health

Primary Care Partnership Program Logic 2013-17

State Government Victoria

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Introduction

In July 2012 the one-year *Primary Care Partnerships 'bridging year' guidelines 2012–2013* aligned the planning cycles for Primary Care Partnerships (PCP), community and women's health and municipal public health and wellbeing. From July 2013 PCPs will revert to a four-year planning cycle covering 2013–17. This alignment of planning cycles will facilitate greater integration in planning and avoid duplication of effort.

Crucial to the development of this document has been stakeholder consultation and consideration of current, significant primary health policy developments including the *Victorian health priorities framework 2012–2022*, national primary health reform as well as current Victorian primary health directions and community health service improvement initiatives.[1] Equally, the current evidence base, previous PCP program logics and bridging year guidelines, lessons learnt and current work have also been considered. Importantly, the development process highlighted the need for the 2013–17 PCP program logic to be developed in a more integrated way to better reflect system complexity and best practice.

A glossary has been included in Appendix 1 to assist in a common understanding of key concepts that are articulated within this document. This should be read in conjunction with the program logic.

[1] For further information please visit <www.health.vic.gov.au/pch/commhealth/improvement.htm>.

Figure 1: PCP program logic 2013–17

Program logic 2013–17

Strategy goal 2013–17

To strengthen collaboration and integration across sectors by 2017, in order to:

- maximise health and wellbeing outcomes
- promote health equity
- avoid unnecessary hospital presentations and admissions.

Primary Care Partnership program logic 2013–17 guiding principles

Consistent with the evolution of PCPs in Victoria, PCP action must be informed by the PCP guiding principles. It is a requirement that PCP action over 2013–17 is shaped by the following seven guiding principles:

Tackling health inequities	Adopting a social determinants of health approach to tackle health inequity across the full continuum of health and wellbeing, particularly for the most disadvantaged. PCPs should work at the system level to address health inequities within locally agreed and consolidated priority conditions. For broader determinants, PCPs have a responsibility to advocate for change with cross-sector partners.
Person and family centred	Building relationships between service users and the community, sharing power and responsibility, meeting individual and community needs by being sensitive to values, preferences and expressed needs, coordinating and integrating care and support by service providers and an environment conducive to person-centred care for providers and service users.
Evidence-based and evidence-informed decision making and action	Evidence-based decision making founded on a shared understanding of community need and priorities and – where possible – the range of evidence-based (or evidence-informed) interventions that are available.
Cross-sector partnerships	Striving for seamless service delivery throughout the consumer journey across health and relevant non-health sectors.
Accountable governance	Effective and accountable leadership and facilitation. Transparent, accountable and responsive. Shared commitment to and participation in addressing health inequities in partnerships across health (public and private) and non-health sectors.
Wellness focus	Holistic focus on prevention, early intervention and wellness.
Sustainability	Efficient and effective use of resources, including optimum use of technology where it is available and cost effective.

Primary Care Partnership priority areas

Maximising the health of Victorians requires consolidated action targeting statewide priorities. This will strengthen the primary health system as well as empower individuals to live a healthy lifestyle.

In order to maximise impact across the state, the significant majority of PCP work in 2013–17 must be focused on one to two locally identified early intervention and integrated care priorities and one to two prevention priorities. At least one of the PCP early intervention and integrated care priorities must include a disease that is major and chronic in Victoria (as identified in Table 1).

The PCP prevention priorities must be selected from the priorities identified in the *Victorian public health and wellbeing plan 2011–2015* (refer to Table 1). When identifying prevention priorities, PCPs should consider alignment with local municipal public health and wellbeing plan priorities, their selected early intervention and integrated care priorities, target groups, population health data and what is important to the communities within the PCP catchment.

PCPs will continue to retain discretion (in consultation with their Department of Health region) to direct a small proportion of their work to an additional regional priority, where applicable. Examples of regional priorities may include family violence, social inclusion or problem gambling.

All PCP action must embody the seven PCP guiding principles identified earlier and target locally identified priority disadvantaged[2] or marginalised[3] groups for each priority.

