



Australian Government

Department of Health and Aged Care



An Australian Government Initiative

PHN Program Performance and Quality Framework

Appendix B – Indicator Specifications

for the **Primary Health Network Program Annual Performance Report 2021-22**

February 2025

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Program indicators

P1: PHN activities address prioritised needs¹

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>Activities being delivered by the PHN address the prioritised needs in the PHN Health Needs Assessment and/or national priorities.</p> <p>Activities are defined as services delivered by a contracted provider, or individual projects that are delivered by the PHN directly. Activities may address one or more identified needs.</p> <p>Prioritised needs are defined as those identified in the PHN Health Needs Assessment and the PHN Activity Work Plan (AWP).</p>
Purpose	<p>This information will provide the Department with a summary of the needs in each PHN region and how they are being addressed. The PHN Health Needs Assessment is a key deliverable under the PHN Program which supports PHNs in understanding and prioritising the health needs of their region.</p> <p>This information could also identify synergies or best practices that can be shared more widely across PHNs and assist in identifying emerging issues.</p>
Outcome Theme: Addressing Needs	<p>Outcome:</p> <p>PHN activities and initiatives address local needs.</p>
Performance Criteria	100% of delivered activities address prioritised needs in PHN Health Needs Assessment and/or national priorities.
Data Source	PHN Health Needs Assessment, AWP and twelve monthly reporting.
Calculation	Department of Health and Aged Care will assess information provided in the Variance Report. The Variance Report comprises a list of individual PHN activities pre-populated from their AWP where PHNs detail expected spend by reporting period against actual spend, identify the related need or priority area and assign a risk rating.
Limitations	This indicator will not provide information in relation to whether the activity being delivered provides value for money.
Additional information	This indicator will also be used to measure organisational capability of PHNs.

¹ The reporting rows where PHNs are required to supply data are coloured orange as a visual cue.

P2: Health system improvement and innovation

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>Description of health system improvements, innovations or commissioning best practice in the PHN region. The examples provided could be based on PHN or commissioned service provider work.</p> <p>Health system improvements are where the PHN has worked within its region to improve health systems or relationships.</p> <p>Innovations are changes which are a significantly new or redesigned product, service, or general improvement to the health system or structures in the PHN region.</p> <p>Commissioning best practices can include where the PHN has used co-design processes, outcomes-based commissioning, engaged with new stakeholders or other approaches for a good outcome.</p>
Purpose	This indicator provides an opportunity for PHNs to provide information on improvements they have made to their local region through commissioning, system integration or introduction of innovation.
Outcome Theme: Addressing Needs	Outcome: PHN activities and initiatives address local needs.
Performance Criteria	At least one example of a health system improvement, innovation or commissioning best practice.
Data Source	PHN supplies a short description of health system improvement, innovation or commissioning best practice.
Calculation	Department of Health and Aged Care will assess the qualitative information provided by the PHN.
Limitations	-
Additional information	It is an expectation that PHNs are innovative organisations.

P3: Rate of general practice accreditation

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by PHN.

Item	Description
Definition	<p>Rate of accredited general practices as a percentage of all general practices in the PHN region.</p> <p>A general practice is a practice or health service which provides general practice services, and is eligible to be accredited under the Australian Commission on Safety and Quality in Health Care's (ACSQHC) National General Practice Accreditation Scheme, including meeting the Royal Australian College of General Practitioners (RACGP) definition of a general practice.</p> <p>Accreditation means that the practice has current full accreditation under the ACSQHC's National General Practice Accreditation Scheme.</p>
Purpose	<p>The ACSQHC's National General Practice Accreditation Scheme provides a measure that the quality and safety of a general practice is satisfactory. Increasing the number of general practices which meet the requirements of this Scheme could improve quality of care, patient experience and health outcomes.</p> <p>Under the ACSQHC's National General Practice Accreditation Scheme, general practices are currently required to meet the requirements of the RACGP Standards for General Practice (Standards). The Standards promote improvements in patient safety and care built on a practice's own information system. (This in turn assists general practices to target quality improvement to their local region and/or population groups).</p>
Outcome Theme: Quality Care	<p>Outcome: PHNs support general practices and other health care providers to provide quality care to patients.</p>
Performance Criteria	<p>This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.</p>
Data Source	<p>PHN – number of general practices which are accredited and number of general practices in the PHN region.</p>
Calculation	<p>Numerator: Number of general practices in the PHN region which are accredited.</p> <p>Denominator: Number of general practices in the PHN region.</p> <p>Computation: $100 \times (\text{numerator} / \text{denominator})$ presented as a percentage in PHN region.</p>
Limitations	<p>Not all general practices will seek accreditation or be eligible to seek accreditation due to a number of reasons, despite support offered by PHNs.</p>
Additional information	<p>The Department will investigate nationally consistent methods of counting both general practices and accredited general practices by PHN region. This will provide more accurate data and reduce PHNs' reporting burden.</p>

