Australian Government

Department of Health and Aged Care

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# Primary Health Network Program Annual Performance Report 2018-19

# Acknowledgement

This document was developed by the Australian Government Department of Health as part of the Primary Health Networks Program Performance and Quality Framework.



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### Disclaimer

Opinions expressed in PHN Program Performance Report 2018-19 are those of the authors and not necessarily those of the Australian Government Department of Health. Data may be subject to revision.

## Contents



# 1. Introduction

This is the first Primary Health Networks (PHN) Program-wide performance report conducted under the PHN Program Performance and Quality Framework (the Framework). The Framework commenced on 1 July 2018. It is the first outcomes based reporting framework for the PHN Program, and was developed in close collaboration and consultation with PHNs.

The Framework introduced a set of program outcomes across five themes: addressing needs, supporting quality care, improving access, coordinated care and capable organisations. Performance indicators are used to measure individual PHNs' progress towards these outcomes. These indicators were selected as they reflected areas where PHNs could be expected to influence changes. In addition, a number of Program wide performance indicators have been collected to assist in measuring how the PHN Program contributes to achieving a range of health outcomes.

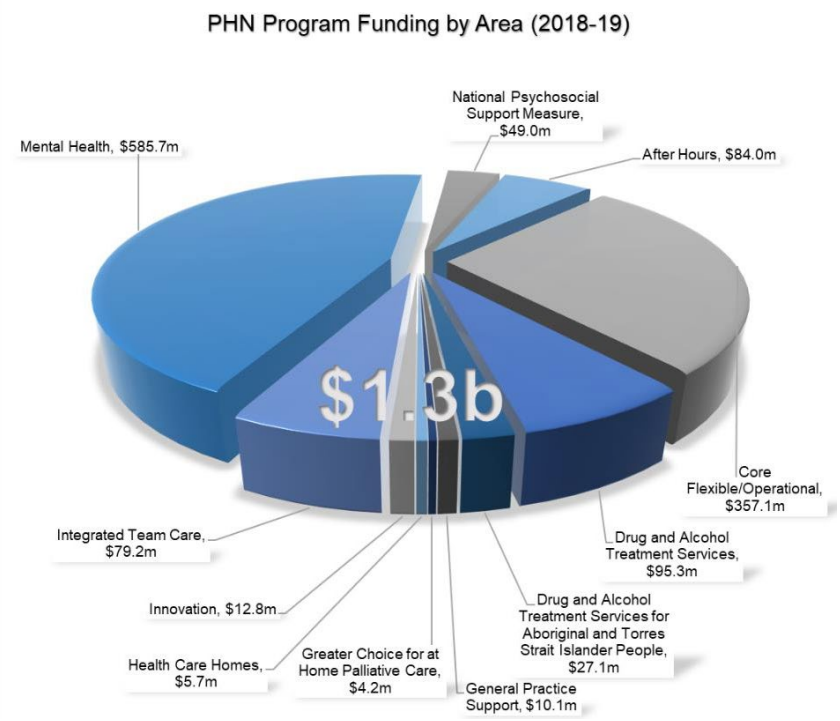
PHNs reported against the performance indicators in their 12 Month Performance Reports. These reports include reporting on financial expenditure, delivery of activities and the performance indicators. The Department assessed the performance of each individual PHN, which informed decisions around contract extensions. The individual assessments have been drawn on to create this PHN Program Performance Report.

The Framework and supporting documentation can be found on the Department's website.

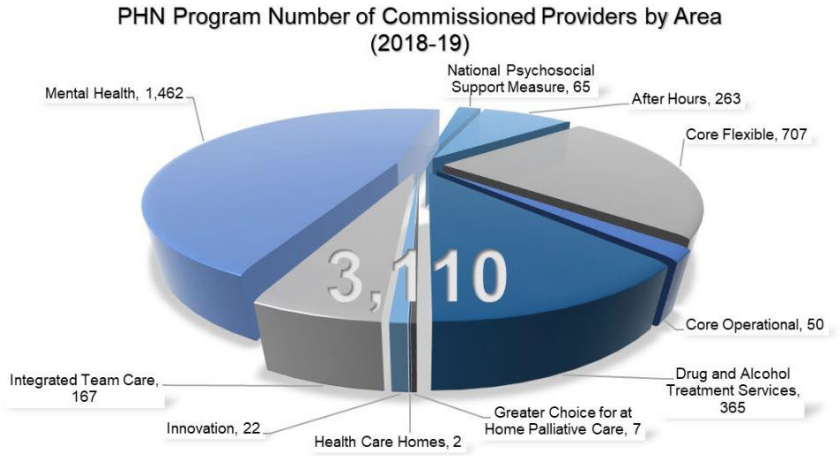
# 2. PHN Program Overview

## 2.1 Allocation of PHN Funding

The Primary Health Networks Program funding of $1.3 billion[1] in 2018-19 was allocated across eleven key areas, with the greatest amount allocated to Primary Mental Health Care services, followed by Core Flexible and Operational, then Drug and Alcohol Treatment services.




On the basis of needs assessment and prioritisation, the PHNs commissioned regional specific services and health care interventions, taking into account determining who should provide the services and how they should be paid, and working closely with providers to do this. In 2018-19, this enabled 3,110 service providers to be engaged to deliver over 1,200 activities, with the majority of service providers commissioned to deliver mental health services.




[1] Note: Amount includes Departmental funding and amounts carried forward from prior years.

## 2.2 Highlights for 2018-19

The Department identified six outcomes as key highlights for the PHN Program in 2018-19:

- PHN activities and initiative address local needs
- PHNs support general practices and other health care providers to provide quality care to patients
- PHNs support general practices and other health care providers to provide quality care to patients
- People in the PHN region receive coordinated, culturally appropriate services from local health care providers
- Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care
- PHNs support health care providers to use digital health systems to improve patient care and communication

## 2.3 Summary of Outcome Achievements

**Outcome: PHN activities and initiative address local needs**

The PHN Program's key contribution to improving health outcomes of Australian community is the delivery of services designed to meet the needs of their region. The PHNs are working in collaboration with local health care providers and their communities to identify health needs and design and deliver services to address those needs.

The most common needs identified in 2018-19 included mental health services, drug and alcohol treatment services and management of chronic health conditions. Further analysis of prioritised health needs across Australia will be possible in 2019-20 due to the introduction of the PHN Program Electronic Reporting System.

**Outcome: PHNs support general practices and other health care providers to provide quality care to patients**

All PHNs are delivering comprehensive support programs for general practices. PHNs offer a broad range of support to general practices including face-to-face practice visits, GP support phone lines, arranging and hosting education and networking events, and providing topical newsletters.

PHNs are also supporting the introduction of new models of care, such as Health Care Homes (HCH), which provides patients with chronic and complex health conditions and through the Greater Choice for At Home Palliative Care (GCfAHPC) Pilot Measure, which enables participating PHNs to implement different initiatives that aim to improve access to safe, quality palliative care at home. As at 22 April, there were 123 practices registered and 9,151 patients enrolled in HCH. Under the GCfAHPC Measure, eleven PHNs have received funding to engage staff members and implement different models, to help improve awareness for patients and health providers, and facilitate access to palliative care services at home, including advance care planning.

**Outcome: PHNs support general practices and other health care providers to provide quality care to patients**

PHNs have been integral to the roll out of the new Practice Incentive Program Quality Improvement (PIP QI) measure. The new PIP QI aims to recognise and support those practices that commit to improving the care they provide to their patients.

Practices participating in PIP QI are supported by PHNs to utilise the clinical information they have about their own communities and their knowledge of the particular needs of their own patients to develop innovative strategies to drive improvement.

Nearly 5,900 practices are registered under PIP QI with all practices sharing a minimum set of de-identified aggregated data with their local PHN. This includes the proportion of patients who are diabetic, the proportion who smoke, the cardiovascular risk and weight profile. This information is being collated at the local level by PHNs to assist in supporting improvement and understanding population health needs.