Table 1: Statewide PCP priorities

PCP early intervention and integrated care priorities	PCP prevention priorities
• **Major chronic diseases in Victoria**[4] – Arthritis – Heart disease – Cancer – Osteoporosis – Stroke – Diabetes – Depression or anxiety – Respiratory conditions (including COPD and asthma) – Renal conditions • **Service coordination priorities** (for example, referral pathways or coordination of services for a particular target group)	• Healthy eating • Physical activity • Tobacco control • Oral health • Alcohol and drug use • Sexual and reproductive health promotion • Mental health promotion • Injury prevention • Skin cancer prevention
Target group: Locally identified priority disadvantaged or marginalised groups such as Aboriginal and Torres Strait Islander peoples, refugees, asylum seekers, vulnerable children, people experiencing homelessness or people with an intellectual disability	

[2] Community disadvantage occurs due to the complex interplay between the characteristics of residents living in a community (for example, unemployment or low income) and the effects of the social and environmental context within the community (for example, weak social networks, relative lack of opportunities, geography and so on). A number of new perspectives have recently emerged that highlight the multifaceted nature of disadvantage and demand a more sophisticated response to it. People who experience variables of community disadvantage include people on low incomes, people who do not speak English well, Aboriginal and Torres Strait Islander peoples, people who are homeless or at risk and people with limited education.

[3] People may be marginalised by virtue of their social exclusion, disempowered as a result of a lack of resources or vulnerable on account of mental illness or other issues. Examples of marginalised communities include people living in rural or outer metropolitan areas, vulnerable women or children, refugees, asylum seekers, sex and gender-diverse people or injecting drug users.

[4] *Victorian health priorities framework 2012–2022: rural and regional health plan*, *Victorian health priorities framework 2012–2022: metropolitan health plan*

Primary Care Partnership program logic 2013–17 domains

The PCP program logic for 2013–17 has three integral domains:

1. Early intervention and integrated care
2. Consumer and community empowerment
3. Prevention

It is expected that PCPs apply comparatively equal action across all domains.

These domains are supported by six enablers:

- Governance
- Partnerships
- Workforce
- Consumer and community engagement
- E-health
- Continuous quality improvement

Program logic domain 1: Early intervention and integrated care

Objective

To strengthen the primary health system to deliver person-centred and accessible early intervention and integrated care that aims to keep people as well as possible for as long as possible, particularly people with complex care needs

Strategies, indicators and enablers

Strategies	Accountability indicators
Work with member organisations and Medicare Locals to strengthen integration and communication practices among providers (including between state-funded and private providers) to facilitate consumer transitions between services and reduce the need for consumers to retell their stories Facilitate advancement of *Victorian service coordination practice manual 2012* implementation to broader health and wellbeing agencies	• Number of member organisations with guidelines and expectations for shared care plans including referral, monitoring, transition and identification of a care/case coordinator • Number of member organisations that demonstrate evidence of communication regarding the shared care plan of consumers with multiple or complex care needs, with general practitioners (GP) • Number of member organisations that communicate referral outcomes to referring GPs • Number of member organisations that respond to all of the issues of consumers (identified at Initial Needs Identification) with appropriate action • The percentage of consumers whose issues (identified at Initial Needs Identification) have all been responded to with appropriate action
Work with member organisations to identify and address access barriers, particularly for the identified local priority group	• Improvement against the key domains of the Assessment of Chronic Illness Care (ACIC) Survey – *Integration of Chronic Care Model components scale – Organisational planning for chronic illness care* (additional item)
Develop and implement local agreements for care planning, care coordination and case conferencing to ensure systemic care planning (including e-care planning) within and across organisations	• Number of member organisations that have a shared care plan in place with consumers using their services • Improvement against the key domains of the ACIC Survey – *Integration of Chronic Care Model components scale*
Facilitate implementation of local agreements and systematic interagency care pathways for defined consumer cohorts using evidence-based guidelines	• Number of member organisations that have a shared care plan for consumers with multiple or complex care needs who are using their services • The percentage of consumers with multiple or complex needs with a shared care plan • Improvement against the key domains of the ACIC Survey – *Integration of Chronic Care Model components scale* and *Organisation of the healthcare delivery system scale* • **Optional stretch measure**: Number of member organisations that have high-quality shared care plans for the consumers using their services (as defined by the Victorian Healthcare Association criteria listed in the *Victorian service coordination practice manual 2012*, p. 30).

