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Purpose of the Operational Guidelines

The purpose of the Operational Guidelines is to provide operational advice, expectations and guidance and should be read with reference to the Service Order for the delivery of the Gippsland PHN Primary Mental Health and Suicide Prevention Stepped Care Program.

Overview of Gippsland PHN

Gippsland PHN is a not for profit organisation that works at a regional level to achieve improved whole of system health care. We work with general practice, allied health, hospitals and other primary and community health providers; to drive, support and strengthen primary health in Gippsland to meet the needs of local communities.

Gippsland PHN is consumer focused and established to reduce fragmentation of care by integrating and co-ordinating health services and supporting general practice. Our primary support is GPs/local doctors, allied health professionals and other community services to provide coordinated, efficient and effective medical services to patients, particularly for those at risk of poor health outcomes.

Gippsland PHN works at a regional and local level to achieve better whole of system care. We drive, support and strengthen primary healthcare in Gippsland. We leverage and administer health program funding from a variety of sources to commission flexible services to realise our vision of a measurably healthier Gippsland.

Commissioning role

Gippsland PHN is a commissioning, not service delivery, organisation. This means, that to successfully secure outcomes, priority setting is based on needs assessments and planning and a market that can understand, interpret, respond and deliver effectively.

Gippsland PHN has developed a Commissioning Model based on models developed by the Scottish Government and the Commonwealth Department of Health PHN Needs Assessment Guide. The model is structured across four themes that ensure an approach of continuous quality improvement.

Commissioning is a continual and iterative cycle involving the development and implementation of services based on needs assessment, planning, co-design, procurement, monitoring and evaluation. Commissioning encompasses this full range of activities, not simply the procurement of services.

An overarching PHN commissioning framework (Figure 1, below) has been developed to help PHNs ensure that their commissioning approaches are consistent with the approach adopted for the PHN Program, and that the process results in consistent, comparable and measurable outputs and outcomes as well as supporting PHNs to realise their own local vision.

As a commissioner, Gippsland PHN, has a role to play in supporting the development of markets so that they are sustainable, and provide scalable solutions that leverage local workforces. Gippsland PHN need to ensure that in partnership with stakeholders and providers, it can appropriately support local primary health care needs.

Commissioning provides a new way of:

- Understanding and assessing local primary health care needs.
- Prioritising needs and planning the services to support them.
- Partnering with the provider market and stakeholders to influence the design and delivery of primary health care services to better meet regional needs.
- Procuring and contracting services.
- Monitoring and evaluating commissioned services that extends beyond traditional contract compliance.

Historically, planning and delivery of services has traditionally focussed on an output/throughput approach (volume of activity). This has not translated in health improvement nor has it stimulated innovation but often closed opportunities and isolated services and providers.

Commissioning promotes an outcomes approach that promote improved health, positive impact where it matters and allows the person to be the centre of care.

Table 1: The Commissioning Cycle

![Commissioning Cycle Diagram]

*Derived from The Scottish Government, "Commissioning of Public Services" (2013)*
1. Program summary

Gippsland PHN Primary Mental Health and Suicide Prevention Stepped Care Program is funded by incentives and grants through the Australian Government Department of Health (DoH).

The aim of the Primary Mental Health and Suicide Prevention Stepped Care Program is to provide access to primary mental health and suicide prevention programs within a stepped care model to improve the overall health and wellbeing of people living in Gippsland. Gippsland PHN has the flexibility to commission evidence-based treatment services to meet local need, catchment priorities and service gaps.

The Program is commissioned within the overarching parameters of the Primary Health Network Grant Programme Guidelines and will contribute to the key program objectives of:

- Increase the efficiency and effectiveness of primary mental health and suicide prevention services for people with or at risk of mental illness and/or suicide; and
- Improve access to and integration of primary mental health care and suicide prevention services to ensure people with mental illness receive the right care in the right place at the right time
- The intent of the Program is to complement existing Commonwealth and state/territory services and improve regional coordination, sector efficiency and duplication of existing initiatives.

