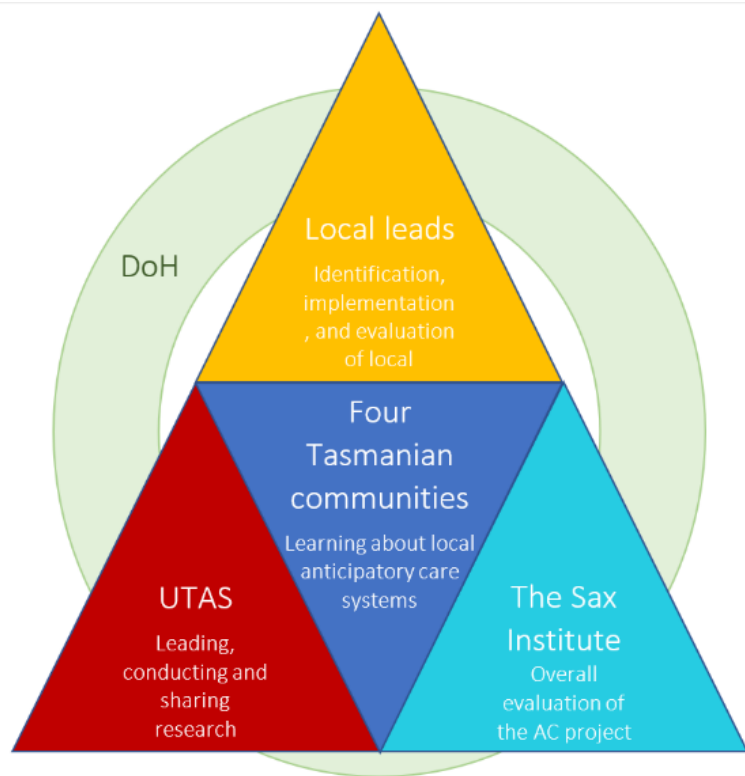


Figure 2: The Anticipatory Care Action Learning Project collaboration

The communities were selected, by DoH, for the project on the basis of:

- Potentially Preventable Hospitalisations data over 3 years from 2012/13 to 2015/16 (inclusive of both the separation and actual rates)
- Australian Bureau of Statistics data including socio-economic indices for areas (SEIFA)
- Qualitative criteria including for community development and readiness, local leadership and collaboration potential and ability to improve and innovate [see 5, 14]
- Equity criteria including ensuring there is a spread of selected sites across the three regions of Tasmania (north, north west and south) and a balance of urban and rural/remote sites.

The community lead organisations were Clarence City Council (a local government), the Starting Point Neighbourhood House and the Northern Suburbs Community Centre in Launceston (neighbourhood houses), the Patrick Street Clinic in Ulverstone (a GP clinic) and the Flinders Island Aboriginal Association Inc. (an Aboriginal Community Controlled Organisation). The span of partners in diverse communities enabled us to learn what roles an array of organisations might have in anticipatory care.

The local lead organisations appointed project leaders and local project support officers (PSOs) and formed local advisory groups (LAG); these are the site teams.

What we did

Anticipatory care was understood as a complex system. Action learning and systems thinking guided our work with the sites to:

- Gather and analyse data to better understand the nature of the anticipatory care in the four sites, and identify opportunities and actions to enhance the system
- Support site teams to develop actions (action planning)
- Determine what impact local actions had on the system
- Devise recommendations for future preventive health initiatives.

Action learning and systems thinking

Action learning helped us to understand the distinct anticipatory care systems, and to rethink approaches to chronic disease prevention. The approach also enabled communities to build a shared ownership of the system, identify opportunities for local intervention, direct initiatives at the underlying causes of problems in the anticipatory care system, and realise how small shifts in practice can have profound system effects.

Systems thinking supports action learning, and helped us to trace the ‘causes of the causes’ using causal loop analysis. Systems thinking approaches and tools can reveal the intricacies of the complex health problem of rising rates of chronic illness, identify opportunities for change, and track the impacts of such change. We can use systems ideas to “. . . help us to conceptualise and work with complex issues” [15] like anticipatory care.

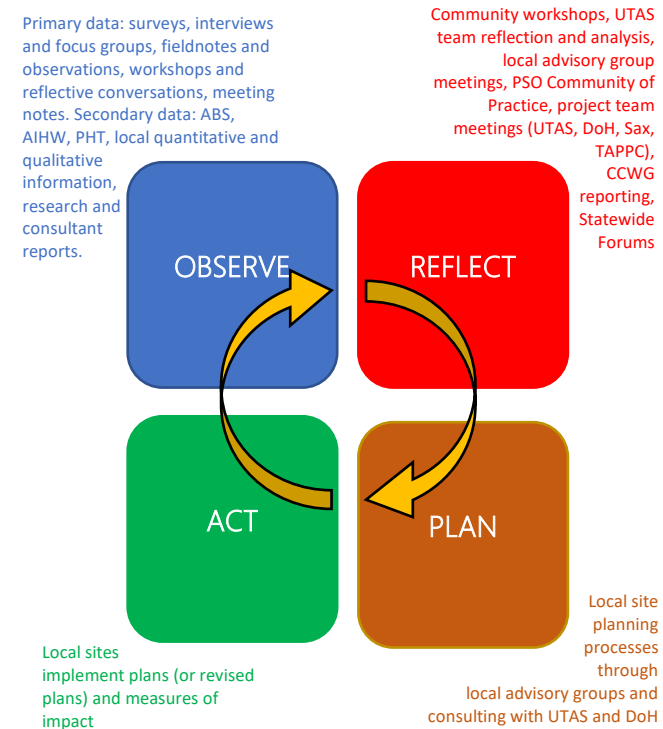


Figure 3: The action learning cycle

Observe: Initial data gathering (July 2018–May 2019)

We used multiple types of primary (gathered by the researchers) and secondary (pre-existing) data to answer the research questions. Secondary statistical and other information gave us resources to describe the context of the project and to guide development of data gathering tools. We gathered new data using surveys, interviews, focus groups, workshops and observations, notes of meetings, and

from the PSOs. Preliminary analysis of this data clarified how people experienced the anticipatory care system and where change might be possible. We also asked survey participants how they thought about health. Understanding people's way of thinking about health is crucial if we are to design a more effective anticipatory care system.

Nearly 770 people contributed directly to the data, through formal data collection processes. Many more were indirectly involved, through observation.

Reflect and Plan: Support site teams to develop actions (May–July 2019)

We reported our preliminary analysis to each site, and reflected with them through workshops and discussions, on the nature of the system and where there were opportunities for change. We worked with the project sites to define a locally relevant *boundary* for the anticipatory care as a means to manage the scale of the system and prevent it from becoming unwieldy given the project timeframe (2019–2020). Using the findings from our first phase of data analysis and insights from community forums, we identified a small number of 'systemic' themes in each of the communities, which were understood as barriers or enablers to effective anticipatory care system function. Bounding the local system according to a systemic theme enabled the local AC teams to develop actions in areas that were of greatest importance to them. In this regard it was a "system of relevance" [16]. In each site, the local theme was used to focus action.

Researchers and local teams used the systems thinking tool causal loop diagrams (CLD) to identify the variables affecting the focusing

theme, and to surface where taking action might enhance the anticipatory care locally.

Causal loop analysis is a form of collaborative group modelling. Participants work together to identify different parts of the anticipatory care system in their community, the casual connections between those parts, the feedback loops and potential leverage points (Figure 4 is an example, tracing the possible impacts of the Adventure Play program in the Launceston site). It brings together the themes in the quantitative and qualitative data, and enabled participants to add what they know or have experienced to the analysis.

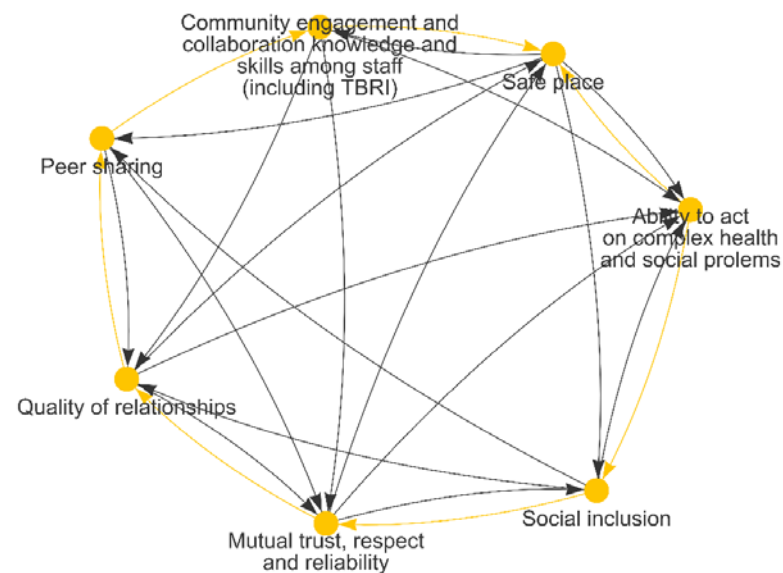


Figure 4: Causal loop diagram (possible impacts of Adventure Play)

Act and Observe: Determine the impact of local actions on the anticipatory care system (August 2019–June 2020)

We returned to communities to re-draw the CLDs at the end of the project (May/June 2020), using evidence in the data and presented at the CLD sessions by participants. In these sessions, we were exploring what impacts the local projects had had on the anticipatory care system.

Findings

Local site findings

In this section, we first report on the nature of anticipatory care in each site, what barriers and enablers existed, key issue for change and the focus of local action, and the change we observed. These elements are summarised in site tables, below.



Clarence—Help to Health (H2H)

Clarence is a large and dispersed community. Services are generally clustered in the main centre (Rosny/Bellerive), and are some distance from the parts of the municipality where people are most at risk of developing a chronic illness. As well as not having enough local services, these places are also less likely to have other sorts of hard infrastructure to support anticipatory care: adequate transport, housing, and technology, for example. There are important resources for social inclusion and relationships in local organisations like neighbourhood houses and Men’s Sheds, or clubs.

How does anticipatory care function in Clarence?

Our initial data analysis in 2019 showed that the anticipatory care system in Clarence was impeded by problems of access—geographical and physical, emotional and psychological, and to resources. CLD identified the variables (system sub-parts) involved in access, and possibly opportunities for action. In response, the H2H team developed and implemented activities to improve access into and through the anticipatory care system. These were aimed at

improving information for navigation of services and building relationships between actors in the system to meet community and service needs.

