Government of **Western Australia**
Department of **Health**

Performance Activity and Quality Division

Activity Based Funding and Management Program

Annual Performance Management Framework 2010-2011

improving care | managing resources | delivering quality

Delivering a **Healthy WA**

Contents

Foreword

Activity Based Funding and Management will provide a clearer link between the dollars we spend and the services we provide to patients and the community.

Effective performance management is integral to the success of the WA Activity Based Funding and Management program (ABF/ABM).

In the context of ABF/ABM performance management will relate to the requirement each of us has, to manage activity performance, manage budget performance and to manage the quality of patient care and outcomes.

WA Health operates as a single health system. Within that system, activity based resource allocation means we are introducing specific requirements around the management of organisational accountabilities and defining responsibilities between the different organisations involved in providing public health services in WA.

As the purchaser of health services, the Department of Health is responsible for ensuring the services commissioned meet the needs of the community and stay abreast of innovations in models of care and health service delivery.

Providers of health services, including hospitals and Area Health Services, are responsible for delivering safe, high quality care within agreed activity and financial parameters.

Everyone has a responsibility to ensure the best use of taxpayer's funds in the delivery of health services to the community. This will be achieved by working in partnership with the shared purpose of ensuring excellent care and health services management.

This document outlines the roles, responsibilities and expectations of all parties in improving care, managing resources and delivering quality for 2010-11. A more comprehensive approach for the next triennium (2011-12 – 2013-14) will be developed for future years in consultation with our colleagues across WA Health.

We look forward to working with interested people in developing a robust and useful performance approach which supports all of our staff in their daily work.

Dr Dorothy Jones

Executive Director

Performance Activity and Quality Division

Acknowledgements

This document was developed by the Activity Based Funding and Management Team within the newly established Performance Activity and Quality Division of WA Health.

This document has also been developed with reference to other jurisdictions that have introduced a Performance Management Framework approach to their health system including Victoria, New South Wales, Queensland and South Australia. We thank them for their willingness to share ideas and lessons.

Finally, the purpose of performance management and activity based health improvement reform is to improve health services and hospitals for WA patients, communities and populations. We acknowledge and thank them as our partners in improvement.

Performance Activity & Quality Division

July 2010

http://activity

1 Performance Management in 2010-11- At a Glance

WA Health is moving to a more accountable way of funding health service delivery. Activity Based Management will be how we plan, budget, allocate and manage activity and financial resources to ensure delivery of safe, high-quality health services to the WA community.

The new system is aligned to the Council of Australian Governments (COAG) Activity Based Funding (ABF) initiative under the National Partnership Agreement[1] and will be tailored to meet the needs of the health system in WA.

The application of activity based funding in all Australian states currently using it is complemented by Activity Based Management (ABM). In practice this involves a Performance Management Framework (PMF) designed to drive better patient outcomes and more efficient service delivery.

Annual Performance Management Frameworks will start in the 2010-11 financial year. Over the course of 2010-11 Area Health Services and other stakeholders will be engaged in extensive consultation to further develop the triennial PMF.

The outcome of that collaboration will be a revised PMF that provides the vehicle for improvement in service delivery across WA Health over the triennium 2011-12 to 2013-14. The full PMF will also cover shared services such as Health Corporate Network (HCN) and Health Information Network (HIN), and other non-Area Health Service (AHS) budget holders.

The 2010-11 PMF will cover inpatients, ambulatory surgery initiative patients and emergency department attendances, both for metropolitan hospitals and the 21 WA Country Health Service (WACHS) Regional Resource Centres and Integrated District Health Centres. In addition, the Performance Management process will also cover other services provided by Area Health Services.

The 2010-11 Performance Management process establishes:

- Area Health Service (AHS) Performance reporting obligations for 2010-11;
- Key Performance Indicators (KPIs), targets and thresholds; and
- Performance monitoring and evaluation.

Further information about the full implementation of the PMF is contained in the *WA Health Triennial Strategic Directions for Performance Management 2011-12, 2012-13 and 2013-14*. This will be circulated to stakeholders for comment following consideration by the ABF/ABM Steering Committee.

