health

Primary Care Partnerships: Achievements 2000 to 2010

Primary Care Partnerships: Achievements 2000 to 2010

Contents

Tables

Figures

1 Primary Care Partnership achievements: 2000–10

Achieving better health for people and strengthening the communities they live in are critical to improving the quality of life for all Victorians. Developing a more effective and efficient primary health care system that is well connected to the broader health and human services system is essential for achieving these goals. The Primary Care Partnerships (PCP) Strategy has demonstrated that these goals are achievable, and that when organisations work in partnership they can better respond to people's needs. This document summarises the achievements of PCPs.

The PCP Strategy was launched by the Victorian government in 2000 and has contributed to improved health outcomes for Victorians through:

- early identification of their full range of health and care needs
- easier navigation of the health and human services system
- improved access to health and human services
- more active involvement in programs to improve their health and well-being
- quality health promotion practice across organisations contributing to healthier communities
- improved coordination, consistency and continuity of care.

The establishment of 31[1] local PCPs across the state represents a diverse range of 1,200 health and human service organisations. The partners engaged in local PCPs have worked together to create a more responsive, integrated and health promoting service system. This is being achieved through improved service coordination, integrated health promotion and integrated chronic disease management.

Service coordination—aims to place the consumer at the centre of service delivery—taking the burden of navigating the service system away from consumers to providers of services. The goal is to ensure that consumers have access to the services they need, opportunities for early intervention and health promotion and improved health outcomes. Service coordination is facilitated by PCPs where agencies come together to agree on how they will coordinate their services so that consumers experience a health system that works together.

Integrated health promotion means agencies in neighbouring areas are working together to tackle priority health and well-being issues within their own community. Through PCPs, this joint approach harnesses resources and effort from various organisations and directs them to greater effect by working together in smarter ways, rather than in isolation.

Integrated chronic disease management aims to provide people with responsive, person centred care over time and through the different stages of disease progression. PCPs facilitate the change management and service system integration to deliver proactive Integrated Chronic Disease Management using the evidence-based Wagner Chronic Care Model.

> If we do our job well the changes will be hard to notice, things will just work better and people will experience smooth stress free journeys through the health care system.
>
> Sophy Athan, Chair, Outer East Primary Care Partnership Consumer Reference Group (2010)

---

1 In 2004 the number of PCPs reduced from 32 to 31 when Boroondara and Central East PCPs merged to become the Inner East PCP. From July 2010 the number of PCPs will change from 31 to 30 due to PCP boundary changes in the North-West Region.

Figure 1 Types of organisations engaged in Primary Care Partnerships and their respective focus on core activities
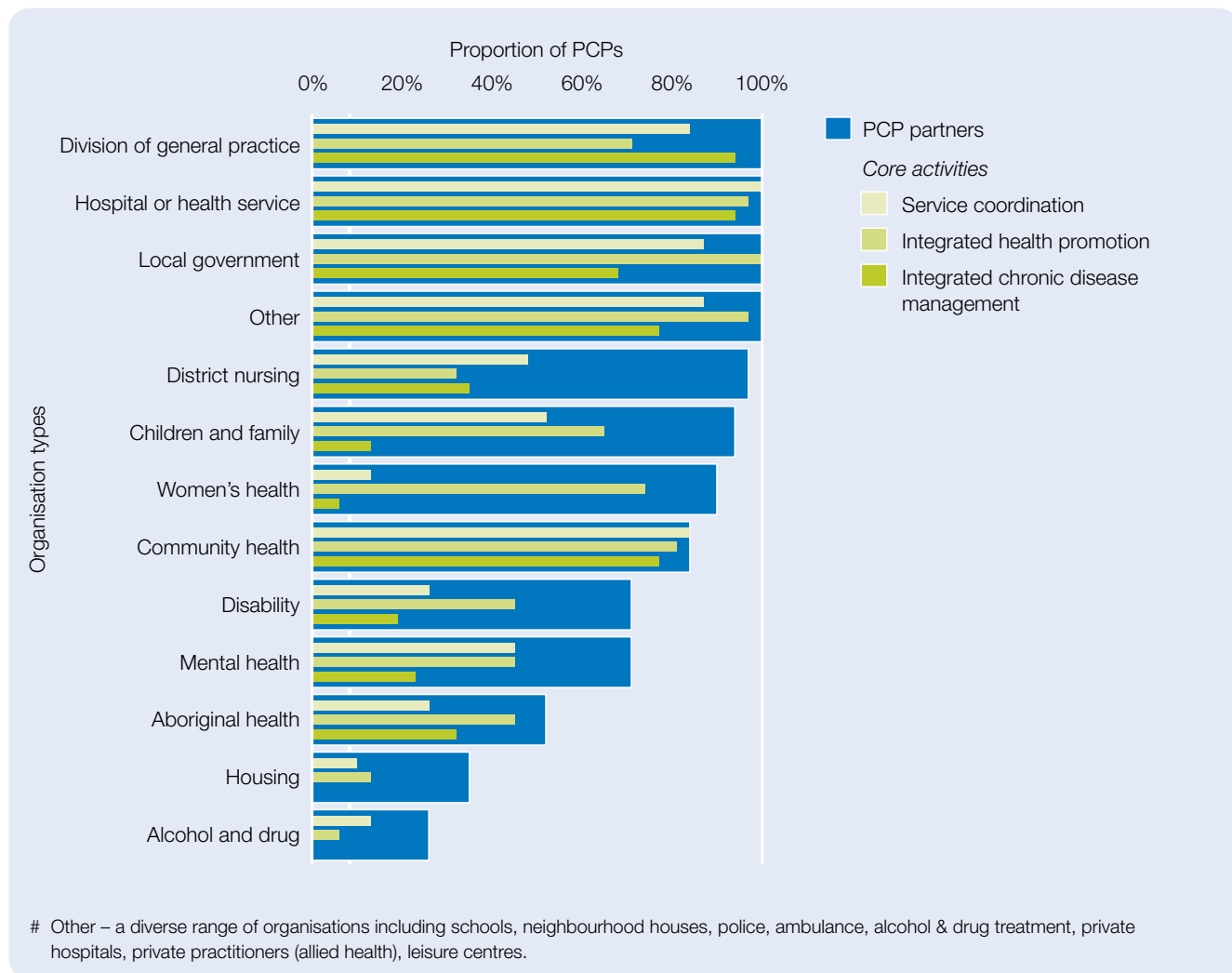

\# Other – a diverse range of organisations including schools, neighbourhood houses, police, ambulance, alcohol & drug treatment, private hospitals, private practitioners (allied health), leisure centres.