Conclusion: Anticipatory care in the H2H site, Clarence

The changes to the anticipatory care system here (shown in Table 1) were supported by a dedicated, anticipatory care-focused local project team (lead, PSOs and Leadership Group) engaged with the action learning and systems thinking approach, the researchers and, especially through the PSOs, the community.

There remain barriers to anticipatory care in Clarence and in the lead organisation including:

- historical stigmatising attitudes to some parts of the community that reduce opportunities to enhance equitable access to the anticipatory care system
- Clarence City Council’s investment in a hard infrastructure (buildings, walking trails, services) approach to public health that overshadows support for the soft infrastructure (relationships, knowledge, collaboration) which is essential for effective anticipatory care.

Table 1: Theme, actions and outcomes, Help to Health

Guiding theme	Actions	Outcomes at end of project, 2020
<p><i>Access: The anticipatory care system is unavailable to some people (including in services) because of barriers to access that are:</i></p> <ul style="list-style-type: none"> • <i>geographical and physical, emotional, and psychological,</i> • <i>or that require financial, educational, or other resources to surmount</i> 	<ul style="list-style-type: none"> ➤ successful navigation of systems and services to address community needs (sub-project: improving connections between GPs and community through a reference group; sub-projects: The Right Place, It’s Okay To Ask, Help to Health Friends, Clarence Talks) ➤ quality relationships between actors in the anticipatory care to address community and service needs (sub-project: developing and describing the Health Connector role) ➤ PSO outreach to community and additional services 	<p>The H2H project increased:</p> <ul style="list-style-type: none"> • service provider and H2H team capacity to create supportive environments for health, enabling more connections and networks between service providers and with community, including engagement of some previously hard to reach people • understanding of the breadth of the anticipatory care system and the importance of place and belonging in anticipatory care, and • recognition of the effectiveness and health authority of the lead organisation, Clarence City Council.



Launceston's northern suburbs—Our Community Our Care (OCOC)

Launceston's northern suburbs are clustered on the city's rural edge and have historically been dominated by broadacre public housing. There is a lack of local 'hard' infrastructure (including GP services, adequate public transport, secure housing, and technology). There are important resources for social inclusion and relationships in local organisations like neighbourhood houses, Men's Sheds, and a Child and Family Centre, which also go some way towards benefiting the social determinants of health.

How does anticipatory care function in Launceston's northern suburbs?

Our initial data analysis in 2019 showed that the local anticipatory care system was impeded by a lack of safety—through stigma and a lack of local services and infrastructure. Causal loop analysis identified the variables (system sub-parts) involved in safety, and possible actions to enhance the system. In response, the OCOC team developed and implemented activities to improve safety across the anticipatory care system.

Conclusion: Anticipatory care in the OCOC site, Launceston's northern suburbs

The OCOC lead organisations are embedded in their communities and have a strengths-based approach. The changes to the local anticipatory care system (shown in Table 2) were enabled and driven by these characteristics and a dedicated, anticipatory care-focused local project team (lead, PSOs and Local Advisory Group), who engaged with the action learning and systems thinking approach, the researchers and, especially through the PSOs, the community. The local team listened to community members and acted on what has been heard—including in very public ways (e.g., media stories). They

also modelled—and offered practical ways of working—to reduce stigma and increase safety in the anticipatory care system.

There remain barriers to anticipatory care, including:

- historical stigmatising attitudes to the community that reduce external and internal opportunities to change
- continuing poor distribution of necessary services
- government policies (e.g., for bulk-billing, welfare supports, and funding arrangements) that actively work against taking a social determinants of health—including mental health—preventive approach, including—
 - competitive funding models that reduce connection and collaboration between parts of the anticipatory care system
 - lack of resources to support outreach.

Table 2: Theme, actions and outcomes, Our Community Our Care

Guiding theme	Actions	Outcomes at end of project, 2020
<p><i>Safety: The anticipatory care system is unsafe for some people (including in services) because of:</i></p> <ul style="list-style-type: none"> • <i>stigma, exclusion, and restriction</i> • <i>precarity</i> • <i>poorly targeted and delivered information</i> 	<ul style="list-style-type: none"> ➤ transport access (physical/financial) (sub-project: bus services, Green Cards) ➤ access to GPs (sub-project: working with local clinic to increase information sharing) ➤ physical activity and social connection (sub-projects: Ravenswood Basketball Bins, Clean-up Walks) ➤ social connection and information sharing (sub-project: Facebook page, videos, Local Advisory Group) ➤ safe responses to people experiencing trauma (sub-project: Trust Based Relational Intervention Professional Learning session) ➤ community pride, local positive identity, and engagement (sub-project: community arts projects, clean-up walking group). ➤ PSO outreach to community and additional services ➤ PSO collaboration with services, for advocacy (to politicians, media) ➤ Expansion of the Local Advisory Group to include new members 	<p>The OCOC project increased:</p> <ul style="list-style-type: none"> • Understanding that anticipatory care involves a wide range of people and services and their inter-connectedness, and built new collaborative relationships with shared goals, language, and ways of working for health advocacy • Capacity in key players and organisations to work safely and effectively with community members • Engagement of some groups (including previously hard to reach people) in health-promoting activities • ‘Good news’ media stories about the OCOC community (with potential reductions in stigmatising of community and individuals) • The effectiveness and authority of the lead agencies in health.



Ulverstone and the 7315 postcode— Connecting Care (CC)

The Connecting Care site is the rural town of Ulverstone, and its surrounds, in the State's north west. The area is relatively well-resourced with local health services. There is a strong presence of service organisations (e.g., Rotary), but a lack of engagement by 'at risk' people.

How does anticipatory care function in Ulverstone and surrounds?

Our initial data analysis in 2019 showed that the anticipatory care system in the Connecting Care site was impeded by fragmentation—through a lack of connection, and access to and sharing of health and social care information. Services did not coordinate to support preventive health, and a personal responsibility for health discourse dominated. This sidelined the importance of the SDoH, but those determinants still prevail. Causal loop analysis identified the variables (system sub-parts) involved in connection and information sharing, and where action might benefit the system. In response, the CC team developed and implemented activities to reduce fragmentation and increase information sharing across the anticipatory care system.

Conclusion: Anticipatory care in the CC site, Ulverstone and the 7315 postcode area

The changes to the anticipatory care here (shown in Table 3) have been enabled by the local project team's understanding that the system is complex, and by the active outreach by members of the Community Reference Group, to build connections with important players in the anticipatory care system, supporting sustainable change. The team listened to community members, acted on what they heard (e.g., in the research and through information hubs) and

shared information about the project with services and residents, using social media and the CC resources portal (online).

Anticipatory care is best viewed through a social determinants of health (SDoH) lens. This approach is not yet fully embraced by some GPs and people in the broader community, and there are policy and attitudinal barriers that constrain how the community and GPs respond to the SDoH. Further, there are barriers due to:

- business models operating in general practices and other services that do not factor in externalities, soft infrastructure measures, and experiential data and therefore cannot effectively support equitable access to health
- local stigmatising attitudes to some parts of the community that reduce opportunities for change
- some local, state and national policy settings that reduce options for taking a SDoH preventive approach; this is evident in competitive and short-term funding models that reduce connection and collaboration between parts of the anticipatory care system, a lack of resources to support outreach, and continuing poor distribution of necessary services (e.g., bulk billing, and the continuing lack of adequate, local and financially accessible mental health services).

Table 3: Theme, actions and outcomes, Connecting Care

Guiding theme	Actions	Outcomes at end of project, 2020
<p><i>Connection: The anticipatory care system is fragmented for some people (including in services) because of:</i></p> <ul style="list-style-type: none"> • <i>beliefs and attitudes about health and the ac system that focus on individual responsibility</i> • <i>poor quality information</i> <ul style="list-style-type: none"> • <i>poor communication and collaboration</i> 	<ul style="list-style-type: none"> ➤ information sharing through health and social care information hubs (sub-projects: the CC portal, social media, and printed resources, as well as pop up hubs) ➤ health literacy training for staff and volunteers (based somewhat on The Right Place model operating in the Clarence Help to Health project site, and in the Huon Valley) ➤ the effectiveness of (and potential improvements to) responses to chronic conditions by GPs (sub-project: practice audit) ➤ developing a framework and governance model to sustain enhancements of the anticipatory care system in this site (sub-project: the Roundtable) ➤ Community Reference Group collaboration for resource directory (new collaborations, reflexive services) 	<p>The CC project demonstrated:</p> <ul style="list-style-type: none"> • some engagement by GPs with other parts of community that they may not previously have recognised as being part of the anticipatory care system • more connections and networks linking service providers with one another and with the community, and more options for communication to share knowledge for anticipatory care • a more widespread understanding of the nature and makeup of the anticipatory care system, and embracing of the role of elements not traditionally associated with medical models of health • the adaptability of the lead organisation to new circumstances (evident during the COVID-19 pandemic).



Flinders Island—Our Health Our Future (OHOF)

Flinders Island's small population is in two small townships and dispersed across the island. Health and social care services are delivered by a range of on-island and fly-in-fly-out practitioners, presenting a challenge for coordination. Some Islanders contend with poverty, unemployment, lack of education, and racism, which has been increasingly recognised as affecting health [e.g., 17, 18]. Flinders Islanders are much more likely than other Tasmanians to be volunteering, and many health and social care services are supported by volunteers who take on several roles.

How does anticipatory care function on Flinders Island?

Our initial data analysis in 2019 showed that the anticipatory care system on Flinders Island was impeded by problems with service collaboration, driven by the mix of on- and off-island services, and by a need for better cultural competency. Causal loop analysis identified the variables (system sub-parts) involved in collaboration, and opportunities for intervention. In response, the OHOF team developed and implemented activities to improve collaboration and cultural competency across the system.

