Health Practitioner Research Scheme 2027 Launch- Transcript

11 June 2026, 11:00am

Emma Finch 0:28

Hi everyone and welcome.
Welcome to the 2027 funding round launch of the Health Practitioner Research Scheme. I'm Emma Finch and I'm currently the Acting Director of Allied Health Research here in OCAHO. Before we officially start, just some quick reminders. Please submit any questions that you have during the presentation using the chat function and if time permits, we'll take questions towards the end of the launch.

Also as a heads up, this meeting is currently being recorded and will be published on the HPRS webpage, which is a public site, for those who are unable to attend today's meeting. This means that your personal information, such as name, image, commentaries, and opinions, may be collected during this meeting. If you have any objections to this meeting being recorded, please let us know. For more information, you can refer to the Queensland Health Privacy Notice, use of Microsoft Teams for meetings and recordings, and the Microsoft Privacy Statement.

To begin, Queensland Health acknowledges the traditional and cultural custodians of the lands, waters and seas across Queensland. We pay our respects to elders past and present, and recognise the role of current and emerging leaders in shaping a better health system. We recognise the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination and commitment to Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of our peoples for millennia.

OCAHO would like to welcome you to the launch of the 2027 funding round of the Health Practitioner Research Scheme, or HPRS. For those of you who aren't familiar with the Scheme, OCAHO administers the HPRS, which runs annually and has been operating since 2004 in multiple forms. So excitingly, the Scheme has funded and supported over 150 research projects from new to experienced HP researchers to build research capacity and capability among the health practitioner workforce.

The aims of the HPRS are to support research that adds to the evidence for health practitioner services in enhancing patient, consumer and community outcomes, and demonstrates the value of the health practitioner workforce. The Scheme also aims to build the research capacity and capability of the health practitioner workforce in Queensland Health. It also aims to build and contribute to multidisciplinary research and health delivery partnerships and collaboration. The Scheme also aims to provide opportunities for health practitioner researchers across the state and aims to enhance the dissemination of research findings and the translation of research into practice.

Excitingly, today we'll provide more information about what is available and new to the Scheme for the 2027 round. We're also delighted to have two guest speakers today who have both recently completed their HPRS projects. As a new researcher recipient, we welcome Dr. Hannah Olufson, who is a senior dietitian at STARS and the Metro North Lead for AH-TRIP, and an honorary fellow at UQ. We also welcome an experienced researcher, Associate Professor Helen MacLaughlin, who is a consultant dietitian in Metro North Health and an Associate Professor at QUT. Hannah and Helen will briefly discuss their HPRS supported projects and how participating in the HPRS has contributed to their personal research career progression and the research capacity building of their wider teams. We're also pleased to welcome Dr. Alice Cairns, who is an Allied Health Rural Research Lead and previous longstanding member of the HPRS peer review panel.

So, a little bit about the current round. The HPRS is open to Chief Investigators from the Health Practitioner Professions, listed in the Health Practitioner and Dental Officer Certified Agreement Number 4, employed in Queensland Health, Mater Health Services and Health and Wellbeing Queensland. The HPDO4 provides for up to $400,000 in funding for eligible health practitioners to build research capacity in the health practitioner workforce and to facilitate the implementation of evidence-based clinical services in Queensland Health.

The 2027 funding round is open to all categories of chief investigators. This includes new researchers, for up to $40,000 for a one-year project; mid-career researchers, up to $75,000 for two-year projects; and experienced researchers up to $150,000 for two-year projects. I'll now hand over to Dr. Kristyan Guppy-Coles, who is an

Advanced Allied Health Research Development Officer, to provide more information on the scheme.

Kristyan Guppy-Coles 5:43

Thank you, Emma, and good morning, everybody. As Emma had mentioned, this year the HPRS is open to health practitioner chief investigators from all researcher categories, and that is the new, mid-career, and experience for researchers. So, in the table you can see in front of you, these categories are defined as outlined, and they are in the HPRS guidelines document that will be that is now accessible through the HP Research webpage. I'll just briefly run through what those categories are.