Facilitate development and implementation of a robust identification and recall system for people with complex and multiple needs for review and quality control	• Improvement against Part 3c of the ACIC Survey regarding systems for patient follow-up • Improvement against key domains of the ACIC Survey – *Delivery system design scale* and *Clinical information systems scale*
Facilitate continued system improvements for early identification and intervention for priority target groups	• Improvement against Part 3d of the ACIC Survey regarding maintenance of registries of patients with specific conditions
Continue to strengthen e-health initiatives	• Increase in the number and type of agencies participating in e-referral • Increase in the number of e-referrals sent • Increase in the number of e-referrals received • E-care planning data (localised to those areas where e-care planning projects have been implemented) • **Optional stretch measure**: Percentage of the total referrals for an organisation that are e-referral

Enablers
Workforce
Continually identify, promote and action opportunities to link organisations with relevant workforce initiatives across government and across jurisdictions to build capacity in service coordination, integrated disease management and integrated health promotion
E-health
Strengthen local e-health initiatives that support improved quality of service coordination practices and efficiencies, including increased e-referral and e-care planning
Support and encourage agencies to work with vendors to ensure that service coordination tool templates (SCTT) technical and functional specifications are adopted and that SCTT 12 is embedded in client management software in a timely fashion
Support and encourage e-referral vendors to improve reporting functionality that assists organisations to measure and monitor their service coordination practice, including their e-referral and emerging e-care planning practice
Continue to monitor alignment with national e-health policy initiatives
Partnerships
Maintain a strong culture of collaboration among member agencies including formalising agreements with Medicare Locals to improve communication and avoid duplication of effort.
Work with agencies in a collaborative way to mobilise member agencies to achieve PCP outcomes
Continuous quality improvement
Maintain a strong culture among member agencies of ongoing review, quality improvement and rigorous evaluation contributing to the evidence base in their work

Department of Health actions

• Continue work to implement the Victorian Community Health Indicators and investigate potential outcome indicators for work with consumers with chronic conditions
• Make Victorian Community Health Indicators available to PCPs to promote continuous quality improvement and monitor the implementation of good practice
• Where available, support implementation of the Chronic Care Model including shared care planning, care coordination and case conferencing
• Provide technical resources that support the implementation of SCTT into client information management systems
• Continue to monitor alignment with national e-health policy initiatives
• Biennial support to the Service Coordination and ICDM Survey – analysis and reporting back to PCPs
• Facilitate implementation of an annual integrated chronic disease management forum
• Support a PCP interface with Medicare Locals

Available resources

• *Victorian service coordination practice manual 2012* available at <www.health.vic.gov.au/pcps/coordination/ppps.htm>
• SCTT and user guide available at <www.health.vic.gov.au/pcps/sctt.htm>
• SCTT online training module
• Workforce capacity-building resources available at <www.health.vic.gov.au/pcps/workforce/index.htm>
• PCP integrated chronic disease management resources available at <www.health.vic.gov.au/pcps/coordination/icdm.htm>
• Statewide PCP *Integrated Chronic Disease Management Network induction package* available from <www.vicpcp.org.au/sites/default/files/Statewide%20PCP%20ICDM%20induction%20package_August%202013.pdf>

Program logic domain 2: Consumer and community empowerment

Objective

For consumers, carers and community members to be meaningfully involved in decision making about health planning, care and treatment and the wellbeing of themselves and the community

Strategies, indicators and enablers

Strategies	Accountability indicators
Support implementation of person-centred models of care that incorporate self-management support and goal-directed shared care planning across the health and wellbeing continuum	• Improvement against the key domains of the ACIC Survey
Support member organisations to implement strategies that build consumers' capacity to engage with services (including health literacy)	• Number of member organisations where consumers receive a copy of their shared care plan • Improvement in the Patient Assessment of Chronic Illness Care (PACIC) Survey
Encourage regular updates of information in the National Health Services Directory by PCP member agencies and promote the use of the National Health Service Directory across the PCP catchment	• PCP member organisation details in the National Health Service Directory are current and complete
Action improvements identified to improve the consumer journey for the local target group	• Improvement in the PACIC Survey
Enablers	
Consumer and community engagement in service system planning and design	
Support further implementation of the 'Doing it with us, not for us' initiative with a particular focus on fostering consumer involvement in planning and service development	
Facilitate service system planning and design that is integrated, collaborative and across the health spectrum (down, mid and upstream) and across life stages in ways that engage members and communities at all levels, from the system level to the consumer level	
Workforce	
Support member agencies to improve their understanding of person-centred approaches (including health literacy and self-management support) to tailor interventions for identified local priority groups	

