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# **Performance Indicators in Community Health: Development of a Process**

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March 2000–October 2001

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Final Project Report  
February, 2002

Performance Indicators in Community Health  
Project Working Group

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A joint initiative between the Department of  
Human Services and Community Health Services  
in South Australia.

This report was written by the Performance Indicators in Community Health Project Working Group.

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# Section 1: Executive Summary

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## Introduction

This report outlines the findings of the *Performance Indicators in Community Health* Project undertaken in 2000-2001 which was concerned with process requirements for the development of meaningful and 'robust' performance indicators in the community health sector. The Project was funded by the SA Department of Human Services and undertaken jointly by workers from the Department of Human Services and community health services across South Australia.

## Description and context

A national framework of performance indicators has been developed for the public acute health sector (Commonwealth, 1998). However, in the community health sector, Australian attempts to develop performance indicators thus far, have resulted in an unwieldy number of indicators that have been costly (in time and resources) to measure and report on (See Maher, 1998 and Jolley, 1999). These attempts have not effectively nor sensibly measured performance. Neither have they efficiently used the limited health dollar.

The *Performance Indicators in Community Health* Project emerged as a response to a perceived need to develop indicators of community health performance in South Australia. Performance indicators developed currency in the 1990s within a broad context of changes in the nature of public sector human service provision, including an emphasis on accountability and performance measurement.

The emphasis throughout the Project has centred the identification and trial of a process to develop a set of indicators for community health services.

The Project adopted an action research methodology. The Project was developmental, highly participatory and involved four steps: preparation, development, trialling and reflection. The project developed and then tested performance indicators in seven development groups, before piloting these indicators in other places.

## **Project outcomes**

Clear outcomes identified over the course of the Project include:

1. A functional process for developing performance indicators for a range of community health settings was defined.
2. An understanding that performance indicators for community health can be developed at different levels was developed. For example, core performance indicators may fall out of a central policy position negotiated with services and articulated in service agreements.
3. Over 130 participants in the process gained a high level of understanding of performance indicators which they are able to translate into their work areas.
4. A successful collaboration between the funder and community health services in trialling a process for the development of performance indicators.
5. The Project provided opportunities between the funder and community health services to redefine philosophical positions on issues such as equity and participation.

## **Project Learnings**

The Project identified that:

1. The original process for developing performance indicators needs refinement. The refined process is recorded in Section 6.
2. There was not an agreed level at which performance indicators were developed. For example, testing of a number of different performance frameworks occurred, with performance indicators ranging from the DHS level through to a program level being produced. This compromised the robustness of the performance indicators even though over 71 performance indicators were developed in total. In the future, there is a need to set the desired level of performance indicator at the start of the process.
3. There must be an agreed set of principles and a single performance framework from which to develop a common set of performance indicators and derive benchmarks for the community health sector. This performance framework should to be informed by a primary health care policy for the community health sector as indicated in the Metropolitan Community Health Review (DHS 2001).

4. Additional work needs to be undertaken to clarify the appropriateness of the process across different cultural groups. In response to this, the Project is supporting an additional development group comprising Aboriginal Health Workers and DHS participants to develop performance indicators, using their organisation's Strategic Plan as their performance framework.
5. The development of robust performance indicators is constrained by existing data collection systems.
6. There is a dilemma between needing to develop indicators of sufficient breadth and depth to capture the broad spectrum of work conducted in the community health sector, or limiting the use of performance indicators to what is practicable.
7. The need to identify the information required to accompany a performance indicator in order for it to be understood and valued in other locations/settings.

## **Project Recommendations**

The following recommendations are made:

1. That the process outlined in this report be considered in the development of performance indicators for the community health care sector within the context of a policy for primary health care based on the Metropolitan Community Health Review, Action 1 (DHS, 2001). This should include determining benchmarks in relation to quantitative indicators. If this process is adopted for this purpose, additional resources (including time and education) would have to be made available for community health service involvement.
2. That current developments in a new information system for community health services take into account the need to measure potential common performance indicators for the community health sector. With regard to this, the information system should consider:
  - collecting data to support qualitative indicators to capture the diversity and complexity of community health work (for example, health promotion, and community development),
  - links between performance measurement and existing accreditation systems to avoid duplication of effort and reporting.
3. To consider current accreditation systems in future performance frameworks, in order to prevent duplication of effort in data collection, analysis and monitoring of quality.

4. To consider cultural diversity when beginning a process for developing performance indicators for the community health sector
5. The need to consider the development of outcome performance indicators, acknowledging this is an incremental process, due to the complexity of measuring outcomes.
6. That the recommendations be referred to the Community Health Review Implementation Group for consideration. This needs to occur in conjunction with country community health services, to ensure dissemination of the Project's findings across the community health sector in South Australia.

# Section 2: Introduction

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## Community Health in South Australia

Community health includes curative, preventive, social support and health promotion activities for, and with, people in a community setting. Community health practice, as a component of primary health care, is underpinned and informed by the values and principles espoused in the Alma Ata Declaration on Primary Health Care (WHO, 1978), and the Ottawa Charter for Health Promotion (WHO, 1986). In summary these are:

- ▶ Recognition of the broad social, economic and environmental determinants of health and illness
- ▶ The importance of health promotion and disease prevention
- ▶ The importance of community participation in decision making
- ▶ The importance of working with a variety of sectors outside of health
- ▶ Viewing equity of health outcome as an important component of health service delivery.

In South Australia, community health services are provided by a variety of public sector agencies. The services provided by community health are diverse: one-to-one (medical/clinical care and counselling), health education and support groups, population based health promotion and community development initiatives. Many of these activities involve multi-disciplinary teams and use a variety of strategies to protect and promote the health of their defined communities.

The recent Metropolitan Community Health Review (DHS, 2001) has identified key aspects of community health in SA. These include a strong emphasis on community development work and capacity building, a focus on working with disadvantaged clients, responding to local needs, a social view of health and interagency work. Moreover, accountability to communities is a central concern for community health services.

## Developing indicators of community health performance

The *Performance Indicators in Community Health* Project emerged in response to a perceived need to develop indicators of community health performance. Performance indicators developed currency in the 1990s within a broad context

of changes in the nature of public sector human service provision, with an emphasis on accountability and performance measurement.

A national framework of performance indicators has been developed for the public acute health sector (Commonwealth Government Printing Service, 1998).

In the community health sector, Australian attempts to develop performance indicators for community health, thus far, have resulted in an unwieldy number of indicators that have been costly (in time and resources) to measure and report on (See Maher, 1998; and Jolley, 1999). These attempts have not effectively nor sensibly measured performance. Neither have they efficiently used the limited health dollar.

Major issues identified from a review of the literature conducted by the SA Community Health Research Unit (Jolley, 1999) and interviews with the community health sector conducted as part of a national project on the development of performance indicators highlight the wide range of opinions about performance indicators in community health. These issues include:

- Dilemmas in capturing the diversity and complexity of what it is that community health does, in ways that are not reductionist
- The lack of a national policy framework for community health
- Issues of causality (eg environments that are community based and not able to be controlled, and the multiple determinants of health acting at any one time)
- The long time scale between intervention and outcome
- Concern about appropriateness of performance indicators for primary health care and how they will be used, including the level at which performance is or should be measured (individual, agency, sector, system)
- Issues about ways to collect data to record the performance indicator, for example quantitative measures versus qualitative. It is difficult to represent much of primary health care activity in quantitative terms yet it remains a challenge to develop qualitative indicators
- The difficulty of collecting reliable data. This is resource intensive, systems are poor and most current data measures process or output rather than outcomes
- The issue of who determines the indicator. Is it set by the funder or from the field or is there a way that bridges the perspectives of service providers, the community and funders?