**Outcome: People in the PHN region receive coordinated, culturally appropriate services from local health care providers**

PHN have a key role in building integration in the primary health sector and the broader health system, with the aim of improving integration of services, coordination of care and ultimately health outcomes for patients.

A key component of this integration work is improving relationships and partnerships between local hospitals and primary care. PHNs have established GP Liaison Units in hospitals, commissioned Local Hospital Networks to deliver early intervention services, and developed new patient care pathways to improve the process for patients leaving hospitals.

PHNs also lead the development of Health Pathways in their region. The development of these pathways brings together health providers across the region to identify and agree on best practice for managing different health needs. As a result, services become more coordinated and easily accessible for patients.

**Outcome: Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care**

Aboriginal and Torres Strait Islander Health is a priority area for the PHN Program. In 2018-19, PHNs contributed to the provision of culturally safe and accessible primary care for Aboriginal and Torres Strait Islander people by working with primary health sector to improve access and delivery and collaborate with Aboriginal and Torres Strait Islander health care providers.

PHNs delivered coordinated care services under the Integrated Team Care (ITC) program to 39,000 Aboriginal and Torres Strait Islander people. As part of ITC PHNs also engaged with mainstream primary health services to improve understanding and awareness of Aboriginal and Torres Strait Islander health issues. PHNs also supported commissioned mental health care and drug and alcohol providers to deliver culturally appropriate services to their Aboriginal and Torres Strait Islander clients.

Across all PHNs, a reported $147.4 million (12.7 per cent of total PHN funding) was used to fund over 520 Aboriginal and Torres Strait Islander-specific activities in the 2018-19 financial year.  Of this, $91 million (7.8 per cent of total PHN funding) was provided to ACCHSs, AMSs or Aboriginal and Torres Strait Islander organisations.

There are many examples of where PHNs have developed proactive engagement and strong partnerships with their local ACCHS, AMSs and Aboriginal and Torres Strait Islander organisations. The Department is working with PHNs and ACCHSs to improve engagement and health outcomes for Aboriginal and Torres Strait Islander people. This includes the commitment to a PHN and ACCHS Collaboration Forum (Collaboration Forum) in 2020, which will involve the National Aboriginal Community Controlled Health Organisation (NACCHO), ACCHS and PHNs (recently postponed until later in 2020 from 31 March 2020 due to the COVID-19 outbreak).

**Outcome: PHNs support health care providers to use digital health systems to improve patient care and communication**

PHNs have supported and encouraged the uptake and use of digital health tools, including My Health Record, via their GP Support programs. Digital Health is a priority area for the PHN Program as it can enable better-coordinated care and better informed treatment decisions for patients.

PHNs reported that 99% of general practices and 100% of pharmacies were informed and encouraged to use My Health Record (PHNs were funded for this activity by the Australian Digital Health Agency). There was also an increase in 27 PHN regions in the rate of regular uploads to My Health Record by GPs, which suggests that this tool is being used more regularly leading to better coordination of care and outcomes for patients.

## 2.4 Areas for Improvement in Future Years

The performance assessment process identified a number of areas for improvement and focus for the PHN Program. These include:

**Outcome: PHN commissioned mental health service improve outcomes for patients**

Improving the reporting by commissioned mental health service providers – while the Mental Health indicators have been set at baseline level, the Department expects that PHNs will continue to work with their commissioned providers to increase and improve the required reporting via the National Mental Health Data Set.

**Outcome: People in PHN region are able to access appropriate drug and alcohol treatment services**

Supporting accreditation process of drug and alcohol treatment service providers – the development of the National Quality Framework for Drug and Alcohol Treatment Services identifies a list of accreditation standards and includes a three-year transition period. PHNs have identified that there are barriers to smaller providers being able to take on accreditation.

**Outcome: Health care providers in PHN region have an integrated approach to mental health care and suicide prevention**

Improving the follow up of persons who attempted suicide – in 2018-19, on average across the PHNs only 52.7 per cent of persons who had attempted suicide were followed up within seven days. Most PHNs advised that they are investing in new approaches to improve the follow up rate. The target is for all persons to be followed up within seven days.

**Outcome: Local workforce has suitable cultural and clinical skills to address health needs of PHN region**

Improving the support for health workforce – most PHNs were able to report on how they are supporting their local health workforce, including the Aboriginal and Torres Strait Islander identified health workforce. However there are some regions where this support is limited and could benefit from a more integrated and planned approach.

**Outcome: Older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home**

The design and delivery of health care to older people will also be an area for future focus for the PHN Program, noting the ongoing Royal Commission into Aged Care Quality and Safety. While Aged Care is a priority area within the PHN Program there has been limited focus on it to date within the Program. PHNs are well placed to work with other health care providers to implement recommendations from the Royal Commission.

## 2.5 Recommendations

The Program Report makes a number of recommendations to improve reporting and assessment of performance. The recommendations will be implemented by the Department in consultation with PHNs.

| Outcome Theme | Recommendation |
|---|---|
| **Addressing Needs** | 1. Continue to monitor how PHNs identify and address prioritised health needs<br>2. Continue to monitor the delivery of ITC services to ensure they are meeting needs |
| **Quality Care** | 3. Support PHNs to improve service provider reporting for Mental Health services in their regions<br>4. Consider provision of additional guidance to PHNs on how to support the delivery of culturally appropriate services to Aboriginal and Torres Strait Islander people<br>5. PHNs consider how to better support Aboriginal and Torres Strait Islander identified health workforce in their regions<br>6. Support PHNs to assist drug and alcohol treatment providers to achieve appropriate accreditation<br>7. PHNs address how cultural appropriateness is considered as part of commissioning cycle in their Commissioning Frameworks<br>8. Support PHNs to collect information on use of digital tools by health care providers in their regions |
| **Improving Access** | 9. Support PHNs to consider ways to improve access of aged care residents to primary health care assessments<br>10. Support PHNs to consider ways to improve the rate of health assessments being conducted for persons over 75 years<br>11. Source further data to assist in measuring coordinated care for Aboriginal and Torres Strait Islander people |
| **Capable Organisations** | 12. PHNs consider ways to improve representation on PHN Boards of Aboriginal and Torres Strait Islander people<br>13. The Department and the PHNs continue to work together to improve financial understanding across the Program with a view to achieving consistency in financial reporting |

# 3. Indicator Assessment

## 3.1 Addressing Needs

The Addressing Needs outcome theme measures the progress of PHNs in meeting the health needs of people in their region. All PHNs are required to conduct formal analysis and planning of regional health priorities (a Health Needs Assessment) to target available resources and services to meet these health needs.

**Outcome: PHN activities and initiatives address local needs**

**Assessment:** The PHN Program is successfully identifying and addressing prioritised health needs across Australia. PHNs are actively engaged in improving health outcomes by introducing innovative new models of care, working with health care providers to address needs and building relationships across the health sector.

More information: Fact Sheet: Primary Health Networks and PHN Needs Assessment Guide

**P1 – PHN activities address prioritised needs**

All activities delivered by PHNs address prioritised needs.

PHNs provided evidence in their twelve-month reports that their delivered activities addressed prioritised regional and/or national priorities. 3,110 providers were commissioned to provide services across the PHN Schedules.

**100%**
of PHNs

Among the most common needs identified across the PHN Program, were management of chronic conditions, mental health support, and drug and alcohol treatment.

**P2 – Health system improvement and innovation**

All PHNs are making improvements in their local region through health system improvements, innovation or commissioning best practice.

PHNs are supporting a range of improvements and innovations in their regions including:

**100%**
of PHNs

- improving relationships and partnerships between local hospitals and primary care through GP Liaison Units, commissioning Local Hospital Networks to deliver early intervention services, and developing new patient care pathways to improve the process for patients leaving hospitals;

- development of new Health Pathways in their region, bringing together health providers across the region to identify and agree on best practice for managing different health needs;
- leading development and delivery of new models of care, such as Health Care Homes, palliative care, coordinated care for chronic conditions and integrated holistic health approaches for Aboriginal and Torres Strait Islander people;
- leading emergency response planning in their regions, which necessitates the building of relationships across different providers; and
- encouraging and supporting the uptake of new digital health systems.

