



Australian Government

Department of Health



An Australian Government Initiative

PHN Program Performance and Quality Framework

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1 Introduction

1.1 The Primary Health Networks Program

The Primary Health Networks Program (PHN Program) commenced in 2015 with the establishment of 31 Primary Health Networks (PHNs). Individual PHNs are responsible for identifying and addressing the primary health needs in their region through strategic planning, commissioning services, supporting general practices and other health care providers and supporting the integration of local health care services.

The PHN Program has two objectives and seven priority areas for targeted work:

Table 1: PHN Program objectives and priority areas

PHN Program Objectives	PHN priority areas for targeted work
Increase the efficiency and effectiveness of medical services, particularly for patients at risk of poor health outcomes.	Mental Health Aboriginal and Torres Strait Islander Health Population Health Workforce Digital Health Aged Care Alcohol and Other Drugs
Improve coordination of care to ensure patients receive the right care in the right place at the right time.	

PHNs are expected to respond to the health needs of their region while being guided by the priority areas for targeted work and National priorities as decided by the Government.

PHNs receive funding from the Australian Government for a range of activities and functions:

- Commissioning health services to meet local service needs – this includes analysing relevant health data; prioritising local health needs; working with providers, clinicians and communities to co-design services to meet those needs; and monitoring and evaluating service delivery to inform future needs. PHNs are provided with specific funding to commission services for core primary health care activities, as well as mental health treatment services, drug and alcohol treatment services, and Indigenous-specific health services.

- Health systems improvement – with the alignment of PHN and Local Hospital Networks (LHN) boundaries, PHNs are in a position to support joint planning, collaborative commissioning and health service integration between Commonwealth and state and territory funded health services. PHNs are working closely with service providers to agree referral pathways and support secure sharing of patient information.
- Sector support activities – PHNs play an important role in providing support to general practice, as a key part of strengthening the primary health care system. PHNs' work in this area includes: supporting general practice and other health care providers with quality improvement and accreditation; cultural awareness and competency; workforce development; digital health systems; and patient centred care and best practice service delivery models.
- Operational functions – including the administration, governance (including the establishment and maintenance of Clinical Councils and Community Advisory Committees) and core functions of PHNs.

Some PHNs also receive other Australian Government funding, for specific activities such as Health Care Homes, Palliative Care or Per- and poly-fluoroalkyl substances (PFAS). In addition, PHNs may deliver activities funded by State and Territory Governments or other funding bodies.

1.2 Purpose of the PHN Program Performance and Quality Framework

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

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

The Framework has three purposes:

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

In addition, individual PHN performance against the Framework will be used to inform Department of Health (the Department) decisions concerning eligibility for future contract extensions, as well as any associated negotiations with individual PHNs.

The Framework encompasses the activities that are delivered by all PHNs from 1 July 2018. It offers a structure which can accommodate additional activities and functions, should the Australian Government seek to deliver these through PHNs in the future.

The Framework is effective from 1 July 2018 and supersedes the PHN Performance Framework Version 1 (March 2016 – June 2018).

1.3 Principles

The following principles underpin the Framework:

- Minimise burden – the Framework should focus on minimising reporting requirements for PHNs and gathering information that is useful for assessing performance and quality.
- Transparent – the Framework should be clear about what it is measuring and how it will assess performance.
- Outcomes based – the Framework should measure progress towards outcomes and program objectives, to build a strong picture of the impact of the PHN Program.
- Quality – the Framework should provide an opportunity to identify continuous quality improvement for the PHN Program and individual PHNs.
- Holistic – the Framework should consider the performance of the PHN Program as a whole and any future functions of the Program.
- Alignment – the Framework should align with the PHN Program objectives, national performance frameworks in health, and the health priorities of the Australian Government.
- Flexibility – the Framework needs to accommodate the different priorities of PHNs depending on the health needs of their region.

2 Conceptual Framework

Version 1 of the Framework primarily reflected program performance monitoring under the PHN Program's Core Schedule. The new Framework has been designed to provide a structure for monitoring and assessing PHNs' individual performance and progress towards achieving outcomes under all Funding Schedules of the PHN Program.

The conceptual framework consists of the following four components:

- PHN Program Objectives – describe what the PHN Program is intended to achieve
- Outcome Themes – five themes which link the outcomes to the PHN Program objectives
- Outcomes – drawn from the program logic models which describe the activities, outputs and outcomes for the PHN Program
- Indicators – for assessing progress towards the outcomes

2.1 Outcome themes

There are five outcome themes which link to the PHN Program's objectives. This grouping helps explain how different activities contribute to the overall PHN Program objectives.

Table 2: Outcome themes

Outcome theme	Outcomes
Addressing Needs	Activities conducted by PHNs to address the needs of people in their local region, including an equity focus
Quality Care	Activities and support offered by PHNs to general practices and other health care providers to improve quality of care for patients
Improving Access	Activities by PHNs to improve access to primary health care by patients
Coordinated Care	Activities and support by PHNs to improve coordination of care for patients and integration of health services in their region
Capable Organisations	Operational activities of PHNs which support the successful delivery of the PHN Program

2.2 Outcomes

The primary health care system is a complex mix of service delivery with many interdependencies and stakeholders. Consideration also needs to be given to social determinants of health, individual behaviour and personal circumstances. There are a large number of determinants at play which produce changes in outcomes.

Program logics for the PHN Program and the seven priority areas have been developed to simply describe the activities and outputs PHNs deliver (including by commissioning) and the outcomes these activities are designed to achieve. While there are a number of contextual and environmental factors at play, the program logics attempt to reflect outcomes which are most closely aligned to the actions of individual PHNs. The PHN Program and priority area program logics are set out in Appendix A - Program Logics.

The Framework acknowledges that PHNs are individual organisations using different approaches to address the needs of their region. PHNs may find that they have few activities against some outcomes due to the different priorities of their region. The Framework offers a way to consider how different activities can contribute to broader outcomes.