2. The Stepped Care Model

In 2014 the National Mental Health Commission undertook a review of Commonwealth programmes and services across the government, non-government and private sectors. The review was released in June 2015 and highlighted the existing complexity, inefficiency and fragmentation of the mental health system. It recommended three components to improve the longer-term sustainability of the mental health system. These include:

- Person-centred design principles.
- A new system architecture.
- Shifting funding to more efficient and effective upstream services and supports.

To achieve system reform, the National Mental Health Commission’s Review outlined 25 recommendations across nine interconnected areas of reform. One of these reforms was ‘Refocusing primary mental healthcare programs and services to support a stepped care model.’ Primary Health Networks have been tasked with implementing this reform in parallel with the commissioning of locally relevant mental health services. In addition, each PHN is required to undertake the development of a comprehensive Regional Mental Health and Suicide Prevention Plan in collaboration with service providers underpinned by the stepped care approach.

“Stepped care is an evidenced-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual’s needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional step, but rather offer a spectrum of service interventions.” The aim is to start at the lowest intensive level that meets their needs, but people can move up and down the levels as required.

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2 Australian Government Department of Health. PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. 2015. P.2
According to the Commonwealth Department of Health, there are four key elements to a stepped care approach to mental health. These include:

1. Stratification of the population into different needs groups.
2. Setting interventions for each group.
3. Defining a comprehensive menu of evidence-based services required to respond to spectrum of need.
4. Matching service types to treatment targets and deliver services accordingly.

2.1 Primary Mental Health and Suicide Prevention Stepped Care Program Priority Areas

Gippsland PHN works with Health Services to contribute to a quality, innovative, and effective mental health and suicide prevention service system for their Gippsland communities to:

- Improve targeting of psychological interventions to most appropriately support people with mild mental illness at the local level through low intensity mental health services;
- Support region-specific, cross sectoral approaches to early intervention for children and young people with, or at risk of mental illness (including those with severe mental illness who are managed in primary care);
- Address service gaps in the provision of psychological therapies for people in under-serviced and/or hard to reach populations, including rural and remote populations;
- Provide services for people with severe mental illness being managed in primary care, including clinical care coordination for people with severe and complex mental illness;
- Encourage and promote a regional approach to suicide prevention including community-based activities and liaising with Local Hospital Networks (LHNs) and other providers; and
- Enhance and better integrate Aboriginal and Torres Strait Islander mental health services at a local level facilitating a joined-up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services.
3. Program scope

3.1 Service planning

When planning and implementing mental health and suicide prevention services within a stepped care model, Health Services are to consider local models that are responsive to the health needs of their community, that utilise available and skilled workforce and align to the aim and objectives of the Program. It is expected that Health Services will adopt broad processes when planning and delivering services such as:

- Engaging with Gippsland PHN Health Planning, Research and Evaluation Program to access and/or assist with the interpretation of health and population data and other statistical information to assist to identify community needs;
- Identifying and engaging with local stakeholders to plan, implement, report, continually review and evaluate activities; and
- Consulting and liaising with other local health and community services to assist in integrating services, identifying complementary services whilst avoiding duplication.

Refer to Gippsland PHN Population Health Planning Resources for assistance.

The Australian Department of Health have documented the types of interventions and workforce requirements relevant for each step – see below. This table is not meant to be prescriptive rather it is to provide information and guidance on the stepped care approach.3