Table 1 Achievements of the PCP Strategy 2000–2010

Service coordination between health and human services	
2000	**2010**
Limited common practice within and between services More than 350 different tools used for screening, referral and assessment Limited use of information technology by services Limited communication between services	A single set of statewide guidelines that outlines agreed standards for service coordination practice for consistent client care within and between services and sectors A single suite of service coordination tools used for screening, referral and coordinated care planning. Service coordination tools used by more than 600 health and human services across the state. resulting in the reduction in the duplication of information collection about consumers and assessment of their needs. The service coordination tools are supported by electronic referral resulting in 130,000 referrals sent and received electronically in 2008–09 Over 230 organisations which represents 770 individual programs have reported their service coordination practice in 2009, providing quantitative evidence of coordinated care and evidence for organisation accreditation and program quality assurance requirements. The majority of programs showed consistent practice in accordance with the statewide standards in these areas: • obtaining client consent for disclosure of information • improved responses to urgent and routine referrals • offering consumers information about services available and providing referral feedback Quality referrals between GPs and other services supported through a GP specific referral tool and the use of up to date services information through the Human Services Directory
Integrated approaches to the planning, delivery and evaluation of health promotion	
2000	**2010**
Organisations primarily working on their own to deliver health promotion Limited common approach within and between organisations Limited understanding about the determinants of health	Evidence-based and integrated approach to the planning, implementation and evaluation of health promotion with a focus on statewide and local priority issues 350 organisations currently engaged, in health promotion activities led by PCPs representing a broad multi-sector approach Focus on the needs of hard-to-reach and vulnerable groups Evaluations indicate improvement in: • integrated planning • an increase in organisational capacity for health promotion • economic and other benefits to partner organisations • a contribution towards healthier communities Shift from health education to a more comprehensive health promotion model based on the Ottawa Charter[2] and inclusive of primary to tertiary prevention

2 The Ottawa Charter for health promotion was developed in 1986 as a clear statement of action for health promotion, aiming to increase the relevance of primary health care philosophy for industrialised countries. For further information see: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

Integrated approaches to chronic disease management	
2000	**2010**
Limited planned or systematic care coordination Coordination of care largely the responsibility of the client Limited common practice within and between organisations Service operations centred on meeting clinician's and organisation's needs	PCPs have led the systematic progression of integrated approaches to chronic disease management using the Chronic Care (Wagner) Model[3] More clients receive care from multidisciplinary teams that include state-funded and private providers Teams ensure they get the right care at the right time, and that the most efficient use is made of funding streams such as the MBS New annual reporting that is built on an evidence base, providing organisations with quantitative evidence of quality of care and for organisation accreditation requirements. In 2009, 137 organisations representing 431 programs reported their integrated chronic disease management practice for the first time. Results from this report indicate that the majority of these organisations have implemented best practice clinical care, proactive ongoing support, support for health behaviour change All PCPs have mapped self-management activity and are using a range of evidence-based approaches with their clients Significant skills and capacity has been developed in the sector to deliver more effective care planning and self-management support Over 80% of PCPs are working on improved systems of care with the GP sector including identifying clients with chronic disease, accessing the right services and coordinated care planning

3 http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/

2 Background

2.1 Development of this report

This report highlights key achievements of the Primary Care Partnership Strategy in relation to the attributes needed for a modern primary health care system.

> Primary health care is central to all Victorians throughout the course of their lives.

Primary health care is central to all Victorians throughout the course of their lives. Most people will see a general practitioner (GP) at least once a year; many require other primary health care services (such as allied health services, community nursing and dental care) to deal with a range of physical, developmental, social and emotional issues and to maintain their health.[4] Some will need active management of their chronic and complex conditions. Regardless of how much a person needs primary health care, all people benefit from a cohesive, high-functioning primary health system. Integrated health promotion and prevention programs support the health of communities and strengthen the social fabric.[5]

2.2 The Primary Care Partnership Strategy

The objective of the Primary Care Partnership Strategy is to bind all this activity together into a coherent system. During the past ten years much has been achieved and many lessons learned. These combine to lay the groundwork for a modern primary health care system in Victoria.

The Primary Care Partnership Strategy supports the statewide operation of 31 local alliances of service providers. These work in partnership to improve the coordination of services to clients, plan and deliver integrated approaches to health promotion and develop integrated approaches to the management of chronic disease. With only modest funding, the key resource is the collaboration between providers. PCPs have been improving the coordination and integration between state-funded health and human services and with General Practice.

> PCPs have been improving the coordination and integration between state-funded health and human services and with General Practice.

The work is ongoing and responsive to innovation and changing priorities. The focus to date has been on state-funded services. Building on this, PCPs are now increasingly engaging with other Commonwealth-financed and private service providers. While full implementation of a modern primary health care system in Australia requires reform at the national level, the PCP Strategy demonstrates the innovative approach that is progressing work in Victoria. The achievements and experiences achieved through the ten-year PCP Strategy offers a major springboard to realising the full benefits of a modern, national primary health care system.

For further information visit: <http://www.health.vic.gov.au/pcps>.

2.3 A modern primary health care system

Building a modern and effective primary health care system is a task for all jurisdictions—both in Australia and for most Western countries.[6] International evidence shows that good primary health care plays a vital role in making health systems sustainable. A good primary care system reduces health inequalities and achieves better health outcomes for a lower overall cost than structures that are narrowly focused on specialist or tertiary care.[7]

---

4 Working with general practice: Department of Human Services position statement. http://www.health.vic.gov.au/communityhealth/gps/position_resource.htm

5 IDeA (UK) 2009, *Valuing Health: developing a business case for health improvement,* accessed 19 January 2010 at: <http://www.idea.gov.uk/idk/core/page.do?pageId=14456158>.

