

# Implementation plan for the Primary Care Partnerships Strategy 2004–2006



**Implementation plan for the  
Primary Care Partnerships Strategy 2004–2006**

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## Vision for Primary Care Partnerships 2004–2006

**An integrated health care system**, based on partnerships, where providers see planning and working together to better meet the needs of their communities as core business.

Widespread **consumer, carer and community participation** in service design, implementation and evaluation.

People with chronic diseases being active partners in their own care, with the **system structured around consumers, not agencies or programs**. Prevention and management of chronic diseases coordinated across the health sectors.

Health system **geared to health promotion, prevention and early intervention** to improve wellbeing for at risk individuals and groups, minimising the onset of disease and preventing hospital admissions.

**More effective, efficient and evidence-based health promotion**, planned, implemented and evaluated through integrated approaches across catchments.

Agency/organisational health promotion plans linked to catchment priorities that are, in turn, linked to state and national health priorities—**coordinating effort for local populations**.

**Consumers' needs identified early and appropriate services delivered promptly**. Improved service coordination practice enhanced and embedded in agency practice, streamlining assessment and access to services. The consumer's record built on and shared with other practitioners involved in their care, with consumer consent.

Widespread, **efficient and effective referral and care coordination** between general practitioners and other health care providers.

**Reliable information and communications technology infrastructure** and agreed standards in place enabling electronic communication, including e-referral.

**Strategic leadership** at all levels of government with expectations of health care integration built into accountability frameworks. Agencies spend less on reporting and accountability and more on service delivery.

**Flexible funding to assist innovation and integration of services** and streamlined reporting and accountability requirements. Agency service agreements linked to catchment-based and agency plans. Common health minimum datasets.

**National primary health policy** guiding Commonwealth, states and territories leading to more effective integration.

## Foreword

Providing services that are locally based, individually focused and fully integrated is a major challenge for the Department of Human Services<sup>1</sup>. The primary health sector is rising to meet this challenge and, over the last four years, the Primary Care Partnership (PCP) Strategy has made significant progress towards the development of a stronger, more integrated community-based health and community service sector. Within partnerships, services have come together to look at the way they work, reducing duplicated practices while increasing understanding about referral pathways and how to improve service coordination and deliver integrated health promotion (IHP) practice.

Benefits are starting to flow from this work, with some agencies reporting more time for service delivery and a consistent approach to collecting and sharing client information. Most importantly, this work is translating into benefits for clients, with agencies reporting a faster response to clients seeking services and the early identification of client needs.

Replicating these benefits across the human services sector was the impetus for the recently released *Primary Care Partnerships strategic directions 2004–2006*. This document signalled a broadening of this collaborative approach with departmental commitment to the PCP agenda of partnerships, service coordination and IHP.

This implementation plan elaborates on this theme, providing information about how the broader Department of Human Services commitment will be realised within individual programs. The vision is broad and provides opportunities for partnerships to develop, lead and contribute to a range of initiatives. Ministers have encouraged PCPs to be bold and some have already demonstrated real leadership in areas such as e-referral, development and implementation of Hospital Admission Risk Program (HARP) projects, and innovative IHP. The opportunities presented to PCPs need to be embraced and I encourage PCPs to be innovative and flexible to take advantage of these new directions.

In addition to broadening the scope of PCP activity into new sectors, the next phase of the strategy aims to consolidate the gains already made by PCP member agencies. This will involve strengthening the collaborative role of PCPs through IHP catchment plans and service coordination focusing on multi-service care planning.

The ultimate aim of PCPs is to improve both the experience and outcomes for clients. Although this will only be achieved through hard work and dedication, PCPs have already demonstrated their commitment to this vision. I applaud PCPs on their achievements to date and look forward to the next phase, which will see the gains already made consolidated and benefits to consumers and practitioners being experienced more broadly across the human services sector.



**P M Faulkner**  
**Secretary**  
**Department of Human Services**

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## Introduction

People's needs do not fit neatly within one agency's responsibility. Partnerships, however, are a potentially powerful way of addressing issues that single agencies cannot resolve by themselves. Those who plan and provide services need to work alongside the people who use them, to put together new and better solutions to difficult problems.<sup>1</sup>

Significant evidence in Australia and internationally demonstrates the value of partnerships in improving the delivery of primary health care services and programs<sup>2</sup>. The research also indicates that partnerships, in building a solid foundation for coordinated action, inevitably take many years to achieve their aims<sup>3</sup>.

The Primary Care Partnership (PCP) Strategy was launched in 2000<sup>4</sup> aiming to create a genuine primary health care service system through a partnership approach. The goals of the reform remain the same four years on, that is:

- to improve the experience and health and wellbeing outcomes of people using primary health care services
- to reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by coordinating a service response to early signs of disease and/or people's need for support.

A recently conducted independent evaluation found that a key benefit of the PCP Strategy has been a substantial improvement in inter-agency relationships<sup>5</sup>. This has helped the sector recover from compulsory competitive tendering and laid the foundations for improving consumer health and wellbeing outcomes.

The evaluation also indicates that PCPs have had mixed success in engaging consumers, although an increasing

number of partnerships are identifying direct benefits to consumers. The challenge for the next phase is to realise these benefits more broadly. Consumer, carer and community participation remains a key tenet of the strategy.

The purpose of this document is to guide the implementation of the next phase of the PCP Strategy as outlined in the *Primary Care Partnerships strategic directions 2004–2006 Better health—stronger communities* document. In taking the PCP Strategy into its next phase, the Department of Human Services is committed to:

- using PCPs to inform and/or implement new initiatives that require collaborative partnerships between primary health care services, or between these services and other health and community services and sectors
- implementing service coordination, specifically the statewide tool templates, where relevant
- using the IHP framework for all community-based health promotion initiatives and having all local planned health promotion activity informed by catchment-wide IHP planning<sup>6</sup>.

For the reform process initiated by the PCP Strategy to be sustainable and succeed in the long term, its principles and objectives need to be embedded in the way agencies and organisations operate. This is the challenge for 2004–2006.

## Section 1 Policy context for the future directions for PCPs

### 1.1 Evidence base

Despite the caveats concerning generalisability, the available evidence confirms improved population health outcomes and equity, more appropriate utilisation of services, user satisfaction and lower costs in health systems with a strong primary [health] care orientation.<sup>7</sup>

The evidence base supporting partnerships, integrated community-based care, and population health approaches to promote better health and wellbeing is plentiful. This evidence base also underpins a number of policies and initiatives developed by the Victorian and Australian governments.

#### 1.1.1 Integrated community-based health services

Integration in health services can be defined as the process of

bringing together common functions within and between organisations to solve common problems, developing a commitment to a shared vision and goals and using common technologies and resources to achieve these goals.<sup>8</sup>

The importance of greater integration across acute and primary health care services, especially to meet the needs of people with chronic and complex health problems, is well recognised. Many sectors are involved in strategic and systemic reform to achieve this end. While the PCP Strategy has influenced and informed other initiatives, there are a number of policies and strategies emerging that inform the way PCPs will evolve. Those

focusing on improving community-based health services include:

- Directions for your health system: Metropolitan Health Strategy<sup>9</sup>
- Directions for your health system: Metropolitan Health Strategy Ambulatory Care Services<sup>10</sup>
- Community health services—creating a healthier Victoria<sup>11</sup>
- Cancer Services Framework<sup>12</sup>
- Improving care for older people: a policy for health services<sup>13</sup>
- HealthSmart, the whole of health information systems strategy being managed by the Office of Health Information Systems which provides a platform for e-referral
- Small rural health services guide 2003–2004<sup>14</sup>
- Department of Human Services Funding Models Flagship Project<sup>15</sup>
- Hospital Demand Management Strategy.

These initiatives advocate for, or support, an increase in ambulatory care services being delivered in community-based settings<sup>16</sup>. This is essential for the health system as a whole to be more effective in promoting wellbeing, in preventing and retarding progression of ambulatory care sensitive conditions (ACSCs) and also in preventing acute presentations and/or admissions.

The PCP service coordination activities, integrated disease management projects and the involvement of primary health care services in HARP projects are laying

the groundwork for improving the coordination of community-based ambulatory care services.

The PCP Strategy acknowledges the importance of the interface between community-based health services and other community services, such as housing, disability and community care. That is, people using these services also use and need health services and should experience a coordinated system that reflects all their needs in a timely and appropriate way. Strengthening this interface between community services and health services is supported by this implementation plan (see Section 2).

#### Opportunities for PCPs

PCP member agencies and organisations should consider how they could position themselves to play a more effective role in improving the acute/primary interface.

PCPs should continue to increase engagement by health services in PCP activities, particularly to drive partnership initiatives that aim to improve care for people with chronic and/or complex conditions (such as HARP and improving ambulatory care services). PCP governance arrangements need to facilitate this.

For example, as HARP changes focus to mainstream projects so that they are provided on an ongoing and systematic basis sustainable partnering arrangements between acute health service organisations and community-based organisations will be a key consideration and opportunity. Issues involved will include the legal

form of the organisational relationship, identification of a coordinating agency, involvement of key senior managers, decision making structures and processes, reporting and accountability requirements dispute resolution and length of agreement. PCPs will need to assess whether existing governance arrangements allow for an effective and efficient way of actively participating in the preventive models of care that are mainstreamed.

In rural areas, rural health services are encouraged to take a leadership role in strengthening a coordinated approach to supporting the interface between primary and secondary health services and the interface with other community services, particularly in supporting people with chronic and complex conditions. PCPs provide the coordinating platform to enable this to happen.

The Department of Human Services has established a Flexible Funding Flagship Project to explore how it may fund agencies and organisations in a more flexible way that maintains accountability and strengthens the link between funding and planning. The Flexible Funding Models Project has developed some alternative funding models that aim to contribute to better integrated service delivery within and between agencies and organisations. One of the models being piloted as part of this project is the area-based funding model that sets in place collaborative approaches to planning and funding of services across groups of agencies and organisations. PCPs

are well positioned to explore this funding approach and participate in the piloting process.

### 1.1.2 Place-based approaches

Neighbourhood Renewal organises responses around people and the places they live, work and play to better connect government programs to real community needs. Partnerships have been built across government, the community and the service sector. Most importantly, local residents are getting involved and leading change that is creating healthier communities.<sup>17</sup>

Other community building and community capacity building projects in Victoria include those initiated by the Department of Victorian Communities<sup>18</sup>. These approaches also aim to strengthen local institutions and local partnerships to improve social connectedness and promote stronger communities.

#### Opportunities for PCPs

PCPs provide a partnership of agencies and organisations working with and for communities; they have cross-sectoral links through their IHP programs. Therefore, PCPs provide an existing partnership to support projects to create better health through stronger communities.

PCPs are expected to participate in Neighbourhood Renewal health and wellbeing working groups, which bring together residents, service providers, government programs and other stakeholders to set priorities and develop strategies to tackle local

health needs. The priority setting processes of these groups should inform PCP planning for IHP and service coordination so these deliverables are targeted to Neighbourhood Renewal communities. This will ensure consistency, integration and relevance of programs and strategies being developed, particularly in regard to IHP programs within the PCP catchment (see Section 2). Involving consumers and carers in these initiatives will help to build social capital in these disadvantaged communities.

### 1.1.3 Population health approaches

Population health approaches are increasingly being recognised as a key element in the planning of quality, efficient and equitable health systems internationally<sup>19, 20, 21, 22</sup> and in Australia<sup>23</sup>. They increase understanding about what makes and keeps people healthy, describe strategies to reduce inequities and improve the health and wellbeing of whole populations, and recognise that collaboration and inter-sectoral action are crucial in population health approaches.

The Department of Human Services, the Australian Government and non-government organisations fund a range of initiatives requiring a population health approach. Many of these require partnership of a wide range of agencies and organisations to address the underlying broad determinants of the population health issue. A recent example is the Victorian Department of Human Services Aged Care Falls

Prevention Program where funds have been allocated through the PCP infrastructure to fund initiatives to reduce falls and injury in older people.

### Opportunities for PCPs

The theoretical and policy drivers for population health approaches are provided through the IHP framework, which underpins PCP member agency/organisation health promotion programs<sup>24</sup>. PCPs are well positioned to ensure population health approaches through the planning, implementation and evaluation of IHP programs in Victoria.

New funding for population health initiatives offers PCPs an opportunity to develop their expertise in facilitating such initiatives as part of their IHP catchment planning process. In some instances, such initiatives may offer an opportunity to expand and strengthen an existing program or incorporate an additional priority plan into the process.