<table>
<thead>
<tr>
<th>Categories</th>
<th>Well population</th>
<th>At risk groups (Early symptoms, previous illness)</th>
<th>Mild mental illness</th>
<th>Moderate mental illness</th>
<th>Severe mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do we need to achieve?</td>
<td>Focus on promotion and prevention by providing access to information, advice and self-help resources</td>
<td>Increase early intervention through access to lower cost, evidence-based alternatives to face-to-face psychological therapy services</td>
<td>Provide and promote access to lower cost, lower intensity services</td>
<td>Increase service access rates maximising the number of people receiving evidence-based intervention</td>
<td>Improve access to adequate level of primary mental health care intervention to maximise recovery and prevent escalation. Provide wrap-around coordinated care for people with complex needs</td>
</tr>
<tr>
<td>What services are relevant? (Service level matched to individual clinical need and suitability)</td>
<td>Mainly publicly available information and self-help resources</td>
<td>Mainly self-help resources, including digital mental health</td>
<td>Mix of resources including digital mental health services and low intensity face-to-face services Psychological services for those who require them</td>
<td>Mainly face-to-face primary care services backed up by Psychiatrists or links to broader social supports. Clinician-assisted digital mental health services and other low intensive services for a minority</td>
<td>Face to face clinical care using a combination of GP care, Psychiatrists, Mental Health Nurses, Psychologists and Allied Health Coordinated, multiagency services for those with severe and complex mental illness</td>
</tr>
</tbody>
</table>

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3 Australian Government Department of Health. PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. 2015. P.3
### Categories

<table>
<thead>
<tr>
<th>Well population</th>
<th>At risk groups (Early symptoms, previous illness)</th>
<th>Mild mental illness</th>
<th>Moderate mental illness</th>
<th>Severe mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>No workforce required</td>
<td>Low-intensity workforce with appropriate skills, training and qualifications to deliver evidence based mental health services, but not at the level required for recognition as a mental health professional, e.g.:</td>
<td>Low intensity workforce as well as some services by GPs, psychologists and other appropriately trained and qualified allied health professionals</td>
<td>Central role of GPs with contribution of psychological therapy provided by psychologists and other allied health professionals</td>
<td>Central role of private psychiatrists, paediatricians and GPs</td>
</tr>
<tr>
<td></td>
<td>Completion of recognised training in delivery of cognitive behaviour therapy</td>
<td>Peer workforce to supplement higher intensity workforce, as appropriate</td>
<td>Private psychiatrists and paediatricians involved for some, particularly for assessment and review of clinical needs</td>
<td>Psychological therapy provided by psychologists and other allied health professionals</td>
</tr>
<tr>
<td></td>
<td>Peer workforce to supplement higher intensity workforce, as appropriate</td>
<td></td>
<td>Peer workforce to complement clinical services provided by other workforce</td>
<td>Mental health nurses involved in coordinating clinical care and supporting the role of GPs and private psychiatrists</td>
</tr>
</tbody>
</table>

### Activities not considered in scope for Primary Health Network commissioning of mental health services within a stepped care approach are those which:

- Are not supported by an empirical evidence base;
- Fall outside the scope of primary mental health care e.g. social support;
- Duplicate or replace existing services provided by other organisations, including governments; or
- Are not in line with PHN funding guidelines.

### 3.2 Workforce competency

The Mental Health Stepped Care Model is based on a multidisciplinary approach. As such, commissioned Providers are expected to have in place an appropriate mix of qualified staff with both formal qualifications and professional experience, who can deliver an appropriate service response across the continuum of acuity.

Health professionals providing the Primary Mental Health and Suicide Prevention Stepped Care Program are recognised health professionals with the qualifications and skills to provide expert care and advice. They must practice in accordance with the relevant professional standards as established by their professional body and/or the regulating and registering authority, Australian Health Practitioner Regulation Authority (AHPRA).

To ensure high quality of service delivery, Health Professionals who deliver these services must:

- be credentialed in the field of mental health, or (to allow for entry of newly trained persons into the field of mental health) under the approved and direct professional supervision of a fully qualified and accredited mental health professional; and
- meet the required qualifications and standards to provide the specified therapies including continuing professional development requirements.
- have completed current, best practice current training relative to priority populations or services being offered.
For the delivery of services within Step 4: Moderate Mental Illness and Step 5: Severe Mental Illness, this will be primarily registered, credentialed and recognised psychologists, mental health nurses, mental health social workers, mental health occupational therapists and Aboriginal and Torres Strait Islander mental health workers).

