ECHO
Extending the Capacity of Healthcare Organisations

General Practice Victoria

Primary Care Integration Program

Program Logic and Planning Framework Development

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1. Introduction

General Practice Victoria (GPV) is a Commonwealth funded peak body, working at the state level to oversee and support the work of Victorian Divisions of General Practice. The key strategic goals for GPV are to: enhance primary health care delivery through general practice; increase the integration of general practice into the health care system and enhance the Victorian Divisions Network (General Practice Victoria, 2008 [online]). GPV provides support to the twenty nine General Practice Divisions across Victoria to enable focused efforts and participation in a range of population based health care approaches aimed at better health outcomes for people in Victoria. GPV is committed to supporting divisions to focus on the development in general practice of knowledge, skills and attitudes required to deliver organised and systematic care.

The Australian Better Health Initiative (ABHI) is a joint initiative of the Commonwealth, State and Territory Governments launched in 2006 by the Council of Australian Government (COAG) as a national population based approach to strengthen the health's systems focus on promoting good health and reducing the burden of chronic disease. The ABHI Initiative consists of five priority areas, the fifth of these being 'improving integration and coordination of care'. To address this priority area within ABHI, the Primary Care Integration Program (PCIP) was developed and funded for the duration of two years.

In Victoria fifteen PCIP project submissions were approved including a series of single Divisions and consortia that involves all twenty nine Divisions of General Practice. Project funding has also enabled the establishment of a PCIP State-wide Coordinator role, based at GPV to provide state-wide leadership and coordination of the PCIP through supporting the PCIP regional coordinators associated with each of the fifteen projects.

At the inception of the PCIP, GPV recognised a need to develop a coordinated planning process and structure for the PCIP initiative. This linked with the goal of maximising the impact of GPV and the State-wide Coordinator role to provide the most effective support for PCIP program sites undertaking the PCIP initiative. The identified need was based upon the following factors related to the PCIP initiative:

- The importance of determining the value and impact of the broader GPV and State-wide Coordinator role throughout the PCIP
- The challenge to articulate and demonstrate evidence of relationship and partnership building, and integration due to the relatively short length of the program and broad program goals
- There are no formal mechanisms for monitoring and evaluating the impact of the PCIP program in place due to the nature of the new program
- A desire to provide comprehensive reporting on the joint Commonwealth/State Government initiative
- Recognition of the opportunity to build capacity and sustainability through the PCIP

[1]General Practice Victoria http://www.gpdv.com.au/content.asp?cid=32&t=About-Us (Accessed 20th July 2008).

ECHO was engaged by GPV to undertake the development of a program logic and planning framework for this purpose. This report was intended to guide GPV in the further development of the role of GPV in the PCIP, in planning for and ultimately optimise the outcomes of the PCIP initiative.

2. Method

The key steps undertaken in the development of the program logic and planning framework included:

1. Initial meetings with GPV staff to determine their needs and the focus for the program logic and planning.

2. Review of key documentation for GPV and the PCIP:
    - Statewide Coordinator Primary Care Integration: Position Description
    - Better Health for all Australians: Action Plan (Attachment D)
    - Australian Better Health Initiative ABHI Primary Care Integration Program: Minimum Reporting Requirements
    - Australian Better Health Initiative ABHI Primary Care Integration Program: Letter to call for expressions of interest for the Regional Coordinator positions
    - General Practice Victoria website

3. Individual interviews with key personnel to gain a range of personal perspectives on the PCIP and inform the development of the program logic. Key personnel interviewed were selected by GPV to cover a range of key PCIP stakeholder perspectives. A list of the interviewees and the questions used can be found in Appendix 2.

4. Survey of the PCIP Regional Coordinators conducted by the PCIP State-wide Coordinator to gain an insight of the expectations for the State-wide Coordinator role and determine the level of support required. Feedback received was provided to the ECHO team to incorporate into the program logic development. A list of the questions used can be found in Appendix 2.

5. The development of the draft program logic. Program logic was seen as a potentially useful tool to guide planning for the GPV role in the PCIP given the complexity of the program, the multiplicity of stakeholders, related program areas and system issues. The program logic makes explicit the factors and links in a chain of reasoning. The program logic was developed with a focus on the role of GPV in the PCIP drawing upon the key documentation, interviews and surveys available. It consists of the following components:
    - Underpinning values
    - Goals
    - Processes
    - Activities (pertinent to Statewide coordinator)
    - Activities (pertinent to broader GPV role)
    - Direct Outcomes
    - Indirect Outcomes

6. Two consultation phases to review and refine the program logic:

    a) Planning workshop at GPV

    The planning meeting provided a forum to review the key interview findings and the draft program logic. Input from this meeting resulted in the refinement of the program logic. A list of attendees can be found in Appendix 3.

    b) Meeting with DHS staff

    A meeting of GPV and relevant DHS staff was convened as a subsequent step in the consultation process following the initial program logic planning workshop. The purpose of the meeting was to engage and gain input from DHS staff in the development of the program logic and planning framework for the PCIP. A list of the attendees can be found in Appendix 4.

7. A prioritisation task was undertaken to determine the level of priority to be given to each component of the program logic. This was circulated to all participants involved in the planning workshop for feedback Appendix 5.

