Evaluation of the Primary Care Partnership Strategy

June 2001

This Information Resource provides information about the evaluation of the Primary Care Partnership Strategy. It describes the background to the development of the evaluation, aims and objectives, the framework, and key tasks for the conduct of the evaluation. The primary intended audience for this Information Resource is members of Primary Care Partnerships.

Background

The Primary Care Partnership Strategy aims to create a genuine primary care service system to improve outcomes for consumers and reduce preventable use of hospital services. This strategy is underpinned by a commitment to a social model of health and to partnerships between communities, consumers, carers and service providers.

The specific aims and objectives of the Primary Care Partnership Strategy are to:

?? Improve the experience and outcomes for people who use primary care services.
?? Plan and deliver more effective health promotion programs and health-promoting services, underpinned by a social model of health.
?? Develop a primary care service *system* to complement the acute system.
?? Enable demands on current services, particularly acute and emergency services, to be better managed.
?? Lead to the development of a system where interventions are delivered pro-actively and at appropriate times rather than in response to emergencies.

Primary Care Partnerships (PCPs) are working with the community and the Department of Human Services to develop and implement Community Health Plans across Victoria. The Plans will identify the priority health and well being needs of their communities and describe how the providers in the Partnership will work with each other and other key stakeholders to respond to these needs. Community Health Plans will become a key tool for negotiating and implementing change in the primary care sector. The Plans will not only document and guide the actions of PCPs - but importantly - inspire further collaboration and improvements to the health and well-being of Victorians.

The *Going Forward: Primary Care Partnerships* policy document notes that regular review and evaluation of the Strategy will enable the Department, PCPs and the sector generally, to share lessons from the experience and provide a basis for ongoing refinement of policy and implementation. *Going Forward* indicates that the evaluation strategy should focus on reform implementation and business '*process*' initially, with consideration being given to '*impacts*' and '*outcomes*', particularly effects on consumers, over the course of time, using baseline data established early in the redevelopment.

Aims and objectives of the evaluation

The overall objective of the evaluation is to provide information to the Department of Human Services, PCPs and the sector more generally to maximise learning from the service system redevelopment experience, and provide a basis for refinement of policy and service development.

Specific aims of the evaluation are to determine whether, and the extent to which, the PCP Strategy has:

?? Been implemented effectively, and as planned, by all key stakeholders including the Department of Human Services, PCP member agencies and other responsible authorities in the wider primary care sector.

?? Enhanced the capacity of PCPs and PCP member agencies to plan and coordinate service and program development, and contributed to the establishment of a primary care service system that implements a social/population focused model of health care and health promotion, delivers services and programs in a coordinated and integrated manner, enhances management of demand on acute and emergency services, and facilitates access for vulnerable populations.

?? Contributed to the enhancement of consumer and carer engagement and satisfaction with services, the reduction of risk factors, and the enhancement of protective factors operating in individuals, environments and social systems.

?? Where possible, contributed to improved wellbeing and health outcomes for clients of primary care services, their carers and families, as well as the populations of PCP catchments.

A further key aim of the evaluation is to:

?? Identify the factors in the wider human services, health, and primary care sectors that facilitate and inhibit the effective implementation of the PCP strategy and the achievement of its goals and objectives.

Internal and external evaluation

Going Forward identifies evaluation activities to take place at the level of local PCPs (local, internal evaluation), as well as activities to be carried out by the Department or external evaluators (overarching, external evaluation). This Information Resource is concerned with both.

Primary Care Partnerships are required to provide regular (quarterly) self assessments of their progress against key indicators identified in Community Health Plan templates and Partnership Implementation Plans (PIPs) during 2001 to 2003. PCPs are also responsible for more rigorous evaluation of a number of strategic initiatives included in their Community Health Plans, particularly Integrated Disease Management and Health Promotion strategies. Details of the basic internal evaluation requirements for PCPs can be found in the policy and guideline documents for particular strategic initiatives and in the Community Health Plan template.

In addition there will be an overarching evaluation of the Statewide Primary Care Partnership Strategy. Independent evaluators will be contracted to conduct the overarching evaluation.

It is critical that local/internal and overarching/external evaluation activities complement and support one another. For example the external evaluation should be able to make use of data collected via internal evaluation processes wherever possible. To this end it will be valuable for the local and overarching evaluations to use similar frameworks (see below) and to aim towards the use of a common data set, where appropriate. External evaluators, the Evaluation Project Manager and other DHS Central Office and Regional Office staff will provide advice and support to PCPs in the conduct of local, internal evaluation activities.

Evaluation Framework

The PCP Strategy is a complex statewide initiative involving multiple strategic initiatives taking place within and among a wide variety of service agencies, and in the context of diverse communities and geographic settings. The complexity of the PCP Strategy indicates that a variety of qualitative and quantitative evaluation methods are required.

However, it is essential that the varied types of evaluation data are brought together to provide a comprehensive picture of what has been achieved by the PCP Strategy as a whole, identify any gaps in achievement, and enhance understanding of major factors responsible for achievement of PCP Strategy goals and objectives. For this reason it is essential that there be a coherent evaluation framework.

An evaluation framework is a broad conceptual approach to evaluation design. Any particular framework will generally support a variety of designs and methods. It does not dictate particular designs and methods, rather it assists evaluators select designs and methods that are appropriate to the program being evaluated.