4 Funding guidelines

4.1 Service Order

A Service Order (Contract) between Gippsland PHN and the eligible Health Service will define the terms and conditions to be performed by both parties to the agreement and define the specifications of the Primary Mental Health and Suicide Prevention Stepped Care Program to be delivered by the Health Service.

4.2 Activity Work Plan

Health Services, funded through the Program, are required to complete an Activity Work Plan on a template provided by Gippsland PHN outlining the Health Service’s stratification of the population into different needs groups. The components of the Activity Work Plan template include details and evidence of:

- The community’s mental health profile and proportional allocation within the different levels of a stepped care model.
- Service delivery and workforce profiles and referral pathways that support greater community access to services.

The Activity Work Plan Template informs the deliverables outlined in the Service Order with Gippsland PHN. In assessing the Activity Work Plan Template Gippsland PHN will consider:

- How well the content meets the aim and objectives of the Primary Mental Health and Suicide Prevention Stepped Care Program.
- The adequacy of coverage and sustainability of the service delivery model to ensure services are maintained in existing communities.
- Whether the content meets the requirements of the Service Order and the Program Guidelines.

4.3 Workforce acquittal

Health Services may have varying employment models that vary from full-time salaried engagement of the Primary Mental Health and Suicide Prevention Stepped Care Program, which may lead to sharing of staff/contractor time across multiple programs. Where this occurs, organisations must ensure that time/services are properly attributed to each program. Organisations must also clearly delineate between Primary Mental Health and Suicide Prevention Stepped Care Program funds (and their use) and funds received from other sources.

Primary Mental Health and Suicide Prevention Stepped Care Program funding should not be used to pay for services funded under other programs such as Victorian State Government funding. Program income and expenditure must be separately reported to Gippsland PHN in the financial statements and reports submitted by the funded organisation under the Terms of the Agreement.

5 Service Delivery Models

When planning the Program, Health Services may consider a range of flexible service delivery models to support greater access to health services within communities including:

- **Region:** service provision to a region which could include several communities who travel to the central point for service provision;
- **Town:** service provision to a single town only;
• **Centre and Outpost**: service provision provided both in the central town (hub) and by the service provider travelling to outlying communities (spoke);

• **Outreach**: service provision provided to outlying communities by service providers travelling to those communities from a larger town; and

• **Telehealth**: service provision using technology that focuses on connecting the client and health professional for the delivery of clinical care *(following Gippsland PHN approval)*

### 5.1 Intake, referral and feedback pathways

The Program has a focus on increasing access to a broad range of health services and activities. Referrals to the Program will increase opportunities for collaborative work by multidisciplinary teams, the use of care planning and case conferencing will promote better continuity of care.

Access to Primary Mental Health and Suicide Prevention services will vary. Referrals may come from any source including General Practitioners, Registered Nurses or other health professional or through self-referrals or from family and carers.

Referrals may be subject to an intake process where an assessment is undertaken prior to acceptance or onward referral to the appropriate service or step. Health Services are required to consider how they will align and integrate with intake, referral and feedback processes with other local and regional Health providers and services. For example, Health Services need to consider methods for standardised Pre and Post Treatment outcome assessments and the appropriate tool to be used for the condition or therapeutic treatment. The PMHC MDS requires providers to collect and report outcome measures at pre and post, and appropriate review points, either Kessler 10 or Kessler 5 for adults and young people, and Strengths and Difficulties Questionnaire (SDQ) for children. Health Services can apply alternative outcome measures, however one of the three mandatory tools listed above must be used.

Consumer access to Primary Mental Health and Suicide Prevention services should not be impeded by the absence of a referral from a General Practitioner either in the form of a referral or Mental Health Treatment Plan. However, it is best practice for Health Services to connect with a client’s usual General Practitioner to provide appropriate feedback regarding mental health treatment and to ensure continuity of mental and primary health care and service provision.

Health Services are required to maintain improved pathways and intake, triage and demand management processes within available resources so that referrals are accepted throughout the contracted period. They must ensure feedback to General Practitioner or other referrer during and at the completion of the client’s service, or more frequently for long term clients. While repeated referrals may not be required, where possible/appropriate Health Services will provide a feedback report to the General Practitioner or referrer midway through the client’s initial episode of care including forecasting total number of therapeutic sessions required and outlining client’s key health and social issues.

