

Primary Care Partnerships
Integrated health promotion
2011





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Introduction

This document sets out the achievements of the Primary Care Partnership (PCP) strategy to deliver Integrated Health Promotion (IHP) in Victoria. The document draws on findings from an evaluation conducted in 2008 on the impact of the PCP IHP strategy. Case studies have been included to demonstrate the range of health promotion programs and activities being led by PCPs, and the breadth of work that can be undertaken when organisations work in partnership. Case study summaries are snapshots of much broader and more extensive programs of work.

In Victoria, the term 'integrated health promotion' refers to agencies and organisations from a wide range of sectors and communities in a local area working in collaboration using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues (IHP Resource Kit).

The goal of the Victorian Public Health and Wellbeing Plan 2011–15 is to improve the health and wellbeing of all Victorians by engaging communities in prevention, and by strengthening systems for health protection, health promotion and preventive healthcare across all sectors and levels of government (Department of Health, 2011). The plan acknowledges PCPs as established mechanisms for collaborative and coordinated planning at the sub-regional level. PCPs function to integrate the efforts of individual organisations and sectors around the needs of local communities is supported by the Plan.

Summary of achievements

The PCP IHP strategy has delivered many achievements, including:

- Improved planning through better use of data, evidence-informed interventions, and through a common planning framework. Organisations are working together to plan around the needs of the community, to share their skills and expertise, and align their efforts. Nearly 600 organisations and programs were involved in IHP in 2009–10.
- Increased understanding of the broader determinants of health has led to improvements in meeting the needs of, and engaging with, hard-to-reach and vulnerable communities. Many IHP activities focus on neighbourhood and community renewal communities and other at-risk communities, to aim to reduce the health disparities between population groups.
- Attracting funding through a range of government departments and local governments who value the benefits of an integrated approach to deliver health promotion.
- Building better governance structures by shifting PCPs away from non-binding memorandums of understanding to binding partnership agreements. By signing the agreement, senior executives from partner organisations commit to their organisation's role in IHP, which has flow-on effects in their own organisations because they must ensure organisational capacity to deliver on the commitment.
- Seeking high-level endorsement of PCP IHP reporting by requiring board sign-off and endorsement by the Department of Health regional offices. This high-level approval means that partners and the region are satisfied with the quality of the work and ensure its alignment with the PCP program logic.

Health promotion: What works?

Health promotion is at its most effective when it is multi-strategy, integrated and complementary. It should also be supported by health and other sectors working in collaborative partnerships with the community (Keleher & Murphy 2004). Multi-strategy health promotion recognises that a person's community influences health, above and beyond their individual characteristics or behaviours (Kothari & Birch 2004).

Health promotion should address the broad determinants of health, be evidence based and build collaborative partnerships to improve integration. It should also strengthen the capacity of individuals, communities and workforces to recognise and respond to factors that influence health in their local contexts.

Activity is required across all domains of the health promotion framework to improve the health of individuals, populations and sub-populations. Such activity includes:

- primary, secondary and tertiary disease prevention¹
- health information and behaviour change strategies
- health education and skill development
- community engagement and action
- policy, legislation and systems change.

The Victorian journey

The PCP strategy was implemented in 2000 to help achieve better health for people and strengthen the communities where they live. PCPs are groups of organisations that play a vital role in facilitating, planning and coordinating health promotion. Through PCPs, individual organisations can collaborate in strategic and integrated health promotion initiatives to achieve shared goals of improved health outcomes for the community. IHP is a driver for change and has demonstrated improvements in health promotion delivery in Victoria (HDG 2008).

Before PCPs, health promotion was often delivered with limited coordination between programs or organisations. It commonly focused on influencing individual behaviour change, without regard for the broader determinants of health, and was often designed with limited data and evidence.

Now, after ten years, IHP is being delivered by different organisations working together using a social model of health framework, combining their strengths to address health and social issues, delivering interventions based on evidence, and targeting hard to reach and vulnerable groups.

(PCP Evaluation – focus group participant)

¹ Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation (WHO 1998).

