

Inner East Primary Care Partnership
Strategic Directions 2009 - 2012 (revised June 2011)



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1. The IEPCP Vision and Mission

Our vision is for Melbourne's inner east community to experience high levels of wellbeing with excellent health and wellbeing outcomes:

- For an *individual and the community*, this means a **larger variety of health and wellbeing needs are being met, with greater ease in accessing and navigating the service system;**
- For the *service system*, it means **greater seamlessness;**
- For the *IEPCP member organisations* it means **greater capacity, opportunity, efficiency and better outcomes along with community and staff satisfaction.**

The IEPCP proposes achieving this through system and practice-level change, with a clearly defined role as *partnership facilitator or network orchestrator and capacity builder*.

Our strategy is an overall approach, based on an understanding of the broader context in which we function, external threats and opportunities, our internal strengths and weaknesses, and the problems we are attempting to address. This strategy gives IEPCP a framework within which to work, it clarifies what we are trying to achieve and the approaches we intend to use. It does not spell out specific activities.

2. Why a Catchment Approach?

Many factors are driving health planning and delivery towards a catchment or areas-based approach:

- Limited resources;
- Increasing service demands;
- Greater emphasis on evidence based practice;
- More embedded and connected technologies;
- Greater diversity of participants having objectives in common;
- Social determinants increasingly proven to impact health outcomes;
- Prevention and early intervention impacting disease prevalence;
- Greater end-user self determination and health literacy;
- Increase in number of 'non-local', catchment wide services;
- Funders looking for efficiencies derived from partnership approaches.

A catchment approach means that:

- Resources can be shared, combined, prioritised and directed more efficiently and effectively;
- Partners benefit in moving from a competitive to collaborative approach;
- 'Common' key messages can be consistently propagated by service deliverers;
- Multi-agency advocacy is more likely to be effective.

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3. Signals from our environment

Health and social services are delivered in an increasingly complex environment. This table uses PESTLE Analysis as a strategic diagnostic tool that explores the political, economic, social, technological, legal and environmental factors likely to impact the IEPCP. The use of this tool assists IEPCP to understand the external environment in which IEPCP operates now and in the future and to consider this in planning and prioritising strategic direction and priorities.

<p>Political</p> <ul style="list-style-type: none"> National Primary Health Care Reforms Advent of Medicare Locals Victorian Health Priorities Framework 2012-2022 Change in State Government Departmental requirements for robust governance structures 	<p>Economic</p> <ul style="list-style-type: none"> Future PCP funding after 2012 uncertain Economic impacts of Global Financial Crisis 	<p>Social</p> <ul style="list-style-type: none"> Growth in populations Growth in ageing population (65 years+) Increasing cultural diversity Increasing health literacy Increasing demands for self management & decision-making Increasing complexity of chronic diseases Increasing pockets of social exclusion & disadvantage
<p>Technological</p> <ul style="list-style-type: none"> More technology based 'connectedness' E-Health policies 	<p>Legal</p> <ul style="list-style-type: none"> PCPs non-legal, unincorporated entities Unable to manage financial matters in own right Unable to enter into legal contracts or agreements in own right 	<p>Environmental</p> <ul style="list-style-type: none"> Effects of climate change Increasing awareness of built environment effects on health and wellbeing Pressure on affordable housing Changes in urban planning and infrastructure investment
<p>Service Providers</p> <ul style="list-style-type: none"> Mix of public/private Increasing range Practitioner culture shifts and multi-disciplinary skills mix Increasing need for care coordination and collaboration Greater fusion between 'health' and 'community' providers 		

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4. Integrated approaches to solve complex health & social problems

The complexity of contemporary health care systems generates what is known as 'wicked problems'. One way to address these 'wicked problems' is by using an integrated approach to problem-solving.

'Wicked problems':

- Are difficult to define;
- Are multi-layered, interdependent & multi-causal;
- Have no clear, single solution;
- Are socially complex;
- Rarely sit conveniently within the responsibility of a single agency or organisation;
- Require solutions involving large-scale behaviour & systems change;
- Are often characterised by chronic & compounding policy failures.

To solve these, new ways of thinking are required of organisations and consortia. These include:

- Working collaboratively to form shared outcomes;
- Recognising a minimal set of 'leverage points' which when activated, will make the biggest difference through synergy;
- Context design, that is, a focus on the system not on the content of the system;
- Finding 'beacons on hilltops', that is, models of existing success in difficult areas;
- Co-creation, which is utilising the resourcefulness of partners in planning, delivery and evaluation processes;
- Inclusivity, which is factoring in all variables (financial costs, opportunity costs, downstream social effects).