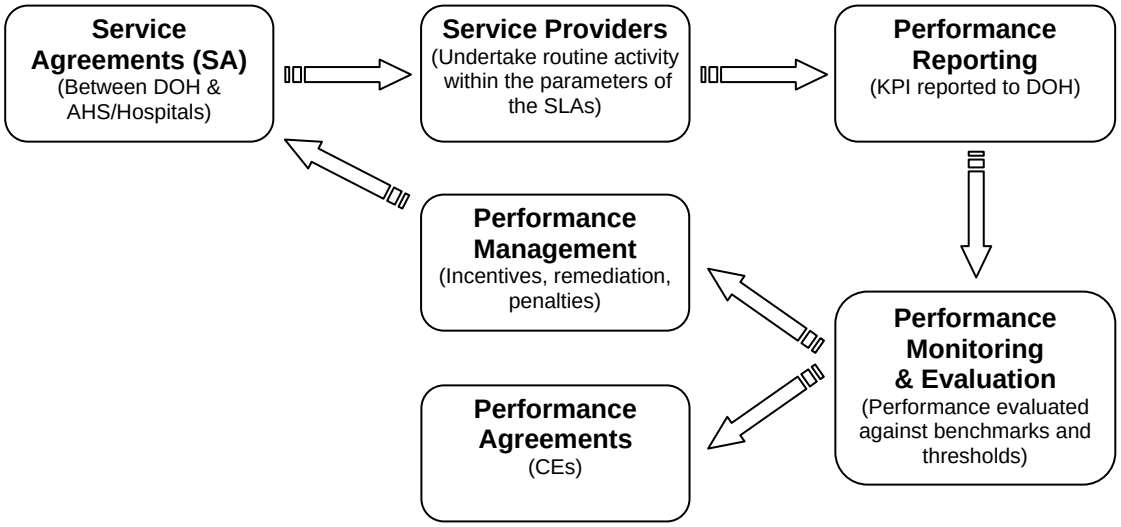
[1] National Partnership Agreement on Hospital and Health Workforce Reform Schedule A Activity Based Funding (2008)

2 Structure of the Performance Management Framework

The basis of the PMF is the Service Agreement between the Department of Health (DOH) as the purchaser and the Area Health Services as providers of services. The PMF involves a system of reporting performance against specified KPIs, tailored to the particulars for each facility. For example, if a facility does not have an emergency department, then there will not be a requirement to report that KPI. All other indicators would still need to be reported.

Service Providers will report against the PMF KPIs on a regular basis, with the level of performance assessed against an agreed target. Figure 1 below maps the structure of the PMF.

Figure 1 Structure of Performance Management Framework



3 Service Agreements

Service Providers will operate in an environment of delivering the services set out in Service l Agreements (SAs). The SAs will be informed by the Clinical Services Framework (CSF), specifying the scope of services and target levels of activity for each facility. The SAs will ensure that the Governments' policy objectives on service delivery are clearly set out and provide the basis for both payment and evaluation of performance.

SAs will initially be partitioned into five components to reflect the phased 'roll-in' of the ABF and the introduction of the Mental Health Commission as a purchaser of services.

1. The first component will be based on the areas identified for first stage activity funding, namely, inpatient services and emergency department services.
2. The second component will be based on activity levels and funding for the Ambulatory Surgery Initiative.

3. The third component of SAs will encompass the remainder of services provided by AHS **that are not subject to** the ABFs "activity volume x price" purchasing formula in 2010-11.
4. The fourth component will cover Mental Health services. These will be clearly identified in reporting and funds explicitly quarantined.
5. The fifth component will relate to special purpose funding. For example funding of the SQuIRE[2] program, Closing the Gap on Indigenous Health Outcomes etc.

SAs will outline the services to be provided by the relevant parties, including access standards[3] for a given level of emergency department (ED) presentations, ED target activity and target activity levels for acute and sub-acute inpatient services. The agreements will also provide details of the linkages between SLAs, the Performance Management Framework and the Performance Agreements for Chief Executives. The SAs will also specify other services provided by Service Providers. Although specifying volumes may not be feasible in some contexts, the nature of the service to be provided, standard of the service and objective outputs or 'deliverables' will be included in SAs. This is currently the case for the performance agreements between the Director General and AHS Chief Executives.