Performance indicators do have the potential to promote accountability and continuous improvement in the community health sector. Indeed it has been argued that performance measurement can be an opportunity to demonstrate the value and effectiveness of a primary health care approach. However some major challenges that remain unexplored are:

- Developing appropriate and meaningful indicators to reflect complex and diverse primary health care activities

- ▶ Redressing the gaps, inconsistencies and lack of timeliness in data collection for community health activities and outcomes
- ▶ Developing indicators which measure equity and how equity inter-relates with efficiency and effectiveness
- ▶ Addressing the multiple accountabilities of community based services to clients and communities and to funders.

Because of the nature of these challenges and the lack of consensus on these issues, the *Performance Indicators in Community Health* Project has been an important collaborative effort between the Department of Human Services and the community health sector. This approach also recognises the changing and complex nature of the landscape of health promotion and early intervention, as well as the futility of rigidly applying a *'one size fits all'* set of performance indicators to the community health sector.

## **Expected project outcomes**

Expected outcomes for the project were identified as follows:

1. A better understanding of the intricacies of developing meaningful performance indicators for community health.
2. A proven process for the development of performance indicators for the community health sector.
3. A bundle of broad and flexible performance indicators for the community health sector that could be used to measure the progress of the sector.
4. Agreement between the Department of Human Services and the community health sector as to workable and realistic performance indicators that can roll-up and integrate.



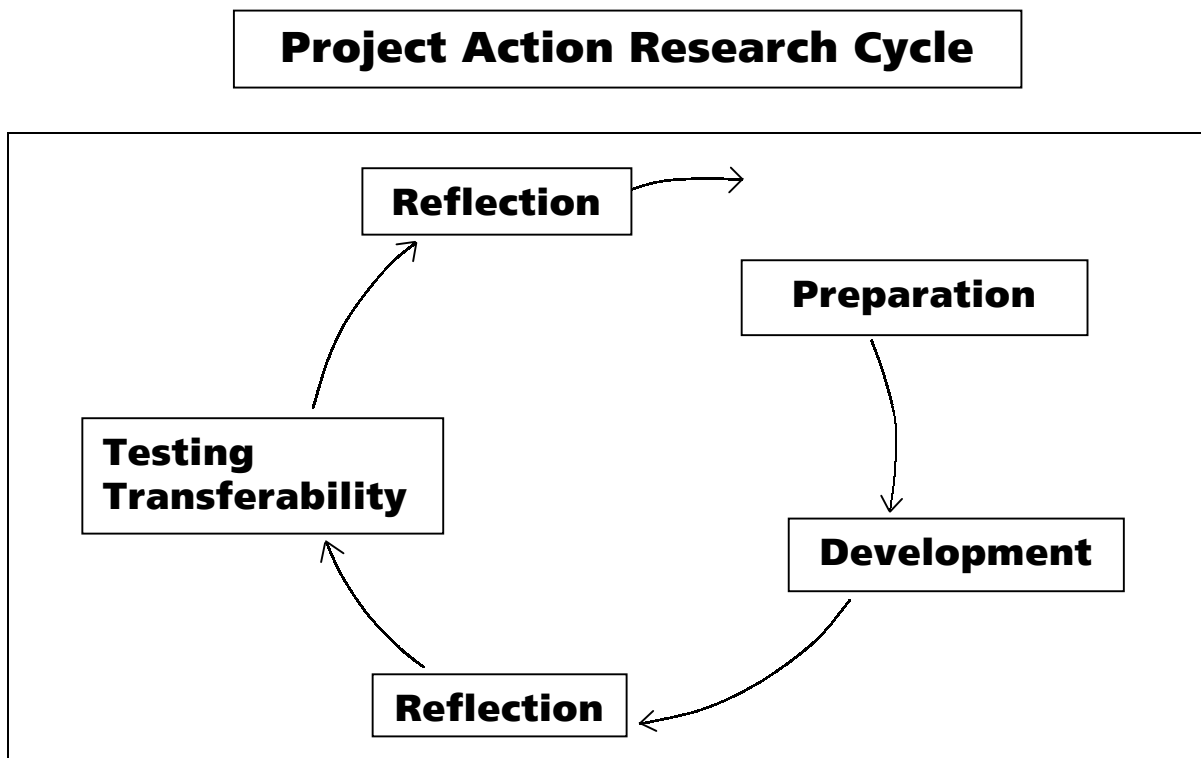
## Section 3: Project Outline

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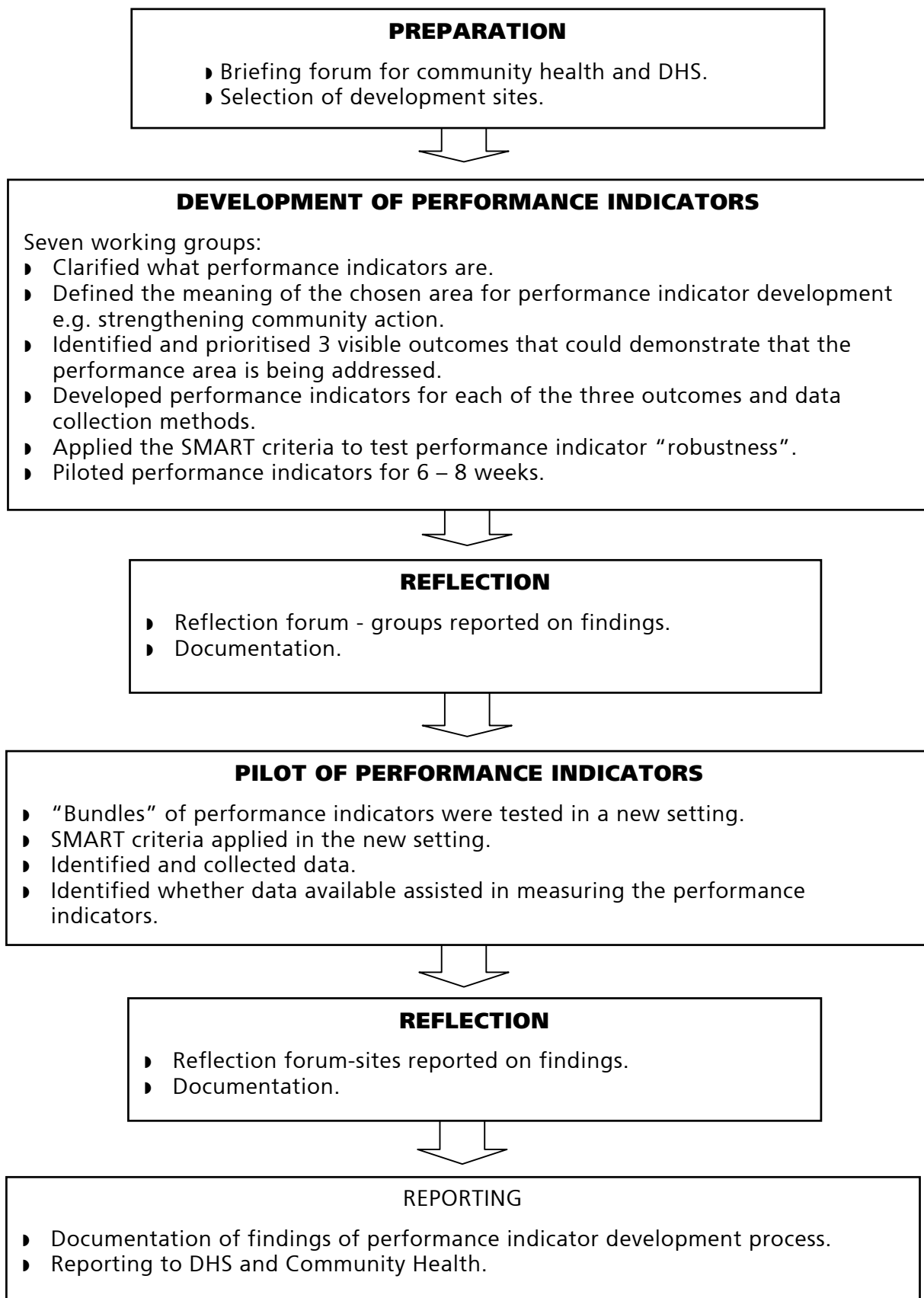
The project involved staff from community health services and the Department of Human Services collaborating to develop processes for establishing performance indicators meaningful to both the community health field and the funder. The emphasis throughout the project has centred on understanding how a process that would lead to the development of a framework of indicators could be developed. A working group comprised of Department of Human Services representatives and staff from community health have met since March 2000 to develop and steer an action research process.