Conclusion: Anticipatory care in the OHOF site, Flinders Island

The lead organisation in the OHOF site, the Flinders Island Aboriginal Association Inc. (FIAAI), follows an Aboriginal Community Controlled Health Organisation model; its approach is guided by an holistic, SDoH understanding of health and wellbeing. This has been vitally important to the anticipatory care system on Flinders Island and to the system changes (shown in Table 4). In working to address the social determinants of health, FIAAI is acting

on the 'causes of the causes' of poor health. Through the project, the OHOF team has increasingly adopted this approach, strengthening the anticipatory care system overall. The OHOF work showed that to build on these outcomes:

- it is essential that practitioners, whether on-Island, fly-in-fly-out, or providing services to Islanders visiting mainland Tasmania, continue to find ways to improve collaboration
- cultural competency training needs to be locally relevant and safe, resourced, and part of the induction and regular professional development for services across the anticipatory care system
- performance measures in some services need to capture the whole picture, account for things like new networks and relationships that are formed through activities, and not privilege specific, countable outputs over community outcomes. KPIs need to take account of the externalities and so-called 'soft' measures such as the social, environmental, emotional and community aspects of service provision.

Some State and national policies and processes actively work against taking a social determinants of health preventive approach:

- uneven provision of supports to counteract poverty
- competitive and short-term funding that reduces connection and collaboration between parts of the anticipatory care system
- a lack of resources to support outreach and collaboration, and continuing problems with discharge processes from major hospitals.

Table 4: Theme, actions and outcomes, Our Health Our Future

<i>Guiding theme</i>	<i>Actions</i>	<i>Outcomes at end of project, 2020</i>
<p><i>Collaboration: The anticipatory care system is undermined by:</i></p> <ul style="list-style-type: none"> • <i>inadequate collaboration and coordination of services</i> • <i>a lack of cultural safety and competency among providers</i> • <i>social norms around risky alcohol consumption</i> 	<ul style="list-style-type: none"> ➤ direct health impact and service collaboration (sub-project: Alcohol Awareness program) ➤ social and physical health impact (sub-project: G. A. M. E. (gear access made easy) On Flinders) ➤ service collaboration (sub-project: Increase clarity and reliability of referrals; sub-project: Community groups booklet/online app; sub-project: Cultural competency training (and development of the training)) ➤ PSO collaboration (across FIAAI and MPC) and with Ochre services ➤ Fluvax clinic ➤ PSO outreach to FIFO services 	<p>The OHOF project increased:</p> <ul style="list-style-type: none"> • understanding that anticipatory care involves a wide range of people and services, and more collaborative relationships with shared goals, language, and ways of working for health advocacy, including with some fly-in-fly-out service staff • skills for anticipatory care and strengthened relationships and collaborations among service providers such as FIAAI, MPC and Ochre; part of this is person-dependent through the PSOs and GPs, who are remaining in their substantive roles, post-project • cultural competency among services staff to work safely and effectively with community members • engagement of some groups (including ‘at risk’ and previously hard to reach people) in health-promoting activities • awareness and support from a key funder of visiting services to the Island of the need to include collaboration in role descriptions for providers visiting the Island (and Cape Barren Island) • the effectiveness and authority of FIAAI in health and anticipatory care.

Vignette. Local change to the anticipatory care system is possible—Anne’s story

Anne’s child is in the Adventure Play program run by the OCOC team. His trauma was recognised by the local school, and he fitted the criteria for participation. We know that kids in the program are attending school more frequently (some were attending as little as 8%; for at least one participant this has risen to 70% attendance rate). They’re also gaining skills in self-regulation and confidence in physical activities. Their interactions with one another are also far more respectful and supportive:

“... I would like to reiterate and congratulate the [Team for making a huge difference in all the lives of all the participants. Providing recreational opportunities, broadening understanding of local facilities, building teamwork, and providing welcomed creative distractions from routine has been invaluable, empowering and physically stimulating for all the young people involved. I believe that the BOOM program has had a profound and life affirmative consequences for all the participants. Wonderful work and great outcomes. Congratulations.” (email from staff member at participating school)

At the end of year BBQ in 2019, some parents joined their children for a few hours of games and food. For some, this was the first time they’d talked to another parent. They told us how great it was to meet new people and share their stories about Adventure Play. Anne is developing a social network in her new community. She’s also using BOOM “as an incentive for good behaviour”, and her son’s “*anxiety levels have gone down*”; there have been “*no phone calls from school for months –used to be daily/weekly*”.

We also talked to a local police officer who, through his involvement in the LAG, had developed a deep understanding of anticipatory care’s potential in reducing people’s risk of mental illness, or of episodes of dangerous mental illness. The police officer spoke of the OCOC project as an opportunity to collaborate in ways that would help understand and address crime in a more holistic way. He recognised how important the health (including mental health) of the community was to the work his team did, and that reducing crime could happen through collective approaches (including collective impact) (Fieldnotes). And other community members and local service providers who’d done the ‘complex trauma’ workshop run as part of the AC project, “talking about trauma”. The workshop had helped to spark “*an ongoing dialogue full of understanding about trauma and what they are going through—not about them being little shits*” (recorded in Fieldnotes).

These changes relied on the identification of a local need to better support local children who live with or have experienced trauma. There is clear evidence that childhood trauma has far reaching implications for individuals and communities. Trauma reduces educational attainment and is linked with poor long-term physical and mental health, homelessness and contact with corrections [4].

Project-wide findings

What does 'healthy' mean?

Survey participants told us how they think about health. If people think in medical terms, it would make sense to focus anticipatory care efforts there; but this is not the case. The overwhelming response to this survey question showed that health was understood in terms of an array of functions: *Can I do the things I want to do, without pain or other restrictions*. People wanted a balanced life: to have the fitness, mobility, energy, and mental wellbeing to go about their daily lives. The sources of support for their health were manifold; getting out and about with other people was prominent, and family and friends were important health supports. Medical and other health services played a role, but not the central one.

Healthy is *"being balanced in my mind, my body, my mental health and my spirituality."* (Survey respondent)

Survey participants also told us about the barriers they experienced to accessing health-related activities and services; the things that might help prevent or better manage chronic illness. Cost was the single largest barrier, followed by time. But grouping the results tells an additional important story. We separated responses into *resource* barriers (transport + cost + gear) and *psycho-social* barriers (people ("I don't like the people who run it") + unwelcome ("I don't feel welcome") + motivation + confidence + comfort; participants could tick as many barriers as they wished, so there is overlap).

Of all responses, 269 (39.4%) were to resource barriers and 364 (53.4%) to psycho-social barriers.

These responses, mirrored in the other data gathered, underlined the fact that there are multiple, linked determinants of health, and they are both personal, inter-personal, and structural:

- Poverty, poor education and housing, etc.
- Stigma, marginalisation, discrimination, and social exclusion

"[We have] seen the look on people's faces. When we took B [to health services] for example ... she doesn't have any teeth and she's skinny and she looks like a drug addict. She's not. And we look different. And the doctors and the nurses [...] I saw an involuntary look of 'Oh my God' or panic. [...] Yes. Absolutely. They see that they're being judged immediately. And that's why so many of them have trust issues around all this stuff, and entering buildings where they need to try and access health ... " (Interview)

- Uneven provision of adequate infrastructure and services
- Business performance measures that ignore the relational aspects of health service provision and risk entrenching marginalisation and lack of access
- Policy settings and belief systems that:
 - Reduce the availability of bulk billed consultations
 - Leave some people and communities without resources
 - Drive short term competitive funding and incoherent processes that discourage sharing and collaboration and prevent long-term trusting relationships.

The following findings reflect the complexity of the anticipatory care system, and roles played by both resources and of psycho-social factors in shaping anticipatory care across the four sites.

Finding 1: Systems thinking reveals that the anticipatory care system is *complex*

UTAS was asked to trial the application of systems thinking to the complex health problem of high rates of chronic illness, in four Tasmanian communities. This process was necessarily incomplete: despite collaborative efforts to reach the most at risk people, we know there is more to be learned about the system, particularly about what—and who—remain missing. With that background, we argue that systems thinking approaches and tools can reveal the intricacies of the complex health problem of rising rates of chronic illness, identify opportunities for change and track the impacts of such change.

Working collaboratively with stakeholders from a range of sectors is central to systems thinking. Many of the factors that influence health lie outside of the health system, and therefore ongoing dialogue between stakeholders is essential to strengthening the system. Systems thinking brought project teams together to understand the many and varied stakeholders in the system, to brainstorm what the system looks like, and to conceptualise the effects of actions and processes on the system.

Systems thinking:

- highlights the role of the SDoH in anticipatory care
- demonstrates the complex interplay of the system parts and their echoes of the social determinants of health

- supports diverse actors, who shared the goal of greater health equity, to work together and draw in additional actors for that goal
- allows for strengths-based, rather than deficit-focused, responses to emerge
- is a means to make action learning genuinely participative
- enables the engagement of multiple stakeholders at various levels and opens the way for collaboration
- can help identify resources (skills, knowledge, time, leadership, etc.) that can be put to good use in the system
- demands time, commitment, and relational, soft skills.

System thinking inherently acknowledges a ‘multiple perspectives’ way of looking. It also allows us to depersonalise a little, to focus on the system and its parts and not people, and on processes not actions. It helps to remove blame and defensiveness, in favour of focusing on connections and what can be changed. It shows that causation is complex. Our data and the causal loop analysis process revealed an extremely complex system, with multiple parts, sub-parts and causal links. We also found that the proposed system parts were useful; that information could be understood in those terms, **and** that there were additional parts that contribute to the system.

Vignette. Causation is complex

We met Andy. He's a retired carpenter and has had a tough time as his wife deteriorated with dementia. They went from being an outgoing, sociable couple, going to the local bowls club, having meals with friends, spending time with their children and grandchildren, to *"more or less hiding"*. It wasn't that Jen didn't want to socialise any more, but that she became more and more aggressive and people weren't sure how to handle that. Andy wanted to protect her, but he was also worried that she'd hurt herself or someone else—and he was ashamed. Andy told us that he had spent the ten years leading up to her death (in 2018) becoming more and more isolated. *"I basically didn't go out"*. The kids stopped visiting, they stopped going out and friends dropped off *"I lost a lot of my friends because of dementia"*. He didn't talk to anyone about it and didn't get any supports from MyAgedCare. He felt too ashamed, for himself and for Jen to tell his story to anyone other than the GP, and that was a one-off when she was diagnosed. There were some days when he was suicidal. When Jen died, he had no friends at all, and had lost touch with their kids. He felt that he had *"forgotten how to be with other people"*.