5. The reform agenda(s)

The primary health care reform agenda is progressing at both a State and Federal level. Significant structural change is anticipated through the advent of Medicare Locals and Local Hospital Networks over the remaining life of this document. Common features, although widely argued and still unknown at time of revision, are likely to be:

- Greater emphasis on health & wellness promotion, illness prevention & early intervention;
- Higher degrees of community engagement and individual self-management ('prosumers');
- Population health approaches informing planning, funding and outcome evaluation;
- More holistic needs assessments as a basis for 'whole of life' care planning;
- Revised health & social service 'gate-keeping' arrangements;
- Increasing choice in service levels, type and locations';
- Proactive outreach to 'difficult to reach' populations;
- Flexible delivery by multi-disciplinary teams;
- Enrolled primary health populations (voluntarily or otherwise);
- Stronger linkages between providers (mandated or otherwise);
- Increasing technology/e-health enablers.

Changes to the Primary Care Partnership platform may result from these reforms requiring variation to this plan. Written within the context of the IEPCP, this document represents a commitment by partner organisations to continue to address agreed priorities 2011-2012.

6. Our 3 Strategic Priorities

Every organisation must focus its efforts in areas where its resource limits are most fertile. The IEPCP takes into account broad environmental variables local social and health/wellbeing needs, our existing service system (see Section 7) and the potential directions suggested by current primary care reforms (see Section 5). Our collective work remains focussed on the three distinct yet inter-related priority areas identified in the initial version for the remainder of the 2009-2012 periods, benefiting those people:

1. Who have complex and chronic conditions;
2. Who are ageing;
3. Who experience poor mental health.

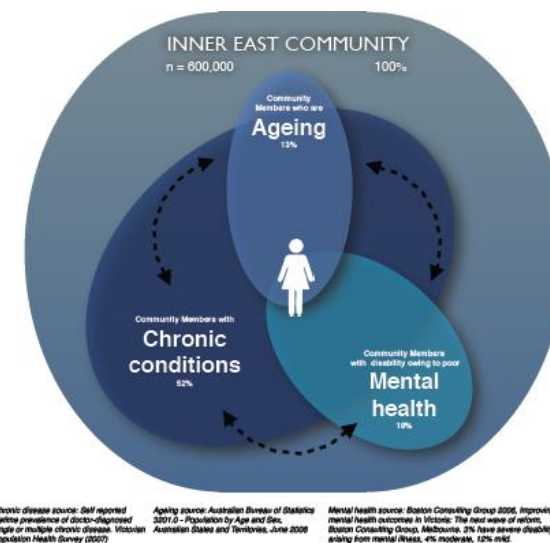
Additional priorities for the 2011-2012 period linking to the above include people:

4. Who experience social isolation;
5. Who are at risk of family violence;
6. Who are at risk of falls related injury;
7. Who are at risk of Elder Abuse;
8. Who are impacted by problem gambling.

These priorities remain the points of greatest leverage for a catchment-wide, collaborative multi-agency approach as evidenced by the population health and wellbeing data for the Eastern Metropolitan Region attests including;

- People aged 65+ are expected to grow in numbers by 34% to 2022;
- Major disease categories (Disability Adjusted Life Years by major disease category 2001) are malignant cancers, cardio-vascular disease, mental disorders, neuro-sensory disorders, Chronic Respiratory diseases, Injuries and Diabetes Mellitus
- There are pockets within the communities in the IEPCP catchment that are more sedentary, have higher smoking levels, lower levels of recommended fruit and/or vegetable daily intakes, and/or higher levels of overweight/obesity particularly in males than Victorian averages.

All IEPCP partners provide services in one or more of these priority areas. As strategic planning is an iterative process, this list does not imply IEPCP is not open to other areas of interest put forward by its member organisations, funding bodies, communities or policy makers. IEPCP continues to pursue opportunities for identifying and addressing health and wellbeing needs within the catchment and regionally. The success of IEPCP's work remains contingent on engagement from a wide variety of sectors and stakeholders where resources can be allocated to solve relevant 'wicked problems' for mutual benefit.