PCPs' governance arrangements and IHP planning should enable PCPs to identify links between current and new population health initiatives. These should also strategically position the partnerships for future population health initiatives, thus ensuring stronger collaboration, better quality and reducing duplication of effort.

### 1.1.4 Australian Government initiatives

The primary care sector is diverse, containing responsibilities for both the Australian and Victorian governments. The Australian Government recognises the importance of greater engagement between general practitioners (GPs) and the wider primary health sector in providing holistic care and the best available care to those with chronic illnesses. It also recognises that a good primary care system is the most cost-effective means of providing health care for the community. Over the last decade, beginning with the establishment of Divisions of General Practice through to the changes to Medicare through *Strengthening Medicare*, there has been a range of reform measures that have an impact on general practice.

The Australian Government recently spelt out its priorities for strengthening primary care in the response to the Review of Divisions of General Practice (May 2004). These priorities are:

- making care more accessible
- focusing on prevention and early intervention
- encouraging better management of chronic disease
- supporting integration and multidisciplinary care
- building the evidence base for effective, quality primary care
- using technology to support best practice
- recognising and respecting the variety of practice styles.

These priorities have much in common with the objectives of PCPs and provide a solid foundation for the continued and active participation of Divisions of General Practice and GPs in the work of PCPs.

The Australian Government Department of Health and Ageing (DoHA) has supported General Practice Division involvement in PCPs and encourages their continued involvement. DoHA also encourages divisions to take an active role in the development of IHP plans, particularly in the context of developing their three-year strategic plans.

### Opportunities for PCPs

Other Australian Government initiatives provide opportunities for PCPs to improve integration of services for consumers. These include linking with rural Divisions of General Practice in the provision of services under the More Allied Health Services Program, with metropolitan and rural divisions in relation to services provided under the Better Outcomes in Mental Health initiative, and working with all divisions on chronic disease programs.

A new initiative, Primary Care Collaboratives, will initially focus on diabetes and cardiovascular disease. PCPs need to take opportunities to participate in this work and share in the learnings from projects. The GP Aged Care Panel initiative may also provide opportunities for closer collaboration between aged care providers and general practice in caring for the needs of residents.

## Section 2 Primary Care Partnerships 2004–2006

Service coordination and IHP remain the two key deliverables for PCPs to 2006. However, where practical, PCPs may facilitate other collaborative initiatives for their catchment.

This document incorporates feedback on the proposed tasks and directions for PCPs to 2006 from consultations with the sector and key stakeholders (including relevant peak bodies, statewide organisations and consumer and carer representatives). In a parallel consultation process, details of the implementation commitments by the Department of Human Services program areas were gathered and these are also included.

### 2.1 Financial arrangements for PCPs

Core funding to each PCP for the financial years 2004–05 and 2005–06 remains as follows:

- \$3.2 million recurrently, which provides \$100,000 per PCP to facilitate partnership activities to support the implementation of the priority tasks and meet accountability requirements
- \$1.5 million recurrently to support PCP catchment IHP program planning and evaluation reporting. PCPs in rural Victoria will continue to receive an additional specific allocation to support rural health promotion (\$750,000 in total for 19 rural PCPs).

PCPs have the option to negotiate flexible resource-sharing arrangements with their regional office and other PCPs within their region to promote efficiencies in implementation and innovation.

Through their collaborative efforts, PCPs are providing the infrastructure to enable a joined-up government response to a range of issues. This is evidenced by the funding provided by the Office of Senior Victorians to support older Victorians to keep active and healthy.

The department will continue to explore collaborative options with the Australian Government and Divisions of General Practice to achieve more integrated service delivery and improved service coordination for people with chronic and complex conditions.

### 2.2 PCP governance and leadership

Not all activities undertaken by the PCP will be equally relevant to all partners. In some cases, initiatives to address local priorities will benefit from the inclusion of agencies and organisations that are not formal members of the PCP, including private providers, such as pharmacists. For example, to be effective, many IHP initiatives require a broad range of partners. The excellent work done by PCPs to date has often been cross-sectoral and groundbreaking.

Governance arrangements are not uniform. They need to work for each catchment and meet the needs of all members. New initiatives may be offered to a few partnerships or rolled out extensively across the state. PCPs should aim to promote their organisational flexibility and invest in their collaborative arrangements to share the load in applying for funds,

planning, and researching future initiatives. As established collaborative entities, PCPs have a collective leadership role to plan and deliver, or advocate for, the best way forward to meet the needs of their communities.

PCP governance arrangements will need to be:

- robust enough to provide funding bodies with confidence that the governance arrangements are appropriate to manage a particular collaborative initiative
- flexible enough for members to be fully informed
- streamlined to facilitate participation and development of working relationships on relevant collaborative activities.

If this is not the case, funding bodies may simply form other governance groups to meet their needs. This is not in the best interests of agencies and organisations that would be involved in many different initiatives and of consumers requiring services. This would also potentially undermine the trust built up by existing partnerships and see smaller alliances competing with each other in the same catchment.

### 2.3 The role of PCPs in planning

IHP catchment planning will require consideration of relevant data and strategic plans to determine priorities for action. Community health plans (CHPs) for 2004–2006 will focus on implementing these priority tasks (see Section 3).

There are various strategic planning mechanisms available to PCP member agencies and organisations that support operational planning and priority setting for IHP. Indeed, local governments lead a wide range of planning processes, such as Municipal Public Health Plans (MPHPs), that can provide evidence to support priority setting and decision-making. With the introduction of the policy framework, “Environments for Health”<sup>25</sup>, municipal public health planning is increasingly a key strategic process to identify health issues at the local level. There do, however, continue to be variations in the quality of approaches across the State.

Sector consultation<sup>26</sup> (conducted in March 2004) identified that although MPHPs are an important resource for planning, other sources of data also need to be considered, including:

- Department of Human Services CHP data set
- other relevant local government plans, including drug action plans, emergency and safety plans, early years plans (from July 2004)
- Neighbourhood Renewal health and wellbeing priorities
- Divisions of General Practice strategic plans
- multi-purpose services needs analyses and service plans
- health service planning (the Metropolitan Health Strategy and Small Rural Health Services Strategy both imply a planning role for health services)

- primary care and population health advisory committees, which can play a key part in determining the role of health services in population health and IHP initiatives in metropolitan areas.

Where there is expertise or partnership commitment, PCP alliances are doing more extensive planning, sometimes on behalf of local governments or as an integrated planning exercise. While cross-sectoral planning is encouraged, planning beyond the priority tasks of PCPs will need to be resourced by other funding sources, such as agency contributions.

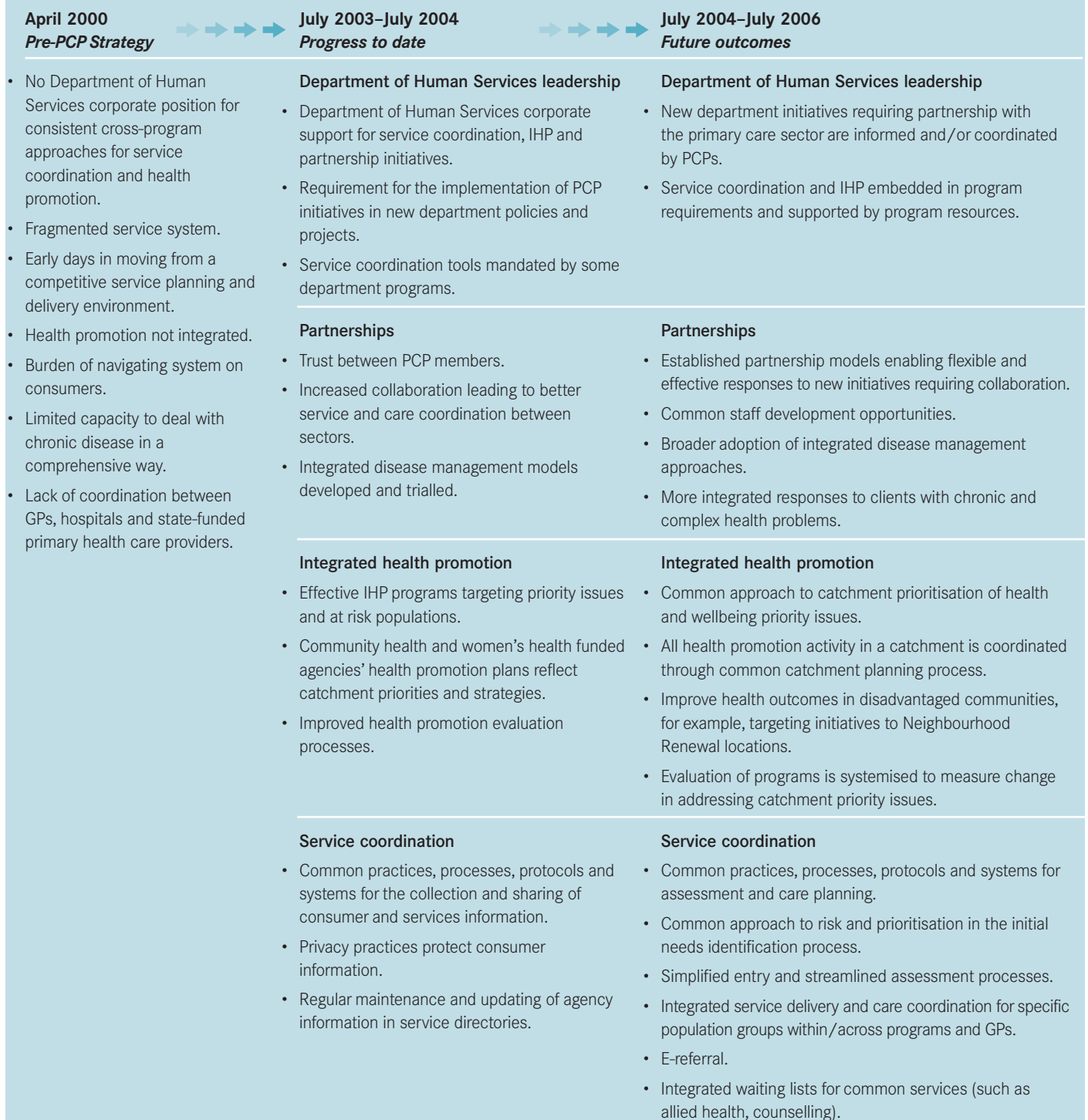
A key issue that arose during the consultations was the need to supplement the data analysis capacity of the sector to support improved planning and priority setting. This issue, which is linked with the variable quality of plans, will be a focus of joint effort between the department’s Public Health and Primary and Community Health Branches in 2004–05.

## 2.4 Moving towards greater integration

The PCP Strategy has moved Victoria towards a more integrated health system. The external PCP evaluation<sup>27</sup>, PCP annual reports and feedback from the latest consultation with the sector reveal that the greatest gains have been made where agencies and organisations have defined tasks to work on, as agreed by the PCP. Working towards tangible outcomes provides a focus for collaboration. Some PCPs are more advanced than others. This is due to a variety of factors, including historical and local

circumstances, and PCPs that have been ready and capable of moving faster may have received higher levels of funding for a range of purposes, including service coordination, information management, information technology and information communications technology.

Figure 1 captures the broad progress to July 2004. While all PCPs may not be at this stage, all should be working to achieve the outcomes listed over the coming years.

**Figure 1: Moving towards greater integration**

## Section 3 Implementation plan for the Primary Care Partnership Strategy

### 3.1 Community health plans—an overview

CHPs will be operational plans that establish goals, objectives, service system change strategies, governance, monitoring and accountability. For a PCP, this involves identifying the tasks that member agencies and organisations agree to tackle together, what each agency will do to accomplish these tasks, and projected timelines. Other stakeholders may also be involved in this process as required.

The CHP will comprise the implementation plan for:

- integrated health promotion
- service coordination.

CHPs will also include a brief description of other collaborative initiatives undertaken by the PCP.

PCPs were required to submit a CHP by 30 September 2004 for the period 1 July 2004–30 June 2006. From 30 June 2006, CHPs will become three-year plans and will be reviewed by PCPs annually.

Reporting against CHPs will continue through the Community Health Plan Implementation Agreement (CHPIA), at 30 July 2005 and 30 July 2006. The annual reporting process should also be used as an opportunity to review and update CHPs as necessary.