Service integration is a requirement of the Stepped Care model. Health Services will be required to provide evidence of health system development as outlined in the Service Order. Evidence of collaboration and integration with other health providers including general practitioners. Evidence of a report sent to the patient’s own primary care provider, general practitioner or other referrer.

Community sector engagement is another requirement of the Stepped Care model. Health Services will be required to provide evidence of community understanding of appropriate access to the service(s) and evidence of engagement and partnership with health and human services sector including Aboriginal.

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Services and other vulnerable groups. Health services are required to put the necessary protocols and procedures in place to ensure services are delivered in a culturally appropriate manner.

5.2 Fees and charges
Primary Mental Health and Suicide Prevention Stepped Care services funded under the Program should be provided free of charge to consumers, with no co-payments.

5.3 Clinical governance
Sound clinical governance structures are an essential component of the Program and ensures accountability and transparency across all disciplines of health care, supporting staff to ensure patients and the community receive high standards of quality care and service provision, and quality improvements are continuously reviewed, monitored and implemented.

Good clinical governance ensures that the community and the health service organisation can be confident that systems are in place to deliver safe and high-quality care and continuously improve services. To effectively measure the quality of service and treatment outcomes, evidence-based outcome tools are suggested practice. The tool of choice should be practical in the context of service delivery and respond to priority groups and concerns.

The Gippsland PHN Clinical Governance Framework and associated policies and procedures are the system of safeguards that govern clinical practice within programs commissioned by Gippsland PHN.

Health Services, funded through the Program, are required to provide evidence of adequate Clinical Governance inclusive of the five domains of clinical governance as outlined in the Gippsland PHN Clinical Governance Framework which are:

1. Leadership and culture.
2. Consumer directed care and partnership.
3. Clinical risk management.
5. Effective workforce and staff education.

Within the five domains, key systems and practices are required to support safe, effective, person-centred care for every consumer.

The domains are interrelated and integrated into the organisation’s broader governance arrangements (for example clinical risk management is a component of broader risk management, leadership and culture is a component of the organisations purpose and culture governance framework).

The following principles will guide effective clinical governance systems and are adopted from the Victorian Clinical Governance Framework (Safer Care Victoria)5.

- **Excellent consumer experience**
  - Commitment to providing a positive consumer experience

- **Clear accountability and ownership**
  - Accountability and ownership displayed by all staff
  - Compliance with legislative and appropriate departmental policy requirements

- **Partnering with consumers**

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5 Delivering high-quality healthcare, Victorian clinical governance framework, Safer Care Victoria, DHHS, June 2017

DOC/18/12833[v2] Primary Mental Health and Suicide Prevention Stepped Care Program Guidelines. 9
Consumer engagement and input is actively sought and facilitated

- **Effective planning and resource allocation**
  - Staff have access to regular training and educational resources to maintain skill set

- **Strong clinical engagement and leadership**
  - Ownership of care processes and outcomes is promoted and practised by all staff
  - Health service staff actively participate and contribute their expertise and experience

- **Empowered staff and consumers**
  - Organisational culture and systems are designed to facilitate the pursuit of safe care by all staff
  - Care delivery is centred on consumers

- **Proactively collecting and sharing critical information**
  - The status quo is challenged, and additional information is sought when clarity is required
  - Robust data is effectively understood and informs decision making and improvement strategies

- **Openness, transparency and accuracy**
  - Health service reporting, reviews and decision making are underpinned by transparency and accuracy

- **Continuous improvement of care**
  - Rigorous measurement of performance and progress is benchmarked and used to manage risk and drive improvement in the quality of care

5.4 Risk management

Health Services, funded through the Program, will be required to demonstrate robust and effective implementation of risk management as a crucial component of the organisation’s operating practice. The effective management of risk is vital to the continued development and success of the Program.