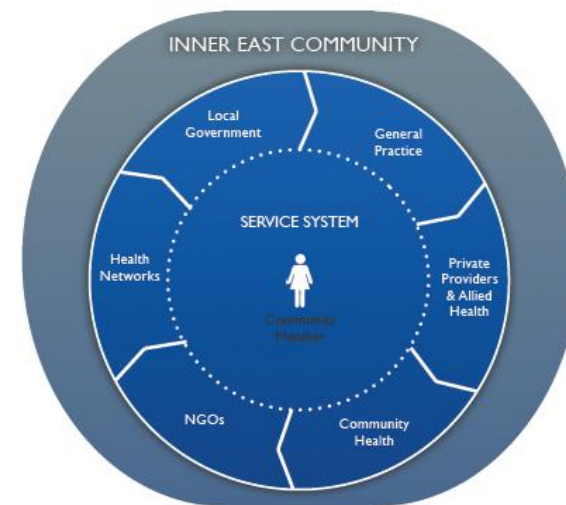


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7. The inner east's service system

The value chain of health care providers and social services in Melbourne's inner east exists within our community of 600,00 people. It is necessarily complex, made up of:

- 4 local government authorities (Manningham, Monash, Boroondara and Whitehorse);
- Several relevant commonwealth and state government regional departments;
- 4 community health services;
- 2 Divisions of General Practice;
- 2 acute health networks which operate hospitals and community-based services;
- A wide range of community, welfare, disability & other non-government organisations



Relationships established within the PCP model vary in terms of the formality of arrangements and how activities or functions are shared or integrated. The most common relationships are illustrated in the following 'continuum of collaboration' diagram:

	COOPERATING	COORDINATING	COLLABORATING	INTEGRATING
DESCRIPTION	Informal structures, processes & relationships. A more fragmented service system. Loose links.			Formal structures, processes & relationships. A more integrated service system. Tight links.
	A form of friendly coexistence.	Some formal relations but each agency maintains its own set of goals, structures and accountability.	Partnership formation that is characterized by mutual benefit, interdependence and a formal commitment to working together for specific purposes.	The coming together of structure, goals and responsibility of being accountable to each other.
FORM	<ul style="list-style-type: none"> • Information sharing • Interagency networks • Ad hoc meetings 	<ul style="list-style-type: none"> • Coordinated planning • Coordinated service provision • Referral network • Advisory committees 	<ul style="list-style-type: none"> • Collaborative alliances • Co-location • Joint ventures • Community-business partnerships • Consortia • Joint tenders 	<ul style="list-style-type: none"> • Amalgamations • Mergers

Evidence indicates that organisations coming together in a Primary Care Partnership to work collaboratively derive several benefits arising from the synergies created by effective partnership:

- Creating or modifying service delivery based on shared evidence and agreed best practice standards;
- Maximising resources;
- Collaborative policy development and advocacy;
- Integrated, cross-agency systems development and change;
- Reducing duplication through clear and agreed definition of roles and responsibilities to meet community needs;
- Social and community development.

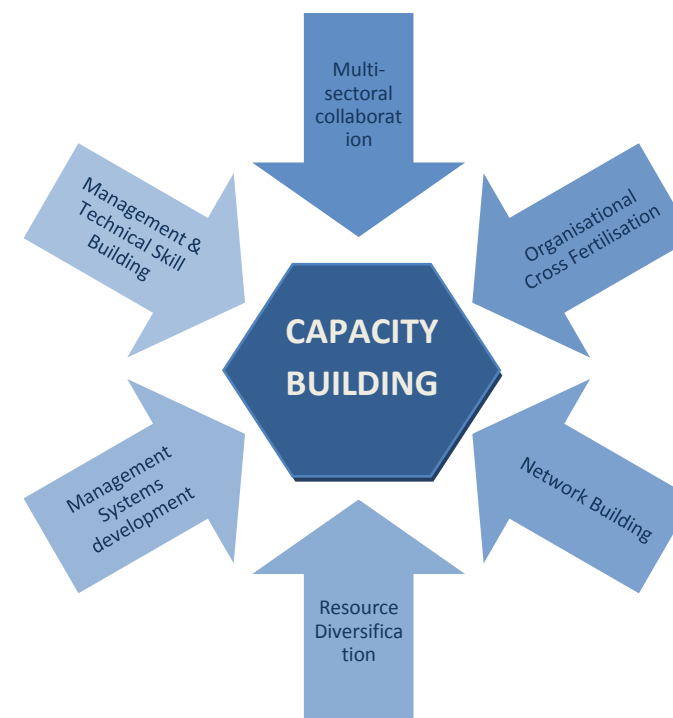
8. How the IEPCP value adds

The IEPCP influences primary care systems and practice change by acting as a *capacity builder*. The term *capacity building* has been used in respect of a wide range of strategies and processes which have the ultimate aim of improved health practices which are sustainable. ¹Facilitating networks of health and human services agencies to form strong relationships (who otherwise have little or no working relationship) is a key feature of the PCP model. These relationships can move along the *collaboration continuum* as needs and capacities dictate but remain strong under the orchestration of the PCP. The principal benefits to agencies and therefore their consumers, derive from the synergies achieved when these relationships work effectively.