6 World Health Organization 2008, *Primary Health Care: Now More Than Ever;* University of Birmingham, Health Services Management Centre 2009, *Primary Care: Current Innovations,* accessed 5 January 2010 at: <http://www.hsmc.bham.ac.uk/news/news/2009/12/Primary-Care-Innovations.shtml>; Commonwealth of Australia 2009, *A Healthier Future For All Australians—Final Report of the National Health and Hospitals Reform Commission—June 2009;* Australian Government, Department of Health and Ageing 2009, *Building a 21st Century Primary Health Care System: A Draft of Australia's First National Primary Health Care Strategy.*

7 Starfield, B., Shi, L. and Macinko, J. 2005, 'Contribution of primary care to health systems and health', *The Millbank Quarterly,* vol. 83, no. 33, pp. 457–502; McDonald, J. et al. 2006 *Systematic review of system-wide models of comprehensive primary health care,* Research Centre for Primary Health Care and Equity, UNSW.

A good primary care system reduces health inequalities and achieves better health outcomes.

Increasing rates of chronic disease, an ageing population and high-cost treatments are strains on the tertiary inpatient components of the health system. Effective management of current and future demand in hospitals, mental health services and drug treatment services will not be achieved without a well-functioning primary health system. The system should also work alongside both the efforts to prevent illness and promote population health and the investments and innovations in tertiary level care.

Key attributes that characterise a modern primary health care system include:

- **integration** of services across the continuum of care and the system, for better outcomes
- **access** to the right service at the right time for the right people
- **quality**, to ensure use of the best knowledge, practices and staff
- **performance**, which is measured for outcomes, and is transparent and accountable.

In Victoria the Primary Care Partnership Strategy has built a strong foundation for a modern primary health care system over the past decade.

3 Integration of services for clients and across the system

3.1 Integration in a modern primary health care system

Integration for health and wellbeing

In a modern primary health care system, one of the critical factors leading to better client outcomes is the extent to which services are integrated. Integration must be evident in two dimensions:

- the continuity of primary health care experienced by individuals
- the systemic linkages between the primary health sector and the acute and specialist care sectors.

> Current arrangements often limit good patient outcomes.

Because primary health is inherently broad in scope, and has been financed by both state and Commonwealth governments, historical legacies mean that current arrangements often limit good patient outcomes. The proliferation of service types, funding models and providers contributes to duplication of data collection, disconnection and poor referral, as well as barriers and navigation difficulties. This is especially so for people who need care across a range of services or who have high need for, but poor access to, primary health care.

> Primary health care encompasses a range of services from health promotion to clinical treatment.

Primary health care encompasses a range of services from health promotion to clinical treatment. Effective integration involves many service relationships—between public and private providers, and between general and specialist clinicians, who often use different intake and referral systems and are driven by different funding imperatives. For many people, success is not only about how the whole range of services they need work together to achieve and sustain an outcome that improves their health, but also how these services enhance their wellbeing. For these goals to be realised, primary health care needs to be linked to the human services and social development sectors and play an effective role alongside preventative health and specialist treatment services in a multi-sector approach to tackling the determinants of health status in the community.

> Primary health care needs to be linked to the human services and social development sectors.

Meeting health needs across changing life circumstances

Another aspect to integration is recognising that people's need for service integration varies and changes across their life.

> People's need for service integration varies and changes across their life.

For most people, for most of their lives, timely use of primary care services such as vaccination, screening and general medical care is sufficient for episodic management and treatment. However, another segment of the population will experience conditions (both health and social) that leave them at higher risk of requiring hospitalisation or residential treatment if their care is not well managed or coordinated in a community setting. Even when tertiary-level care is needed for chronic conditions, strong links with subacute care are vital for effective discharge and continuing care management. Therefore, higher levels of integration are warranted when people have complex health and social needs and for many who, as they age, need a range of well coordinated health care services.

> Effective integration involves many service relationships.

The benefits of strong linkage with the Central Highlands PCP extend well beyond the monthly meetings—partnerships have assisted us progress service scoping in the areas of perinatal infant mental health, chronic disease management and dual diagnosis. Often it is in the conversations between member agencies that drive action and change.

Strong participation in the PCP group is an important adjunct to both our acute health care service development area and our social outreach development.

Lee-Anne Sargeant, Director of Organisational Development, St John of God Hospital, Ballarat

3.2 Primary care partnership achievements

PCP achievements:

- a statewide platform for primary health and human service integration
- strong partnerships tackling statewide and local priorities, guided by three-year strategic plans
- statewide platform for delivering broader state government responses.

Partnerships are critical

International experience[8] strongly suggests that integration and collaboration on primary health services offers potential returns to the health system, including improved health promotion, better planning and effective coordination of services. The research literature sees partnerships as a mechanism for progressing integrated approaches, which can build relationships between agencies and harness existing resources to achieve results beyond the scope of one agency. Partnership requires recognition of the role and expertise of other organisations and agreement about common actions. This principle underlies the PCP Strategy.

All Primary Care Partnerships include hospitals, community health, local government and divisions of general practice as core members.

Membership of PCPs

All Primary Care Partnerships include hospitals, community health, local government and divisions of general practice as core members of the partnerships. The range of agencies and sectors involved in PCPs is growing and diversifying. The more than 1,200 partner agencies involved in PCPs comprise private allied health providers and private hospitals, disability and housing agencies as well as non-health agencies such as police, schools, community groups.