A few months before we met him, he saw a notice about the Men's Shed; it took a few weeks to get up the courage, but eventually he went along. It's been a *"life-saver"*. Since joining the Men's Shed, he's starting to feel a bit more connected. *"Look we'll, we'll sit around this table and catch up about what happened to you that morning and yep, and [...] you know, sometimes we've got a project on with 8 or 10 people here"*. His old skills are getting a run; he used to run his own small business and now he's working with some of the men to write a grant for a piece of machinery they want, a thickener; the one they have is on its last legs. Andy's thoughts of suicide have receded; he still feels a bit tentative about socialising: *"It'll take a while, I reckon"*. And he's connecting with kids—not his own, but with some local kids from the school, who come in and use the shed:

"First up, we signed the school up as a user of the Shed, and they would bring along a couple of kids. Started off with about six. And they're disengaged boys, [...] boys with no father figures in their lives. [...] And they were the naughtiest ones of the lot, basically. They loved coming here. The school could see a lot of benefit out of it. [...] I have a good relationship with them. It's not about making money out of it; it's about including the boys into something, social inclusion. It's good for us." He said he still feels pretty *"stuffed"*, but things are looking up.



Finding 2: *Place and belonging, and Policy and processes* are two important additional anticipatory care system parts

We used systems thinking to identify potential system parts in anticipatory care, and then to find out whether those parts matched the local circumstances. Identification of the initial set of six system parts was informed by the World Health Organisation's [19] "*Building blocks of Health Systems* work, the Anticipatory Care Discussion Paper [1], the CCWG's Anticipatory Care Framework (see Appendix), and preliminary discussions with local lead agencies and systems experts from The Australian Prevention Partnership Centre.



The initial system parts and their impacts on the system are:

-  **Infrastructure** for anticipatory care refers to the resources needed to support and sustain anticipatory care. Both 'hard' infrastructure (services, facilities, technologies, housing, transport, and roads, etc.) and 'soft' infrastructure, the interpersonal skills that support people's engagement in the anticipatory care are needed [20].
-  **Relationships.** Relationships enable social inclusion, collaboration, and coordination, effective communication, connecting with the hard to reach and incidental conversations about anticipatory care. Relationships draw on 'soft' infrastructure.
-  **Attitudes and beliefs** shape relationships. Attitudes and beliefs need to support collaboration, support the inclusion and valuing of the diversity of knowledge and perspectives, and recognise strengths and the importance of cultural and spiritual sensitivity.
-  **Information and data for health** comprises the accessibility of health information and people's awareness and use of that

information to better coordinate or navigate the anticipatory care system. Accessible information is supported by health literacy of community and service providers.

-  The **People and their health** system part includes health promoting behaviours and the emotional load—of community members and of service providers.
-  **Leadership** includes effective priority setting and actions that support and enhance anticipatory care. It is heavily reliant on relationships, data and information, resources and attitudes and beliefs.

Working with communities enabled us to identify *two additional system parts*:

-  **Place and belonging** highlights the importance of listening to local needs and advocating for them, the impacts of geographical isolation and the importance of reach.
-  **Policy and processes** are to some extent external to the system, though a powerful force shaping it. It includes the funding models that enable or constrain the effectiveness of the other system parts. Funding models, though at a higher level, also drive key performance indicators business models that do not factor in the importance of soft infrastructure.

The system parts in action

These eight system parts account for multiple sub-parts in the system. For instance, stigma and marginalisation, a lack of cultural competency and a personal responsibility for health perspective are part of the **Attitudes and Beliefs** system part, and undermine safety in the system. The **Relationships** (and soft-infrastructure skills, including cultural competency) that are needed for collaboration and

coordination, and to support people's access to formal and informal illness prevention rely on inclusive attitudes, and on **Policies** (at local and other levels) that support sharing. The uneven provision of services and supports, including poor housing or a lack of employment, is captured in the **Infrastructure** system part. The inability of GPs to take a more important role in anticipatory care, problems with connection and collaboration, and the lack of infrastructure are, in turn, products of **Policy and processes**. But policy and processes are shaped by **Attitudes and beliefs**.

While the system's parts rely on one another to create anticipatory care, some system parts can be influenced locally, and some cannot. Many of the most powerful forces in the anticipatory cares we explored are controlled from outside local communities. **Policy and processes** shape **Infrastructure** provision, and regulation and legislation drive the business models operating in many services, including whether there are local GPs (and whether those GPs bulk bill), mental health services or specialists. Policy and processes also drive the dominant short-term and competitive funding of many essential services, and thereby undermine long-term trusting **Relationships**, cooperation and collaboration. And policy is at the root of whether people gain or lose from the social determinants of health. Where policy ignores the role of the SDoH in present and future health, communities and individuals will continue to miss out on the benefits of anticipatory care.

There are **Policies and processes** that can be influenced locally. For instance, organisations can adjust their culture and actions to better respond to local needs. We have seen that local training and approaches that take account of **Place and belonging** (including trauma, culture, and history) equip community members and service providers to create a safer and more collaborative anticipatory care.

Combining this with a strengths-based and SDoH inclusive approach (e.g., OCOC and OHOF) enables the voices of community, the **People**, to influence the system. On the other hand, services that stigmatise potential users, whether through overt discrimination or displayed in staff attitudes, reduce access to much-needed prevention and management of chronic illness. These are local level opportunities. **Leadership** is another system part that can be shaped locally.

Finding 3: No single organisation has the full complement of attributes and qualities needed to be the ideal and only AC leadership organisation

The AC project found that the engagement of all four organisation types (along with many others) is necessary in an effective anticipatory care. Each of the project's distinct lead organisations plays a specific role within the anticipatory care system, bringing their own attitudes and beliefs, approaches, knowledge and relationships which are embedded in and shaped by their specific place and community. These differences in the attitudes and attributes can be understood both as organisation specific and potentially more generalisable strengths and weaknesses of leadership within anticipatory care. Taking a systems approach, these organisational attributes also represent organisational boundaries—the values, attitudes, perspectives and attributes that define what is considered relevant, important and worthwhile, or irrelevant and excluded by and within those organisations. These boundaries affect the ways in which the lead organisations understand their local context, situations and people, ethical and social justice issues, marginalization, resourcing, roles, and ways of

approaching and improving the anticipatory care system. The organisational boundaries act as enablers and barriers in the system.

A number of qualities were identified as essential to leadership in the AC project, and for anticipatory care more generally. These leadership qualities suggest opportunities for individual organisations to grow and enhance their own leadership capacity within the anticipatory care by building these qualities internally. They are:

- Collaborate with an openness to multiple perspectives and respect for different types of knowledge
- Deep connection with and responsiveness to at risk communities and cultural competency in those communities.
- A lived and practiced organisational commitment to the principles of social justice, equity and compassion.
- Flexibility, adaptability, creativity, risk taking, self-reflection, and an openness to learning.
- Established networks of relationships and influence.
- Breadth of expertise, knowledge, and skills
- Ability to manage resources, time, activities, people, and projects.
- Commitment to social determinants of health and anticipatory care approach.

Leadership includes the role of the Project Support Officers (PSOs)

PSOs—in most sites—were essential for reaching not only other services in the anticipatory care system, but also to people and organisations that had been invisible. In Clarence’s H2H work, this role was defined in the notion of a ‘Health Connector’.

Whether located in a single organisation, or present in multiple parts of the system, health connectors have an essential role in increasing trust, information flows and connection and collaboration into and across the anticipatory care system.

Local advisory groups are also essential

Finally, a diverse and flexible local advisory group (or community reference group, or leadership group) has been shown to support the anticipatory care system. The advisory groups brought services and community members together, at best including people from marginalised groups and with diverse cultural and practitioner perspectives. They were most effective where they were able to identify and unite around shared goals. This takes time and has been supported by action learnings cycles of observation, reflection, planning and acting.

The possession or lack of the identified leadership qualities, along with the enabling and limiting boundaries particular to each organisation, were often found to be complementary. What is needed to lead efforts to strengthen the system are strong relationships, and collaboration amongst organisations. For example, where FIAAI or a neighbourhood house may have a deep insight into a particular need of their local community, local government may be the organisation with the power to make change in response to that need.

Finding 4: There are *policy and practical barriers preventing GPs from being able to take a central role in anticipatory care*

The potentially important role of GPs in preventive health remains largely unfulfilled in three of the AC project sites (the exception is Flinders Island site where GP consultations are mostly bulk billed). Practice business models and the regulatory environment mean GPs are not accessible to many community members.

“The last time I went, I didn’t pay my rent so I could go to the doctor ... I had to have bloods checked, eyes checked, blood pressure checked, the complete overhaul check, [...] and then I have to wear glasses to drive now [...] So, I had to find the money, go to the doctor within 14 days. I had to get an appointment, and it’s hard to get an appointment. [...] So it’s all, just one thing goes out of whack, and everything falls over.” (Interview)

There are fewer GPs in the least privileged places, their ‘books’ may be closed and waiting lists long. The cost of a consultation is out of reach for many people, and uncertainty about that cost is a barrier to seeking help. People are rarely sure they will be bulk billed, and the ‘gap’ is too expensive. Where doctors do bulk bill, there is often little time in the consultation for screening or other preventive action.

GPs, in general, are, as one person told us “not central to good anticipatory care. In fact, they’re a barrier to good anticipatory—if the only place you can get your health information is from your GP, that’s really limited”. (Interview)

These are resource barriers—individual and systemic.

Present policy focuses on acute care, rather than preventive health. This neglects the role GPs could be playing. The UK model of anticipatory care cannot work where community members are choosing between conflicting demands on their meagre funds. In the absence of reliable bulk billing or low-cost consultations, people are avoiding GP visits, adding to their risk of chronic illness and likelihood of becoming a potentially preventable hospitalisation statistic.

The shame of having to ask to be bulk billed, and to justify that request (“I feel like I have to tell my whole life story”) is a further barrier, and among the psycho-social reasons that GPs are not central to the

“So we do have attitudinal failures. [...] “Oh, well it’s going to [cost]” Well, so what? Why do you expect that it’s going to cost nothing? I mean it costs me \$75.00 or whatever when I go to the doctor now, [...] but I really can’t complain too much, because I’m in a good income bracket. There are many though that can’t, but if I would go through their accounts, they’d still be putting money to registrations on too many cars, or Netflix subscriptions, or mobile phone plans that are too expensive, [...]. They’ll still have Foxtel, but they won’t go to the doctor.” (Interview)

anticipatory care system. As well, in some places, GPs (or their staff) expressed the view that health is an individual responsibility, and that ill-health was the result of poor choices.