P4: Support provided to general practices and other health care providers

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>Support (discrete and/or formal activities) provided to general practices and other health care providers in the PHN region provided either directly by a PHN or by a PHN commissioned service provider. Support may include one on one support, sharing information, facilitating access to or providing training, conducting workshops or disseminating education resources across any of the below focus areas.</p> <p>General practice support – PHNs provide support to general practices in their region.</p> <p>Population health – PHNs support health care providers to improve identification and management of population health issues.</p> <p>Workforce – PHNs provide support to improve health workforce cultural safety and identify and address clinical skill gaps. Health workforce broadly includes all persons working in the health sector within the PHN region.</p> <p>Aged care – PHNs provide support to health care providers on identifying and managing health issues of older people (those 65 years and older), including supporting at-home care.</p> <p>Digital health – PHNs provide support to health care providers to adopt digital health systems and technologies. Digital health systems and technologies describe the use of digital technology to improve the delivery of health care for providers and patients.</p> <p>Support may occur at the following levels:</p> <ul style="list-style-type: none">• high – targeted, tailored support to a general practice, health care provider or individual health care professional to assist in the change of a behaviour or approach (e.g. supporting accreditation or adopting new digital health systems).• moderate – broad based support to a general practice, health care provider or health care professional or several general practices and/or health care providers to raise awareness and knowledge (e.g. information sessions on using My Health Record or cultural safety training).• low – general interactions where information may be shared (e.g. PHN representation at forums or workshops about aged care health issues etc).
Purpose	<p>PHNs support general practices and other health care providers in their region to ensure that health professionals are able to respond appropriately and confidently to the health needs of their region and improve their service delivery.</p> <p>This output indicator can provide a measure of what support PHNs are providing to the local health care providers across several focus areas and can identify areas where additional support may be required.</p>

Item	Description
Outcome Theme: Quality Care	<p>Outcomes:</p> <p>PHNs support general practices and other health care providers to provide quality care to patients.</p> <p>PHNs support health care providers to address factors impacting population health.</p> <p>Local workforce has suitable cultural and clinical skills to address health needs of PHN region.</p> <p>PHNs support health care providers to use digital health systems to improve patient care and communication.</p> <p>Fewer preventable hospitalisations in PHN region for older people.</p>
Performance Criteria	PHN delivers a range of support activities to general practices and other health care providers.
Data Source	<p>Short description of activities undertaken for each focus area above and at each level of support.</p> <p>PHNs may choose not to provide information for focus areas where it is not a priority for the PHN.</p>
Calculation	Department of Health and Aged Care will assess the qualitative information provided by the PHN.
Limitations	Support activities can be limited by the need and willingness of health care providers to participate in activities.
Additional information	<p>Data from this indicator will be used to interpret and provide context to other indicators including:</p> <p>PH1, PH2, W1, W2, DH2, DH3, AC1, FN1, FN2, FN3 and FN4.</p>

P5: Rate of regular uploads to My Health Record

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	<p>Rate of general practices regularly uploading documents to My Health Record (MyHR).</p> <p>Regularly is defined as uploading at least one document each week in a month.</p>
Purpose	This is a measure of use of MyHR. The full implementation of MyHR will enhance co-ordination and continuity of care. PHNs can play a role at a system level to encourage primary health care providers to use MyHR.