Department of Health actions

• Revise the Department of Health *Doing it with us, not for us: strategic direction 2010–13* document
• Finalise the guidelines for the Community Health Integrated Program
• Continue work on a consumer experience survey to be completed by consumers of primary healthcare services that will reflect their experiences with individual services as well as the system as a whole
• Continue work to enhance health literacy, particularly among disadvantaged and marginalised groups

Available resources

• National Health Services Directory
• *Doing it with us, not for us: strategic direction 2010–13*

Program logic domain 3: Prevention

Objective

To work with Victorians, particularly with the most disadvantaged, to maximise their health and wellbeing, reduce the prevalence of risk factors and increase prevalence of protective factors through focusing on local partnership priority health and wellbeing issues

Strategies, indicators and enablers

Strategies	Accountability indicators
Support greater integrated health promotion planning and integration with local government and other key agencies (including Medicare Locals)	• Demonstration that partners identified in plans align with identified prevention priorities • Demonstrate that catchment-wide plans (for example, municipal health and wellbeing plans and community and women's health integrated health promotion plans) reflect collaboration on consolidated and agreed priorities
Implement collaborative practices that deliver evidence-based integrated health promotion	• Prevention priorities align with Victorian priorities
Consolidate primary and secondary prevention activities in line with identified Victorian priorities and local municipal public health and wellbeing plans	• Demonstrate that catchment-wide plans (for example, municipal health and wellbeing plans, community and women's health integrated health promotion plans) reflect collaboration on consolidated and agreed priorities
Systematic use of integrated health promotion indicators	• Integrated health promotion planning and reporting demonstrate the systematic use of integrated health promotion impact indicators
Enablers	
Workforce	
Continually identify opportunities to link organisations with relevant workforce initiatives to build capacity in service coordination, integrated disease management and integrated health promotion	
Continuous quality improvement	
Foster a strong culture among member agencies of ongoing review, quality improvement and rigorous evaluation embedded in their work and contributing to the evidence base	
Consumer and community engagement	
Develop and implement systems for engaging the community in integrated health promotion efforts	

Department of Health actions

Compile and disseminate examples of good and best practice
Explore and implement, as required, ways to support best practice integrated health promotion practice

Available resources

• *Integrated health promotion resource kit* available from <docs.health.vic.gov.au/docs/doc/7C621D9AC5801EEECA257A7F002166E7/$FILE/ihp_section5.pdf>
• Integrated health promotion indicators