8 Glasby, J. and Dickinson, H. 2008, *Partnership working in health and social care,* Bristol, Policy Press; Walker, R. et al. 2007, 'Partnership Management: Working Across organisational Boundaries', *Australian Journal of Primary Health.*

Recent reporting results, summarised in the table below, indicate that the diversified membership of PCPs is increasingly adopting shared practices to improve the coordination of services and better meet the needs of people with chronic and complex conditions. Data on service coordination practices has been collected over two years, and shows an overall 21 per cent increase in the participation rate of programs, including a significant 43 per cent increase in the rate for disability services.

Table 2 Participating programs in service coordination (SC) and integrated chronic disease management (ICDM) data collection, 2009[9]

Programs/services	SC 2009*	ICDM 2009#
Acute health services		
Admitted patients	25	15
Hospital admission risk programs (HARP)	38	33
Emergency services	12	11
Post-acute	29	20
Subacute	24	18
Palliative care	23	18
Outpatients	15	15
Allied health	35	29
Ambulance services	1	2
Aged and home care	207	103
Child and family services	50	17
Disability services	90	21
Mental health	33	14
Drug services	15	6
Housing assistance	22	10
Problem gambling	21	3
Primary and dental health	122	91
Other	11	8
TOTAL	773	434

* Figures for service coordination represent the second year of collection.

\# Figures for integrated chronic disease management represent the first year of collection.

9 Based on analysis done by Integrated Care Branch, Department of Health, 17 February 2010.

> Client outcomes have been improved through a broad, integrated service system approach.

Client outcomes have been improved through a broad, integrated service system approach, highlighted in the collaborative work undertaken by Disability Services and PCPs. A survey[10] of 300 clients with an intellectual disability found that, on average, each person had eight chronic health conditions. A care coordination project brought together disability services and PCP agencies to implement care coordination and improve service coordination. The case study of 'Rebecca', below, shows how this approach enhanced the care of an individual and integration of the overall system.

Case study

'Rebecca' has an intellectual disability and required an enteral feeding tube, but was experiencing frequent hospitalisation due to recurrent complications and no supporting services. The care coordinator, using service coordination practices and tools, communicated with the GP, engaged district nursing and organised training for the support staff. Since these interventions, Rebecca's care is well managed and she has not needed to return to hospital. Support staff feel more confident to manage the feeds and to reduce the risk of complications.

PCPs responding to local needs

Based on a strong ethos of working in partnership, PCPs have demonstrated a capacity to respond to national and statewide policy directions and provide a comprehensive response to local needs. Three-year strategic plans describe how each PCP will implement such responses through the core areas of service coordination, integrated health promotion and integrated chronic disease management.

The value of PCPs as a vehicle for health and human service integration is demonstrated by two examples. First, in 2006 PCPs responded rapidly to the need for a platform to deliver comprehensive mental health initiatives in response to the impacts of drought. Initiatives across drought-affected areas brought together not only health and welfare providers, but also agricultural organisations and financial counsellors, and partnerships with local government were reinforced.

Case study

The Shire of Campaspe developed a range of strategies and actions that aimed to lessen the physical, emotional and social impacts of drought and climate change in its region.

An important part of its response was an assertive outreach program—The Campaspe Farm Gate project. The local shire and PCP implemented a combined drought action plan and improved access to counselling services for a traditionally reluctant group (farmers), and strengthened the community's capacity to support the mental health and meet the related needs of people affected by drought.

In the second case, the redevelopment of the Gamblers Help program by the Department of Justice in 2008 recognised that because problem gamblers faced a multiplicity of issues which traversed service boundaries, a better service response needed to be integrated with a broad range of health and human services providers. PCPs have provided the mechanism to integrate problem gambling services within local planning and coordination structures.

---

10 Department of Human Services, Disability Services 2009,
    Draft Final Report: Complex Health Needs Care Co-ordination Demonstration Project.

4 Better access to services

4.1 Access to services in a modern primary health care system

As the frontline entry point to the health system, a modern primary health care system must ensure access to the right service, at the right time, for the right people. In other words, timely and appropriate service provision to all people delivered seamlessly across the system.

> Access to the right service, at the right time, for the right people.

Suboptimal access is a problem for individuals because they may become sicker than they would otherwise. The overall system also suffers, because poor access fails to prevent avoidable demand on acute and residential treatment services.

Barriers to service access

To achieve effective access, we need to understand how numerous factors can operate as barriers. The cost of services may limit the ability of some people with appropriate needs to access a service. If the right service or practitioner is not available or is located far away, access can be restricted. Cultural factors in relation to language, attitude and practice can also inhibit access, including for people from linguistically and culturally diverse backgrounds, young people, homeless persons and people with drug dependencies. Often those who experience poor access are those with the greatest need and most likely to benefit from good primary health care.[11]

Key enablers for ensuring the right service at the right time for the right people

Planning service delivery to focus on priority needs

This requires the capacity to forecast future demand in a given area, in order to proactively manage access and harness all available services across different financing arrangements. Planning should also reconfigure service delivery for user convenience, including hours of operation, mobile services and relocation of services to areas of highest need.

Service coordination systems

Coordination is required to achieve consistent, optimal access across variable levels of usage. This includes the adoption of common practice standards and tools, supported by information technology, to reduce duplication of information exchange, better deploy the health workforce, and implement effective triage and service priority arrangements.

Additional or supplementary targeted programs

Other programs are required where proactive models of care and flexible funding may be beneficial for some chronic or complex patients who find it difficult to access mainstream services.

---

11 Commonwealth of Australia 2009, *Primary Health Care Reform in Australia: Report to Support Australia's first National Primary Health Care Strategy,* p. 35.

4.2 Primary care partnership achievements

> **PCP achievements:**
>
> - agreed statewide standards for service coordination practice within and between services and sectors
> - consistent practice by more than 600 services through the use of electronic tools for screening, referral and care planning
> - quality referral between GPs and other services through the Victorian statewide referral tool and *Human Services Directory*
> - massive growth in secure e–referral transactions between 2005 and 2009.
>
> For Victorians this has resulted in:
>
> - early identification of health and care needs
> - easier navigation of the health and human services system
> - clinicians spending less time on administration and more time on service provision
> - improved access to health and human services.