The following sections outline three intersecting dimensions that will shape the design of the overarching evaluation and which should also be considered in designing evaluation activities at the level of individual PCPs. These dimensions are:

?? *Program Logic* – defines the levels of strategy activities and effects over time (inputs, processes, impacts and outcomes) and the hypothesised relationships between these activities and effects.

?? *Strategic Initiatives of the PCP Strategy* – the key policy initiatives that need to be evaluated.

?? *Contexts, populations and mediating factors* – the various settings, populations, clinical groups and health issues that need to be addressed.

Program Logic

The framework being used for the evaluation of the Primary Care Partnership Strategy is Program Logic (also known as Program Theory or Theory of Change). Program Logic evaluation frameworks are increasingly being recognised as the preferred approach to the evaluation of complex public policy initiatives which aim to create change in complex service systems and involve communities. (1,2,3,4,5,6) Program Logic/Theory is the framework currently being used to evaluate the Health Action Zones (HAZs) initiative in the UK (1), an initiative with strong similarities to the Primary Care Partnership Strategy.

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1 Judge K & Bauld L (in press) Strong Theory, Flexible Methods: Evaluating Complex Community-Based Initiatives. *Critical Public Health.*

2 Connell JP, Kubisch AC, Schorr LB & Weiss CH eds (1995) *New Approaches to Evaluating Community Initiatives Volume 1 Concepts, Methods and Contexts.* The Aspen Institute, Washington DC. http://www.aspenroundtable.org/vol1/index.htm

3 Fulbright-Anderson K, Kubisch AC and Connell JP eds (1998) *New Approaches to evaluating community initiatives. Volume 2 Theory, Measurement and Analysis*. The Aspen Institute, Washington DC. http://www.aspenroundtable.org/vol2/index.htm

4 Bickman L (1996) The application of Program Theory to the evaluation of a management mental health care system. *Evaluation and Program Planning, 19(2),* 111-119.

5 Department of Finance (1994) *Doing evaluations: A practical guide.* AGPS, Canberra.

6 Funnell S (1997) Program Logic: an adaptable tool for designing and evaluating programs. *Evaluation news and comment, 6(1),* July.

Program Logic involves analysing the logical reasoning that connects program activities to the ultimate goals of the program. It involves clarifying assumptions about how and why particular activities are going to make a difference for consumers.

This process of logical reasoning involves identifying different levels of effect that are predicted to evolve over time as a result of program activities or inputs. Various authors have used slightly different terms to refer to these different levels. Some of these different terms, definitions and examples as they apply to the Primary Care Partnership Strategy are shown in Table 1 (p 7). A preferred set of terms that has gained currency in Australia is *input, process, impact* and *outcome*. (5,7)

- ?? *Inputs* are the strategies, resources and activities that the program provides or entails.
- ?? *Processes* are the changes that occur in service systems including the strength of partnerships, models of service coordination and delivery, the diversity and quality of programs that are offered, and management practices.
- ?? *Impacts* are the changes in modifiable risk and protective factors operating in individuals and environments; the attitudes and behaviours of service users, program participants and populations that affect health and wellbeing; changes in client experience of services and programs.
- ?? *Outcomes* are the changes in the health and wellbeing of the population, service users or program participants.

Once the predicted processes, impacts and outcomes have been clarified Program Logic provides a guide to the nature of data that is necessary to assess whether or not these effects actually occur and test hypotheses about the relationships between particular inputs, processes, impacts and outcomes.

The extent to which the full, or ideal, range of appropriate data specified in Maps of Program Logic can be collected will often be limited by resource and logistical constraints. In this situation the Map of Program Logic serves to alert evaluators to information gaps that may limit the validity and robustness of findings and conclusions.

Strategic Initiatives of the PCP Strategy

The overarching Statewide evaluation will include all of the Strategic Initiatives of the PCP Strategy. These are outlined in the Figure below (p 5).

As noted above PCPs will be reporting on their progress against key indicators identified in Community Health Plan templates and Partnership Implementation Plans (PIPs). This will include assessment of progress in all Strategic Initiatives. In addition PCPs will conduct more rigorous evaluation of projects within particular Strategic Initiatives in their local areas. The results of these local evaluation projects can be considered by the overarching evaluation as long as they can be interpreted within the Program Logic/Theory of Change Framework.

Maps of Program Logic have also been developed for each Strategic Initiative of the PCP Strategy and are shown in *Attachment 1*. These have been distilled from PCP Strategy policy documents and guidelines. Further refinement of these Maps may be required following consultation with PCP staff and member agencies. Maps of Program Logic should reflect a common understanding between key stakeholders.

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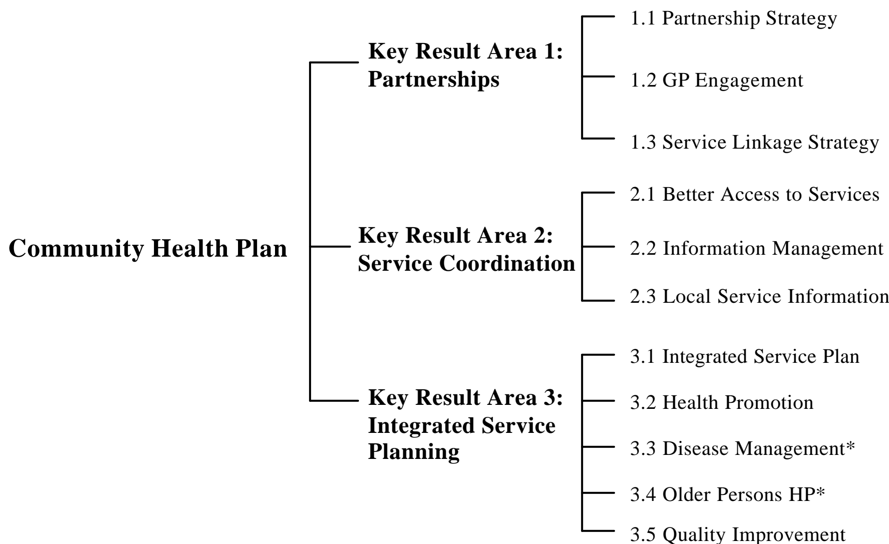
7 Hawe P, Degeling D & Hall J (1990) *Evaluating Health Promotion: A Health Workers Guide*. MacLennan and Petty, Sydney.

