Performance Indicators

Commonwealth Psychosocial Support Program

WA Primary Health Alliance
Better health, together

	Indicator	Data source and measurement	Purpose	Target
Improved health equity	CPS1.1 % of clients with low socio-economic status	Through the Primary Mental Health Care Minimum Data Set (PMHC-MDS), specifically the postcode recorded against the client's address. WA Primary Health Alliance (WAPHA) will then use the postcode information to map to an ABS SEIFA decile.	A critical component of WAPHA's purpose is to ensure that the people most at risk of poor health outcomes have access to quality care. This includes Aboriginal people and clients in low socioeconomic areas.	>50% clients residing in SEIFA deciles 1-3
	CPS1.2 % Aboriginal clients	Through the PMHC-MDS, specifically client-reported Aboriginal status at episode start.		Greater than a certain percentage of clients of Aboriginal status (percentage set at the service/contract level)
	CPS1.3 % services delivered to Aboriginal clients being culturally appropriate	Through the PMHC-MDS, specifically from practitioner-reported Aboriginal status and practitioner-completed cultural training, as reported by the service provider.	Culturally safe, appropriate and competent care is a key strategy for improving access to mental health services and improving mental health outcomes for Aboriginal people.	100% contact with Aboriginal clients culturally appropriate
Improved patient experience	CPS2.1 % clients felt safe using this service	Through the Your Experience of Service (YES) Primary Health Network (PHN) survey, administered via the PMHC-MDS, to clients whose episodes have been closed.	Understanding clients' views of their experiences is critical in optimising care. "Improved Patient Experience" is one of the five domains of the Quintuple Aim.	>70% clients reporting "usually" or "always"
	CPS2.2 % clients had access to this service when they needed it	Through PMHC-MDS, time in days between referral and first service contact.		>70% with a wait time of fewer than 21 days
	CPS2.3 % clients reporting that their individuality and values were respected	Through the Your Experience of Service (YES) Primary Health Network (PHN) survey, administered via the PMHC-MDS, to clients whose episodes have been closed.		>70% clients reporting "usually" or "always"
	CPS2.4 % clients reporting a positive overall experience with the service in the last 3 months	Through the Your Experience of Service (YES) Primary Health Network (PHN) survey, administered via the PMHC-MDS, to clients whose episodes have been closed.		>70% clients reporting "good," "very good" or "excellent"
	CPS2.5 % of clients where support or care available met their needs	Through the Your Experience of Service (YES) Primary Health Network (PHN) survey, administered via the PMHC-MDS, to clients whose episodes have been closed.		>70% clients reporting "usually" or "always"

*A client is considered to reside in a low socio-economic area if their postcode of residence falls in the lower 3 deciles of socio-economic advantage and disadvantage, as per the Australian Bureau of Statistics definition of people's access to material and social resources, and their ability to participate in society.

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	Indicator	Data source and measurement	Purpose	Target
Improved health outcomes	CPS3.1 % of clients who demonstrate clinical improvement	Through the PMHC-MDS, specifically the K10 variables. Targets are not set for the K5 and SDQ tools.	Monitoring clinical improvement levels helps demonstrate the positive impact on health outcomes.	% clients clinically improved: >65% of severe/very severe >50% of moderate clients >35% of mild clients >15% of sub-diagnostic
Improved health outcomes	CPS3.2 Outcomes compliance	Through the PMHC-MDS, recorded valid outcomes measures at Episode Start and Episode End (referred to as "matched pairs"). Includes K10, K5 and SDQ tools.	Standardised outcome measures collected at the first and last occasions of service at a minimum provide the means for assessing effectiveness of services in improving health outcomes.	70% matched pairs on conclusion of episode
Improved health outcomes	CPS3.3 % clients at risk of suicide followed up within 7 days of referral	Through PMHC MDS, % of clients referred because of a recent suicide attempt or at risk of suicide, with an attended service contact within 7 days of referral.	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.	100% of clients at risk of suicide are followed up within 7 days
Improved health outcomes	CPS3.4 % episodes with a capacity and strengths-based assessment completed within 8 weeks of episode commencement	Through PMHC MDS, % of episodes where Service Contact type Assessment is recorded within 8 weeks of Episode Start Date.	Capacity and strengths-based assessment is important for determining eligibility and ensuring services are planned and delivered to meet the needs of the individual.	80% completion
Improved cost effectiveness	CPS4.1 Total number of episodes	Through PMHC-MDS using episode data.	Standardised outcome measure providing insights into the efficiency and effectiveness of services – cost being one of the elements of the Quintuple Aim.	5% increase on prior year
Improved cost effectiveness	CPS4.2 Average cost per episode	Using episode data submitted to the PMHC-MDS combined with contract funding for that financial year. Calculation: contract funding divided by number of service contacts; multiplied by the average number of service contacts per completed episode for that service for that financial year.		On par or below previous year
Improved cost effectiveness	CPS4.3 % planned service contacts attended by client	Through PMHC-MDS, using service contact no show.	High rates of Did Not Attend for service contacts can impact a service's cost efficiency.	>85% of planned service contacts are attended by the client