8. A set of key evaluation questions was developed for GPV based upon the direct outcomes of the program logic, including a list of suggested activities and measures to address the evaluation questions for the purpose of ongoing monitoring and evaluation.

3. Setting the scene for the planning framework

The context for the development of the program logic and planning framework for GPV is described in this section of the report. It includes the findings from the consultation process and details the key issues that influenced the evolution of the framework.

3.1 Aim and objectives of ABHI PCIP

It is important to set this work within the context of the PCIP aims and objectives which are as follows:

The aim of the ABHI PCIP is to enhance integration between general practice and other local primary health care providers to assist in the delivery of more 'seamless' patient care. This is particularly important in the context of better managing patients with chronic or complex conditions who often receive care from multiple providers, funded by different sources, across different settings.

The objective is to encourage more integrated patient centred care by supporting general practice to:

- Engage with PCPs and other state funded primary care initiatives that seek to improve service coordination and integrated chronic disease prevention and management
- Improve communication and linkages with other primary care providers
- Make better use of existing primary and community care services including Commonwealth, State and non-Government funded services with a focus on patients with chronic disease
- Use tools and strategies that will assist in better managing patients with chronic disease; i.e. disease registers, referral, recall and reminder systems, care planning
- Contribute to work around developing local chronic disease care pathways or other priority activities with a chronic disease management (CDM) focus.

3.2 PCIP State-wide Coordinator

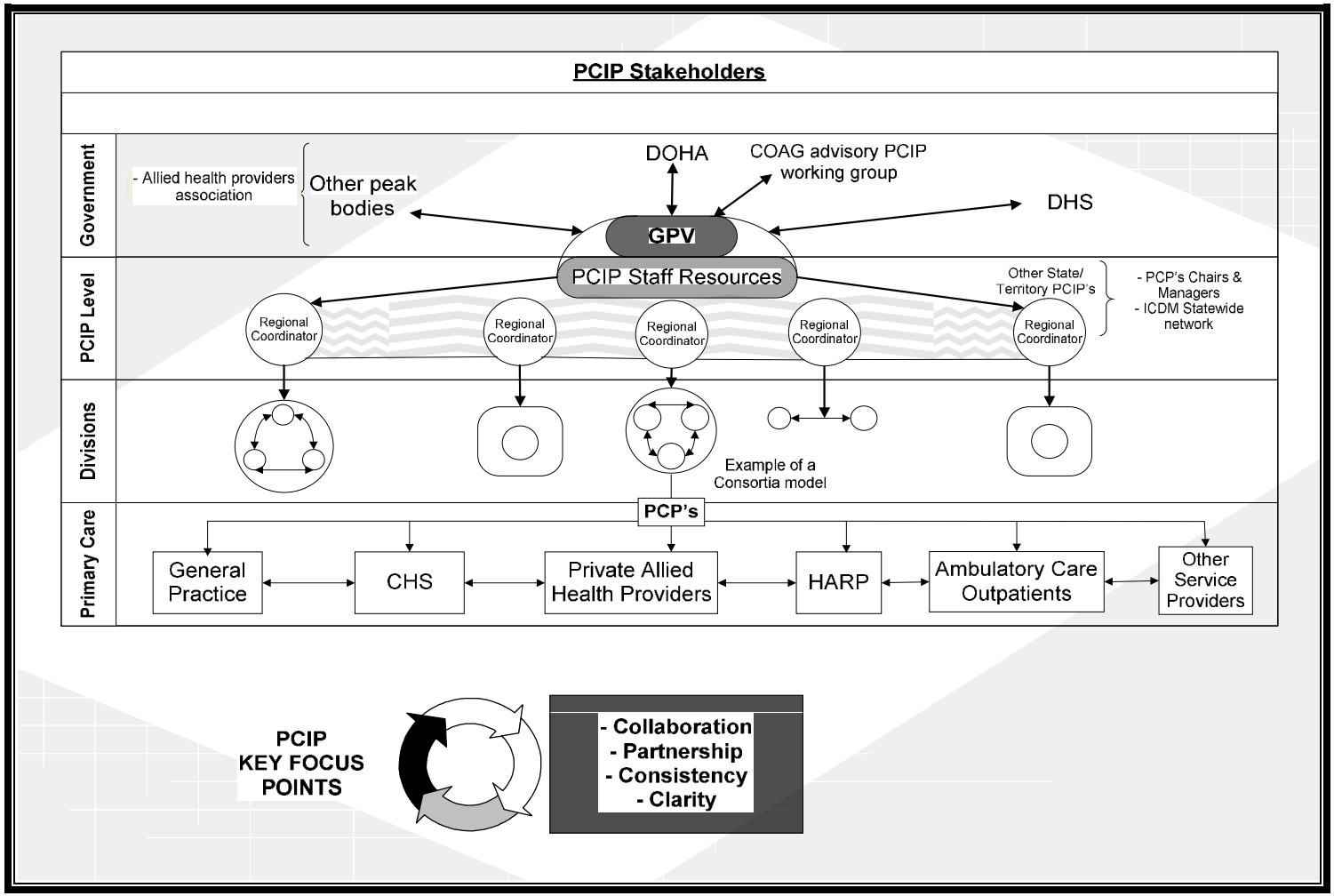
The PCIP State-wide Coordinator role is designed to provide State-wide coordination that supports a strategic and consistent approach in the development and enhancement of productive primary care partnerships, information sharing, stakeholder engagement and identification of opportunities to leverage off key State and Commonwealth initiatives. A series of activities are highlighted for this position across six key areas:

- Leadership
- Representation
- Communication
- Coordination
- Collaboration
- Administration

3.3 PCIP Stakeholders

A range of key stakeholders have been identified as part of the PCIP, the stakeholders are depicted in Figure 1.The schematic highlights the multiple levels and complexity of communication lines, relationships and partnerships that the PCIP initiative seeks to work across and helps to set the context for further planning areas for focused effort.