This approach involves undertaking several tasks or strategies related to the following five capacity building elements:

1. Leadership;
2. Partnership;
3. Organisational Development;
4. Workforce Development; and
5. Resourcing.

Having a capable service system is not enough to bring about real population health and wellbeing - we require 'prepared, proactive community partners' acting in concert with an 'activated community'. The concept of the inner east's service system as part of the community remains valid. This concept is used increasingly to solve complex and interactive social and health issues in communities to good effect.² The IEPCP recognises therefore, the complex interplay between system and capacity building elements as relevant to addressing the large scale outcomes for complex conditions related to ageing, mental health, social isolation, families at risk of harm and chronic disease.



¹ B. Crisp, H. Swerissen, S. Duckett (2000) 'Four approaches to capacity building in health: consequences for measurement and accountability.' in Health Promotion International, Vol.15, No.2; Oxford University Press.

² R. Glasgow, C. Orleans, E. Wagner, S. Curry and L. Solberg (2001) Does the Chronic Care Model also serve as a template for improving prevention? The Millbank Quarterly, 79(4) and World Health organisation, health and Welfare Canada and Canadian Public Health Association (1986). Ottawa Charter of Health Promotion.

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The IEPCP's **Framework for Systems and Practice Change** signifies that the PCP is not separate from the broader service system and the latter is not separate from the community but part of it, with four distinct components:

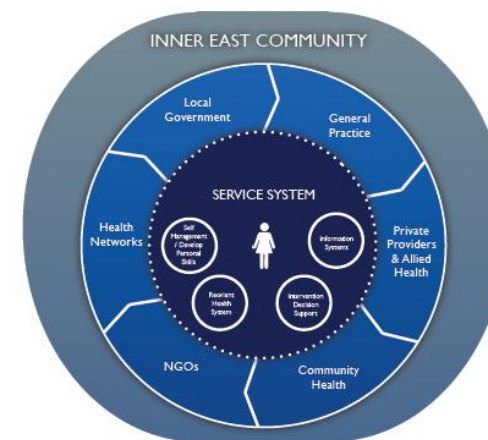
Information systems: A large variety of users access linked products from information systems, such as demographics, population health data, cultural, social and economic trends and needs/strengths assessments. IEPCP focus remains on single contact points such as:

- electronic patient information and care management systems;
- service coordination organisational tools and templates;
- electronic referral systems and protocols;
- implementation of state-wide best practice standards supporting improved coordination and integration of care to enhance clients' journeys through the service system.

Decision support for social & health interventions: This includes providing both service providers and users with information about the impacts and management of social and health conditions and the choices that support desired levels of health and wellbeing from a social determinants perspective. Decision support is one of six elements of the Wagner Chronic Illness Care framework that enables providers and consumers make informed decisions supported by standardised, evidence based systems and practices across sectors and agencies. *The IEPCP's specific focus is the development of primary prevention and early intervention strategies and implementation of integrated, 'best practice' chronic disease management.*

Reorientating services: There continues to be a fundamental shift in the way that services conceptualise their role, encouraging more user-centric, health advocacy rather than specialised/niche, provider-centric, acute treatment approached. This is consistent with the social model of health as more holistic than the traditional acute medical model of diagnosis-treatment-cure. *For IEPCP this involves focusing on prevention and early intervention; constructing service boundaries and entry/exit points which are invisible to community members, and reorienting the service system by building stronger health promotion and awareness of the social determinants of good health and wellbeing.*

Self-management: Increasing an individual's or population's ability to manage a complex condition for themselves with the support of health professionals, and enhancing personal skills necessary to good health and wellbeing requires *IEPCP to facilitate a network of agencies having their own connections to client population, developing workforce and organisational capacity to support health literacy.*



Adapted from: V. J. Barr, S. Robinson, B. Marin-Link, et al. (2003) The expanded chronic care model: an integration of concepts and strategies from population health promotion and the Chronic Care Model. *Hospital Quarterly*, 7(1), 73-82.