These ways of thinking create barriers that reduce attendance by ‘at risk’ people. They are evident throughout the data, in practitioners’ and community members ‘victim blaming’ comments. They mean

that people who need medical help may avoid local GPs and— when the need is pressing—go to the hospital instead.

Finding 5: Despite local differences in focus, access problems are undermining anticipatory care and excluding the 'at risk'

The AC project has made apparent the major barriers to anticipatory care system. The guiding themes in each site—access, safety, connection and collaboration—all reflect the boundaries within and around the anticipatory care system that keep some people, and some services, out. They make the system inaccessible or hard to navigate for community members and service providers. Access barriers keep the 'at risk' outside the system.

'At risk' people are those who experience:

- Life circumstances (socio-economic) e.g. poor housing, low income, low food security, etc.
- Disease/s e.g. cancer, mental illness, etc.
- Health related behaviours (lifestyle) e.g. diet, smoking, low physical activity, alcohol and substance abuse, etc
- Consequences of disease e.g. pain, physical, psychological, etc.
- Clinical risk e.g. obesity, high blood pressure, impaired glucose metabolism, etc. [1]

In the H2H site, access was described as being shaped by physical and geographical factors, personal resources (financial, educational, etc.), and psycho-social barriers like a lack of emotional or psychological comfort. In Launceston's OCOC site, the safety of the anticipatory care system is reduced by psycho-social and resource barriers: stigma was prevalent across poorer communities, and

people in the OCOC site generally had fewer financial resources. Connection, the CC focus, and collaboration, the OHOF focus, are also about access to and through the system. Ulverstone's CC, for instance, was concerned with supporting health literacy among services, and broadening the availability of health information to reduce fragmentation across the anticipatory care system and support people's better health, and OHOF wanted to ensure better collaboration to ensure that on- and off-island services used their resources for greatest effect to better manage chronic illness, and thus extend their reach.

Some of the barriers to access are 'personal'. Poverty and low literacy simply reduce options for seeking formal help.

"Like I can't read and write very well. I don't want people to know that. So, I will say, oh yes, I know where I'm going. And I just won't go."
(Interview)

They also affect how readily people can engage in some of the activities that might better support physical and mental wellbeing.

"You can even see it. [...] if you just look at even the fitness level and how some of the kids are shaped from the more private schools or the more well-off public schools and some of the ones in [this area], I was just there today and some of the other schools there's almost no obese children because they have footy clubs around them. They have soccer clubs, all these other stuff and they eat well but if you go in [this area] there's no afterschool programs. There's no footy clubs around. There's no soccer clubs." (Interview)

People may have fewer resources (including money, literacy, good quality housing), but it is also the case that there is a lack of physical infrastructure in the poorest parts of these sites.

There are too few GPs and too few who consistently and transparently bulk bill. There are fewer safe and pleasant options for physical activity, and poorer internet coverage [21]. These inadequacies are interpreted by some community members as a sign of disrespect.

"It's pretty obvious what the government thinks of us—they don't look after the infrastructure and keep taking things away." (Interview)

In systems terms, access is being shaped by **infrastructure** (e.g., services that are distant or 'full'), by **relationships** (e.g., for collaboration or between services and community), by **information** (e.g., whether it is shared and useable), **attitudes and beliefs** (e.g., stigma, racism), **people** and their personal resources (e.g., money, literacy, SDoH), and by **policy and processes** (e.g., short-term funding, business models).

In each site, project activities made inroads into access, and they show how the 'at risk' might be better reached. In Clarence's Help to Health work, the "Health Connector" role, trialled ways to better hear from and respond to people in the most disadvantaged of the municipality's many 'villages'. This outreach was mirrored by PSOs in the other sites, especially where they were guided by the strengths based, inclusive ways of working of neighbourhood houses and FIAAI. Mentored by trusting project leads, these PSOs found multiple ways to explore and interact with their communities and learn from them. In Launceston and on Flinders Island, the PSOs

were also already familiar to community members; some of the important trust work had begun; it was also not disrupted by the project and—to a large extent—has continued past the end of the AC project. Continuity is important for building community members' trust in and access to the system.

Shifting attitudes (and the actions that they drive) was a focus for the Launceston (OCOC) and Flinders Island (OHOF) teams. In these sites, the CLD process showed the significant negative role played by stigma. In Launceston this drove a decision to better support people living with trauma, making the system safer, and the same need drove the OHOF team's work to build cultural competency among service providers. Ulverstone's health literacy and information sharing work, and Clarence's suite of initiatives were also intended to smooth access, through better informed service providers. And there is evidence in each site that these different ways of improving access have had some effect.

COVID-19 was a test of the anticipatory care system

The declaration, in March 2020, that a novel coronavirus had become pandemic demanded immediate changes in the four project communities. The lead organisations had to find new ways to support their communities and the anticipatory care system. Local teams reported that people across the sites felt anxious, isolated, vulnerable, and distressed. Measures to stop COVID-19 made it harder to take part in social and physical activities outside home, reduced access to good quality food and cut some off from medical services (fear of infection kept many people from attending doctors' surgeries, for instance [e.g., 22, 23]). But the relationships and capacities that the project teams had built were deployed in response.

For example:

- on Flinders Island, new collaborations between FIAAI and the Ochre Medical service that had developed in the OHOF project resulted in a community fluvax clinic run by staff from FIAAI, Ochre and the Island’s Multi-Purpose Centre; this was the first time such a collaboration has happened
- H2H’s ‘Clarence Talks’ moved online and the Clarence Services Online Forum was launched
- Connecting Care used their social media site and the newly launched project Portal (online resource directory) to provide expert advice about the virus, about telehealth and about mental health during the lockdown
- in Launceston, a new collaboration with a local GP clinic meant the OCOC team could add information about using telehealth to their existing suite of online stories celebrating the community, and team members made exercise-at-home, local champion, and gardening videos to support wellbeing. The lead organisations also provided additional food to community members.

Each of these activities extended the system’s reach. And all relied on a knowledge of what the community needed, gained through trusting relationships, and the capacity to meet those needs through familiar people, places and mechanisms.

*Finding 6: The largest single change can be driven by **Policy and processes***

Policy and processes, whether at the organisational or governmental level, shape how the whole anticipatory care functions but are largely outside the bounds of the AC project to change. The most prominent ways this system part affects the anticipatory care system are through:

- Short term competitive funding
- Business models and performance measures
- Policies that establish and maintain the negative social determinants of health.

Short-term competitive funding

It is clear across all the AC project sites that short-term competitive funding is damaging and limiting to the anticipatory care system. Short-term funding refers to project- or activity-specific funding, for periods as short as six months to two years. This sort of funding means that work needed to create the right environment for the project intervention—linking people, gaining knowledge and sharing information, reducing fragmentation, and building relationships—has often just started to take effect when the money runs out. And that destroys relationships, causes fragmentation, and undermines efforts to make larger changes to policy settings, for instance. It also leaves people feeling that they don’t matter and reduces trust. The costs of short-term funding reverberate across the anticipatory care system.

Competitive funding pits potential collaborators against one another, and takes resources from the on-the-ground service or activity to pay for developing funding submissions and evaluations (in other words, to compete). The risk of losing competitive advantage discourages sharing, reinforces silos, and can prevent the all-important trusting relationships—between services and between services and community members—from developing. The competitive environment also tends to gradually reduce the pool of organisations being funded [what the systems thinker, Donella Meadows calls “success to the successful”, 24], since better-resourced organisations

have more capacity to prepare applications. This risks reducing the diversity of voices in the field, reducing opportunities for mentoring new leaders or collaborators, and reducing opportunities for potentially better approaches to develop. Further, the uncertainty of short-term funding means that valuable time is lost (when funding is won) in establishing the program and finding and training staff. Then, as the end of the funded period approaches, those same staff

start to look for other work, often leaving (with their program expertise, local knowledge and developing trust in the community) well before the program ends. This affected PSOs in the AC project. Short contracts can bring new (potentially beneficial) players into the system, but they may come ill-equipped to operate in culturally safe ways, racing to catch up on any existing information that could aid preventive approaches or collaboration.

Vignette. Fly-in-fly-out? The implications of short funding cycles

Short-term competitive funding can have advantages. It can stimulate rapid implementation of new ways of working, or push service providers to reinvigorate their delivery. It also can have disadvantages. It can undermine the “long term productive relationships, between patients and professionals who know and trust each other” [3], and the opportunities for collaboration and care coordination that AC relies upon. For many service providers, their role in the anticipatory care is insecure.

“Each financial year it just changes; the pots of money get moved around [...] what I see is that for 18 months they might be employed by one organisation, and then it all comes up for review again, and then that organisation might get that money to provide the service”

“I think also a lot of people, including myself, for me to be here I need to have multi-funds [...] So I have to kind of have a bit of clinical work and a bit of health promotion and a bit of private work to actually sustain [my role] and have enough funds to work here.”

“And so I guess to be able to better support and help people you have to be able to have that space, for some it's going to take six months, 12 months depending on your degree of trauma and history and we if we have not got the time or the, you know, the funding to be able to sit in that space [...] We [are] kind of expected to deliver and get certain outcomes, but we don't actually recognize a lot of the tiny little outcomes, tiny little achievements, goals that are being achieved and some of them are so tiny, but they're there. We should not be dismissing those because each little thing kind of builds on to something and then you know, you don't just get that big beautiful shiny [cure].”

The aim of funding should be to set broad goals, focus on outcomes rather than outputs and activities, and then allow communities to get on with it, with funders acting as partners in the process. Shifting

national and state policy is a large task, but local sites can advocate for changes to this policy approach and demonstrate the effectiveness of collaboration.

Policy and business models are keeping GPs from their potential role in anticipatory care

The second policy problem is the bulk billing model operating in Tasmania that makes GP and other medical and allied health consultations inaccessible to too many people.¹ The ‘gap’ is too large, and the upfront payment required can be beyond reach. This means that too many people do not seek preventive health or early intervention in health conditions—especially when access is affected by judgmental or stigmatising attitudes among providers, or processes that require people to repeatedly justify being bulk-billed. The lack of transparency about bulk-billing practices adds to this problem.