New researchers are defined as having not achieved a research high degree, but may be enrolled in one, and have received less than $50,000 in competitive research funding as a chief investigator. In a general sense, you know, the new researcher has none or minimal experience in undertaking general research projects, tasks or activities, including the publication, publishing the outcomes of previous research, either as a primary author or as a co-author.

Mid-career researchers are defined as not having any research high degree, or may be enrolled in one, or have completed a research high degree, but is less than six years from completion of that degree. Mid-career researchers have also received less than $150,000 in competitive research funding as a chief investigator. In this definition, a mid-career researcher would be expected to have some experience in connecting research and possibly managing research teams as well as publishing or presenting outcomes of research.

Finally, we have the experienced researcher category. An experienced researcher we define as having held a researcher high degree for greater than six years or has received more than $150,000 in competitive research funding as a chief investigator. Therefore, that expectation is that that level of researcher has significant experience in conducting research, developing and managing research protocols, budgets, and research staff, and has extensive publication and presentation track records as a first author.

If you're unsure about which category you might fit into when you're going for an application, please send us an e-mail via our HP Research e-mail, which we'll provide shortly, and just give us a bit of a short outline of your intended project, your background and experience.

Target areas for the 2027 HP round is essentially the same as last year and aligned to our 10-year strategy, which is the optimising the Allied Health workforce for best care. Three of the five key enablers of the strategy have been selected, as you can see in front of you, as priorities for HPRS projects to address workforce, digital transformation, and clinical education and training. Just to clarify, the idea of all HPRS projects should be improving patient access to care and/or improving health outcomes by evaluations of health practitioner workforce models of care and service delivery, research with a focus of digital transformation, or research with a focus on clinical education and training. Again, if you're a little bit unsure about which one of these categories your project fits into, please again send us an e-mail via HP-Research@health.qld.gov.au with brief information about what your intended project or project idea might be.

Additionally, all HPRS projects should align to one or more of the listed Queensland Health strategies. So that's the strategy I mentioned just before, as well as the Department of Health strategic plan and Rural and Remote Health and Wellbeing strategy. Within the HPRS application, there is a specific field for you to be able to articulate your alignment of your project to one or more of these strategies. You do not have to align with all three, it's at least one. Some of these strategies have changed from previous years, so please ensure that you review these thoroughly if you're going to be writing against each as an alignment of your project.

Finally, HPRS projects are expected to be aligned with particular priorities. This is similar to previous years, and these include consumer involvement in the design/delivery of the research initiative or project, rural and remote and regional partnership or chief investigators, research projects that are led by chief investigators from non-tertiary Queensland health sites, or collaboration across professions, services, sites, and/or external agencies. There's further information in the HPRS guidelines to help guide your identification of which priority you can align your project to.

So the selection criteria are listed in the HPRS guidelines as well, and there hasn't been much of a change to that from the previous year. The criteria align with the target areas, the HP priorities, health strategy, and also obviously focuses on the strengths of the research project in plan in terms of feasibility and impact.

So just also noting that because this round is including your experienced researcher category, experienced researcher applications specifically are also assessed on the applicant, application, or the team's plan to promote research capacity building within their project itself. Again, just a reminder, not every target or priority area needs to be addressed. It's at least one and we do really look at quality over quantity. Again, additional information is available in the HPRS guidelines, which are now available.

So what activities will we fund? In general, backfill for project team members to undertake the research activity, costs for research assistance, statistical support and other expert support, administrative telecommunications and travel costs as appropriate and relevant to the proposed project, as well as costs for research dissemination, including publication fees and conference presentations.

If additional funding is required to undertake the clinical activity, we kind of expect to see that in your budget proposal that you are demonstrating financial support from your local team, your HHS, or from another funding source. Given the aim of the Scheme is to build research capacity of health practitioners, the use of research assistants, you know, funding for research assistants, statisticians and other sort of experts and consultants should again also be sort of reasonable and appropriate and limited where possible. In the application guidelines, as I said before, Section 5 sort of outlines what details of what can be funded and what wouldn't be funded. Again, if and also if you're unsure about where your project is, the criteria of eligible and ineligible funding, you can send us an e-mail as well with a brief about what your query might be in relation to that.