**Outcome: PHNs address needs of Aboriginal and Torres Strait Islander people in their region**

**Assessment:** PHNs are successfully delivering the Integrated Team Care (ITC) program, which provides culturally appropriate one-on-one assistance by Care Coordinators to Aboriginal and Torres Strait Islander people with complex chronic conditions. The ITC program contributes to better treatment, management, access, and service capacity.

Enrolment in the ITC program has remained consistently high since its inception, indicating high demand for culturally appropriate, one-on-one care coordination for chronic disease.

More information: Integrated Team Care (ITC)

**IH1 – Numbers of ITC services delivered by PHN**

A total of 962,136 unique services were delivered to around 39,000 Aboriginal and Torres Strait Islander people via the Integrated Team Care (ITC) program.

**962,136**
unique services

The ITC program supports eligible Aboriginal and Torres Strait Islander people to receive the coordinated care they require to address their particular chronic disease needs. This includes care coordination, supplementary, and clinical services.

**IH2 – Types of Organisations delivering ITC services**

All PHNs have established good relationships with a broad range of health care providers to ensure that ITC patients can access appropriate services.

On average PHNs engaged with between five and six organisations, ranging from Aboriginal Medical Services, mainstream organisations and sometimes from the PHN.

**100%**
of PHNs

**Outcome: Fewer preventable hospitalisations in PHN region for people with chronic and vaccine preventable diseases**

**Assessment:** The PHN Program contributes to achieving reductions in potentially preventable hospitalisations for acute and vaccine preventable diseases through improving general practice care and ensuring delivery of the right care at the right time.

More information: Australian Institute of Health and Welfare (AIHW)

**P12 – Rate of potentially preventable hospitalisations (PPH) – for specific chronic diseases**

In 2017-18 (latest available data), the national number of potentially preventable hospitalisations for chronic and vaccine-preventable diseases was 683,046 and 168,772 respectively. For chronic diseases, the outcome represents a positive result with only a one per cent increase from the previous year. For vaccine preventable diseases however, the outcome shows a marked increase from the previous year.

The average yearly increase in the number of PPH for chronic diseases since 2013-14 through to 2017-18 has been six per cent. PPH for vaccine preventable diseases the average yearly increase has been 22 per cent.

**PPH**
**1%**
increase for chronic and
**51%**
increase for vaccine preventable from previous year

**Recommendations for Addressing Needs**

- Continue to monitor how PHNs identify and address prioritised health needs
- Continue to monitor the delivery of ITC services to ensure they are meeting needs

## 3.2 Quality Care

The PHN Program aims to improve quality of care for patients by providing support to general practices and other health care providers. Through their GP Support programs PHNs support the adoption of new quality care approaches including Health Care Homes trial, coordinated care for patients with chronic conditions and using digital health technologies such as telehealth for patients in rural areas. PHNs also support GPs and other health care providers to understand and deliver culturally appropriate care through facilitating training and education sessions.

**Outcome: PHNs support general practices and other health care providers to provide quality care to patients**

**Assessment:** The PHN Program is supporting general practices and other health care providers to provide quality care to patients. Both higher rates of accreditation and practice support activities contribute to increased quality for patients and a consistent standard of care.

PHNs will need to consider how they can ensure the ongoing uptake and use of My Health Record Expansion by GPs and other health care providers in future years.

More information: Fact Sheet: PHN Practice Support and Digital Health Data

**P3 – Rate of general practice accreditation**

The national average rate of general practices that are accredited is 78.4 per cent. Accreditation rates range from 61.2 per cent to 95.8 per cent across Australia. Future reporting will look to see an increase from this baseline measurement.

An increase in the national average is anticipated for 2019-20 considering the introduction of PIP QI payments is limited to accredited practices.

**78.4%**
of GPs
(Baseline)

**P4 – Support provided to general practices and other health care providers**

All PHNs support general practices and other health care providers that facilitate the improvement of the health care system within its region.

**100%**
of PHNs

Support provided to general practices by PHNs include:

- Data sharing, management and optimisation to improve quality of care in practices;
- Adopting quality improvement approaches within practices;

- New models of care including patient centred, team based, nurse led
- Improving screening for health risk factors and immunisation
- Improving practice management approaches
- Identifying and preparing for workforce shortages
- Adopting new digital health measures including My Health Record, telehealth, e-referrals
- Preparing for and undertaken accreditation.

The work of the PHNs in supporting general practices in this way is hard to quantify or measure. However, other indicators such as the rate of use of digital health tools (see below for further discussion), the rate of accreditation (indicator P3), and the rate of GP team care arrangements (P9) consider the impact of this work. The Department will also continue to monitor the potentially preventable hospitalisations rate, national immunisation rate and breast, bowel and cervical cancer rates to identify where PHNs may need to focus efforts.

**P5 – Rate of regular uploads to My Health Record**

The national average rate of regular General Practice uploads has increased to 13.8 per cent in 2017-18.

**13.8%**
General practices

27 PHNs recorded an increase in the use and uploads of documents to My Health Record in general practices, and 13 regions saw increase in pharmacy use.

**Outcome: PHN commissioned mental health services improve outcomes for patients**

**Assessment:** All PHNs are working with their commissioned mental health service providers to record outcomes for patients receiving services. Improving the collection of outcomes is an important starting point before the Department and PHs can measure whether the services commissioned by PHNs are improving outcomes for patients.

More information: Primary Mental Health Care Minimum Data Set (PMHC-MDS)

**MH6 – Outcomes Readiness - Completion rates for clinical outcome measures**

A median of 25.5 per cent of completed episodes of care have recorded outcome measures at Episode start and Episode end. This will be the baseline measurement for future reporting.

**25.5%**
of episodes (Baseline)

Two PHNs reported that 70 per cent of completed episodes of care had a recorded valid outcome measure at Episode start and Episode end. A further 12 PHNs were above the national average rate of 27.9 per cent and the remaining 17 PHNs were below the national average. One PHN reported data collection problems that will need to be resolved in next reporting period.

**Outcome: Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people**

**Assessment:** The PHN Program is supporting local health care providers to provide cultural appropriate mental health, alcohol and other drugs and mainstream health services to Aboriginal and Torres Strait Islander people.

PHNs will need to consider how to build and maintain continuous improvement across their regions to ensure Aboriginal and Torres Strait Islander people are able to access culturally appropriate services.

More information: National Quality Framework for Drug and Alcohol Treatment Services and Primary Mental Health Care Minimum Data Set (PMHC-MDS)

**IH3 – Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people**

Most PHNs supplied evidence to ensure drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people in order to meet the performance criteria. Five PHNs did not meet reporting requirements for this indicator.

**84%**
of PHNs

The PHNs that did not meet this indicator are required to show that commissioned services are culturally appropriate in the next reporting period.

**IH4 – Proportion of PHN commissioned mental health services delivered to the regional Aboriginal and Torres Strait Islander population that were culturally appropriate**

A national average proportion of 61.3 per cent of commissioned mental health services were culturally appropriate for Aboriginal and Torres Strait Islander population. This will be baseline measurement for future reporting.

**61.3%**
of MH services (Baseline)

PHNs reported that commissioned mental health services were delivered in a culturally safe way by tailoring services to be respectful to Aboriginal and Torres Strait Islander people, including Aboriginal and Torres Strait Islander people as staff, and using

providers who were appropriately skilled in the delivery of culturally safe services.

The figures recorded in 2018-19 will be used as a baseline for future reporting. Particular focus will be on improving those PHNs that have reported low proportions of culturally appropriate services.

**IH5 – ITC improves the cultural competency of mainstream primary health care services**

ITC providers in 30 PHN regions are undertaking activities to enhance and support the cultural competency of mainstream services.

These include commissioning a provider for six months to provide training to 150 primary health care providers in the region, the delivery of Aboriginal health in general practice sessions (to over 400 GP staff), and cultural awareness training, medical practice, allied health and pharmacy engagement, in-service education sessions and general engagement with organisations and service providers.