The elements that will be contained in the SAs are shown at Schedule C.

4 Key Performance Indicators

A total of 10 KPIs have been shortlisted for Performance Management in 2010-11. These are listed in Schedule A.

The PMF covers five domains of performance as follows:

1. Effectiveness
2. Efficiency
3. Equity
4. Sustainability
5. Processes

The first three measures relate specifically to patient care and outcomes delivered and achieved by Service Providers. The sustainability performance domain is included to ensure the system's ongoing viability is not compromised by short-term expediency. The inclusion of the 'Processes' domain is to maintain the integrity of the ABF/ABM system, particularly in relation to the accurate and timely coding of patient

[2] Note: Safety and Quality Investment for Reform

[3] Note: For example, the 4 Hour Rule program establishes access standards. These will be contained within SAs.

cases as these are pivotal to performance measurement, payments to providers and financial probity.

The 10 KPIs that have been selected for performance monitoring in 2010-11 are indicators that are currently reported monthly and have agreed definitions and data sources. Not every performance domain as listed above is represented in the first year-2010-11.

Further KPIs will be proposed for consultation with a view to implementation in the 2011-12 year. By 2011-12 all domains will have at least one KPI.

5 Performance Benchmarks And Thresholds

For each KPI, performance benchmarks have been set. The benchmarks are based on the following approaches:

- previous performance levels
- peer best performance
- system average
- 'aspirational target' linked to a policy objective[4]

The approach used to determine the performance benchmarks depends on whether it is appropriate for a specific KPI and the service context. This means that while some benchmarks will be set as aspirational targets, others will be set at peer best performance. This may change over time as performance management will be responsive to outcomes and changing policy directions.

Performance thresholds, measured against the relevant benchmark, have been set for each KPI.

The PMF will also establish the parameters for the performance agreements with the Chief Executives of the various Service Providers.

The Benchmarks and Thresholds for each KPI are provided at Schedule B.

[4] Note: In some instances these will be targets established by the Commonwealth Government's Department of Health and Ageing.

6 Performance Reporting, Monitoring And Evaluation

6.1 Frequency

Reporting will occur on a monthly basis and will be automated wherever possible to minimise the resources required to facilitate the reporting function within Service Providers and DOH Divisions.

The frequency for the reporting obligation for each KPI is outlined in Schedule A.

6.2 Integrated Reporting Framework

While the shortlist of KPI for the PMF may be desirable and appropriate for the purpose of a balanced scorecard and performance management, it does not replace the current or future obligatory reporting requirements that DOH has to external stakeholders.

The wider suite of indicators for all stakeholders will remain in the DOH's Integrated Reporting Framework (IRF) and will continue to be monitored by the DOH to ensure a more detailed and comprehensive view of performance is available as required. The current and future reporting obligations include, but are not limited to:

- **Performance Management Reporting (commencing 2010-11)**
- Director General's (DG) Report[5]
- The Activity, Expenditure and FTE (AEF)[6]
- Western Australian State Government Budget Papers[7]
- The Annual Reports of DOH, Metropolitan Health Services and WACHS[8]
- The DOH Operational Plan[9]
- Productivity Commission Report on Government Services (ROGS)[10]
- COAG Reform Council performance report on the National Health Care Agreement[11]

Service Providers will still be required to meet their ongoing reporting requirements for existing reports. The new Performance Management Report has been constructed in a way that leverages off existing measures as much as possible. Over

[5] Note: Required by the State Health Executive Forum (SHEF).

[6] Note: Required by SHEF, the Department of Treasury and Finance (DTF), the Economic and Expenditure Review Committee (EERC), and the Minister for Health.

[7] Note: Required by DTF.

[8] Note: Required by the Parliament, Office of the Auditor General and SHEF.

[9] Note: Required by SHEF.

[10] Note: Required by the Council of Australian Governments.

[11] Note: Required by the Council of Australian Governments.

time these reports will be harmonised to reduce duplication and enhance the efficiency of reporting functions.

6.3 Monitoring and Evaluation

Each month the DOH Performance Activity and Quality (PAQ) Division will provide the Director General with a detailed report of Service Provider performance against each of the KPIs due for reporting for that period to SHEF. In addition, 'traffic light' reports, combined with appropriate data analysis, showing critical areas will be developed and circulated to Service Providers for comment. Subsequently, they will be forwarded to the Director General and SHEF for review.

The evaluation will involve an assessment for each of the KPIs at four levels of performance:

1. Highly Performing
2. Performing
3. Under Performing
4. Not Performing

7 Scope And Implementation Of The Performance Management Framework

7.1 Scope

The AHS that fall within the scope of the PMF initially will be the North Metropolitan Area Health Service (NMAHS), the South Metropolitan Area Health Service (SMAHS), the WA Country Health Service (WACHS), and the Child and Adolescent Health Service (CAHS), herein the 'Service Providers'. For 2010-11, the first year of operation, the PMF will not apply to shared services such as Health Corporate Network and Health Information Network, and other non-AHS budget holders. These will be rolled into the PMF in 2011-12.

While the processes and reporting obligations will apply uniformly to all Service Providers, the specific indicators, benchmarks, and thresholds will be tailored to suit the specific circumstances and clinical service obligations of each Service Provider. For example, some KPIs for WACHS will not have an equivalent application for CAHS and vice versa.

7.2 Commencement of Performance Management

The PMF will become operational from 1 July 2010. Service Providers will be consulted over the format, processes and content of the 2011-12 PMF during the 2010-11 financial year.

7.3 Implementation

The initial implementation of the PMF will be structured to complement the phased implementation of activity based funding. This will allow both Service Providers and the DOH to adjust to the new system and will ensure that it is not too onerous in terms of reporting requirements or complexity.

The implementation of the PMF will include the following elements in 2010-11:

- 10 KPIs reported by facility (where applicable)
- monitoring at the facility and AHS level
- performance evaluation only at the AHS level

Rewards and penalties will not be applicable in 2010-11 but will be considered for future Frameworks.

8 Incentives

The move to an ABF/ABM system will involve incentives and penalties based on the level of performance relative to specified benchmarks. Performance Management will be based on a balanced scorecard approach addressing financial, workforce, activity, access, quality and safety domains. Other jurisdictions with ABF/ABM in place build their KPI-Balanced Scorecard around a statement of policy objectives and also involve intervention for non-performance. The structure, intent and processes for the WA Health Incentives and Penalties Program will be determined by the State Health Executive Forum (SHEF) in the second half of the 2010-11 financial year after the assessment of the first 6 months of operation of ABM has been completed.

In the interim, the key financial incentive will be embedded in the pricing structure. Under the new funding arrangements for inpatient separations and emergency department attendances, Service Providers will be paid the “average price” that is based on the average length of stay for a given DRG[12] for cases that are within the 'length of stay' boundaries.[13] Under this approach the incentive is for Service Providers to reduce the average length of stay, thereby receiving more revenue than the cost of delivering care. Service Providers will be able to retain the surpluses achieved from these efficiencies.

The application of retained surpluses will be restricted to activities that do not add to recurrent funding obligations for the Service Provider. For 2010-11, all surplus funds can be expended in this way. Service Providers will be required to itemise the activities that the funds were put towards and the expenditure against these activities.

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[12] Note: Diagnostic Related Group coded under the AN-DRG Version 6.

[13] Note that this approach ensures that exceptional episodes will be identified and appropriately funded.

9 WA Health Policy Drivers

The ABF/ABM program is part of the broader policy context for the WA Health system. This includes, for example, the COAG agreed initiatives such as 'Closing the Gap' on Indigenous health outcomes and the 'National Action Plan on Mental Health'. At a State level, WA Health is responsible for the health and wellbeing of all people residing within Western Australia. This responsibility cascades down through the core policy drivers that impact on health service delivery, effectiveness and efficiency. The Health Activity Purchasing Intentions 2010-11[14] provides details on the policy drivers for WA Health.

10 Governance

As finances and funding are integrally linked to activity under Activity Based Funding, the importance of proper audit and probity arrangements in the recording, measurement and reporting of activity assumes an even greater importance than it has in the past.