The project adopted an action research methodology. The project was developmental and highly participatory. It involved four steps as shown in the following diagram: preparation, development, trialling and reflection. The project developed and then tested performance indicators in seven development groups, and then piloted these indicators in other places.

**Diagram 1 – Project Action Research Cycle**



# Overview of Process for the Development of Performance Indicators for Community Health



## **Step 1: Preparation**

The intentions of the project were outlined at a workshop held in March 2000, attended by community health managers and Department of Human Service staff. This forum allowed for discussion on the need for performance indicators in community health, development of a shared view and agreement on a way to progress performance indicator development. At the workshop, there was an expressed commitment to forge ahead and develop a process whereby community health, in partnership with the Department of Human Services, can be involved in developing and trialling some options for performance indicators in community health.

Workshop participants agreed that it is important to:

- ▶ Make use of a mix of perspectives and skills in the Project
- ▶ Clarify the relationship between service agreements and performance indicators.
- ▶ Allow for different approaches for particular services
- ▶ Consider the involvement of community perspectives in developing meaningful performance indicators
- ▶ Ensure that this project does have a meaningful outcome
- ▶ Explore the current state of the data collection system within community health and its ability to collect performance indicators
- ▶ Explore the capacity and mechanisms to collect base line data
- ▶ Address issues of cultural appropriateness for Aboriginal and Non English Speaking Background communities.

The Working Group, taking into consideration issues raised in the workshop, then devised and tested a process for developing performance indicators. The process used in the development of performance indicators is based on one used in the Whyalla Hospital and Health Service, Developing Best Practice in the Supervision of Rural Allied Health Professionals 1995-1996 RHSET Project. The knowledge gained from this exercise formed the basis of a process used in the performance indicator development groups.

A second briefing forum for community health and Department of Human Services staff was held in July 2000 where more details of the project were outlined. Participants were asked to consider being involved in the project and to discuss it with their organisations. Seven performance indicator development groups were selected on the basis of a number of criteria (See Appendix 1). Once the groups were selected, two facilitators (drawn from the working group) worked with them to prepare for the development process. This preparatory step was important in order to develop a shared view and agreement on the way to progress the development of performance indicators.

It was anticipated that three types of indicators would be used within the project involving both quantitative and qualitative data. These are:

**Rate based:** Measures the number of occurrences of an event in relation to the total possible number of events that could have occurred. A benchmark is set by which the indicator is met or not met.

**Sentinel Events Indicators:** Indicators are written such that each time the event occurs the indicator is failed.

**Narrative Indicators:** depict the story and meaning of what has happened and why.

## **Step 2: The Development Process**

In this stage of the Project, seven performance indicator development groups each worked with two facilitators in using a process to develop performance indicators (See Appendix 2). As performance indicators are developed against some statement of strategic goals and objectives, development groups were asked to nominate the use of a framework. These frameworks were drawn from ones widely used nationally and internationally in the primary health care sector. This allowed the Project to investigate the appropriateness of the process across a number of different frameworks. The frameworks used in the development phase were as follows:

### **The Ottawa Charter**

- ▶ Develop personal skills and knowledge
- ▶ Create supportive environments
- ▶ Strengthen community action
- ▶ Develop healthy public policy
- ▶ Provide personal care services
- ▶ Reorient health services

### **The New South Wales Capacity Building Model**

- ▶ Workforce development
- ▶ Organisational development
- ▶ Resource allocation

### **Primary Health Care Principles**

- ▶ Equity in health outcomes
- ▶ Prevention
- ▶ Participation
- ▶ Co-ordination

### **Women's Health Framework**

This framework was developed in reference to the National Women's Health Policy, Women's Health Five Year Plan and Women, Health and Well-being Framework, which all reflect a women centred approach to service provision.

The table below indicates the frameworks used by each of the performance indicator development groups, and the elements of the framework which were focussed on for the purposes of trialling the process.

**Table 1: Framework used by the performance indicator development groups**

<b>Name of development group</b>	<b>Framework used</b>	<b>Elements of the framework which was focussed on</b>
Women's Health Group	Women Centred Approach	Demonstration of a Women's centred approach
Northern Metropolitan Community Health Service	Ottawa Charter for Health Promotion	Strengthen Community Action
Adelaide Central Community Health Service	Ottawa Charter for Health Promotion	Strengthen Community Action
Statewide Primary Health Care Network	Capacity Building Model	Workforce development
Noarlunga and Inner Southern Community Health Services	Capacity Building Model	Creating supportive environments
Department of Human Services –Service Agreement	Primary Health Care Approach	Access and Equity for the most disadvantaged
South East Primary Health Care Providers Group	Primary Health Care Approach	Equity of health outcome

Development groups systematically developed performance indicators and checked these against a set of set criteria (see Appendices 3 and 4). These criteria assisted in checking that the indicator developed complies with the values and principles of the sector. Given experiences of performance measurement in other sectors, there was a concern that indicators should not be unworkable, unmeasurable, time consuming and ethically comprising. Other criteria were used as appropriate to the requirements of the development groups.

Development groups were asked to record the process, the indicators that emerged and what data would need to be collected to demonstrate that these indicators have been achieved.

Each group participated in two development workshops, a period of data collection, reflection and reporting. At the end of this stage a workshop was held that pulled together the analysis and reflections on the performance indicators as well as the process that occurred. This was combined for all development groups.

The process spanned a four month period.

### **Step 3: Testing Transferability**

This was an additional testing process to check if the performance indicators developed in Step 2 were relevant and transferable in other contexts. This process involved piloting a bundle of performance indicators in new settings, and was facilitated by members of the Working Group, in collaboration with people from development groups.

The facilitators supplied to new sites the performance frameworks used to develop the indicators and supporting information. The new site:

- ▶ Considered if they could physically collect the required data on the performance indicator in their own organisation
- ▶ Checked to see if the indicator had meaning for their organisation
- ▶ Collected the required data
- ▶ Recorded their reflections.

A forum was held for participating groups to feedback and reflect on their experiences of piloting a set of performance indicators that they had not been involved in developing. The outcomes of the forum are recorded in the next section.

### **Step 4: Reporting**

Throughout the project the Working Group met, discussed and documented the process and learnings from the Project. This report represents the synthesis of the action research process described above.

# Section 4: Findings

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This section of the report outlines the main findings of the *Performance Indicators in Community Health* Project. A key aspect of the Project was to further understanding about the process of producing performance indicators in order to develop ways that result in useful and meaningful indicators. In a workshop in December 2000, people came together to discuss the lessons learnt from the development stage. These have been distilled into eight broad but interconnected themes:

- ▶ Complexity
- ▶ The nature of performance indicators
- ▶ Resources
- ▶ Data collection systems
- ▶ Transferability
- ▶ language
- ▶ Cultural appropriateness, and
- ▶ Process

These themes were further explored during the pilot phase when the transferability of indicators was tested. The main issues identified are discussed below.

## **1. Complexity (context, nature of prevention, nature of health issues)**

It is recognised that the work of community health is complex and realised over time. This complexity exists at a number of levels:

- ▶ The complexity of social health needs and the variety of preventative responses required
- ▶ The different service modes that operate within community health (ie, one-to-one services, community development, group programs)
- ▶ The diversity of people that community health services work with (culture, race, age, gender, health issue)
- ▶ Local and regional responses as determined through service planning and review.