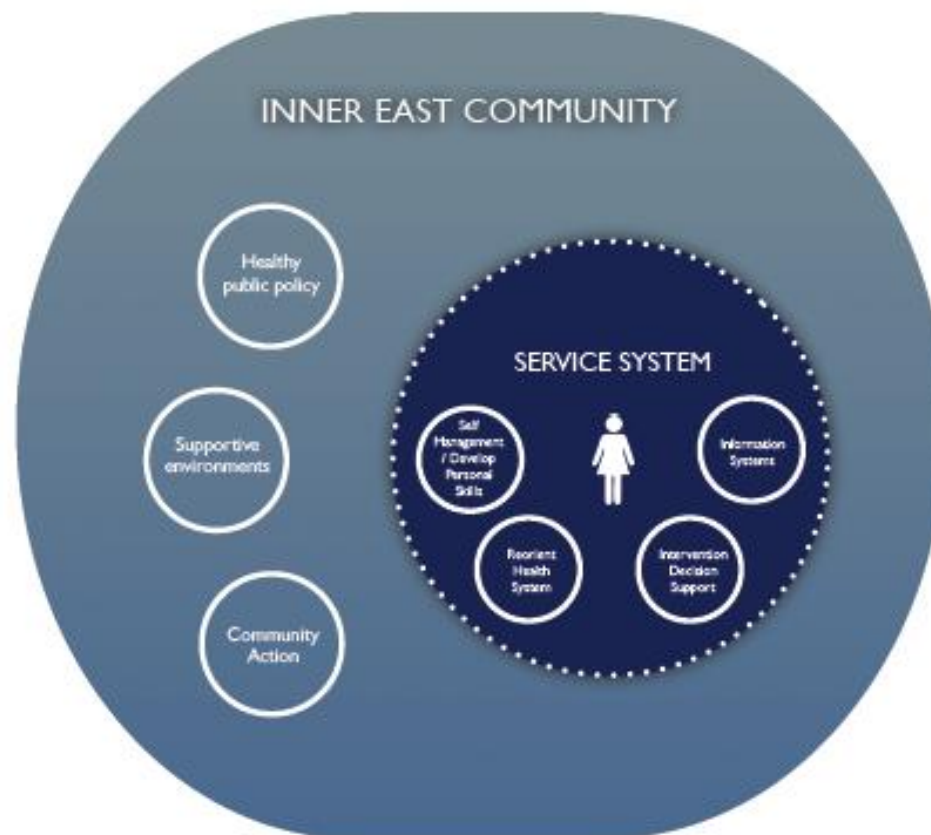
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‘Outside’ the service system circle are three community elements which combine to enable sustainable health and wellness:

Healthy Public Policy: Governments and funding bodies have a vital role to play in fostering greater health and social equities coupled with accessible, appropriate, acceptable and safe services. *The IEPCP’s approach here is to facilitate multi-agency level advocacy and to use high quality information to attract funds and other non-financial resources to partner agencies.*

Supportive Environments: The bedrock for the health of a community is the local ability to ensure four pillars of wellbeing: the social, economic, built and natural environments which predispose residents and visitors to good health (or otherwise). *The IEPCP will assist to integrate the work of its four local government areas (LGAs) through their Municipal Public Health Plans to ensure that the four pillars optimally support the work being undertaken within other sectors.*

Strong Community Action: This recognises the need to mobilise communities directly, rather than presuming that ‘service provision’ or ‘policy’ alone make the biggest differences to a community’s health and wellbeing status. *IEPCPs focus is on empowerment of communities (or sub-communities) and supporting member agencies to improve public participation in health and community planning and evaluation. This focus includes addressing issues of social inclusion and disadvantage.*



Systems change initiatives which can ‘tick’ multiple circles within this model are more likely to create sustainable change and be more effective. IEPCP does not provide direct services to the community, but must achieve improvements in engagement via the service providers who are our members and partners.

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9. Our Key Domains of Activity

The Department of Health funds the IEPCP to “enhance wellbeing and quality of life, reduce the prevalence, incidence and burden of illness/disability, meet the needs of hard to reach and vulnerable groups and reduce health inequalities between population groups”.