HO **Emma Finch** 12:21

Thanks, Kristyan. I'd like to welcome Dr. Hannah Olufson. As I mentioned earlier, Hannah is a senior dietitian at STARS, Metro North lead for AH-TRIP, and an honorary fellow at UQ. I'll hand over to you, Hannah.

Hannah Olufson 12:51
As Emma mentioned, I was fortunate to gain a Health Practitioner Research Scheme new researcher grant, and that was in the 2024 funding round. And this work was to explore a question that arose from my PhD research and clinical practice, that didn't fit into the tight scope of an RHD. And that thought was that consumers in subacute wards, so talking about rehabilitation and mental health wards specifically in hospitals, may value different things when it comes to nutrition and food services, as opposed to consumers in shorter stay acute care settings. And this project was a huge team effort with lots of statewide collaboration with consumers and multidisciplinary staff.

So a bit of background to how this research came about. Quality indicators for nutrition and food services were being developed in the acute care setting. As I mentioned, we had a hunch that these may not holistically measure what matters to patients in longer stay sub-acute services or the managers who design these services. I applied for a health practitioner research scheme grant to support this exploration.

Why develop standardised indicators, you might be asking. Well, it's a requirement to measure nutrition and food services processes of care and outcomes in the National Safety and Quality Hospital Standards, but what we found was that there's actually no consensus about what or how to measure. There were over 800 quality indicators in the literature, but these were primarily focused on acute care and there was also lots of local audits and dashboards, which really limited our availability to benchmark or learn from others. We also noted that there had been limited consumer and multidisciplinary input in creating these. So, while we acknowledge quality can look different across care types, we aim to develop a standardised set of quality indicators that could help to identify best practices, support statewide advocacy, and increase the visibility and value of nutrition care.

We undertook a process similar to that used in the acute care quality indicated development process and our first aim was to define what makes hospital nutrition and food services great quality in rehabilitation and mental health wards. We did this through a nominal group technique process with a variety of focus groups for rehabilitation consumers and mental health consumers. All of these were

co-facilitated and planned by myself and another dietitian and our two consumer researchers as well, and we also went through the data analysis process together.

This led on to our second aim, which was to look at what elements of quality from that first part were essential to measure, and if the measurement of quality needed to be any different in rehabilitation or mental health wards as opposed to other hospital wards. We did this through a consensus process through voting and leading to endorsement in the end on the quality indicators that you see here on the screen now, which have been developed for testing. From our rehabilitation and mental health specific focus findings, however, what we found was a recommendation that the quality indicator change in nutritional status should be expanded to focus not only on hospital acquired malnutrition or harm, but also on the prevention and treatment of overnutrition in rehabilitation mental health settings. However, the definition and measurement of this overnutrition concept is still a work in process, and this needs future research with consumer partners. So, if anyone out there wants to do a PhD in that area, feel free to reach out.

The other thing that we found was that there should be a new quality indicator added, which should be essential for rehabilitation and mental health wards and optional for acute care and this was the mealtime environment indicator. We also identified several context specific improvement ideas and implementation consideration when it comes to doing these indicators which have been reported back through different dietetics communities of practice.

The findings from my Health Practitioner Research Scheme supported research project had fed into a much larger research programme being led by Dr. Adrienne Young, the beginnings of which were also funded by another Health Practitioner Research Scheme grant. I have the pleasure of continuing to contribute to this work, which includes work to embed the measurement and reporting of nutrition and food services outcomes across Queensland hospitals based on these quality indicators, data-driven decision making and improvements through the planning and trial of a discipline-specific focused quality improvement collaborative using and adapting the proven AH-TRIP model to build improvement capacity with the opportunity to look at adapting this to other professions. And lastly, hoping to lead to improved nutrition outcomes and experiences for patients across all hospital wards.

This work has been disseminated far and wide in partnership with our consumer co-leads, including presentations at the Herston Health Precinct Symposium, several communities of practice, and our national conference. We also facilitated a workshop last year at the Queensland Health Statewide Food Services Workshop on engaging consumers in food services and we have three publications underway in collaboration with consumer co-authors.