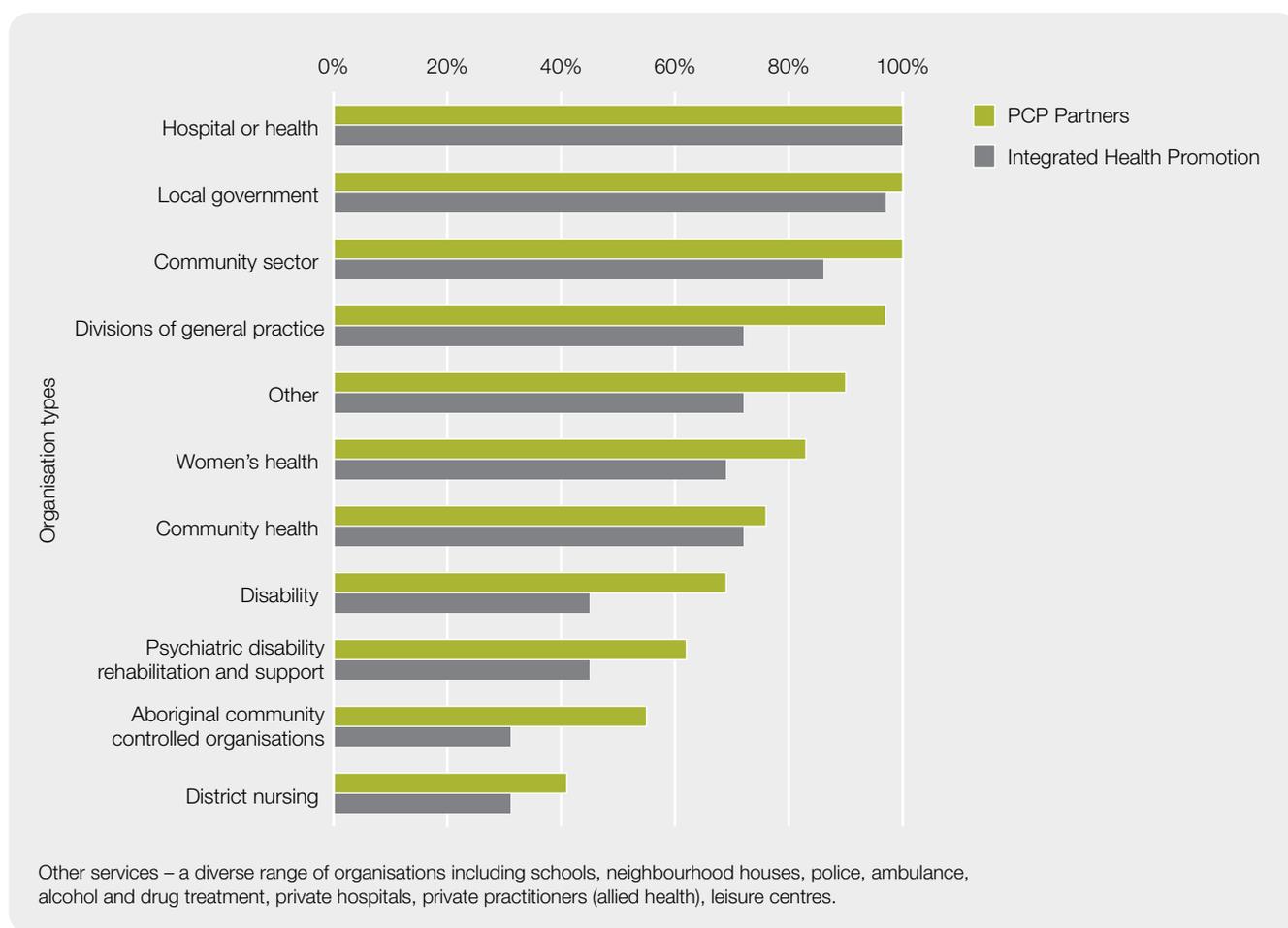
Who are the partners?

The 2010 PCP partnership reports show that nearly 600 organisations in 30 PCPs are currently involved in PCP IHP – an increase from 350 in 2009. Partnerships are increasingly formed with a range of organisations and sectors, including primary health and other health services, local government, aged care and disability organisations, women’s health services, mental health services, community drug services, ethno-specific services, divisions of general practice, sporting agencies, the Country Fire

Authority, land care agencies, schools, neighbourhood houses, police and a range of community groups and consumers (PCP 2010).

The graph below shows the proportion of organisation types involved in IHP. For example, all PCPs have local government as a member, and 97 per cent of these are involved in IHP.