One PHN had not undertaken an ITC activity in mainstream primary health service. This PHN has been requested to report on efforts to improve competency of mainstream services in next reporting period.

**30**
PHNs

**Outcome: Aboriginal and Torres Strait Islander identified health workforce capability and capacity matches needs of region**

**Assessment:** PHNs are helping to support local Aboriginal and Torres Strait Islander identified health workforce, including the ITC workforce, improve their capability and capacity to address the health needs in their region.

Ensuring workforce development and upskilling opportunities are provided to the Aboriginal and Torres Strait Islander identified workforce is a key part of improving the quality of services offered to Aboriginal and Torres Strait Islander people, as well as improving workforce retention and satisfaction levels of health workers.

PHNs are engaging with Aboriginal Community Controlled Health Services on a number of partnership initiatives, including a Collaboration Forum in 2020. This collaboration aims to improve effective communication and engagement between sectors and increase PHNs commissioning of ACCHS to deliver services.

As a result of this work, and the ongoing work of PHNs in supporting local Aboriginal and Torres Strait Islander identified health workforce, it is expected that workforce capability and capacity will continue to improve and meet the needs of region.

**IH6 – PHN provides support for Aboriginal and Torres Strait Islander identified health workforce**

Most PHNs demonstrated that they provide formal/informal support to improve the capability, capacity and proportion of Aboriginal and Torres Strait Islander identified workforce.

**84%**
of PHNs

For the five PHNs that did not meet reporting requirements for this indicator it is expected that this will be addressed in the 2019-20 period.

**Outcome: PHNs support health care providers to address factors impacting population health**

**Assessment:** All PHNs are supporting health care providers in their region to identify and manage population issues, and improve take up of population health measures like cancer screening and immunisation in their population.

More information: Australian Institute of Health and Welfare (AIHW), Australian Institute of Health and Welfare (AIHW) and Cancer Screening

**PH1 – Rate of children fully immunised at 5 years**

The national average increased by 0.7 per cent to 93.5 per cent in 2016-17 from the previous year (latest available data). This outcome is approaching the national immunisation target of 95 per cent and shows a continued increase from 91.5 per cent in 2012-13.

**93.5%**
of 5yr olds

The national immunisation target of 95 per cent child immunisation was reached in seven PHN regions, with a further 23 regions seeing an increase in the child immunisation rate and one seeing a decrease.

**PH2 – Cancer screening rates for cervical, bowel and breast cancer**

National cancer screening participation increased for breast cancer (women aged 50-74) programs to 55.0 per cent in 2016-17 (latest available data).

↑
**55.0%**
Breast cancer

National cancer screening participation increased for bowel cancer (men and women aged 50 to 74) programs to 42.4 per cent in 2017-18 (latest available data).

↑
**42.4%**
Bowel cancer

National cancer screening participation declined for cervical cancer (women aged 20-69) programs to 55.3 per cent in 2015-16 (latest available data).

↓
**55.3%**
Cervical cancer

### P4 – Support provided to general practices and other health care providers

PHNs are providing support to general practices and other health care providers regarding population health.

**100%**
of PHNs

In particular, PHNs whose regions have lower immunisation and screening rates are working with health providers to address factors that may be affecting these rates.

**Outcome: Local workforce has suitable cultural and clinical skills to address health needs of PHN region**

**Assessment:** The Program is supporting organisations and health professionals to develop the necessary awareness and skills required to ensure patients receive high quality and culturally appropriate health care. PHNs could work together to ensure best practice activities are shared to ensure an increase in outcomes for their local health workforce.

More information: PHN Commissioning Resources

### W1 – Rate of drug and alcohol treatment service providers with suitable accreditation

This information was not collected for 2018-19.

Data not collected

From 1 July 2019, accreditation details are being collected as part of the Alcohol and Other Drug Quarterly Reports and the implementation of the National Quality Framework for Drug and Alcohol Treatment Services will support transition to accreditation for the sector.

### W2 – PHN support for drug and alcohol commissioned health professionals

24 PHNs supplied evidence that they are supporting drug and alcohol commissioned health professionals to meet the performance criteria. Seven PHNs did not meet reporting requirements for this indicator.

**24**
PHNs

PHNs are providing a range of education and training support to drug and alcohol health professionals in their region. This included developing drug and alcohol specific education and training events for general practices, and facilitating sector network meetings.

**W3 – PHN Commissioning Framework**

All PHNs have a Commissioning Framework. 17 PHNs have Frameworks that include strategic planning, procuring services and monitoring and evaluating phases, with cultural appropriateness and stakeholder engagement considered throughout.

**17**
PHNs

13 PHNs need to include greater consideration of cultural appropriateness in their Frameworks to meet the performance criteria. One PHN needs to include cultural appropriateness and stakeholder engagement elements in their Framework.

**IH3 – Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people**

Most PHNs supplied evidence to ensure drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people in order to meet the performance criteria. Five PHNs did not meet reporting requirements for this indicator.

**26**
PHNs

PHNs that did not meet this indicator are required to show that commissioned services are culturally appropriate in the next reporting period.

**IH4 – Proportion of PHN commissioned mental health services delivered to the regional Aboriginal and Torres Strait Islander population that were culturally appropriate**

A national average proportion of 61.3 per cent of commissioned mental health services were culturally appropriate for Aboriginal and Torres Strait Islander population. This will be baseline measurement for future reporting.

**61.3%**
of MH services (Baseline)

PHNs reported that commissioned mental health services were delivered in a culturally safe way by tailoring services to be respectful to Aboriginal and Torres Strait Islander people, including Aboriginal and Torres Strait Islander people as staff, and using providers who were appropriately skilled in the delivery of culturally safe services.

The figures recorded in 2018-19 will be used as a baseline for future reporting. Particular focus will be on improving those PHNs that have reported low proportions of culturally appropriate services.

**IH5 – ITC improves the cultural competency of mainstream primary health care services**

Most PHNs demonstrated that the ITC commissioned services work to improve the cultural competency of mainstream primary health care services. One PHN did not meet the reporting requirements for this indicator.

**30**
PHNs

Activities included delivery of Aboriginal health in general practice sessions and cultural awareness training, medical practice, allied health and pharmacy engagement, in-service education sessions and general engagement with organisations and service providers.

**P4 – Support provided to general practices and other health care providers**

All PHNs are supporting the ongoing professional development of their local health care workforce by providing information on available training and sharing information on best practices.

**100%**
of PHNs

Common general practice support across the PHNs included activities aimed at: quality improvement, building capacity and capability of practice teams, data management and optimisation, My Health Record, cancer screening, immunisation, accreditation and digital health.

**Outcome: PHNs support health care providers to use digital health systems to improve patient care and communication**

**Assessment:** General practices and other health care providers are being supported by PHNs to adopt and use new digital health systems. In particular, general practices and pharmacies are being supported to increase their use of My Health Record as a way to better serve patients. The use of digital health systems are also increasing which should improve integration and communication between health care providers.

More information: Digital Health Data

**DH2 – Rate of health care providers using specific digital health systems**

PHNs reported that they do support health care providers to use digital health systems to improve patient care and communication.

(Baseline)

However, difficulties in recording and reporting the use of smart forms, e-referrals, and telehealth digital systems has meant the quantitative data collected is not considered a sufficient sample to

publish. The Department will work with PHNs to improve reporting in 2019-20.

**P4 – Support provided to general practices and other health care providers**

All PHNs demonstrated they provide support to general practices and other health care providers to adopt and use digital health systems.

**100%**
of PHNs

This includes working with general practices to share data, holding information and awareness sessions on the use of digital health systems and developing new digital health tools for use by health providers.

**P5 – Rate of regular uploads to My Health Record**

The national average rate of regular General Practice uploads has increased to 13.8 per cent in 2017-18 (latest available data).

**13.8%**
General practices

27 PHNs recorded an increase in the use and uploads of documents to My Health Record in general practices, and 13 regions saw increase in pharmacy use.

**P10 – Cross views of My Health Record**

The national average number of cross views per general practice for 2018-19 was 19.4 cross views / general practice.