The Framework reflects that PHNs are working towards intermediate outcomes, which can be expected to be achieved in the near future, and longer term outcomes, which accord with both the PHN Program's objectives and PHN's strategic visions.

In addition, PHNs aim to meet organisational capability outcomes to demonstrate their ongoing viability as commissioning organisations.

Table 3 on the next page maps the outcomes to four of the outcome themes, and to the PHN Program's priority areas. Longer term outcomes are also included in a separate column. The outcomes for the Capable Organisations outcome theme can be found in Table 13.

Table 3: Outcomes and outcome themes

Areas	Addressing Needs	Quality Care	Improving Access	Coordinated Care	Longer Term
Program	PHN activities and initiatives address local needs	PHNs support general practices and other health care providers to provide quality care to patients	<p>People in the PHN region are able to access general practices and other services as appropriate</p> <p>PHNs support general practices and other health care providers to provide appropriate after hours access</p>	People in the PHN region receive coordinated, culturally appropriate services from local health care providers	<p>PHNs support local primary health care services to be efficient and effective, meeting the needs of patients at risk of poor health outcomes</p> <p>Patients in local region receive the right care in the right place at the right time</p>
Mental Health	-	PHN commissioned mental health services improve outcomes for patients	People in PHN region access mental health services appropriate to their individual needs	Health care providers in PHN region have an integrated approach to mental health care and suicide prevention	People in PHN region enjoy better mental health and social and emotional wellbeing
Aboriginal and Torres Strait Islander health	PHNs address needs of Aboriginal and Torres Strait Islander people in their region	Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people	Aboriginal and Torres Strait Islander people are able to access primary health care services as required	Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care	PHNs contribute to closing the gap and Aboriginal and Torres Strait Islander people experience improved emotional, social and physical wellbeing

Areas	Addressing Needs	Quality Care	Improving Access	Coordinated Care	Longer Term
		Aboriginal and Torres Strait Islander identified health workforce capability and capacity matches needs of region			
Population Health	Fewer preventable hospitalisations in PHN region for people with chronic and vaccine preventable diseases	PHNs support health care providers to address factors impacting population health	-	-	Improved health outcomes for all population groups in the PHN region
Workforce	-	Local workforce has suitable cultural and clinical skills to address health needs of PHN region PHNs support general practices and other health care providers to provide quality care to patients	-	-	People in PHN region are able to access a high quality, culturally safe and appropriately trained workforce

Areas	Addressing Needs	Quality Care	Improving Access	Coordinated Care	Longer Term
Digital Health	-	PHNs support health care providers to use digital health systems to improve patient care and communication General practices and other health care providers use data to improve care	-	Health care providers are aware of digital health systems and technologies	Digital health enables better coordinated care and better informed treatment decisions
Aged Care	-	Fewer preventable hospitalisations in PHN region for older people Local health and other care providers are supported to deliver coordinated, effective and appropriate care to older people in the PHN region	Older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home	-	Older people in the PHN region are supported to enjoy a greater quality of life Local health care system provides coordinated, quality care to older people
Alcohol and Other Drugs	-	-	People in PHN region are able to access appropriate drug and alcohol treatment services	Health care providers in PHN region have an integrated approach to drug and alcohol treatment services	Decrease in harm to population in PHN region from drug and alcohol misuse

2.3 Indicators

Indicators have been selected to monitor and assess progress towards achieving the outcomes for the Program, each priority area and organisational capability. All of the indicators will be used to measure the performance of the PHN Program as a whole and a subset of the indicators will be used to assess individual PHN performance. See Table 14 for the subset of indicators for individual PHN performance.

The indicators selected are a mix of output/process indicators, existing health outcome indicators, existing performance indicators from PHN Schedules and qualitative statements of activities and expected change. The mix of indicators reflects that measuring outcomes under the PHN Program is new. As the Program continues to mature, the Framework's indicators will be reviewed and updated to reflect the progress to achieving Program outcomes. This includes a review of performance criteria of indicators.

2.4 Alignment to other frameworks

The outcome themes of the Framework can be used to align the PHN Program outcomes, activities and functions against other existing health Frameworks. The two most relevant for PHNs are the new Australian Health Performance Framework (AHPF), which seeks to support system-wide reporting of Australia's health and health care performance, and the Quadruple Aim¹, which many PHNs use as a tool for measuring their progress towards achieving optimal health system performance.

Table 4 on the next page shows how the outcome themes are aligned to the AHPF and the Quadruple Aim.

¹ Bodenheimer T and Sinsky C. 2014 From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med* November/December 12:573-576; doi:10.1370/afm.1713

Table 4: Alignment between outcome themes and AHPF and Quadruple Aim

Framework	Elements of Framework	Addressing Needs	Quality Care	Improving Access	Coordinated Care	Capable Organisations
AHPF Health System Dimensions	Effectiveness	✓	✓	✓	✓	✓
	Safety	—	✓	—	—	—
	Appropriateness	✓	✓	—	—	—
	Continuity of Care	—	—	—	✓	—
	Accessibility	—	—	✓	—	—
	Efficiency and Sustainability	✓	✓	✓	✓	✓
Quadruple Aim	Improving patient experience	✓	✓	✓	✓	—
	Improved population health outcomes	✓	✓	✓	✓	—
	Reducing the per capita cost of health care ²	✓	✓	✓	✓	✓
	Improved clinician experience	—	✓	✓	✓	✓

² Many PHNs are adapting this aim to ensure a focus on the importance of achieving value for money

3 Performance Indicators

The Framework contains 54 indicators:

- 39 performance indicators – which are used to measure performance towards PHN Program and priority area outcomes
- 15 organisational indicators – which are used to measure performance towards the capable organisations outcomes³.

PHNs will provide information against individual Schedule performance indicators and an additional 24 indicators. The amount of information or data that a PHN provides against each indicator will vary depending on the activities it has undertaken to address prioritised needs in that area. For some indicators PHNs may have no or limited input. The Framework includes sufficient flexibility to ensure where this occurs a PHN's performance assessment will not be negatively impacted.