Templates to assist with planning and reporting service coordination and IHP have been developed and are available at [www.health.vic.gov.au/pcps](http://www.health.vic.gov.au/pcps)

### 3.2 Service coordination

Through PCPs, agencies have come together under the banner of service coordination to provide a consistent approach to identifying consumer health and care needs and the collection and sharing of client information. Reports from agencies suggest that this approach is resulting in positive outcomes for clients and agencies. A major aim of the PCP Strategy until 2006 is to increase the number of agencies implementing service coordination so that these benefits can be experienced across the human services sector. Another aim is to support agencies that have already successfully implemented initial contact and initial needs identification (INI) to progress the Better Access to Services operational framework in the areas of care planning and assessment.

For PCPs, this means that while most of their effort will focus on supporting agencies new to service coordination, they will also continue to work with agencies that are further advanced in service coordination implementation. Agencies that are advanced in service coordination implementation will need support to continually improve service coordination practice, as well as improve their service response to clients with chronic and complex needs.

### PCP action

#### Planning

The service coordination element of the CHP will be based on three major areas of activity and include the goals to be achieved over the two years within these areas. The three major areas of activity are:

- to **support priority human services agencies, which are new to service coordination**, implement the Better Access to Services operational framework (significant PCP service coordination effort and resources should be applied to this task)
- to support general practices to improve the quality of referral and care planning and, in particular, implement the General Practice Statewide Referral Form
- to continue to **support agencies that have already successfully implemented** the Better Access to Services operational framework for initial contact and INI, and to support those agencies to move on to **implement the Better Access to Services operational framework for assessment and care planning**.

The service coordination element of the CHP should identify priority agencies for the PCP to support in relation to achieving the three areas of activity. As resources are limited, PCPs need to focus their efforts strategically, particularly when considering which new agencies they are going to work with. This approach recognises that in an environment of limited resources, PCP resources are best directed to those agencies and general practices

that will deliver the greatest returns for consumers and carers.

When determining this list of agencies, PCPs need to consider an agency's willingness to implement service coordination. It is important to note that these agencies may not necessarily be current members of the PCP. One consideration is the level of support provided by the agency's funding body to participate in service coordination activity. Care continuity programs including post acute care and sub-acute services, as well as alcohol and drug (A&D) counselling providers, are required in their funding guidelines to implement service coordination. Therefore, these agencies are likely to represent new sectors open to approaches to implement service coordination. PCP member agencies also need to target providers of acute services, as part of their work with agencies new to service coordination, to improve the care of clients with chronic and complex conditions. Other considerations when determining priority agencies may include:

- agency role in care coordination
- number of clients
- characteristics of clients (for example, level of risk, acuity, need for care coordination, complexity)
- number and nature of referrals
- referral destination and referral source
- levels of throughput of clients
- position in service system, for example, entry point, tertiary service
- number of services provided

- size of services provided
- capacity/infrastructure within services, for example, electronic capacity
- delivery of multiple programs (which might already have implemented service coordination)
- number of staff
- skills of staff
- basis on which the services is offered, for example, office-based or outreach.

PCPs should continue to work with their Divisions of General Practice to identify GP practices that are willing and appropriate for engagement in the implementation of practices, processes, protocols and systems to improve referral and care planning. The General Practice Small Grants Scheme has provided a way to engage individual GP practices in service coordination and may provide an opportunity for further GP engagement.

Once suitable GP practices and prioritised human service agencies are identified, the PCP, in conjunction with the Department of Human Services regional office, will determine which prioritised organisations the PCP has the capacity to work with over the next two years. The prioritised agencies will then be asked to confirm their in principle agreement to work with the PCP on service coordination implementation and be invited to participate in planning for this.

It is expected that most of the time and effort involved in developing the service coordination element of the CHP will be associated with negotiating

with priority agencies and general practices, rather than in documenting the workplan. To assist PCP alliances in their planning process, a service coordination planning template has been developed and is available at [www.health.vic.gov.au/pcps](http://www.health.vic.gov.au/pcps). PCPs are invited to complete the template as the service coordination element of the CHP, although this is not compulsory, as PCPs may prefer to document their service coordination planning activity in another format. If the template is not used, PCPs need to ensure that the service coordination element of their CHP provides the following information about planning:

- **Area of service coordination activity being addressed in the plan:** outline goals, strategies, responsibility, timelines and measures for each of the three major areas of service coordination activity
- **Goal:** document the projected outcome for each area of service coordination activity
- **Strategies:** describe how the goal will be achieved and the individual or agency responsible for the task
- **Timelines:** indicate when the strategy will be completed
- **Measures:** describe how the PCP member agencies will decide whether they have achieved their goal.

### Implementation

As the nature of implementation may vary, the workplan is likely to include a range of activities, from implementing service coordination in new agencies to progressing the Better Access to

Services operational framework in assessment and care planning in agencies with sophisticated service coordination practice.

The implementation activity described below reflects the diversity of approaches PCPs may take to further the service coordination agenda. When determining appropriate implementation activity, PCPs need to consider that agencies are often pursuing service integration in other ways. This is because improving the way services work together and coordinate care for consumers is a major aim of many government initiatives, not just service coordination. Examples of this trend can be found in the recently released Divisions of General Practice Future Directions report where supporting integration and multidisciplinary care is a major priority, and also in many State Government initiatives, such as HARP, HealthSmart and the Improving Care for Older People Policy. It is expected, therefore, that service coordination implementation activity would align with other service integration initiatives that agencies may be involved in.

Although implementation activity may vary, PCPs need to work towards achieving:

- **improved consumer care and agency operations**, through improving client entry and needs identification
- **better quality referrals and referral feedback between GPs and primary health providers** through the establishment of protocols, to improve the quality of referral and referral feedback

- a consistent approach to the sharing of consumer health and care information through the use of agency software and e-referral
- **enhanced referral practice and ability to provide information to consumers** about service options to address their health and care needs through use of the statewide services directory (SSD)
- **broader use of local/regional practices, processes, protocols and systems** and the associated service coordination tool templates (SCTTs) in agencies new to service coordination
- **better meeting the needs of people with chronic and complex conditions** through strengthening the delivery of ambulatory care services across the primary and acute health sectors.  
In addition to these aims, implementation activity may support:
  - improved waiting list management through the increased use of technology
  - adoption of an integrated disease management approach for the care of consumers with complex needs and chronic conditions
  - development and implementation of a demand management framework, with a common approach to initial prioritisation criteria in the INI process and a streamlined approach to comprehensive assessment
  - aligned program-specific work around demand management.

When planning implementation activity for the period July 2004 to June 2006, PCP agencies need to consider:

- existing Department of Human Services program requirements, such as Home and Community Care (HACC)
- encouraging member agencies to implement, regularly review and update PCP agreed practices, processes, protocols and systems for the initial contact and INI elements
- where appropriate, moving towards regional/statewide consistent approaches, particularly in PCP practices, processes, protocols and systems
- participating in the SCTT revision process
- focusing on entry points to services, articulating expectations of entry points and their relationship with other agencies in the partnership
- improving referral pathways and feedback processes (particularly in relation to general practice) through the broader use of the tool templates in line with program requirements.

In the interest of disseminating learnings and sharing good practice, PCPs are requested to provide the Department of Human Services with a copy of their practices, processes, protocols and systems for inclusion on the DHS website, [www.health.vic.gov.au/pcps](http://www.health.vic.gov.au/pcps), to enable easy access by agencies within the catchment. PCPs are also encouraged to explore opportunities to develop regional consistency in their practices, protocols, processes and systems documents.

### Service coordination reporting process

PCP alliances are required to report annually on their service coordination achievements for the period June 2004 to June 2006 through the CHPIA. Although reporting information pertains to work with agencies, the CHPIA is expected to report on the activities undertaken by the PCP, not on individual agency implementation of service coordination.

A service coordination reporting template has been developed to assist PCPs and is available at [www.health.vic.gov.au/pcps](http://www.health.vic.gov.au/pcps). The reporting template mirrors the service coordination planning template, except that it provides additional columns to record actual measures and comments. PCP member agencies should use the service coordination reporting template to reflect on what has been achieved and describe changes to the plans that have occurred over the year. It is possible that not all the strategies outlined in the plan will have been completed, often due to circumstances beyond the control of the PCP, such as when a timeline changes because a task takes longer than expected or an agency requests postponement of training due to IT issues. If the template is not used, PCPs need to ensure that the service coordination element of the CHPIA provides the following information: changes to the plan (if necessary); actual measures and comments on progress.

### 3.3 Integrated health promotion

Intersectoral action and partnerships are widely supported to improve effectiveness and quality practice. The department has sought to strengthen and emphasise the need for inter- and intra-sectoral action by introducing the term ‘**integrated health promotion**’ (IHP). This is defined in the Department of Human Services *Integrated health promotion resource kit* (2003)<sup>28</sup> as:

agencies and organisations, from a wide range of sectors, and communities in a catchment, working in a collaborative manner, using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.

The statewide objectives of integrated health promotion are to:

- reorient the primary health care system to be population-focused and underpinned by the social model of health
- consolidate and enhance health promotion infrastructure and resources to reduce duplication and fragmentation of effort
- contribute to the health promotion evidence base for priority issues and population groups
- increase the potential for sectors other than health in to be involved in quality health promotion service delivery
- strengthen the capacity of the service system in Victoria to plan, implement and evaluate IHP programs.

### Catchment planning

To support IHP, the department is keen to work with PCP member agencies and organisations to implement catchment planning for key topics and settings, using the IHP common planning framework.<sup>29</sup> Catchment planning that addresses these priorities aims to:

- move towards a population health approach for health promotion program activity
- strengthen collaborative partnerships
- improve the quality of integrated approaches to health promotion planning, implementation, evaluation and dissemination.

The pace at which this is implemented by each PCP alliance will vary, depending on the existing working relationships and levels of integration across the PCP member agencies and organisations. The department’s timeframe for introducing catchment-wide planning is outlined in Table 1 (adapted from Department of Human Services (2003) *Integrated health promotion resource kit*, section 1, page 4).<sup>30</sup>

Mirroring this emphasis on collaboration, the department will undertake a phased approach to:

- introduce a common planning and evaluation reporting mechanism, using the IHP common planning framework, for departmental community-based health promotion funding
- review and minimise accountability requirements for departmental community-based health promotion funding where relevant.

**Table 1: A phased approach to collaborative catchment planning**

PCP strategy timeframe	Level of integration	Description
2000–2003	Networking	Agencies/organisations meet to exchange information for mutual benefit. This requires little time and trust between partners. Can serve as a clearinghouse for information, such as regional health promotion network meetings/PCP health promotion meetings.
	Coordination	Agencies/organisations in a PCP come together to exchange information and alter activities for a common purpose. In developing the PCP IHP plan, needs and activities are matched and coordinated. Provides an opportunity to limit duplication of services. Plan tends to reflect PCP health promotion funding allocated to projects.
2004–2006	Cooperation	Agencies/organisations in a PCP catchment come together to plan an integrated approach to common health promotion priorities. Planning process reflects individual agency/organisation resource allocation. This requires a significant amount of time and high level of trust between partners.
2006–2009	Collaboration	As for cooperation plus enhances the capacity of the other partners for mutual benefit and a common purpose. Build interdependent systems to address issues and opportunities. The majority of health promotion funding for the catchment is reflected in the planning process.

### Integrated health promotion priorities 2004–2006

From 2004–2006, to provide greater direction and leadership for health promotion, the department is establishing key topics and one setting as **priorities for IHP**.

The five key topics are:

- Physical activity
- Food and nutrition
- Mental wellbeing and social connectedness
- Tobacco, alcohol and other drug issues
- Healthy weight.

### The setting is neighbourhood renewal sites

(where a Neighbourhood Renewal program exists in the PCP catchment).

Consolidating IHP to focus on these priorities will enable PCP agencies/organisations and community representatives (key stakeholders) to align their local health promotion program activity to **contribute** to, and benefit from, statewide and national directions. These include the:

- Victorian Government's obesity and diabetes prevention strategies that emphasise increasing levels of physical activity, improving options for healthy eating and achieving healthy weight

- Victorian Government's support of neighbourhood renewal, community building, municipal public health planning and the Victorian Health Promotion Foundation Strategic Directions 2003–2006, which all emphasise the importance of social connectedness, supportive environments and the underlying determinants of health
- Australian Government's national health priority areas (diabetes, cardiovascular disease, mental health, injury, arthritis, asthma)
- Australian Government's Be Active Australia initiative.