Currently, the reporting requirements for activity do not specifically link into financial payments for activity volume or type for the core business of the services. However some programs, such as arrangements with the Department of Veterans Affairs, are tied to regular reporting of eligible patients to expedite payments.

Under the ABF/ABM framework, the role of reporting on activity and performance is crucial to the success of the program. The information systems and processes provide the data that facilitate payments for activity as well as possibly linking to incentive payments for meeting and exceeding policy targets and benchmarks.

10.1 Focus on Data Integrity

The DOH will focus on reforming the way data is collected, managed and reported, including audits to support the implementation of ABF/ABM. This will involve the development of improved functionality and management capability consistent with the ABF/ABM project. This will include, but not be limited to:

- developing the classification and costing for non-inpatient services as well as refining aspects of the inpatient services costing
- improving the Clinical Costing System and Patient Administration System (PAS) across WA Health
- continuing to focus on regular and transparent performance monitoring, and the review and evaluation of service delivery and outcomes.

[14] Department of Health (WA) Health Activity Purchasing Intentions 2010-2011 http://activity

Schedule A KPI and Reporting Frequency

Table 1 KPI and Reporting Frequency 2010-11

		KPI #	DOH PERFORMANCE MANAGEMENT KPI	CURRENT REPORT FREQUENCY	PROPOSED REPORT FREQUENCY
EFFECTIVENESS	**Access**	1	Proportion of emergency department patients seen within recommended times		
			% Triage Cat 1 - 2 mins	M	M
			% Triage Cat 2- 10min	M	M
			% Triage Cat 3- 30 min	M	M
			% Triage Cat 4- 60 min	M	M
			% Triage Cat 5- 2 hours	M	M
		2	"4 Hour Rule" Program – % Admitted, transferred or discharged within 4 hours	M	M
		3	Elective surgery number of cases remaining over boundary by category	M	M
		4	Elective surgery patients seen within boundary times:		
			% Cat 1 < 30days	M	M
			% Cat 2 < 90 days	M	M
			% Cat 3 < 365 days	M	M
	Appropriateness		To be agreed for 2011-12		
	Quality		To be agreed for 2011-12		
EFFICIENCY	**Inputs per output unit**	5	Expenditure to date – distance to budget (for whole of provider budget)	NR	M
		6	Volume of activity to date – proportion of target	NR	M
		7	Elective surgery day of surgery admission rates	M	M
EQUITY	**Access**		To be agreed for 2011-12		
SUSTAINABILITY	**Workforce**	8	Staff turnover	M	M
	Facilities & Equipment		To be agreed for 2011-12		
PROCESSES	**Coding**	9	Percentage of cases coded by end of month closing date	Q	M
		10	Percentage of cases coded within boundary- 80% in 2 weeks and remaining cases within 4 weeks of discharge	Q	M
	Finance		To be agreed for 2011-12		

Schedule B KPI Reporting Targets, Benchmarks and Thresholds

Table 2 2010-11 KPI Reporting Targets, Benchmarks and Thresholds

Number	Indicator	Strategic Pillar	Target	Thresholds			
				Not Performing	Underperforming	Performing	Highly Performing
1	**Proportion of emergency department patients seen within recommended times:**	Pillar 1[15]					
	(a) Triage Cat 1- within 2 mins		Cat1 100%	Triage Cat 1: <95%	Cat 1: >95% <100%	Cat 1: 100%	Cat 1: N/A
	(b) Triage Cat 2- 10min		Cat2 80%	Triage Cat 2: <75%	Cat 2: >75% <80%	Cat 2: >80% <85%	Cat 2: > 85%
	(c) Triage Cat 3- 30 min		Cat3 75%	Triage Cat 3: <70%	Cat3: >70% <75%	Cat 3: >75% <80%	Cat 3: > 80%
	(d) Triage Cat 4- 60 min		Cat4 70%	Triage Cat 4: <65%	Cat4: >65% < 70%	Cat 4: >70% <75%	Cat 4: > 75%
	(e) Triage Cat 5- 2 hours		Cat5 70%	Triage Cat 5: <65%	Cat 5: >65%< 70%	Cat 5: >70% <75%	Cat 5: > 75 %