Figure 1. PCIP Stakeholder Schematic



3.3 Interview findings

Interview respondents from a range of positions agreed to participate in the interview process to provide their views on the PCIP and the role of the PCIP State-wide Coordinator. These interviews were conducted over the phone and face to face at GPV. The interviews generated a substantial amount of information from varying perspectives to inform the program logic development (Appendix 2).

In brief, the information gathered highlighted consistencies in the general understanding of the background, values, goals and key stakeholders involved in the PCIP initiative. All personnel described the PCIP as arising from the Australian Better Health Initiative and commented on the joint Commonwealth / State funding and collaborative approach as a strength of the PCIP. The underpinning values for the project identified consistent themes in responses; of integration; seamless care; collaborative understanding of CDM; the rights of the consumer and a population based approach to CDM. The degree of importance of these values varied depending on the position the interviewees held within the health sector and their direct responsibilities for the PCIP initiative.

3.3.1 The role of GPV

GPV is seen to hold an important role in assisting PCIP sites to achieve their goals. To fulfill this role GPV is armed with a range of resources described as including: the PCIP State-wide Coordinator role; dedicated funding, IM/IT systems; credibility with government, Divisions of General Practice, health services and peak bodies and existing learning's from other related GPV programs. A particular strength was noted of the State-wide Coordinator's role to act as a change agent, to work across the various sectors to translate and share information, identify strategic opportunities and trouble-shoot issues as they arise.

In the short time that the PCIP initiative has been in place, the following achievements have been noted:

- The establishment of the PCIP State-wide Coordinator role
- Engagement of PCIP Regional Coordinators (across the 15 projects / consortia) and Division staff
- Development of communication lines with relevant partners
- Establishment of regional PCIP peer networks and face to face and web-based communication mechanisms
- Facilitation of training and forums to assist in the development of work plans
- Establishment of supports for the use of IM/IT systems to improve data collection and extraction in CDM
- Progress in:
    - fostering a culture of sharing of information, resources and learnings across sectors
    - engendering integration of primary health care services as a key goal for PCIP initiatives
    - articulating a focus on improving relationships through better understanding of primary health care service providers roles and pathways to shared care

3.3.2 Challenges and limitations facing the PCIP

A series of challenges and limitations were identified by interview respondents:

Government level (State/Commonwealth)

- Absence of clear pathways
- Achieving a collaborative focus on better consumer outcomes whilst working across different systems, sectors, multiple providers and tackling issues with MBS items
- High expectations of PCIPs to overcome systemic barriers in short timeframes and limited funding
- Challenge to reflect impact and achievements for PCIPs - beyond KPIs. Being able to make defensible claims for links between activities and changing practice is difficult.

PCIP Program level

- Lack of clarity in program aims
- Acting as '*change agents not change leaders*'-the ability to influence but not to enforce change
- Potential questions and learnings from the process of the consortia group's development
- Onerous nature of work plan development
- Risk of processes taking precedence over the heart of the matter '*strengthened clinical connections between GPs and other clinical providers*' however this point was also countered with the view that it could be *'easy to get lost in the doing without a clear vision*'
- The value and importance of relationships - '*how do you value and justify time spent upon these?*'

Local level PCIP projects / consortia

- Integration of different types of care and negotiating an agreed pathway i.e. Medical and community models
- '*Reporting requirements are becoming more difficult*' due to reporting across a number of different but overlapping programs
- Funding considered to be a small amount for the task required with *'fuzzy funding boundaries*'
- Risk that individual PCIP projects / consortia may go off on a tangent to each other rather than taking a united and consistent approach
- Compatibility of PCIP systems
- Nature of IM/IT systems and set up at a Division and practice level

Across all sectors

- Capturing and measuring success and the related issues of attribution.

Potential challenges for integration and the development of collaborative relationships which are key to the success of PCIP include differences in:

- Intrinsic values and language used depending on the place in the health system
- Culture of the existing workplace
- Relationships
- Tradition and resistance to change
- Demographics
- Information systems
- All aspects for referring appropriately (who to, how to and receiving feedback)
- Gathering data
- Knowing how to locate services
- Modes of communication

3.3.3 Criteria for success

The State-wide Coordinator will play a key role in building vision and capacity at PCIP project / consortia level. This will include monitoring progress, gathering examples of information and resources which have worked and disseminating these amongst Victorian PCIPs and reporting to DHS and DOHA.