Focusing on these topics will **contribute** to preventing and minimising the effects of a range of diseases and conditions, such as diabetes, cardiovascular disease, cancer, chronic disease, falls and other injuries, suicide and other mental illness, asthma, arthritis, food insecurity, dental caries and related oral disease. This contribution is vital in reducing avoidable hospital admissions caused by ACSCs and, ultimately, in reducing the sizeable burden of disease in Victoria. These five topics also capture the most common priorities identified through local needs assessments and health promotion activity implemented by primary health care agencies and organisations.

Recognising the need for a continuous quality priority setting process, the priorities will be reviewed by the Public Health Group in partnership with other key departmental program areas leading up to 2006–07 and to establish statewide priorities for 2006–2009.

#### PCP action

##### Planning and implementation

To meet the department's requirements for IHP and the use of PCP IHP and rural health promotion funding, PCP agencies and organisations are required to:

- Facilitate catchment-wide planning for IHP. The PCP CHP should articulate this by identifying the key priorities for IHP action in the catchment and outlining a **summary** of planned action, and estimated budgets and timelines for action by participating agencies/ organisations and community representatives
- Use the IHP guiding principles and common planning framework<sup>31</sup> to guide catchment priority setting and planning processes. For each PCP catchment, agencies, organisations and community representatives (key stakeholders) will determine a **minimum of one** and a **maximum of three** priorities, of which **at least one** is selected from the key topics above. **All health promotion activity should incorporate action in Neighbourhood Renewal sites (where applicable) but this does not imply that all health promotion funds should be spent in the Neighbourhood Renewal area**
- Provide leadership and support in the planning process and actively contribute to catchment priority setting for IHP. IHP planning committees and PCP governance groups should ensure the participation of Neighbourhood Renewal health and wellbeing working groups in catchment planning, so that the processes of defining problems and generating solutions is locally relevant and community-driven
- Coordinate and support capacity building strategies, such as workforce development, to improve integrated approaches to health promotion practice
- Coordinate the evaluation of the IHP catchment activity, and report process and impact indicators resulting from addressing the catchment priorities. PCP IHP/rural health promotion funding can be used to support this work.
 

Agencies funded for health promotion from the Community and Women's Health Program will participate in at least one of their respective PCP health promotion catchment priorities. This should represent a minimum of 25 per cent of the agency funding from the Community and Women's Health Program for health promotion.

Specific agency priorities may also be pursued as part of an organisation-specific health promotion plan. These should be negotiated with regional offices to achieve a balance between:

  - allowing a phased approach to catchment planning, which reflects the varying levels of readiness for collaborative action amongst PCP agencies and organisations
  - ensuring individual organisational activities do not undermine the potential of comprehensive collaborative action on the catchment priorities.

For further information related to planning and evaluation reporting requirements for Community and Women’s Health Program activity (health promotion), please refer to the “*Community and Women’s Health Program June 2004—Health promotion planning and reporting 04–06*”<sup>32</sup>. Where **regional and/or statewide services** cover more than one PCP catchment, the role that these services play in catchment planning and program delivery depends on the priorities and population groups identified and will vary depending on each PCP context. This should be negotiated directly with the Department of Human Services regional office.

Foothold on Safety Program funds for PCP IHP action is for quarantined action to address particular priority issues such as falls prevention. Where this action does not represent one of the catchment health promotion priorities, the planning process can be summarised in part three of the CHP (Collaborative Initiatives).

As outlined in Table 1, the department’s vision is that PCP agencies and organisations will use 2004–2006 to align their PCP alliance to fully implement catchment planning from 2006–2009. The IHP planning cycle will then be aligned with three-year service agreements. The pace at which this is implemented in different catchments will vary and will be subject to negotiation with individual PCPs and Department of Human Services program areas.

### Evaluation reporting by July 2005

[PCP alliances submit a case study for each IHP priority issue.](#)

PCP alliances will meet with Department of Human Services regional staff to discuss the case study and implementation of the CHP for 2004–2006. This meeting will also allow PCP alliances and department staff to discuss longer-term planning and sustainability issues for the PCP. Department of Human Services regional staff will document the outcomes of the meeting.

### Evaluation reporting by July 2006

[In addition to the June 2005 requirements, PCPs alliances submit the IHP summary grid for all IHP catchment priorities covering their work for the whole of the 2004–2006.](#)

The report should include both the narrative (part 1) and the summary grid (part 2) for all PCP IHP catchment priorities. The proforma can be found at [www.health.vic.gov.au/pcps](http://www.health.vic.gov.au/pcps). The department’s formal feedback meeting with the regional office and PCP member agencies and organisations after the submission of the CHP will include discussion of this evaluation report.

Accountability for program-specific funding for health promotion remains as directed by individual Department of Human Services programs. Agencies funded for health promotion from the Community and Women’s Health Program will participate in catchment evaluation reporting by summarising their contribution to the PCP health promotion catchment

priorities. For further information related to accountability and evaluation reporting requirements for Community and Women’s Health Program activity (health promotion), refer “*Community and Women’s Health Program June 2004—Health promotion planning and reporting 04–06*”<sup>33</sup>.

Accountability and evaluation reporting requirements for Foothold on Safety funding remain with Aged Care. The nature of this reporting has now been changed to align with the IHP framework.

## 3.4 Regional office support

Regional Department of Human Services offices will continue to support implementation of the PCP Strategy by:

- providing leadership to support local PCPs and their initiatives within the region
- identifying and encouraging local innovation
- encouraging and facilitating engagement of relevant local stakeholders
- actively promoting coordination of consistent approaches between program areas at the regional level, for example, establishing cross-program health promotion and/or service coordination committees
- monitoring and reporting to the Primary and Community Health Branch and other programs as required regarding the implementation of the PCP’s priority tasks and other PCP based initiatives

- supporting opportunities for workforce development and other activities to assist agencies and organisations to embed service coordination and IHP into their operations
- supporting the alignment of the local/regional planning and development with relevant department policy/project developments, such as HARP, and supporting alignment of agency planning, for example through MPHs and three-year service agreements
- disseminating good practice examples to ensure systematic demonstration of the PCP initiatives.

As more department programs increase commitment to implement the PCP strategic directions 2004–2006, regional offices will take a greater role in facilitating agency participation in, and progress of, partnership activities as part of their responsibilities in monitoring performance against individual agency service agreements and/or program requirements.

Regions were required to develop a detailed implementation plan by 30 September 2004 outlining their roles and responsibilities to 2006 to support PCPs in developing and implementing IHP programs, service coordination activities and other PCP activities.

### **3.5 Other opportunities for collaborative service development and innovation**

As discussed in Section 1, opportunities requiring collaboration may arise from time to time, funded by the department, the Australian Government or other non-government organisations. PCPs are a strong platform to inform and facilitate such initiatives.

#### **Reporting**

To indicate their scope and capacity, PCPs are asked to provide information about other collaborative initiatives they are involved in, in their annual reports. This is not an onerous exercise; PCPs should simply list the initiative and briefly describe the PCP's role.

## Section 4 Contributions by Department of Human Services program areas, other government departments and external stakeholders

The Primary and Community Health Branch has been working with other department program areas, other government departments and external stakeholders in relation to their plans to implement the PCP strategic directions for 2004–2006.

Significantly, these stakeholders have identified key actions for implementation of the strategic directions. A full list of these commitments is provided on pages 20–43.

Over the next 12 months, engagement with a number of other relevant department program areas will be initiated.

### 4.1 Service coordination— an overview

The Department of Human Services will focus on four major areas of activity to progress the implementation of the Better Access to Services framework. These are to:

- further develop information and communication technology (ICT) capacity
- provide workforce development
- support best practice in service coordination
- support implementation in general practice.

#### Further develop information and communications technology capacity

Integral to the success of service coordination implementation is continued capacity in ICT. When ICT is complemented with agreed data standards, the result will be ICT that is effectively used to support best practice and provide a better coordinated health system for consumers.

Improving communication between agencies is vital to providing a better coordinated health system. PCPs are a key player in Victoria's whole of health ICT strategy, HealthSmart, which aims to improve the way consumers' information is managed and shared. HealthSmart will implement a patient and client management system to improve client information management and optimise use of the SCTTs across and between primary and community health agencies and hospital-based services. Access to this system will be supported through the communications infrastructure.

A consistent approach to the way consumer information is collected is another element to providing a better coordinated health system. A major focus of ICT activity will be increasing the number of applications that carry the SCTTs. To date, 30 different client management software applications, including six popular GP clinical software applications, include the tool templates and, between 2004–2006, several more key applications will

implement the software. Software applications soon to include the SCTTs include the Alcohol and Drug Information System (ADIS), the Client Relationship Information System (CRIS) and the Client Relationship Information System for Service Providers (CRISSP) systems used by Department of Human Services direct care services and the Integrated Reports and Information System (IRIS), used by some Community Care funded services.

Electronic referral (e-referral) has been, and will continue to be, a major focus of work. So far, more than 50 primary and community health agencies throughout Victoria have implemented e-referral. To enable the growth of e-referral, \$15 million has been invested in connectivity, with more than 450 primary and community health agency sites soon to be connected to the health communications network. To continue this growth, the department is continually exploring opportunities for further investment in ICT connectivity and e-referral. Some examples of department program areas that are progressing e-referral include Dementia Services, which are supporting electronic record keeping and transfer within their funded agencies, and HARP, which will prioritise projects that implement connectivity and e-referral between primary care and acute providers. Mental Health is also supporting their sector, particularly Psychiatric Disability Rehabilitation and Support Services and Area Mental

Health Services, to have the capability to generate secure e-referrals using the SCTTs.

Supporting the ICT work is the development of electronic messaging standards for the SCTTs that will allow disparate software to exchange consumer information and dramatically improve information exchange between services. The HACC program, in particular, sees merit in this approach and has agreed to contribute to the cost of upgrading HACC software to include the finalised messaging standards, subject to budget availability.

In addition to improving the experience and outcomes for consumers, achievements in ICT have strategically positioned the primary health sector for future investment, including the trialling of the Commonwealth national health information network, Health Connect.

#### **Workforce development**

The Primary and Community Health Branch will provide workforce development opportunities to the sector through service coordination orientation train the trainer sessions and the release of a self-paced learning module for service coordination. Also within the Primary and Community Health Branch, the Community Health Program will prioritise service coordination for the expenditure of agency workforce development grants in 2004–05. Other areas of the department are also

planning workforce development. The Continuing Care Program will facilitate consultative forums, working parties, training and IT support to assist programs to implement service coordination. A&D agencies will be encouraged to attend service coordination training and then provide training for other A&D agencies within their local network. Personal Alert Victoria (PAV) will provide staff training for assessment officers in 2004 and the Support for Carers Program will provide workforce development to support agency implementation of service coordination.

#### **Support best practice in service coordination**

Continuous improvement in service coordination practice is a major goal for the next two years and will be supported through activities that encourage the sharing of learnings. A major quality improvement project to improve the functionality and scope of the current suite of SCTTs is planned to commence later this year. Many program areas have indicated that they will participate in the tool revision process (for example, programs funded by HACC, some Family and Community Support programs including Early Childhood, the Continuing Care area, and the Alcohol and Drug Program).

A range of other activities is also planned by department program areas to support best practice in service coordination. One example is the implementation of the Review of

Counselling in Community Health in 2004–05, which will focus on service coordination intake practices. The Continuing Care Program will develop a service coordination implementation framework to assist their agencies, while A&D services will develop processes to monitor service coordination implementation. The Alcohol and Drug Program area will also encourage feedback from their sector regarding how the tools could be improved for their clients. Progress on the Better Access to Services framework will also be assisted by work planned by HARP to develop tools for risk screening and comprehensive assessment and to further work on care planning. In addition, PAV will review their assessment record to improve compatibility with the SCTTs and to eliminate overlap.

#### **Support implementation in general practice**

The funding of the primary health care consultant position at General Practice Divisions Victoria (GPDV) will enable their involvement in general practice implementation of service coordination. Consultation with, and advice to, Divisions of General Practice to help identify opportunities and strengthen strategies for local leadership on GP participation will continue through statewide processes. The primary health care consultant will also ensure that best practice examples, at the general practice level, are identified and widely disseminated.

