

**CLARIFIED COUNTING RULES UNDER THE REVISED PHFA  
JULY 2007**

Following are clarified counting rules under the revised Primary Health Funding Approach (PHFA). These counting rules are definitive and supersede any previous iterations of counting rules, including those that are detailed in SWITCH manuals and the *Community and Women's Health Programs Data Reporting Requirements* document.

However, it is important to note that excepting the cessation of counting travel time towards an hour of service, the counting rules have not changed from the previous PHFA.

Currently, Health Promotion capacity building (eg training and education) and partnership development can be funded from the Health Promotion allocation and can be counted as indirect service time.

Capacity building and partnership development for Direct Care-related activities cannot be counted as direct or indirect service time.

It is important to note that Workforce Development funding can be used for such purposes. For agencies that are funded for both Direct Care and Health Promotion, to redress any undesirable imbalance between Health Promotion and Direct Care capacity building activities due to the different counting rules for each, it would be acceptable for the majority of an agency's Workforce Development funding to be spent on capacity building activities for Direct Care.

It should also be noted that the increased unit prices for Direct Care and the increase in funding for Health Promotion as a result of the redistribution of the former Development and Resourcing funding, is intended to support activities that cannot be counted as direct or indirect service time for either Direct Care or Health Promotion. Such activities could include, but would not be limited to, partnership development, team meetings and non-clinical supervision. Therefore, such activities should not be considered to be 'unfunded'.

SERVICE TYPE	WHAT CAN BE COUNTED
Direct Care – direct service time	<p>The time (in minutes) that has been spent in direct contact with a client or clients during service provision.</p> <p>Includes face-to face, remote video link, email and extended telephone communication with a client or clients for the provision of a health service.</p>
Direct Care - indirect service time	<p>The time (in minutes) that has been spent away from a client or clients in essential activities to provide support to a client or clients.</p> <p>Includes minor contact with a client or clients relating to a future direct contact (eg confirming a future appointment), organising case meetings, preparing case notes, referral, clinical supervision (including individual, group and peer) and preparation for group sessions that are not Health Promotion sessions.</p> <p>In terms of secondary consultation with another service provider, when two service providers discuss a client or an</p>

	<p>organisation, if they are both seeing the client it can be counted as indirect time by both. If only one service provider is seeing the client, then only that provider can count the time as indirect. The time of the other provider cannot be counted.</p> <p>Includes presentations and other contact by a clinician to a target group for potential future direct contact (eg contact by a counsellor on counselling-related social recovery interventions with a community affected by bushfires). It does not include presentations to groups that are not clearly potential clients (eg other clinicians, government officials).</p> <p>Includes the manufacture of products for a client or clients (eg orthotics).</p>
<p>Health Promotion – direct service time</p>	<p>The time (in minutes) that has been spent in direct delivery of a health promotion intervention.</p> <p>Includes face-to face, remote video link, email and extended telephone communication with a person or people who are part of a target group for a health promotion intervention. Also includes time spent with other clinicians where the activity is part of a capacity building intervention.</p> <p>Can include individual contacts with clients (eg health screenings).</p> <p>In the case of an intervention that focuses on a social determinant of health, direct service time for Health Promotion includes face-to face, remote video link and extended telephone communication with a person or persons who are integral to the intervention but not necessarily the target group. For example, for an intervention relating to improved public transport where contact is made with public transport operators, that contact can be counted as direct service time.</p> <p>A minimum of 70% of direct service time for Health Promotion must relate to activities detailed in a health promotion plan. The exact percentage will vary from agency to agency depending on the agency’s percentage for the flexible component. 100% of activities reported as direct service time for Health Promotion must be reported in a health promotion report.</p>

<p>Health Promotion – indirect service time</p>	<p>The time (in minutes) that has been spent away from directly delivering a health promotion intervention in essential activities to support the delivery of a health promotion intervention.</p> <p>Indirect service time for Health Promotion work includes:</p> <ul style="list-style-type: none"> <li>• preparing a health promotion plan including research to inform priority setting and the selection of interventions;</li> <li>• evaluating and reporting on a health promotion plan;</li> <li>• attending stakeholder/partnership meetings specifically relating to a planned health promotion intervention;</li> <li>• attending stakeholder/partnership meetings specifically relating the development of a health promotion plan;</li> <li>• the development or preparation of health promotion material to be used to support a planned health promotion intervention; and</li> <li>• attending capacity building forums (eg training, workshops, meetings) where such attendance has been identified as a capacity building intervention in a health promotion plan (eg organisational capacity building).</li> </ul> <p>A minimum of 70% of direct service time for Health Promotion must relate to activities detailed in a health promotion plan. The exact percentage will vary from agency to agency depending on the agency’s percentage for the flexible component. 100% of activities reported as indirect service time for Health Promotion must be reported in a health promotion report.</p>
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<b>SERVICE TYPE</b>	<b>WHAT CANNOT BE COUNTED</b>
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<p>Activities that cannot be counted and direct or indirect service time for either Direct Care or Health Promotion</p>	<p>Travel time cannot be included as direct or indirect service time for either Direct Care or Health Promotion. Agencies are encouraged to continue to record and report on travel time. This information will be used as part of future considerations of the treatment of travel under the revised PHFA.</p> <p>Time spent at meetings not strictly related to Direct Care or Health Promotion work cannot be counted. For example, attendance at PCP health promotion meetings can be counted as indirect service time for Health Promotion; but attendance at a PCP meeting for service coordination cannot be counted as direct or indirect service time for either Direct Care or Health Promotion.</p> <p>In instances where a student who is supervised by a professional performs a Direct Care consultation, the professional can record the consult but the student time cannot be counted.</p> <p>The following cannot be counted as either direct or indirect service time for Direct Care or Health Promotion:</p> <ul style="list-style-type: none"> <li>• attendance at Executive PCP meetings;</li> <li>• internal or external management meetings;</li> <li>• internal or external allied health clinician meetings;</li> <li>• quality assurance processes;</li> <li>• non-clinical supervision; and</li> <li>• internal or external training for any activity other than health promotion.</li> </ul>
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