Appendix 1: Terminology

ACIC	See Assessment of Chronic Illness Care
Assessment of Chronic Illness Care	A validated tool that covers the basic elements for improving chronic illness care at the community, organisation, service and consumer level. For further information please visit <www.improvingchroniccare.org/index.php?p=ACIC_Surveyands=35>.
Assessment	A decision-making methodology that collects, weighs and interprets relevant information about the consumer. Assessment is not an end in itself but part of a process of delivering care and treatment. It is an investigative process using professional and interpersonal skills and in-depth enquiry to identify relevant issues that will guide a responsive intervention.
Care planning	A dynamic process that incorporates a range of activities such as care coordination, case management, referral, feedback, review, reassessment and monitoring. Care planning involves the judgement or determination of relative need as well as competing needs and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.[5]
Carer	Carers provide unpaid support to a family member or friend who needs assistance. They may care for a frail aged person, someone with a disability, chronic illness or mental illness, or someone recovering from an illness or accident.[6] Carers help people to remain living at home. The caring experience is a dynamic one with the level of support offered by carers changing in relation to the dependency and health needs of the care recipient.
Consumer journey	Priorities for an improved service system response include reviewing, defining and improving care pathways. This work includes assessing the consumer journey (or consumer flow through the system) and identifying strengths, weakness, possible gaps, areas of duplication and opportunities for improvement.
Continuous quality improvement	A tool for improving the quality of services provided by organisations using a systematic approach to collect and review data or information in order to identify opportunities to improve the operations of an organisation, with the end result of delivering better services to consumers.[7] Continuous quality improvement practice includes the use of tools and techniques to identify opportunities for improvement, action planning, measuring and monitoring improvements, empowering staff to identify opportunities and using a multidisciplinary approach to solve problems and take action. Continuous quality improvement is consumer centred, driven by evidence and organised for safety.
Cultural responsiveness[8]	Being respectful of and relevant to the beliefs, practices and culture needs of the community. It describes the capacity to respond to the issues and needs of Aboriginal and Torres Strait Islander peoples and people of culturally diverse backgrounds. Awareness is only a first step. What matters is how organisations and individuals within organisations behave as a result of that awareness. Organisations will have processes and systems in place if they are to achieve cultural change that is embedded in everyday behaviour. Cultural awareness, sensitivity and competence are building blocks; cultural responsiveness is the desired outcome.

[5] www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

[6] www.carersvictoria.org.au/facts/who-are-carers

[7] www.health.gov.au/internet/publications/publishing.nsf/Content/oatish-accreditation-manual_toc~sn1%3Aterms_definitions~cont-qty-improvement

[8] www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

Disadvantaged populations	Disadvantaged populations in both higher and lower income countries suffer a disproportionate share of the disease burden and are often poorly served by existing health systems.[9] Community disadvantage occurs due to the complex interplay between characteristics of residents living in a community (for example, unemployment or low income) and effects of the social and environmental context within the community (for example, weak social networks, relative lack of opportunities, geography and so on). People who experience variables of community disadvantage include people on a low income, people who do not speak English well, Aboriginal and Torres Strait Islander peoples, people who are homeless or at risk and people with limited education.
Discharge, transition and exit	As services are goal orientated and time bound, there must be a point when discharge or exit is considered. Ensuring safety and effective management of ongoing care needs is essential. The process of discharge or exiting involves ensuring the consumer is at a point where they are able to manage their current and ongoing care needs through self-support or additional support. This should occur in a partnership with the consumer, carer, family and relevant additional service providers. A planned approach to discharge and exit is essential to ensure a smooth, coordinated transition from service provision. If indicated, recall pathways should be implemented prior to discharge from service. Transition to additional care providers can assist the consumer with independent living with effective self-management skills. Exiting can occur at any stage of service provision. Discharging consumers assists with throughput and access for new consumers. Further information on discharge, transition and exit can be found in the *Health independence programs guidelines* available from <www.health.vic.gov.au/subacute/hip-manual08.pdf>.
E-health[10]	The transfer of health resources and healthcare by electronic means. It encompasses three main areas: • the delivery of health information for health professionals and health consumers through the Internet and telecommunications • using the power of information technology and e-commerce to improve public health services, for example, through the education and training of health workers • using e-commerce and e-business practices in health systems management. E-health provides a new method for using health resources, such as information, money and medicines, and should help to improve efficient use of these resources over time.
Evidence-based practice	The use of information derived from formal research and systematic investigation to identify causes and contributing factors to health needs and the most effective actions to address these in given contexts and populations.
Evidence-Informed practice	An approach that aims to ensure that decision making is well informed by the best available research evidence. It is characterised by systematic and transparent access to, and appraisal of, evidence as an input into practice.
Exit or discharge information	Communication to the referring clinician about the outcomes of the consumer's episode of care to support that clinician to effectively manage the consumer's care.