The Small Grants for Service Coordination with General Practice Project will be funded again in 2004–05 to encourage implementation of protocols for systematic referral and feedback with general practice. Use of the General Practice Statewide Referral Form as a key component of a quality referral will also be supported through further refinement of the tool, and ongoing field-testing of its value in both clinical and business terms. Once developed, messaging standards will be implemented in selected general practice clinical software products. Specific funding has been provided for workforce development activities in each Victorian Division of General Practice aimed at staff and key GP representatives.

## 4.2 Integrated health promotion—an overview

The following summarises the six areas in which the Department of Human Services will progress work in IHP.

### Health promotion funding requiring partnerships to use PCP infrastructure

Evidence shows that single interventions, such as providing health information, have limited impact. Using a mix of interventions to achieve a health promotion goal is consistent with the evidence that working at both individual and population-wide levels provides the best outcomes. This initiative has been supported through the implementation of a health promotion framework, including

planning, reporting and workforce development. All PCPs and community and women's health services are using this framework for their health promotion funding. Broader use by Department of Human Services programs will enable more consistent and meaningful collection of data on the impacts of health promotion interventions.

The Primary and Community Health Branch will support other department program areas to identify initiatives where the PCP infrastructure can be used to help achieve program goals. The Dental Health Unit has already incorporated the use of the PCP infrastructure for partnership initiatives in its funding guidelines.

Neighbourhood Renewal will ensure that health promotion programs offered in their areas operate within the PCP infrastructure to take advantage of the expertise available. Aged Care has allocated falls prevention funding through PCPs and the Well for Life guidelines identify PCPs as a mechanism for partnership approaches.

### Quality planning approaches for integrated health promotion programs

The introduction of the IHP planning framework has improved the quality of health promotion programs, reducing much of the ad hoc activity that has been a feature of this area in the past. This improvement has largely been seen in community and women's health services, which have used the

framework for the last two years. The commitments made by program areas will enable these benefits to be realised more widely.

The partnership development section in Public Health will facilitate a more coordinated policy approach within RRHACS Division and the department more broadly to strengthen the commitment to health promotion development and implementation in Victoria; planning and implementation of the Problem Gambling Community Education and Partnerships Program is underpinned by IHP principles and processes; Drugs Policy and Services Branch will support A&D agencies to plan and implement IHP activities; and Rural and Regional Health Services Branch will do likewise for rural health services.

### PCP catchment planning

To enhance the existing level of collaboration, the Department of Human Services will work in partnership with PCP member agencies and organisations to implement catchment planning for key topics and settings as identified earlier. Primary and Community Health Branch will update program guidelines to reflect this requirement of community health services (CHSs); the Health Surveillance and Evaluation Section of Public Health will support this initiative by enhancing its evidence-based publications, such as the Burden of Disease (BoD) and ACSCs studies; and the Rural and Regional Health Services Branch will strengthen population

health planning by rural health services.

### **Common mechanisms for reporting/evaluation**

One of the points frequently made by sector representatives in discussion with department officers is the multiple reporting requirements placed on agencies and organisations. The strategic directions document outlines a commitment to use a common reporting approach for health promotion programs. As well as providing benefits to the sector, such a move also provides the department with more meaningful information about the impacts of the health promotion activities it funds.

Primary and Community Health Branch will look to develop an automated reporting mechanism to streamline the process for the sector; and recipients of oral health promotion grants will use the IHP reporting framework.

### **Build evidence base and dissemination**

The PCP Strategy has supported best practice health promotion through policy documents, information sessions and workshops. It will continue to support the sector in this way and to disseminate examples of good practice widely.

Primary and Community Health and Public Health will continue to develop the health promotion website to support this. In addition, Partnership Development will continue to support

the development and dissemination of evidence-based reviews and Aged Care will publicise the findings from research programs targeting older people to inform practice.

### **Workforce development**

The strategic directions will not be successfully implemented without dissemination of good practice or targeted workforce development to support practitioners to improve their skills and knowledge. All program areas that have made commitments in this document have identified workforce development as a key initiative.

Workforce development activities include briefings by the School Nursing Program to nurse managers to encourage them to identify areas for collaboration; regional forums by Health Surveillance and Evaluation to support stakeholders on the use of key health information; and Mental Health Branch support of suicide prevention initiatives within PCPs through rural workforce development.

### 4.3 Contributions by Department of Human Services program areas, other government departments and external stakeholder 2004–2006—in more detail

Detailed descriptions of contributions by Department of Human Services program areas, other government departments and external stakeholders to implement the PCP strategic directions are outlined in Table 2.

The Strategic Development Unit of the Primary & Community Health Branch will coordinate and support implementation of all these commitments.

**Table 2: Contributions by Department of Human Services program areas, other government departments and external stakeholders to implement PCP strategic directions**

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<b>Community Care</b>			
Family and Community Support	Relevant early childhood services to participate in the revision and further development of the Service Coordination Tool Templates (SCTT).	Depends on timelines developed by Primary Care for revision of the SCTT.	Program area to participate in the revision and further development of the service coordination tools. Support available to engage relevant sectors in identifying appropriate stakeholders to participate in the revision and further development of the SCTT.
	The Early Childhood Intervention Service's (ECIS) <i>Vision and Key Priorities</i> , released in September 2003, outlines the key directions and underpins the planning and development of a range of service improvement initiatives for ECIS over the next three years. It outlines strategies to progress a more integrated and effective ECIS system with a focus on facilitating earlier identification, strengthening supports for families and promoting collaboration with universal children's services to facilitate inclusion of children with a disability or developmental delay within their local communities. Collaboration and service coordination within a range of community organisations supports a systems approach to the implementation of this vision.	Ongoing	Program area: <ul style="list-style-type: none"> <li>encourages local networking approaches</li> <li>supports the interface of SCTT with CRIS software development for ECIS sector</li> <li>supports the inclusion of the SCTT in IRIS software</li> <li>encourages local networking approaches—program area has already arranged presentation to Family and Parenting Services Advisory Group in relation to service coordination component</li> <li>to participate in the revision and further development of the SCTT to promote and identify appropriate stakeholders to participate in the revision and further development of the service coordination tools.</li> </ul>
	A <i>Strategic framework for family services</i> , released in October 2002, provides an overarching framework to promote early and proactive intervention for vulnerable families. Development of local partnerships and collaboration is a key component of the framework to promote a stronger focus on the health and wellbeing of children and young people. Many family and parenting services funded by Community Care Division are currently members of local PCPs.		

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Family and Community Support (cont)</i>	The Problem Gambling Strategy includes a Community Partnership Strategy, which focuses in part on the development of integrated service approaches. Discussions are currently being undertaken in relation to the inclusion of problem gambling questions in the SCTT.	Ongoing	The program has developed guidelines and a deliverables document that specifies a requirement to integrate problem gambling services with community-based organisations and community service providers.
	Health promotion funding requiring partnerships to use PCP infrastructure.	Ongoing	Development of local partnerships and collaboration is key to Strategic Framework for Family Services promoting early intervention for vulnerable families. The program area encourages local networking approaches through PCP infrastructure.
		Ongoing	The Problem Gambling Strategy includes a Community Partnership Strategy, which focuses in part on the development of integrated service approaches. The program has developed guidelines and a deliverables document that specifies integration of problem gambling services with community-based organisations and community service providers.
	Quality planning approaches for IHP programs.	Ongoing	IHP principles and processes underpin the planning and implementation of the Problem Gambling Community Education and Partnerships Program. Future directions for the maternal and child health service highlights the Integrated health promotion resource kit (2003) as a tool to support the service.
	Workforce development.	Ongoing	Principles and practice of IHP from five-day health promotion short course undertaken by funded agencies are reinforced by the program service standards.
Disability Services	Work with divisions and consultants to identify assessment tools that can be used across sectors for initial and subsequent specific or specialist assessment.	Initial consultants report by July 2004	Provide staff support: attendance at meetings, provision of information and advice regarding DS practice and processes, member of working group overseeing consultants.
	Participation in information sessions and forums to develop a protocol for use across the state, which will assist in facilitating appropriate referral and assessment for access to residential care for people with a disability who are ageing.	Draft protocol for statewide trial by July 2004	Provide staff support to project: fund a forum and consultant to facilitate development of the protocol. Protocol to be signed off by DSD and Aged Care for implementation. Training for DSD and ACAS in protocol use.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Disability Services (cont)</i>	<p>Hume Region Trial</p> <p>Use of the SCTT to submit/receive applications to the Special Needs Register for supports for people with a disability and endorsement by regional panels.</p>	To be determined	Processes to be developed.
	<p>Use of the SCTT to facilitate appropriate referrals to PCP member agencies by intake and response care managers.</p>	Ongoing, SCTT implemented in CRIS/CRISSP software	Where requested.
	<p><b>Gippsland Region implementation</b></p> <p>Develop consistent use of the SCTT across the region for individuals who request access to services in the aged, disability and health sectors.</p>	To be determined	Processes to be developed.
<b>Housing and Community Building</b>			
Housing Services	Support further development of the SCTT.	Timelines to be in line with SCTT development	Explore opportunities to develop family violence and homelessness screens as part of the SCTT.
	Build on service coordination work developed through department regions.	Ongoing	Housing Services to liaise with regions in relation to local projects involving PCPs and funded services (such as homelessness assistance programs).
	Explore potential for service coordination within Housing Services context.	Ongoing	Housing Services is looking at the issue of intake and assessment more broadly in the context of the Housing Office Review and other program development work across the range of housing and homelessness services.
Neighbourhood Renewal	Health promotion funding requiring partnerships to use PCP infrastructure.	Ongoing	Ensure that health promotion programs offered to Neighbourhood Renewal areas operate within the PCP infrastructure.
	Workforce development.	2004	Joint resourcing of planning session with PCPs and Neighbourhood Renewal areas.
	Other	Ongoing	Support relationships between Neighbourhood Renewal and PCPs at a regional and central level.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<b>Metropolitan Health &amp; Aged Care</b>			
Continuing Care	<p>Continuing Care to implement service coordination in the following programs by June 2006:</p> <ul style="list-style-type: none"> <li>• <b>Post acute care</b>—significant progress already made with most agencies having implemented service coordination or working towards implementation, particularly e-referral. Those agencies that have not progressed have cited that they do not generate significant numbers of referrals. Further work to be done to clarify their issues.</li> <li>• <b>Sub-acute ambulatory care (SAC)</b>—a number of SAC agencies have implemented IT capacity for SCTT. More work needs to be done to progress implementation across the field.</li> <li>• <b>Community-based palliative care</b>—a limited number of agencies have implemented the SCTT. More work needs to be done to progress implementation across the field.</li> <li>• <b>Cognitive, Dementia and Memory Clinics (CDAMS)</b>—have included implementation of service coordination by 2006 in their strategic directions.</li> </ul> <p>Development of a common approach to assessment of people with chronic and complex needs via the use of the common assessment tools.</p>	<p>June 2006</p> <p>Continuing care team responsible for coordinating and supporting program areas in unit to implement service coordination.</p> <p>Continuing Care has included the requirement to implement service coordination in the 2004–05 policy and funding guidelines.</p> <p>Commitment to implement service coordination has been included in the strategic framework for palliative care (not yet released).</p> <p>Framework to be developed covering key implementation issues including:</p> <ul style="list-style-type: none"> <li>• referral tools and processes</li> <li>• data sets and data standards</li> <li>• referral processes</li> <li>• IT issues and support</li> <li>• assessment processes</li> <li>• information sharing</li> <li>• departmental support of programs</li> <li>• consultation processes.</li> </ul> <p>Department to facilitate consultative forums, working parties, training and IT support as required to assist programs to implement service coordination.</p> <p>Continuing Care to actively contribute to the review of the SCTT to facilitate broader implementation.</p>	
Hospital Admission Risk Program (HARP)	<p>Use and build on the service coordination framework to facilitate the sharing of client information.</p>	<p>Ongoing Ongoing</p>	<p>Encourage use of SCTT by HARP projects.</p> <p>Fund projects that implement connectivity and e-referral between primary care and acute providers.</p>
	<p>Develop and extend the tools used within the service coordination framework.</p>	<p>2004–05 2004–05 2005–06</p>	<p>Inter-branch work on risk screening tools.</p> <p>Inter-branch work on comprehensive assessment tool.</p> <p>Inter-branch work on care planning.</p>
	<p>Incorporate SCTT tool templates into program guidelines developed under HARP.</p>	<p>2004–05 2005–06</p>	<p>Program Guidelines for Disease Management—COPD &amp; CHF to support uptake of SCTT tool templates.</p> <p>Program Guidelines for Integrated Care for Complex Needs to support uptake of SCTT tool templates.</p>