Current regulatory and business models constrain GPs from reaching out into communities and engaging in local health promotion work. Where a service is measured by throughput and uses a ‘billable hours’ model, there is little incentive for outreach, or for forming and nurturing the long-term trusting relationships upon which anticipatory care relies, since those activities and skills are often left un-accounted for. Funding models also reduce the attractiveness to general practice graduates of working in poor areas where people have complex chronic and other health needs and little money, contributing to lower local GP numbers. This is exacerbated by criteria for subsidising GP graduate placement that may exclude areas that have greatest need. It may be quite difficult for GPs to run a viable practice in some communities under the present policy settings.

¹ Dentistry, important for preventive health is another example of a part of anticipatory care that remains beyond the reach of many people.

Policies need to guarantee the social determinants of health are benefiting everyone

The social safety net, including social welfare payments and associated policies and processes, places significant stress on recipients and can reduce their trust in services and make them unwilling to engage. Policy that leaves people poor and processes and rules that are sometimes punitive add to existing mental distress in communities (where rates of mental illness are much higher [25]), and undermine cooperation, collaboration, and safety.

Local services can adjust their rules and develop coherent and locally appropriate processes that make the systems safer for all its users. By coherent, we mean processes that are easy to follow and make sense, that are delivered locally or by accessible means, and that use language that is familiar to the intended audience. As the AC project has shown, services can also adopt processes and rules that reduce stigmatising encounters and increase trustworthiness and safety for users and providers (e.g., trauma-informed approaches, The Right Place, and cultural competency).

The conditions that make people sick are cause for policy change

Anticipatory care’s beginnings, with Dr Julian Tudor Hart, were driven in part by his concern that while he could treat a person’s presenting symptoms, he was also sending them home to the conditions that had contributed to their illness in the first place. He spoke of an ‘inverse care law’ [11]—the idea that *“The availability of good medical care tends to vary inversely with the need for it in the*

population served". The 'at risk' people in Tasmanian communities are, almost invariably, being sent home to those conditions.

The foregoing has argued that creating and sustaining the complex anticipatory care system relies on time to develop trusting relationships, to recognise diversity and the particularity of place and belonging (including culture), and on equitable resources for physical, financial, cultural, psychological and emotional access to the anticipatory care system. The local project teams have demonstrated their resourcefulness in supporting the long-term health of community members; community members want to look after one another, make their 'place' safer, and took the opportunity to do so. Those lead organisations closest—and most clearly accountable—to their community, put that the opportunity of this project to use in ways community is directly experiencing (e.g., Adventure Play, cultural competency training, changes to Metro Tas bus routes, new ways of working with other anticipatory care players).

But these successes, enabled by one-off, short term, project-based funding and driven by engaged and resourceful people and their 'soft' relational skills, begs the question: why are some communities in need of these (rare) buckets of money, with which they can then make some inroads into inadequate anticipatory care? Why does the inverse care law still apply? Chronic illness risks and prevalence and potentially preventable hospitalisations are driven in part by a lack of individual resources, but there is a lack of public—or private sector—infrastructure. There is a dearth of accessible health services, transport, appropriate and stable housing, fresh food and so on (the social determinants of health). This project has shown the soft infrastructure to be essential. It is being undermined by the same short-termism: staff and services come and go, jobs are insecure and

projects look for gains that fit tick-a-box performance measures of number of services delivered, or reduction in complaints, are missing the point. The model in which communities are given short term funding to patch up long term disadvantage demands an accountability from communities that is not reciprocated. We need to move away from these funding models, but also from the unreasonable inequities that leave some communities reliant on the energies and devotion of those people, like neighbourhood house, Men's Shed or ACCHO staff and volunteers, hoping for the next time-consuming grant application to succeed.

Finding 7: We need to *replace 'doing to' with 'doing with'*

"[The approach from this FIFO worker,] "how can I work with you and your community", not "I'm bringing this into your community" was very important. [Worker] wasn't going into the office and shutting the door ... [They were] wanting, looking for a way into the community". (Interview)

"So [connecting with other services is] important, but it's hard and we have to think creatively around how do we build that communication and that collegial aspect, because it can be very isolating over here as a [chronic condition] worker, so knowing how to support each other is important." (Interview)

When a community joins a place-based, and place-driven, project, or just plays host to researchers, they are also acknowledging that their 'place' might have a problem [26, 27]. However, the risk of stigmatising comes with the potential benefit of funding, of the opportunity to try something new, and of the community being listened to. In this project, capacity building was part of the research

process (e.g., in action learning, in systems thinking and in research and sense-making, especially for the PSOs).

The UTAS research group had a commitment to flexibility, to co-design and to a comprehensive investigation of anticipatory care. We needed to learn—from the project teams and their communities—not only about anticipatory care, but also about how to work effectively with them. This meant reflecting on our own cultural competency; we wanted to understand and respect culture, place and belonging. But the problem of short-term funding applies equally to research projects: communities see us come and go, apparently caring yet withdrawing when the money is spent. Further, the communities used the research—and the action learning and systems thinking tools—not only in their planning and decision making, but also in advocacy, for example. The continuation of this mutual learning benefits the anticipatory care system itself.

Finding 8: The Anticipatory Care Framework needs revisions to reflect the system's complexity and breadth

The Anticipatory Care (AC) Framework (Appendix) guided the development of the overall AC project. The Framework is evidenced based and emerged from a discussion paper [1] designed to adapt the UK model of anticipatory care to a Tasmanian context. The Framework has six domains:

- Priorities
- Description
- Elements
- Enablers/supports
- Consumer Outcomes
- Population Outcomes

The priorities describe what is considered to be the most important features of an anticipatory care model from 'Outreach to people who most need care' to enabling 'people to improve their health'.

The AC project has provided a unique opportunity to review and consider the AC Framework in light of four different lead agencies and approaches to anticipatory care. The systems approach to the research provided another lens through which to consider the veracity of the AC Framework. We found that, overall, the range of actions and activities undertaken over the life of the project could be mapped onto the existing AC Framework. However, the current AC Framework assumes a narrowly bounded 'health care system'—one based on the health of an individual patient and their medical care. On reviewing the AC Framework it was found that:

- The health care system focus of the Framework renders invisible the work of broader groups of professionals and organisations who are playing roles in anticipatory care and health and wellbeing in their communities. It is proposed that the Framework 'boundary' is expanded and the language modified to be more inclusive of multi-sectorial involvement in AC.
- While the person-centred model of care in the current AC Framework is important, it does not adequately capture the broader contextual factors that influence health and make up the anticipatory care system in communities. As such, it is proposed that the Framework be modified to reflect the importance of a) place and identity (namely the culture and history of a community and how this influences health and wellbeing); b) shared goals and values (how people in the anticipatory care system identify shared goals and work together to improve health), and c) adaptability and agility, referring to the way

systems evolve and change. (See Working Paper, Review of the Anticipatory Care Framework, Riley, October 2020.)

Finding 9: The *term ‘anticipatory care’ is not useful* if we are to engage with ‘at risk’ Tasmanians and their communities



‘Anticipatory care’ is an obscure description and a mouthful. Many of the stakeholders struggled with the term, and wondered how it differed from ‘preventive health’. All sites made finding a local project name a priority.

Our recommendations still use the term, but we recognise that it may not be appropriate in preventive health work.

Conclusions

Anticipatory care is “a population approach with long term productive relationships, between patients and professionals who know and trust each other, and who are guided by evidence and audit” [3]. The AC project has used action learning and system thinking to investigate the nature of anticipatory care in four Tasmanian communities, identify important system parts, barriers to and enablers of anticipatory care, and ways in which communities and health services can work together to engage those most at risk of chronic illness.

Aim 1—Increase our knowledge and understanding of how anticipatory care occurs in different communities

The AC project has increased our knowledge of how the anticipatory care system operates in four Tasmanian sites. The systems are complex, with multiple causal links and local characteristics. They also include a very wide range of services, reflecting the social determinants of health; in most sites, the project activities brought more types of organisation into anticipatory care and enabled them to reflect both on their role and on how to better support the long term health of community members. Collaboration has increased, with potential benefits for better management of chronic illness.

Although there are shared system parts, local factors mean that building a better system needs to take account of local people, place and belonging, infrastructure and particular attitudes and beliefs. These local characteristics mean that it is possible to take local action to influence the system. External structural factors, however, exert considerable force on the systems in each site, and reduce individuals’ capacity to change. Chief among these is the policy and

processes that drive funding decisions, business models, and people’s equitable access to the social determinants of health.

Aim 2: —Better understand the enablers and barriers to anticipatory care experienced by communities

Policy and the processes it drives can be a barrier to an effective anticipatory care. The communities where people are most at risk of chronic illness and of potentially preventable hospitalisations are experiencing barriers of access (in multiple forms), of a lack of safety and of inconsistent service provision. These barriers curtail the much needed trusting long-term relationships, sharing of information, and collaboration upon which anticipatory care relies. Attitudes and beliefs underpin much of what works, as well as what doesn’t work in the anticipatory care system. Stigma and discrimination are evident not only in poor or absent relationships, but also in the lack of trust, and resourcing of our poorest people and communities. Community members need to be trusted and respected by service providers. This is one way in which individual barriers can be reduced. Service providers need to trust and respect one another. Cultural competency, guided by local culture, history and circumstances needs to be embedded in organisations, in how they collaborate and in how they work in local communities. Communities need to be resourced to inform that competency. Time, a necessity for the development of trusting, culturally competent relationships, is often in short supply. A focus on performance measures that count incidents of service, or hard infrastructure, allows policy makers to remain ignorant of the essential role played by soft skills—nurturing, respectful, collaborative ways of being in

and with others in the anticipatory care—and the need for time to build and sustain these skills. All these things take time. Performance measures also need to take into account the unpaid time spent by so many in community organisations, without which chronic illness and PPH would be an even larger problem. Finally, communities need the on-the-ground (and in the ether) infrastructure of facilities, organisations, and services.

Aim 3. —Increase our knowledge and understanding about how communities and health services can work together to engage ‘at risk’ Tasmanians in primary and preventative health care, including assessment and management of their health needs

Some communities and services work together to better engage people ‘at risk’ in preventive health. They have a strengths-based (rather than deficit) approach, and a safe and accessible system, populated with adequate infrastructure, and the time and safety to build and nurture long-term trusting relationships. No one person, service or organisation has the ‘keys’: all players in the anticipatory care need to be safe and accessible. Equipping system players to be genuinely accessible and collaborative requires listening, trusting relationships and mutuality, and cultural competency. This cannot be achieved within short timeframes, and without structural change to reverse the negative social determinants of health.