The nature of preventative work is that it happens over time in ways that build the preconditions of health for tomorrow (Legge et al, 1996). This has implications for what is accepted as signs of performance and it suggests that performance is located in a social, economic and political context that shifts over time. Signposts to performance thus vary according to the particular configuration of variables at work at a given point in time. As Zaheer et al. (2000) note in relation to the importance of time and timing in organisations:

The Chinese leader Mao Zedong was once asked what he thought of the French Revolution. He is reported to have answered, "It's too early to say." This seemingly flip reply raises an important question: over what time frames can phenomena be understood or evaluated? ...The meaning of an action and its consequence often depends on the time scales over which they are manifested (Zaheer et al. 2000, page 1)

Context, questions of time and timing present a set of challenges to the use of meaningful performance indicators in community health that is not shared to the same extent by other sectors. For example, in the acute health sector, the inputs, throughputs and outcomes are more neatly ordered, although it is still hard to demonstrate long term health outcomes. Performance indicators for community health need to capture the complexity of community health work and accommodate the changing nature of the work and the environment. In this regard context is critical. Stripping performance from context would give a partial view of the measurement of community health performance. This again clearly demonstrates the dilemma between needing to develop indicators of sufficient breadth and depth to capture the broad spectrum of work conducted in the community health sector, and limiting the use of performance indicators to what is practical.

## **2. The nature of performance indicators**

The community health sector engages in many activities that are monitored and evaluated using constructs such as discourse analysis and action research. This has been captured to some extent in the mapping exercise of the Metropolitan Community Health Review (DHS, 2001). If performance measures are to be used in the evaluation of these activities, performance indicators need to be developed that cater for non-numerical and text based data. Numerical data captures the breadth of the work conducted within community health settings whilst the text based methods are needed to capture the rich depth of the work undertaken.

The Working Group observed that during the Project:

- ▶ Qualitative indicators were more likely to be rejected (especially after the testing criteria were applied)
- ▶ Performance indicators were developed over a range of levels, including the program level, the organisational and the community health sector level

- ▶ Some of the performance indicators which were developed did not have a structure to them, and were not rigorous in nature. This is partly due to the desire in this project to “test the process” and worry less about the wording of performance indicators
- ▶ Generally process and impact indicators have been developed rather than outcome indicators. This result is not surprising given the framework and topics chosen for development
- ▶ There was a lack of indicators measuring quality
- ▶ That for some areas, it was difficult to develop appropriate and meaningful performance indicators
- ▶ A recurrent issue was the question of baselines and benchmarks. It was perceived that quantitative indicators need a corresponding baseline or benchmark to work from. This was also reiterated during the pilot phase. The process should allow for the people who write the performance indicators to comment and set the benchmark that they feel is appropriate to their place of work. Once the benchmark is realised it can be raised in the pursuit of continual improvement. There are at present no National or State policy positions on community health, and consequently no agreed benchmarks or targets.

### **3. Resources (human, financial, expertise)**

Research on performance indicators has identified that, at all levels, reporting on inappropriate performance indicators can be costly and inefficient. To undertake the tasks associated with performance indicator development, resources (human, financial, expertise) are needed at all stages of the process. One of the driving concerns in undertaking this Project was to determine ways that performance indicators can be developed that are cost-effective in use. It is clear from this Project that adequate resources are needed to make the use of performance indicators practical within community health settings.

***Before performance indicators are developed*** participating staff require skills, education and information on the *whys and hows* of performance indicators. This needs to include background information on what performance indicators are, potential benefits to the clients and community, service or worker and funders, dimensions of performance, types of indicators and how they might best be formulated. Information is also required about ways to collect information that incorporate numbers and counting as well as stories, or qualitative indicators.

***In the development phase*** time is needed to ensure that staff from community health services are involved in the determination of meaningful indicators. A very clear outcome of this Project is that if the indicators are to have relevance they need to be meaningful to practitioners. This point cannot be stressed enough. Time is needed to develop and sustain a dialogue about performance and the critical aspects of performance. As one development

group member commented ' *we need time to explore the issues and go through the muck to get clarity*'. In a climate where there are pressures on service delivery, finding this time is difficult. In rural and remote South Australia geographic distance means that alternative mechanisms for dialogue need to be used (such as teleconferencing). Involvement of community, clients and other stakeholders in the process of developing performance indicators also has resource implications, however it is important in terms of primary health care principles of participation. Concern has been expressed about putting considerable effort into developing performance indicators that may take limited community health resources away from the central concern to meet the needs of the community and the provision of vital services.

#### **4. Data collection systems**

At the point indicators are utilised, systems are needed to efficiently collect and analyse the data. Methods to collect "rich information" are important given the complexity of health promotion outcomes.

The current sector wide community health data collection systems are not watertight in a way that will ensure meaningful and accurate reporting on performance indicators. This point is identified in the Metropolitan Community Health Review (DHS 2001).

Resourcing the advancement of data collection systems that integrate with existing service strategic planning, evaluation, and accreditation systems is needed. Linking performance indicators with existing accreditation models would also make them more efficient and effective. In addition the following comments have been made about data collection.

- ▶ There is a need to extend the variety of data collection methods and count different facets of community health activity
- ▶ There is a need for more flexibility around data collection methods, e.g. story telling and capturing the nature of the work. (i.e. work often occurs with family and significant others and the client is only counted for data purposes)
- ▶ There is a need to develop ways to collect culturally appropriate information, especially in regard to our Indigenous and migrant communities.

## 5. Transferability of performance indicators and process

One of the factors explored in this Project was the issue of transferability. There was a concern to know more about what type of performance indicators could be transferred to other sectors, locations and services within community health, as well as across operational levels within community health organisations. Furthermore, could meaningful indicators be developed that would be relevant no matter where they were applied, or did they need to be developed in the location in which they were to be used?

The Project has identified that there are dilemmas that impact on how well transferability can occur. At a very basic level, it was found that often the performance indicator was not understood outside the group who developed it. For example, in the performance pilot phase if the indicator was clear then it was more likely to be considered 'robust' and meaningful. However, if the performance indicator was ambiguous then the pilot group found it harder to see the relevance of the indicator and of collecting data to report against the indicator. It was common that meaning was lost in a transfer of the indicator from the site where the indicator was developed to elsewhere. One participant said that '*the performance indicator was esoteric for those not originally involved*'.

There are some further dilemmas in transferring the indicators themselves that were tested out more fully in the pilot phase.

- ▶ Performance is tied to the goal of meeting needs and circumstances as articulated in strategic and local plans. There a trade-off between a common set of indicators across a sector and specific micro level indicators that make sense to those who are using them
- ▶ The need to develop **key** indicators and not try to 'nail down' everything that is done, or expected, in community health performance.
- ▶ Different data systems used in different agencies mitigate against being able to apply performance indicators that work well elsewhere. Strategies need to be developed to ensure greater consistency in data collection
- ▶ Given it is resource intensive to cover all performance domains within an organisation or region, it may be necessary to determine a number of core performance indicators and a number of service or program specific performance indicators
- ▶ The need to identify the information required to accompany a performance indicator in order for it to be understood and valued in other locations

While there is debate about the transferability of the performance indicators identified, the Project clearly demonstrated that the process for developing performance indicators is transferable and of intrinsic benefit.

The development and pilot process required those involved to spend time reflecting on aspects of performance and how they can be encapsulated in an indicator. Skills learnt in focusing on a process to increase understanding of performance measurement can be transferred to other areas of work.

A number of participants commented that the process which has been trialed would be useful in other areas of service development. Others said that they could use this process to create performance indicators for their work.

## 6. Language

The very nature of the task of defining what is critical about performance in community health, is complicated by the complexity and diversity of preventative work, and the values that underpin community health. It is also a highly value laden exercise and this was recognised throughout the Project. Given this, it is not surprising that language and developing shared meanings was important. As with any group of people who work together there were different understandings and uses of terms in the seven development groups. This was further reflected in the pilot groups. The concepts used (for example, achieving equity, participation, prevention and working across sectors) have value as well as descriptive dimensions.