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
Office of Health Information Systems/ HealthSmart	<p>The development and implementation of ICT projects that support service coordination include:</p> <p>The introduction and implementation of patient and client management systems that will provide improved ways of managing client information and support the use of the service coordination tools. As a minimum requirement, the patient and client management system will replace SWITCH (used by the majority of CHSs) and HOMER PAS (used by hospitals).</p> <p>The development and implementation of shared ICT services will provide a secure centralised facility to host patient and client management systems and other core applications as a managed service to agencies.</p> <p>Development of e-referral messaging standards and acquisition of integration tools and technologies will enable e-referral between agencies using different software applications.</p>	Procurement activity to commence first quarter 2004–05	Tender and implementation process managed by the Office of Health Information Systems. The application will be deployed as a managed service provided through shared ICT services.
The development and implementation of shared ICT services will provide a secure centralised facility to host patient and client management systems and other core applications as a managed service to agencies.	Interim arrangements being finalised	The development and implementation managed by the Office of Health Information Systems. Access to shared ICT services will be supported through developing communications infrastructure in each region.	
Development of e-referral messaging standards and acquisition of integration tools and technologies will enable e-referral between agencies using different software applications.	Development of e-referral messaging standards completed by October 2004	The Office of Health Information Systems is managing the development of the e-referral messaging standards, underpinned by SCTT. The standards will be tested as part of the implementation of patient and client management systems. The e-referral messaging standards will be included in broader developments in relation to the enterprise architecture managed via Interface Services within the Office of Health Information Systems.	
Explore opportunities for additional connectivity for agencies to provide access to shared ICT services.	Ongoing	The Primary and Community Health Branch will work closely with the Office of Health Information Systems and Department of Human Services program areas to develop the business case.	
Mental Health	Area Mental Health Services will be required to participate in the PCP service coordination strategy by developing standard protocols with their local PCPs regarding referral processes.	31 Dec 2005	The Mental Health Branch will develop guidelines to support the consistency in these protocols by December 2004 and will then distribute these guidelines to Area Mental Health Services.
Psychiatric Disability Rehabilitation and Support Services will have the capacity to receive and generate referrals using SCTTs and secure electronic means via client management software.	30 June 2005	The Mental Health Branch will provide written communication to specialist mental health services to specify requirements for participation in PCP service coordination strategy in order to promote consistency of implementation.	
Area Mental Health Services will enhance communication with the primary care sector by having the capacity to generate secure e-referrals using SCTT.	30 June 2005		

DHS Division / Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Mental Health (cont)</i>	Mental health specifications for HealthSmart patient administration systems will be developed to use this initiative as the vehicle for area mental health services to have the capacity to receive e-referrals using SCTT.	30 June 2005	Develop mental health specifications for HealthSmart, in collaboration with the Office of Health Information Systems.
	Health promotion funding requiring partnerships to use PCP infrastructure.	2004–06	Support mental health promotion officers in working with PCPs to ensure mental health promotion partnership funding initiatives use the PCP program structure.
	Quality planning approaches to IHP programs.	2004–06	Support mental health promotion officers and primary mental health early intervention teams in working with PCPs on mental health strategic planning.
	PCP catchment planning.	2004–06	Support mental health promotion officers and primary mental health early intervention teams in working with PCPs on catchment-based mental health strategic planning.
	Build evidence base and dissemination.	2004–06	Support the dissemination of mental health promotion related evidence base through PCPs, including the work being undertaken by the Centre for Rural Mental Health on rural suicide prevention.
	Workforce development.	2004–06	Support mental health promotion officers and primary mental health early intervention teams in working with PCPs on mental health workforce development initiatives.
Programs Branch, Service Planning	Ambulatory Care Framework.		Contribute to development of statewide Ambulatory Care Framework by supporting use of PCP catchments as a starting point for planning ambulatory care service provision in metropolitan Melbourne.
<b>Policy &amp; Strategic Projects</b>			
Flexible Funding Models Flagship Project	Pilot an area based approach to funding of services using applicable flexible funding models with the PCP infrastructure as the vehicle.	2004–05	Project funding together with advice and support from central program area.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<b>Rural &amp; Regional Health &amp; Aged Care</b>			
Aged Care			
Aged Care Assessment Services (ACAS)	Implementation of service coordination was mandated for ACAS from January 2004. Monitoring and practice improvement activities will be ongoing for example, consideration of expanding mandated requirements to include functional screen and living arrangements.	2004–06	Include use of service coordination tools in funding and policy guidelines. Collate statewide data on extent of service coordination implementation.
	Input into Service Coordination Tool Templates (SCTT) review process.	2004–05	Coordinate ACAS program response to SCTT review.
	Support e-referral process and implementation of SCTT messaging standards.	2004–05	Contribute to the cost of upgrading Aged Care Evaluation (ACE) software to include messaging standards, subject to budget availability.
	Consistent approach to identification and referral of people with chronic and complex needs.	2004–06	The HACC assessment framework development process will clarify the relationship between ACAS and HACC with regard to comprehensive assessment.
	Develop common approach to assessment of people with chronic and complex needs via the use of common assessment tools.	May–October 2004	Identify comprehensive, validated assessment tool. Joint project between Aged Care Branch and Continuing Care—across ACAS, HARP and HACC.
		2004–05	Continue Cross Divisional Working Party on Functional Assessment to achieve identified objectives.
Dementia Services			
	Support for Links Program.	Ongoing	Include implementation of service coordination in program and funding guidelines.
	Support for carers of people with dementia.		Workforce development to support agency implementation of SCTT, including electronic record keeping and transfer.
Falls Prevention			
	Develop a consistent approach to identifying and responding to the risk of falls and fall-related injuries among older people.	Dec 2004	Development of protocol to facilitate referral pathway for older people identified as being at risk of falls and fall-related injuries.
	Health promotion funding requiring partnerships to use PCP infrastructure.	Ongoing	Falls prevention funding provided through PCP infrastructure and made explicit in project brief and funding agreement. Program area supports funded projects to use partnership approaches within local communities. Extension of Falls Prevention Network meetings to include all PCP member agencies.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Falls Prevention (cont)</i>	Nature of implementation		Support to be provided by program
	Quality planning approaches for IHP programs.		Quality planning approaches required for all community-based falls prevention health promotion initiatives.
	PCP catchment planning.		Identification of links between falls prevention and catchment priorities within project brief.
	Common mechanisms for reporting/evaluation.		Use common planning and reporting mechanisms identified in project brief and funding and service agreement. Development of a common mechanism for capturing falls prevention indicators and case studies to demonstrate the effectiveness of IHP programs.
	Build evidence base and dissemination.		Findings from research programs targeting older persons health promotion to be applied to inform practice. Facilitate links between Aged Care and PCP websites.
	Workforce development.		Quality health promotion planning, implementation and evaluation for falls prevention initiatives will be supported and interface with other PCP workforce development initiatives. Provide leadership to funded projects to support partnership approaches within local communities.
Home and Community Care (HACC)	Implementation of service coordination was mandated for the HACC program from January 2004. Monitoring and practice improvement activities will be ongoing including input into SCTT review process.	2004–06	Collate statewide data on service coordination implementation. Coordinate HACC response to service coordination tool review. Contribute findings from the HACC Dependency Trial to the tool review process.
	Support e-referral process and messaging technology.	2004–06	Contribute to the cost of upgrading HACC software products to include messaging standards, subject to budget availability.
	Support HACC agencies in achieving efficiency gains from the implementation of service coordination.	2004–06	Identify outcomes from the Analysis of the Impact of Service Coordination on Service Capacity Project that are relevant to HACC agencies. Identify strategies for applying these learnings more broadly across the sector.
	Support Aboriginal HACC agencies in their uptake of service coordination and the SCTT.	2004–05	Support Aboriginal Client Information And Referral Record/SCTT project and identify relevant workforce and training issues that arise.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Home and Community Care (HACC) (cont)</i>	Nature of implementation Improve sector understanding of the relationship/interface/ overlap between INI and assessment.	2004–06	The first stage of the HACC assessment framework development will scope the relevant literature on assessment and consult with the sector to identify strategic directions for assessment in HACC. This will include clarification of the relationship between INI and assessment.
	Develop consistency in approach to assessment including assessment of people with chronic and complex needs.	May–October 2004	HACC assessment framework will clarify the relationship between ACAS and HACC and other specialist agencies in undertaking comprehensive assessments. Identification of a validated comprehensive assessment tool. This is a joint project funded by Continuing Care and Aged Care Branch. Continue Cross Divisional Working Party on Functional Assessment to achieve identified objectives.
	Use HACC national service standards instrument process to remind agencies that it is a program requirement to implement the SCTT. Identify key access, INI and assessment points for HACC services. Improve access and entry points to community services for people from culturally and linguistically diverse (CALD) backgrounds to improve access to and use of services.	2004–06	Provide ongoing support to assist HACC agencies to meet their national service standards requirements, for example, best practice for service coordination. Culturally Equitable Gateways Strategy will identify models for improving access to core HACC services provided by local government for people from CALD backgrounds. Partnerships between local government and CALD agencies are supported by DHS central department grants.
	HACC assessment and service delivery to achieve improved levels of functioning and greater independence.	2004–06	HACC assessment framework development will identify the relationship between assessment and health promotion and improved levels of functioning. Various program initiatives are promoting better health outcomes for HACC clients, for example, Well for Life promoting improved levels of physical activity; the Food Services Review recommendations promoting better nutritional risk screening and assessment.
Personal Alert Victoria (PAV)	PAV assessment record developed based on SCTT.	Mandated 1/1/04	Implementation of service coordination is included in PAV program and service guidelines.
	Trial e-referral using interactive PAV assessment tool building on existing PCP e-referral projects.	Dec 2004	Staff training for assessment officers June–Dec 04.
	Review PAV assessment record to improve compatibility with SCTT for electronic transfer and eliminate overlap.	June 2005	