PHNs will be individually assessed against a sub-set of 39 indicators, which consists of all of the organisational indicators and 24 of the performance indicators. Indicators have been selected which reflect areas where PHNs can and should have influence (see Table 14). Section 7 explores how PHNs will be assessed on their performance. Appendix B - Indicator Specifications provides the necessary details for reporting against each indicator.

3.1 Indicator selection

Each outcome has been assigned at least one indicator. In some cases, multiple indicators have been used to account for the different factors that contribute to achieving outcomes.

Indicators have been selected by considering:

- Alignment – does the indicator assist in measuring progress towards the relevant outcome, either independently or in consideration with other indicators?
- Practicality – do the data already exist, or could they be derived from existing data sets or by PHN activity data?
- Availability – are the data frequently available, with limited time lags?
- Reliability – are the data sourced from reliable and stable sources?

³ Note that three indicators from the PHN Program and priority area outcomes are also used to assess organisational capability

Wherever possible indicators have been selected using measures that already exist within the Australian health care system. This includes data reported by the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS), along with Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data which is collected by the Department of Human Services and provided to the Department. The use of this data has been prioritised as a way to minimise the burden on PHNs.

In addition, existing performance indicators for specific programs of work, contained in the Primary Mental Health and Suicide Prevention (MH) Schedule, the Drug and Alcohol Treatment Information Strategy (DATIS) and the My Health Record Expansion Program (MHREP) Schedule (managed by the Australian Digital Health Agency (ADHA)) have been selected for inclusion in the Framework.

3.2 Aspirational indicators

There are a number of outcomes in the Framework where no suitable indicator is currently available. Instead, an aspirational indicator has been included which describes what could be collected as part of future versions of the Framework. This includes potential indicators for assessing progress towards the longer-term outcomes.

3.3 Indicator tables

The tables on the following pages contain the outcome, the selected indicators and where the data for each indicator will be obtained from. The same indicator may be used to report against several outcomes.

Table 5: PHN Program indicators

Outcomes	Indicators	Data Provision
Addressing Needs: PHN activities and initiatives address local needs	P1 PHN activities address prioritised needs	PHN
	P2 Health system improvement and innovation	PHN
	To be developed: an indicator of health literacy in each PHN region	TBD
Quality Care: PHNs support general practices and other health care providers to provide quality care to patients	P3 Rate of general practice accreditation	PHN
	P4 Support provided to general practices and other health care providers	PHN
	P5 Rate of regular uploads to My Health Record	ADHA

Outcomes	Indicators	Data Provision
	To be developed: an indicator of use of Patient Reported Experience Measures in determining provision of quality care	TBD
<p>Improving Access:</p> <p>People in the PHN region are able to access general practices and other services as appropriate</p> <p>PHNs support general practices and other health care providers to provide appropriate after hours access</p>	P6 Rate of general practices receiving payment for after hours services.	DHS
	P7 Rate of GP style emergency department presentations	AIHW
	P8 Measure of patient experience of access to GP	ABS
<p>Coordinated Care:</p> <p>People in the PHN region receive coordinated, culturally appropriate services from local health providers</p>	P9 Rate of GP team care arrangements/ case conferences	DoH / ABS
	P10 Cross views of My Health Record (MHREP indicators 9-10)	MHREP reporting
	P11 Rate of discharge summaries uploaded to My Health Record	AIHW / ADHA
	To be developed: indicator on cultural appropriateness	TBD
<p>Longer Term:</p> <p>Patients in local region receive the right care in the right place at the right time</p>	P12 Rate of potentially preventable hospitalisations	AIHW / ABS
	P13 Numbers of health professionals available	PHN / National Health Workforce Dataset / healthdirect

Outcomes	Indicators	Data Provision
<p>Longer Term:</p> <p>PHNs support local primary health care services to be efficient and effective, meeting the needs of patients at risk of poor health outcomes</p>	<p>To be developed: indicators on system integration and impact on health outcomes for patients</p>	<p>TBD</p>

Table 6: Mental Health indicators

(Note: all indicators are drawn from the MH Schedule item B.3 5)

Outcomes	Indicators	Data Provision
<p>Improving Access: People in PHN region access mental health services appropriate to their individual needs</p>	<p>MH1 Rate of regional population receiving PHN commissioned low intensity psychological interventions (MH indicator Acc-1)</p>	<p>MH reporting</p>
	<p>MH2 Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals (MH indicator Acc-2)</p>	<p>MH reporting</p>
<p>Coordinated Care: Health care providers in PHN region have an integrated approach to mental health care and suicide prevention</p>	<p>MH3 Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness (MH indicator Acc-3)</p>	<p>MH reporting</p>
	<p>MH4 Formalised partnerships with other regional service providers to support integrated regional planning and service delivery (MH indicator regional integration)</p>	<p>MH reporting</p>
	<p>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 (MH indicator App-3)</p>	<p>MH reporting</p>
<p>Quality Care: PHN commissioned mental health services improve outcomes for patients</p>	<p>MH6 Outcomes Readiness - Completion rates for clinical outcome measures (MH Indicator Out-3)</p>	<p>MH reporting</p>
<p>Longer term outcome: People in PHN region enjoy better mental health and social and emotional wellbeing</p>	<p>-</p>	<p>-</p>

Table 7: Aboriginal and Torres Strait Islander Health indicators

(Note: some indicators drawn from MH Schedule and DATIS)