[9] www.georgeinstitute.org.au/focus-areas/disadvantaged-populations

[10] www.who.int/trade/glossary/story021/en/

General practice	Provides primary medical care and may include GPs, practice managers, practice nurses and other allied health services.
Goal-directed care planning	See Shared care plan
Guiding principles for PCPs	Values and principles that PCPs apply and reflect throughout all action, irrespective of changes in its goals, strategies, type of work or staffing. The PCP guiding principles are articulated in this document.
Health continuum: upstream, midstream and downstream interventions	Interventions to maximise health may be categorised by their approach to addressing the 'upstream,' 'midstream,' or 'downstream' determinants of health.[11] **Upstream interventions** include reform of fundamental social and economic structures and involve mechanisms for addressing the determinants of health, for example, the redistribution of wealth, power, opportunities and decision-making capacities. Upstream interventions typically involve structural and system-level changes. **Midstream interventions** seek to reduce risk factors and associated risky behaviours by influencing health behaviours or psychosocial factors or by improving material working and living conditions. Midstream interventions generally occur at the community or organisational level. **Downstream interventions** occur at the micro or individual level and mitigate the inequitable impacts of upstream and midstream determinants through delivery of accessible and responsive healthcare services. Adapted from National Collaborating Centre for Determinants of Health 2012, *Assessing the impact and effectiveness of intersectoral action on the social determinants of health and health equity: an expedited systematic review*, St. Francis Xavier University, Antigonish, NS. Available from <nccdh.ca/images/uploads/ISA_Report_EN1.pdf>.
Health literacy	'… the cognitive and social skills which determine the motivation and ability of individuals to access, understand and use information in ways which promote and maintain good health. Health Literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment'.[12]
Health promotion	The *Ottawa charter for health promotion* (1986) defines health promotion as '…the process of enabling people to increase control over and to improve their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and realise aspirations, to satisfy needs and to change or cope with the environment. Health is, therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing'.[13]

[11] John McKinlay first used the 'health river' analogy in an address to the American Heart Association in 1974 (Cypress 2004:249). He described a rapidly flowing river representing illness and argued that health professionals were so caught up in rescuing victims from the river that they had no time to look upstream to see who was pushing their patients in. McKinlay also described his frustration with the 'downstream endeavours' – which he characterised as short-term, problem-specific, individual-based interventions and challenged health professionals to refocus and look upstream, where the real problems lie (Cypress 2004:249). The phrase 'looking upstream' is now a familiar term related to preventive healthcare and population health. However, population health recognises that an 'upstream' orientation does not diminish the importance of delivering quality, affordable and timely health services downstream, or addressing behavioural risks such as smoking and physical inactivity (which are categorised as midstream actions). Rather, this upstream shift in focus has the potential to lessen the burden on these critical services.

[12] World Health Organization <www.who.int/healthpromotion/conferences/7gchp/track2/en>.

[13] World Health Organization 1986, *The Ottawa charter for health promotion*, World Health Organization, Geneva.

Inequity and inequality	Health inequalities are differences in health status or in the distribution of health determinants between different population groups, for example, differences in mobility between elderly people and younger populations. It is important to distinguish between inequality in health and inequity. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second case, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so the resulting health inequalities also lead to inequity in health.[14]
Initial Needs Identification	A brief, broad screening process to uncover underlying issues and presenting issues. It is not a diagnostic process but an identification of the consumer's risk, eligibility and priority for service.
Integrated chronic disease management[15]	Integrated chronic disease management includes the following: • planned and proactive care intended on keeping people as well as possible, rather than responding to an illness • empowering, systematic and coordinated care that includes regular screening, support for self-management and assistance to make lifestyle and behaviour changes • care that is provided by a range of health services and practitioners (for example, GPs, podiatrists, physiotherapists, counsellors, dieticians, nurses, specialists and dentists) • care that is provided over time through the stages of disease progression.
Integrated health promotion	Refers to agencies and organisations from a wide range of sectors and communities in a catchment (local area) working in collaboration using a mix of health promotion interventions and capacity-building strategies to address agreed priority health and wellbeing issues. To achieve effective integrated health promotion program delivery in the current Victorian context, the following points should be considered: • effective partnerships • a mix of interventions and common planning frameworks • a broad range of sectors. PCP integrated health promotion is focused on system-level integrated health promotion activities incorporated into the role of Primary Care Partnerships and its member agencies.
Integrated health promotion indicators	For further information, please see *Integrated health promotion evaluation planning framework 2010–11 to 2011–12* available for download from <docs.health.vic.gov.au/docs/doc/9CF1F628F2BE470FCA257A7F0022825E/$FILE/measuring_hp_impacts.pdf>
Interagency care pathways	Interagency care pathways are disease-specific, for example, for diabetes. The adoption of disease-specific care pathways ensures that consumers get appropriately targeted care regardless of where they enter the service system.
Local agreements	An agreement reached by key stakeholders within a given local area. The purpose of the local agreement is to bring together key stakeholders to ensure consistent and appropriate strategies and approaches are employed to address common issues and to minimise duplication and service gaps.