Program Logic can also be used as a tool for program planning. PCPs may consider developing their own Maps of Program Logic to assist in the planning and evaluation of particular local projects and activities. A model template showing how Program Logic can be used as a tool for planning and evaluation of a hypothetical project is shown in *Figure 1* (p 8). Examples of planning goals, objectives and aims are shown alongside their associated evaluation outcome, impact and process indicators.



* Strategies that will initially be developed by selected PCPs on a pilot basis.

Contexts, populations and mediating factors

The extent to which the PCP Strategy meets its aims and objectives is likely to vary across different geographic settings, service settings, populations, clinical groups and health issues. Both overarching and local evaluations need to be sensitive to these variations. Certain combinations of factors are also likely to influence or mediate processes, impacts and outcomes. It is important for evaluation to provide information that furthers understanding of these mediating factors.

A simplified model of how inputs, processes, impacts and outcomes of the Primary Care Partnership Strategy interact with the context of primary care services in Victoria is shown in *Figure 2* (p 9).

Key tasks

Independent evaluators are being contracted to conduct the overarching statewide evaluation of the PCP Strategy. It is anticipated that they will begin work in July 2001. A detailed Evaluation Plan will be developed during July to September 2001 in consultation with stakeholders, thus precise details of methods and procedures are not yet available. The key tasks involved in the statewide evaluation are outlined below.

Development and finalisation of a detailed Statewide Evaluation Plan

The Evaluation Plan will be developed and finalised in consultation with all key stakeholders including PCPs. It is anticipated that the external evaluators will meet with staff from all PCPs during this process.

Data collection and analysis

External evaluators will use a variety of methods to collect and analyse data. These methods will be determined during the finalisation of the Evaluation Plan, but may include such methods as analysis of program documentation, interviews with stakeholders, surveys of PCPs and PCP member agencies, interviews with or surveys of consumers and carers, observational methods, analysis of population health data and service utilisation data. Data collection will require assistance from staff of PCPs and PCP member agencies.

Preparation of reports

Reports on the results of data analysis will be provided by the external evaluators at regular (6 monthly) intervals throughout 2001 to 2003. A final report will be submitted in June 2003. Interim and final reports will include discussion of the results of evaluation and recommendations for program and policy development. Draft reports will be provided to stakeholders including PCPs for comments prior to publication.

Evaluation assistance for PCPs

External evaluators will be available to provide advice and assistance to PCPs in the planning and conduct of internal evaluation activities. The Evaluation Project Manager in DHS Central Office is also available to provide advice. Contact details are provided below.

Project Management

The external evaluation is being managed by the Community Health Unit of the Department of Human Services. It will be overseen by an Evaluation Advisory Group and an Internal Working Group. The role of the Evaluation Advisory Group is to provide high level management advice and oversight to the evaluation. It will comprise representatives from: DHS; Commonwealth Department of Health and Aged Care; Local Government; PCPs; academia; and relevant peak non-government organisations.

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Evaluation consultants

To be advised.

Table 1: Program Logic for Primary Care Partnership Strategy

Levels of activity and effect	*Definition*	*Examples of indicators (or groups of indicators)*
Outcomes Ultimate outcomes	Changes in the health and wellbeing of the population, service users or program participants	Wellbeing/Quality of life Prevalence and incidence of disease Burden of illness/disability Levels of health inequality between population sub-groups
Impacts Intermediate outcomes Determinants of health and wellbeing	Changes in modifiable risk and protective factors operating in individuals and environments; the attitudes and behaviours of service users, program participants and populations that affect health and wellbeing; changes in client experience of services and programs.	Environmental factors Socioeconomic factors Community capacity Individual/person related factors (biological, psychological and social risk and protective factors) Health behaviours and skills (eg health literacy, smoking, diet, exercise) Engagement with, and experience of services/programs Active involvement of consumers and carers in case and program planning Access to services, health promotion and prevention and early intervention programs Utilisation of services (eg lower use and lower costs of tertiary and crisis services)
Processes Proximal outcomes Outputs Deliverables Performance indicators	The changes that occur in service systems including the strength of partnerships, models of service coordination and delivery, the diversity and quality of programs that are offered, and management practices.	Service and program availability and appropriateness (Extent to which local service/program profiles match assessed community needs and population diversity and are evidence based) Accessibility of services and programs (Extent to which people obtain services and programs at the right place and time irrespective of income, geography and cultural background) Continuity/coordination of service and program delivery Organisational capacity (Strength of the infrastructure, partnerships, problem-solving ability, organisational learning systems) Competencies, skills and knowledge of staff Interagency and intersectoral collaboration and networking Appropriate mechanisms for consumer participation
Inputs Program operations Resources Strategies Activities	The strategies, resources and activities that the program provides or entails.	Service development and program implementation Service and program planning Education and training Networking and partnership development Communications Funding Policies, guidelines and protocols Research and evaluation