Interviewees were asked how they would determine whether the PCIP had been a success at its completion. The responses included:

- Performance indicators in the State-wide Coordinator's work plan would be met
- Engagement of allied health professionals in the strategic process and evidence that GP's and allied health are working together
- Relationships would be formed amongst primary health care providers
- Information sharing would be occurring, particularly examples of where PCIP initiative's are working well
- Improved communication between primary health care providers, particularly in understanding of each other's roles and in making appropriate referrals
- Improvement in coordination of care for people with CDM
- Progress would be seen in the use of MBS items i.e. GP referrals
- Appropriate use of business systems and audit tools e.g. Recall and reminder systems, clinical audit tools and Practice Health Atlas
- Improved quality and use of data:
    - Increased numbers of foot checks and eye checks being performed and recorded for diabetic patients
    - Increased numbers of home medication reviews for people on five or more medications
- GPs recognise and articulate the value of primary care providers
- General practices find it easier to refer and obtain feedback from public, private and allied health services about patients
- Consumers have access to services, and they are seeing the 'right person at the right time in the right place'
- Consumers are experiencing coordinated care

3.4 GPV Planning workshop (outcomes)

The program logic workshop undertaken on 3rd June at GPV was attended by a small group of key personnel involved in the PCIP initiative. The group was largely made up of GPV representatives from a range of areas and one representative from DOHA (Appendix 3). The planning meeting provided a forum for participants to review the key findings and the draft program logic for the first time.
The key objectives identified by the participants for the planning workshop were to:

- Identify priority areas for GPV activities from the program logic
- Refine the program logic
- Reach consensus from all stakeholders on the program logic so that it can be a useful working document

A presentation was given to set the scene for the work of the planning meeting. Upon reviewing the interview findings the group identified further issues and challenges related to the PCIP initiative for consideration including:

- The PCPs add another layer of complexity to the PCIPs
- Gate-keeper issues
- Different agencies involved in the PCIPs have differing objectives for their individual programs
- General Practitioners and the general practices are difficult to engage and consequently have can limit the capacity for practice change

A focused planning discussion was centred on the content of the draft program logic covering all areas of the logic chart. Specific focus was given to working through the Processes, Activities and Direct Outcomes components of the logic chart. This productive discussion allowed the group to clarify and revise the program logic components to come to an agreed representation of the PCIP (with an emphasis on GPV's role). The planning workshop provided a useful forum to meet all of the objectives set by the participants for the day. A subsequent consultation process to engage and gain input from DHS to further refine and focus the development of the program logic development was convened with the key DHS representatives as outlined in 3.6.

3.5 Prioritisation task

Feedback was sought from the workshop participants and other stakeholders for the content of the program logic in the form of a prioritisation activity. The participants were invited to prioritise the Processes, Activities, and Outcomes components in order from most to least significant, by rating the components. Only two completed forms were returned the feedback was discussed with the State-wide Coordinator and responses incorporated into the program logic chart accordingly.

3.6 DHS meeting (outcomes)

A meeting of GPV and relevant DHS staff was held on 30th June 2008 as a subsequent step in the consultation process following the program logic planning meeting.

The participants identified the following objectives for the meeting:

- To gain a better understanding of the program logic
- To determine the phases of the PCIP initiative, specifically how divisions will roll out the project
- To discuss PCIP implementation issues
- To identify opportunities for information sharing, collection and dissemination of learnings

ECHO provided a brief overview of the development of the program logic to date, including the key findings from the consultation phases and review of the program logic chart and stakeholder diagram. The meeting offered a valuable opportunity for discussion amongst the small group of participants around the objectives, the planning framework and potential opportunities and links that can be made through the PCIP initiative.

Of particular note were the following outcomes arising from the meeting:

- A shared understanding of the PCIP initiative from GPV and DHS perspectives
- An improved understanding of each other roles and the chance to build rapport amongst the participants
- DHS staff were able to share their thoughts and inputs about the PCIP, particularly regarding the program logic and stakeholder diagram
- Recognition from both GPV and DHS that differences exist in the understanding and language used for the relationship between Divisions and PCPs. The disparity of opinions highlighted to GPV that a clear and consistent position is necessary when articulating the 'divisions relationship with PCPs' in all documentation and correspondence

DHS staff expressed that the meeting had provided them an insight into the purpose of the program logic for PCIP that GPV have undertaken to assist them to develop a realistic and workable planning framework for the PCIP program.

3.7 Potential Opportunities and links

The program logic development process was considered to provide an opportunity to identify strategic alliances and links with other state programs and priorities for focus.

The following opportunities were identified to include:

- Agreement was reached for the development of a case study approach to showcase the good work of the PCIPs at the local level
- Working collaboratively between DHS and GPV at the program level by maximising resources through means of education, training and information sharing.

- Joint education and training opportunity - PCIP Regional Coordinators to attend relevant DHS forums/workshops e.g. MBS items, Community of Practice and HARP (Jane Canaway/ Peter Larter & Merrian Oliver-Weymouth)
- Improving communication and linkages between CDM teams and PCIP Regional Coordinators. DHS to circulate contact details for PCIP Regional Coordinators to Community Health Managers and PCPs (Kim Marr & Merrian Oliver-Weymouth)

- GPV would like to see the areas of program overlap put into perspective by exploring the use of the Wagner model to display these points of interception, as a model for change.