A statewide service coordination system

The PCP Strategy has delivered a statewide service coordination system, resulting in better access to primary health and community support services. Standard practices[12] for coordinating services and sharing consumer health and care information have been widely adopted. Consequently, information sharing between service providers has been simplified, through the use of a standard suite of tools (service coordination tool templates, or SCTTs). The SCTTs are used by more than 600 agencies and have replaced more than 350 different tools that were previously used.

> Information sharing between service providers has been simplified.

Service coordination and general practitioners

A version of the SCTT specifically for general practitioners (called the Victorian statewide referral form, or VSRF) and collaborative work between Divisions of General Practice and PCPs on practice issues such as care planning and better referral have contributed to better coordinated care for people with chronic and complex conditions. The work undertaken in Victoria and through the Commonwealth have resulted in improved access to allied health for patients with chronic disease and who require multidisciplinary care. This trend ensures that the most efficient use is made of funding streams such as the Medicare Benefits Schedule (eg. team care arrangements or TCA).

The Victorian statewide referral form has been further developed to support improved quality of referral information from GPs to specialist (outpatient) clinics including urology, orthopaedics and maternity. The VSRF is also suitable for referrals to other hospital specialist clinics where a service specific referral tool does not already exist.

---

12 The *Victorian Service Coordination Practice Manual* is at: <http://www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm>.

Figure 2 Proportion of Victorian and Australian population with team care arrangements

Medicare Australia, <http://www.medicareaustralia.gov.au/provider/medicare/mbs.jsp#N10030>

The Victorian statewide referral form is a highly useful referral tool which is widely accepted by hospitals and health agencies. It also works well for specialist referrals…

Dr Andrew Batty, GP, Monash Division

Service coordination and demand on hospital services

The service coordination standards and tools are being implemented by a range of health and human services, see table 1. Hospital based programs and services include:

- health independence programs (post-acute care, subacute and hospital admission risk program)

- emergency department care coordination

- palliative care.

The 2009 service coordination reporting results show a growing level of adoption of the service coordination practices in hospital admission risk programs (HARP). For example, Eastern HARP has developed a set of key performance indicators for community health HARP providers that directly relate to standards for service coordination. The service coordination tools are embedded in the Eastern HARP client management system, which allows consistency of information across HARP and community health.

> What electronic referral has offered to our service is an ability to search for clients, update their demographic information, create and track the progress of referrals or service requests and having all this information accessible at any time… I doubt our service would cope using a paper-based referral system again.
>
> Peter Green, Manager Continuing Care, West Gippsland Health Care Group

Information that is available when and where a person needs care

Improved electronic communication between agencies supports services to be better coordinated, and is an important element in making sure that information is available when and where a person needs care. Figure 3 shows the massive growth in the sharing of standardised consumer health and care information, with client consent, between Primary Care Partnerships member agencies. Secure electronic sharing of information has improved levels of efficiency and effectiveness for service providers by reducing duplication of information collection and client assessment and making it easier for clinicians to refer a client to multiple services.

Victoria has been a leader in the adoption of statewide implementation of e-referral in Australia through the efforts of the PCPs and the implementation of standard practice and tools.

In a recent review[13] of referral arrangements in Australia, the National e-Health Transition Authority (NeHTA) singled out the success of the service coordination tools in rationalising the collection of common data when a vast number of referral forms exist. The review also highlighted the e-referral work in Victoria for possible national application to improve the process efficiency for referrals in an e-health environment.

Figure 3 Sent and received e-referrals by financial year
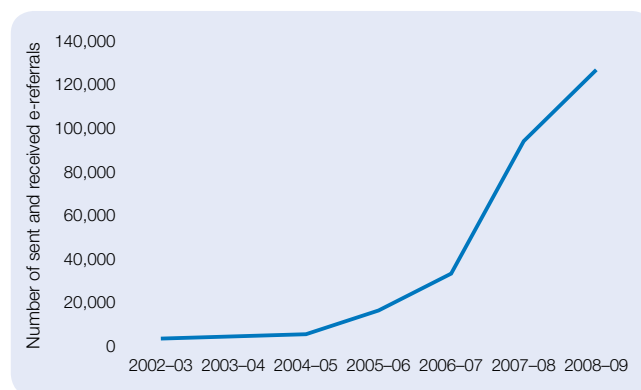
The total number of e-referrals sent and received in 2008–09 represents the engagement of over 550 services including the several major hospitals.
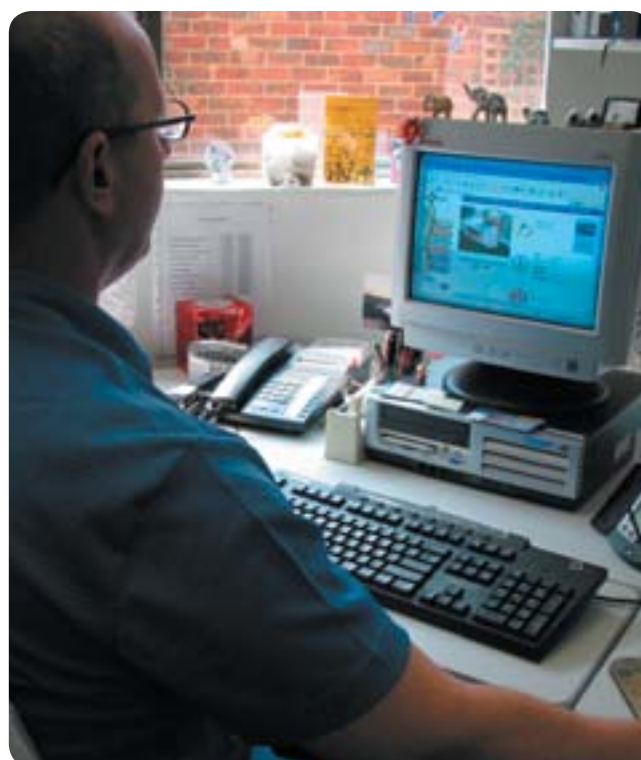
13 Valintus Pty Ltd 2009, *NEHTA Referrals Environmental Scan Overview.*

5 Quality driving improved practice

5.1 Quality in a modern primary health care system

A commitment to quality standards and continuous improvement is critical to ensure use of the best knowledge, practices and staff throughout a modern primary health care system.

