Attachment 1

Primary Care Partnerships
Revised Program Logic
July 2009

1.0 PROGRAM LOGIC: PARTNERSHIPS
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From: Primary Care Partnerships strategic directions 2004 -2006, Better health - stronger communities

'The State Government initiated the Primary Care Partnerships (PCP) Strategy in 2000 to improve the health and wellbeing of people using primary care services and to reduce avoidable use of hospital, medical and residential services.

Victorian Policy Context
Growing Victoria Together, Victoria's whole of government policy framework, integrates and shapes the policies and plans for the future of Victoria's health and community services. Growing Victoria Together also affirms the government's commitment to sound financial management in the public sector. Key priorities are:

- High quality, accessible health and community services.
- Building cohesive communities and reducing inequalities.
- Promoting rights and respecting diversity.

To achieve high quality, accessible health and community services, Growing Victoria Together acknowledges:

- The need to invest to improve local access to essential health, aged care and community services, particularly in rural and regional communities.
- That sustaining and improving essential hospital, community health, aged care, mental health, disability, child protection and family support services is fundamental.
- That early intervention and prevention are vital to keep people of all ages and abilities living healthy and active lives in the community and to break the cycles of inequality, poverty and crime.

The PCP strategy is a key part of implementing this statewide agenda.' [1]

1. http://www.health.vic.gov.au/pcps/downloads/strategy/pcp_strat_2002_06.pdf

1.0 PROGRAM LOGIC: PARTNERSHIPS

Outcomes
Enhanced wellbeing and quality of life, reduced prevalence, incidence and burden of illness/disability, the needs of hard to reach and vulnerable groups are met, and health inequalities between population groups are reduced.

Objectives
Consumers experience a better connected human services system.
Indicators

- Effective and robust partnership arrangements with partner agencies, consumers and community groups.
- Mechanisms are in place for consumers and the community to interact with the partnership governance structures (including the most vulnerable and disadvantaged groups).

Process
1. The work of the partnerships reflects community health and care needs.
Indicators

- An evidence based process is undertaken by the partners to identify community health and care needs.
- Community health and care needs are reflected in the PCP strategic plan.

2. Performance of the partnership is enhanced through the engagement of relevant partners and quality of partnering relationships.
Indicators

- The partnership implements continuous quality improvement to the planning, implementation and evaluation of the strategic plan.
- A variety of formal and informal mechanisms are implemented for involving and engaging with relevant partners including general practice and other private providers.
- Formal evaluation of the partnership (see tools described in 1.1) indicates positive feedback from partner agencies.

3. Performance of partner agency is enhanced
Indicators

- Formation of partnerships between agencies is defined and formalised through a Partnership Agreement.
- Agreed actions in the PCP strategic plan reflected in partner agency strategic plans.

DHS Inputs

- DHS provides governance advice for PCPs. This will include a draft Partnering Agreement template.
- DHS continues to enhance coordination and linkages with: other relevant state, Commonwealth, local government programs and initiatives and through peaks; across sectors; with specialist services; and general practice.
- DHS provides guidance to support planning and reporting for partnerships, service coordination, integrated health promotion and integrated chronic disease management.
- DHS Regions provide support and direction in relation to the development of the PCP strategic plan.

1.1 DHS EXPECTATIONS: PARTNERSHIPS 2009-2012
All PCPs are expected to:

- Implement robust PCP governance arrangements in accordance with DHS governance requirements.
- Implement governance processes and structures that promote shared accountability of partner agencies to each other and to DHS.
- Adopt a quality improvement approach to assess partnership strengths and weaknesses using the *VicHealth* or *Centre for the Advancement of Collaborative Strategies in Health* partnerships evaluation tool.
- Develop and implement a 3 year strategic plan with a focus on two to three strategic health and wellbeing priorities.
- Extend the breadth and depth of the partnership to effectively respond to the strategic priorities.
- Have relevant elements of the PCP strategic plan reflected in partner agency strategic plans.
- Implement the PCP strategic and operational plans using continuous quality improvement principles by:
  - Developing robust and flexible partnerships with a range of organisations, including consumers, and community groups to effectively pursue collaborative opportunities to enable integrated responses to local health and care needs.
  - Facilitating change management through supporting leadership and capacity building within and between partner agencies.
  - Developing greater engagement and active participation in PCP processes and activities with relevant stakeholders, in particular acute health services, divisions of general practice and relevant private providers.
- Report annually to DHS in accordance with PCP reporting requirements.
- Act on DHS reporting feedback as part of strategic planning processes and annual review of the strategic plan.