When undertaking risk assessment for the Program, Health Services will use the best available information, data and research and will engage and consult to identify issues and seek feedback to inform the risk assessment process. The risk assessment process will involve three steps, risk identification, risk analysis and risk evaluation.

- Risk assessment is traditionally structured and assessed for likelihood and consequence on a rating of low to high.
- Risk identification is the process of identifying key risks and involves analysing the sources of risks, potential hazards, possible causes and the potential exposure.
- Risk assessment involves consideration of the source of the risk, determining the consequence of the outcome of the risk, and the likelihood that those consequences may occur, and then understanding the controls that are currently in place and how effective they are.
- An evaluation of each risk is undertaken to determine those risks that are acceptable and those that require further treatment.

A Risk Assessment will be provided to Gippsland PHN prior to services commencing and will consider risks related but not limited to access, workforce, funding, service delivery, infrastructure and resources.
6  Financial guidelines

Strong financial management is essential under the Program, financial management responsibilities are set out in the Service Order. Funding under the Program is for Primary Mental Health and Suicide Prevention Stepped Care services, and is as follows:

6.1 Unit Costing

Gippsland PHN has developed unit pricing to determine the value to deliver one hour of service for primary mental health stepped care services. Unit pricing, for an hour of service, is based on the number of hours available to deliver the service, and the total cost to employ a suitably qualified professional to deliver the service.

**Unit pricing for an hour of service includes:**

- Annual salary
- Salary on-costs
- Organisation support

A time fraction has been allocated for each of Steps 3 to 5 to determine an Occasion of Service. An Occasion of Service is defined as an individual session (1:1) or as an individual session within a defined Group Program.

The time fraction allocated for an Occasion of Service is reflective of the level of acuity, complexity and care coordination required to support consumers in each step and outlined below:

**Time allocation per Occasion of Service in minutes:**

- Mild Mental Illness: 60 minutes
- Moderate Mental Illness: 75 minutes
- Severe Mental Illness: 100 minutes

**Occasions of Service include the following three activities:**

1. Clinical intervention
2. Coordination and Integration Activities (including step up and down)
3. Indirect time (administration)

7  Reporting guidelines

Health Services funded through the Primary Mental Health and Suicide Prevention Stepped Care Program are required to submit reports periodically to Gippsland PHN and as specified in the Service Order to:

- Support effective contract performance and management.
- Enable Gippsland PHN to evaluate the system changes achieved by the delivery of the Mental Health Stepped Care Model and to inform future commissioning decisions.
- Fulfil Gippsland PHN’s reporting requirements to the Australian Government.
- Inform any independent review, evaluation or audit process initiated by the Australian Government.

Gippsland PHN will request quantitative and qualitative data and other evidential information to measure the performance and effectiveness of service provided by the Health Service.

Key Performance Indicators (KPIs) are set in the Service Order as a contractual agreement between Gippsland PHN and the Health Service.
Reports must be provided on reporting templates supplied by Gippsland PHN and submitted electronically by the dates outlined in the Service Order. Health Services may also submit other data sources to provide evidence of performance and service delivery.

7.1 Quantitative Data

Data submitted by Health Services must comply with the National Minimum Data Set relevant to Primary Mental Health and Suicide Prevention Stepped Care (PMHC-MDS)\(^6\) and submitted by the dates outlined in the Service Order. headspace centres are required to utilise the HAPI system and other data systems as requested.

**Performance Targets**

Performance targets are calculated on the total number of Occasions of Service provided by the Health Service and are outlined in the Activity Work Plan, as approved by Gippsland PHN.

A time fraction has been allocated for each of Steps 3 to 5 (Mild, Moderate, Severe) to determine an Occasion of Service. An Occasion of Service is defined as an individual session (1:1 between client and health professional) or as an individual session within a defined Group Program of 3 or more people.

An Individual Session is defined as one (1) Occasion of Service. The time fraction allocated will be reflective of the Step for which the Group is being delivered.

A Group Program is calculated as three (3) Occasions of Service. The time fraction allocated will be reflective of the Step for which the Group is being delivered.