Figure 1: Model Program Logic template for planning and evaluation of a comprehensive depression prevention strategy targeting young people

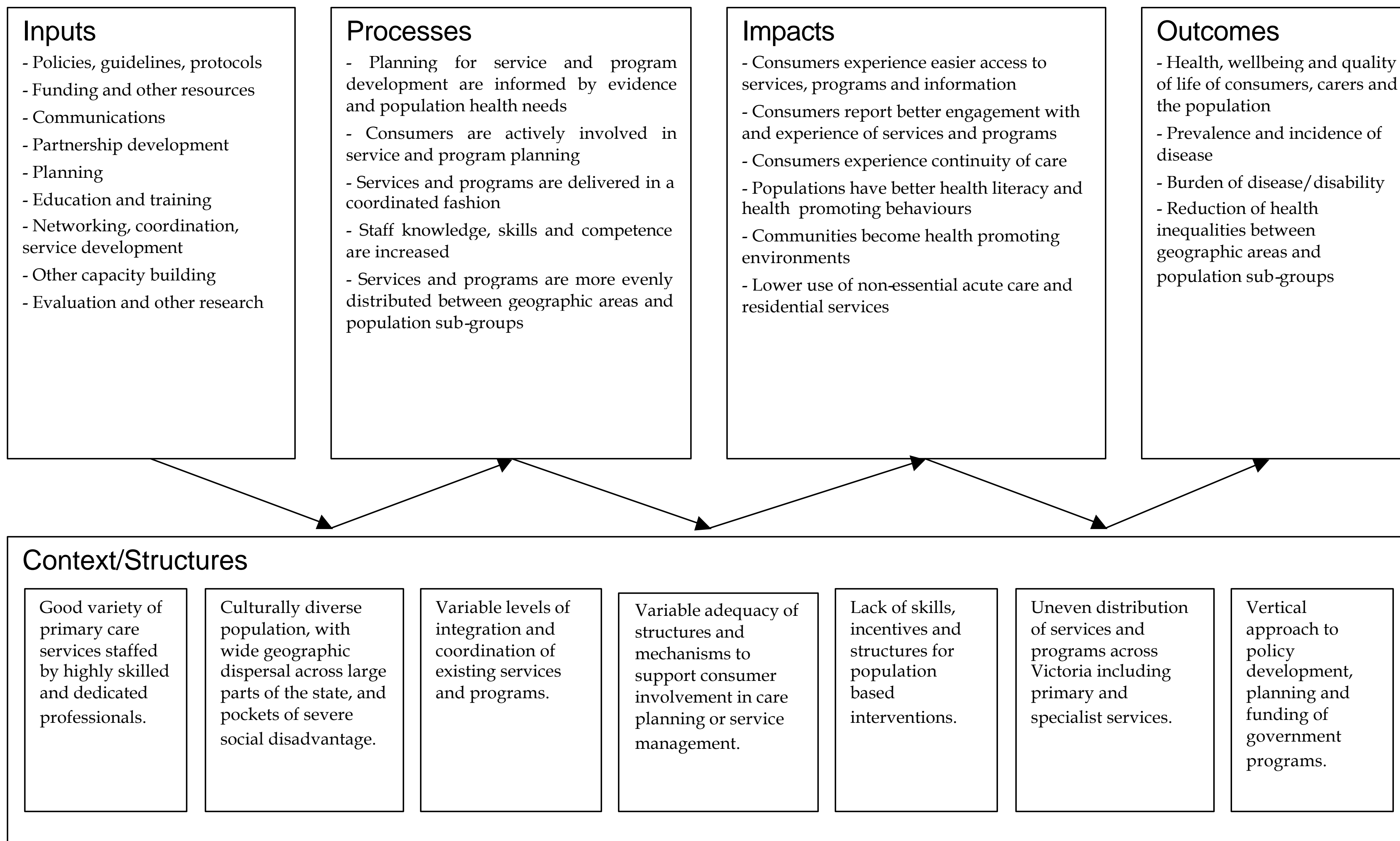
Goals *Should be expressed in terms of health and wellbeing for the target population*	**Outcome indicators** *Should tell us the extent to which we have met our goals*	**Objectives** *Should be expressed in terms of changes in risk and protective factors for consumers. 8*	**Impact indicators** *Should tell us the extent to which we have met our objectives*	**Process Aims** *Should be expressed in terms of a vision of how the service system should operate in order for objectives to be met 9*	**Process indicators** *Should tell us the extent to which aims have been met*	**Strategies/Activities** *Should tell us what the project is going to do in order to work towards meeting the stated aims 10*
Reduce the prevalence of depression among young people **Improve quality of life for young people**	Community surveys show reduction in prevalence of depression among 15 to 24 years over a five year period Improvements in self reported QoL using a standardised instrument	Increase awareness of young people and parents about risk and protective factors Increase social skills and problem solving skills of young people Increase family connectedness and reduce family conflict Reduce incidence of bullying in schools Increase young people's sense of connectedness to community	Increased levels of awareness demonstrated in pre and post surveys over 3 years Increased levels of social and problem solving skills, increased family and community connectedness and reduced family conflict demonstrated in surveys over 3 years Routine monitoring of bullying in schools shows reductions in incidence after 3 years	All relevant agencies in the area including schools have information displayed and available on depression and young people Youth health services and mental health services collaborate with schools to deliver depression prevention and anti-bullying programs in schools Community Health Services, Mental Health Services and Family Services collaborate to deliver a range of parenting programs PCPs work with schools, welfare services and community organisations to plan and deliver community development programs which involve young people at risk of depression as active participants	Audits or case study research show that after 2 years programs are in place, adequately resourced, thoroughly documented and seen to be consistent with best practice by relevant stakeholders Skill audits reveal staff have adequate knowledge and competence to deliver the programs	Establish a project Steering Group including representation from young people, parents and schools Recruit Project Officers with high level skills in mental health program planning and evaluation Link with national, state, regional and local mental health promotion strategies Review existing educational material on depression and utilise or modify Link with academic centres managing evidence based programs and secure training and support in selected programs Develop a coordinated approach to assessment and referral of young people at risk Develop protocols for responding to special population groups (eg Koori and NESB)