2.0 PROGRAM LOGIC: SERVICE COORDINATION

Outcomes
Enhanced wellbeing and quality of life, reduced prevalence, incidence and burden of illness/disability, the needs of hard to reach and vulnerable groups are met, and health inequalities between population groups are reduced.

Objectives
Consumers and carers experience enhanced engagement and access to services.
Indicators

- Consumers and carers experience improved identification of their needs as early as possible.
- Consumers and carers have timely access to the most appropriate services.
- Consumers and carers experience coordinated delivery of services and a continuum of care.
- Consumers and carers have confidence in the advice, support, treatment, and care coordination they are receiving.
- Consumers and carers receive care and support that is appropriate to their cultural background, circumstances, needs and preferences.
- Consumers and carers actively participate in the development of their own care plans and in the delivery of their care.
- Consumers and carers have confidence in the way their health and care information is collected and shared.

Processes
1. Partner agencies develop and implement a consistent, streamlined and evidence-based approach to initial contact, initial needs identification, referral, assessment and care planning.
Indicators

- Implementation of common practice standards as stated in the Victorian Service Coordination Practice Manual within and between partner agencies, including acute and residential services, general practice and other public and private service providers.
- Services are delivered in a coordinated manner to facilitate access for hard to reach and vulnerable groups.
- Sharing of quality consumer health and care information in accordance with the Victorian Service Coordination Practice Manual and privacy requirements.
- Sharing of quality services information with consumers and carers and within and between agencies.
- Reduce unnecessary use of acute and residential care.
- Reduce unnecessary duplication of consumer health and care information collection.
- Reduce unnecessary duplication of screening and assessment processes.
- Improved management of waiting lists.

2. Greater collaboration between general practice and other privately funded services.
Indicators

- Clarity of roles and responsibilities of general practice and other relevant private (e.g. private allied health) and public providers relating to shared consumer care.
- Increase the levels and quality of shared care and care planning between general practice, other private services and publicly funded providers.
- Increased use of the Victorian State-wide Referral Form (VSRF) by general practice to assist appropriate referral of GP patients to other services.
- Increased access by general practice to information about human services offered locally and knowledge by general practice about how to assist their patients to access these services.
- Embed feedback to GPs as part of service delivery.

DHS Inputs

- DHS produces and distributes information resources to support service coordination.
- DHS implements workforce development strategies to support the implementation and use of the Service Coordination Tool Templates (SCTT).
- DHS continues to enhance coordination and linkages with: other relevant state, Commonwealth and local government programs and initiatives; across sectors; with specialist services; general practice and peaks.
- DHS will coordinate DHS program input into further development of the Victorian Service Coordination Practice Manual.
- DHS continues to work to improve collaboration with divisions of general practice and shared care with general practice.
- DHS works with general practice peak bodies (such as General Practice Victoria) and, other private provider peak bodies to identify, influence and respond to common strategic directions.

2.1 DHS EXPECTATIONS: SERVICE COORDINATION 2009-2012

All PCPs are expected to:

- Implement the Victorian Service Coordination Practice Manual with a broader range of agencies, services and programs.
- Implement the updated SCTT/VSRF.

- Develop and implement agreed service coordination practice for prioritised hard to reach and vulnerable groups including indigenous communities.
- Contribute to the ongoing development of the Victorian Service Coordination Practice Manual and associated resources.
- Apply the Continuous Improvement Framework (resource of the Victorian Service Coordination Practice Manual) as part of partner agencies quality systems and report impacts through the Service Coordination Survey.
- Have shared care and multi-agency care planning protocols developed and implemented between general practice, other private and publicly funded services.
- Embed communication (including feedback) between general practice and other service providers.
- Support the sharing of relevant consumer health and care information (with consumer consent) via secure electronic systems (e-referral).
- Improve the depth and accuracy of services information available on the Human Services Directory for partner agencies engaged in service coordination.

3.0 PROGRAM LOGIC: INTEGRATED CHRONIC DISEASE MANAGEMENT

Outcomes
Enhanced wellbeing and quality of life, reduced prevalence, incidence and burden of illness/disability, the needs of hard to reach and vulnerable groups are met, and health inequalities between population groups are reduced.