Recommendations

Anticipatory care is an innovative community-driven approach to identifying and addressing barriers to better health and wellbeing, to reduce long-term chronic disease. The AC project has demonstrated that enhancing the anticipatory care system is possible at the community level through locally-developed and delivered initiatives.

We make six high-level recommendations to enhance anticipatory care and reduce the risk of potentially preventable hospitalisations. These six recommendations are supported by sub-level recommendations and steps to achieving recommended change (Table 5). The high-level recommendations are:

1. Reflect the complex and multi-disciplinary nature of anticipatory care in local, state and commonwealth policy
2. Develop place-based commissioning and whole-of-community outcome indicators (e.g., OECD “better life”) to measure progress towards addressing chronic illness
3. Create culturally safe health, education, and social services. (training, policy, engagement)
4. Ensure equitable access by addressing the structural and individual barriers and system road blocks to medical, psychological and dental services for preventive health
5. Increase awareness of the anticipatory care system and services
6. Revise the AC Framework in light of the AC Project findings.

Recommendation	Sub-level recommendation	Steps to achieving recommended change
<p>1. Reflect the complex and multi-disciplinary nature of anticipatory care in local, state and commonwealth policy</p>	<p>1(a) Embed systems thinking approaches in preventive health work</p> <p><i>(see UTAS Policy Brief: Systems Thinking, September 2020)</i></p>	<p>1(a)i. Factor specific time for developing systems thinking skills and capacity in practitioners and agencies</p> <p>Resource the adaptation of systems thinking tools to local applications.</p>
	<p>1(b) Reflect the complexity of AC in collaborations for preventive health</p> <p><i>(see UTAS Policy Brief: Funding Models for Preventive Health)</i></p>	<p>1(b)i. Include independent research support for evidence-based planning and action learning, systems thinking, ongoing reflection and review (i.e., university support) in collaborations.</p> <p>1(b)ii. Resource policy and relational contracting support and management, and access to tools and information (i.e., DoH support).</p> <p>1(b)iii. Work with community to identify and drive change based on local needs and ways of working, and using systems thinking methods</p> <p>1(b)iv. Build opportunities for mutual learning between community, services, universities and researchers, and relevant government personnel into future preventive health (including anticipatory care) projects.</p> <p>1(b)v. Create and resource long-term ‘Health Connector’ roles in communities to support and enhance anticipatory care through:</p> <ul style="list-style-type: none"> • Physical activity, social connection, and information sharing initiatives

- Relationships with existing and new service providers, researchers and community to strengthen locally-based coordinated approaches
- Innovation to surface and address AC needs

I(b)vi. Incorporate outreach and system-wide collaboration as key tasks for all services operating in or to the community and find ways to coordinate with one another to support the anticipatory care system.

I(b)vii. Factor time and establishing coordination mechanisms into collaboration planning, development and maintenance.

1(c) Support mutual learning in approaches to enhance anticipatory care

I(c)i. Build opportunities for mutual learning between community, universities and researchers, and relevant government personnel into future preventive health (including anticipatory care) projects.

I(c)ii. Resource a longer-term trial of the Anticipatory Care Action Learning Project approach, with a focus on the complex health problem of mental illness.

1(d) Implement funding models that support multi-disciplinary collaboration for preventive health

(see UTAS Policy Brief: Funding Models for Preventive Health)

I(d)i. Replace competitive funding models that reduce connection and collaboration between parts of the anticipatory care system and pool resources and develop models that promote and support collaboration between governments, universities and researchers, NGOs and communities.

I(d)ii. Funding models need to be flexible, long term and adaptable to meet community need. This is because communities have different strengths, gaps and priorities. Proportionate universalism has been proposed as a suitable framework.

I(d)iii. Funders to set broad goal/s (e.g., “improve OECD ‘betterlife’ indicators in a community, such as self-

reported health and life expectancy”) and allow lead organisations, in consultation with their community, to determine what success looks like, how it will be measured, and how to allocate and manage the funding.

1(d)iv. Funders need to work as partners, providing:

- guidance and monitoring of processes (e.g., community engagement, how resources are being utilised/targeted, without being prescriptive)
- a conduit for knowledge, information, and evidence to support local activities, founded on principles of mutual learning and ongoing sharing of information.

1(d)v. Place relationships at the centre of funding models. Build time and “relational contract management” into funding to develop and nurture a shared understanding of the community and the initiative.

1(d)vi. Support collaborative governance arrangements in which government is a partner in the initiative rather than a top-down driver of process and outcome. In this model, shared goals and outcomes can be worked on together.

1(d)vii. Build into funding models regular opportunities for all project partners to reflect on their expectations, assumptions, values and biases that could inhibit the development of trusting relationships.

<p>2. Develop place-based commissioning and whole-of-community outcome indicators (e.g., OECD “better life”) to measure progress towards addressing chronic illness</p>	<p>2(a) Factor the importance of place and belonging (including cultural concerns) into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing and, potentially, mirroring or adopting the ACCHO model</p>	<p>2(b)i. Support ACCHOs to continue their central role in supporting the health of Aboriginal people</p>
	<p>2(b) Recognise, at State and federal government levels, that the Aboriginal Community Controlled Health Organisation (ACCHO) model, with its holistic approach guided by the social determinants of health and cultural competency is an appropriate framework for anticipatory care, and develop policy and funding models that supports this model being applied more widely</p> <p>The ACCHO/social determinants model demands a whole-of-government approach to preventive health</p>	<p>2(b)ii. Investigate ways to adapt the ACCHO model for other communities, including resourcing ACCHOs to support such adaptation.</p>
	<p>2(c) Include quantitative and qualitative performance measures to reveal how the AC (or other health and wellbeing) system is performing</p>	<p>2(c)i. Develop KPIs within local, state and federal government that reflect externalities, soft infrastructure and experiential dimensions of performance</p> <p>2(c)ii. Revise health and social service KPIs to reflect externalities, soft infrastructure and experiential dimensions of performance</p> <p>2(c)iii. Promote policy-level recognition of the SDoH factors affecting the community and continue to advocate for better provision of GP and other health and social services in disadvantaged communities</p>

2(d) Work with existing place-based collaborations to support anticipatory care

(see UTAS Policy Brief: Organisational Leadership for AC)

2(d)i. Maintain and resource local advisory groups and revise terms of reference to reflect the social determinants of health (SDoH)

2(d)ii. Work to enhance the diversity of representation on local advisory groups, engaging community members and reflecting the social determinants of health (e.g., LAG should include, but not be limited to, agencies with roles in housing, education, health, Aboriginal organisations, etc.), whether locally-based or coming to the community from elsewhere.

2(d)iii. Where no local collaborative group exists, create and fund multi-organisation and long-term collaborative leadership groups that incorporate and take advantage of multiple roles, scope, perspectives, system entry points, and complementary leadership qualities.

2(d)iv. Resource local bodies to develop or maintain cultural competency, trauma-informed relational skills and knowledge of the anticipatory care.

2(d)v. Each local government needs to articulate and be accountable for their role in AC – to community and to other levels of government.

2(d)vi. Tailor local service delivery to suit the financial, educational and technological capacity of community members; this relies on services' capacity.

2(e) Provide time, support, funding and facilitation to build leadership and collaboration

(see UTAS Policy Brief: Organisational Leadership for AC)

2(e)i. Create and fund multi-organisation and long-term collaborative leadership groups that incorporate and take advantage of multiple roles, scope, perspectives, system entry points, and complementary leadership qualities.

2(e)ii. Ensure that collaborative leadership groups include strengths-based and place-based organisations

with deep community connections and local cultural competency that can effectively engage with local communities.

2(e)iii. Ensure that leadership collaborations include organisations and mechanisms that are able to engage with, and draw in, groups and communities who are affected or marginalised by the system.

2(e)iv. Create criteria for the selection of leadership for preventive initiatives that incorporate identified leadership qualities and enablers across key organisational attributes.

2(e)v. Build senior level organisational alignment amongst partners across the system with a commitment to creating a shared vision and purpose, including core project approaches such as SDoH built into funding,[28] contract, and governance guidelines.

2(e)vi Create project initiation processes and events that extend organisational alignment and shared purpose further into the partner organisations.

2(e)vii Build and support relationships, trust, and understanding across all levels of participating organisations through flexible service agreements and funding arrangements, action learning processes, and relational contract management approaches.

2(e)viii Create shared governance and dynamic multi-level collaboration mechanisms[28] and processes, which support the key leadership qualities, and provide for ongoing flexibility, self-reflection, managed risk-taking, learning, negotiation, and change.

3. Create culturally safe health, education, and social services (training, policy, engagement)

3(a) Resource place-based cultural competency

Note: Cultural competency takes into account history, place, and inter-generational or other trauma

3(a)i. Resource and collaborate with local communities (including local palawa) to develop and deliver place-based cultural competency training, and to design appropriate performance measures

3(a)ii. Involve people who are already culturally competent in development and delivery of training

3(a)iii. Build cultural competency into employment induction, professional development and organisational culture, policy, and processes

3(a)iv. Equip researchers and project officers working in community to work in culturally competent ways, through self-education and respectful engagement

3(a)v. Build cultural competency into employment induction, organisational culture, policy and processes, and performance reviews or evaluations for all agencies, institutions and services collaborating in anticipatory care

4. Ensure equitable access by addressing the structural and individual barriers and system road blocks to medical, psychological and dental services for preventive health

4(a) Support the medical, social and economic health of communities, through all levels of government, by providing/subsidising GP, mental health and dental services where they are needed

4(a)i. Review national and state regulation of GP services to increase equity of access to bulk-billed telehealth (e.g., the recent guideline that only people who have a regular GP can use bulk billed telehealth reduces access to this service for many who do not have a 'regular' GP)

4(a)ii. Review subsidies for GPs servicing rural and remote areas to include outlying and disadvantaged communities

4(a)iii. Review national and state regulation of GP services (including regulation of international medical graduates (IMG) to counter supply shortages

4(a)iv. Implement different funding and contract arrangements for rural and remote GPs to do outreach and education, with ongoing evaluation of the effectiveness and reach for engaging those most unable to access services

4(a)v. Continue bulk billed telehealth services, subject to evidence that this is improving access to GPs for members of marginalised communities who may also have poor internet and telephone resources

4(a)vi. Adopt clear and transparent information and easily understandable guidelines explaining GP bulk billing policy and practices

5. Increase awareness of the anticipatory care system and services

5(a) Ensure health service information is accessible

5(a)i. Invest in face to face delivery modes for information about health and services.