**19.4**
General practices

The national average number of cross views per pharmacy for 2018-19 was 5.0 cross views / pharmacy.

**5.0**
Pharmacies

Four PHNs reported significantly higher rates for general practice cross views. The Department will consider how the approaches used in these regions could be shared across the PHN Program.

**Outcome: General practices and other health care providers use data to improve care**

**Assessment:** The PHN Program is supporting general practices to improve the quality of care for patients through the strategic use of health data sets. PHNs have been integral in the roll out of the new PIP QI measure, which will see general practices sharing data with PHNs who will then assist the practices to use this data to understand population health needs.

More information: Practice Incentives Program Data

**DH3 – Rate of accredited general practices sharing data with PHN**

The national average per cent of general practices sharing data with PHNs was 76 per cent. This will be baseline measurement for future reporting.

27 PHN regions reported rates of sharing with PHNs of 60 per cent or higher and will be looking to maintain this rate for the 2019-20 period. Four PHN regions recorded rates less than 60 per cent and will be looking to increase the rate by five per cent for the 2019-20 period.

The Department will work with those PHNs that reported some difficulty in engaging regional general practices in data sharing.

**76%**
General practices (Baseline)

**Outcome: Fewer preventable hospitalisations in PHN region for older people**

**Outcome: Local health and other care providers are supported to deliver coordinated, effective and appropriate care to older people in the PHN region**

**Assessment:** Across the Program, PHNs are supporting general practices and other health care providers to provide suitable, effective and coordinated health care to older people. Data for potentially preventable hospitalisations for older people by PHN region was not available for this report, but will be sourced for future reporting to provide better indication of the progress towards these outcomes.

More information: Australian Institute of Health and Welfare (AIHW)

**P4 – Support provided to general practices and other health care providers**

All PHNs demonstrated they provide support to general practices and other health care providers to improve quality care for older people.

This includes providing support to health care providers on identifying and managing health issues of older people particularly in regards to reducing potentially preventable hospitalisations.

**100%**
of PHNs

**P12 – Rate of potentially preventable hospitalisations (PPH) – for people over 65**

In 2017-18 (latest available data), the total number of PPH for people over 65 was 344,118, showing an increase from the previous year by 5.6 per cent.

**344,118**
Total PPH >65

Comparable increases for acute and chronic conditions occurred for people under 65; however, the increase for vaccine preventable conditions in people over 65 doubled the increase for people under 65.

**Recommendations for Quality Care**

- Support PHNs to improve service provider reporting for Mental Health services in their regions
- Consider provision of additional guidance to PHNs on how to support the delivery of culturally appropriate services to Aboriginal and Torres Strait Islander people
- PHNs consider how to better support Aboriginal and Torres Strait Islander identified health workforce in their regions
- Support PHNs to assist drug and alcohol treatment providers to achieve appropriate accreditation
- PHNs address how cultural appropriateness is considered as part of commissioning cycle in their Commissioning Frameworks
- Support PHNs to collect information on use of digital tools by health care providers in their regions

## 3.3 Improving Access

All PHNs are expected to engage in activities and efforts which ensure all individuals of their region have suitable access to primary health care services. This includes individuals who need to access general practice care after hours and treatment services for mental health, drug and alcohol issues. PHNs need to also consider access issues for Aboriginal and Torres Strait Islander people and older people including those in residential aged care facilities.

**Outcome: People in the PHN region are able to access general practices and other services as appropriate**

**Outcome: PHNs support general practices and other health care providers to provide appropriate after-hours access**

**Assessment:** Across the PHN Program, access to general practices appears to be improving during both core business and after-hours periods.

More information: Practice Incentives Program Data, Australian Institute of Health and Welfare and Australian Bureau of Statistics

✓

**P6 – Rate of general practices receiving payment for after hours services**

The national average rates of general practices receiving a PIP payment for after hours services have increased for levels 1-5 in the 2nd quarter of 2018 (latest available data) compared to the 2nd quarter of 2017

The average rate in the 2nd quarter 2018 was: 35.7 per cent (level 1); 7.2 per cent (level 2); 4.6 per cent (level 3); 4.0 per cent (level 4); and 13.7 per cent (level 5).

↑
**all rates**

✓

**P7 – Rate of GP style emergency department (ED) presentations**

The national average rate of GP style ED presentations for all persons was 11.5 per cent in 2017-18 (latest available data) which was a decrease of 1.5 per cent from the previous year.

23 PHN regions saw a reduction in the rate of people presenting to emergency departments with GP style concerns. The average reduction was 1.2 per cent. The remaining PHN regions saw a slight increase in presentations or the rate remained stable.

↓
**11.5%**
All persons

**P8 – Measure of patient experience of access to GP**

In 2016-17 (latest available data), 546,000 people went to an emergency department (ED) rather than a GP because the GP was not available which was a small decrease from previous year. 44,000 people went to the ED because the waiting time for a GP appointment was too long.

16 PHNs saw a decrease in the number of people electing this reason as collected by the ABS patient experience survey.

↓ **546,000**
GP not available

**Outcome: People in PHN region access mental health services appropriate to their individual needs**

**Assessment:** Rates of people receiving specific mental health services vary across the PHN regions. Service delivery rates will be monitored by the Department to ensure that they remain stable at a minimum and increase where needed.

More information: Primary Mental Health Care Minimum Data Set (PMHC-MDS)

**MH1 – Rate of regional population receiving PHN commissioned low intensity psychological interventions**

The number of people across all PHNs receiving low intensity psychological interventions ranged between 10 people to 520 people per 100,000. The median number across the PHNs was 108 people per 100,000.

Increasing access to low intensity services is fundamental to building a stepped care model of mental health service delivery. These figures will be used as a baseline for future reporting.

**108 people**
per 100k (Baseline)

**MH2 – Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals**

The number of people across all PHNs receiving commissioned psychological interventions ranged from 50 to 1,670 people per 100,000. The median rate was 355 people per 100,000.

Psychological therapy episodes of care by an organisation or an individual service provider are a key component of Primary Mental Health Care commissioned by the PHN. These figures will be used as a baseline for future reporting.

**355 people**
per 100k (Baseline)

**Outcome: Aboriginal and Torres Strait Islander people are able to access primary health care services as required**

**Assessment:** Ensuring that Aboriginal and Torres Strait Islander people have access to appropriate primary health care is a priority of the PHN Program. PHNs are supporting this priority through their GP Support program, the ITC program and specific activities to address health needs of Aboriginal and Torres Strait Islander people.

More information: Australian Institute of Health and Welfare (AIHW)

**IH8 – Rate of population receiving specific health assessments**

The average rate of Aboriginal and Torres Strait Islander population receiving health assessments (MBS 715) is 33.7 per cent (in 2016-17), which is an increase by 7 per cent from previous year.

28 PHNs saw increases in the rate in 2016-17 and the remaining three saw small decreases.

↑
**33.7%**

**Outcome: Older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home**

**Assessment:** The rates of access to MBS services in RACF varies significantly between PHN regions and less than a quarter of people aged over 75 have a GP health assessment.

These indicators suggests that the PHN Program needs to consider how to ensure appropriate access to primary health care for residents in RACF. The Department will also work with PHNs to consider recommendations from the Royal Commission into Aged Care Quality and Safety.

**AC1 – Rate of MBS services provided by primary care providers in residential aged care facilities**

The average rate of MBS services provided by primary care providers in residential aged care facilities (RACF) per residential aged care place increased for both GP consultations and GP after hours care. The rates vary significantly between PHN regions.

The rate of services provided in residential aged care facilities in PHN regions decreased or remained similar for: other non-referred consultations; residential medication management review, telehealth in RACF; and other non-referred after hours care.

↑
**16.9**
GP consultation services / RACF place

↑
**3.2**
GP after hours care services / RACF place

**AC2 – Rate of people aged 75 and over with a GP health assessment**

The rate of people aged 75 and over with a GP health assessment is 24.2 per cent in 2016-17 (latest available data) which is a slight increase on the previous year.