Outcomes	Indicators	Data Provision
Addressing Needs: PHNs address needs of Aboriginal and Torres Strait Islander people in their region	IH1 Numbers of ITC services delivered by PHN	ITC reporting
	IH2 Types of organisations delivering ITC services	ITC reporting
Quality Care: Local health care providers provide culturally appropriate services to Aboriginal and Torres Strait Islander people	IH3 Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people (DATIS indicator 4.2)	DATIS reporting
	IH4 Proportion of PHN commissioned mental health services delivered to the regional Aboriginal and Torres Strait Islander population that were culturally appropriate (MH indicator App-2)	MH reporting
	IH5 ITC improves the cultural competency of mainstream primary health care services	ITC reporting
	To be developed: indicator on patient experience of cultural appropriateness	TBD
Quality Care: Aboriginal and Torres Strait Islander identified health workforce capability and capacity matches needs of regions	IH6 PHN provides support for Aboriginal and Torres Strait Islander identified health workforce	PHN

Outcomes	Indicators	Data Provision
<p>Coordinated Care:</p> <p>Aboriginal and Torres Strait Islander people with chronic conditions receive coordinated care</p>	<p>IH7 ITC processes support Aboriginal and Torres Strait Islander people enrolled in the program to access coordinated care</p>	<p>ITC reporting</p>
	<p>P9 Rate of GP team care arrangements/ case conferences</p>	<p>P9</p>
	<p>P12 Rate of potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people</p>	<p>P12</p>
<p>Improving Access:</p> <p>Aboriginal and Torres Strait Islander people are able to access primary health care services as required</p>	<p>IH8 Rate of Aboriginal and Torres Strait Islander population receiving specific health assessments</p>	<p>MBS / ABS</p>
<p>Longer term outcome:</p> <p>PHNs contribute to closing the gap and Aboriginal and Torres Strait Islander people experience improved emotional, social and physical wellbeing</p>	<p>To be developed: indicators on contribution to closing the gap and Aboriginal and Torres Strait Islander experiences of care</p>	<p>TBD</p>

Table 8: Population Health indicators

Outcomes	Indicators	Data Provision
<p>Addressing Needs:</p> <p>Fewer preventable hospitalisations in PHN region for people with chronic and vaccine preventable diseases</p>	<p>P12 Rate of potentially preventable hospitalisations - for specific chronic diseases</p>	<p>P12</p>
<p>Quality Care:</p> <p>PHNs support health care providers to address factors impacting population health</p>	<p>PH1 Rate of children fully immunised at 5 years</p>	<p>DoH – Australian Immunisation Register</p>
	<p>PH2 Cancer screening rates for cervical, bowel and breast cancer</p>	<p>DoH – screening programs</p>
	<p>P4 Support provided to general practices and other health care providers – population health</p>	<p>P4</p>
<p>Longer term outcome:</p> <p>Improved health outcomes for all population groups in the PHN region</p>	<p>To be developed: indicators on improving health outcomes for all population groups</p>	<p>TBD</p>

Table 9: Workforce indicators

(Note: some indicators drawn from MH Schedule and DATIS)

Outcomes	Indicators	Data Provision
Quality Care: Local workforce has suitable cultural and clinical skills to address health needs of PHN region	W1 Rate of drug and alcohol treatment service providers with suitable accreditation (DATIS indicator 3.2)	DATIS reporting
	W2 PHN support for drug and alcohol commissioned health professionals (DATIS indicator 3.1)	DATIS reporting
	W3 PHN Commissioning Framework	PHN
	IH3 Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people (DATIS indicator 4.2)	IH3
	IH4 Rate of PHN commissioned mental health services for the Aboriginal and Torres Strait Islander people that are culturally appropriate (MH indicator App-2)	IH4
	IH5 ITC improves the cultural competency of mainstream primary health care services	IH5
	P4 Support provided to general practices and other health care providers - workforce	P4
	To be developed: indicator on patient experience of cultural appropriateness	TBD
Quality Care: PHNs support general practices and other health care providers to provide quality care to patients	P3 Rate of general practice accreditation	PHN
	P4 Support provided to general practices and other health care providers	PHN
	P5 Rate of regular uploads to My Health Record	ADHA

Outcomes	Indicators	Data Provision
<p>Longer term outcome:</p> <p>People are able to access a high quality, culturally safe and appropriately trained workforce</p>	<p>To be developed: indicators on improved access, delivery of culturally appropriate services and skill levels of workforce</p>	<p>TBD</p>

Table 10: Digital Health indicators

(Note: some drawn from MHREP Schedule section 1.13)

Outcomes	Indicators	Data Provision
<p>Coordinated Care:</p> <p>Health care providers are aware of digital health systems and technologies</p>	<p>DH1 Rate of health care providers informed about My Health Record (MHREP indicators 1-4)</p>	<p>MHREP reporting</p>
<p>Quality Care:</p> <p>PHNs support health care providers to use digital health systems to improve patient care and communication</p>	<p>DH2 Rate of health care providers using specific digital health systems</p>	<p>PHN</p>
	<p>P4 Support provided to general practices and other health care providers – digital health</p>	<p>P4</p>
	<p>P5 Rate of regular uploads to My Health Record</p>	<p>P5</p>
	<p>P10 Cross views of My Health Record</p>	<p>MHREP reporting</p>
<p>Quality Care:</p> <p>General practices and other health care providers use data to improve care</p>	<p>DH3 Rate of accredited general practices sharing data with PHN</p>	<p>PHN</p>
<p>Longer term outcome:</p> <p>Digital health enables better coordinated care and better informed treatment decisions</p>	<p>To be developed: indicator on improvements to health outcomes from use of digital health</p>	<p>TBD</p>

Table 11: Aged Care indicators

Outcomes	Indicators	Data Provision
<p>Improving Access:</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>	AC1 Rate of MBS services provided by primary care providers in residential aged care facilities	DoH
	AC2 Rate of people aged 75 and over with a GP health assessment	DoH / ABS
<p>Quality care:</p> <p>Fewer preventable hospitalisations in the PHN region for older people</p> <p>Local health and other care providers are supported to deliver coordinated, effective and appropriate care to older people in the PHN region</p>	P4 Support provided to general practices and other health care providers – aged care	P4
	P12 Rate of potentially preventable hospitalisations - for older people	P12
<p>Longer term:</p> <p>Older people in the PHN region are supported to enjoy a greater quality of life</p>	To be developed: indicator on improved quality of life for older people	TBD
<p>Longer term outcome:</p> <p>Local health care system provides coordinated, quality care to older people</p>	To be developed: indicator on improvements to health care system to support quality care for older people	TBD

Table 12: Alcohol and Other Drugs indicators

(Note: all indicators are drawn from DATIS section 3)

Outcomes	Indicators	Data Provision
<p>Improving Access:</p> <p>People in PHN region are able to access appropriate drug and alcohol treatment services</p>	<p>AOD1 Rate of drug and alcohol commissioned providers actively delivering services (bi-monthly AOD reporting)</p>	<p>AOD reporting</p>
<p>Coordinated Care:</p> <p>Health care providers in PHN region have an integrated approach to drug and alcohol treatment services</p>	<p>AOD2 Partnerships established with local key stakeholders for drug and alcohol treatment services (DATIS 1.3 and 1.4)</p>	<p>DATIS reporting</p>
<p>Longer term outcome:</p> <p>Decrease in harm to population in PHN region from drug and alcohol misuse</p>	<p>To be developed: indicators on impact of services on health outcomes for patients</p>	<p>TBD</p>

4 Capable Organisations

The Framework has identified six aspects that contribute to a PHN being a successful and capable commissioning organisation. Outcomes have been developed for each aspect along with indicators to measure progress towards achieving the outcome. These indicators will all be used to measure an individual PHN's performance.

Figure 1: Aspects of the Capable Organisations outcome theme

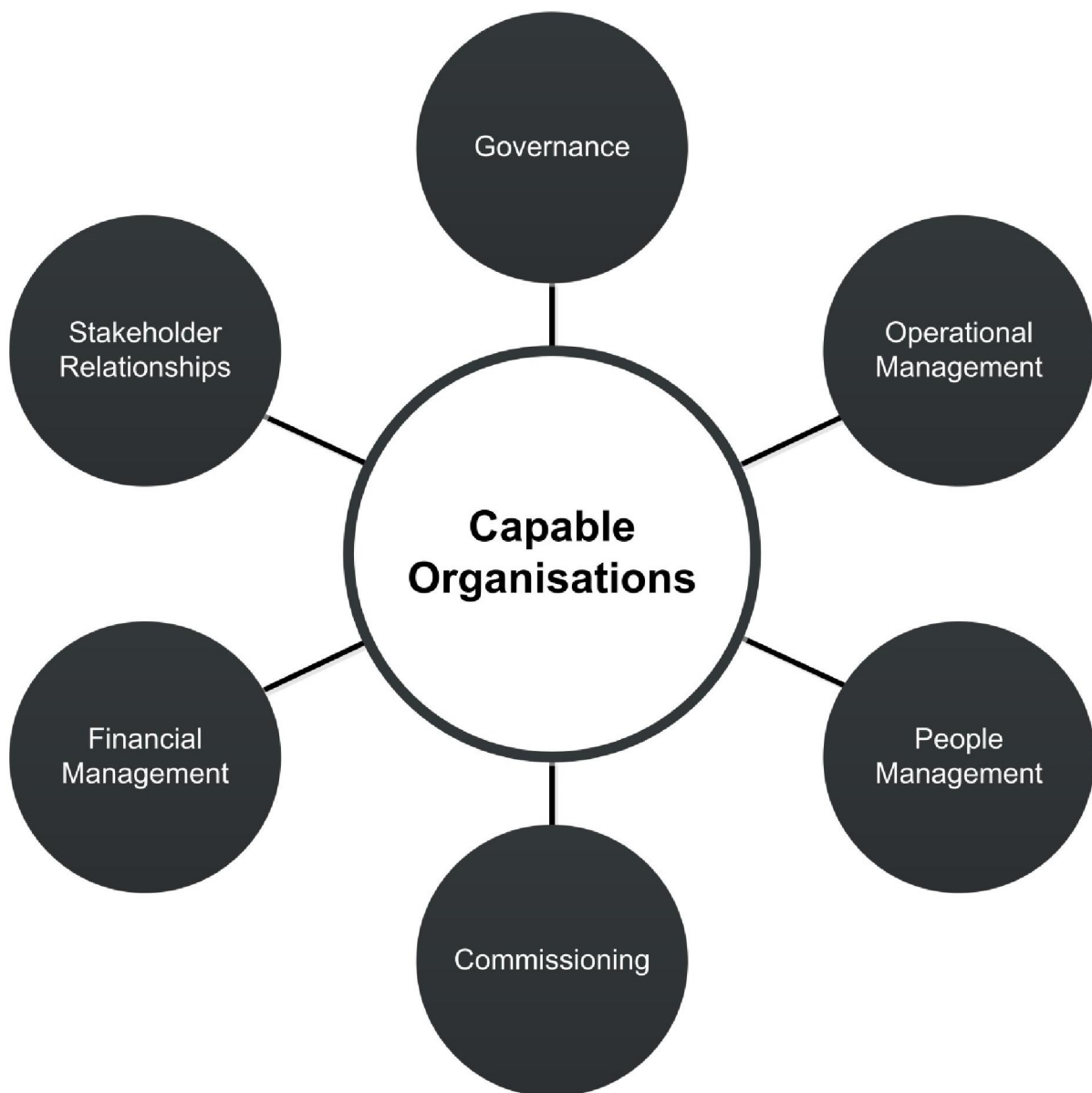


Table 13 below lists the outcomes for each aspect and the indicators being used to measure performance towards achieving that outcome.