How do these priorities and ‘value adds’ map onto the four key Domains of Activity described in PCP Program Logic? By targeting priorities within each domain of:

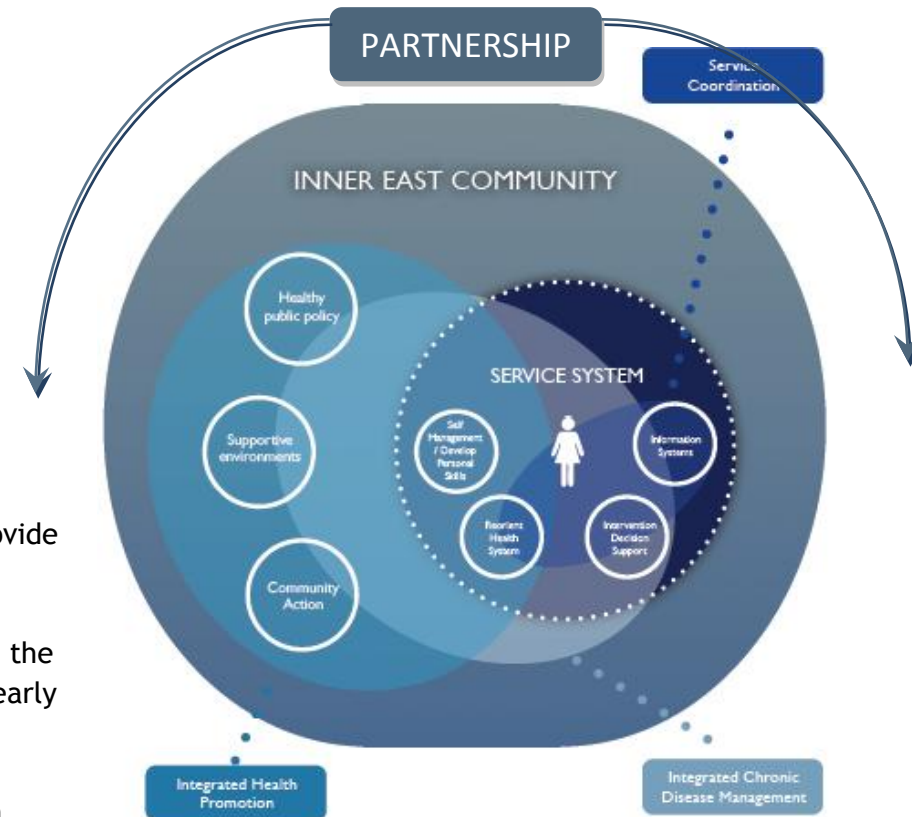
1. Partnership;
2. Integrated Health Promotion (IHP);
3. Service Coordination (SC);
4. Integrated Chronic Disease Management (ICDM).

There are close, and overlapping links between all four domains within the IEPCP framework.

- IHP work concerns the elements of primary prevention, health literacy and service system reorientation toward health promotion and addressing social determinants;
- SC work is concerned with the integration of services and information to provide a seamless journey for service users and their families and links also with decision support and delivery system design;
- ICDM work relates also to decision support and self management, along with the other elements of the Wagner Chronic Illness Care model and also includes early intervention strategies and improving access.
- Partnership development involves demonstrating good governance and leadership in system and practice reforms, engaging key service providers in collaborative networks and sustaining these relationships to achieve the desired benefits of the partnership.

The principles underpinning IEPCP work in all four Domains of Activity are:

- Community/client at the centre;
- Addressing inequities;
- Focusing on primary prevention and early intervention;
- Working within a social determinants framework.



10. Our Objectives



■ Specific to priority areas in Chronic Disease (CVD,T2D etc), Ageing (Social Inclusion) and Mental Health (Family Violence, Problem Gambling)

Systems and Practice Change

Capacity Building
Leading, Partnering, Planning,
Evaluating, Advocating

IEPCP Partners

Develop specific strategies & projects which achieve the following:

Improved Interventions & Systems of Care

Evidence bases are translated into documented interventions &/or systems of care and embedded into practice

Coordinated Care Planning

Examples of inter-agency & inter-disciplinary care planning are developed, promoted and evaluated

Risk Factors and Determinants

Processes are in place to identify & manage risk factors and determinants of diseases common to the catchment

Self Management

Organisational practices are aligned & workforces up-skilled to enable client-centric self management support consistent with contemporary Chronic Illness Care standards

The achievement of these objectives is facilitated by the PCP team who provide the following in their role as capacity builders:

Gathering and Communicating Data & Information

Collate and disseminate well referenced population, best practice, qualitative and quantitative data to inform planning and evaluation processes, contribute to the existing evidence base and facilitate best practice

Resource Acquisition

Assist partners to access/share financial and non-financial resources for the achievement of mutually agreed goals.

Informing Policy direction and Policy Alignment

Inform & reconcile locally relevant policies to facilitate an integrated policy framework.

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11. Our measures of success

Measures of success applying to IEPCP are illustrated as follows:

