



Australian Government

Department of Health



An Australian Government Initiative

# PHN Program Performance and Quality Framework

Appendix B – Indicator Specifications

September 2018

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<sup>1</sup> The reporting rows where PHNs are required to supply data are also coloured orange as a visual cue. PHNs will also continue to supply data for existing Schedule indicators as part of six and twelve month reporting.

# Program indicators

## P1: PHN activities address prioritised needs

Item	Description
Assessment	Individual PHN
Reporting	PHN - Six monthly by PHN
Definition	<p>Activities being delivered by the PHN address the prioritised needs in the PHN Needs Assessment and/or national priorities</p> <p>Activities are defined as services delivered by a contracted provider, or individual projects that are delivered by the PHN directly. Activities may address one or more identified need</p> <p>Prioritised needs are defined as those identified in the PHN Needs Assessment and the PHN Activity Work Plan (AWP)</p>
Purpose	<p>This information will provide the Department with a summary of the needs in each PHN region and how they are being addressed. The PHN Needs Assessment is a key deliverable under the PHN Program which supports PHNs in understanding and prioritising the health needs of their region</p> <p>This information could also identify synergies or best practices that can be shared more widely across PHNs and assist in identifying emerging issues</p>
Outcome Theme: Addressing Needs	<p>Outcome:</p> <p>PHN activities and initiatives address local needs</p>
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN uses commissioning cycle processes to plan, procure, monitor and evaluate services to respond to the prioritised health needs of its region</p>
Performance Criteria	100% of delivered activities address prioritised needs in PHN Needs Assessment and/or national priorities
Data Source	PHN Needs Assessment, AWP and six month reporting
Calculation	Department of Health will assess information provided in the Variance Report. The Variance Report comprises a list of individual PHN activities pre-populated from their AWP where PHNs are to detail expected spend by reporting period against actual spend, identify the related need or priority area and assign a risk rating
Limitations	This indicator will not provide information in relation to whether the activity being delivered provides value for money
Additional information	This indicator will also be used to measure organisational capability of PHN

## P2: Health system improvement and innovation

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly reporting by PHN
Definition	<p>Description of health system improvements, innovations or commissioning best practice in the PHN region. The examples provided could be based on PHN or commissioned service provider work</p> <p>Health system improvements are where the PHN has worked within its region to improve health systems or relationships</p> <p>Innovations are changes which are a significantly new or redesigned product, service, or general improvement to the health system or structures in the PHN region</p> <p>Commissioning best practices can include where the PHN has used co-design processes, outcomes based commissioning, engaged with new stakeholders or other approaches for a good outcome</p>
Purpose	This indicator provides an opportunity for PHNs to provide information on improvements they have made to their local region through commissioning, system integration or introduction of innovation
Outcome Theme: Addressing Needs	<p>Outcome:</p> <p>PHN activities and initiatives address local needs</p>
Performance Criteria	At least one example of a health system improvement, innovation or commissioning best practice
Data Source	PHN supplies a short description of health system improvement, innovation or commissioning best practice
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	While formal innovation funding will be concluding prior to the introduction of the PHN Performance and Quality Framework, it is still an expectation that PHNs are innovative organisations

### P3: Rate of general practice accreditation

Item	Description
Assessment	PHN Program
Reporting	PHN - Twelve monthly reporting by PHN
Definition	<p>Rate of accredited general practices as a percentage of all general practices in the PHN region</p> <p>A general practice is a practice or health service which provides general practice services, and is eligible to be accredited under the Safety and Quality Commission's National General Practice Accreditation Scheme, including meeting the Royal Australian College of General Practitioners (RACGP) definition of a general practice</p> <p>Accreditation means that the practice has current full accreditation under the Safety and Quality Commissions National General Practice Accreditation Scheme</p>
Purpose	<p>The Safety and Quality Commission's National General Practice Accreditation Scheme provides a measure that the quality and safety of a general practice is satisfactory. Increasing the number of general practices which meet the requirements of this Scheme could improve quality of care, patient experience and health outcomes</p> <p>Under the Safety and Quality Commissions National General Practice Accreditation Scheme, general practices are currently required to meet the requirements of the RACGP Standards for General Practice (Standards). The Standards promote improvements in patient safety and care built on a practices own information systems. (This in turn assists general practices to target quality improvement to their local region and/or population groups)</p>
Outcome Theme: Quality Care	Outcome: PHNs support general practices and other health care providers to provide quality care to patients
Performance Criteria	<p>Increase in rate of general practice accreditation</p> <p>*Where the rate has been stable for at least 3 years, the performance criteria is to maintain the existing rate of accreditation</p>
Data Source	PHN – number of general practices which are accredited and number of general practices in the PHN region
Calculation	<p>Numerator: Number of general practices in the PHN region which are accredited</p> <p>Denominator: Number of general practices in the PHN region</p> <p>Computation: <math>100 \times (\text{numerator} / \text{denominator})</math> presented as a percentage in PHN region</p>
Limitations	Not all general practices will seek accreditation or be 'eligible' to seek accreditation due to a number of reasons, despite support offered by PHNs
Additional information	The Department will investigate other methods to gather accreditation rates

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

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>Support (discrete and/or formal activities) provided to general practices and other health care providers in PHN region provided either directly by PHN or by a PHN commissioned service provider. Support may include one on one support, sharing information, facilitating access to or providing training, conducting workshops or disseminating education resources across any of the below focus areas</p> <p><b>General practice support</b> – PHNs provide support to general practices in their region</p> <p><b>Population health</b> – PHNs support health care providers to improve identification and management of population health issues</p> <p><b>Workforce</b> – PHNs provide support to improve health workforce cultural appropriateness and identify and address clinical skill gaps. Health workforce broadly includes all persons working in the health sector within the PHN region</p> <p><b>Aged care</b> – PHNs provide support to health care providers on identifying and managing health issues of older people (those 65 years and older), including supporting at home care</p> <p><b>Digital health</b> – PHNs provide support to health care providers to adopt digital health systems and technologies. Digital health systems and technologies describe the use of digital technology to improve the delivery of health care for providers and patients</p> <p>Support may occur at the following levels:</p> <p>high – targeted, tailored support to a general practice, health care provider or individual health care professional to assist in the change of a behaviour or approach. (e.g. supporting accreditation or adopting new digital health systems)</p> <p>moderate – broad based support to a general practice, health care provider or health care professional or several general practices and/or health care providers to raise awareness and knowledge. (e.g. information sessions on using My Health Record or cultural awareness training)</p> <p>low – general interactions where information may be shared (e.g. PHN representation at forums or workshops on the issue of aged care health issues etc.)</p>
Purpose	<p>PHNs support general practices and other health care providers in their region to ensure that health professionals are able to respond appropriately and confidently to the health needs of their region and improve their service delivery</p> <p>This output indicator can provide a measure of what support PHNs are providing to the local health care providers across several focus areas and can identify areas where additional support may be required</p>

Item	Description
Outcome Theme: Quality Care	<p>Outcomes:</p> <p>PHNs support general practices and other health care providers to provide quality care to patients</p> <p>PHNs support health care providers to address factors impacting population health</p> <p>Local workforce has suitable cultural and clinical skills to address health needs of PHN region</p> <p>PHNs support health care providers to use digital health systems to improve patient care and communication</p> <p>Fewer preventable hospitalisations in PHN region for older people</p>
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN creates and maintains relationships that facilitate the improvement of the health care system within its region</p>
Performance Criteria	PHN delivers a range of support activities to general practices and other health care providers
Data Source	<p>Short description of activities undertaken for each focus area above and at each level of support</p> <p>PHN may choose not to provide information for focus areas where it is not a priority for the PHN</p>
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	Support activities can be limited by the need and willingness of health care providers to participate in activities
Additional information	<p>Data from this indicator will be used to interpret and provide context to other indicators including:</p> <p>PH1, PH2, W1, W2, DH1, DH2, DH3, AC1, IH1, IH2, IH3 and IH4</p>

## P5: Rate of regular uploads to My Health Record

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by Department of Health
Definition	Rate of health care providers regularly uploading documents to My Health Record (MyHR) Regularly is defined as uploading at least one document each week in a month
Purpose	This is a measure of use of MyHR. The full implementation of MyHR will enhance co-ordination and continuity of care. PHNs can play a role at a system level to encourage primary health care providers to use MyHR
Outcome Theme: Quality Care	Outcome: PHNs support general practices and other health care providers to provide quality care to patients PHNs support health care providers to use digital health systems to improve patient care and communication
Performance Criteria	Increase in the rate of regular usage by general practices and other health care providers
Data Source	Australian Digital Health Agency (ADHA) – health care providers regularly uploading documents healthdirect – number of pharmacy and allied health services PHN – number of general practices
Calculation	Numerator: Number of general practices, pharmacies and allied health service practices which regularly uploaded documents to MyHR Denominator: The number of all general, pharmacy and allied health service practices in the PHN region Computation: $100 \times (\text{numerator} / \text{denominator})$ presented as a percentage in PHN region
Limitations	-
Additional information	-



## P6: Rate of general practices receiving payment for after hours services

Item	Description
Assessment	PHN Program
Reporting	DoH - Quarterly by Department of Health
Definition	<p>Rate of general practices receiving a Practice Incentives Program (PIP) level 1-5 payment for after hours services</p> <p>For the PIP, the complete after hours period is outside 8 am to 6 pm weekdays, outside 8 am to 12 noon on Saturdays, and all day on Sundays and public holidays</p>
Purpose	<p>The PIP aims to improve access to care, detection and management of chronic conditions, and quality, safety, performance and accountability where PHN can play an important role. Practices must register for the PIP</p> <p>The PIP After Hours incentive aims to ensure that patients have access to care throughout after hour periods. The rate of general practices receiving a PIP level 1-5 payments for after hours services reflect the services provided by general practice during after hours</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>People in the PHN region are able to access general practice and other services as appropriate</p> <p>PHNs support general practices and other health care providers to provide appropriate after hours access</p>
Performance Criteria	<p>Maintain the existing rate of general practices receiving payment for after hours services</p> <p>*contextual information supplied by PHN will be used in assessing the performance criteria</p>
Data Source	<p>Department of Human Services - number of general practices receiving an after hour incentive payment</p> <p>PHN - number of general practices</p>
Calculation	<p>Numerator:</p> <p>Number of general practices receiving an after hour incentive payment for each level in each PHN region</p> <p>Denominator:</p> <p>Number of general practices in each PHN at each financial year.</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math> presented as a percentage in PHN region</p>
Limitations	PHNs may have limited ability to affect this rate. Contextual information will be considered in determining whether the performance criteria is met
Additional information	The Department of Human Services administers the PIP on behalf of the Department of Health

## P7: Rate of GP style emergency department presentations

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by Department of Health
Definition	<p>Rate of GP style presentations to emergency departments (ED) within the PHN region during normal and after hours periods</p> <p>Total number of GP type ED services, defined as triage category 4 and 5, provided to patients' who reside within the PHN region</p> <p>After hours is defined as: on a public holiday; on a Sunday; before 8am, or after noon on a Saturday; and before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday</p>
Purpose	Measures the use of ED when GP care would be appropriate, implying lack of general practice access or information on general practice access. PHNs have a responsibility for improving access to general practice, potentially decreasing demand on ED services
Outcome Theme: Improving Access	<p>Outcome:</p> <p>People in the PHN region are able to access general practice and other services as appropriate</p> <p>PHNs support general practices and other health care providers to provide appropriate after hours access</p>
Performance Criteria	<p>A decrease in rate of GP style ED presentations*</p> <p>*contextual information supplied by PHN will be used in assessing the performance criteria</p>
Data Source	Australian Institute of Health and Welfare (AIHW)
Calculation	<p>Numerator:</p> <p>total number of triage category 4 and 5 patients attending ED disaggregated by normal and after hours</p> <p>Denominator:</p> <p>total persons in PHN region</p> <p>Computation:</p> <p>100 x (numerator / denominator) presented as a percentage in PHN region</p>
Limitations	<p>PHNs may have limited ability to affect this rate. Contextual information will be considered in determining whether the performance criteria is met</p> <p>This indicator may register waiting times at ED, rather than whether an issue was appropriate for a GP</p>
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including P6 and P8

## P8: Measure of patient experience of access to GP

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by Department of Health
Definition	Reasons why a patient went to an emergency department (ED) rather than a GP Reasons as collected by ABS patient experience survey: Taken by ambulance or condition was serious GP not available when required Sent to emergency by GP Waiting time for GP appointment too long Lower cost than GP visit GP does not have required equipment or facilities Other
Purpose	Results of ABS patient experience survey reflecting the reasons why the patient decided to go to ED rather than GP From the results it is possible to identify why patients are attending ED and identify any areas which PHNs can work with health providers to address
Outcome Theme: Improving Access	Outcome: People in the PHN region are able to access general practice and other services as appropriate PHNs support general practices and other health care providers to provide appropriate hours access
Performance Criteria	Decrease in GP not available or waiting time too long as reasons for why patient attended ED* * Contextual information will be considered in determining whether the performance criteria is met
Data Source	ABS patient experience survey
Calculation	Numerator: Reasons collected by survey Denominator: Total persons in PHN region, taken to ED Computation: $100 \times (\text{numerator} / \text{denominator})$ presented as a percentage in PHN region
Limitations	This survey may have too small a sample size to allow reporting for some PHNs PHNs may have limited ability to affect this rate. Contextual information will be considered in determining whether the performance criteria is met
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including P6 and P7

## P9: Rate of GP team care arrangements / case conferences

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by Department of Health
Definition	<p>Number of GP team care arrangements and case conferences as a proportion of patients with diagnosed chronic conditions</p> <p>Chronic conditions are defined according to Australian Institute of Health and Welfare's (AIHW) 'prominent conditions', as those including: arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes or mental health conditions</p>
Purpose	<p>The team care arrangements provide patients with access to Medicare Benefits for relevant allied health services. This therefore provides both access to services and improves continuity of care. While PHNs would not commission the team care arrangements, they have capacity to influence GPs to consider their use, and capacity to improve linkages and communications to facilitate their use</p> <p>Case conferencing brings together a range of clinics skills to plan and co-ordinate care for patients with chronic and complex conditions, and materially adds to the benefits of patients beyond conventional consultations. PHNs have the capacity to facilitate case conferencing directly, and have capacity to influence GPs to consider their use, and to improve linkages and communications to facilitate their use</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>People in the PHN region receive coordinated, culturally appropriate services from local health care providers</p> <p>Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care</p>
Performance Criteria	<p>Increase in the rate of people diagnosed with chronic conditions who receive GP team care arrangement and case conferences*</p> <p>*Assessment of this performance criteria will take into account the Health Care Homes trial where relevant</p>
Data Source	<p>MBS - number of MBS services</p> <p>ABS Australian Health Survey - number of patients</p>
Calculation	<p>Numerator:</p> <p>Number of MBS services for item numbers 723, 732, 735 and 758.</p> <p>Denominator:</p> <p>Number of patients with diagnosed chronic conditions in the PHN from the most recent Australian Health Survey</p> <p>Computation:</p> <p>100 x (numerator / denominator) presented as a percentage in PHN region</p> <p>Disaggregation:</p> <p>Aboriginal and Torres Strait Islander status</p>

Item	Description
Limitations	Some disaggregation may result in numbers too small for publication. National disaggregation by Indigenous status will be based on data from jurisdictions where quality of Indigenous identification in the dataset is considered acceptable
Additional information	<p>Data from this indicator will be used to interpret and provide context to other indicators including P12</p> <p>This indicator will also draw information from the Health Care Homes trial</p>

## P10: Cross views of My Health Record

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by the Department of Health
Definition	<p>Cross views of My Health Record (MyHR) by health professionals from practices with different Healthcare Provider Identifier – Organisation (HPI-O)</p> <p>A cross view is when health providers from different practices view the same MyHR for a patient</p>
Purpose	Cross views of MyHR by different HPI-Os suggests that health providers are working together to deliver coordinated care to a patient. As MyHR use increases, supported and encouraged by PHNs, it would be expected that cross views will also increase
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>People in the PHN region receive coordinated, culturally appropriate services from local health care providers</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>PHNs support health care providers to use digital health systems to improve patient care and communication</p>
Performance Criteria	<p>5% increase in general practice MyHR provider viewing a record authored by another (from separate HPI-Os) annually</p> <p>5% increase in pharmacy MyHR provider viewing a record authored by another (from separate HPI-Os) annually</p>
Data Source	My Health Record Expansion Program (MHREP) Reporting – Indicators 9-10
Calculation	<p>Numerator:</p> <p>Net increase of number of general practice/pharmacy MyHR provider in the PHN region of current financial year and last financial year</p> <p>Denominator:</p> <p>Number of general practice/pharmacy MyHR provider in the PHN region of last financial year</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math> presented as a percentage in PHN region</p>
Limitations	<p>Data will not be available until MHREP is implemented (1 August 2018)</p> <p>Health providers within the same health care provider organisation who share a patient will not have their views of MyHR recorded</p>
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including DH1

## P11: Rate of discharge summaries uploaded to My Health Record

Item	Description
Assessment	PHN Program
Reporting	DoH - twelve monthly by Department of Health
Definition	Rate of discharge summaries uploaded to My Health Record (MyHR) by hospitals Discharge summary is defined as the document containing details about the patient's hospital stay, including the diagnosis, diagnostic procedures performed, the prognosis, medications prescribed and follow-up actions recommended
Purpose	A discharge summary supports the transfer of a patient from a hospital back to the care of their nominated primary health care provider. This is an important indicator to reflect the coordination between hospitals and GPs about patients' conditions. PHNs can encourage local hospitals to upload summaries as part of their stakeholder engagement work
Outcome Theme: Coordinated Care	Outcome: People in the PHN region receive coordinated, culturally appropriate services from local health care providers
Performance Criteria	Increase in rate of discharge summaries uploaded to MyHR
Data Source	Australian Digital Health Agency (ADHA) – discharge summaries uploaded to MyHR Australian Institute of Health and Welfare (AIHW) – number of discharges from hospital not to another facility
Calculation	Numerator: The number of discharge summaries uploaded to MyHR annually Denominator: The number of discharges for each PHN region Computation: $100 \times (\text{numerator} / \text{denominator})$ presented as a percentage in PHN region
Reporting	Twelve monthly by Department of Health
Limitations	It is assumed that each patient admitted to hospital has a discharge summary
Additional information	-

## P12: Rate of potentially preventable hospitalisations

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by Department of Health
Definition	<p>Rate of potentially preventable hospitalisations (PPH) in PHN region by all, vaccine-preventable conditions, acute conditions, and chronic conditions</p> <p>PPH definition from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)</p> <p>Vaccine-preventable conditions : tetanus, measles, mumps, rubella, pneumonia/influenza</p> <p>Acute conditions : ear, nose and throat infections, cellulitis, convulsions and epilepsy, dental conditions, eclampsia, gangrene, pelvic inflammatory disease, perforated/bleeding ulcer, pneumonia(not vaccine- preventable), dehydration/gastroenteritis, urinary tract infections including pyelonephritis</p> <p>Chronic conditions : asthma, angina, bronchiectasis, diabetes complications (principle diagnosis), hypertension, iron deficiency anaemia, nutritional deficiencies, rheumatic heart disease, congestive heart failure and chronic obstructive pulmonary disease</p>
Purpose	PPH are admissions to hospital that may have been avoided by timely and effective health care, usually delivered in primary care and community-based care setting. Rate of PPH can indicate improvements in the effectiveness of prevention programs and/or accessibility and more effective management of selected conditions in the primary and community-based health care sector
Outcome Theme: Longer Term	<p>Outcome:</p> <p>Patients in local region receive the right care in the right place at the right time</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care</p>
Outcome Theme: Addressing Needs	<p>Outcome:</p> <p>Fewer preventable hospitalisations in PHN region for people with chronic and vaccine preventable diseases</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Fewer preventable hospitalisations in PHN region for older people</p>
Performance Criteria	<p>Decrease in PPH rates*</p> <p>*Where the rate has been stable for at least 3 years, the performance criteria is to maintain the existing rate of PPH</p>



Item	Description
Data Source	<p>Australian Institute of Health and Welfare (AIHW)</p> <p>ABS estimated resident population (ERP)</p> <p>ABS Indigenous experimental estimates and projections (2001 Census-based)</p>
Calculation	<p>Numerator:</p> <p>Number of potentially preventable hospitalisations</p> <p>Denominator:</p> <p>Resident population of PHN region</p> <p>Computation:</p> <p>100 x (numerator / denominator) presented as a percentage in PHN region</p> <p>Disaggregation:</p> <p>Aboriginal and Torres Strait Islander status, people aged 65 and over, vaccine preventable, acute conditions and chronic conditions</p>
Limitations	<p>It may be difficult to readily measure changes in rates for categories of PPH, especially acute events that can be attributed to the effect of PHNs. PPHs are only one measure of potentially avoidable hospitalisations and exclude hospitalisations for injury and poisoning that may also be considered potentially avoidable</p> <p>PPHs exclude episodes of non-admitted patient care provided in outpatient clinics or emergency departments. Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions</p> <p>Reporting age-standardised rates at regional levels below state/territory depends on the availability of ABS population estimates, including age breakdowns, for the same geographical regions or for other regions that can be aggregated to align with the region of interest and PHN</p> <p>The data quality and/or definition of categories used to refine PPH reporting (for example SEIFA, Indigenous status) can vary over time and therefore could cause PHN performance levels between different time periods to not be directly comparable</p> <p>Changes in ICD-10-AM coding standards may affect the interpretation of PPH trends over time. This has been evident in previously published PPH statistics and has led to the refinement of PPH definitions to account for changes such as excluding counts for additional diagnoses of Diabetes mellitus in the definition of the PPH 'diabetes' category. After refinement, it is likely historical PPH performance would need to be backdated to maintain consistent definitions over time and to remove the presence of coding change affects</p> <p>Patient location is only available at SA2 or postcode levels. PPH level data can be constructed using concordance files</p>
Additional information	<p>Some disaggregation may result in numbers too small for publication. National disaggregation by Indigenous status will be based on data from jurisdictions where quality of Indigenous identification in the dataset is considered acceptable</p>

### P13: Numbers of health professionals available

Item	Description
Assessment	PHN Program
Reporting	PHN - Twelve monthly by Department of Health DOH - healthdirect and National Health Workforce Data Set (NHWDS)
Definition	<p>Numbers of primary health care professionals (GPs and allied health services) available within the PHN region</p> <p>A general practice is defined by the Royal Australian College of General Practitioners as an entity which 'provides person centred, continuing, comprehensive and coordinated wholeperson health care to individuals and families in their communities.' Therefore, practices which do not provide 'wholeperson' or mainstream health services should be excluded from the count. This would include skin clinics and travel doctors etc</p> <p>These include:</p> <ul style="list-style-type: none"> <li>Number of general practices in region</li> <li>Number of GPs</li> <li>Number of GP full time equivalents</li> <li>Number of GP services</li> <li>Number of nurses working in general practice</li> <li>Number of occupational therapists</li> <li>Number of optometrists</li> <li>Number of pharmacists</li> <li>Number of physiotherapists</li> <li>Number of podiatrists</li> <li>Number of psychologists</li> </ul>
Purpose	Numbers of primary health care professionals is core information in assessing the capacity of a region to meet its primary health care needs, with improving trends over time providing indications of success in meeting potential service gaps
Outcome Theme: Longer Term	<p>Outcome:</p> <p>Patients in local region receive the right care in the right place at the right time</p>
Performance Criteria	There are a range of primary health care professionals available within the PHN region
Data Source	<p>NHWDS – number of occupational therapists, optometrists, pharmacists, physiotherapists, podiatrists, psychologists</p> <p>PHNs – number of general practices, GPs, nurses</p> <p>healthdirect – supplementary data</p>
Calculation	Number of primary health care professionals in the PHN per 100,000 population

Item	Description
Limitations	-
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including: P3, P5, P6, DH2 and DH3

## Mental Health indicators

### MH1: Rate of regional population receiving PHN commissioned low intensity psychological interventions

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly produced from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs
Definition	<p>Percentage of the regional population who received one or more low intensity episodes of care provided by an organisation or an individual service provider commissioned by the PHN</p> <p>Low intensity services include cognitive behavioural therapy and other evidence based interventions that may be delivered by health professionals or non-mental health workers who have received specific training and work in a supervised arrangement with a qualified mental health professional. These services should be easy to access, high quality services that people can access directly, with or without needing a referral, and are generally provided at a lower cost than more traditional forms of mental health treatment</p> <p>Services can be provided individually or in groups either face-to-face, by telephone or online</p> <p>Particular groups in the region may be targeted for low intensity services</p>
Purpose	A driving factor underpinning the development of low intensity mental health services is to increase overall community access to evidence based psychological interventions for people with, or at risk of, mild mental illness who do not require traditional services. Increasing access to low intensity services is fundamental to building a stepped care model of mental health service delivery
Outcome Theme: Improving Access	<p>Outcome:</p> <p>People in PHN region access mental health services appropriate to their individual needs</p>
Performance Criteria	At least 5% growth in number of people accessing Low Intensity episodes compared with previous year, or where service capacity has been reached, a maintenance of the previous year's rate
Data Source	<p>MH Schedule reporting – Indicator Acc-1</p> <p>Constructed from PMHC MDS (numerator) and ABS Estimated Resident Population (denominator)</p>

Item	Description
Calculation	<p>Numerator:</p> <p>Number of people who received one or more episodes of care classified as low intensity from a PHN commissioned organisation or individual service provider</p> <p>Denominator:</p> <p>Total population residing in the region in the reporting period</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math></p> <p>*May be presented as a rate per targeted age cohort in PHN region</p>
Limitations	<p>Unique counting of persons and episodes is at the Provider Organisation level, not region. It is possible therefore that a person receiving an episode of care by more than one organisation within the region, or from another PHN region, will be counted more than once</p> <p>PHNs may fund services for individuals who live in other regions. The indicator specification does not adjust for this</p> <p>This indicator looks only at service provision funded by the PHN and does not take account of the role of other primary care funding streams in overall service delivery to the regional population. The role of mental health treatment accessed through the MBS is the most significant, and to a lesser extent, service delivery by specialist mental health services funded by state and territory governments</p>
Additional information	See 'Performance Indicators for Primary Health Network-Led Mental Health Reform: Technical Specifications'

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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly produced from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs
Definition	<p>Percentage of the regional population who received one or more psychological therapy episodes of care provided by an organisation or an individual service provider commissioned by the PHN</p> <p>Psychological therapies are delivered by qualified mental health professionals. Referral from a GP, psychiatrist or paediatrician is usually required, but service provision may commence with a provisional referral. These may have been provided face-to-face (either individually or in a group), by telephone or online on the proviso that this was a personalised service</p>
Purpose	<p>Flexible funding has been provided to allow PHNs to reduce service gaps and inequities across the region by commissioning mental health services targeting selected underserved populations. These services are to be provided both where there are limited or not easily accessible Medicare Benefits Schedule subsidised psychological services or to particular subpopulations that are not accessing available services to the same extent as the general population</p> <p>These services are primarily focussed on people with mild and moderate mental illness, who are not clinically suited to lower intensity services, and also people with severe mental illness may benefit from psychological therapy as part of their care</p> <p>Groups that may be targeted include traditionally hard-to-reach subpopulations, such as people experiencing or at risk of homelessness, and people living in more remote communities. Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse (CALD) people, those who have experienced trauma or abuse, and women experiencing perinatal depression. Determination of target groups will depend upon local needs and prioritisation of activity within regions</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>People in PHN region access mental health services appropriate to their individual needs</p>
Performance Criteria	At least 5% growth in number of people accessing Psychological Therapy episodes compared with previous year, or where service capacity has been reached, a maintenance of the previous year's rate
Data Source	<p>MH Schedule reporting – Indicator Acc-2</p> <p>Constructed from PMHC MDS (numerator) and ABS Estimated Resident Population (denominator)</p>

Item	Description
Calculation	<p>Numerator:</p> <p>Number of people who received one or more episodes of care classified as psychological therapy from a PHN commissioned organisation or individual service provider</p> <p>Denominator:</p> <p>Total population residing in the region in the reporting period</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math></p>
Limitations	<p>Unique counting of persons and episodes is at the Provider Organisation level, not region. It is possible therefore that a person receiving an episode of care by more than one organisation within the region, or from another PHN region, will be counted more than once</p> <p>PHNs may fund services for individuals who live in other regions. The indicator specification does not adjust for this</p> <p>This indicator looks only at service provision funded by the PHN and does not take account of the role of other primary care funding streams in overall service delivery to the regional population. The role of mental health treatment accessed through the MBS is the most significant, and to a lesser extent, service delivery by specialist mental health services funded by state and territory governments</p>
Additional information	See 'Performance Indicators for Primary Health Network-Led Mental Health Reform: Technical Specifications'

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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly produced from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs
Definition	<p>Percentage of the regional population who received one or more clinical care coordination episodes of care provided by an organisation or an individual service provider commissioned by the PHN</p> <p>Services provided may include direct client contact, either face-to-face or by telephone, and also contact with families and carers, other service providers and agencies on the consumer's behalf</p>
Purpose	<p>PHNs are required to commission clinical mental health services to meet the needs of people with severe mental illness, whose care can be appropriately managed in a primary care setting. This will include making optimal use of the available and new mental health nursing services funding to support clinical coordination</p> <p>Fragmentation of care is particularly problematic for people with severe and complex mental illness who require services from multiple agencies</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers in PHN region have an integrated approach to mental health care and suicide prevention</p>
Performance Criteria	At least 5% growth in number of people accessing Care Coordination episodes compared with previous year, or where service capacity has been reached, a maintenance of the previous year's rate
Data Source	<p>MH Schedule reporting – Indicator Acc-3</p> <p>Constructed from PMHC MDS (numerator) and ABS Estimated Resident Population (denominator)</p>
Calculation	<p>Numerator:</p> <p>Number of people who received one or more episodes of care classified as clinical care coordination from a PHN commissioned organisation or individual service provider</p> <p>Denominator:</p> <p>Total population residing in the region in the reporting period</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math></p>



Item	Description
Limitations	<p>Estimates of the number of people in the region with severe and complex mental illness and those that could be managed in a primary care setting are required to better gauge access to these services. Numbers using care coordination services will, however, provide an indication of activity and changes over time</p> <p>Unique counting of persons and episodes is at the Provider Organisation level, not region. It is possible therefore that a person receiving an episode of care by more than one organisation within the region, or from another PHN region, will be counted more than once</p> <p>PHNs may fund services for individuals who live in other regions. The indicator specification does not adjust for this</p> <p>This indicator looks only at service provision funded by the PHN and does not take account of the role of other primary care funding streams in overall service delivery to the regional population. The role of mental health treatment accessed through the MBS is the most significant, and to a lesser extent, service delivery by specialist mental health services funded by state and territory governments</p>
Additional information	See 'Performance Indicators for Primary Health Network-Led Mental Health Reform: Technical Specifications'

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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly by the Department of Health
Definition	Agreements (both formal and informal) with other regional entities that support integrated regional planning and service delivery, including delineation of the role of services, referral pathways and other processes related to the access to PHN commissioned services and the transition of consumers according to their needs between different levels of care and service types
Purpose	<p>PHNs are undertaking a broader role in the provision of mental health and suicide prevention service delivery by assessing regional needs and planning services, as well as in the commissioning services in identified regions of need. Services commissioned by PHNs must fit within a complex framework of current mental health and related services, supplementing services provided by a broad variety of other service providers</p> <p>Coordinated service delivery by multiple agencies is also essential to best address the needs of those with more severe and/or persistent mental illness, particularly those with more complex needs</p> <p>PHNs are required under the mental health funding schedules to develop comprehensive regional mental health and suicide prevention plans that engage other agencies in their development. This is also a formal requirement of the 5th National Mental Health Plan, with all regional plans expected to be completed by mid 2020</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers in PHN region have an integrated approach to mental health care and suicide prevention</p>
Performance Criteria	Comprehensive regional mental health and suicide prevention plans to be jointly developed with local hospital networks (LHN) by mid 2020
Data Source	MH Schedule reporting – Indicator Regional Integration
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

**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**

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly produced from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs
Definition	Proportion of people referred to PHN commissioned services where suicide risk was identified at referral and were followed up within 7 days of referral
Purpose	<p>PHNs are to take a lead role in planning and commissioning community-based suicide prevention activities</p> <p>There is a particular imperative to improve follow-up for people in the high risk period following a suicide attempt. Individuals are known to be particularly vulnerable in the period between leaving hospital and transitioning to community mental health care</p> <p>Planning should be undertaken in partnership with local hospital networks (LHN) and other local organisations to ensure there are no gaps in services and that referral pathways are clearly defined</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers in PHN region have an integrated approach to mental health care and suicide prevention</p>
Performance Criteria	100% of people referred to PHN commissioned services followed up within 7 days of referral
Data Source	<p>MH Schedule reporting – Indicator App-3</p> <p>Constructed from PMHC MDS</p>
Calculation	<p>Numerator:</p> <p>Number of episodes that commenced in the reporting period where the Suicide Referral Flag was recorded as 'Yes' and where the first Service Contact was recorded as occurring within 7 days or less of the Referral Date</p> <p>Denominator:</p> <p>Number of episodes that commenced in the reporting period where the Suicide Referral Flag was recorded as 'Yes'</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math></p>

Item	Description
Limitations	<p>This indicator represents a proxy of the underlying concept of prompt response and follow up for people at risk of suicide or who have made a recent attempt</p> <p>Estimates of the number of people attempting suicide in the region and those presenting for treatment of injuries as a result of an attempt are required to better gauge the effectiveness of and access to services.</p> <p>Referral arrangements and information exchange with other regional service providers are also required to ascertain the effectiveness of services in following up all referrals. In the interim the numbers of people receiving appropriate follow up provide an indication of net activity and allows for tracking changes over time.</p>
Additional information	See 'Performance Indicators for Primary Health Network-Led Mental Health Reform: Technical Specifications'

## MH6: Outcomes Readiness - Completion rates for clinical outcome measures

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly produced from Primary Mental Health Care(PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs
Definition	The proportion of mental health care episodes delivered by PHN commissioned organisations or individual service providers with valid clinical outcome measures at both baseline and follow-up.
Purpose	<p>A key objective of funding PHNs is to commission mental health services to improve outcomes for those receiving mental health and suicide prevention services in primary care.</p> <p>Standardised outcome measures, collected at the first and last occasions of service at a minimum, provide the means for assessing effectiveness of services and are included in the PMHC MDS as mandatory requirements.</p> <p>The purpose of indicator MH6 is to monitor the implementation progress of outcome measurement within regions. Completion rates will point to whether the coverage of outcome measurement is sufficient to enable meaningful and valid indicators to be constructed from the outcomes data.</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>PHN commissioned mental health services improve outcomes for patients</p>
Performance Criteria	70% of completed episodes of care have recorded valid outcome measures at Episode Start and Episode End
Data Source	<p>MH Schedule reporting – Indicator Out-3</p> <p>Constructed from PMHC MDS</p>
Calculation	<p>Numerator:</p> <p>Number of completed episodes of mental health care which have valid outcome measures recorded for Episode Start and Episode End within the reference period</p> <p>Denominator:</p> <p>Number of completed episodes of mental health care delivered by PHN commissioned organisations or individual service providers within the reference period</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math></p> <p>Coverage/Scope is all completed episodes of care in the reporting period that have a 'matched pair' of valid outcome measures collected at Episode Start and Episode End</p>

Item	Description
Limitations	<p>Clinical outcomes do not necessarily reflect the client experience of service delivery</p> <p>Development of a consumer experience of services measure suitable for the primary mental health care sector, based on the Your Experience of Service instrument, is ongoing work for future implementation</p>
Additional information	<p>For purposes of this indicator, a valid clinical outcome measure is defined as one where the number of items completed meets minimal threshold requirements. Translated to individual rating scales this means:</p> <ul style="list-style-type: none"> <li>- For the K10, a minimum of 9 of the 10 items</li> <li>- For the K5, a minimum of 5 items (nil missing data)</li> <li>- For the SDQ, a minimum of 3 items for each of the 5 subscales</li> </ul> <p>See 'Performance Indicators for Primary Health Network-Led Mental Health Reform: Technical Specifications'</p>

# Aboriginal and Torres Strait Islander Health indicators

## IH1: Numbers of ITC services delivered by PHN

Item	Description
Assessment	Individual PHN
Reporting	DoH - Integrated Team Care (ITC) six and twelve month reporting
Definition	<p>ITC services comprise of care coordination services, supplementary services and clinical services</p> <p>Care coordination services relate to each occasion of care provided to an ITC client</p> <p>Supplementary services relate to support to access approved medical aids or specialist and/or allied health service appointments</p> <p>Clinical Services are appointments organised for an ITC patient</p> <p>Other can be any other services delivered which are within the ITC Guidelines</p>
Purpose	This indicator counts the number of services the PHN is delivering under ITC. It will assist in understanding how PHNs deliver ITC services to Aboriginal and Torres Strait Islander people
Outcome Theme: Addressing Needs	<p>Outcome:</p> <p>PHNs address needs of Aboriginal and Torres Strait Islander people in their region</p>
Performance Criteria	Services are being delivered across the range of services allowed within ITC Guidelines
Data Source	PHN – number and type of organisations engaged with
Calculation	<p>Number of care coordination services</p> <p>Number of supplementary services</p> <p>Number of clinical services</p> <p>Other – provide details</p> <p>The Department will assess the qualitative information provided by the PHN</p>
Limitations	-
Additional information	-

## IH2: Types of organisations delivering ITC services

Item	Description
Assessment	Individual PHN
Reporting	DoH - Integrated Team Care (ITC) six and twelve month reporting
Definition	<p>ITC program funds are used to deliver services across a range of organisations, including Aboriginal Medical Services (AMS), mainstream organisations and sometimes from the PHN, noting PHNs may engage Indigenous Health Project Officers (IHPO) to undertake ITC activities</p> <p>AMS means a health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals</p> <p>Mainstream organisations are any primary health care provider that is not an Indigenous Health Services or an Aboriginal Community Controlled Health Service (ACCHS)</p> <p>PHN – the PHN may retain some funding for IHPO workforce activities</p>
Purpose	This indicator counts the number and type of organisations that the PHN is engaging with in the delivery of ITC services. It will assist in understanding how the services are being delivered across the PHN region.
Outcome Theme: Addressing Needs	<p>Outcome:</p> <p>PHNs address needs of Aboriginal and Torres Strait Islander people in their region</p>
Performance Criteria	A range of organisations are engaging in ITC program
Data Source	PHN – number and type of organisations engaged with
Calculation	<p>Number of AMS</p> <p>Number of mainstream organisations</p> <p>PHN activities</p> <p>The Department will assess the information provided by the PHN</p>
Limitations	-
Additional information	-



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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Drug and Therapeutic Information Service (DATIS) reporting
Definition	Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people
Purpose	<p>PHNs aim to provide tailored and culturally appropriate treatment for Aboriginal and Torres Strait Islander people</p> <p>PHNs will report on how mainstream and Aboriginal and Torres Strait Islander services have been delivered in recognition of the six domains and focus areas of the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-26</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people</p> <p>Local workforce has suitable cultural and clinical skills to address health needs of PHN region</p>
Performance Criteria	PHN supplies evidence that commissioned drug and alcohol services are culturally appropriate
Data Source	DATIS reporting – Indicator 4.2
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly produced from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs
Definition	Proportion of PHN commissioned mental health services delivered to Aboriginal and Torres Strait Islander clients where the service was provided by service providers that can demonstrate the delivery of culturally safe services as evidenced by:  behaviours, attitudes, policies, practices and physical structures that are respectful and tailored to Aboriginal and Torres Strait Islander people; and/or the inclusion of Aboriginal and Torres Strait Islander staff; and/or delivery by providers appropriately skilled in the delivery of culturally safe services
Purpose	PHNs are funded to increase access to integrated, culturally appropriate and safe mental health services for Aboriginal and Torres Strait Islander peoples. This funding supplements that provided to PHNs for services in other key areas  Culturally safe, appropriate and competent care is a key strategy for improving access to mental health services and also mental health outcomes for Aboriginal and Torres Strait Islander peoples. Services can be provided through Aboriginal Community Controlled Health Organisations (ACCHOs) or mainstream services
Outcome Theme: Quality Care	Outcome: Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people  Local workforce has suitable cultural and clinical skills to address health needs of PHN region
Performance Criteria	At least 5% growth on proportion of previous year or where all services were culturally appropriate, maintenance of this
Data Source	MH Schedule reporting – Indicator App-2  Constructed from PMHC MDS

Item	Description
Calculation	<p>Numerator:</p> <p>Number of PHN commissioned mental health service contacts provided to Aboriginal and/or Torres Strait Islander people where the service provider is either:  recorded as of Aboriginal and/or Torres Strait Islander origin; or  employed by an Aboriginal Community Controlled Health Service; or  has indicated they have completed a recognised training programme in the delivery of culturally safe services to Aboriginal and Torres Strait Islander peoples</p> <p>Denominator:</p> <p>Total number of PHN commissioned mental health service contacts provided to Aboriginal and/or Torres Strait Islander clients</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math></p>
Limitations	<p>Accuracy of this indicator is dependent on the integrity of data reported by service providers on their Aboriginal and/or Torres Strait Islander status and Aboriginal and Torres Strait Islander Cultural Training</p> <p>Further work is required on approaches to identifying the delivery of culturally safe services to Aboriginal and Torres Strait Islander people from routine datasets</p>
Additional information	<p>See 'Performance Indicators for Primary Health Network-Led Mental Health Reform: Technical Specifications'</p>

## IH5: ITC improves the cultural competency of mainstream primary health care services

Item	Description
Assessment	Individual PHN
Reporting	DoH - Integrated team care (ITC) twelve and six month reporting
Definition	<p>ITC commissioned services work to improve the cultural competency of mainstream primary health care services through a variety of activities, including but not limited to:</p> <ul style="list-style-type: none"> <li>delivering or organising cultural awareness training for staff;</li> <li>encouraging uptake of relevant MBS items;</li> <li>helping practices create a more welcoming environment for Aboriginal and Torres Strait Islander people</li> </ul> <p>Mainstream primary care means any primary health care service provider that is not an Indigenous Health Service or an Aboriginal Community Controlled Health Service (ACCHS)</p>
Purpose	This indicator provides an opportunity for PHNs to describe the work undertaken as part of ITC to improve the cultural competency of mainstream primary care services
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people</p> <p>Local workforce has suitable cultural and clinical skills to address health needs of PHN region</p>
Performance Criteria	PHN provides evidence that as part of ITC it is working to improve cultural competency of mainstream primary health care services
Data Source	Short description of activities undertaken to improve cultural competency of mainstream primary health care services
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

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

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>PHN provides formal/informal support to improve the capability, capacity and proportion of Aboriginal and Torres Strait Islander identified health workforce</p> <p>Support may include general activities or a workforce strategy/plan which outlines the planned approach by the PHN to improve the Aboriginal and Torres Strait Islander identified health workforce. It may be part of a broader workforce strategy/plan for the PHN or separate</p>
Purpose	Improving the capacity, capability and proportion of Aboriginal and Torres Strait Islander identified health workforce should result in an improvement in the quality of services offered to Aboriginal and Torres Strait Islander people and also improve the accessibility and cultural appropriateness of services for Aboriginal and Torres Strait Islander people
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Aboriginal and Torres Strait Islander identified health workforce capability and capacity matches needs of regions</p>
Performance Criteria	PHN supplies evidence of support provided to Aboriginal and Torres Strait Islander identified workforce in its region
Data Source	PHN supplies short description of formal/informal support activities provided to Aboriginal and Torres Strait Islander identified health workforce and/or provision of a workforce strategy/plan addressing capability, capacity and proportion of Aboriginal and Torres Strait Islander identified health workforce
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	This indicator does not consider the impact the support or workforce strategy/plan has on improving the capability, capacity and proportion of Aboriginal and Torres Strait Islander identified health workforce
Additional information	This indicator will be adjusted over time to measure effectiveness of the support and/or workforce strategy/plan

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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Integrated Team Care (ITC) six and twelve month reporting
Definition	ITC processes include: Referral – the processes to identify possible patients of ITC program Intake – the processes to accept and assess the patients of ITC program Discharge – the processes by which patients leave the care of the ITC program
Purpose	This indicator provides information on the referral, intake and discharge processes which are supporting Aboriginal and Torres Strait Islander people receiving care under the ITC program
Outcome Theme: Coordinated Care	Outcome: Aboriginal and Torres Strait Islander people with chronic conditions enrolled on the ITC program receive coordinated care
Performance Criteria	PHN provides evidence of its ITC processes
Data Source	Short description of referral, intake and discharge processes of ITC program
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

## IH8: Rate of population receiving specific health assessments

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by the Department of Health
Definition	Rate of Aboriginal and Torres Strait Islander population receiving health assessments (MBS item 715) for children aged 0-14; adults aged 15-54; adults aged 55 years and over
Purpose	<p>This indicator shows the degree to which Aboriginal and Torres Strait Islander people are accessing a range of primary health care services designed to both identify and prevent health care problems, and to plan and manage treatment in a multidisciplinary manner</p> <p>PHNs will have a role to inform practices and patients of the value of these services and encourage their use</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>Aboriginal and Torres Strait Islander people are able to access primary health care services as required</p>
Performance Criteria	<p>Increase in rate of population receiving specific health assessment</p> <p>*Where the rate has been stable for at least 3 years, the performance criteria is to maintain the existing rate of receiving specific health assessments</p>
Data Source	<p>MBS – number of people receiving health assessments</p> <p>ABS – Aboriginal and Torres Strait Islander population in the PHN</p>
Calculation	<p>Numerator:</p> <p>The total number of Aboriginal and Torres Strait Islander people receiving health assessment (MBS715)</p> <p>Denominator:</p> <p>The total Aboriginal and Torres Strait Islander population in the PHN</p> <p>Computation:</p> <p>100x (numerator / denominator) presented as a rate per targeted population in PHN region</p>
Limitations	This indicator does not reflect the quality of assessment or effectiveness of ongoing care
Additional information	-

# Population Health indicators

## PH1: Rate of children fully immunised at 5 years

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by the Department of Health
Definition	<p>Childhood immunisation coverage is an indicator of the Australian Governments' objective to achieve high immunisation coverage for children to prevent selected vaccine preventable diseases. Childhood immunisation rates are a well-established performance indicator and reported in national health care agreements and frameworks</p> <p>Childhood immunisation is defined as the number of children who are fully immunised in the Australian Immunisation Register (AIR) at 5 years</p> <p>'Fully immunised' at 5 years (60 to &lt;63 months) of age is defined as a child having a record on the AIR of 4 doses of a DTP- containing vaccine; 4 doses of polio vaccine; and 2 doses of an MMR-containing vaccine</p>
Purpose	<p>There is evidence of a link between immunisation and better health outcomes. Rates are also reported internationally, which allows local comparisons to be made with Organisation of Economic Cooperation and Development (OECD) countries</p> <p>This indicator appears to be sensitive to change over time and it is possible to report at the PHN and sub-PHN level to detect any variations and identify regional hotspots</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>PHNs support health care providers to address factors impacting population health</p>
Performance Criteria	95% national immunisation target or increase in immunisation rate for region
Data Source	AIR
Calculation	<p>Numerator:</p> <p>Children who turned 5 years of age in the reference year who recorded as fully vaccinated on the Australian Immunisation Register in the reference year</p> <p>Denominator:</p> <p>Number of children 5 years in the reference year registered on AIR</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math> presented as a rate per 100 children</p>
Limitations	PHNs' capacity to directly influence childhood immunisation rates may be affected by service delivery arrangements and incentive schemes



Item	Description
Additional information	<p>Nationally consistent immunisation data are available 3 months after the period that providers submit immunisation records after providing the service (December, March, June and September)</p> <p>Standard coverage reports for all children, and for Aboriginal and Torres Strait Islander children, are produced on a regular basis at the postcode and Statistical Area Level 2 and 3 level. Coverage at these geographical levels is grouped within state and territory boundaries (e.g. postcodes for South Australia, SA3 for Western Australia)</p>

## PH2: Cancer screening rates for cervical, bowel and breast cancer

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by the Department of Health
Definition	<p>Cancer screening rates are participation rates in breast, bowel and cervical cancer screening programs</p> <p>Screening population cohorts are:</p> <p>Breast – women aged 50 to 74 years who undertake screening every 2 years;</p> <p>Bowel – women and men aged 50 to 74 years who are invited to screen in a 24 month period who returned a completed test within this period or the following 6 months;</p> <p>Cervical – women aged 25 to 74 years who undertake the Cervical Screening Test every 5 years</p>
Purpose	<p>Screening programmes are effective in the early detection of cancers in people with no symptoms. This allows for the early treatment of discovered cancers and reduces death rates. Participation in screening programmes is the single most important factor in achieving these outcomes and can be measured and reported for target populations</p> <p>PHNs can help to improve participation rates in the national breast, bowel and cervical cancer screening programmes, particularly in regions with low screening participation rates</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>PHNs support health care providers to address factors impacting population health</p>
Performance Criteria	<p>Increase in rate of specified population participation rates in cancer screening</p> <p>*Where the rate has been stable for at least 3 years, the performance criteria is to maintain the existing participation rate</p>
Data Source	BreastScreen Australia Program, Bowel Screening Programme and Cervical Screening Programme
Calculation	<p>Numerator:</p> <p>Participants in screening</p> <p>Denominator:</p> <p>Estimate of persons in target population (or for Bowel Cancer those who were invited to participate)</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math> presented as a percentage in PHN region</p>

Item	Description
Limitations	<p>Aboriginal and Torres Strait Islander populations and culturally and linguistically diverse populations are not routinely identified in all cancer screening registers</p> <p>Aboriginal and Torres Strait Islander population data is only available at PHN level for breast screening participation</p> <p>Due to the introduction of the Cervical Screening Test and the change to the screening population, there will be no baseline data available for the Cervical Screening Programme</p>
Additional information	<p>Future developments:</p> <p>Bowel cancer screening is currently transitioning from 5 yearly screening intervals to 2 yearly screening intervals. By 2020, all Australians between 50 and 74 years of age will be eligible for screening every 2 years</p> <p>The new Cervical Screening Test, targeting women between 25 to 74 years of age and conducted every 5 years, replaced the biannual Pap Test on 1 December 2017</p> <p>The development of a new national cancer screening register to support both the expanded Bowel Screening Programme and the new Cervical Screening Programmes is underway</p>

## Workforce indicators

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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly by the Department of Health
Definition	Number of commissioned service providers which have completed or are completing accreditation
Purpose	<p>PHN aims to promote quality improvement approaches and support health professionals through education and training. PHN also facilitates evidence based treatments</p> <p>PHN will need to maintain records of commissioned services providers' accreditation status</p> <p>It is the Department's expectation that all specialist drug and alcohol treatment service providers are accredited or are working towards accreditation</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Local workforce has suitable cultural and clinical skills to address health needs of PHN region</p>
Performance Criteria	All specialist drug and alcohol treatment service providers have or are working towards accreditation
Data Source	Drug and Therapeutic Information Service (DATIS) reporting – Indicator 3.2
Calculation	<p>Numerator:</p> <p>Number of commissioned service providers which have completed or are or are working towards accreditation</p> <p>Denominator:</p> <p>Total number of commissioned drug and alcohol service providers in PHN region</p> <p>Computation:</p> <p>100x (numerator / denominator) presented as a rate per targeted population in PHN region</p>
Limitations	-
Additional information	-

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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly by the Department of Health
Definition	Support provided by PHN to drug and alcohol commissioned health professionals including number of education/training modules delivered
Purpose	PHN aims to promote quality improvement approaches and support health professionals through education and training. This indicator will reflect how PHNs demonstrate support for health professionals in the management of drug and alcohol dependence and related morbidities
Outcome Theme: Quality Care	Outcome: Local workforce has suitable cultural and clinical skills to address health needs of PHN region
Performance Criteria	PHN supplies evidence of support provided to drug and alcohol commissioned health professionals
Data Source	Drug and Therapeutic Information Service (DATIS) reporting – Indicator 3.1
Calculation	Number and type of completed education and/or training modules for health professionals, relating to the management of drug and alcohol dependence and related morbidities
Limitations	-
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including P4

### W3: PHN Commissioning Framework

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN has a Commissioning Framework is structured around three broad phases of strategic planning, procuring services, monitoring and evaluation. It also includes consideration of cultural appropriateness and stakeholder engagement at every stage of the process</p> <p>Cultural appropriateness refers to ways of working with people of different cultural backgrounds with an understanding of their cultural differences, needs and respect</p> <p>See PHN Commissioning Resources for further information:  <a href="http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources">http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources</a> </p>
Purpose	<p>Under the PHN Program model, PHNs use commissioning to address the prioritised needs of their region</p> <p>A Commissioning Framework is a tool which assists PHNs to fulfil their commissioning role in a strategic way</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Local workforce has suitable cultural and clinical skills to address health needs of PHN region</p>
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN uses commissioning cycle processes to identify, plan, procure, monitor and evaluate services to respond to the prioritised health needs of its region</p>
Performance Criteria	The PHN has a Commissioning Framework which includes strategic planning, procuring services and monitoring and evaluation phases, with cultural appropriateness and stakeholder engagement considered throughout the process
Data Source	Copy of the PHN's Commissioning Framework
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	This indicator does not include an assessment of the quality of the Commissioning Framework or its ability to commission high quality, effective services
Additional information	As the Program and Framework matures, this indicator will be amended to consider the quality and effectiveness of the Commissioning Frameworks

# Digital Health indicators

## DH 1: Rate of health care providers informed about My Health Record

Item	Description
Assessment	Individual PHN
Reporting	DoH - My Health Record Expansion Program (MHREP) Schedule reporting
Definition	<p>Rate of health care providers informed about My Health Record (MyHR)</p> <p>Health care providers include general practice, community pharmacy, private specialist practice and allied health services</p> <p>Informed about MyHR describes activities funded under MHREP to improve awareness</p>
Purpose	<p>PHNs are required to inform health care providers about MyHR including encouraging ongoing adoption and use of the MyHR</p> <p>PHNs are required to deliver MyHR awareness and training to health care providers</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers are aware of digital health systems and technologies</p>
Performance Criteria	100% of general practices are aware of and provided with access to MyHR education
Data Source	MHREP reporting – Indicators 1-4
Calculation	<p>Numerator:</p> <p>The total number of general practices/community pharmacy/private specialist practice/allied health service receiving information about use of MyHR by the PHN</p> <p>Denominator:</p> <p>The total number of general practices/community pharmacy/private specialist practice/allied health service in PHN region</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math> presented as a percentage in PHN region</p>
Limitations	-
Additional information	-

## DH2: Rate of health care providers using specific digital health systems

Item	Description
Assessment	Individual PHN
Reporting	PHN - Six monthly by PHN
Definition	<p>Rate of health care providers in PHN region using smart forms; e-referrals and telehealth digital health systems</p> <p>Health care providers include general practices, pharmacies and allied health service practices</p> <p>Smart forms are electronic forms issued by receiving providers that sending providers use to extract information from their client management system and assemble that information into an e-referral or other communication</p> <p>E-referrals describe the reliable, secure transfer of referral information from one provider's client management system to another provider's client management system. E-referrals are a leading indicator of the use of secure electronic messaging for other types of clinical exchange</p> <p>Telehealth describes where health care is provided remotely by means of telecommunications technology</p>
Purpose	<p>PHNs provide support to health care providers to adopt digital systems which improve the delivery and experience of health care for provider and patients. This indicator can provide a measure of how effective this support has been in encouraging the use of these systems</p> <p>The use of telehealth is also a good measure of access, particularly for people in rural/remote parts of PHN regions. PHNs can encourage the use of these technologies to improve access for people at risk of poor outcomes</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>PHNs support health care providers to use digital health systems to improve patient care and communication</p>
Performance Criteria	<p>Increase in the rate of health care providers using smart forms, e-referrals and/or telehealth</p> <p>Where the rate has been stable for at least 3 years, the performance criteria is to maintain the existing rate of using specific digital health systems</p>
Data Source	<p>PHN - number of health care providers using the specified systems</p> <p>healthdirect - number of health care providers</p>



Item	Description
Calculation	<p>Numerator:</p> <p>Number of general practices, pharmacies and allied health service practices using smart forms; e-referrals; telehealth in the PHN region</p> <p>Denominator:</p> <p>Number of all general practices, pharmacies and allied health service practices in the PHN region</p> <p>Computation:</p> <p>100 x (numerator / denominator) presented as a percentage in PHN region</p>
Limitations	-
Additional information	<p>As new digital systems are developed, relevant definitions may be added to this specification</p> <p>Note: PHNs may choose to provide information on individual or all digital health systems being used in their region</p>

### DH3: Rate of accredited general practices sharing data with PHN

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>Rate of accredited general practices involved in sharing data with PHN</p> <p>A general practice is defined by the Royal Australian College of General Practitioners (RACGP) as an entity which 'provides person centred, continuing, comprehensive and coordinated wholeperson health care to individuals and families in their communities.' Therefore, practices which do not provide 'wholeperson' or mainstream health services should be excluded from the count. This would include skin clinics and travel doctors etc</p> <p>An accredited general practice is one which is accredited or registered for accreditation against the RACGP Standards for general practices</p> <p>Sharing data describes where a general practice is actively sharing their practices' data with the PHN</p>
Purpose	General practices are being encouraged to share their data with the PHN as part of quality improvement activities. PHNs can offer support and analysis to improve delivery and experience of health care. PHNs can also use the data to inform their Needs Assessments
Outcome Theme: Quality Care	<p>Outcome:</p> <p>General practices and other health care providers use data to improve care</p>
Performance Criteria	<p>At least 5% growth on rate of accredited general practices sharing data with the PHN each year</p> <p>Where the rate is over 60%, the performance criteria is to maintain the existing rate</p>
Data Source	PHN - number of accredited general practices involved in sharing data and total number of accredited general practices
Calculation	<p>Numerator:</p> <p>Number of accredited general practices involved in sharing data with PHN</p> <p>Denominator:</p> <p>The number of all accredited general practices in the PHN</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math> presented as a percentage in PHN region</p>
Limitations	-
Additional information	This does not include Aboriginal Community Controlled Health Organisations (ACCHO). The denominator data will be sourced from indicator P3.

## Aged Care indicators

### AC1: Rate of MBS services provided by primary care providers in residential aged care facilities

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by the Department of Health
Definition	<p>Rate of MBS services provided by primary care providers in residential aged care facilities (RACF) per residential aged care place</p> <p>Specific MBS items for services provided in residential aged care include:</p> <p>GP consultations (20,35,43,51)</p> <p>other non-referred consultations (92,93,95,96)</p> <p>residential medication management review (903)</p> <p>telehealth in RACF (2125,2138,2179,2220)</p> <p>GP after hours care (5010,5028,5049,5067)</p> <p>other non-referred after hours care (5260,5263,5265,5267)</p>
Purpose	<p>Primary health care is difficult to obtain in RACF, and when medical care cannot be obtained patients depend on the hospital system which is less appropriate for the patient and a cost to the system</p> <p>PHNs have opportunities through their networks and commissioning to take steps to facilitate the minimisation of these problems</p> <p>This indicator will reflect whether access to appropriate MBS health services for people aged 65 and over in RACF has improved</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>Older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home</p>
Performance Criteria	Increase in rate of MBS services in RACF
Data Source	Department – MBS items and RACF places
Calculation	<p>Numerator:</p> <p>Specific MBS items per person for services provided in residential aged care</p> <p>Denominator:</p> <p>Number of RACF places</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math> presented as a percentage in PHN region</p>
Limitations	-
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including P4, P12 and AC2

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

Item	Description
Assessment	PHN Program
Reporting	DoH - Twelve monthly by the Department of Health
Definition	<p>Rate of people aged 75 and over with a GP health assessment.</p> <p>GP health assessment includes MBS items:</p> <p>701, 703, 705 and 707</p>
Purpose	<p>This indicator will reflect whether access to appropriate GP health services for people aged 75 and over has improved</p> <p>This indicator will provide information on trends in usage of GP services by older people to identify gaps and weaknesses in the systems which PHNs may be able to influence</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>Older people in the PHN region are supported to access primary health care services that meet their need including self-care in the home</p>
Performance Criteria	Increase in rate of people aged 75 and over with a GP health assessment
Data Source	<p>MBS – 701, 703, 705 and 707</p> <p>ABS – population data</p>
Calculation	<p>Numerator:</p> <p>Specific MBS items per person for services provided to people aged 75 and over</p> <p>Denominator:</p> <p>Population of the PHN aged 75 and over for the most recent year available</p> <p>Computation:</p> <p>100 x (numerator / denominator) presented as a percentage in PHN region</p>
Limitations	-
Additional information	<p>A health assessment for people aged 75 years and older is an assessment of a patient's health and physical, psychological and social function for the purpose of initiating preventive health care and/or medical interventions as appropriate. This indicator targets the population of those aged 75 years and over as opposed to 65 years, to align with the above MBS items</p> <p>Data from this indicator will be used to interpret and provide context to other indicators including P4, P12 and AC1</p>

## Alcohol and Other Drugs indicators

### AOD1: Rate of drug and alcohol commissioned providers actively delivering services

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly by the Department of Health
Definition	Rate of providers commissioned to deliver drug and alcohol services and actively delivering services Actively delivering means that patients are being referred and accessing services
Purpose	PHNs are helping to address demand for treatment services through commissioning providers to deliver services. This indicator measures how successful the PHN and commissioned providers are in moving from design to delivery of services
Outcome Theme: Improving Access	Outcome: People in PHN region are able to access appropriate drug and alcohol treatment services
Performance Criteria	Rate of drug and alcohol commissioned providers actively delivering services increases or remains the same
Data Source	Bi-monthly reporting from PHNs
Calculation	Numerator: Number of providers commissioned to deliver drug and alcohol services actively delivering services within reporting period Denominator: Number of providers commissioned to deliver drug and alcohol services Computation: $100 \times (\text{numerator} / \text{denominator})$ presented as a rate Disaggregation: Indigenous Specific Services
Limitations	-
Additional information	-

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

Item	Description
Assessment	Individual PHN
Reporting	DoH - Twelve monthly by the Department of Health
Definition	<p>Partnerships and collaborations established with local key stakeholders including Non-Government Organisations (NGO) (including specialist drug and alcohol treatment services), local health networks, state government, peak bodies and primary health services in relation to the delivery of drug and alcohol services</p> <p>Evidence of formalised partnerships and collaboration includes strategies to facilitate collaboration, establishment of governance structures, joint service planning and delivery and Memorandum of Understanding between service providers that have been facilitated by the PHN</p>
Purpose	This indicator measures the range of partnerships established in the PHN region in relation to the delivery of drug and alcohol services. PHNs promote linkages with other health services and improve integration and quality of services
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers in PHN region have an integrated approach to drug and alcohol treatment services</p>
Performance Criteria	A range of organisations are involved in delivering drug and alcohol services
Data Source	Drug and Therapeutic Information Service (DATIS) reporting Indicator 1.3 and 1.4
Calculation	The Department will assess the information provided by the PHN
Limitations	-
Additional information	-

# Organisational indicators

## O1: PHN has an independent and diverse skills based Board

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN is governed by an independent and diverse skills based Board</p> <p>Independent means the Board is not directed by any other person or corporation</p> <p>Diverse skills-based means the Board is comprised of a mix of people from different backgrounds, gender and professions. Aboriginal and Torres Strait Islander status (where available and appropriate) is to be noted for each Board member</p> <p>Affiliations include professional academic, corporate, government or other institutions that Board members are an associate of or have associations with</p>
Purpose	<p>PHNs are contractually required to have an independent and skills based Board</p> <p>The Board is accountable for the performance of the PHN in relation to outcomes, as well as clinical, financial, risk, planning, legal and business management systems. It is important to have an appropriately skilled, diverse and independent group of individuals providing strategic direction and leading the organisation</p>
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN's governance structures support the delivery of the organisation's objectives through providing oversight and direction</p>
Performance Criteria	PHN has an independent and diverse skills based Board
Data Source	Statement provided by PHN of the Board composition
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

## O2: PHN Clinical Council and Community Advisory Committee membership

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN Clinical Council (CC) and Community Advisory Committee (CAC) has appropriate membership and range of skills</p> <p>Defined as appropriate membership and range of skills as per the PHN contract.</p> <p>Skills are defined as the specialty or experience that that particular member brings to the council/committee. This could include being a general practitioner, pharmacist, clinical specialist, Indigenous health practitioner or health consumer etc</p>
Purpose	The PHN CC and CAC are important committees providing expertise and advice to the Board on how the PHN can meet the needs of the PHN region. A range of skills and membership ensures that the views and needs of the PHN region are accounted for
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN's governance structures support the delivery of the organisation's objectives through providing oversight and direction</p>
Performance Criteria	PHN has at least one Clinical Council and Community Advisory Committee
Data Source	Statement provided by PHN of the composition of the CC and CAC
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-



### O3: PHN Board considers input from committees

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN Board has and maintains policies and processes to consider input from committees (including Audit and Risk Committee, Finance Committee, Clinical Council and Community Advisory Committee)</p> <p>Considers input describes how the Board receives and acts on information from their committees</p>
Purpose	<p>The PHN is expected to draw on expertise from within their local region. Input from the PHNs committees ensures that PHNs have the variety of reliable information needed to make decisions and establish strategic direction.</p> <p>Formal processes for the Board to consider this should be documented</p>
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN's governance structures support the delivery of the organisation's objectives through providing oversight and direction</p>
Performance Criteria	PHN Board considers input from committees
Data Source	<p>List of PHN committees</p> <p>Short statement explaining how Board considers input from PHN committees</p>
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

#### O4: Record of PHN Board member attendance at meetings

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	A numerical score of each Board member's attendance at Board meetings Board meetings are defined as meetings where the full Board is expected to attend
Purpose	A PHN Board is charged with providing leadership and strategy to the PHN Board members are responsible for participating in discussions and decision-making processes for the PHN at Board meetings. Attendance at Board meetings is a guide as to whether all Board members are fully represented in the decision-making process for the PHN
Outcome Theme: Capable Organisations	Outcome: The PHN's governance structures support the delivery of the organisation's objectives through providing oversight and direction
Performance Criteria	Board members meet the minimum attendance requirement defined under their PHN Board constitution or where a PHN does not have a minimum attendance requirement, attended at least 50% of meetings.
Data Source	Statement provided by PHN on Board member attendance and minimum attendance
Calculation	Numerator: Number of Board meetings attended (for each Board member) Denominator: Number of Board meetings eligible to attend (for each Board member) Provision of minimum attendance number if relevant Computation: sum of individual Board member attendance (numerator/denominator) for each Board member / total number of Board members = average attendance
Limitations	The indicator does not measure the level of engagement of the Board member, only attendance
Additional information	-

## O5: PHN Board has a regular review of its performance

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN Board takes part in a regular review of its performance</p> <p>A review of performance is an internal or external review which assesses how the Board is performing in its strategic governance role and identifies areas for improvement</p> <p>*Regular in this context means at least every three years</p>
Purpose	Regular reviews of the Board's performance allow the Board to reflect on its governance and make continual improvements in order to support the PHN reaching its objectives. Reviewing performance also facilitates greater accountability and continuous improvement
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN's governance structures support the delivery of the organisation's objectives through providing oversight and direction</p>
Performance Criteria	PHN Board is reviewed every three years
Data Source	Statement provided by PHN on process for reviewing Board performance
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	Over time this indicator could become a measure of the Board's actual performance and measure how feedback on performance is acted upon