From the potential areas identified within the meeting it was agreed that the State-wide Coordinator would follow up with the relevant DHS staff.

4. The Program Logic & Planning Framework

The program logic and planning framework consists of four components:

- The Program Logic chart
- Bringing the Program Logic to life: planning for monitoring and evaluation
- Evaluation Questions
- Suggested activities/measures for monitoring and evaluation
- Recommendations

4.1 GPV PCIP Program Logic

The program logic was developed with a focus on the role of GPV in the PCIP, it makes explicit the factors and links in a chain of reasoning and presents the series of values, goals, resources, processes, activities and outcomes guiding the PCIP initiative.

Following the consultation phases of the planning workshop and meeting with DHS staff the program logic chart was significantly revised to incorporate all inputs and changes. Of note were the large number of activities and outcomes identified in the logic chart making the chart appear visually complex. The Activity and Outcome components were simplified by separating out each component into two columns and titled accordingly:

Activities

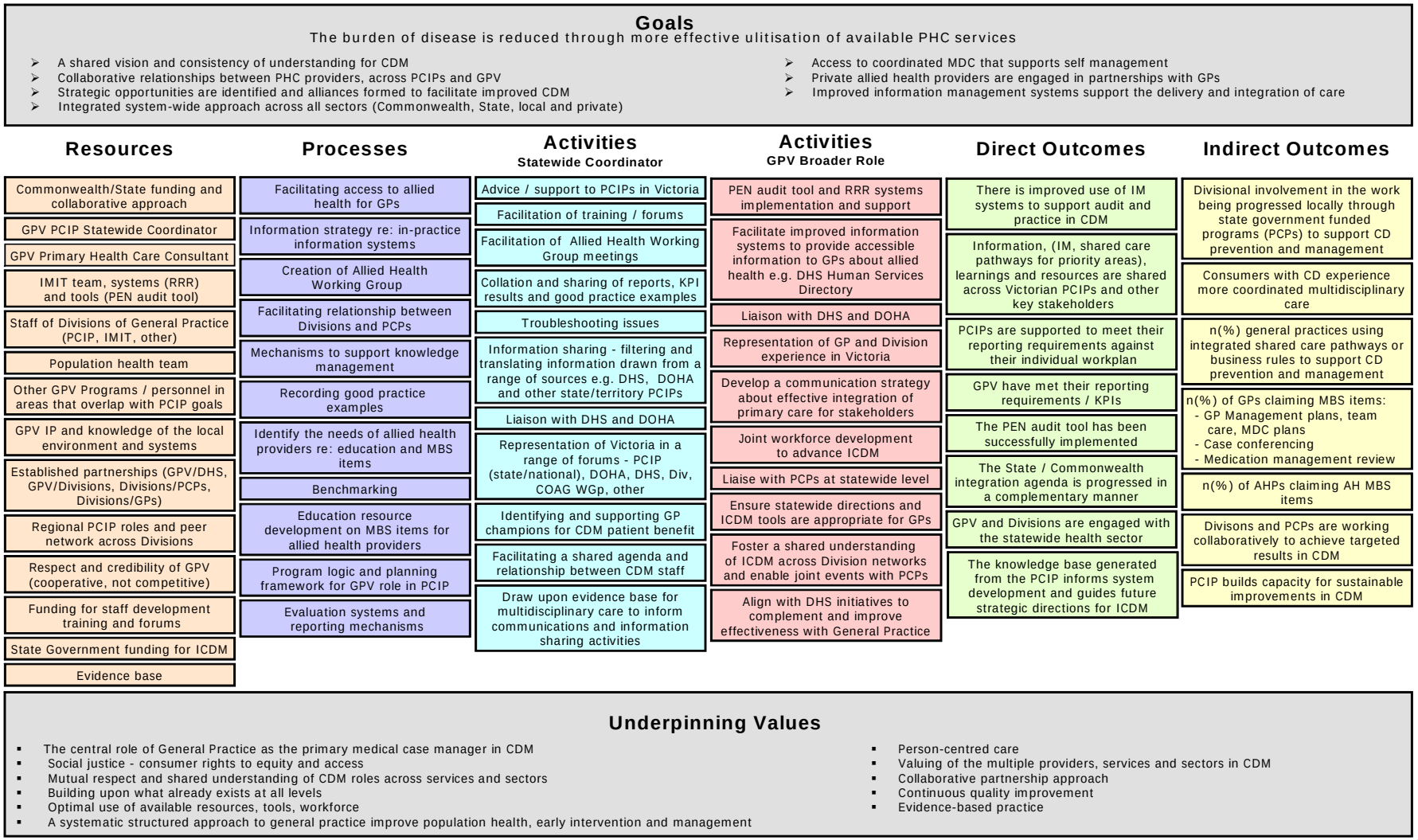
- *Activities Statewide Coordinator* - activities pertaining to the PCIP State-wide Coordinator role
- *Activities GPV broader role* - activities that pertain to a broader context for GPV's role

Outcomes

- *Direct outcomes* - based on the PCIP State-wide Coordinator role and areas of direct influence
- *Indirect outcomes* - including outcomes expected at the PCIP project / consortia level that the State-wide Coordinator through successful implementation of their role, will be aiming to influence.