[14] www.who.int/hia/about/glos/en/index1.html

[15] www.health.vic.gov.au/pcps/coordination/icdm.htm

Marginalised populations	People may be marginalised by virtue of social exclusion, disempowered as a result of a lack of resources or vulnerable on account of mental health or other issues.[16] Examples of marginalised populations include communities in rural or outer metropolitan areas, vulnerable women or children, refugees, asylum seekers, sex and gender-diverse people or injecting drug users.
Medicare Locals[17]	As part of national health reform the Australian Government established Medicare Locals. Medicare Locals have been tasked with improving coordination and integration of primary healthcare in local communities, addressing service gaps and making it easier for consumers to navigate their local healthcare system. Medicare Locals should reflect their local communities and healthcare services in the composition of their governing bodies, which will include consumers, doctors, nurses, allied health services and state-funded community health providers.
PACIC	See Patient Assessment of Care for Chronic Conditions
Patient Assessment of Care for Chronic Conditions	A validated tool that measures specific actions or qualities of care – congruent with the Chronic Care Model – that patients report they have experienced in the delivery system. The survey includes 20 items and should be sufficiently brief to use in many settings. For further information on the PACIC, please visit <www.improvingchroniccare.org/index.php?p=PACIC_surveyands=36>.
Partnership assessment tools	PCPs will be required to adopt a quality improvement approach to plan their strategic partnerships for the planning cycle in line with their identified priorities using the VicHealth or the Centre for the Advancement of Collaborative Strategies in Health partnerships evaluation tool. PCPs will be required to report annually on their current strategic partnerships based on the plan. Further information on these tools can be accessed from <www.health.vic.gov.au/pcps/partnerships>.
PCP	See Primary Care Partnership
Person-centred care	Treatment and care provided by health and community services that places the person at the centre of their own care and considers the needs of the person's carer as well.[18] It involves considering the needs of the person receiving care and treating them as a person (rather than just a consumer or a patient) and offering them respect similar to that you would like to receive. It is also about recognising strengths and capacities rather than shortcomings or limitations and involves: • building relationships between service users and the community • sharing power and responsibility • meeting individual and community needs by being sensitive to values, preferences and expressed needs • coordinating and integrating care by service providers • an environment conducive to person-centred care for providers and service users.[19]

[16] Buck A, Curran L 2010, 'Delivery of advice to marginalised and vulnerable groups: the need for innovative approaches', *Public Space: The Journal of Law and Social Justic*e, vol. 3, no. 7. pp. 1–29.

[17] www.medicarelocals.gov.au/internet/medicarelocals/publishing.nsf

[18] www.health.vic.gov.au/older/toolkit/02PersonCentredPractice

[19] For further information visit <www.health.vic.gov.au/older/toolkit/02PersonCentredPractice/docs/Guide%20to%20implentating%20Person%20centred%20practice.pdf>.