Table 13: Organisational indicators

Outcomes	Indicator	Data Provision
<p>Governance</p> <p>The PHN's governance structures support the delivery of the organisation's objectives through providing oversight and direction</p>	O1 PHN has an independent and diverse skills based Board	PHN
	O2 PHN Clinical Council and Community Advisory Committee membership	PHN
	O3 PHN Board considers input from committees	PHN
	O4 Record of PHN Board member attendance at meetings	PHN
	O5 PHN Board has a regular review of its performance	PHN
	O6 PHN Board approves strategic plan	PHN
<p>Operational Management</p> <p>The PHN has policies and processes which support the effective and efficient delivery of the organisation's objectives</p>	O7 Variance report of scheduled activities	PHN
	O8 Quality Management System	PHN
<p>People Management</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>	O9 Staff satisfaction	PHN
	O10 Performance management process	PHN
	O11 Cultural awareness training	PHN

Outcomes	Indicator	Data Provision
<p>Commissioning</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>	P1 PHN activities address identified needs	P1
	W3 PHN Commissioning Framework	W3
	O12 Rate of contracts for commissioned health services that include both output and outcome performance indicators	PHN
<p>Financial Management</p> <p>The PHN manages its finances in a manner that maximises efficiency without compromising effectiveness</p>	O13 Annual Report and audited financial statements	PHN
<p>Stakeholder relationships</p> <p>The PHN creates and maintains relationships that facilitate the improvement of the health care system within its region</p>	O14 PHN stakeholder engagement	PHN
	O15 Engaging with complaints	DoH and PHN
	P4 Support provided to general practices and other health care providers	P4

5 Interpreting Indicators

Each indicator has a one page indicator specification (found in the Indicator Specifications document at Appendix B) which provides details about the purpose of the indicator, the outcome it relates to, what data will be collected and importantly, what the performance criteria is for each indicator. The performance criteria helps to interpret the information or data collected for the indicator.

The performance criteria may require qualitative or data based input. Where an indicator uses qualitative information the Department will assess the information supplied and determine whether it meets the specification. For indicators which use data, the performance criteria may require an improvement over time or may require a specific benchmark or target to be met.

5.1 Review of performance criteria

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

5.2 Peer grouping

Over time, PHN performance peer groups will be established in order to share results across different indicators. Sharing successes and challenges can help drive improvements.

Comparison between individual PHNs presents challenges due to the demographic, geographic and other differences in the regions that PHNs cover. Establishing peer groups as measurement criteria can address this issue. PHNs will be informed of their peer group and encouraged to work within their peer group to share information.

PHN peer groups will initially be based on:

- geographic characteristics
- demographic characteristics
- baseline health status on a range of indicators
- sophistication of the health system in the region
- density of general practices and other health care providers

PHN peer grouping will be used in three ways:

- peer group best practice sharing – where best practice ideas and strategies are shared, with permission, between PHNs in the same peer group; and
- peer group trends – where individual PHNs will compare against trends within their group; and
- peer group benchmarking – as the Program continues to mature, internal peer group benchmarks can be established.

In the early stages of the Framework’s implementation the best practice sharing will be the prime focus of peer grouping. As the PHN Program and the Framework matures, trend analysis and benchmarking will be introduced.

The Department will continue to review performance information and data to establish a robust peer grouping process.