Figure 2 depicts the refined program logic chart.

Figure 2. GPV PCIP Program Logic



4.2 Bringing the program logic to life: planning for monitoring and evaluation

The development of the program logic and planning framework provides a solid platform for developing monitoring and evaluation systems and processes to facilitate continual reflection and assessment of the effectiveness of the GPV role in the PCIP.

The next steps required to bring this planning framework to life as a tool for evaluation will include a thorough review of the planning framework for key methods to establish evaluation activities and systems to record and assess key activities, progress and outcomes. The benefit of establishing the proposed systems is two-fold, firstly to provide a comprehensive evaluation process for the life of the PCIP program and secondly to assist GPV to meet their reporting requirements to DOHA thus decreasing the onerous nature of reporting requirements.

Six key criteria have been identified from the program logic for monitoring and evaluation purposes. The six key criteria include: Knowledge Management, Information Management, Partnerships and Relationships, Integration, Achieving Specific PCIP Goals and Looking forward: building capacity and sustainability. Suggested evaluation questions centred around these criteria are provided in Table 1.

4.3 Suggested Key Evaluation Questions

Table 1. GPV PCIP Evaluation Questions

Suggested Evaluation Questions
Knowledge Management
What mechanisms have been developed to support knowledge management?
What activities have been undertaken to share knowledge and learnings as part of the PCIP?
How have knowledge management activities through the PCIP contributed to:
-achieving PCIP goals and reporting requirements?
-systems development?
-sustainable approaches to ICDM?
Information Management
What activities have been undertaken to implement and support the use of registry, recall and reminder systems and the clinical audit tools?
What is the perception of and uptake of IM systems across PCIP program sites?
What impact have the IM systems had for improving ICDM?
Partnerships and Relationships
What strategic partnerships/relationships have been developed or enhanced through the PCIP?
What is the perceived value of the relationship between the State-wide Coordinator and the PCIP Regional Coordinator/ program sites?
Integration
What activities has GPV undertaken to more closely align Divisions/PCIPs with other DHS and DOHA initiatives and directions?
In what ways has the GPV role in PCIP influenced a shared CDM agenda across GPV program areas?
Achieving specific PCIP goals
How has GPV supported the PCIPs to meet their reporting requirements?
What progress has GPV made towards meeting their specific reporting requirements?

Table 1. continued

Looking forward: building capacity and sustainability
What capacity for ICDM has been built through the GPV role in the PCIP? In terms of:
-Knowledge management
-Information management
-Partnerships and Relationships
-Integration
What opportunities exist to further build capacity for GPV in ICDM?
What are the strategic priorities for GPV in ICDM?

4.4 Suggested activities to generate data to address the evaluation questions

The following activities are provided as suggestions for how to address the identified evaluation questions and establish routine mechanisms for ongoing monitoring and evaluation purposes for the duration of the PCIP initiative. The activities are designed to capture a mixture of qualitative and quantitative data, and require a whole of system approach between GPV/PCIP Regional Coordinators/Divisions and within GPV.

Table 2. Suggested activities

Knowledge Management
• Review key documentation to identify activities undertaken to gather, retain and make accessible knowledge from learnings throughout the PCIP e.g. information sharing and disseminations strategies, web based networks, forums, training, recording of stories, good practice examples and case studies • State-wide Coordinator to maintain a journal of interactions (activities and communication) with PCIP Regional Coordinator/ program sites and other key activities to guide evaluation of the role and its focus. The journal should have a focus on capturing key outcomes as listed in the program logic and evaluation questions • Establish routine feedback mechanisms for PCIP Regional Coordinators and project sites to communicate and trouble shoot issues relating to PCIP i.e. web-forum, teleconference • Conduct routine interviews and surveys of PCIP sites/consortia to capture information on the value of knowledge management activities in attaining PCIP goals, reporting requirements, development of systems and making sustainable approaches to ICDM
Information Management
• Liaise with e-health staff to determine activities undertaken to implement and support the ongoing registry, recall and reminder systems and clinical audit tools • Seek feedback through a routine survey of PCIP Regional Coordinator/sites to gauge perceptions on e-health system implementation and adequacy of support provided by GPV • Review documentation to determine the impact of e-health systems use on CDM

Table 2. continued

Partnerships and Relationships
• Review stakeholder diagram and document a baseline perspective on the existing relationships, information transfer, communication modes. Undertake a comparative review of partnerships/relationships at selected time intervals over the course of the program recording enhancements observed and evidence to support these observations • Conduct an internal survey of GPV to determine how existing strategic partnerships align with the strategic directions of ABHI PCIP. Determine areas that require focussed attention and review progress over time • Conduct an independent survey/focus group of PCIP Regional Coordinator/sites to gain feedback upon the value of the relationships between the State-wide Coordinator role, the PCIP sites and other stakeholders
Integration
• Conduct a survey of PCIP program sites to determine the level of influence that the GPV role has had upon a shared CDM agenda across program areas over selected time intervals
Achieving specific PCIP goals
• Conduct an independent survey of PCIP Regional Coordinator/sites to determine the level of influence of GPV role for reporting requirements • Review key documents i.e. PCIP reports, GPV reports to DOHA for evidence of reporting requirements being met • State-wide Coordinator to maintain a journal of activities and stories/anecdotal reports that provide evidence to support achievement of reporting targets
Looking Forward: Capacity and Sustainability
• Review key documents for evidence of capacity building activities, good practice examples and sustainable measures as a result of PCIP and GPV role i.e. PCIP progress reports, State-wide Coordinator journal • Conduct a targeted forum/s to review PCIP achievements/strategic directions involving PCIP Regional Coordinators/sites and GPV staff near the completion of the program.