Organisations involved in IHP



PCP IHP evaluation: How the partnership approach is improving health promotion

An evaluation conducted in 2008 on the impact of the PCP IHP strategy found quantitative and qualitative evidence for the success of the partnership approach to improve health promotion (HDG 2008). Data collection methods included:

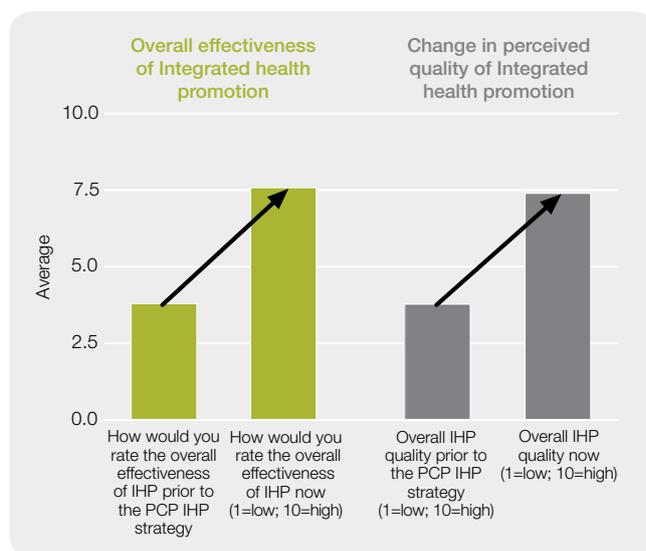
- semi-structured interviews with senior and middle managers from partner organisations
- broad level consultation and semi-structured interviews with other government departments, peak bodies and other relevant stakeholders
- a comprehensive questionnaire for organisations in the sample group as well as a shorter questionnaire for organisations in the non-sample group
- analysis of written reports from health promotion projects and plans.

The evaluation shows that PCP IHP has:

- improved integrated planning
- increased organisational capacity for health promotion
- delivered economic benefits and resource efficiencies
- contributed to healthier communities.

The graph below shows changes in the effectiveness and perceived quality of IHP, based on responses from more than 100 organisations. Partners working with a common purpose and having clear roles and responsibilities are key success factors for IHP.

Changes in quality and effectiveness of integrated health promotion



Source: PCP Partnership Reports 2009–10.



Improvements in integrated planning

Integrated planning requires strong partnerships, trust, commitment and a willingness of organisations to work together and to draw on one another's strengths.

Long-term planning is improving health promotion in Victoria and delivering better integration of effort. PCP program logic (HDG 2008) structures the strategic direction for PCPs, and ensures that IHP is linked to the broader goals of the PCP strategy.

Three-year PCP IHP plans concentrate effort under two or three health promotion priority areas. Plans describe strategies for a mix of interventions, specify target groups and timeframes, and identify the expected contributions of key implementation partners.

PCP IHP plans are active documents which are annually reviewed and updated. Activity in the coming year is strengthened and refined, based on evaluation findings from the previous year.

One of the most important bodies of work the PCP did was a health and wellbeing needs analysis for the region. This enables all of the agencies whether public or private, or community health or welfare, to check where their strategic alliance is in relation to the overall regional view. I think this is a very helpful and aligning practice that you can't get unless you have a structure that brings all agencies together.

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

Better use of data

The use of data is improving. IHP plans draw on data from a range of sources, including international, national and state policy documents, state and local data sets and input from community members (HDG 2008). Two PCPs, the Inner East PCP and the Outer East Health & Community Support Alliance, with the support of the Department of Health's Eastern Region, produced the regional *Population & Place Profile Data Project* to improve the use of data to determine health promotion priorities and partnership interventions (Inner East PCP 2009).

By using a common planning framework, organisations can consider the bigger picture, link with organisations beyond their immediate area, and systematically plan and coordinate activities around the needs of the local community (HDG 2008).

The PCP approach provides leadership and legitimacy for all agencies to have a role in health promotion, and has enabled a cohesive approach to planning across the catchment.

(PCP Evaluation – focus group participant)

The PCP IHP planning model provided an excellent opportunity to raise awareness of the needs of specific population subgroups.

(PCP Evaluation – focus group participant)

Ability to deliver a mix of interventions

The PCP strategy has strengthened the nexus between local government and the community health sector, which is critical to delivering the mix of interventions required to improve population health. Both organisations have different roles and responsibilities, and potentially different levels of expertise.