6 Performance and Quality Reporting

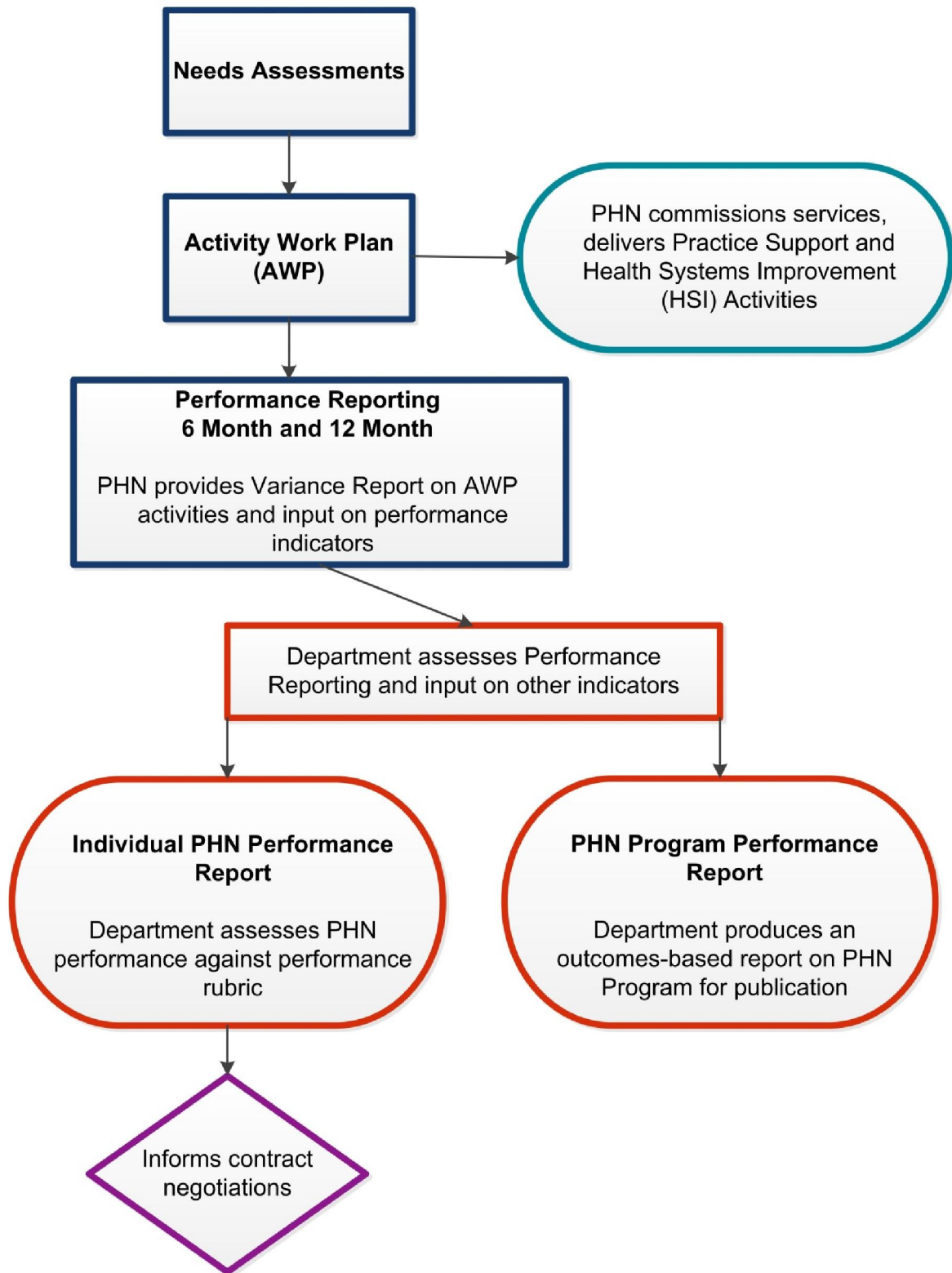
6.1 PHN Deliverables

PHNs will continue to submit the deliverables required in their contracts: a Needs Assessment, Activity Work Plan and six and twelve month performance reports. The Activity Work Plan should continue to be based on the needs identified and prioritised through the Needs Assessment process. The Framework’s outcomes and indicators should not be used to frame or guide Needs Assessments or Activity Work Plans.

The Framework uses information supplied in the six and twelve month performance reports, along with other data, to prepare individual PHN and PHN program performance assessments.

The diagram on the following page (Figure 2) demonstrates the links between the Framework and deliverables.

Figure 2: Deliverables and Framework



6.2 PHN Performance Reports

The six month performance reports will consist of:

- a Variance Report for all activities in approved AWP's for all Schedules;
- input for other indicators specified in Funding Schedules and any other documentation.

The twelve month performance reports will consist of:

- a Variance Report for all activities in approved AWP's for all Schedules;
- input for Framework performance indicators requiring information from PHNs;
- contextual information for performance indicators used for PHN Program assessment (optional);
- input for other indicators specified in Funding Schedules and any other documentation.

The Variance Report will track progress for delivery of scheduled activities, including spend, meeting milestones and stakeholder engagement. PHNs will be able to flag where there are issues with delivery of an activity and what strategies they have in place to address these issues.

PHNs can choose to provide contextual information for 13 of the performance indicators that are used to measure the performance of the PHN Program (excluding indicators which are drawn from existing PHN Schedule reporting). This may include information on PHN activities, contextual information about the region or a statement explaining that the outcome is not a priority. This additional information will be used in the PHN Program performance report.

7 Assessment

7.1 Assessing individual PHN performance

The Department will use the information provided by PHNs in their six and twelve month reporting to assess individual PHN performance. This can include additional information PHNs supply as part of PHN Schedule reporting. PHNs will be assessed against all of the organisational indicators and 24 of the other performance indicators which reflect areas where PHNs can and should have influence. For some of these indicators PHNs may have limited input as the area may not be a priority for their region. This will not negatively affect their performance assessment.

Each outcome theme will be reported separately in the individual assessment. The input for each indicator will be assessed against the performance criteria and then an overall assessment for the outcome theme made based on a performance rubric. The performance rubric can be found in Table 14. The performance rubric contains three assessment standards: *On Track*, *Progressing* and *Initial*.

The Department will work closely with any PHNs which rate as Initial for an outcome theme, with the intention to improve their assessment in following years. It is expected over time that PHNs will rate as On Track for all outcome themes. The Department will communicate performance expectations to PHNs as part of reviewing their performance under the Framework.

A performance report for each PHN will be produced annually. PHNs will have an opportunity to comment on their draft report before it is finalised. The performance report will identify achievements and areas where the PHN could make improvements. This report will be supplied to each PHN but not publicly shared. The report will also be considered during contract extension negotiations

Table 14: Performance rubric for individual PHN assessment

Outcome Theme	Indicators	Performance criteria	Assessment standards
Addressing Needs	P1 PHN activities address prioritised needs	100% of delivered activities address prioritised needs and/or national priorities	<ul style="list-style-type: none"> • Initial: PHN has met performance criteria for one indicator • Progressing: PHN has met performance criteria for two indicators and is working towards meeting the other indicators • On Track: PHN has met performance criteria for all indicators
	P2 Health system improvement and innovation	At least one example of a health system improvement, innovation or commissioning best practice	
	IH1 Numbers of ITC services delivered by PHN	Services are being delivered across the range of services allowed within ITC Guidelines	
	IH2 Types of organisations delivering ITC services	A range of organisations are engaging in ITC program	
Quality Care	P4 Support provided to general practices and other health care providers	PHN delivers a range of support activities to general practices and other health care providers	<ul style="list-style-type: none"> • Initial: PHN has met performance criteria for one indicator • Progressing: PHN has met performance criteria for at least half of the indicators and is working towards meeting the other indicators • On Track: PHN has met performance criteria for all indicators
	MH6 Outcomes Readiness - Completion rates for clinical outcome measures	70% of completed episodes of care have recorded valid outcome measures at Episode Start and Episode End	
	IH3 Evidence that all drug and alcohol commissioned services are culturally appropriate for Aboriginal and Torres Strait Islander people	PHN supplies evidence that commissioned drug and alcohol services are culturally appropriate	

Outcome Theme	Indicators	Performance criteria	Assessment standards
	IH4 Proportion of PHN commissioned mental health services delivered to the regional Aboriginal and Torres Strait islander population that were culturally appropriate	At least 5% growth on proportion of previous year or where all services were culturally appropriate, maintenance of this	
	IH5 ITC improves the cultural competency of mainstream primary health care services	PHN provides evidence that as part of ITC it is working to improve cultural competency of mainstream primary health care services	
	IH6 PHN provides support for Aboriginal and Torres Strait Islander identified health workforce	PHN supplies evidence of support provided to Aboriginal and Torres Strait Islander identified workforce in its region	
	W1 Rate of drug and alcohol treatment service providers with suitable accreditation	All specialist drug and alcohol treatment service providers have or are working towards accreditation	
	W2 PHN support for drug and alcohol commissioned health professionals	PHN supplies evidence of support provided to drug and alcohol commissioned health professionals	
	W3 PHN Commissioning Framework	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	