[W]hen we come into sites of social practice that bring together people from different discursive traditions and backgrounds we cannot assume that the meaning we associate with given words and concepts are the same as other people's. Indeed in many cases we can safely assume that they are not. (Gee and Lankshear, 1995, page 11)

The value of the process used is that it allowed space for people to talk with one another about meanings and arrive at shared meanings. This was important in establishing common ground from which to then define performance and performance measures. The groups that spent some time clarifying terms, values and understandings usually moved more easily to the task of gaining agreement on performance and likely indicators. The importance of this was also seen in the piloting process. People not involved in developing an understanding of the indicator were likely to report that they found the indicator ambiguous and not highly relevant.

Some lessons about language include:

- ▶ Shared meaning is a critical starting point to develop meaningful performance indicators.
- ▶ The indicator needs to be precise and not written in jargon, but not so precise that it ceases to be transferable or have generic meaning.
- ▶ The language used needs to be sensitive to cultural meanings.
- ▶ The indicator should not reproduce oppressive workings (for example practices that are racist or inherently disempowering).
- ▶ The need to find a way to talk about different meanings without being bogged down in differences and semantics.

- ▶ It is important to understand the language of performance indicators.
- ▶ It is important to understand the use of definitions within the structure of a performance Indicator.

## **7. Cultural appropriateness**

The need to consider the involvement of Aboriginal and Torres Strait Islander and Non-English speaking background workers in the Project was highlighted, as a means of testing the cultural appropriateness of the process.

A limitation of the Project was that although there was the intention to involve workers from a variety of cultural backgrounds throughout the process, additional effort was not made to recruit Aboriginal and Torres Strait Islander and Non English Speaking Background worker participants. Indeed, only a few Indigenous and Non English Speaking Background workers participated in the development groups and pilot process, and informal feedback received from them was that additional training and information needed to be provided in order for them to participate fully in a process for developing performance indicators.

A development group involving members of an Aboriginal Health Team was subsequently established in the latter parts of the Project, with the identification of additional training to be provided to Aboriginal and Torres Strait Islander and Non English Speaking Background workers on the use and development of performance indicators. The outcomes of this aspect of the Project will be reported separately.

Cultural appropriateness was also added as a separate element to the testing of SMART criteria used to assess the effectiveness and robustness of performance indicators.

## **8. Process**

The Project was concerned to learn about a process for the development of meaningful yet robust performance indicators. Overall the workshop process worked effectively to produce a range of performance indicators (71 in total). Participants were supportive of the project and were enthusiastic of the task of developing performance indicators for their selected performance areas. Importantly, as already discussed, the process of developing performance indicators had allowed participants the opportunity to discuss the application of performance indicators to their service. In this section of the report the lessons learnt about the process of the workshops is detailed.

### **a) Pre-workshop preparation**

Many of the participants identified the importance of comprehensive pre-reading, including: the development and use of performance indicators, key documents on the selected performance area and purpose of the day. Some groups felt that it was important for the staff involved in developing performance indicators to have selected the performance area to maximise the relevance to their work.

### **b) Membership of the development groups**

All groups were made up of community health service providers, management and DHS representatives. There was strong agreement that this composition added value to discussions and the outcomes. In some groups continuity of membership changed, which affected group dynamics and content of discussion. Many groups and facilitators thought it important to have consistency in the people involved in the development stage given the importance of time and space to create a shared meaning of performance in the nominated areas.

### **c) Workshop process**

A range of process issues were identified which are outlined below.

- ▶ People experienced the process differently in part due to the composition of the group and the facilitation process. A lesson was that in planning workshops, facilitators need to be flexible about methods used for decision making and priority setting and be informed by group participants
- ▶ Most of the groups highlighted the richness of discussions concerning the selected performance areas – discussions that they did not usually have within their own organisations
- ▶ In many instances where there was disagreement about definitions or when discussions got “stuck”, facilitators would bring groups back to task by reminding them that this particular exercise was about testing a process rather than coming up with a definitive set of performance indicators. This highlights a fundamental issue in future performance indicator development of a tension between trying to capture everything and pinpointing the most important elements of work in the nominated area
- ▶ The importance of taking time to set the scene for the development of future performance indicators was highlighted, together with the need to include appropriate examples of future performance indicators
- ▶ It is important to test the key question that is to be presented to the development group (this is one of the first phases in the development process). A few groups highlighted the importance of asking the right questions when a) ascertaining the key elements of a performance area, b) assessing when a service is performing in the selected area
- ▶ Some groups experienced “pain and resistance” to clumping elements together and voting
- ▶ In some cases gaining agreement on the most salient indicators was not easily reached and a process for development of performance indicators needs to take heed of this

- ▶ Should we ensure that the indicator demonstrates ‘best practice’ although it is recognised that this is a contested notion? Performance indicators should reflect the most crucial elements of practice and therefore could be argued to encapsulate the key areas of operation essential for best practice.

**d) Length of the workshop**

Rather than a full day workshop, a few groups suggested having three sessions over a series of half days. While it was felt that it was useful to split the process over a number of days as it gave participants the opportunity to appraise and refine indicators with fresh eyes, the process can be shortened to accommodate service/participant needs. In one development group in the rural and remote sector, the process was modified to allow the process to occur over one day.

In summary, the process is flexible enough to allow workshops to be run over a number of sessions to suit participants.

**e) Changes recommended to the CRI-TEST or SMART Criteria**

There was recognition of the need for changes to the CRI-TEST or SMART criteria so that indicators can be narrowed down to a more realistic number, and two additional criteria were suggested:

- ▶ ‘Inclusiveness’ was added as a component of ‘Realistic’
- ▶ Compatibility with Australian Health and Community Services Standards was added as a separate criterion.



# Section 5: Project Recommendations

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The following recommendations are made, in light of the findings of *the Performance Indicators in Community Health Project*.

1. That the process outlined in this report be considered in the development of performance indicators for the community health care sector within the context of a policy for primary health care based on the Metropolitan Community Health Review, Action 1 (DHS, 2001). This should include determining benchmarks in relation to quantitative indicators. If this process is adopted for this purpose, additional resources (including time and education) would have to be made available for community health service involvement.
2. That current developments in a new information system for community health services take into account the need to measure potential common performance indicators for the community health sector. With regard to this, the information system should consider:
  - collecting data to support qualitative indicators to capture the diversity and complexity of community health work (for example, health promotion, and community development),
  - links between performance measurement and existing accreditation systems to avoid duplication of effort and reporting.
3. To consider current accreditation systems in future performance frameworks, in order to prevent duplication of effort in data collection, analysis and monitoring of quality.
4. To consider cultural diversity when beginning a process for developing performance indicators for the community health sector
5. The need to consider the development of outcome performance indicators, acknowledging this is an incremental process, due to the complexity of measuring outcomes.
6. That the recommendations be referred to the Community Health Review Implementation Group for consideration. This needs to occur in conjunction with country community health services, to ensure dissemination of the Project's findings across the community health sector in South Australia.



# Section 6: A Refined Process for Developing Performance Indicators in Community Health

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The process outlined in this section is a refined version of the original process used in the *Performance Indicators in Community Health* Project. Feedback from organisations on the effectiveness and appropriateness of this refined version is welcomed.

## 1. Selection of Performance Area and Performance Level

### 1.1 Performance Area

Community Health in SA has existing frameworks that can guide what it is that the sector strives to achieve. Performance areas can be identified within each of the following frameworks, or, alternatively other framework/performance areas may be developed.

Examples of performance areas include:

#### **The Ottawa Charter**

- Develop personal skills and knowledge
- Create supportive environments
- Strengthen community action
- Develop healthy public policy
- Provide personal care services
- Reorient health services

#### **The New South Wales Capacity Building Model**

- Workforce development
- Organisational development
- Resource allocation

#### **Primary Health Care Principles**

- Equity in health outcomes
- Prevention
- Participation
- Co-ordination

## **1.2 Performance Level**

Select the desired **level** of performance (eg. whole of Community Health sector, State health department, geographical area, organisational, team, specific service) that is to be measured.