This Health Practitioner Research Scheme funded work built both my research capacity but also the capacity of others in research and improvement in various ways, with just a really brief snapshot here on the slide. The 1st way is definitely a new skill development. For me, enhancing my skills and using the nominal group technique, as well as in consumer partnering through co-planning and co-facilitating focus groups and collaborative qualitative analysis of findings. These findings and this work has also led to evidence-based changes with context-specific findings shared locally, which has led to various different improvement projects, which we as a team continue to support.

As well, future collaborations have been fostered through ongoing collaborations on the statewide research programme I mentioned, as well as the strengthening of relationships with the consumer co-leads who participated in this project, which have led on to various other endeavours together, and research supervision opportunities. I had the opportunity to co-supervise 2 dietetic students, working on parts of this research programme during my funded time. We've also had a clinician enrolled in a PhD to develop a PREM for hospital nutrition care, which I have the opportunity to be an associate supervisor for.

As Emma mentioned, I hold two roles. One is a clinical dietitian at STARS hospital in Brisbane and also as the Metro North lead for the AH-Trip program, so I use the skills that I learnt and enriched through my research project in a variety of ways. For example, in supporting others in planning or doing research projects or knowledge translation projects, group facilitation and consensus method facilitation, consumer engagement, collaboration and co-design, project management and design. Also the findings of this work have led on to another research program, which I'm finishing up currently, which was funded by Metro North Allied Health CAHRLI Early Career Fellowship, looking at assessing the feasibility of using precision body composition

monitoring tools in rehabilitation nutrition care, linking back to that change in nutritional status quality indicator.

A big thank you to OCAHO for funding this work through a Health Practitioner Research Scheme grant back in 2024, which has built my capacity, but also the capacity of others. I strongly encourage you, if you're thinking about applying for one of these grants, to definitely do it, and please reach out if you have any questions. Thanks.

Emma Finch 20:56

Thank you, Hannah. It's fantastic to hear about the outcomes of your research and how the HPRS funding has helped you on your journey. We look forward to hearing more about where you go next.

I'd now like to welcome Associate Professor Helen MacLaughlin, who is a consultant dietitian in Metro North and an Associate Professor at QUT. Thank you, Helen.

Helen MacLaughlin 22:00

Thanks. Hi everyone. Thanks for having me, inviting me, Emma. It's always to talk about this work that we've done with the funding from the HP Research Scheme. My project was, it was called Paving the Way, so it was as much about as evaluating the implementation of a complex obesity pathway, but it was also really set up to test a model of improving research capacity in our Allied Health and HP teams.

So just briefly going to talk about the project itself, and then more about the research capacity building. We used this Procter's model as our framework for using implementation science to evaluate our tertiary obesity multidisciplinary service based at the Royal Brisbane and Women's Hospital. This model is nice and simple in terms of implementation science. Not only does it measure the patient-client outcomes, which we all know, which are over there on the right, it also measures health service outcomes and implementation outcomes. The way you implement your evidence-based practise is also measured and assessed, and then the brilliant part about this model is actually that you then look at how the implementation outcomes affect the patient or client outcomes. So, then you can work out which

parts of how you delivered the service or the programme are the ones that actually helped it to be effective but that's a story for another day.

So this is TOMS. It's a complex slide, but I'll kind of walk you through it. TOMS is a multidisciplinary, long-term programme for people living with clinical obesity. It's multidisciplinary with a dietitian, physiotherapist, pharmacist, psychologist. We also have access to an endocrinologist and, most importantly, a brilliant admin and coordinator for the service to put everything together. There's an intensive phase at first with a very low energy diet and exercise, and then it steps down through the step-down phase and the maintenance phase and the frequency of sort of face-to-face support sessions reduces as the patients transition through to self-management throughout that program.

We have evaluated a lot of outcomes here but what we started with were the questions. When we started TOMS, we used the Procter model and developed lots of research questions. There's about three or four pages of questions. Here's just a couple of them here, something around implementation. Does it meet the needs of the group? Is it feasible to meet the needs of the target audience? Does it reduce complications of chronic disease? And does it actually reduce health service use? Compared to how participants use of health services before TOMS and then 12 months, after they completed TOMS, were there differences there? So those are just some. We also did things like functional capacity, you know, did they improve in their exercise capacity, their dietary intake, and the patient experience as well?