4.5 Recommendations

The next steps required in order to make the best use of the newly developed GPV PCIP program logic and planning framework from this point on are to:

1. Review the program logic and planning framework against the DOHA reporting requirements and align with DOHA plan for GPV
2. Review the program logic and planning framework against the State-wide Coordinators work plan, compare and update work plan as deemed necessary
3. Utilise the program logic as a communication tool for interactions with the PCIP program sites
4. Establish systems to facilitate monitoring and evaluation data collection and reporting
5. Explore overlay/ alignment with the Wagner model for change
6. Review potential opportunities and links that were identified for GPV and the PCIP and assess program and achievements periodically. Set up routine meeting with DHS to report progress made.

5. Appendices

Appendix 1: Excerpt from ABHI Primary Care Integration Program

Minimum Reporting Requirements

Focus	Performance Indicator
1. Collaboration between primary and community care services.	The number and proportion of general practices using integrated shared care pathways or business rules to support chronic disease prevention and management.
	Divisional involvement in the work being progressed locally through state government funded programs [e.g. *insert name of specific state primary care integration initiative e.g. CHIC, HealthOne NSW, PCPs]* to support chronic disease prevention and management.
2. The use of electronic systems or communications applications to support integrated primary care.	The extent of general practices using a communications application, or an electronic system between primary care providers and hospitals where relevant, that supports the timely and appropriate exchange of patient information, e.g.: clinical software tools, secure messaging.
3. Uptake of MBS items that support integrated primary care service delivery for patients with chronic disease including those with complex needs.	The number and proportion of general practitioners claiming MBS GP Management Plans, Team Care Arrangements, and Multidisciplinary Care Plans items (721 – 731).
	The number and proportion of allied health professionals claiming Allied Health Services MBS items (10950 – 10970 and 81100 – 81125).
	The number and proportion of general practitioners claiming case conferencing items (734 – 779).
	The number and proportion of general practitioners claiming Medication Management Review items (900 and 903).

Appendix 2: Interview respondents and questions

Interview respondents

Aimee Black	Population Health and Chronic Disease Management, GPV
Michelle Callander	Health Strategies Branch, DOHA
Jane Canaway	Primary Care Branch, DHS
Chris Hayward	IMIT Team Leader, GPV
Lenora Lippman	Integration Team Leader, GPV
Sharon Lowe	Ballarat Division of General Practice
Michelle MacGillivray	Ballarat Division of General Practice
Andrew McPherson	CEO, Ballarat Division of General Practice
Ross Nable	Research Field Officer – Information Management, GPV
Merrian Oliver-Weymouth	ABHI PCIP Coordinator, GPV
Mary Saunders	Program Manager, Monash Division of General Practice
Sonya Tremellen	Primary Health Care Consultant, GPV (now Team Leader, General Practice Development)

Interview questions

1. What is your role in the Primary Care Integration Project?
2. Please describe the Australian Better Health Initiative in your own words?
3. Please describe the Primary Care Integration Program in your own words?
4. What do you consider to be the values that underpin the ABHI and PCIP?
5. What are the goals of the PCIP?
6. What is the role of the GPV in the Victorian component of the PCIP?
7. What resources/assets does GPV have to help fulfill this role?
8. Who are the key stakeholders in this project?
9. What can be achieved in the short/long term?
10. What has already been achieved?
11. How will PCIP initiatives impact upon other key programs areas within the GPV? E.g. Disease registers, recall and reminders.
12. What are the strengths of the PCIP initiative?
13. What are the limitations or challenges facing the PCIP?

14. At the completion of the project, how would you know that the PCIP initiative and GPV's involvement had been a success?

PCIP Program site questions

15. What would you see as the role of GPV?
16. What do you see as the role of the Primary Care Integration Regional Coordinator?
17. What type of support do you require to complete the PCIPs?
18. How might we work together?

Appendix 3: GPV Planning workshop participants

GPV Planning Workshop 3rd June 2008

Present

Merrian Oliver-Weymouth	ABHI PCIP Coordinator, GPV
Lenora Lippman	Integration Team Leader, GPV
Sonya Tremellen	Primary Health Care Consultant, GPV (now Team Leader, General Practice Development)
Michelle Callander	Health Strategies Branch, DOHA
Louise Willis	Policy Analyst, GPV
Brendan Wickham	Program Consultant e-Health Support, GPV

Apologies

Aimee Black	Population Health and Chronic Disease Management, GPV
Jane Canaway	Primary Care Branch, DHS
Ross Nable	Research Field Officer – Information Management, GPV
Mary Saunders	Program Manager, Monash Division of General Practice