5(a)ii. Ensure digital infrastructure is available across the State, particularly where alternatives are limited, and provide appropriate technical and guidance supports for people to make use of this.

5(a)iii. Prioritise health literacy programs that address the design and delivery of information to support health and access; improvements in community members' literacy is a secondary—though important—goal.

5(a)iv. Use culturally competent processes, and co-design where possible, to collaborate with organisations with connections into communities (e.g., ACCHOs, neighbourhood houses) to identify appropriate mechanisms for delivering health information.

6. Revise the AC Framework in light of the AC Project findings and conclusions	6(a) Include the complexity of the anticipatory care system in the AC Framework (see Riley, T. (2020). <i>Working Paper, Review of the Anticipatory Care Framework</i>)	6(a)1. Expand the Framework boundary and language to reflect multi-sectorial involvement in anticipatory care. 6(a)ii. Modify the Framework to capture the broader contextual factors that influence health and make up the anticipatory care system in communities, including: <ul style="list-style-type: none">• place and identity (namely the culture and history of a community and how this influences health and wellbeing)• shared goals and values (how people in the anticipatory care system identify shared goals and work together to improve health)• adaptability and agility, referring to the way systems evolve and change.
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Appendix: The Anticipatory Care Framework

Priorities	Description	Elements	Enablers/ supports	Consumer outcomes	Population outcomes
<p>Outreach to people who most need care</p>	<p>Focus care on individuals and their carers who are hard to reach and who have the greatest need in the community</p>	<ul style="list-style-type: none"> → Use proactive outreach strategies → Use population and disease registers and do 'case finding' → Develop partnerships with community → Seek opportunistic ways to engage people in their health care 	<p>Governance and leadership</p> <ul style="list-style-type: none"> → Support and leadership → Joined up health and social services (acute to community) → Local area coordination → Partnerships with services who can outreach → Consumer engagement <p>Health workforce</p> <ul style="list-style-type: none"> → Identify needs and attitudes → Training and resources (health promotion, self-management) <p>Health literacy</p> <ul style="list-style-type: none"> → Easy to understand education resources → Health literate organisations <p>Data and information</p> <ul style="list-style-type: none"> → Data sharing agreements → Community health profiles → Local community knowledge <p>Technology</p> <ul style="list-style-type: none"> → Patient registration → 'flagging' systems → EHealth Resources → funding models → Screening & assessment tools → Chronic Disease self-management programs <p>Research & evaluation</p> <ul style="list-style-type: none"> → Action Learning projects → Monitor patient outcomes and population → Effective outreach models 	<p>My community encourages me to adopt a healthy lifestyle.</p> <p>I am supported to make good proactive choices about my health and wellbeing.</p> <p>I am able to participate in purposeful and meaningful activities.</p> <p>My informal carers are recognised as an important support element in my life, and are included in my care.</p> <p>I can access and use tools to make decisions about my health.</p> <p>Any illness I have is picked up early and I get help managing it.</p> <p>My healthcare is tailored to my needs.</p> <p>Everyone in my care works together as a team, considering the many factors that keep me healthy and well.</p> <p>With my consent, my care team can easily access information about my contact with different parts of the health system.</p>	<p>Tasmanians have good physical health.</p> <p>Tasmanians have good mental health.</p> <p>Tasmanians at risk of poor health or living with chronic conditions are supported to stay well for as long as possible.</p> <p>Tasmanians are supported to overcome addictions.</p> <p>Tasmanians are supported to overcome crises, addictions and adverse life events.</p> <p>Tasmanians have a voice and choice in decisions about their health and wellbeing.</p> <p>Tasmanians can access the support they need in a timely manner from a well-working service system.</p> <p>Tasmanians are aware of important public health issues.</p> <p>Tasmanians have resilience to overcome adversity.</p>
<p>Early identification and risk assessment</p>	<p>Work with people to assess and anticipate risk: life circumstances and psychosocial factors ↔ lifestyle factors ↔ clinical risk factors ↔ impact of disease</p>	<ul style="list-style-type: none"> → Develop long term trusting relationships → Identify individual care needs (psychosocial and physical health) → Use many ways to engage people in assessment (e.g. proactive, system reminders and opportunistic screening) 	<p>Health literacy</p> <ul style="list-style-type: none"> → Easy to understand education resources → Health literate organisations <p>Data and information</p> <ul style="list-style-type: none"> → Data sharing agreements → Community health profiles → Local community knowledge <p>Technology</p> <ul style="list-style-type: none"> → Patient registration → 'flagging' systems → EHealth Resources → funding models → Screening & assessment tools → Chronic Disease self-management programs <p>Research & evaluation</p> <ul style="list-style-type: none"> → Action Learning projects → Monitor patient outcomes and population → Effective outreach models 	<p>I am able to participate in purposeful and meaningful activities.</p> <p>My informal carers are recognised as an important support element in my life, and are included in my care.</p> <p>I can access and use tools to make decisions about my health.</p> <p>Any illness I have is picked up early and I get help managing it.</p> <p>My healthcare is tailored to my needs.</p> <p>Everyone in my care works together as a team, considering the many factors that keep me healthy and well.</p> <p>With my consent, my care team can easily access information about my contact with different parts of the health system.</p>	<p>Tasmanians at risk of poor health or living with chronic conditions are supported to stay well for as long as possible.</p> <p>Tasmanians are supported to overcome addictions.</p> <p>Tasmanians are supported to overcome crises, addictions and adverse life events.</p> <p>Tasmanians have a voice and choice in decisions about their health and wellbeing.</p> <p>Tasmanians can access the support they need in a timely manner from a well-working service system.</p> <p>Tasmanians are aware of important public health issues.</p> <p>Tasmanians have resilience to overcome adversity.</p>
<p>Enable people to improve their health</p>	<p>Strengthen personal skills and create connections with social and community services to enable people to influence the determinants of their health</p>	<ul style="list-style-type: none"> → Strengthen health literacy and consumer engagement → Develop self-management skills → Provide evidence based care across the disease prevention continuum → Help people address psychosocial and physical care 	<p>Health literacy</p> <ul style="list-style-type: none"> → Easy to understand education resources → Health literate organisations <p>Data and information</p> <ul style="list-style-type: none"> → Data sharing agreements → Community health profiles → Local community knowledge <p>Technology</p> <ul style="list-style-type: none"> → Patient registration → 'flagging' systems → EHealth Resources → funding models → Screening & assessment tools → Chronic Disease self-management programs <p>Research & evaluation</p> <ul style="list-style-type: none"> → Action Learning projects → Monitor patient outcomes and population → Effective outreach models 	<p>I can access and use tools to make decisions about my health.</p> <p>Any illness I have is picked up early and I get help managing it.</p> <p>My healthcare is tailored to my needs.</p> <p>Everyone in my care works together as a team, considering the many factors that keep me healthy and well.</p> <p>With my consent, my care team can easily access information about my contact with different parts of the health system.</p>	<p>Tasmanians are supported to overcome addictions.</p> <p>Tasmanians are supported to overcome crises, addictions and adverse life events.</p> <p>Tasmanians have a voice and choice in decisions about their health and wellbeing.</p> <p>Tasmanians can access the support they need in a timely manner from a well-working service system.</p> <p>Tasmanians are aware of important public health issues.</p> <p>Tasmanians have resilience to overcome adversity.</p>
<p>Improve the personal experience in the healthcare system</p>	<p>Develop teams around people with support and planned pathways of care to respond to their prevention needs at different life circumstances and different stages of disease</p>	<ul style="list-style-type: none"> → Multidisciplinary team based care → Include informal carers → Integrated and coordinated care → Support care pathways which are easy to navigate → Use shared health records 	<p>Health literacy</p> <ul style="list-style-type: none"> → Easy to understand education resources → Health literate organisations <p>Data and information</p> <ul style="list-style-type: none"> → Data sharing agreements → Community health profiles → Local community knowledge <p>Technology</p> <ul style="list-style-type: none"> → Patient registration → 'flagging' systems → EHealth Resources → funding models → Screening & assessment tools → Chronic Disease self-management programs <p>Research & evaluation</p> <ul style="list-style-type: none"> → Action Learning projects → Monitor patient outcomes and population → Effective outreach models 	<p>My healthcare is tailored to my needs.</p> <p>Everyone in my care works together as a team, considering the many factors that keep me healthy and well.</p> <p>With my consent, my care team can easily access information about my contact with different parts of the health system.</p>	<p>Tasmanians can access the support they need in a timely manner from a well-working service system.</p> <p>Tasmanians are aware of important public health issues.</p> <p>Tasmanians have resilience to overcome adversity.</p>
<p>Plan care using local health information and consumer input</p>	<p>Use local health information, consumer records and consumer input to identify local health needs and focus proactive care</p>	<ul style="list-style-type: none"> → Use local health data and practice, population and disease registers to identify health need → Provide proactive care focusing on need → Involve consumers in the planning of services 	<p>Health literacy</p> <ul style="list-style-type: none"> → Easy to understand education resources → Health literate organisations <p>Data and information</p> <ul style="list-style-type: none"> → Data sharing agreements → Community health profiles → Local community knowledge <p>Technology</p> <ul style="list-style-type: none"> → Patient registration → 'flagging' systems → EHealth Resources → funding models → Screening & assessment tools → Chronic Disease self-management programs <p>Research & evaluation</p> <ul style="list-style-type: none"> → Action Learning projects → Monitor patient outcomes and population → Effective outreach models 	<p>My healthcare is tailored to my needs.</p> <p>Everyone in my care works together as a team, considering the many factors that keep me healthy and well.</p> <p>With my consent, my care team can easily access information about my contact with different parts of the health system.</p>	<p>Tasmanians are aware of important public health issues.</p> <p>Tasmanians have resilience to overcome adversity.</p>

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These references support the material included in this Final Report only. The Full Report has a comprehensive list of cited material.

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