Objectives
Consumers with chronic disease (particularly hard to reach and vulnerable groups) consistently experience safe, effective, client-centred, timely, efficient, and equitable health care delivered by an integrated and coordinated health system.

Indicators

- Consumers and carers receive care that optimises their health and quality of life.
- Consumers and carers receive support that is evidence based.
- Consumers and carers receive support that enhances their capacity to self-manage their health and care.
- Consumers receive care that proactively identifies, responds to and supports their needs over time.
- Consumers receive care and support delivered in an appropriate mode and setting.

As per indicators in Service Coordination:

- Consumers and carers experience improved identification of their needs as early as possible.
- Consumers and carers have timely access to the most appropriate services.
- Consumers and carers experience coordinated delivery of services and a continuum of care.
- Consumers and carers have confidence in the advice, support, treatment, and care coordination they are receiving.
- Consumers and carers receive care and support that is appropriate to their cultural background, circumstances, needs and preferences.
- Consumers and carers actively participate in the development of their own care plans and in the delivery of their care.
- Consumers and carers have confidence in the way their health and care information is collected and shared.

Processes
Partner agencies collaborate to develop an integrated and coordinated health system (informed by the Wagner Chronic Care quality improvement framework) that enables a seamless client journey and consistent quality in the provision of chronic illness care.
Indicators

- The provision of coordinated, best-practice clinical care and support for self-management, for consumers with chronic disease, occurs systematically across the service system (in accordance with relevant disease specific and/or generic evidence-based clinical guidelines).
- The impacts of clinical care and support for self-management are measured and monitored using agreed clinical and lifestyle indicators.
- Workforce sustainability, efficiency, and effectiveness (in the provision of: coordinated, best-practice clinical care and support for self-management for consumers with chronic disease; and planning, implementing, and measuring improvement initiatives) is enhanced.
- See Service Coordination and Partnerships indicators for further information relating to this process/aim (see note above under "objectives").

DHS Inputs

- DHS publishes policy documents and guidelines for Integrated Chronic Disease Management.
- DHS provides resources to support integration and coordination of chronic disease management.
- DHS produces and distributes information resources.
- DHS implements workforce development strategies to support the work of integrated chronic disease management.
- DHS works with general practice peak bodies (such as General Practice Victoria) and other private provider peak bodies to identify, influence and respond to common strategic directions.

3.1 DHS EXPECTATIONS: INTEGRATED CHRONIC DISEASE MANAGEMENT 2009-2012
All PCPs are expected to:

- Develop and review local agreements, implementation plans, and supporting resources to improve chronic disease care by:
  a) Enhancing the capacity of the local workforce to:
    - provide coordinated, best-practice clinical care and support for self management, and
    - plan, implement and measure service system improvements, including evaluation of impacts and outcomes for consumers.

  b) Developing local service systems (focused on a common client cohort) that provide coordinated, best-practice clinical care and support for self-management. This work should (where appropriate):
    - cover each point in the continuum of care (access & initial contact, initial needs identification, assessment, care planning, care delivery, liaison & referral, monitoring & review, transition & exit, and proactive recall and ongoing support);
    - consider continuity of care and the provision of proactive and ongoing support;
    - clearly articulate intra - and inter-agency roles and responsibilities (including general practice and relevant

private providers);
  - clearly articulate intra- and inter-agency linkages and pathways (including with general practice and relevant private providers);
  - identify mixed models of care that utilise Medical Benefits Schedule (MBS) services and other public and privately funded services; and
  - clearly articulate communication and information sharing arrangements within and between agencies (including feedback and communication with general practice and relevant private providers).

To progress this work, it is expected that all PCPs will:

- Maintain a formalised continuous quality improvement approach which includes:
  - chronic disease management as a priority focus;
  - intra- and inter-agency elements;
  - involvement of the full range of stakeholders (including consumers);
  - intra-agency leadership and mechanisms to effectively implement agreed improvement initiatives;
  - use of relevant data to set priorities;
  - measurement of service system improvements; and
  - evaluation of impacts and outcomes of PCP activities.