Evidence and accreditation

Programs and treatments provided, and the practices and protocols that support them, should be based on evidence. This means they are reviewed and adapted in response to innovation and new knowledge, which in turn relies on sound evaluation and research being undertaken, the findings disseminated and applied through agreed clinical guidelines and best practice standards.

> Programs and treatments provided, and the practices and protocols that support them, should be based on evidence.

Accreditation processes and scope of practice regulations should support and reflect the desired outcomes of a modern primary health care system. Safety is of paramount importance and the quality standards in place across the system should serve to build confidence to provide care in community and home settings where it is safe and effective to do so.

Honouring the client experience

> The experience of being engaged with one's own health care is empowering.

Fundamental to the practice of primary health is the value that people are at the centre of care. Not simply because performance is measured by client outcomes, but profoundly because the experience of being engaged with one's own health care is empowering. Contemporary application of consumer participation principles relies on:

- the availability and use of information and knowledge (health literacy)

- skills and confidence to partner with clinicians in self-managing, especially for those with chronic care needs
- opportunities for involvement in service planning and design.

Client experience should be collected as part of outcome measurement, and transparent information about service performance should facilitate patient choice and provide a feedback loop for service improvement.

5.2 Primary care partnership achievements

PCP achievements:

- systematic application of continuous quality improvement in strengthening local partnerships and in progressing core activities
- evidence-based approach to planning, implementing and evaluating integrated health promotion
- shift from health education to comprehensive health promotion, inclusive of primary to tertiary prevention
- solid progress on implementing best practice chronic disease management approaches
- annual reporting on adoption of best practice, which links to organisation accreditation and quality assurance requirements.

For Victorians this has resulted in:

- a strong focus on addressing the needs of vulnerable and hard to reach population groups
- quality health promotion practice across organisations contributing to healthier communities
- an experience of more consistent quality of care across services.

Figure 4 Integrated health promotion priorities of PCPs (2009–12)

- Reducing tobacco—related harm—3%
- Sexual and reproductive health—5%
- Reducing and minimising harm from alcohol and other drugs—5%
- Other—9%
- Promoting accessible and nutritious food—18%
- Promoting mental health and wellbeing—34%
- Promoting physical activity and active communities—26%
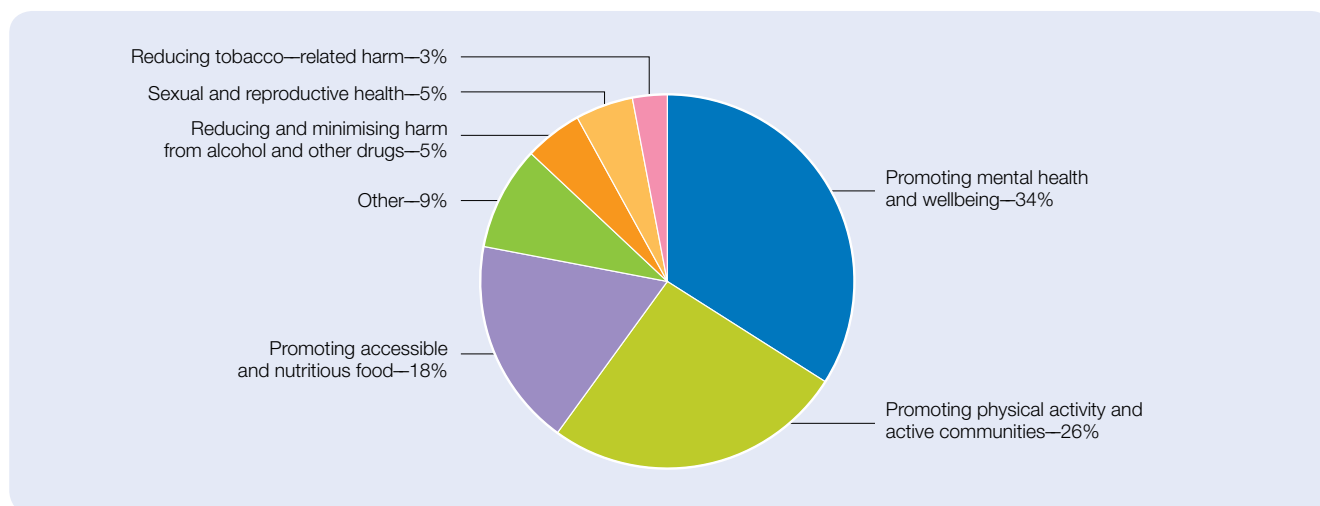
Strong collaborations

Integrated health promotion through Primary Care Partnerships has created highly developed networks that engage different sectors and stakeholders and use a mix of interventions and capacity building strategies to address priority health and wellbeing issues. A feature of these networks is the strong collaboration with local government authorities that play a leading role in local health planning. The figure below shows, by percentage, the key health promotion issues for PCPs over the period 2009 to 2012. This demonstrates a strong alignment of local health promotion effort to state-level priorities across the 350 organisations engaged in integrated health promotion.

A common planning framework

Supported by the evidence-based *Integrated health promotion resource kit*[14] and a sustained program of organisational and professional development, partnerships use a common planning framework to identify, plan and implement robust and tested health promotion interventions to benefit communities throughout the state. This activity has substantially lifted the quality of health promotion in Victoria.

The figure below shows changes in the effectiveness and perceived quality of integrated health promotion based on interviews and questionnaires completed with more than 100 organisations.