8 Priority risk and protective factors to target should be identified by thorough problem analysis (eg studying research literature, epidemiological data and results of formal needs assessment)

9 Aims should be determined by reference to evidence from service development research and evaluation of initiatives that have had similar goals and objectives, and by critical review of existing services and programs in the local area.

10 Strategies should be determined by reference to evidence from service development research and evaluation of initiatives that have had similar aims, and by critical review and evaluation of existing services and programs in the local area.

Figure 2: Program Logic/Theory of Change: Primary Care Partnership Strategy



Attachment 1

Maps of Program Logic for Strategic Initiatives of the Primary Care Partnership Strategy

1.1 and 1.3 Partnerships and Service Linkage Strategy
1.2 GP Engagement Strategy

2.1 Better Access to Services
2.2 Information management

3.1 Integrated Service Planning
3.2 Health Promotion Strategy
3.3 Integrated Disease Management

Program Logic: 1.1 and 1.3 Partnerships and Service Linkage Strategy

Outcomes/Goals
Enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, reduce health inequalities between population subgroups.
[Note: Progress against health outcomes is dependent upon all components of the PCP Strategy.]

Impacts/Objectives
Consumers, carers and other community members report enhanced access to, engagement with, and experience of services and programs.

Indicators

?? Consumers have confidence in the advice, support, treatment, and care coordination they are receiving
?? Consumers and carers report an ability to easily to navigate the service system.

Processes/Aims
Performance of PCPs and member and associated non-member agencies is enhanced in reflection of the range and quality of partnerships.

Indicators

?? Consumers and carers are actively involved in a variety of service development activities;
?? Service providers (both clinicians and other staff) increasingly work in collaboration with staff of partner agencies as well as non-member agencies and community groups;
?? Protocols are adopted to formalise and guide collaboration between relevant agencies in the PCP and associated non-member agencies;
?? Service agencies develop and implement an increased number of service development projects in partnership with consumers, other agencies and community groups

[Note: Progress against this aim will be affected other components of the PCP Strategy, particularly Better Access to Services.]

PCPs involve effective partnerships with: member agencies; consumers and carers; other associated non-PCP member agencies and community groups
Indicators

?? Formation of partnerships between agencies is defined and formalised through the development of Memoranda of Understanding or legally binding agreements;
?? PCPs establish a Steering Committee (or Executive Committee or Management Team) which acts as the basic decision-making body of the PCP;
?? Relationships between PCPs and associated non-member agencies are formalised through Service Linkage Protocols;
?? Strategies are implemented to engage and recruit small/specialist multi-catchment providers;
?? Contribution of partners to core PCP work;
?? Attendance of the full range of partners at PCP meetings and other key activities;
?? Each PCP supports a variety of formal and informal mechanisms for involving consumers and carers and community groups including the most vulnerable and disadvantaged groups (eg indigenous, NESB, people with mental illness);
?? Involvement of a range of non-PCP agencies and community groups in consultations;
?? Each PCP develops a Consumer Charter of Rights and Responsibilities;
?? Each PCP develops articulates a range of strategies for creating and supporting a range of partnerships in

Inputs

?? DHS produces and distributes, in a timely fashion, a range of guides and discussion papers describing the range of partnerships required and the components required to support establishment and maintenance of each partnership;
?? DHS provides training, workshops and discussions with PCPs regarding partnership development;
?? DHS provides PCPs with funding to support consumer participation;
?? DHS coordinates the trial of pilot training programs for service providers and consumers to build capacity for consumer participation;
?? DHS employs an Aboriginal Primary Care Partnership Liaison Officer to facilitate engagement and input of Koori communities and Aboriginal Community Controlled Health Organisations;
?? DHS sponsors a Consumer Participation Conference;
?? DHS funds Best Practice Projects which include a focus on mechanisms for supporting consumer and carer participation;
?? DHS creates an electronic Primary Health Knowledge Base to enable information sharing.

Program Logic: 1.2 GP Engagement Strategy

Outcomes/Goals
Enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, reduce health inequalities between population subgroups.
[Note: Progress against health outcomes is dependent upon all components of the PCP Strategy.]

Impacts/Objectives
Consumers, and carers report enhanced access to, engagement with, and experience of services and programs.

Indicators

?? Consumers experience improved access to information and greater ability to navigate the service system;
?? Consumers have increased likelihood of being referred by a GP to an appropriate primary care provider in their area in a timely fashion;
?? Consumers have confidence in the advice, support, treatment, and care coordination they are receiving.

Processes/Aims
Performance of GPs, PCPs and PCP member agencies is enhanced in reflection of the range and quality of partnerships.