[15] WA Health Strategic Intent 2010-2015. Pillar 1: Caring for individuals and the community, Pillar 2: Caring for those who need it most, Pillar 3: Making the best use of funds and resources, Pillar 4: Supporting our team

Number	Indicator	Strategic Pillar	Target	Thresholds			
				Not Performing	Underperforming	Performing	Highly Performing
2	**Four Hour Rule:** % of patients admitted, transferred or discharged	Pillar 1	**Stage 1** 85% by Apr 2010, 98% by Apr 2011 **Stage 2** 85% by Oct 2010, 98% by Oct 2011 **Stage 3** 85% by Apr 2011, 98% by 2012	Phase 1 <80% Phase 2 <90%	> 80% <85% >90% <98%	>85% <90% >98% <100%	>90% =100%
3	**Elective Surgery:** Median wait time over boundary (days) (a) Cat 1 > 30days (b) Cat 2 > 90 days (c) Cat 3 > 365 days	Pillar 1	N/A				

Number	Indicator	Strategic Pillar	Target	Thresholds			
				Not Performing	Underperforming	Performing	Highly Performing
5	**Expenditure to date** – distance to budget	Pillar 3	+/- 0.5%	>2%	0.5% -2 %	0 - 0.5%	< = 0%
6	**Volume of activity to date** – proportion of target	Pillar 3	+/- 2%	<98% or >102%		>99% <101%	
7	**Elective surgery day of surgery admission rates**	Pillar 1	95%	<85%	>=85% and <95%	>=95% and <98%	
8	**Staff turnover**	Pillar 4	1.2% per month	> 1.7%	>1.2 <1.7%	>1.0 <1.2%	< 1.0
9	**Percentage of cases coded** by end of month closing date	Pillar 4	100%	<100%		=100%	
10	**Percentage of cases coded** within boundary- (a) 80% in 2 weeks and (b) remaining cases within 4 weeks of discharge	Pillar 4	80% 100%	<75% <85%	75%- 80% 85% -95%	80% - 85% 95-98%	>85% >98%

Schedule C Generic Service Agreements

Purpose

Service Agreements (SAs) will be tailored to each Service Provider's specific circumstances and be in alignment with the WA Health Clinical Services Framework 2010-2020 (CSF 2010). The SAs will identify the parties to the agreement and formalise the service expectations and funding obligations of the Department in relation to each Service Provider.

Each SA will include the following schedules:

Parties to the Agreement

The parties to each agreement will be the Chief Executive of the Service Provider and the Director General.

Activity and Funding

This schedule will detail the activity levels specified in the CSF 2010 for ED and Inpatients and the total funding provided to meet the specified level of services.

Other non-ED and Inpatient services to be provided will be shown for each facility, along with the funding allocation at the Service Provider level (i.e. the aggregate funding). Service Providers will have flexibility as to how that funding is applied across and within facilities to meet the service provision requirements to the total AHS catchment.

This schedule will also detail specific Mental Health Services to be purchased from the Service Provider.

Detailed funding and Service Provider obligations in relation to the SQuIRE Program[2] will also be included in this schedule.

In addition, any additional funded State Government initiatives established in the 2010-11 Budget not covered by the above will be included this schedule.

Reporting Obligations

This schedule will provide the detailed KPIs to be reported for each facility, the frequency of reporting, and the accompanying reference to data specifications. These are shown in Table 1 at Schedule A of the 2010-11 PMF.

Service Provider Performance

This schedule will outline the performance targets/benchmarks and the threshold levels for intervention in 2010-11 for each Service Provider. The 2010-11 draft schedule is shown in Schedule B.

Service Provider Governance Accountabilities

The Service Provider will ensure structures and processes are in place to fulfil its statutory obligations and to ensure good corporate governance, as outlined in relevant legislation, DOH operational directives, and policy and procedure manuals and technical bulletins.

Reportable Items for 2010-11

Service Providers are to report compliance with relevant governance standards as established within Western Australian legislation, DOH operational directives, and policy and procedure manuals and technical bulletins. Governance reporting will be undertaken on a self-reporting basis.

Delivering a **Healthy WA**

This document can be made available in alternative formats such as computer disc, audio tape or Braille, on request.

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