And how we did it was we wanted to test this research capacity building. So rather than kind of try and give all the time to one person to work on a project over long term, we split it up. We had four research internships, we called them, for clinicians, and it was for the TOMS team. Members of the TOMS team each were able to have of their time for six months. They could still work in the clinic and do this in their other time, and do a research internship. They had the time, space, training, and mentoring support to actually learn some research skills in the area of their work that they were really interested in, and they were still able to do their clinical work at the same time.

Down at the bottom here, you can see some of the skills that may developed. So right from planning, project management, ethics applications, consent forms, setting up a database and managing it. There was one of the practitioners, and it was a pharmacist actually, who did the qualitative interviews because they really wanted to extend their skill set to do something that they had never done before and completely different. The dietitian did some data linkage and worked with health informatics to get the health service use data, and also set up our consumer engagement group. And again, they were very new skills. We all learned some, we all did critical appraisal and MDT meetings, and everybody had learned some implementation science methods.

All of the four clinicians all wrote abstracts for conferences, made posters, and have done oral presentations on their research. I did a little bit of post-project research to ask them what they thought of this. They were really saying that they were out of their comfort zone and switching from, in their clinical role, they're experienced clinicians, they knew what they were doing. They'd do short, sharp work with a patient, focus, finish it, next one, patient focus, finish. Switching to this kind of project model was really quite different and challenging to have those longer periods of time concentrating on one thing. That was one of the hardest parts that they found but they did get such great satisfaction out of doing it and out of being able to evaluate their service and see the brilliant results that that they all achieved. This is our sort of summary of the research capacity developing, that they were able to actually ask critical questions and select the right outcome measures to answer those questions, and then follow through and actually collect that data, analyse it, and look at the effectiveness and implementation. They were both qualitative and quantitative research measures.

Overall, there were 17 abstracts and seven members of the TOMS team have actually presented at national or international conferences. There's another one tomorrow at the Metro North Innovation Showcase if you want to see the TOMS results in 3 minutes, come along at 10:30am. We also had some students come in in V-Res vacation projects, so the team could supervise those as well. The clinicians really also talked about that they have a cohesive and supportive team. Everybody was happy for different people to take on this research role and their team is cohesive. They work together really well as an MDT, so it's that support as well that really helped to

drive the research culture as well. Protected time was essential and that really what we've got here is that switching from the short focus to longer focus can be really difficult to establish. That's where sort of my role came in in terms of mentoring, supporting, checking in and managing.

What else have we done? So some of the impact from this project. Aside from the health practitioners who gained research skills within the project, there were a couple of other related projects that had come from the TOMS evaluation model, also funded by OCHAO. There was a Designing Obesity Care project led by Karrie-Anne Lewis, which created a patient-centred obesity model of care with a pilot evaluation of that up in Mackay, which was using TOMS, but adapting it so to be able to deliver an obesity treatment service within their existing resources and using the dietitian training and learning from TOMS and link in with other exercise physiology services external to the hospital, and also bring in a comprehensive obesity assessment done by a dietitian at the beginning of that program. It's more flexible, that's only one of their options.

That's now being evaluated by Louise Moodie up in Mackay and also to be implemented in Cairns and also funded by OCAHO, so thank you very much. Logan Hospital is also implementing a similar model and we have shared it with their overweight and obesity community of practise in our Queensland health team. One of the team members had also used her skills and had applied for a grant from the RBWH Foundation to bring dietetics into the pre-operative diabetes clinic, which was written by the pharmacist actually, so really nice to see that cross collaboration there. Just a big thank you to the TOMS team. Before I finish, this is everyone in the team and I kind of hang out on the side of the team, but as a part of it, but this is the clinical team here and the rest of our research team as well at the bottom. So thanks very much.

Emma Finch 32:21

Thank you, Helen. It's incredible hearing about the amazing capacity building work that you do and I'm blown away by the 17 abstracts and all the flow on and related projects. So really lovely to hear about the outcomes that this scheme can have. Now, bear with me all while I share Alice's slides.

Alice Cairns 32:41

AC Morning everyone.