## **2. Appointment of Group Convenor**

The group convenor is responsible for ensuring that the desired outcome, that is, the development of performance indicators for community health, is achieved in accordance with this tested process. The person given this role will depend on the level at which the performance is being measured.

## **3. Formation of Development Groups**

Invite members based on pre-selected performance area and level.

It is important to note these key issues:

- ▶ Representation from different levels of service delivery (eg. State health department, CEO, middle managers, service providers)
- ▶ Consistency of membership
- ▶ 8-10 members is considered ideal
- ▶ The group should include some people who have knowledge/experience and responsibility for the performance area.

## **4. Development Group Facilitators**

The role of the development group facilitator is to guide and direct the performance indicator development group through this process. Select from a pool of experienced performance indicator development group facilitators in SA.

It is strongly recommended that:

- ▶ Groups have two facilitators
- ▶ At least one of the facilitators has had experience in facilitating performance indicator development groups
- ▶ Both facilitators have proven group work skills
- ▶ Both facilitators have extensive knowledge of the nature of performance indicators.

For a comprehensive outline of facilitators' tasks during the process refer to Appendix 2.

## 5. Workshops

### 5.1 Time

The time needed to develop performance indicators (excluding preparation reading/discussion) is approximately two days, over a seven day period. This timeframe ensures sufficient time for group processes and also allows opportunities for reflection between sessions.

### 5.2 Preparation

Preparation for participants could include pre-reading on the following areas.

- ▶ Performance indicators in community health
- ▶ Nature of performance indicators
- ▶ Performance area(s)

Information sheets and examples of performance indicators are included in Appendices 2, 5, 6, 7, and 8.

### 5.3 Critical Components

Critical steps of the development workshops are:

#### **Workshop 1: Pre-workshop (half day)**

- Step 1 Brief the group on the purpose and nature of performance indicators
- Step 2 Develop shared understanding and meaning of the selected performance area.

#### **Workshop 2 (6 hours over full day, or, two half days).**

- Step 1 Briefly revisit shared understanding and meaning of selected performance area
- Step 2 Identify priority / crucial performance elements
- Step 3 Develop performance indicators for each priority performance element
- Step 4 Identify data collection details (nature and method) for each indicator (See Appendix 9).

**Workshop 3 - (half day, approximately one week after first workshop).**

- Step 1 Reflect on performance indicators developed in Workshop 2
- Step 2 Apply a CRI-TEST analysis to each performance indicator (See Appendix 4)
- Step 3 Refine/reject performance indicators as determined by CRI-TEST analysis
- Step 4 Clarify data collection details (what time period, how, by whom) for the surviving performance indicators. Use data collection forms and distribute.

## **6. Data Collection and Analysis**

This stage involves the use of performance indicators to measure performance ie. data collection and data analysis. Data collection and analysis against each performance indicator is undertaken by the people involved in the workshops. This stage is likely to occur over a four to twelve week period in order to give sufficient time to test the appropriateness of the data collection activities.

## **7. Documentation of Findings**

The data collected should be recorded against each performance indicator. Compile a report using the standardised data collection format generated in the workshops (See Appendix 9). It is also useful to record any contextual information such as problems encountered.

## **8. Outcome**

The outcome of the above development process will be a set of meaningful performance indicators for the nominated performance area, as well as an increased understanding in participants regarding the nature and use of performance indicators in community health.

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## **Appendix 1**

# **Developing Performance Indicators for Community Health**

## **Selection of Development Groups – Guiding Principles for Selection**

Listed below are a set of guiding principles that informed the working group's selection of a development site.

Staff at the community health centre needed to demonstrate:

- A willingness to work with other Community Health Services.
- An ability to work within the frameworks provided.
- The time to commit to the development of performance indicators.
- A letter from the CEO endorsing involvement.
- A skill mix that would facilitate the development of performance indicators.
- A sense of feasible and achievable outcomes.

## **Appendix 2**

# **Facilitator Notes – Performance Indicator Workshops**

### **Requirements before you begin**

- Contact members of the workgroup to ensure that all practical matters are organised (dates for both workshops, lunch, tea/coffee, venue, etc).
- Prior to the development workshop, member/s from the development site will have attended a briefing workshop.
- The service will have nominated the type of indicators and levels of indicators they are interested in developing prior to the workshop.
- Facilitators will have met with each other and clarified the agenda and the way they will guide the workshop processes.
- Facilitators need to stay clear and focused on the process. Each group will respond differently to the proposed agenda and it is vital that facilitators are able to stick to the method we have agreed on.

### **At the start of Workshop 1**

- Provide an overview of the task and the expected outcomes and benefits. Need to thank the group for participating in what is a voluntary project. Explain practicalities of the day (lunch breaks, toilets etc) and timelines.
- Outline the agenda and the method for the development of PIs. It is important that the group agree to follow the method you are using and not to try and steer the workshop in other directions.

#### **Overview of the day**

- Today we will spend some time defining PIs (i.e. what is an indicator, the different types of indicators and the ways PIs are used), outline the structure of an indicator and give some examples of the three different types of indicators the project is using. We will then define PIs for the area the group has agreed to work on. We will be closely adhering to a set method of developing PIs so please ensure you feel comfortable with the definitions etc before we proceed.

### **Definitions of the terms**

- **What is an indicator?** Performance indicators are practical tools that provide flags to critical areas of our work. The performance indicator articulates an activity, process or outcome that has a significant impact on the quality of our work. Performance indicators

do not and cannot measure everything, rather than are designed to measure those activities which are most **critical** to our work. The structure of an indicator is outlined below:

<b>Indicator Topic</b>	What is being monitored by the indicator i.e.: the most crucial aspect of the work
<b>Rationale</b>	Why is this considered to be the most crucial aspect and from what context. For example, workforce development goals from the capacity building framework.
<b>Indicator</b>	Write the indicator statement. It must be stated in terms that are both measurable and valid.
<b>Definition of Terms</b>	Define the terms within the indicator. These definitions are of particular importance as they ensure that users are all monitoring the same activity, process or outcome.
<b>Indicator Recording Instructions</b>	Instructions that define the way in which you record the data required to monitor each performance indicator.
(Adapted from the Whyalla Hospital and Health Service, Developing Best Practice in the Supervision of Rural Health Professionals, 1995-1996 RHSET Project.)	

Ensure the group understands each component of the indicator and the importance of each element.

The different types of indicators need to be defined and discussed:

**a) Rate based:** Rate based indicators measure the number of occurrences of an event in relation to the total possible number of events. An example of a rate based indicator:

*The community health centre will consult with community on 50% of the total policies generated over a three month period.*

$$\frac{\text{Number of times the community were consulted re: policy}}{\text{The total number of policies developed}}$$

Both of these rates are based on a specified period of time. The benchmark would need to be set at a level that was felt appropriate by staff and community. For example, do members of the community want to comment on every policy that is developed within an organisation or are there key policies upon which they should be consulted? Important within this indicator is the definition of **consult**. How this process is facilitated will impact on the quality of comments received and there is a risk of tokenism unless the definition is tight.

The threshold for the indicator must be set. In the example above, the benchmark is set at 50%.

## b) Sentinel Event Indicator

Indicators that are written such that each time the event occurs the indicator is failed. These events are critical to equality, e.g. a staff member's breach of confidentiality or leaving a dirty cup in the staffroom sink. It may be relevant to talk about the history of this example. An example from the medical world are events such as maternal death during delivery of an infant. Within our context what are those activities that should be investigated each time they occur?

## c) Qualitative Indicators:

In this project we are also keen to develop qualitative or narrative indicators of performance. These types of indicators are shaped by words and what we see, rather than counting numbers.

## Performance Framework

In this project we are working from a selected performance framework. Go over the framework and ensure that all are familiar with this.

Might need a tea break here.

## Development process

**Pose question to the group** (this should be devised by the facilitators prior to the workshop)- along the lines of 'what is the most crucial aspect in this area?'

Five minutes of quiet time to think of individual responses.

**Brainstorm list and write on the board/butchers paper.** Clarify each one as you go and look for themes that may be linked and re-defined.