25 PHN regions saw increases in 2016-17.

**24.2%**
GP health assessments >=75 yrs

**Outcome: People in the PHN region are able to access appropriate drug and alcohol treatment services**

**Assessment:** The PHN Program is effectively commissioning drug and alcohol service providers to actively deliver services, ensuring that people in each region are able to access appropriate treatment services. This indicator shows that PHNs are successfully moving from design to delivery of services to address health needs in their region.

**AOD1 – Rate of drug and alcohol commissioned providers actively delivering services**

98 per cent (national average) of providers commissioned to deliver drug and alcohol services are actively delivering services. This will be baseline measurement for future reporting.

24 PHNs reported that 100 per cent of their commissioned providers were actively delivering services.

**98%**
Commissioned providers (Baseline)

**Recommendations for Improving Access**

- Support PHNs to consider ways to improve access of aged care residents to primary health care assessments
- Support PHNs to consider ways to improve the rate of health assessments being conducted for persons over 75 years

## 3.4 Coordinated Care

The provision of coordinated care is an important element of ensuring patients can access the right care at the right time in the right place. PHNs support the provision of coordinated care as part of their support to general practices and other health care professionals. They also champion integrated and coordinated care in liaison with Local Hospital Networks and other local health stakeholders.

**Outcome: People in the PHN region receive coordinated, culturally appropriate services from local health care providers**

**Assessment:** PHNs have an important role to play in supporting the delivery of coordinated, culturally appropriate health services via their GP Support activities. This includes encouraging and supporting the use of My Health Record, which is a key tool to improve coordinated care between health providers.

The trial of Health Care Homes in PHN regions is demonstrating how patient centred models of care could work in general practices.

More information: Digital Health Data

✓

**P9 – Rate of GP team care arrangements / case conferences**

The national average rate of persons with chronic conditions who receive GP team care arrangements and case conferences was 28.4 per cent in 2014-15 (latest available data).

There is significant variation between PHN regions on the use of GP team care arrangements and case conferences, which may be due to the introduction of Health Care Homes in 10 PHN regions.

**28.4%**
People with chronic conditions receiving team care services

✓

**P10 – Cross views of My Health Record**

The national average number of cross views per general practice for 2018-19 was 19.4 cross views / general practice.

The national average number of cross views per pharmacy for 2018-19 was 5 cross views / pharmacy.

Four PHNs reported significantly higher rates for general practice cross views. The Department will consider how the approaches used in these regions could be shared across the PHN Program.

**19.4**
General practices
**5**
Pharmacies

**P11 – Rate of discharge summaries uploaded to My Health Record**

The data for this indicator was not available and consideration will need to be given to reporting this information in following years

Data not collected

**Outcome: Health care providers in PHN region have an integrated approach to mental healthcare and suicide prevention**

**Assessment:** PHNs are providing specialist mental health care services and working with local health care providers to develop an integrated approach to mental healthcare and suicide prevention. Increased outcomes will be required from all PHNs to ensure the performance criteria is met for 2019-20.

More information: Primary Mental Health Care Minimum Data Set (PMHC-MDS)

**MH3 – Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness**

The rates of people with severe and complex mental illness receiving clinical care coordination ranges from 4 people to 796 per 100,000, with a median rate of 61 persons per 100,000.

These figures will be baseline measurement for future reporting.

**61 people**
per 100k
(Baseline)

**MH4 – Formalised partnerships with other regional service providers to support integrated regional planning and service delivery**

30 PHNs provided reports of their formalised partnerships with regional service providers, and were engaged in developing comprehensive joint mental health and suicide prevention plans with Local Hospital Networks (LHN).

One PHN did not provide sufficient information to meet the criteria and has been requested to provide further information.

**30**
PHNs

**MH5 – Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral**

The median proportion of people referred to PHN commissioned services due to a recent suicide attempt followed-up with 7 days

**55.5%**
of people
(Baseline)

was 55.5 per cent. The range across PHNs was 12.3 per cent to 100 per cent.

The Department will work with those PHNs who are not meeting the seven-day referral to ensure that this measure is improved.

**Outcome: Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care**

**Assessment:** The ITC Program supported 39,000 Aboriginal and Torres Strait Islander people with chronic conditions to access coordinated care for their specific health needs.

More information: Integrated Team Care (ITC)

**IH7 – ITC processes support Aboriginal and Torres Strait Islander people enrolled on the program to access coordinated care**

All PHNs have processes around referrals, intake and discharge for their ITC program, which supports Aboriginal and Torres Strait Islander people with chronic conditions to receive coordinated care.

**100%**
of PHNs

**P9 – Rate of GP team care arrangements / case conferences – Aboriginal and Torres Strait Islander people**

Data was unable to be sourced for this disaggregation

Data not collected

**P12 – Rate of potentially preventable hospitalisations – Aboriginal and Torres Strait Islander people**

Data was unable to be sourced for this disaggregation

Data not collected

**Outcome: Health care providers are aware of digital health systems and technologies**

**Assessment:** Across the PHN Program, general practices and pharmacies are being supported to understand and use new digital health systems like My Health Record.

**DH1 – Rate of health care providers informed about My Health Record**

All PHNs are working with general practices to help inform them about and provide them with access to My Health Record.

**99%**
General practices
**100%**
Pharmacies

PHNs report that 99 per cent of general practices are aware of and provided with access to MyHR education and 100 per cent of pharmacies. One PHN did not meet reporting requirements for this indicator.

**Outcome: Health care providers in PHN region have an integrated approach to drug and alcohol treatment services**

**Assessment:** PHNs are working with a range of organisations to establish key partnerships and make available a range of drug and alcohol treatment services to meet the health needs of the population in their region.

More information: Drug and Alcohol Treatment Services PHN Circular 1

**AOD2 – Partnerships established with local key stakeholders for drug and alcohol treatment services**

PHNs are engaging with a broad range of stakeholders in the provision of drug and alcohol treatment services. 29 PHNs demonstrated evidence of formalised partnerships and collaboration established with local key stakeholders.

**29**
PHNs

Two PHNs needed to provide greater details to support meeting the indicator performance criteria.

**Recommendations for Coordinated Care**

- Source further data to assist in measuring coordinated care for Aboriginal and Torres Strait Islander people

## 3.5 Capable Organisations

PHNs have demonstrated that they are capable organisations able to deliver a successful PHN Program. This includes having a strong governance structures, policies and processes to support the organisation's delivery of objectives, a well-trained and supported workforce, clear commissioning processes including commissioning for outcomes, and broad stakeholder engagement with the community.

**Outcome: The PHN's governance structures support the delivery of the organisation's objectives through providing oversight and direction**

**Assessment:** PHNs have suitable governance structures are in place to ensure that PHN Boards are engaged and being appropriately advised. PHNs have processes in place to ensure that their Boards are being held accountable for their performance and have visibility of key outputs from their organisation to provide oversight and direction.

✓

**O1 – PHN has an independent and diverse skills based Board**

All PHNs have an independent and diverse skills based Board. The Department works closely with all PHN regions to make sure the Boards are not directed by a person or corporation.

The average number of Board members per region was 8.7 members per Board with representation of 41 per cent female and 6 per cent that identified as Aboriginal and Torres Strait Islander. The range of skills varied across most of the PHNs with representatives from clinical, financial, legal and business management backgrounds.

The Department has suggested that 15 PHN regions consider working with their Boards to improve representation, particularly around increasing the number of Board members that identify as Aboriginal and Torres Strait Islander.

**100%**
of PHNs

✓

**O2 – PHN Clinical Council and Community Advisory Committee membership**

All PHNs have at least one Clinical Council and one Community Advisory Committee, which support the design and delivery of targeted health activities.

Each of the PHNs clinical committees included members with identified specialty or experience in general practice. The range of skills varied across the PHNs with good representation in the areas of nursing, pharmacy, mental health and allied health.

**100%**
of PHNs

**O3 – PHN Board considers input from committees**

All PHNs have formal and regular processes to have committee information considered by its Board.

**100%** of PHNs

**O4 – Record of PHN Board member attendance at meetings**

All PHNs reported that their Board members met the minimum attendance of at least 50 per cent of meetings.