Primary Care Partnership[20]	Catchment-based partnerships among health and allied services to improve access to services and continuity of care for people through improved service coordination as well as chronic disease prevention, integrated health promotion and partnership development. PCPs are made up of a diverse range of member agencies. All PCPs include hospitals, community health, local government and Medicare Locals as core members of the partnerships. Other types of agencies such as area mental health, alcohol and drug treatment and disability services are also members of PCPs. The partners can also be specific to local issues and needs. For example, some PCPs have engaged with the police, schools and community groups.
Prevention – primary and secondary prevention[21]	Primary prevention refers to activities that aim to prevent health problems in whole populations before they occur (reduce incidence), for example, tobacco control regulation, health promotion campaigns, fluoridation and immunisation. Secondary prevention refers to population-based activities that aim to identify precursors to, and early signs of, illness when treatment can be most effective and supported by clear referral pathways, for example, using screening programs to test healthy but high-risk populations to identify individuals who have a disease but do not yet have any symptoms.
Recall and reminder system	A systematic approach to ensure that consumers are flagged for and reminded about routine and other planned follow-up episodes of care.
Referral[22]	The transmission, with consent, of a consumer's information from one service provider to another for the purpose of further assessment or service provision. Referral can occur at, or result from, any stage of the service coordination process.
SCTT	Service coordination tool templates. For further information visit <www.health.vic.gov.au/pcps/coordination>.
Self-management[23]	The consumer (and their family or carers as appropriate) working in partnership with their service provider to: • know their condition(s) and various options • negotiate a plan of care • engage in activities that protect and promote health • monitor and manage the symptoms and signs of their condition(s) • manage the impact of their condition(s) on physical functioning, emotions and interpersonal relationships.
Self-management support	The care and encouragement provided to people with chronic conditions and their families to help them understand their central role in managing their illness, make informed decisions about care and engage in healthy behaviours.[24] Self-management support may be provided through a range of strategies and approaches – individual and group based, face to face or by phone, as part of clinical intervention or as a separate interaction with the person with a chronic disease. It includes provision of information, but also assistance in practical application of health information in the individual context through goal setting and problem solving. Self-management support is not just an intervention, it is a philosophical approach to working in partnership with people with a chronic condition.

[20] www.health.vic.gov.au/pcps/about/index.htm

[21] docs.health.vic.gov.au/docs/doc/Victorian-Public-Health-and-Wellbeing-Plan-2011–2015

[22] www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

[23] www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

[24] www.improvingchroniccare.org/index.php?p=self-management_supportands=39

Service coordination	Service coordination aims to place consumers at the centre of service delivery – ensuring that they have access to the services they need, opportunities for early intervention and health promotion and improved health outcomes. The practice of service coordination particularly supports more effective ways of working with people with complex and multiple needs. For example, it provides a good foundation for the practice of integrated chronic disease management. 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.
SCTT shared support plan	The SCTT shared care planning template. For a definition of a shared care plan, please see Shared care plan.
Shared care plan	A shared care plan is required when a consumer has numerous issues that require the coordinated support of multiple program areas from within and among organisations. It shows who is involved in the consumer's care, the main issues, consumer goals, planned actions and who is responsible. Documenting consumer goals assists all the service providers involved in their care to work towards a common goal.
Shared care planning	Shared care planning is required when the consumer has numerous issues that require the coordinated support of multiple program areas from within or between organisations. Service assessments and service-specific shared care plans will inform the shared care planning process. More information about shared care planning can be found in the *Victorian service coordination practice manual 2012*, available at <www.health.vic.gov.au/pcps/downloads/sc_pracmanual2>.
Social determinants of health	The range of personal, social, economic and environmental factors that determine the *health status* of individuals or populations. The factors that influence health are multiple and interactive. *Health promotion* is fundamentally concerned with action and *advocacy* to address the full range of potentially modifiable determinants of health – not only those factors that are related to the actions of individuals, such as *health behaviours and lifestyles*, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services and the physical environment. In combination, these factors create different *living conditions* that impact on health. Achieving change in the lifestyle factors and living conditions that determine health status are considered to be *intermediate health outcomes* (World Health Organization).
Transition	See Discharge, transition and exit
Victorian service coordination practice manual 2012	The *Victorian service coordination practice manual 2012* has been developed as a reference guide for managers responsible for leading and managing service coordination and for practitioners involved in the implementation of service coordination. The purpose of the manual is to define practices that support Victorian service providers to work together in a coordinated way to give consumers a streamlined and integrated response.
Vignette	A short piece of writing that depicts a short 'scene' capturing some key changes resulting from PCP action in the specified domain. It may be useful to explore the question 'What would a community member with a priority condition or issue experience?'.
Wellness	Wellness is the optimal state of health of individuals and groups. There are two focal concerns: the realisation of the fullest potential of an individual physically, psychologically, socially, spiritually and economically, and the fulfilment of one's role expectations in the family, community, place of worship, workplace and other settings (World Health Organization).