- **Local government** is responsible for local public policy, municipal public health planning and the built environment.
- **Community health services** provide a strong platform for delivering services and programs across the care continuum, underpinned by the social model of health. Funding supports local community health services to work in partnership and develop flexible models of care that meet the needs of their communities, particularly vulnerable groups at risk of poorer health.

By working in partnership, local government and community health services can influence more domains of the health promotion framework, including those that affect individuals and populations, than could be achieved working in isolation.



Case study: Wellington Shire Council Physical Activity Strategy

An example of local government involvement in IHP planning is the Wellington Shire Council Physical Activity Strategy. The council recognised their role in promoting physical activity beyond the traditional role of planning, developing and maintaining assets, and is working with the Wellington PCP to improve the physical activity opportunities in the shire. The strategy aims to formulate one plan across the catchment by June 2012 to identify partners' roles and responsibilities in the delivery of a mix of interventions to encourage greater levels of physical activity in the community. The collaborative partnership established to develop and implement the Physical Activity Strategy has created further partnership opportunities, for example, the shire's Community Wellbeing Strategy (the Municipal Public Health and Wellbeing Plan) has demonstrated relationships and links with the PCP IHP catchment plan. The PCP model of organisations working together is recognised in the shire's plan as a positive way to improve the health and wellbeing of the community.

The Department of Health promotes partnership development across regions to foster better integrated planning and service delivery across several domains, including health promotion. The Gippsland Health Services Partnership includes CEOs from health, community and Aboriginal organisations and local government and PCP chairs. Sub-groups, including a health promotion sub-group, report to the partnership. Integrated planning has increased commitment from all partners, enhanced communication, clarified what each member aims to achieve, and produced a greater understanding of how to approach community health better by working together.



Case study: Linking public land for public health

Wellington PCP partners worked together under a project led by the Department of Sustainability to link, upgrade and develop new and accessible walking, all-purpose and all-abilities trails. These paths encourage physical activity, which can reduce the risk of preventable chronic diseases such as obesity and cardiovascular disease. Collaborative cross-sector partnerships were also developed with the Country Fire Authority, West Gippsland Catchment Management Authority, land care organisations, Aboriginal organisations and sporting organisations.

An extensive evaluation is underway with users of the trails, which has so far identified the following impacts.

- Respondents reported that the trails inspired them to do more exercise (67%), and that they started regular exercise after completion of the trails (42%).
- Evidence exists that trail use contributes to a broader sense of wellbeing and social connectedness because families and other groups use it together.
- Other evidence suggests that the partnership approach led to enhanced relationships between stakeholders and mutual benefits for local and state government as well as community organisations (Wellington PCP 2010).

Influencing sectors where people live, work and play

Health is determined by a range of biological, social and environmental factors, among others (Keleher & Murphy, 2004). Biological factors can be addressed by the health system, but social and environmental factors (for example, poverty, employment status, access to nutritious food or transport and social isolation) can be better influenced by sectors outside of health. For example, encouraging the consumption of more fruits and vegetables during a medical assessment has a limited effect if poverty or access to transport prevents the person from following the advice. Primary prevention and health promotion activities that improve access to nutritious food will deliver longer-lasting impacts.

Case study: Community kitchens: Improving nutrition for at-risk populations

Healthy food basket research conducted in the Latrobe Valley and Baw Baw Shires in 2008 showed that outer-lying towns have less access to some foods compared to major centres. Central West Gippsland PCP partners set up community kitchens to improve access to nutritious foods for people on low incomes, and for socially or geographically disadvantaged populations. Nine community kitchens have been established so far.

A partnership of Monash University, other Gippsland PCPs and the Department of Health has developed tools to measure the impacts of community kitchens on health and wellbeing, which will be administered at various stages to measure change. So far the work has delivered community-strengthening impacts with non-health organisations, with neighbourhood houses, football clubs and churches establishing the kitchens. Setting up the kitchens in already well-established community facilities potentially attracts a broader range of participants who may already use the facilities, and this could improve sustainability (Central West Gippsland PCP 2010).

Case study: Climate change adaptation – from policy to programs to at-risk communities

South East Healthy Communities Partnership is leading the development of new policies to support the community to adapt to climate change and associated adverse weather, heatwave conditions and fire. This work aims to:

- build community resilience through increasing capacity to learn and adapt to the impacts of environmental change
- reduce the impacts of associated rising household energy and water costs
- minimise harmful effects of climate change on health
- embed climate change responses into service coordination practices.