Note:

All Integrated Chronic Disease Management (ICDM) work of agencies and partnerships is to be targeted towards meeting the expectations outlined above. Where agencies receive Early Intervention in Chronic Disease (EIiCD) funding, these funds are to be used to accelerate or broaden the scope of ICDM work set out in the requirements above. Specifically, the funds are to be used to:

  - extend the breadth and depth of the ICDM work across the partnership or agency (which may include working with additional population subgroups or undertaking work against additional points in the continuum of chronic disease care);
  - further augment change management through supporting leadership and capacity building within the agency and between partners and/or
  - have greater engagement and active participation in PCP processes and activities with relevant stakeholders (particularly the private sector).

4.0 PROGRAM LOGIC: INTEGRATED HEALTH PROMOTION

Outcomes
Enhanced wellbeing and quality of life, reduced prevalence, incidence and burden of illness/disability, the needs of hard to reach and vulnerable groups are met, and health inequalities between population groups are reduced.

Objectives
Consumers and population groups experience reduced prevalence of risk factors, and increased prevalence of protective factors around priority health and wellbeing issues for action, including physiological, psychosocial, behavioural, environmental, and social factors.
Indicators

- Reductions in prevalence of risk factors and increased prevalence of protective factors (eg physical activity, smoking, diet and social connectedness).
- Enhanced access to services and participation in health promotion programs, especially by hard to reach and vulnerable groups e.g. children and young people, Indigenous and culturally and linguistically diverse populations.
- Consumers have enhanced engagement, improved experience of health promotion programs and improved impacts and outcomes for integrated health promotion.

Processes
1. Develop and implement a comprehensive integrated health promotion plan (component of the PCP strategic plan) which addresses the local priority health and wellbeing issues and target groups identified for action.
Indicators

- Integrated health promotion priorities are informed by state and local data and information about the demographic and social characteristics and health and wellbeing of the population; participation of consumers, carers and the broader catchment population; and national and state policy documents.
- Implementation of evidence based health promotion programs that involve cooperative and coordinated effort between partner agencies and consumer and community groups.
- Integrated health promotion plan is developed in consultation with other relevant partners, including general practice and the Department of Justice (Gambler's Help Services).
- The needs of hard to reach and vulnerable groups are included in the integrated health promotion plan.
- Integrated health promotions plan define problems and include evidence based solutions, clearly identified goals, objectives, and target groups, specify a mix of interventions, define roles and responsibilities of partner agencies, and include a systematic approach to evaluation.

2. Build capacity to implement evidence-based integrated health promotion programs that address the health and wellbeing issues that are of common significance to consumers and the broader catchment population.
Indicators

- Capacity for health promotion is built in partner agencies (including workforce development, organisational development, leadership, partnerships, involvement of consumers, development of management and governance structures, and monitoring and evaluation).
- Access to targeted health promotion programs is facilitated by a streamlined service coordination system and the sharing of quality consumer and services information.

DHS Inputs

- DHS publishes guidelines and case studies describing the range of planning, organisational development, service re-orientation and partnership strategies required to initiate and sustain a range of health promotion programs.
- DHS provides data and information to support planning processes.
- DHS provides advice and assistance to PCPs in developing their health promotion effort.
- DHS will support the implementation of the improved IHP performance measures.
- DHS provides advice regarding the roles general practice may have to support and participate in integrated health promotion.

4.1 DHS EXPECTATIONS: INTEGRATED HEALTH PROMOTION 2009-2012
All PCPs are expected to:

- Implement integrated health promotion programs that address the health and wellbeing issues of significance to consumers and the broader catchment population, are implemented based on the model of the social determinants of health and consistent with the Integrated Health Promotion kit.
- Ensure integrated health promotion practice engages with hard to reach population groups and vulnerable communities.
- Embed social equity principles, particularly equity of access, into all levels of engagement from strategic policy to implementation and evaluation.
- Embed capacity building into integrated health promotion practice at all levels.
- Engage with Divisions of General Practice and GPs with the planning, implementation and evaluation of the integrated health promotion plan.
- Focus the greatest effort on the chosen statewide health promotion priority (s).
- Implement improved integrated health promotion performance measures including annual provision of case studies for dissemination through the PCP web site.

- Demonstrate use of evidenced based interventions.
- Embed evaluation practice with the planning and implementation of health promotion.
- Use a continuous quality improvement approach to the integrated health promotion plan with routine evaluation of interventions.