Facilitator to go through list and ensure all are clear of the meaning of each statement.

**Agree on list.**

**Prioritise list.**

**Rank order list** using the nominal group technique:

1. Hand out to each participant a set of 5 cards. Each card has one number printed on it (Cards are individually numbered one to five).
2. Tell the group that they are going to rank order their top five priorities to defining quality or best practice in <insert topic area i.e. Re-orientating services>
3. The top priority is given the 5 ranking and then in decreasing priority order down to 1. You need to say this a couple of times and write it on the board as people usually rank the other way round.
4. When everyone has finished collect the cards and let the group break for 10 minutes.

5. Add the scores on the cards and the **highest** scoring item is the first priority etc.
6. Draw up a prioritised list with the 'score' for that item next to it.
7. Re-form the group and check the order of the list with the group.

Agree on prioritised list.

### **Develop indicator**

Start with the item that had the highest priority...

Discuss with the group the type of indicator needed to monitor the item. Try to word the indicator (if it doesn't flow easily you need to break down the item and you may generate a couple of indicators from the item).

Identify the data to be collected, the data sources, timeframe and the method of data collection.

Keep working through the prioritised list until the group feels happy with the number of indicators for that topic and also what is realistic from a data collection point of view.

### **Towards the end of the day**

Revisit the complete list and describe the process from here:

- Time to reflect on the indicators
- At the ½ day workshop there will be time to reflect on the indicators and test them using the SMART criteria.

Ask participants to complete an evaluation of the day and to please come back!!

(Process adapted from the Whyalla Hospital and Health Service, Developing Best Practice in the Supervision of Rural Health Professionals, 1995-1996, RHSET project).

## Appendix 3

### SMART Criteria

- S** **imple** Can the people involved in the service understand and use the indicator. (For example, can community health workers, board members, community advisory groups understand and use the indicator? Can the indicator be understood and used by DHS for monitoring reporting and/or planning purposes?).
- M** **asurable** Is the data available to verify the indicator? Does the indicator use a standard? Is it measurable and able to show trends? Also:  
  
Can the indicator measure outcomes or milestones towards outcomes? (not all indicators will measure outcomes but outcomes should be reflected in any “Indicator Package”). Can the indicator demonstrate best practice or be a predictor of service enhancement?
- A** **chievable** Can this be done within the resources and time available?
- R** **ealistic** Are the indicators appropriate to the locality/or community? Do the people involved with the service value the indicator? (for example – does the community, staff and DHS value the indicator?). Does the indicator reflect inclusiveness.  
  
Is the indicator in keeping with the politics and values of the organisations involved? (For example: Is the indicator in keeping with the aims and values of community health? Are the indicators in keeping with the overall objectives of DHS and the relevant Division?)
- T** **imely** Is the indicator appropriate to the timeframe? Can the indicator signal an early warning of potential problems? Does the indicator fit with budget and or planning cycles?

## Appendix 4

### 'CRI-TEST' Cross check tool

Question: Does the proposed indicator stand up against certain criteria?

Performance Indicator area	Proposed Indicator	testing criteria					Other criteria QIC review developmental goals Local planning criteria/strategic directions DHS Strategic Planning criteria Other critical local criteria?
		S	M	A	R	T	
Develop personal skills and knowledge	1.						
	2.						
Reorient Services	1.						
	2.						
Create Supportive environments	1.						
	2.						
Strengthen community action	1.						
	2.						
Develop Healthy Public Policy	1.						
	2.						
Provide Personal Care Services	1.						
	2.						

Modified version of the Evaluation Matrix in the discussion paper *Tracking Progress-using indicators*/Prepared by the City Of Onkaparinga March 2000.

## Appendix 5

### Information sheet 1

#### What do indicators look like?

A performance indicator is generally defined as a unit of information that is used in the measurement of progress towards a goal or objectives (Hall and Rimmer 1994<sup>1</sup>) and may entail measurement of success in terms of efficiency, effectiveness, and appropriateness (NCOSS 1990<sup>2</sup>). Armstrong (1994<sup>3</sup>) has defined an outcome related performance indicator as:

'a statistic or other unit of information which reflects, directly or indirectly, the performance of a health or welfare intervention, facility, service or system in maintaining or increasing the well being of its target population'.

The National Health Minister's Benchmarking Working Group 3rd Performance Indicator Report<sup>4</sup> defines a performance indicator as:

'a measure that quantifies the level of performance for a particular aspect of [health] service provision and allows comparison between service providers, models of service provision or both'

Indicators are units of information that can be either numerical or qualitative. The structure of performance indicators developed by this project will be:

- Topic (including a definition of terms)
- Rationale – ie why the performance indicator is important
- Indicator recording instructions

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<sup>1</sup> Hall, C and Rimmer, S (1994), Performance Monitoring and Public Sector Contracting. *Australian Journal of Public Administration*, 53(4) 453-461

<sup>2</sup> NCOSS (1990) *Performance Indicators for Community Organisations*. Council of Social Service of New South Wales.

<sup>3</sup> Armstrong, B (1994) *Getting health outcomes into state and national health policy*. Paper presented to the NSW Health Outcomes Conference, Sydney, 12-13 August, 1994.

<sup>4</sup> NHMBWG (1999) *Third national report on health sector performance indicators*. Department of Health and Aged Care: Canberra.

Three types of indicators are commonly used. These are:

- ▶ Rate based: Measure the number of occurrences of an event in relation to the total possible number of events that could have occurred. A benchmark is set by which the indicator is met or not met.
- ▶ Sentinel Events Indicators: Indicators are written such that each time the event occurs the indicator is triggered.
- ▶ Narrative Indicators: qualitative information.

## Appendix 6

### Information Sheet 2

Examples of Performance Indicators relating to:

INDIVIDUAL ACTIVITY LEVEL (eg speech therapy, counselling, diabetes management classes)		
PERFORMANCE DOMAIN	PERFORMANCE AREA	PERFORMANCE INDICATORS EXAMPLES
Effectiveness	Quality	<ul style="list-style-type: none"> <li>▶ achievement of CHASP accreditation</li> <li>▶ client satisfaction with services</li> <li>▶ number of complaints</li> <li>▶ level of skills/experience of staff</li> <li>▶ extent of use of good practice guidelines</li> <li>▶ client outcomes (compared to benchmarks &amp;/or individually set goals)</li> </ul>
	Appropriateness	<ul style="list-style-type: none"> <li>▶ extent of needs assessments</li> <li>▶ client satisfaction with range of services</li> </ul>
	Access	<ul style="list-style-type: none"> <li>▶ waiting lists for services</li> <li>▶ waiting times for services</li> <li>▶ physical access</li> </ul>
Equity	Access	<ul style="list-style-type: none"> <li>▶ proportion of clients from specified sub-groups</li> <li>▶ proportion of staff from specified sub-groups</li> <li>▶ proportion of staff who have undergone cultural awareness training</li> <li>▶ extent of resource available in community languages</li> </ul>
	Outcomes	<ul style="list-style-type: none"> <li>▶ client outcomes for sub-group compared to control population?</li> <li>▶ change in health status for sub-group compared to control population?</li> </ul>
Efficiency	Unit costs	<ul style="list-style-type: none"> <li>▶ cost per occasion of service</li> <li>▶ labour cost per occasion of service</li> <li>▶ caseload per worker</li> </ul>

EXAMPLE OF PERFORMANCE INDICATORS FOR PRIMARY HEALTH CARE PRINCIPLES	
PRINCIPLES	PERFORMANCE INDICATORS
Socio-environmental approach	<ul style="list-style-type: none"> <li>▶ number of programs/activities which take account of socio-economic determinants of health</li> </ul>
Focus on health promotion/illness prevention	<ul style="list-style-type: none"> <li>▶ proportion of budget spent on health promotions/illness prevention</li> </ul>
Participation in planning, implementation and evaluation	<ul style="list-style-type: none"> <li>▶ number and characteristics of people participating</li> </ul>
Intersectoral action for health	<ul style="list-style-type: none"> <li>▶ number and extent of intersectoral relationships</li> <li>▶ number of programs with input from other sectors</li> </ul>
Equity	<ul style="list-style-type: none"> <li>▶ proportion of clients who are in specified target groups</li> <li>▶ extent to which services are accessible to disadvantaged groups</li> <li>▶ extent to which programs are adapted to needs of specific groups</li> </ul>

EXAMPLES OF DISEASE INDICATORS		
	MENTAL HEALTH INDICATORS	CARDIOVASCULAR DISEASE INDICATORS
Health outcomes	reduction of suicide rate	percentage of weight reduction clients maintaining healthy weight after 6 months
Health output	open caseload per mental health worker	percentage of weight reduction programs available per annum per catchment
Service Quality	degree to which national minimum standards are met	existence of protocols for integrated care of people with CVD and those at risk of developing the disease, by hospital and community based public and private service

Taken from: Jolley, G (1999). Performance Indicators for Community Health: A South Australian Perspective. Second Edition. SA Community Health Research Unit.