Figure 5 Changes in quality and effectiveness of integrated health promotion[15]
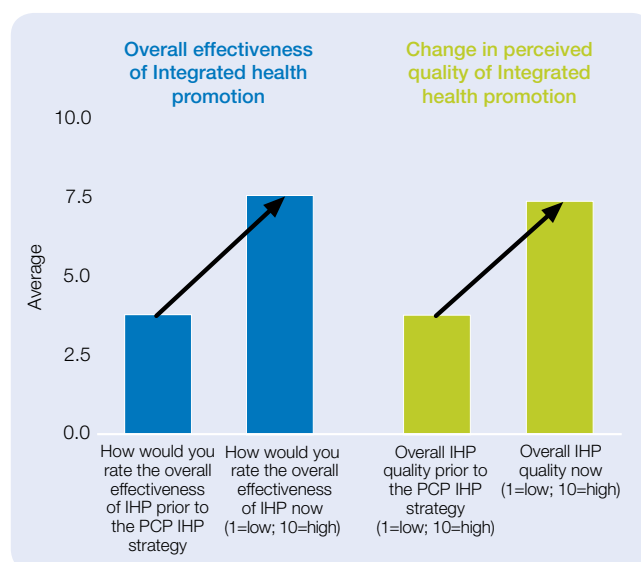
14 The *Integrated health promotion resource kit* is available from: <http://www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm>.

15 HDG Consulting Group 2008, *Partnerships for effective integrated health promotion—An analysis of impacts on agencies of the Primary Care Partnership Integrated Health Promotion Strategy,* Final Report, 23rd October 2008.

> [prior to PCP integrated health promotion]… we struggled to plan and implement health promotion projects effectively, however we are now able to devise a plan based on what the community needs… and skills to implement successful health promotion… They have given us direction, skills and knowledge.
>
> Respondent to questionnaire undertaken by HDG Consulting, 2008.[16]

Accreditation and standards

Industry accreditation bodies are working to ensure that quality standards and systems adjust to support the implementation of best practice in a modern health system.

In regard to standards for agency-to-agency work, the PCP-developed *Victorian Service Coordination Practice Manual 2009*[17] is acknowledged by the Quality Improvement Council's Standards and Accreditation Program[18] as a reference guide for leading, implementing and continuously improving the practices and standards that underpin service coordination. Additionally, the Victorian Department of Health has provided advice, consistent with the service coordination principles, to the Royal Australian College of General Practitioners, to progress a review of their standards for general practice in the areas of service coordination and access to services for disadvantaged groups.

Chronic care model

Integrated chronic disease management is being supported by PCPs across Victoria using an internationally respected model for improving chronic care.[19] Called the Wagner chronic care model, the approach is based on recognising the need to transform a health care system which is reactive (that is, treating people when they get sick) to one that is proactive and focused on keeping people as well as possible. The Wagner model identifies the changes required in the system to improve the coordination of care for people with chronic disease. Using a systems approach, the model identifies six interdependent elements which all contribute to achieving the goal of informed, activated clients engaged with a prepared and proactive care team resulting in improved outcomes.

In 2009 the take-up of best practice arrangements in integrated chronic disease management was measured for the first time. The majority of the 137 organisations who reported, have or are developing protocols to deliver best practice clinical care; proactive and ongoing support for clients with chronic disease, and health behaviour change support as part of self-management.

16 HDG Consulting Group 2008, *Partnerships for effective integrated health promotion—An analysis of impacts on agencies of the Primary Care Partnership Integrated Health Promotion Strategy,* Final Report, 23rd October 2008, page 8.

17 *The Victorian Service Coordination Practice Manual 2009* is available from: <http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf>.

18 Quality Improvement Council's Standards and Accreditation Program is the process by which health and community services are assessed against the Quality Improvement Council's standards for safety and quality.

19 Department of Human Services, Primary Health Branch, 2008, *Chronic Disease Management Program Guidelines,* revised October 2008.

Case study

Improving access to services for people with chronic disease

The Banyule Nillumbik Primary Care (Partnership) Alliance has developed common protocols, processes and promotional resources across organisations to improve access and integration of services for people with chronic disease. The work has focused on improving referral processes and increasing consistency of referral information. Recognising that general practice plays a crucial role for these clients, the Division of General Practice has provided strong support in developing and implementing the approach.

Organisations in receipt of referrals from GPs identify the most appropriate service/s for clients (reducing the need for GPs to have knowledge about local chronic disease programs and service eligibility). This is accompanied by agreements to provide consistent and quality feedback to GPs. Changes within organisations have facilitated the implementation of agreed new ways of working to improve the client experience of the service system.

Outcomes from the approach include clients receiving services earlier, thus preventing or delaying disease progression.

6 Measurable performance for outcomes

6.1 Performance in a modern primary health care system

Performance and reward in a modern primary health care system should focus on measuring and assessing the health impacts and outcomes of people who use (or should use) the primary health care system, rather than the prevailing arrangements that focus on activity-based measurement and payment.

> Outcome-focused measures need to be applied at both patient benefit level and at the system effectiveness level.

Outcomes for clients and the system

Outcome-focused measures, supported by appropriate data collection, need to be applied at both patient benefit level and at the system effectiveness level. For example, are patients getting the best set of services to manage their condition, and is this benefiting their health outcome? At the system effectiveness level, are the number of primary health-type presentations at emergency departments reducing? Is the data robust enough to do a cost-benefit analysis of substituting community-based treatment for inpatient care?

Determining the right governance structure to foster accountability for performance at all levels of the primary health system requires clear, agreed roles and responsibilities for:

- overarching policy and funding frameworks
- geographic-level service planning and commissioning of (some) services
- monitoring and reporting on health impacts and outcomes at patient and system levels
- service coordination and integrated service delivery for target populations.

Interdependency of health sectors

Sustainable improvement over the longer term must recognise the interdependency of the primary, acute and continuing care sectors within the wider health system. Poor performance in any one sector will adversely affect the performance of the whole system. Efforts to improve the health system should be guided by clear investment logic aimed at:

- reaping longer-term benefits (including managing demand on hospital and residential treatment services)
- sound forecasting of future pressures on the system and adaptability to emergencies (for example, fire, epidemics)
- robust forward planning for appropriate workforce supply.