**100%** of PHNs

**O5 – PHN Board has a regular review of its performance**

All PHNs have formal and regular reviews of Board performance that occur at least every three years.

**100%** of PHNs

**O6 – PHN Board approves strategic plan**

All PHNs provided evidence that their Board approves the strategic plan

**100%** of PHNs

**Outcome: The PHN has policies and processes which support the effective and efficient delivery of the organisation's objectives**

**Assessment:** PHNs have effective processes in place to manage the effective and efficient delivery of the PHN Program. PHNs are continuing to support service providers to deliver services including building the maturity and capacity of organisations.

The Department will continue to work with PHNs to understand the commissioning cycle and provide as much flexibility as possible in recognition of changing circumstances. The introduction of three year AWPs and three year rolling contracts should assist PHNs to be able to plan for longer service delivery.

**O7 – Variance report of scheduled activities**

All PHNs provided a variance report to indicate how their activities, across all Schedules, are tracking in terms of timeliness, actual expenditure and engagement with stakeholders.

Common issues affecting successful delivery of activities include delays in receiving funding from the Department, commissioning or tendering processes taking longer than expected, delays with partnering organisations (including local hospitals) or change in scope of planned activity. All PHNs have satisfactory mitigation strategies in place to address these issues.

**100%** of PHNs

**O8 – Quality Management System**

All PHNs have or are in the process of moving towards a fit for purpose Quality Management System with many using or working towards relevant ISO certification standards or equivalent

**100%** of PHNs

**Outcome: The PHN has a well-trained and supported workforce that is able to deliver to a high standard to meet the needs of the organisation, stakeholders and region**

**Assessment:** PHNs all have processes that ensure staff satisfaction, performance, and cultural awareness are recognised as organisational priorities. This has allowed PHNs to demonstrate that they have strong workforces which are supported and are trained appropriately to best deliver on organisational objectives.

**O9 – Staff satisfaction**

All PHNs have a fit for purpose process to measure staff satisfaction at least every two years

**100%** of PHNs

**O10 – Performance management process**

All PHNs have a fit for purpose process to measure staff performance at least every two years

**100%** of PHNs

**O11 – Cultural awareness training**

All PHNs conducts or offers cultural awareness training to staff at least every two years

**100%** of PHNs

**Outcome: PHN uses commissioning cycle processes to plan, procure, monitor, and evaluate services to respond to the prioritised health needs of their region**

**Assessment:** PHNs are using their commissioning processes to ensure the appropriate procurement, monitoring and evaluation of activities in their region.

More information: PHN Commissioning Resources

**P1 – PHN activities address prioritised needs**

All activities delivered by PHNs address prioritised needs

**100%** of PHNs

### W3 – PHN Commissioning Framework

All PHNs have a Commissioning Framework. 17 PHN regions have Frameworks that include strategic planning, procuring services and monitoring and evaluating phases, with cultural appropriateness and stakeholder engagement considered throughout.

**17**
PHNs

13 PHN regions need to include greater consideration of cultural appropriateness in their Frameworks to meet the performance criteria. And one PHN region needs to include cultural appropriateness and stakeholder engagement elements in their Framework

### O12 – Rate of contracts that include both output and outcome performance indicators

PHNs are including output and outcome performance indicators in their contracts with an average of 78 per cent of contracts including both types of indicators.

**78%**
Average rate

The shift towards commissioning for outcomes is encouraging and should support greater focus on meeting the health needs of PHN regions.

One PHN was not able to provide a rate of the number of contracts, but have processes in place to address this for future reporting.

**Outcome: The PHN manages their finances in a manner that maximises efficiency without compromising effectiveness**

**Assessment:** The Department is working with PHNs to improve financial management and accountability for the PHN Program. A new working group of PHNs has been established to create better financial understanding and guidance for financial reporting.

The Department is monitoring the level of unspent funds and is working with PHNs with high amounts of unspent funds to ensure that they are spent on appropriate services for the community.

### O13 – Annual Report and audited financial statements

All PHNs provided their Annual Reports and audited financial statements for 2018-19.

**100%**
of PHNs

All PHNs reported unspent funds for 2018-19 financial year. Most these funds have been approved for use future financial years. There are ongoing issues with inconsistency in how PHNs report their finances to the Department.

PHNs reported a total of 1,892 staff (fulltime equivalent) are employed across the 31 PHN organisations (average = 61 FTE / PHN).

**Outcome: The PHN creates and maintains relationships that facilitate the improvement of the health care system within their region**

**Assessment:** All PHNs show a commitment to building and maintaining positive relationships with stakeholders and community members to ensure their activities are targeted and successful in addressing health needs of the community.

### O14 – PHN stakeholder engagement

PHNs are engaging with stakeholders in their region that represent the specific needs, functions and priority groups of the PHN including, general practices, other health care providers, Local Hospital Networks and community groups.

**100%**
of PHNs

PHNs have detailed stakeholder engagement strategies for engaging with community groups, health practitioners, patients and carers to identify needs, design services and evaluate effectiveness.

### O15 – PHN engages with complaints

The Department received formal complaints about nine PHNs. These PHNs have all taken steps to resolve the complaints. PHNs are committed to working within their community to address concerns being raised.

**100%**
of complaints addressed

A total of 12 complaints were made during 2018-19, ranging from concerns about tender processes, PHN Governance, workplace issues, access to services and concerns about management of contracted services.

### P4 – Support provided to general practices and other health care providers

All PHNs support general practices and other health care providers that facilitate the improvement of the health care system within its region.

**100%**
of PHNs

Working closely with key stakeholders in their regions PHNs where able to facilitate health system improvements ranging including:

- commissioning a Local Hospital Network partner to deliver a culturally sensitive and family-based Aboriginal children's early intervention speech pathology service
- a project involving GPs, nurses, allied health professionals and Local Health Districts to facilitate a streamlined and coordinated system of care across the health system.

- participating in a data linkage program with other organisations and the State Government with general practice data being used for identifying opportunities to change common practices including after-hours opportunities and avoidable hospital admissions.

**Recommendations for Capable Organisations**

- PHNs consider ways to improve representation on PHN Boards of Aboriginal and Torres Strait Islander people
- The Department and the PHNs work together to create better financial understanding and guidance for financial reporting.

# 4. Good News Stories

PHNs submitted good news stories to the Department throughout the reporting year. Some examples of PHN's innovative approaches to addressing the needs of their regions are below:

### 4.1 GP Support

- PHNs often arrange and host workshops and conferences for health care providers. One PHN hosted Primary Health Care Conference, held over two days in June, attracted over 400 people, including delegates, speakers, exhibitors, service providers and staff. It brought together country and regional primary healthcare providers and enabled them to network and share information, and included an interactive program covering themes of collaboration, integration and innovation.

  Evaluations were very positive, with 93% of delegates responding that they would attend another Primary Health Care Conference in 2021 and 82% of delegates agreeing or strongly agreeing that their expectations of the conference were met.

- All PHNs engaged general practices to prepare them for the Practice Incentives Program Quality Improvement (PIP QI) incentive introduced on 1 August 2019. One particular PHN provided general practices with access to a data extraction software that practices can use to inform quality improvement activities and measure their success.

  Through this initiative, the PHN has increased the number of accredited general practices ready to participate in PIP QI from 189 to 242 – representing a 28 per cent increase. Eighty per cent of accredited general practices in the region now have the data extraction software installed and are well prepared to participate in PIP QI. A PIP QI information evening was also well attended by 87 people from general practices across the region.

### 4.2 Improving Access

- A PHN identified a need to develop information for people from culturally and linguistically diverse backgrounds on how to access an ambulance when needed. The PHN found that people had concerns about how to call an ambulance, the cost and what would happen to them in the ambulance. A video was created to ensure that everyone in the community has equal access to an ambulance when they need it. The video is available in English, Amharic, Arabic, Burmese, Dari, S'gaw Karen, Somali, Swahili, Tigrinya, and Vietnamese and has received excellent feedback from the community.