Indicators

?? There is effective (ie clear, timely, comprehensive) communication between GPs and other service providers (including active use of formal and informal communication processes and feedback);
?? Increased levels of joint care planning, case conferencing, care coordination and shared care between GPs and relevant agencies in the PCP as well as other primary care agencies;
?? Improved processes for GPs to appropriately refer patients to public primary care services;
?? PCP member agencies and other primary care services develop and implement an increased number of service development projects in partnership with GPs (eg health promotion, early intervention, quality enhancement projects).

[Note: Progress against this aim will be affected other components of the PCP Strategy, particularly Better Access to Services and Local Service Information.]

Build the capacity of GPs and other primary care service agencies to work in collaboration
Indicators

?? Increase the involvement of GP Divisions and local GPs in a range of PCP activities;
?? Increase the knowledge of GPs and local GP Divisions about the local primary health care system including eligibility criteria and waiting lists;
?? Increase knowledge and skills of GPs in the areas of population health, health promotion and early intervention;
?? Enhance attitudes of GPs and other primary care providers towards each other (eg levels of trust and confidence);
?? Relationships between GPs, PCP members and other agencies are increasingly formalised through development of protocols for referral, feedback, care planning, case conferencing and shared care;
?? GPs and other primary care providers report improved working relationships.
?? Involvement of GP Divisions in consultations and service planning processes.

Inputs

?? DHS produces and distributes, in a timely fashion, a range of guides and discussion papers aimed at enhancing the relationship between GPs and other primary care providers;
?? DHS works with GPD-V and Divisions and provides funding for a Primary Health Care Consultant based at GPD-V;
?? DHS coordinates the provision of training to state funded primary care providers, with GP participation, to build capacity for a multidisciplinary approach to consumer care, especially through the use of the Enhanced Primary Care Medical Benefits Schedule items;
?? DHS works with the Commonwealth Department of Health and Aged Care to ensure that the PCP GP Engagement Strategy takes maximum advantage of all relevant national initiatives.

Program Logic: 2.1 Better Access to Services

Goals/outcomes
Enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, reduce health inequalities between population subgroups.

Objectives/impacts
Consumers and carers experience enhanced engagement with services and programs and experience services as being provided in a seamless, coordinated fashion.

Indicators

- ?? Consumers have confidence in the advice, support, treatment, and care coordination they are receiving
- ?? Consumers and carers report the ability to easily to navigate the service system.

Consumers and carers obtain appropriate services and programs (including treatment and early intervention programs) in a timely fashion and at convenient locations, irrespective of demographic and social factors (including income, geography, age, gender and cultural background).

Indicators

- ?? Consumers are able to obtain needed primary care services and attend programs without excessive waiting times, at convenient hours, and in their preferred settings, without excessive travelling;

Processes/aims
In partnership with consumers and community groups, develop and implement a consistent, streamlined and evidence-based approach to needs identification and assessment across all consumer groups

Indicators

- ?? Develop a clear and agreed understanding about the roles, responsibilities and practice of assessment across different primary care agencies within PCPs
- ?? Establish and maintain a consistent approach to the assessment process among different primary care agencies (This will include defining and adhering to agreed roles in regard to initial contact, initial needs identification, service specific assessment, specialist assessment, comprehensive assessment and care planning, and collection of client data. All relevant service providers, consumers and carers are involved in the development process);
- ?? The assessment process is holistic, able to detect static and changing needs, addresses the wider care environment, and is sensitive to the diversity of the local population (including population groups with special needs or who are poorly represented in service client populations);
- ?? Reduce the average number of assessments per client;
- ?? Enhance sharing of consumer information while maintaining high levels of client confidentiality.

In partnership with consumers and community groups, develop and implement strategies for ensuring that services are delivered in a coordinated manner which incorporates strategies for facilitating access for vulnerable populations

Indicators

- ?? *Eligibility and priority of access criteria are clear and consistently applied;*

Inputs

- ?? DHS produces and distributes, in a timely fashion, a range of guides and discussion papers describing the range of strategies required;
- ?? DHS develops an Initial Needs Identification tool, a Care Planning tool and a primary care minimum dataset;
- ?? DHS implements workforce development strategies aimed at ensuring minimum competency standards are met throughout primary care agencies;
- ?? DHS continues to enhance coordination and linkages with: other relevant state, Commonwealth and local government programs and initiatives; across sectors; with specialist services; and general practitioners;
- ?? DHS continues to improve planning, funding, information management and reporting arrangements.

Program Logic: 2.2 Information management

Outcomes/Goals
Enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, reduce health inequalities between population subgroups.
[Note: Progress against health outcomes is dependent upon all components of the PCP Strategy.]

Impacts/Objectives
Consumers and carers experience services and programs as being provided in a seamless, coordinated fashion.

Indicators

?? Consumers and carers perceive that accurate and sufficient information about their health and health care is transferred in a timely fashion between relevant providers, only when their consent is given, and are confident that their privacy is effectively protected;
?? Consumers and carers are able to understand and follow agreed care plans;
?? Consumers and carers work in partnership with service providers to develop care plans;
?? Consumers and carers feel they have the knowledge required to work with providers to develop care plans.

Consumers and carers have access to the information they need to genuinely participate in the care they receive and to participate in the governance of services and programs.