6.2 Primary Care Partnership achievements

> PCP achievements:
>
> - a framework to improve and measure the performance of the health and human services system
>
> - improving how organisations and sectors contribute to the performance of the health and human services system
>
> - a more efficient and effective service system using statewide standards, tools and resources.
>
> For Victorians this provides:
>
> - greater confidence about the way services are coordinated and care is managed
>
> - more transparent and cost effective approaches to addressing people's health and care needs.

Program logic

The PCP Strategy has been guided by program logic[20] thinking since 2001. The program logic for the PCP Strategy is reviewed and updated regularly and has consciously evolved from initially measuring inputs, to measuring impacts and moving towards measuring outcomes. The funding for each PCP is based on delivering the core areas of activity identified in the three-year program logic, and implementation of the strategic plan developed by each PCP. Feedback from the department about the performance of the PCP informs the revision of strategic plans. The guidance provided by the program logic and the planning and reporting framework drives a cycle of continuous improvement and review.

> The guidance provided by the program logic and the planning and reporting framework drives a cycle of continuous improvement and review.

Figure 6 Program logic
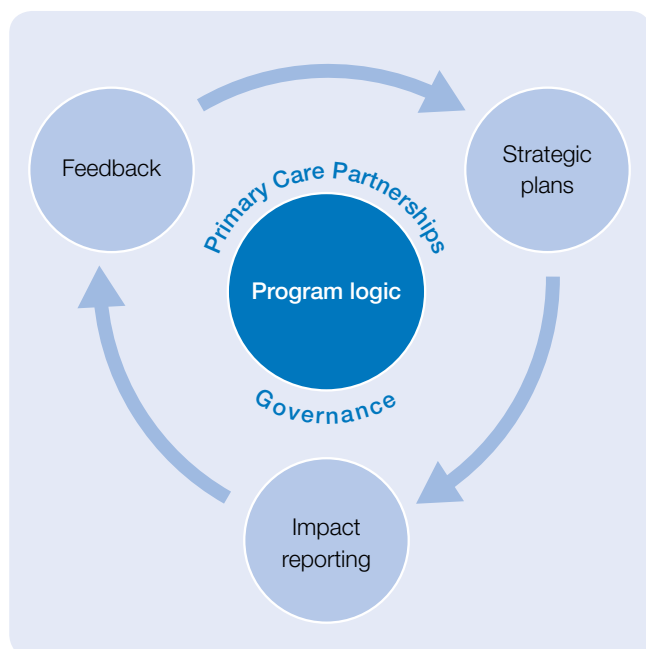
Improved reporting and efficiency

The integrated health promotion work of the PCPs has fostered greatly improved reporting capacity in the challenging area of measuring the effectiveness of health promotion activity, by shifting the focus of reporting to the impact of interventions on behaviour change in individuals. From 2011 funded services will use impact measures to report and review their health promotion activities.

Case study

Towards a Healthy Heart

'Towards a Healthy Heart' is a structured primary prevention program which addressed the risk factors for heart disease in 'hard to reach men' within the high-risk age group of 30–60 year old industry workers.

Initiated by the Portland District Health and Southern Grampians Glenelg Primary Care Partnership, the program involved 16 agencies including the Portland YMCA, Physiotherapy Centre, district health, the Leisure and Aquatic Centre, a range of sports clubs, local industries, local general practitioners (GPs) and Monash University.

Ninety men working in five different industries took part. By the end of the program the men's blood cholesterol, blood glucose, blood pressure, weight, Body Mass Index and waist measurements had all reduced, they were less depressed and anxious, and their eating was healthier. Alcohol consumption and cigarette smoking were also reduced or ceased.

Best of all, the men (many whom did not even have a GP, or hadn't seen one in years) established a better connection with the health system.

---

20 http://www.health.vic.gov.au/pcps/evaluation/index.htm#maps
    Program logics are a type of outcomes model which sets out the steps which occur in a program, leading from low level activities right up to high level outcomes.

7 Lessons learned

Time and trust

A decade of implementing the PCP Strategy has demonstrated that it takes time to build sufficient trust for integration systems to be fully adopted into practice. Critical for success has been striking the right balance between central leadership and local responsiveness while maintaining a clear focus on common objectives across the state.

Authorising environment

A number of components have been brought together to support system wide change. These include policy levers that deliver constant and consistent messages through for example, government funding and program guidelines. Opportunities to build on the PCP platform have been achieved through a range of government program funding rounds, where initiatives require a partnerships approach.

The PCPs are supported to deliver on a shared scope of work around the client, providing a small amount of recurrent funding, and a range of capacity building and workforce development activities.

Deep change

Improved health impacts and outcomes flow from bringing together the right set of providers using consistent tools and practices to deliver the intensity and mix of care required for each person. A primary care system characterised by a 'no wrong door' approach for consumers requires transformational change and involves much more than the physical co-location of services.

Working with others

Achieving improvements in the service system does not start with a blank slate. Several organisations, through their expertise or obligations, play leading roles in the health sector. For example, general practice divisions are the key structure for service development and change management in the crucial area of general medical practice. Local government has a statutory role in leading local health planning. The PCP Strategy has recognised the role of such bodies and sought to bring these players, along with others, together to achieve improvements when shared action is the best approach. Central to this approach has been developing the necessary skills and knowledge for working collaboratively.

Good governance

The Victorian government has recently moved to strengthen the governance arrangements for PCPs.

The Victorian government has recently moved to strengthen the governance arrangements for PCPs as a consequence of the growing maturity of the relationships between members. This is evident in the readiness of members to enter collective, binding arrangements to deliver on their three-year strategic plans and program logic aims. The PCP Strategy has been prepared to review and change governance to match the readiness and need for greater accountability.

Our role… is to make sure that the voice of consumers, carers and community members is heard loud and clear in all aspects of partnership work.

We have also witnessed a shift in thinking that recognises that good health is more than just the absence of physical illness… we have seen a greater focus in the individual being able to have a voice… and how working with a system that is focused on health and wellbeing can support them to achieve their goals for better health.

Sophy Athan, speaking about the role and impact of the Consumer Reference Group, Outer East PCP (2010)