The time fraction allocated for an Occasion of Service is reflective of the level of acuity, complexity and care coordination required to support consumers in each step and outlined below:

**Time allocation per Occasion of Service in minutes:**

- **Mild Mental Illness:** 60 minutes
- **Moderate Mental Illness:** 75 minutes
- **Severe Mental Illness:** 100 minutes

**An Occasion of Service includes the following three activities:**

1. Therapeutic intervention
2. Coordination and Integration Activities (including step up and down)
3. Administration Time (indirect time)\(^7\)

Health Services will provide to Gippsland PHN monthly data summarising the total number of:

- Individual Occasions of Services for Steps 3 to 5 (Mild, Moderate, Severe)
- Group Programs delivered for Steps 3 to 5 (Mild, Moderate, Severe)

7.2 Qualitative reports:

Periodic qualitative reports will collect evidence of adequate clinical governance practices inclusive of the five domains of the Gippsland PHN Clinical Governance Framework. Health Services will also be assessed to ensure a range of services are available to meet the needs of individuals and population groups, and that

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\(^6\) [https://pmhc-mds.com/](https://pmhc-mds.com/)

\(^7\) Health Services are not required to separately report indirect time to Gippsland PHN, as this is already captured in an Occasion of Service.
the best use of available workforce and technology has been achieved. Periodical reports to Gippsland PHN will seek evidence of health system development including but not limited to:

- Localised planning and development with relevant stakeholders promoting system redesign, co-design and service integration working towards a stepped care model.
- Regular updating of the National Health Services Directory.
- Utilisation of digital health platforms and systems used by the Supplier or provided by Gippsland PHN.
- Utilisation of My Health Record.
- Utilisation and contribution to the development of HealthPathways.
- Contribution to population health planning, i.e. Gippsland PHN Needs Assessment.

7.3 Financial reports

Health Services are required to provide financial reports (using accrual accounting) as specified in the Schedule to the Agreement. A Program Profit and Loss Statement (P&L) is accepted as the approved financial statement. This statement should be divided into two sections: Revenue (income) and Expenses, indicating how funding has been spent. The P&L Statement requires sign off from an Executive Officer at the Health Service.

An example format is as follows, including notes, although if providers wish to use their own format provided it shows Revenue (or Income) and Expenses:

**Program Profit and Loss Statement**

**Revenue**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds from GPHN</td>
<td>50,000</td>
</tr>
<tr>
<td>Other Funds</td>
<td>2,000</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>52,000</td>
</tr>
</tbody>
</table>

**Expenses**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Wages</td>
<td>38,000</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>14,000</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>52,000</td>
</tr>
</tbody>
</table>

**Surplus / (Deficit)** 0

**Note 1:** Depreciation was not claimed as an expense. Equipment purchases were not made without prior permission from the GPHN Program Manager.

**Note 2:** Some funds received from GPHN [xxxx] remain on the Balance Sheet as at [Report Date]

When annual funding to Health Services exceeds $100,000 (GST exclusive) an **Audited financial statement** will be required at the end of the funding period. Where a Health Service is funded for multiple programs, funds must be separately reported to Gippsland PHN in the financial statements and reports submitted by the funded organisation under the terms of the Service Order.
General Practices are exempted from this requirement for audit, unless they are normally audited, as the audit cost is too high to be beneficial in getting program deliverables completed. A Program P&L is accepted as the approved financial statement and must be signed off by an Executive Officer of the Practice.

Financial reports should be submitted as per the dates outlined in the service order agreement and sent to Gippsland PHN at commissioning@gphn.org.au

7.4 Access Target Thresholds

A standardised approach to access target thresholds will apply to all service providers:

- An achievement of 90% or higher of access targets will qualify for full payment.
- An achievement of less of than 90% of access targets will be paid as a percentage of the total amount, if all other contractual obligations for the payment period are met. For example, 50% access target achieved will result in 50% payment.
- Cumulative achievement of access targets will be calculated each quarter, prompting reconciliation of previous partial payments.