Indicators

?? Consumers have 24 hour access to accurate and sufficient information about their health needs and available services (eg through Internet knowledge bases and 'information, support and referral call centres');
?? Consumers and carers have access to a personal electronic health record, which they can use to record personal health care actions;

Processes/Aims
Enhance the flow of information between service agencies (within and between PCPs), and between service providers and consumers

Indicators

?? *Enhance reciprocity of information flow between DHS and service agencies;*
?? In partnership with consumers, develop interagency and inter-PCP agreements on information sharing, including procedures for ensuring privacy and data security;
?? In partnership with consumers, develop clear 'pathways'/protocols guiding consumers and providers through the service system;
?? PCPs establish 'information, support and referral services' staffed by competent personnel, contactable by telephone by service providers and consumers;
?? PCP and associated non-member practitioners have access to comprehensive client records and/or information (consumers can choose to limit access to particular practitioners);
?? PCP and associated non-member practitioners can make referrals and schedule appointments electronically.

Enhance the quantity, quality and usefulness of data available about the health care provided to consumers

Indicators

?? DHS, providers and PCPs develop information management systems and IT infrastructure to support

Inputs

?? DHS conducts extensive consultation with stakeholders around the vision and work processes;
?? DHS produces and distributes, in a timely fashion, a range of discussion papers, guides, protocols and templates describing the range of strategies required;
?? DHS funds a dedicated information management function (position) in each PCP;
?? DHS outlines an approach for the deployment of dedicated training and development resources;
?? DHS plots a direction for development of IT infrastructure which meets the needs of PCP stakeholders;
?? DHS continues to improve and streamline its own data collection, processing and dissemination and rationalise its internal and external data requirements;
?? DHS develops an overarching Aged, Community and Mental Health funding reform strategy which includes a consistent method for funding units of service across programs.

Program Logic: 3.1 Integrated Service Planning

Outcomes/Goals
Enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, reduce health inequalities between population subgroups.
[Note: Progress against health outcomes is dependent upon all components of the PCP Strategy.]

Impacts/Objectives
Consumers and populations experience reduced prevalence of risk factors, and increased prevalence of protective factors identified as priorities for action in local Integrated Service Plans.
Indicators

- ?? Surveys of local community and other routine data collections demonstrate reductions in prevalence of risk factors and increased prevalence of protective factors identified as priorities for action in local community needs assessment;
- ?? Evaluation of strategies and programs demonstrates reductions in risk factors and increases in protective factors targeted by those strategies and programs;
- ?? Data indicates enhanced access to services and programs, especially by priority groups;
- ?? Consumers report enhanced access to and experience of services and programs.

[Note: Progress against these Impact Indicators is dependent upon all components of the PCP Strategy.]

Primary Care Partnership service systems provide a range of quality services and programs that match the assessed needs of local populations.

Indicators

- ?? PCP catchments provide a cohesive service system, comprised of services and programs that address population needs articulated in Integrated Service Plans.

[Note: Progress against this aim will be affected other components of the PCP Strategy.]

Primary Care Partnerships develop and implement collaborative strategies to address priority health and wellbeing issues.
Indicators

- ?? PCPs develop Integrated Service Plans, framed within a social model of health, which identify community needs based on a variety of data about the demographic and social profile and the health and wellbeing of the local population, and the characteristics of existing services and programs;
- ?? Consumers, carers and community members, especially members of marginalised populations, are involved in the development of Integrated Service Plans;
- ?? Integrated Service Plans identify priority issues for the catchment. Priority issues are agreed by a broad range of service providers, local governments and consumers, carers and the community.
- ?? Integrated service plans include feasible, evidence-based strategies for addressing the priority health issues identified;
- ?? Strategies outlined in Integrated Service Plans specify the ways in which a range of relevant agencies and local governments will work together to deliver coordinated services and programs;
- ?? Individual agencies and local governments reflect priorities of PCP Integrated Service Plans in their individual service planning and delivery;
- ?? Integrated service plans specify milestones or performance indicators that can be used to assess the comprehensiveness and efficiency of implementation, as well as indicators of impacts and outcomes;
- ?? Integrated service plans are implemented and steady progress against milestones, and indicators of impact and outcome is recorded

Inputs

- ?? DHS produces and distributes, in a timely fashion, guidelines describing systematic approaches that can be taken to integrated service planning;
- ?? DHS develops and implements a Common Planning Protocol in collaboration with local governments;
- ?? DHS develops Community Health Planning Data sets in consultation with the sector;
- ?? DHS develops an information resource on selecting and accessing population-based data that can be used to assess demographics, socio-economic status and health and wellbeing of local populations;
- ?? DHS implements a funding strategy that will provide PCPs with the flexibility to operationalise service delivery plans.
- ?? DHS uses Integrated Service Plans developed by PCPs to inform DHS priorities and funding decisions.
- ?? DHS provides advice and assistance from regional and central offices in developing Integrated Service Plans (for example forums, meetings, etc).

Program Logic: 3.2 Health Promotion Strategy

Outcomes/Goals

Enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, reduce health inequalities between population subgroups.

[Note: Progress against health outcomes is dependent upon all components of the PCP Strategy.]

Impacts/Objectives

Consumers and populations experience reduced prevalence of risk factors, and increased prevalence of protective factors identified as priorities for action in local community needs assessment (including physiological, psychosocial, behavioural, environmental, and social factors as well as consumer experience of health services and programs).

Indicators

?? Surveys of local community and other routine data collections demonstrate reductions in prevalence of risk factors and increased prevalence of protective factors identified as priorities for action in local community needs assessment;

?? Evaluations of health promotion programs demonstrate reduction in risk factors and increases in protective factors targeted by those programs;

?? Data indicates enhanced access to services and programs, especially by priority groups;

?? Consumers report enhanced access to and experience of health promotion programs.