## O6: PHN Board approves strategic plan

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	The PHN Board approves the strategic plan for the PHN The strategic plan outlines the PHN's aims and objectives
Purpose	It is an expectation under Department of Health governance principles that the PHN Board approves the strategic plan for the PHN so that it remains current, tailored to the need of the local region, is in line with other comparable PHNs and is accurate  Review by the Board is also necessary for accountability as the body responsible for decision making
Outcome Theme: Capable Organisations	Outcome: The PHN's governance structures support the delivery of the organisation's objectives through providing oversight and direction
Performance Criteria	PHN Board approves strategic plan
Data Source	Statement provided by PHN of the processes to review/approve strategic plan
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

## O7: Variance report of scheduled activities

Item	Description
Assessment	Individual PHN
Reporting	PHN - Six monthly by PHN
Definition	<p>A variance report of scheduled activities of the PHN tracking achievement and spend is produced</p> <p>Scheduled activities are those that are included in the PHN Activity Work Plan (AWP)</p> <p>Achievement is measured against milestones/indicators developed by PHN</p>
Purpose	There will be some variance between projected achievement and spend and actual achievement and spend on activities. A variance report helps to keep track of this spend and can identify where there may be significant barriers to delivery of an activity or an over or underspend. This can suggest whether the PHN is delivering as expected or it is experiencing problems. This information would be supported by contextual information from the PHN on whether variance is expected and/or plans to address variances
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN has policies and processes which support the effective and efficient delivery of the organisation's objectives</p>
Performance Criteria	All variations are accounted for by PHN
Data Source	Variance report on scheduled activities
Calculation	Department of Health will assess information provided in Variance Report (O7) against PHN Needs Assessment, PHN AWP and national priority areas. The Variance Report comprises a list of individual PHN activities pre-populated from AWP's where PHNs are to detail expected spend by reporting period against actual spend, identify the related need or priority area and assign a risk rating
Limitations	-
Additional information	-

## O8: Quality management system

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN has or is working towards a quality management system, which could include accreditation status against relevant International Organization for Standardization (ISO) certification standards or equivalent</p> <p>A quality management system is a formal system for documenting processes, procedures and responsibilities for achieving quality policies and objectives</p> <p>Accredited means it has been assessed by an authorised accrediting company according to relevant ISO certification standards and that the accreditation is current</p>
Purpose	A quality management system supports the effective and efficient delivery of an organisation's objectives by providing a means to review and continually improve processes and procedures
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN has policies and processes which support the effective and efficient delivery of the organisation's objectives</p>
Performance Criteria	PHN has or is in the process of moving towards a fit for purpose quality management system
Data Source	Statement provided by PHN about its quality management system and accreditation if relevant
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

## O9: Staff satisfaction

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN has a process in place to measure staff satisfaction at least every two years</p> <p>Staff means active and ongoing persons directly employed by the PHN, not including those persons employed by organisations contracted by the PHN</p> <p>Satisfaction can be assessed by PHN through a survey or other mechanisms of how staff view or experience their work environment and culture</p>
Purpose	PHNs which review their staff satisfaction levels can address any emerging issues with staff that may affect long term goals. An organisation with highly satisfied staff will perform better and are more likely to achieve their objectives
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>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</p>
Performance Criteria	PHN has a fit for purpose process to measure staff satisfaction at least every two years
Data Source	Statement provided by PHN on its measure of staff satisfaction
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	Over time this indicator could become a measure of the rate of staff employed by the PHN which report high levels of satisfaction and/or engagement with the PHN

## O10: Performance management process

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN has a performance management process in place to measure staff performance at least every two years</p> <p>Staff means active and ongoing persons directly employed by the PHN, not including those persons employed by organisations contracted by the PHN</p> <p>Performance management process describes any formal/informal process that the PHN uses to review performance of their staff and provide feedback on improvements and achievements</p>
Purpose	Effective performance management processes help to improve both individual and team performance, which assists in making progress towards the achievement of business objectives
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>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</p>
Performance Criteria	PHN has a fit for purpose process to measure staff performance at least every two years
Data Source	Statement provided by PHN on its performance management review process
Calculation	Department of Health will assess the qualitative information provided by the PHN.
Limitations	-
Additional information	Over time this indicator could become a measure of the rate of staff employed by the PHN who have participated in the performance management process



## O11: Cultural awareness training

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN conducts or offers cultural awareness training to staff at least every two years</p> <p>Staff includes active and ongoing persons employed by the PHN, not including those persons employed by organisations contracted by the PHN</p> <p>Cultural awareness training is a formal information sharing process about understanding and appreciating the differences between persons from other cultures, countries or backgrounds</p>
Purpose	PHNs must ensure that their staff are culturally aware and able to respond appropriately, confidently and respectfully to all persons in the PHN region
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>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</p>
Performance Criteria	PHN conducts or offers cultural awareness training to staff at least every two years
Data Source	Statement provided by PHN on its cultural awareness training activities
Calculation	Department of Health will assess qualitative information provided by the PHN
Limitations	-
Additional information	<p>Over time this indicator could become a measure of the rate of staff employed by the PHN who have participated in cultural awareness training</p> <p>PHNs may also choose to provide information on other training provided to staff to better meet their client's needs. This may include training specific to Aboriginal and Torres Strait Islander people, people who identify as LGBTIQ+, people with a low Socio-Economic Status (SES) or people with a disability</p>

**O12: Rate of contracts for commissioned health services that include both output and outcome performance indicators**

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN includes both output and outcome performance indicators in its active contracts with commissioned service providers</p> <p>Output performance indicators measure the services and/or products delivered by the process or activity that was funded</p> <p>Outcome performance indicators measure the impact of the services and/or products delivered</p>
Purpose	PHNs are encouraged to include both output and outcomes performance indicators in their contracts with commissioned service providers. This will allow the PHN to demonstrate the impact of their commissioning over time towards the PHN Program outcomes
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN uses commissioning cycle processes to plan, procure, monitor and evaluate services to respond to the prioritised health needs of its region</p>
Performance Criteria	Increase in the number of contracts containing both output and outcome performance indicators
Data Source	PHN provides number of contracts and extracts of output and outcome measures from contracts
Calculation	<p>Numerator:</p> <p>Number of active contracts with output and outcome measures</p> <p>Denominator:</p> <p>Number of total contracts executed</p> <p>Computation:</p> <p><math>100 \times (\text{numerator} / \text{denominator})</math> presented as a percentage in PHN region</p>
Limitations	-
Additional information	It is noted that PHNs construct the most appropriate performance indicators for each service they commission. For some contracts it will be most appropriate to include output performance indicators initially

### O13: Annual Report and audited financial statements

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>Annual Report and audited financial statements are submitted to the Department and are lodged in accordance with the Corporations Act 2001</p> <p>PHN Full-Time Equivalent (FTE) is also to be provided. Contextual information may also be included to support FTE numbers if necessary</p>
Purpose	PHNs are contractually required to provide their Annual Report and audited financial statements as the Department has a responsibility to account for the spending of public money
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN manages its finances in a manner that maximises efficiency without compromising effectiveness</p>
Performance Criteria	<p>Annual Report meets requirements</p> <p>Audited financial reports have unqualified auditor statement</p>
Data Source	PHN supplies Annual Report and audited financial statements
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

#### O14: PHN stakeholder engagement

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	The PHN engages with a wide range of stakeholders that represent the specific needs, functions and priority groups of the PHN including: General practices and other health care providers, Local Hospital Networks and specific community groups etc
Purpose	<p>PHNs must engage with a broad range of stakeholders throughout their planning and commissioning work</p> <p>PHNs must have strong relationships with stakeholders in their region to better understand the concerns, needs, service gaps and demographics of the community</p> <p>Stakeholder engagement is necessary to ensure that commissioned services are appropriate and address local health needs. This may be facilitated through collaboration or co-design processes with these stakeholder groups</p>
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN creates and maintains relationships that facilitate the improvement of the health care system within its region</p>
Performance Criteria	PHN engages with a broad range of stakeholders in its region
Data Source	PHN provides a statement on its stakeholder engagement activities
Calculation	Department of Health will assess the qualitative information provided by the PHN
Limitations	-
Additional information	-

## O15: Engaging with complaints

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The feedback received about a PHN, including both complaints and compliments</p> <p>A complaint is an expression of dissatisfaction with an aspect of the PHN Program that requires the Department to review or refer the information provided and where appropriate, facilitate a resolution</p> <p>Complaints received means those received by the Department and referred to the PHN as per the Primary Health Networks Complaints Management Policy and Procedures document</p> <p>Compliments received means positive feedback received by the Department and/or PHN about a specific PHN</p>
Purpose	PHNs must be able to work with a broad range of stakeholders. Where complaints are received, the PHN should be able to engage with the complainant and address the matter. Compliments received are an indicator that the PHN is working well with stakeholders in the region
Outcome Theme: Capable Organisations	<p>Outcome:</p> <p>The PHN creates and maintains relationships that facilitate the improvement of the health care system within its region</p>
Performance Criteria	PHN attempts to address all complaints referred to it by the Department
Data Source	<p>Primary Health Networks Complaints Management Policy and Procedures</p> <p>Statement from PHN regarding complaints resolved and compliments received</p>
Calculation	<p>Numerator:</p> <p>Total number of complaints resolved of those referred to the PHN</p> <p>Denominator:</p> <p>Total number of complaints referred to the PHN</p> <p>Information on compliments received about PHN</p>
Limitations	The Department acknowledges that PHNs cannot control the number of complaints they receive. They should however, engage with and attempt to address all complaints that they are made aware of
Additional information	-

## Version History

Version	Description of change	Author	Effective date
1.0	Initial release version	Department of Health	1 / 7 / 18
1.1	Addition of Version History, Creative Commons licence notification, clarification of performance criteria wording for indicators MH1, MH2 & MH3, and the collapse of Mental Health indicators MH6 and MH7 into a single performance indicator.	Department of Health	1 / 9 / 18

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