So far, eight organisations have developed new policies to assist clients with environmental change and six organisations have made changes to their delivery of programs and services, with a view to minimising environmental impacts.

The City of Greater Dandenong Home and Community Care Program has incorporated a checklist into home visits to determine a person's risk in the event of heatwave or an extreme weather event. Workers ensure that air-conditioners, heaters and fridges are working, and that window frames and doors are checked for draughts. Low-cost options such as draught-stoppers and fridge seals have been installed. The goal is to help as many people as possible with low-cost, sustainable options. This minor adjustment to service delivery has increased the level of support for frail people living at home.

Care workers also identify people at greater risk of fire or extreme weather events through a simple survey and local knowledge. People who are ill, live alone, socially isolated or isolated through language are contacted when fire threatens or during periods of extreme heat, to ensure they are safe (SEHCP 2010).

Building organisational capacity for health promotion

Capacity building involves developing sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors (Hawe et al. 2000). Organisations need more than just skilled and competent staff to build capacity for health promotion; they need to make health promotion a priority and embed it into all levels of the organisation (Johnson & Paton 2007).

Improved organisational capacity for health promotion is being sustained through:

- having senior executives of organisations participate on the PCP executive: the flow-on effect means that senior executives can drive policy and practice changes with programs in their own organisations
- embedding IHP principles in staff position descriptions, policies and procedures: this shares the responsibility

for health promotion, ensures consistency and builds sustainable effort

- implementing training and orientation programs with a focus on IHP: this means the principles and practices of IHP are explained to staff through training updates or during induction (HDG 2008).

Through cross-sector partnerships, knowledge about health issues and health promotion is built and shared. For example, the Department of Justice funds problem gambling initiatives through PCPs, which connects Gamblers Help Services and health and community agencies in tackling the burden of problem gambling. Cross-sector work increases the awareness of problem gambling, its risk factors, co-morbidities and the stress it creates for individuals, families and communities amongst health and community organisations.

Case study: Improving Aboriginal access to health services – capacity building to support policy implementation

Aboriginal people are at increased risk of many preventable and chronic diseases and poorer mental health. The Outer East Health and Community Support Alliance is developing an Aboriginal access and engagement policy to enhance mental health and wellbeing of Aboriginal people by improving access to mainstream health services. Over 90 health and community sector workers participated in cultural respect training in 2009–10 to build the capacity of the workforce to underpin the principles of the policy. Five more sessions will run in 2011, with a further 125 staff expected to receive training.

The training has improved the service delivery for Aboriginal people; for example, some organisations now:

- offer greater flexibility regarding appointments
- schedule longer appointment times to accommodate Aboriginal clients' holistic needs
- offer group appointments for families and friendship groups
- sometimes visit clients in their own homes and environments.

The PCP also delivers an organisational leadership program for senior executives and middle managers of community and women's health services, community organisations and divisions of general practice. With support from Monash University, the program uses a participatory action research methodology, where participants are required to implement policy or practice change during the program to improve access for Aboriginal people. This work recognises that achieving real change involves practitioners and frontline staff being aware of issues that affect Aboriginal people, and organisations reorienting to improve access and practise sensitivity and respect for cultural needs.

Access and engagement policies are important tools for delivering primary prevention. When people are connected to services, the opportunity to screen, inform, refer and link to primary prevention initiatives is enhanced.

The program aligns with Closing the Gap strategies and is informed by past National Aboriginal Health Policies (OEHSA 2010).

Building capacity for evaluation

Improving evaluation drives continuous quality improvement in health promotion. Many PCPs and regions allocate resources and effort to support and build evaluation capacity in the sector. Some regions and PCPs are engaging universities to improve evaluation, for example, a partnership with Monash University, Gippsland PCPs and the Department of Health has developed tools to measure the impacts of community kitchens on health and wellbeing.

The Department of Health, together with the sector, developed a reporting measures framework to better

measure the impact of health promotion interventions and capacity building activities.

Improved planning leads to improved evaluation. PCPs are required to include evaluation methods in their IHP plans and to report on the process and impact measures. For example, the *Campaspe Primary Care Partnership Strategic Plan 2009–2012* includes process and impact measures and, where possible, evaluation methods (Campaspe 2009).