- Another PHN is trialling the provision of psychological services in two aged care facilities. The pilot offers suitably assessed aged care residents the opportunity to receive mental health services similar to those that people in the community can access through Medicare. The Mental Health Clinicians who have been visiting the residents have noticed a significant difference in the residents' mental health and wellbeing as well as their engagement in activities. They are also increasing their social connectedness, which is improving their overall wellbeing.

- A new Patient Information Booklet: Accessing the National Disability Insurance Scheme, was developed by a PHN Disability Network. This booklet is designed to assist patients

accessing the National Disability Insurance Scheme (NDIS). It was produced in conjunction with a resource for GPs, General Practice Toolkit: Understanding your role in the NDIS. The booklet provides patients with information to prepare them for a GP visit to discuss the NDIS and complete their access request form.

- To improve after-hours access to GP services, a PHN has funded an app that facilitates a video consultation with an Australian-registered specialist emergency doctor within minutes when a person's usual GP is not available after-hours. Through the PHN's funding, the service is free for residents living in the region in the after-hours period, and is also available at cost to people Australia-wide.

  The service fills a gap where communities located on the urban fringe cannot access the urgent advice and care they need, as home visiting doctors may not be available or take too long to get to a patient. Even in metropolitan areas, patients can wait long periods for a home doctor to attend, resulting in many patients attending emergency departments unnecessarily. Since the implementation of the initiative in July 2018, patients have provided overwhelmingly positive feedback for the service with calls to the service growing at a rapid rate with 97.3% of survey respondents saying they would call the service again.

### 4.3 Quality Care

- Nellie is a digital health initiative funded by the PHN, which uses an automated SMS-based persona for promoting patient self-care. The system is clinician led. Using existing or newly developed shared action plans, doctors and nurses work together on the priorities in their clinics. The action plans shape the development of the technical protocols that manage the sending and receiving of messages. The messages are warm and friendly, enhancing connection with patients and changing outcomes. User feedback has been positive and report that it improves their motivation to exercise and has resulted in weight loss and lower blood pressure as an example.

- Many PHNs are working with local Aboriginal and Torres Strait Islander groups to design and deliver culturally appropriate services. In one region, a Statement of Cooperation has been signed with five organisations to improve Aboriginal and Torres Strait Islander access to mental health and alcohol and other drug treatment. The PHN is funding and supporting the initiative, with the newly formed consortium called Murri Binda meaning 'sitting down, yarning and healing together'. Two years in the making, the consortium is designed to help healthcare professionals offer the right care, in the right place, at the right time.

### 4.4 Addressing Needs

- The Let's Shape Up project, launched in 2018, aims to address the prevalence of chronic disease in a PHN region. The link between obesity and type 2 diabetes is strong, with both chronic diseases leading to long-term health issues affecting not only individuals, but also communities and the healthcare industry.

  Let's Shape Up encourages and supports community leaders to make pledges on how they plan to shape up and inspire their tribes to make small and sustainable changes and healthier lifestyle choices at home and at work. The project aims to educate and upskill community members at risk of developing obesity and type 2 diabetes so they can take control of their health and improve their overall wellbeing. Some simple ideas are to

introduce walking/standing meetings in your workplace, swap screen time for more physical activities, introduce vegetable gardens, or introduce the traffic light system in community organisation's canteens.

Let's Shape Up also encourages better nutrition through community cooking classes and motivational coaching to increase physical activity. Jamie's Ministry of food delivered 270 cooking and nutrition education classes by 45 volunteers and staff to over 500 participants.

- Another PHN used a local resident's experience to highlight the importance of completing the free bowel cancer screening kit when turning 50. Interviews were conducted with the local resident, who was diagnosed with bowel cancer after completing his kit at 50, and with a doctor in the GP practice. These were shown on television and in local newspapers, reaching almost 321,000 local residents.

- The ITC program delivered by a PHN identified that a client required education on management of their diabetes. The ITC team referred the client to the diabetes service at the local Hospital. The client was provided with comprehensive diabetes education and trialled the Libre sensors to allow him to better understand his sugar levels and how his diet had effected these levels in real time.

  Through the education from the Diabetes Service, close support and encouragement from the ITC Care Coordinator and Aboriginal Health Outreach Worker, access to the dietician, along with the information gained from the use of the Libre sensors, the client is now self-managing his diabetes effectively. This client has not had a further hospital admission and now no longer requires the Libre sensors. This client is now so confident in managing his diabetes that staff at the diabetes service have asked him to do a talk about diabetes management at the next diabetes information session.

### 4.5 Coordinated Care

- A PHN is funded a discharge program which connects vulnerable and disadvantaged people with critical social and mental health support as they are discharged from justice services and emergency Departments at two Hospitals. The pilot program is the brainchild of the PHN, who recognised vulnerable people can have intertwined contact with hospital and police services and can often be caught in a cycle of re-presentation due to a range of underlying social issues and unmet basic needs.

- Aboriginal people travelling from rural and remote areas to metropolitan areas for treatment for chronic conditions are benefitting from a coordinated care project funded by the PHN. This came about following a collaborative project led by PHN to better understand the issues impacting Aboriginal people travelling from remote areas, and design solutions to address system-wide problems.

### 4.6 Emergency Response

- The Western Queensland Flood Response Alliance was established within 24 hours in February 2019, led by two PHNs and the Royal Flying Doctors Service (RFDS) to provide an immediate and coordinated response to the devastating floods occurring across Queensland.

The Alliance established a forum for information sharing with key stakeholders, ensuring much needed psychological and trauma support was available on the ground, targeting the needs of those in communities hardest hit by the unprecedented disaster.

A 24-hour free phone and online service "NQ Connect", providing a single point of access to different local mental health support services across rural and remote Queensland. "When you have to act quickly and decisively, the imaginary borders we draw on the land that can separate health organisations no longer apply," the PHN CEO said.

"This Alliance is a great example of how collaboration in times of need shows what can be achieved in a short space of time," said RFDS CEO. "We have a deep connection to rural and remote Queensland, and we need to ensure that support to these affected communities is well coordinated, agile and fit for purpose," she said.

The pathways to care and the strong relationships built during the initial phase of the Alliance were implemented in a way that is sustainable into the long term, so that residents are not left stranded in the months and years to come.

# 5. PHN Program Performance and Quality Framework and Data Sources

### 5.1 PHN Program Performance and Quality Framework

The PHN Program Performance and Quality Framework (the Framework) aims to consider how the broad range of activities and functions delivered by PHNs contribute towards achieving the Program's objectives.

PHNs determine where to direct their activities and resources as a result of the needs assessment of their region. The Framework does not intend to change this approach or direct PHNs to undertake work in priority areas that are not relevant to their region.

The Framework has three purposes:

- providing opportunities to identify areas for improvement for individual PHNs and the PHN Program;
- supporting individual PHNs in measuring their performance and quality against tangible outcomes; and
- measuring the PHN Program's progress towards achieving its objectives of improving efficiency and effectiveness of medical services for patients and improving coordination of care to ensure patients receive the right care, in the right place, at the right time.

PHNs were established with two key objectives:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and,
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

The key roles of PHNs are:

- to commission health services to meet the identified needs of the local community – and national priorities as decided by the Government – in a continuous cycle of improvement;
- support general practices and other health providers to deliver high quality, coordinated care to patients; and
- act as system integrators in the health sector in their region.

More information on the PHN Program and on Australia's 31 PHNs can be found on the Department of Health PHN website available at PHN-Home.

### 5.2 Data Sources and Calculations

The data sources used in this report and the respective calculations can be found in the PHN Program Performance and Quality Framework documents online at PHN-Performance Framework.

### 5.3 PHN Framework Review of Performance Criteria

The performance criteria for each indicator will be reviewed as part of the regular review of the Framework. In particular, consideration will be given to whether the performance criteria continue to be relevant or if they need to be amended to reflect changes in activities or expected standards. Quality standards, benchmarks or agreed targets may be introduced as the Framework matures and more data is collected against the indicators. PHNs will be consulted as part of this review.