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
Research initiatives	Other	2004	“Achieving Health Promoting Behaviour Change among Older People” Research Project includes PCP representation.
Support for Carers	Develop a consistent approach to collection and sharing of client (as carer) information, identification of needs and referral.	June 2005	Include implementation of service coordination in program and funding guidelines. Workforce development to support agency implementation of SCTTs, including electronic record keeping and transfer.
Well for Life	Health promotion funding requiring partnerships to use PCP infrastructure.	Ongoing	Well for Life Program funding guidelines identify PCP infrastructure as one mechanism to support partnership approaches.
	Build evidence base and dissemination.		Development of mechanisms for dissemination of falls prevention resources and Well for Life kits. Independent support and evaluation of Well for Life will provide evidence-based approaches to program implementation and evaluation findings available for broader dissemination.
Drug Policy & Services	Alcohol and drug (A&D) treatment agencies have the capacity to generate and receive referrals, either paper-based and/or using secure electronic means via client management software.	1/7/2005	Include the implementation of service coordination in program funding and policy and guidelines.
	Create a systems approach to using SCTT in A&D sector.	Ongoing, starting 2003	Encourage A&D agencies to attend SCTT training and to organise training for other A&D agencies in the local network to facilitate the use of SCTT.
	Modify existing consumer information tools to eliminate overlap.	Oct/Nov 2004 (roll-out)	Integrate main forms of the SCTT in the Alcohol and Drug Information System (ADIS) to make use of SCTT readily available for all A&D agencies.
	Improve practice around INI.	Ongoing	
	Enhance practice to support more effective and efficient client entry processes using the SCTT.	July 2004	SCTT implementation by A&D agencies supported and monitored by Drug Policy and Services Branch and by regional A&D coordinators.
		Ongoing	Develop an ‘A&D profile’ for Department of Human Services service coordination team to consider for inclusion in SCTT to help non-A&D agencies with better referrals to A&D services.
		Ongoing	Service coordination team feedback from A&D sector re: SCTT for improvement.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Drug Policy &amp; Services</i> (cont)	Input to and use the statewide services directory (SSD) to improve referral practice and support broader integration and coordination across the health and other sectors.	June 2004	Through regional A&D coordinators, encourage A&D agencies to use and input into the electronic SSD. Encourage A&D Turning Point Centre to work with the department officer responsible for the electronic SSD to consider streamlining the directories.
	Quality planning approaches for IHP programs.	Ongoing	Support A&D agencies to plan and implement IHP activities in partnership with relevant PCP member agencies.
	PCP catchment planning.	Ongoing	Support A&D agencies to contribute to PCP CHPs where relevant.
	Other	2004	Premier's Drug Prevention Council to explore the possibility of providing support to drug prevention initiatives with PCPs that identified A&D issues as a priority.
		Ongoing	To support regional A&D coordinators to take a role in identifying opportunities for collaborative approaches to program delivery and IHP.
Planning and Resources	Funding and accountability.	2004–06	Work with Primary and Community Health Branch to ensure the review of funding and accountability for health promotion under the Primary Health Funding Approach links with catchment health promotion planning directions for 2004–2006.
Public Health—Health Development	Health promotion funding requiring partnerships to use PCP infrastructure.	June 2006	Diabetes Prevention—Support for pilot programs targeting individuals at risk of diabetes.
	Quality planning approaches for IHP programs.	June 2006	Obesity prevention—Comprehensive obesity prevention strategy. Will link with PCP activities.
		June 2005	Physical activity promotion—Direct support provided to PCPs building expertise and developing strategic approaches for physical activity promotion.
	PCP catchment planning.	Ongoing	Diabetes local interventions—DPMI—Final year with outcomes to inform future planning.
	Common mechanisms for reporting/evaluation.	Dec 2004	Ongoing working partnership with P&CH to build a consistent language in the reporting requirements for HP, including investigated minimising/streamlining reporting requirements where relevant.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Public Health—Health Development (cont)</i>	Build evidence base and dissemination.	Dec 2004	Evidence based review of asthma—Distribution through PCPs and other networks. CALD Diabetes Project—DPMI—CALD Diabetes Project and Report—resources developed and made available to PCPs. Safe Start—Injury project—Child injury prevention initiatives implemented in 3 LGAs. Report will be made available to PCPs and will inform ongoing injury prevention activities. Child Safety Video—Dissemination Of Child Safety Video developed as a part of the City Of Hume Child Safety Project.
	Workforce development.	June 2006	Filling the Gap 5—Workforce development/capacity building in public health nutrition including primary health workers.
		Dec 2004	Active Script Extension Project—Outcomes of project will inform ongoing activity in physical activity promotion in primary health sector.
		Dec 2004	Risk factor assessment—Resources available to PCPs via internet.
	Other	March 2005	Injury Prevention Strategy—Strategy will be developed to inform injury prevention priorities and initiatives for Victoria. Ongoing working partnership with P&GH to build a consistent language in funding HP by using the HP common planning framework.
Public Health—Health Surveillance and Evaluation	PCP catchment planning.	Ongoing	Produce regional fact sheets summarising key data on topics in the Victorian Population Health Survey (VPHS).
	Build evidence base and dissemination.		Incorporate small area analyses (LGAs/PCPS) into products including the BoD, the VPHS and the Victorian ACSCs study. Published updated Victorian Life Expectancy at Birth and Year of Life Lost (YLL) data by LGA. Develop indicators on preventable mortality for Victoria by PCP and LGA.
	Workforce development.		Provide access to resources through links to health promotion website. Regional forums to support stakeholders on use of key health information from BoD, VPHS, ACSC studies.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
Public Health— Partnership Development	<p>Nature of implementation</p> <p>Health promotion funding requiring partnerships to use PCP infrastructure.</p> <p>Quality planning approaches for IHP programs.</p>	Ongoing	<p>Support regional staff where opportunities for collaborative work arise.</p> <p>Provide leadership for regional teams to support PCP project officers and local government in the use of the IHP framework and “Environments for Health” to support good health promotion practice.</p>
	PCP catchment planning.		<p>Support the strengthening of municipal public health planning in local government, both centrally and through supporting regional staff.</p> <p>Advise and support primary health and other areas of Department of Human Services on the role of local government in integrated planning and public health.</p> <p>In conjunction with other parts of the Public Health Group and the broader departmental program areas, review health promotion priorities leading up to 2006-07 so as to establish department statewide priorities for 2006-09.</p>
	Build evidence base and dissemination.		<p>Assist in the ongoing maintenance and active use of the Health Promotion Website and training calendar.</p> <p>Support the development and dissemination of evidence-based reviews for informing program planning, implementation and evaluation.</p>
	Workforce development.		<p>Investigate workforce development opportunities to enhance quality approaches to planning, implementation and evaluation of IHP programs.</p>
	Other		<p>Convene interdivisional cross-program group for health promotion.</p> <p>Partnership Development staff to provide support to regional staff where opportunities for collaborative work with the primary health care sector are identified.</p>

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
Rural & Regional Health Services	Rural and Regional Health Service policy directions.	Ongoing	<p>Support the continued involvement of rural health services in PCPs with a focus on broadening the involvement and commitment of senior health service staff and strengthening service delivery partnerships.</p> <p>Promote PCPs as a key operational vehicle for health promotion and service coordination initiatives.</p> <p>Support department regions and rural health services in building partnership approaches for IHP programs.</p> <p>Encourage rural health services to use the PCP IHP resources to plan and implement health promotion activities.</p> <p>Encourage rural health services to use common (PCP) processes and protocols in all community-based programs that are provided by health services, to link with PCPs, avoid duplication and streamline service provision.</p> <p>Continue to support the strengthening of population health planning by rural health services, which promotes PCP priorities.</p>
	Support for the rural and regional workforce.	Ongoing	Support the alignment of recruitment and retention initiatives with PCP workforce development strategies.
	Ministerial Rural and Regional Health Advisory Forum.	Ongoing	Promote the PCP Strategy within the Ministerial Rural and Regional Health Forum program and forum reports as a significant contributor to rural population health.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<b>Primary &amp; Community Health</b>	<p>Implementation of service coordination was mandated for CHSs from July 2003. Many CHSs have embraced service coordination and have fully implemented service coordination for all or core programs across the service (beyond Community Health Program) and use service coordination tools for all internal and external referrals. By 2006, all CHSs should similarly have embedded service coordination into their business practice.</p> <p>Between 2004–06, CHSs are encouraged to focus on practice improvement in the areas of care planning and comprehensive assessment, particularly for clients with chronic and complex conditions.</p> <p>Introduce Client Information Management System to incorporate statewide SCTT.</p>	Ongoing	<p>Service coordination implementation mandated in CHSs from July 2003.</p> <p>The Community Health Program area will support the embedding of service coordination through workforce development activities, including publishing of case studies highlighting best practice in service coordination and other activities designed to share knowledge and learnings.</p> <p>As outlined in the Community and Women's Health Program guidelines, the priority for expenditure of agency workforce development grants is to support activities to implement the SCTTs to support initial contact, INI, referral and care planning.</p> <p>Implementation of the Review of Counselling in Community Health in 2004–05 will include a focus on service coordination and intake practices.</p> <p>Troubleshooting of service coordination implementation will continue to be a focus of Department of Human Services central office and regional advisor discussions. Issues to be clarified include the funding and reporting of intake activity, sharing best practice and the inclusion of service coordination in agency quality processes.</p> <p>Consult with Client Information Management System developers to ensure systems incorporates SCTT in a way that meets the business requirements of agencies.</p>
	Health promotion funding requires partnerships to use PCP infrastructure.	2004–06	Implement final community health policy and proposed ambulatory care policy within community health services to encourage greater cross-program and cross-sector collaboration.
	Quality planning approaches for IHP programs.	2004-06	Program guidelines outline requirement of CHSs to participate in PCP health promotion planning, implementation and evaluation.
		2004	Community health policy will reaffirm the social model of health as a key foundation of the community health platform.
		2004–06	Continue support for Quality Improvement Program Planning System (QIPPS) to become self-supporting over four years.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Community Health Program (cont)</i>	PCP catchment planning.	2004	Require all CHSs to participate in catchment planning and incorporate catchment priorities in their organisational health promotion plans. A minimum of 25 per cent of agency funding is to be allocated towards a catchment health promotion priority.
		2004–06	Update program guidelines to incorporate the above requirements.
	Common mechanisms for reporting/evaluation.	2004–06	Program requires 15–35 per cent of agency Community Health Program budgets to be allocated to planned health promotion activities, with reporting required against health promotion plan.
		2004	Update program guidelines in 2004 to incorporate new reporting requirements.
		2004	Progress Rural Hospital Leadership Project, identifying population health priorities.
	Workforce development.	2004	Undertake regional information sessions to support implementation of revised program guidelines.
			Workforce development activities in place or planned include health promotion evaluation and planning, writing skills and further support of the health promotion five-day short course. The program has also supported a documentation project to assist building an evidence base.
	Other	2004	Community health policy and proposed Ambulatory Care Framework within CHSs will encourage cross-program and cross-sector collaboration. Revised program guidelines and resourcing and workforce development strategies will reflect cross-program and cross-sector collaboration. State participation for relevant CHSs in local Neighbourhood Renewal projects within the community health policy document and revised program guidelines.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
Dental Health	<p>The Dental Unit recognises that public dental providers are at different points in the introduction of SCTT to their agencies. The diversity of practices and starting points is something valuable that needs to be built upon. Agencies are asked to take the opportunity to think through the introduction of SCTT to their dental services and to integrate these with their existing practices.</p>	Ongoing	<p>The original work undertaken by a working group convened through Dental Health Service Victoria (DHSV) identified opportunities for public dental services to strengthen integration with other services and to facilitate referrals to different services. Opportunities exist within and across the public dental system (such as transferring Community Dental Program and Youth Dental Program clients from one agency to another, referring to specialist services at the Royal Dental Hospital Melbourne (RDHM) as well as between public dental and other health services (for example, receiving referrals from GPs and from mental health programs).</p> <p>The Dental Unit, in partnership with the Community Health Program, will identify and support initiatives that agencies develop as part of introducing service coordination and the SCTT. The programs will also identify and communicate best practice models to encourage learning across the sector.</p>
	Support for use of the SCTT in public dental services.	Complete	Public Dental Program, in collaboration with DHSV has included the core referral forms of the SCTT in EXACT software used by public dental services.
		June 2004	DHSV will send a copy of the latest version of EXACT software to all agencies by the end of June 2004. Support with installation will be available from DHSV.
		June 2004	Orientation sessions on the use of the latest version of EXACT software are currently being conducted by DHSV. The sessions are being held at the RDHM and at other venues across the State.
	Introduction of service coordination and the SCTT in DHSV, RDHM and statewide School Dental Services.	Sept 2004	The Dental Unit will develop timelines with DHSV to introduce Service Coordination and SCTT at the RDHM, including their specialist services.
		TBD	Service Coordination and SCTT will be introduced to the SDS, in partnership with DHSV, as part of the HealthSmart Strategy.
	Health promotion funding requiring partnerships to use PCP infrastructure.	Ongoing	Emphasis on forming partnership approaches using PCP infrastructure supported in Dental Health Service Victoria funding guidelines.
		2004	The 2003–2004 Pre-School Dental pilots funded through PCP infrastructure.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Dental Health (cont)</i>	Quality planning approaches for IHP programs.	Ongoing	Oral Health Promotion Strategy to acknowledge working through PCP infrastructure where relevant.
		Ongoing	Articulation of good practice planning for oral health promotion program guidelines and service agreements and reference to IHP resource kit.
	PCP catchment planning.	2004–06	For any oral health promotion initiatives, identification of opportunities to interface with PCP catchment health promotion priorities (where relevant) will be encouraged.
	Common mechanisms for reporting/evaluation.	2004–06	Recipients of oral health promotion grants to use common IHP reporting templates. To investigate option for common reporting mechanisms for other IHP activity.
	Build evidence base and dissemination.	2004–06	Oral health promotion evidence base review available. An updated evidence-based review will be commissioned and supported to be disseminated through existing forums. Disseminate findings from oral health promotion projects through website and forums.
	Workforce development.	Ongoing	Provide training opportunities for oral health promotion planning, implementation and evaluation.
	Other	Ongoing	Oral Health Promotion Strategy Partnership group has PCP representation.
Strategic Development	Support inclusion of the SCTTs in additional software applications supported by program areas including ADIS, CRIS/CRISSP and IRIS.	Dec 2004	The Strategic Development Unit will work with Drugs Policy Services, Disability Services and Community Care Division to support the inclusion of the SCTTs in additional software applications.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Strategic Development (cont)</i>	<p>Nature of implementation</p> <p>Support the inclusion of the SCTTs and SCTT messaging standards in the patient and client management systems as part of the HealthSmart initiative.</p> <p>Support the development and implementation of the SCTT messaging standards in agency software.</p> <p>Support the implementation of broadband connectivity for primary and community health agencies as part of the \$15 million 'Growing Victoria' funding.</p>	2004–05	<p>The Strategic Development Unit will liaise with Office of Health Information Systems about the development and implementation of key projects as part of HealthSmart, Victoria's Whole-of-Health ICT Strategy.</p>
	<p>Further develop and implement the SSD Stage Two to support improved referral processes.</p>		<p>The Strategic Development Unit will liaise with regional ICT governance groups, Department of Human Services regional contacts and the Office of Health Information Systems to support the connectivity implementation.</p>
	<p>Support implementation of e-referral.</p>	2004–05	<p>The Strategic Development Unit will work closely with RRHACS Information Systems and Services Branch, department regions, PCPs and the SSD User Group.</p> <p>Develop an agency 'how to implement e-referral' guide.</p>
	<p>Explore opportunities for further funding to support broadband connectivity for primary and community health agencies and e-referral activity across the state.</p>	Ongoing	<p>Working closely with the Office of Health Information Systems and department program areas, the Strategic Development Unit will develop the business case for additional funding building on the investment made through Growing Victoria and PCPs.</p> <p>The Strategic Development Unit will pursue continued discussions between Office of Health Information Systems, State and Commonwealth Government departments regarding the trialling of a national health information network—HealthConnect—<a href="http://www.healthconnect.gov.au">www.healthconnect.gov.au</a>.</p>