Outcome Theme	Indicators	Performance criteria	Assessment standards
	DH2 Rate of health care providers using specific digital health systems	<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>	
	DH3 Rate of accredited general practices sharing data with PHN	<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>	
Improving Access	MH1 Rate of regional population receiving PHN commissioned low intensity psychological interventions	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	<ul style="list-style-type: none"> • Initial: PHN has met performance criteria for one indicator • Progressing: PHN has met performance criteria for at least half of the indicators and is working towards meeting the other indicators • On Track: PHN has met performance criteria for all indicators
	MH2 Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals	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	
	AOD1 Rate of drug and alcohol commissioned providers actively delivering services	Rate of drug and alcohol commissioned providers actively delivering services increases or remains the same	

Outcome Theme	Indicators	Performance criteria	Assessment standards
Coordinated Care	MH3 Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness	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	<ul style="list-style-type: none"> • Initial: PHN has met performance criteria for one indicator • Progressing: PHN has met performance criteria for at least three of the indicators and is working towards meeting the other indicators • On Track: PHN has met performance criteria for all indicators
	MH4 Formalised partnerships with other regional service providers to support integrated regional planning and service delivery	Comprehensive regional mental health and suicide prevention plans to be jointly developed with LHNs by mid 2020	
	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	100% of people referred are followed up within 7 days	
	IH7 ITC processes support Aboriginal and Torres Strait Islander people enrolled in the program to access coordinated care	PHN provides evidence of its ITC processes	
	DH1 Rate of health care providers informed about My Health Record	100% of general practices are aware of and provided with access to My Health Record education	
	AOD2 Partnerships established with local key stakeholders for drug and alcohol treatment services	A range of organisations are involved in delivering drug and alcohol treatment services	

Outcome Theme	Indicators	Performance criteria	Assessment standards
Capable Organisations	O1 PHN has an independent and diverse skills based Board	PHN has an independent and diverse skills based Board	<ul style="list-style-type: none"> • Initial: PHN has met performance criteria for one indicator • Progressing: PHN has met performance criteria for at least half of the indicators and is working towards meeting the other indicators • On Track: PHN has met performance criteria for all indicators
	O2 PHN Clinical Council and Community Advisory Committee membership	PHN has at least one Clinical Council and Community Advisory Committee	
	O3 PHN Board considers input from committees	PHN Board considers input from committees	
	O4 Record of PHN Board member attendance at meetings	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.	
	O5 PHN Board has a regular review of its performance	PHN Board is reviewed every three years	
	O6 PHN Board approves strategic plan	PHN Board approves strategic plan	
	O7 Variance report of scheduled activities	All variations are accounted for by PHN	
	O8 Quality Management System	PHN has or is moving towards a fit-for-purpose quality management system	
	O9 Staff satisfaction	PHN has a fit for purpose process to measure staff satisfaction at least every two years	

Outcome Theme	Indicators	Performance criteria	Assessment standards
	O10 Performance management process	PHN has a fit for purpose process to measure staff satisfaction at least every two years	
	O11 Cultural awareness training	PHN conducts or offers cultural awareness training to staff at least every two years	
	P1 PHN activities meet identified needs	100% of delivered activities address prioritised needs and/or national priorities	
	W3 PHN Commissioning Framework	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	
	O12 Rate of contracts that include both output and outcome performance indicators	Increase in the number of contracts containing both output and outcome performance indicators	
	O13 Annual Report and audited financial statements	Annual Report meets requirements. Audited financial reports have unqualified auditor statement.	
	O14 PHN stakeholder engagement	PHN engages with a broad range of stakeholders in its region	

Outcome Theme	Indicators	Performance criteria	Assessment standards
	O15 Engaging with complaints	PHN attempts to address all complaints referred to it by the Department	
	P4 Support provided to general practices and other health care providers	PHN delivers a range of support activities to general practices and other health care providers	

7.2 PHN Program Performance and Quality Report

The Department will produce an annual PHN Program Performance and Quality Report. All indicators will be used to assess progress towards achieving Program outcomes. Each outcome will then be considered as part of its outcome theme, to provide an overall assessment of the PHN Program's performance in meeting its objectives.

The report will draw on the contextual information provided by PHNs and identify opportunities for improvement for the Program. The report will not discuss individual PHN performance except in a generalised aggregated way. Individual examples of best practice in commissioning or achievement may be included with the agreement of the PHN.

8 Review of the Framework

The Framework will be reviewed every two years. The review will consider whether:

- program logics and outcomes remain relevant;
- new outcomes should be included in the Framework;
- the indicator specifications, including performance criteria, require amendment;
- new indicators should be included to assess outcomes; and
- indicators that are no longer fit for purpose should be removed

9 Acronyms and Abbreviations

Below is a list of acronyms and abbreviations utilised in this document, and its corresponding documents Appendix A – Program Logics and Appendix B – Indicator Specifications, with their names, titles or descriptions spelled out in full.

ABS	Australian Bureau of Statistics
ADHA	Australian Digital Health Agency
AHPF	Australian Health Performance Framework
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
AWP	Activity Work Plan
CAC	Community Advisory Committee
CC	Clinical Council
DATIS	Drug and Alcohol Treatment Information Strategy
HSI	Health System Improvement
ITC	Integrated Team Care
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
MH Schedule	Primary Mental Health Care Schedule
MHREP	My Health Record Expansion Program
PBS	Pharmaceutical Benefits Scheme
PFAS	Per- and poly-fluoroalkyl substances
PHN	Primary Health Network
the Department / DoH	Commonwealth Department of Health
the Framework	PHN Program Performance and Quality Framework

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