Case study: Partners unite – a collaborative approach to evaluation

Campaspe PCP partners in the Physical Activity and Nutrition Network include local government, health services, sporting and community organisations, and they have pooled funds and resources to improve evaluation across the catchment to better capture the impacts of their work. Surveys and audit tools have been developed and validated for local use, along with data entry templates and data management tools. An evaluation kit is under development, which will contain advice on preparing surveys, and includes validated demographic, nutrition and physical activity survey questions.

The use of standard evaluation questions and approaches provides an opportunity to compare data across a number of local projects and map impacts over time.

Some of the impacts so far include improved knowledge, skills and capacity of local health promotion staff to plan for and undertake evaluation.

This example of true collaboration, with several partners working together to achieve a shared goal, has led to more streamlined and efficient evaluation practices, and reduced duplication and fragmentation of effort (Campaspe PCP 2010).

Economic benefits and resource efficiencies

Qualitative data indicates that the PCP IHP approach of shared responsibility and consolidated effort has reduced duplication, improved efficiencies and maximised the return on finite resources (HDG 2008).

The partnership approach has attracted funding from other government programs and departments, for example:

- falls prevention initiatives for Victorians have been funded through PCPs
- the Department of Planning and Community Development has funded walking grants and elder abuse prevention initiatives

- the Department of Justice is currently investing in a four-year program to address problem gambling through PCPs
- other PCPs have been funded for health promotion through Health Promoting Communities: Being Active and Eating Well, Go For Your Life, local government community grants and other sources.

Creating healthier communities

Delivering a more planned and coordinated approach that is built on a stronger evidence base has meant that health promotion initiatives are better targeted to address local health priorities. Communities are benefiting from the linked effort of different organisations combining their expertise, responsibilities and scope, to achieve greater impacts on health.

Consumer input ensures that capacity building or health promotion interventions focus on improving the health and lives of consumers. It also is a valuable mechanism for ensuring that interventions meet and are acceptable to the local community context.

Many PCPs are actively seeking the participation of consumers in IHP planning. For example: the Outer East Health and Community Support Alliance's health promotion committee includes a consumer representative; Campaspe PCP's IHP guiding principles include a focus on consumer empowerment and active consumer and community participation; and Central Highlands PCP is linking with the University of Ballarat to improve consumer consultations and engagement approaches. Many other PCPs are engaging with consumers to deliver IHP planning more effectively.

Case study: Family violence prevention is everyone's business

Frankston Mornington PCP is developing a plan to prevent family violence and improve mental health and wellbeing in the community. Family violence rates in the area are one of the highest in the state. Partners involved in this work include health, community, family violence and women's organisations, neighbourhood and community renewal and Victoria Police. The partnership approach has attracted a grant through the Department of Planning and Community Development's community strengthening program for approximately \$320,000 which, along with in-kind contributions from partners, takes the project budget to \$700,000 over three years to April 2013.

Community members have been involved in developing this project to ensure that it meets their needs, uses language they can relate to and, most importantly, highlights the role community members play in making positive changes in the lives of others in their neighbourhoods and communities.

Sustainability measures for the project include skills and training incorporated into all levels of implementation, so that community members and staff in partner agencies are better equipped to identify family violence, referral pathways and ways to prevent family violence. The project has developed a partnership with the Office of Women's Policy and is aligned with elements of the State Plan to Prevent Violence Against Women (FMPPCP 2010).



Opportunities for further improvement

More work is required to fully integrate plans.

Better aligning the planning cycles of local government, community health services and PCPs will improve integration and lead to better understanding about how each organisation can contribute to population health improvements.

Strengthening the use of evidence-based interventions

and building skills to guide the selection of interventions remains a priority for improvement in health promotion practice. A number of factors should be considered when choosing interventions, including: what works, what is cost-effective, current government policy and investment, impact of health disparities, feasibility, sustainability and acceptability to stakeholders.

Continued improvements in evaluation quality and measuring and reporting of impacts

are required to demonstrate the value of the approach and build evidence for health promotion. The department has developed tools and guidelines to support the workforce, and compiled indicators for physical activity, nutrition and obesity programs, as well as tools and guidelines to support the workforce in evaluation (Victorian Government Department of Health 2009).

Sharing knowledge about *what worked*, *what the results were* and *how the activity was delivered* is vital to grow knowledge and capacity in the sector. Traditional methods such as journals, seminars and the Internet continue to be important for disseminating IHP results. Use of social media applications for sharing knowledge to lead to improved IHP practice, should be further considered.



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More information about PCPs is available at <http://www.health.vic.gov.au/pcps>