## Appendix 7

# Performance Indicators in Community Health

## Examples of Performance Indicators developed by Development Groups

INDICATOR TOPIC	KEY ELEMENT	PERFORMANCE INDICATORS
Access and equity for the most disadvantaged groups in the community within a Primary Health Care framework.	Aboriginal and Torres Strait Islander (ATSI) people are coming to the service/using the service.	<ul style="list-style-type: none"> <li>• % of ATSI people receiving a service as a proportion of the total regional ATSI population.</li> <li>• Age comparison between % of ATSI people receiving a service and that of the regional ATSI population.</li> <li>• % of ATSI people receiving a service by gender.</li> <li>• % of ATSI people receiving a service by type of service.</li> <li>• % of client group who are ATSI.</li> </ul>
Equity of health outcome <i>equity of health outcomes is defined as equal opportunity for everyone to access the health services they require.</i>	Community awareness about what services could be available.	<ul style="list-style-type: none"> <li>• Number of clients accessing the service by team. (The organisational structure is based on teams. Clients include all people who are registered to receive a service from the CHS.)</li> <li>• Type/source/appropriateness of referrals to the service. (Type = what service they are being referred to, Source = where is the referral coming from, Appropriateness = does the service provided by CHS match the need of the client.)</li> </ul>
Equity of health outcome	Cross cultural service delivery (culturally appropriate youth, aboriginal, NESB, gender.)	<ul style="list-style-type: none"> <li>• Are the number of registered clients using the service culturally representative of the general population in the region? (e.g. If ATSI comprise 1% of region's population, 1% of services clients should be ATSI. Cultural backgrounds that are consistent with the ABS e.g. Aboriginal, first generation, youth.)</li> <li>• Number of people from culturally diverse backgrounds that participate in groups, committees within the service.</li> </ul>
Equity of health outcome	Availability of services/service providers.	<ul style="list-style-type: none"> <li>• Waiting lists for current available services. (Not all sites may offer the full range of services.)</li> <li>• Access to individual &amp; group programs.</li> </ul>

## Appendix 8

# Example of a Community Health Service Performance Indicator Workshop: Process and Outcomes

### The Process used

As it was a small group and participants were all familiar with each other the facilitators decided not to split into smaller groups to workshop specific issues.

#### Workshop 1 - Commenced 10am – 16<sup>th</sup> October 2000

- 1 Introduction, overview of the project, presentation of development model, expectations of the group (60 minutes)
- 2 Discussion of the planning and reporting processes currently used (15 min)
- 3 Pls what are they (group brainstorm then overhead presentation) (10 min)
- 4 The process
  - Step 1 Identify the framework (10 min)
  - Step 2 Identify and prioritise the key components of each area (30 min)
  - Step 3 Develop Indicators keeping in mind the SMART criteria (2.25 hrs)
    - Topic
    - Rationale
    - Indicator
    - Definition of the terms
    - Recording instructions

#### Workshop 2 – Commenced 10am – 25<sup>th</sup> October 2000

1. Reflection on first workshop (20mins)
2. Review and refinement of Performance Indicators by defining the terms and the data collection processes. Only had sufficient time to cover the first two areas: Community awareness about what services could be available; Cross-cultural service delivery. There was insufficient time to finalise indicators for *Availability of Services/Service Providers*. (2 1/2 hours)
3. Assessing performance indicators against SMART criteria. Initially the group elected to apply the criteria in two small groups but then as the process continued they went through the criteria as one group (15min)
4. Data collection and where to from here (10 min)

## The outcomes

### What are Performance Indicators? (brainstormed by the group)

- Measurable
- Flag a need/problem
- Indicates what is working/not working
- Efficiency/direction

### Performance Area (Primary Health Care Principles)

The submission proposed that the workshop focus on two areas 1) Equity of Health Outcomes and 2) Coordination of Services. Due to time constraints only area 1 was addressed.

*The group defined “Equity of Health Outcome” as “Equal Opportunity for Everyone to Access the Health Services they require”.*

### Key Components

The group brainstormed the following when presented with the question “What are the key components of equal opportunity for everyone to access health services they require?”

1. Addressing barriers to access (18)
2. Cross cultural service delivery (culturally appropriate – youth, Aboriginal, NESB, gender) (20)
3. Availability of services/service providers (19)
4. Equity in access – need this to enable outcomes (13)
5. Community needs analysis (5)
6. Community awareness about what could be available (23)
7. Community education about specific issues e.g. mental illness, stigma, etc. (0)
8. Community participation (12)
9. Education of referring agencies (1)
10. Cost to clients to access services (2)
11. Cost of providing services (0)
12. Recruitment and retention of staff/service providers (6)
13. Social action/community development (6)
14. Responsibility (2)
15. Community management e.g. Aboriginal (0)
16. Staff of service reflect community at large (0)

### Top 3 Components

The group was asked to prioritise the components by choosing their top 5 assigning a value of 5 to the top priority then decreasing priority down to 1.

1. Community awareness about what could be available
2. Cross cultural service delivery (culturally appropriate Youth, Aboriginal, NESB, gender)
3. Availability of services/service providers

## Indicators

The group developed indicators for each of the top 3 components through prompting with the following question “How do you know when these components are present?”

At this stage the group were presented with the SMART criteria and informed that the indicators will need to meet these criteria. Data recording arrangements were also identified at this stage.

Due to time constraints only the indicators developed under the first two key components were matched against the SMART criteria. The group agreed that the indicators met the criteria. The indicators for the third key component will be further refined by the health service at a later date.

**Performance area: Equal opportunity for everyone to access the health services they require**

Key Component	Indicators	Source of Data	Method of Collection
1. Community awareness about what services could be available	<ul style="list-style-type: none"> <li><b>Number of clients accessing service by team</b></li> </ul> <p>The organisational structure is based on teams. Clients include all people who are registered to receive a service from the CHS.</p>	MMSS/CME demographic data	Electronic
	<ul style="list-style-type: none"> <li><b>Number of presentations at community groups</b></li> </ul> <p>Community groups include general community members and other agencies. Other agencies are those that also provide service or referral for clients of the CHS. presentations = providing information about services provided by CHS</p>	Public presentations conducted collected by MMSS	Electronic
	<ul style="list-style-type: none"> <li><b>Type/source/appropriateness of referrals to the service</b></li> </ul> <p>Type = what service they are being referred to Source = where is the referral coming from Appropriateness = does the service provided by CHS match the need of the client</p>	Team Leaders collect data from teams through referral form	Manual

MMSS  
CME

Monthly Management Summary Statement – DHS wide reporting system  
Client Management Engine – data management system for community services (currently being installed)

**Appendix 9**

PERFORMANCE INDICATOR WORKING GROUP  
DATA COLLECTION SHEET

Performance Indicator	What information needs to be collected? Include comments about the way in which the information should be gathered	Data source	Person collecting the information	Outcomes