[Note: Progress against these Impact Indicators is dependent upon all components of the PCP Strategy.]

Processes/Aims

PCPs develop comprehensive health promotion strategies as part of Integrated Service Plans, which address the health and wellbeing issues that are of common significance to consumers and the broader catchment population.

Indicators

?? Health promotion strategies are informed by data about the demographic and social characteristics and health and wellbeing of the population, participation of consumers, and carers and the broader catchment population, and national and state policy documents;

?? Health promotion program plans identify goals, objectives, target groups, the range of interventions, the roles and responsibilities of partner agencies, and indicators of progress for evaluation;

?? Health promotion program plans include strategies for building capacity for health promotion in PCP member agencies and throughout the wider catchment area.

Build capacity and implement 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 PCP member agencies and the wider PCP catchment areas (including resource allocation, workforce development, organisational development, leadership, partnerships, involvement of consumers, development of management and governance structures, and monitoring and evaluation);

?? PCPs implement health promotion programs that involve cooperative and coordinated effort between PCP member agencies, between PCPs, across programs and sectors and involve a variety of provider, consumer and community groups including local and statewide organisations;

?? Access to (selectively targeted) health promotion programs is facilitated by streamlined needs identification, assessment and client information management processes;

?? Health promotion strategies address the needs of consumers of disease management programs and are directly linked to these programs;

?? Service users and broader populations are provided with health information and advice using a range of methods including new technologies such as the Internet;

[Note: Progress against this aim will also be affected all components of the PCP Strategy.]

Inputs

?? DHS publishes, in a timely fashion, a range of guidelines and evidence based reviews describing the range of planning, funding, organisational development, service re-orientation and partnership strategies required to initiate and sustain a range of health promotion programs appropriate to population needs;

?? DHS delivers a statewide health promotion workforce development and infrastructure program;

?? DHS develops a Community Health Planning Database in consultation with the sector;

?? DHS implements a funding strategy that will provide PCPs with the flexibility to implement integrated health promotion strategies;

?? The Department's Regional Health Promotion Officers will provide advice and assistance to PCPs in developing their health promotion effort;

?? DHS will provide other technical support resources such as tools for impact and outcome evaluation.

Program Logic: 3.3 Integrated Disease Management *(4 funded projects only)*

Outcomes/Goals

Enhance wellbeing and quality of life, reduce the prevalence and incidence of disease, reduce the burden of illness/disability, reduce health inequalities between population subgroups.

[Note: Progress against health outcomes is dependent upon all components of the PCP Strategy.]

Impacts/Objectives

Limit/reverse disease progression, reduce the severity of symptoms and enhance self care and health promoting behaviours among consumers

?? Reduce the duration of illness;

?? Reduce the severity of symptoms;

?? Reduce the incidence of acute episodes (exacerbations) of ill-health including hospital admissions;

?? Consumers report increased ability to self manage key aspects of care and an increase in health promoting activities and behaviours.

Consumers and carers experience enhanced access, engagement and satisfaction with services and programs and experience services as being provided in a seamless, coordinated fashion

Indicators

?? Consumers have confidence in the advice, support, treatment, and care coordination they are receiving;

?? Clinical 'pathways' are appropriate to consumers' circumstances;

?? Increase utilisation of appropriate services, particularly by vulnerable populations;

?? Consumers are actively involved in the development of care management plans;

?? Consumers are able to adhere to care plans;

?? Consumers and carers report an ability to easily to navigate the service system;

?? Reduce overall consumption of health care resources.

[Note: Progress against these Impact Indicators is dependent upon all components of the PCP Strategy, especially BATS/IM.]

Processes/Aims

PCPs implement integrated disease management strategies consistent with evidence of best practice

Indicators

?? Care is provided in a coordinated fashion by multidisciplinary teams in accordance with explicit care management plans developed in collaboration with consumers and carers, and includes regular follow-up and systematic assessment;

?? Basic clinical pathways for all IDM clients include the 3 stages of initial contact, comprehensive assessment, and care planning;

?? Implementation of care management plans is supported by the IDM project;

?? Management plans identify aspects of care that can be self managed by consumers and carers;

?? Consumers and carers are provided with ongoing education and training to support adoption and maintenance of self management strategies.

Build capacity for implementation of Integrated Disease Management processes

Indicators

?? PCPs plan clinical and non-clinical interventions based on evidence of best practice (including health promotion, early intervention and treatment);

?? PCPs develop IDM strategies in collaboration with consumers, as part of Community Health Plans;

?? PCPs identify specific strategies for ensuring that IDM models are appropriate for vulnerable populations;

?? PCPs identify population sub-groups at highest risk of priority diseases/conditions to target for entry into IDM pathway, establish clear entry and prioritisation criteria, and develop recruitment strategies;

?? PCPs plan and implement change management strategies including planned interagency partnership development, consumer participation strategies, communication protocols, resource allocation, peer leadership, education and training, monitoring and feedback.

Inputs

?? DHS publishes, in a timely fashion, a range of policy documents and guidelines describing the range of strategies required to initiate and sustain Integrated Disease Management strategies;

?? DHS develops a Community Health Planning Database in consultation with the sector;

?? DHS continues to work with the Commonwealth to encourage mechanisms which support practitioner involvement in population health initiatives such as IDM;

?? DHS implements a funding strategy that will provide PCPs with the flexibility to implement integrated disease management strategies.