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Strategic Development (cont)</i>	<p>Nature of implementation</p> <p>Support agency implementation of service coordination best practice.</p> <p>Further development of the SCTTs to support best practice and meet the needs of additional programs using the SCTTs.</p>	2004–05	<p>Service coordination 'train-the-trainer' workshops to be held in each region.</p> <p>Develop a service coordination self-paced learning module.</p> <p>Seek opportunities to showcase innovative approaches to service coordination, including a best practice forum to share learnings.</p> <p>Include PCP practices, processes, protocols and systems manuals on the Primary Health Knowledgebase.</p> <p>The Strategic Development Unit will disseminate learnings from the Better Health Care in Gippsland project.</p> <p>Workshops will be held and a report published about key learnings from the Victorian Integrated Disease Management projects.</p> <p>The Strategic Development Unit will liaise with department program areas to adopt supportive policy approaches, such as GPs in Community Health, the Community Health Policy, the Ambulatory Care Policy, HARP.</p> <p>Revision the SCTTs, guidelines and associated data standards.</p>
	<p>Support GP engagement in service coordination through a focus on quality referral practice and feedback processes.</p>	2004–05	<p>The Strategic Development Unit will fund an additional round of general practice and service coordination small grants.</p> <p>The primary care consultant position at General Practice Divisions Victoria (GPDV) will continue to be funded.</p> <p>Workforce development activities will be provided for Victorian General Practice Divisions and Board members.</p> <p>The Strategic Development Unit will work closely with GPDV and the GP Engagement Working Group to further develop the Statewide Referral Forms in GP software applications.</p> <p>The Strategic Development Unit will work closely with GPDV and the Office of Health Information Systems to explore ways of linking GP IM/ICT initiatives with the department's ICT initiatives outlined in this document.</p>
	<p>Health promotion funding requiring partnerships to use PCP infrastructure.</p>	Ongoing	<p>Collaborate with department program areas and other key stakeholders to support PCP strategic directions and coordination and integration of IHP initiatives.</p>

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>Strategic Development (cont)</i>	Quality planning approaches for IHP programs.	2004–06 2004	Support regional review of IHP plans and reports. Online development of QIPPS to support its use in planning and evaluation.
		Ongoing	Collaborate with department program areas to support consistent quality program planning approach.
	PCP catchment planning.	2004–06	Leadership and support for catchment planning through communication strategy, regional consultation, statewide forums, and development of information resources.
	Common mechanisms for reporting/evaluation.	2004–06	Develop automated process for health promotion planning and reporting.
		Ongoing	Collaborate with department program areas to support consistent reporting and evaluation templates.
	Build evidence base and dissemination.	2004	Build on and maintain health promotion website.
		Ongoing	Document and disseminate IHP case studies.
		Ongoing	Identify other department program health promotion evidence base and support dissemination of this.
		Ongoing	Communicate statewide health promotion priorities.
		Ongoing	Develop evaluation course and supporting resources and provide evaluation training.
	Workforce development.	2004–06	Training in use of QIPPS for IHP planning and evaluation.
		Ongoing	Training to enhance use of local data for IHP planning.
		2004–05	Primary and Community Health Branch joint forums with department program areas: with Neighbourhood Renewal and Health Surveillance and Evaluation.
	Other	Ongoing	Identify opportunities to support change management.
		Ongoing	Collaboration with DHS program areas to identify synergies and support integration of workforce development opportunities.
		2004–06	To monitor progress of IHP strategic directions to include joint forums with Regional and Central DHS program officers.
School Nursing Program	The program's data collection application has been enhanced to ensure consistency with SCITs for referral.	Ongoing	Training has been provided on the use of the application to all nurses, existing and new starters. Nurses are well placed to refer to Community Health Services and other PCP member agencies using this tool.

DHS Division/ Branch/Program	Nature of implementation	Timeline to 30 June 2006	Support to be provided by program
<i>School Nursing Program (cont)</i>	Quality planning approaches for IHP programs.	Ongoing	<p>Encourage innovation in primary and secondary school nursing practice using multidisciplinary responses to children and young people's issues through contact with PCPs using PCP priorities in the formulation of annual school plans, where relevant.</p> <p>Support the continuation of the role for secondary school nurses (SSNs) to work collaboratively with school communities to address the causes of ill health and to use a variety of good practice strategies to effect long term change including influencing school policy.</p>
	PCP catchment planning.		<p>Encourage regional and local school nursing staff to input to local government early years and municipal health planning processes through the input of data collected through the School Entrant Health Questionnaire and the School Nursing Information System.</p>
	Build evidence base and dissemination.		<p>Collate a sound evidence base to propose an informed, integrated primary health approach for primary school nurses.</p>
	Workforce development.		<p>Provide briefings on PCP strategic directions to nurse managers to encourage them to identify opportunities for collaboration.</p> <p>Offer workforce development opportunities to support the sector in quality health promotion planning, implementation and evaluation.</p>
	Other		<p>Incorporate health promotion as a key focus in SSN program standards.</p> <p>Continue to identify health promotion as the core business of SSNs with inclusion of 'understanding or experience of health promotion' as a key result area on the SSN job description.</p> <p>Identify opportunities for collaboration between primary care services, PCP IHP activity and the school nursing program components.</p>
Women's Health Program	The major role for women's health services (WHSs) in terms of service coordination is the provision of information.	Ongoing	<p>Program area encourages WHSs to promote their services and activities on the SSD.</p> <p>One of the Women's Health &amp; Well Being Strategy's initiatives for the current year is to enhance the capacity of the SSD to provide relevant information to women who use the tool, such as child care availability, access hours.</p>

<b>DHS Division/ Branch/Program</b>		<b>Timeline to 30 June 2006</b>	
<i>Women's Health Program (cont)</i>	Nature of implementation	Ongoing	Support to be provided by program
	Quality planning approaches for IHP programs.		Support QIPPS as a quality tool for health promotion planning and monitoring.
	PCP catchment planning.	2004–06	WHSS will contribute to at least one PCP HP catchment priority. This should represent a minimum of 25% of the agencies funding for HP. The detail of this catchment activity will be provided in the organizational health promotion plan.
	Common mechanisms for reporting/evaluation.	2004–05	Work with Regional Advisers to negotiate the role and contribution of WHSS to catchment planning in 2004–2005.
	Workforce development.	Ongoing	Align reporting, evaluation and accountability arrangements across the sector.
Other	Ongoing	Offer workforce development opportunities to support the sector in quality health promotion planning, implementation and evaluation.	
Other	Ongoing	Continue to be responsive to agencies regarding inclusion of population groups and priority health issues.	
<b>Other government departments</b>	Nature of integrated health promotion implementation	<b>Timeline to 30 June 2006</b>	Support to be provided by program
<b>Department for Victorian Communities</b>			
<b>Sport and Recreation Victoria</b>	Health promotion funding requiring partnerships to use PCP infrastructure.	2004–06	Continue to explore opportunities for engaging PCPs in the implementation of Healthy and Active Victoria initiatives for the promotion of physical activity.
	Health promotion funding requiring partnerships to use PCP infrastructure.	2004–05	Phase 1 and Phase 2 of the Healthy and Active Living Grants Program are using PCP infrastructure to fund programs. Funding guidelines and service agreements to articulate use of PCP platform for program implementation.
<b>Office of Senior Victorians</b> Healthy and Active Living Program	Quality planning approaches for IHP programs.	2004–05	Support program planning principles as identified in IHP framework. Incorporate IHP planning framework principles, where relevant, in development of a best practice model for strength training programs targeting older persons.

<b>Other government departments</b>	Nature of integrated health promotion implementation	<b>Timeline to 30 June 2006</b>	Support to be provided by program
<i>Office of Senior Victorians</i>	Common mechanisms for reporting/evaluation.	2004–05	Support common reporting mechanisms for Healthy and Active Living program.
<i>Healthy and Active Living Program (cont)</i>	Build evidence base and dissemination.	2004–05	Findings from phase 1 of Healthy and Active Living Grants Program to inform further statewide activity.
	Workforce development.	2004–05	PCPs funded through Healthy and Active Living Grants Program will participate in a planning forum.
Strength Training Review	Health promotion funding requiring partnerships to use PCP infrastructure.	2004	Identify PCP platform and its member agencies (as key stakeholders) in the provision of strength training programs across Victoria. Include PCP representatives on steering committee and in scoping activities.
	Quality planning approaches for IHP programs.	2004–05	Incorporate IHP planning framework/service coordination where relevant in development best practice model.
<b>External stakeholders</b>	Nature of integrated health promotion implementation	<b>Timeline to 30 June 2006</b>	Support to be provided by program
<b>General Practice Divisions Victoria</b>		2004–06	Identify opportunities for enhanced collaboration between Divisions of General Practice and PCPs in relation to IHP and population health approaches to care through general practice. Develop an action plan in consultation with Primary and Community Health Branch identifying key areas for supporting IHP within the general practice context and policy environment.
<b>Victorian Health Promotion Foundation (VicHealth)</b>	Build evidence base and dissemination.	June 05	A mental health promotion evidenced based review is being developed and will be disseminated to PCPs.
	Workforce development.	June 05	The VicHealth Mental Health Promotion Short Course will be delivered to inter-sectoral workforces including sport and recreation, arts, local government and health organisations. The course will be progressively rolled out across Victoria in 2004–2005 and will be accessible to PCP members. VicHealth mental health promotion publications and resources will be made available during provision of the professional development short course and are available to all PCPs via the VicHealth website.

## Abbreviations

A&D—Alcohol and drug	ICT—Information and communications technology
ACAS—Aged Care Assessment Service	IHP—Integrated health promotion
ACE—Aged Care Evaluation	INI—Initial needs identification
ACSCs—Ambulatory care sensitive conditions.	IRIS—Integrated Reports and Information System
ADIS—Alcohol and Drug Information System	LGAs—Local government authorities
BoD—Burden of Disease	MPHP—Municipal public health plan
CHC—Community health centre	PAV—Personal Alert Victoria
CHP—Community health plan	PCP—Primary Care Partnership
CHPIA—Community Health Plan Implementation Agreement	PHKB—Primary Health Knowledge Base
CHS—Community Health Service	QIPPS—Quality Improvement Program Planning System
CIARR—Client Information and referral record	RRHACS—Rural and Regional Health and Aged Care Services (Department of Human Services Division)
CRIS—Client Relationship Information System	SCTT—Service Coordination Tool Templates
CRISSP—Client Relationship Information System for Service Providers	SNR—Special Needs Register
DoHA—Department of Health and Ageing (Australian Government)	SSN—secondary school nurse
ECIS—Early childhood intervention services	VPHS—Victorian Population Health Survey
E-referral—Electronic referral	WH&WBS—Women’s Health & Well Being Strategy
GP—General practitioner	WHSs—Womens health services
GPDV—General Practice Divisions Victoria	YLL—years of life lost
HACC—Home and Community Care program	
HARP—Hospital Admission Risk Program	

## Endnotes

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