It's a great idea - that is the first step, but it's really important that that idea is translated really well into an application. The HP Research Scheme has become quite competitive, particularly in the last few years, so I really can't reinforce enough how important the content of this slide is. Particularly as a former panel member, it's really, really important that that justification for the need of the project is really clear in that background, and that if you are talking about evaluating a model, which a lot of the applications do, as that is one of the core priorities, that you actually clearly describe the model. It is not uncommon that people give a wonderful justification or describe the problem, but they often don't describe the model that they're going to evaluate clear enough. Please think about the logical flow and make sure that the aims clearly link back to the need and also the target and priority areas of the scheme. Make sure that the outcomes and the objectives really match those aims.

As a panel member, we would often look for that logical flow. Is there objectives matching the aims that they have, which matches the need that they express at the start of their application. Every piece of that application gets looked at and scored so please don't leave anything out. Again, sample sizing, I'll just raise that as something that people often perhaps don't always pay attention to. We definitely look at that. We definitely score that. Please just make sure as all the pieces of the application are scored. There's a checklist on Appendix B of the guidelines to make sure you have all those components in that application. It's definitely something that we look at.

I will talk next about the project team. As you have probably gathered from looking at Hannah and Helen's presentations, a project team is really important. Research is not a solo sport. Everyone has a role to play, and it's definitely a diverse team with the skills and experience to deliver on the research project that is really important. Again, it is definitely something as a panel member that I used to look at. I would look quite closely at the methodology that was being described and then really look at the research team to make sure that the skills and experience to deliver that was either in that research team or there was clear description of how that team was going to access those supports, whether that's through universities or other supports within the HHS or across the system.

I recommend really early and frequent engagement of team members when you think about your application, and then really think about the impact that you're hoping this work will do. Obviously I am a rural researcher, so I'll give the plug for the rurals, but if you are wanting your research to have an impact or be translated into a rural setting and you're going to talk about that language in your application, I would then be looking for a rural team member to be a part of that so that they are engaged in that research process from the very start.

Please really consider those HP research priorities when you think about the team. These do prioritise and favour the mix of consumers, different professions, and partnerships across the HHS and non-tertiary sites. Again, if you're unsure of where to connect to rural researchers, your professional statewide professional groups are excellent places to start. Any contacts in regional hospitals that you have are great places to start but you can also contact HP Research and they will flick that request for support to me or my co Allied Health Rural Research lead, Rachelle Pitt, and we can help think about who in the rural and remote sites might be interested and research active.

EF **Emma Finch** 38:24

Thanks, Alice, for those great tips and tricks. Just a quick heads up about the application process for the 2027 round. Applications are again to be submitted through the HPRS application portal hosted by REDCap. Now, a really important note for you, applications completed and certified on the Word version of the application form provided will not be accepted in this round. The Word copy of the application form is provided to you for drafting purposes only.

An application submission guide will be provided on the HPRS webpage and available through the application portal and we're very happy to answer any other queries that pop up about this via e-mail.

Excitingly, applications are now open. The call for applications will close at 5pm on Friday the 2nd of October 2026. All applicants will be advised of the outcome of their applications by the 31st of December 2026, and our expectation is that successful applicants will commence ethics and governance approval processes early in the new

year. Funding will be made available to successful applicants from July 2027, with evidence of ethics and governance approvals due by August 2027.

The 2027 Scheme guidelines, supporting application submission guidelines, and the link to the application portal are all available on the HPRS webpage that you can see on the screen here. We'll also be publishing the launch recording and the transcript after today's session for anyone who wasn't able to attend or if you want to go back and double cheque anything. If you have any queries about your application, please reach out to the e-mail address HP-Research@health.qld.gov.au. Also, please note that the earlier you reach out to us for support, the more time we'll have to assist you.

As we finish up, I'd also like to announce that we'll be running a consumer engagement workshop led by Dr. Lisa Anemaat to help support your HPRS applications. Join us on Monday the 13th of July between 10 and 11am to learn about implementing meaningful consumer engagement in research, which is applicable to your HPRS project and beyond. The link to register will be posted in the chat and also available on the HPRS webpage. We hope to see you all there.

Thank you everybody for joining us and a massive thank you to our guest presenters, Hannah, Helen and to Alice. Good luck with your applications. If you have any questions, just reach out to the HP Research e-mail address and we look forward to receiving and reading your applications. Good luck everybody.