Appendix 4: List of participants from GPV and DHS staff meeting

Primary Health Branch

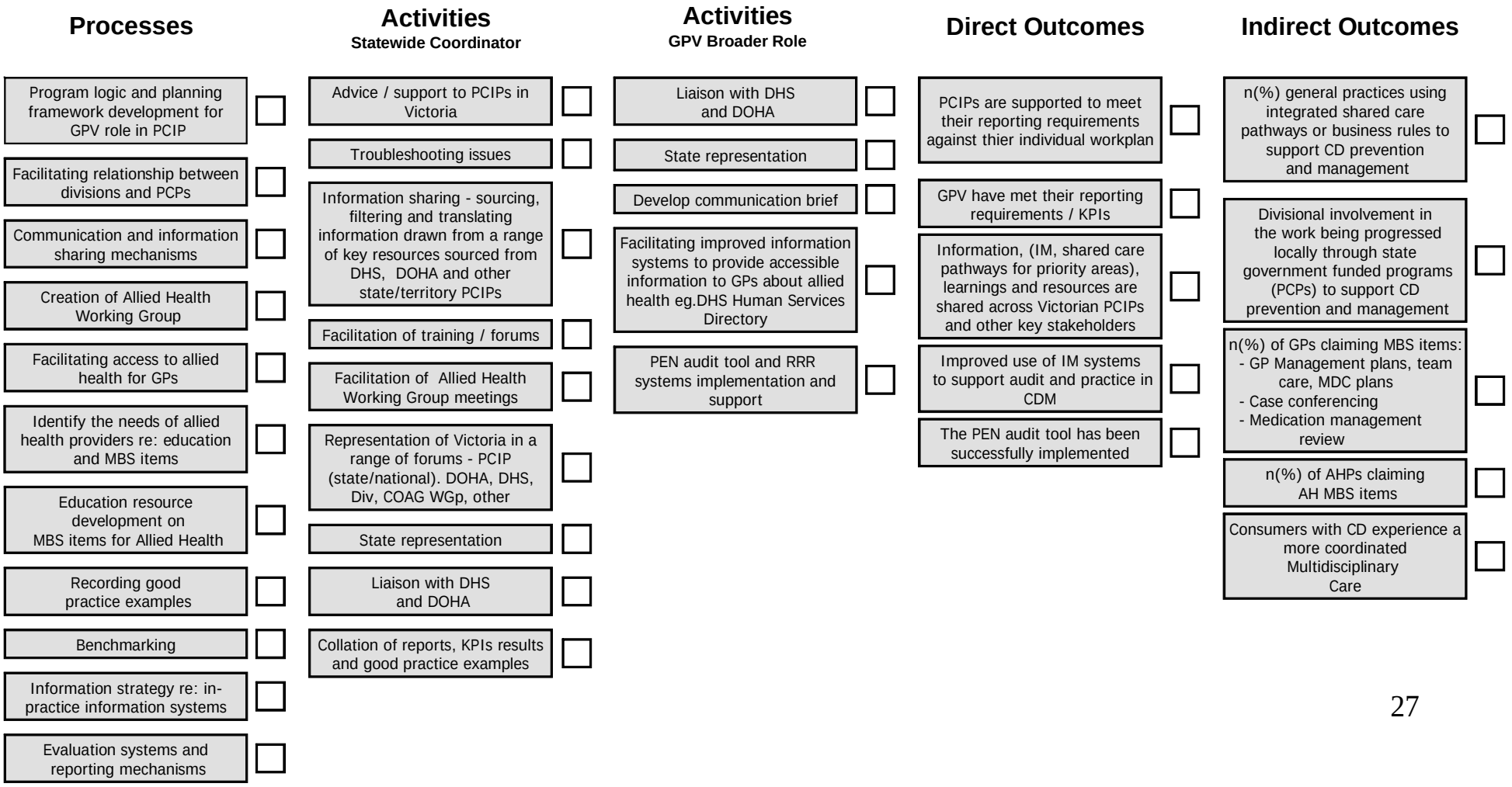
Jane Canaway	Primary and Community Health
Kim Marr	Manager General Practice Partnerships, Primary Health, Rural & Regional Health & Aged Care Services
Sylvia Barry	Strategic Development Manager, Primary and Community Health
Peter Larter	Senior Policy Officer, General Practice Partnerships Team, Primary Health

General Practice Victoria

Lenora Lippman	Integration Team Leader
Merrian Oliver-Weymouth	ABHI PCIP Coordinator

Appendix 5: Prioritisation activity for the program logic

To determine priority areas for focus for GPV, a prioritising activity has been designed to focus on the content of the program logic areas. Please prioritise the Processes, Activities, and Outcomes components in order of most to least significant, by rating these from 1, 2, 3… onwards for each area.



6. List of Abbreviations

AHPA	Allied Health Providers Association
COAG	Council of Australian Governments
CD	Chronic Disease
CDM	Chronic Disease Management
CHS	Community Health Services
DHS	Department of Human Services
DOHA	Department of Health and Ageing
GP	General Practice
GP	General Practitioner
GPV	General Practice Victoria
HARP	Hospital Administration Risk Program
ICDM	Integrated Chronic Disease Management
MDC	Multi-Disciplinary Care
PCP	Primary Care Partnerships
PCIP	Primary Care Integration Program
PHC	Primary Health Care

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