Item	Description
Outcome Theme: Quality Care	<p>Outcome:</p> <p>PHNs support general practices and other health care providers to provide quality care to patients.</p> <p>PHNs support health care providers to use digital health systems to improve patient care and communication.</p>
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	Australian Digital Health Agency (ADHA) – general practices regularly uploading documents; number of general practices that are registered MyHR providers.
Calculation	<p>Numerator:</p> <p>Number of general practices which regularly uploaded documents to MyHR.</p> <p>Denominator:</p> <p>Number of general practices that were registered MyHR providers in the PHN region at the end of financial year.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$ presented as a percentage in PHN region.</p>
Limitations	-
Additional information	-

P6: Rate of general practices receiving payment for after-hours services

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	<p>Rate of general practices receiving a Practice Incentives Program (PIP) level 1-5 payment for after-hours services.</p> <p>For the PIP, the complete after-hours period is outside 8 am to 6 pm weekdays, outside 8 am to 12 noon on Saturdays, and all day on Sundays and public holidays.</p>
Purpose	<p>The PIP aims to improve access to care, detection and management of chronic conditions, and quality, safety, performance and accountability where PHNs can play an important role. Practices must register for the PIP in order to receive payment.</p> <p>The PIP After-Hours incentive aims to ensure that patients have access to care throughout after hour periods. The rate of general practices receiving a PIP level 1-5 payments for after-hours services reflect the services provided by general practice during after-hours.</p>

Item	Description
Outcome Theme: Improving Access	<p>Outcome:</p> <p>People in the PHN region are able to access general practice and other services as appropriate.</p> <p>PHNs support general practices and other health care providers to provide appropriate after-hours access.</p>
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	<p>Department of Health and Aged Care - number of general practices receiving a PIP After-Hours incentive payment.</p> <p>PHN - number of general practices.</p>
Calculation	<p>Numerator:</p> <p>Number of general practices receiving an after-hours incentive payment for each level in each PHN region.</p> <p>Denominator:</p> <p>Number of general practices in each PHN at each financial year.</p> <p>Computation:</p> <p>100 x (numerator / denominator) presented as a percentage in PHN region.</p>
Limitations	PHNs may have limited ability to affect this rate.
Additional information	Services Australia administers the PIP on behalf of the Department of Health and Aged Care.

P7: Use of emergency departments for lower urgency care

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	<p>Rate of lower urgency presentations to emergency departments (ED) within the PHN region during normal and after-hours periods.</p> <p>These are presentations at formal public hospital EDs where the patient:</p> <ul style="list-style-type: none"> • had an Emergency presentation type of visit • had a Triage category of 4 (semi-urgent) or 5 (non-urgent) • did not arrive by ambulance, or police or correctional vehicle • was not admitted to the hospital, not referred to another hospital, and did not die. <p>(See https://meteor.aihw.gov.au/content/740847 for more information.)</p> <p>After-hours is defined as: on a public holiday; on a Sunday; before 8am, or after 12:59pm on a Saturday; and before 8am, or after 7:59pm on any day other than a Saturday, Sunday or public holiday.</p>

Item	Description
Purpose	<p>Measures the use of ED for lower urgency care, which may be impacted by lack of general practice access. PHNs have a responsibility for improving access to general practice, potentially decreasing demand on ED services.</p> <p>As AIHW state in their technical notes on lower urgency ED presentations, care should be taken when using this data to identify 'avoidable GP type' or 'GP style' presentations because it is based on urgency (triage) categories which may not reflect the various factors that influence the use of EDs such as the complexity of a presentation, the patient's choice or condition, the most appropriate model of care for such presentations, or the accessibility and availability of primary and community health services.</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>People in the PHN region are able to access general practice and other services as appropriate.</p> <p>PHNs support general practices and other health care providers to provide appropriate after-hours access.</p>
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	Australian Institute of Health and Welfare (AIHW).
Calculation	<p>Numerator:</p> <p>Total number of lower urgency ED presentations.</p> <p>Denominator:</p> <p>Total persons in PHN region.</p> <p>Computation:</p> <p>$1000 \times (\text{numerator} / \text{denominator})$ presented as a rate per 1,000 population in the PHN region.</p> <p>Disaggregation:</p> <p>Normal and after-hours, people aged 0-64 and 65+. The age-standardised rate is used for AIHW-supplied PHN groups of national, metropolitan, and regional only; all other comparisons must use the crude rate.</p>
Limitations	PHNs may have limited ability to affect this rate.
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including P6.

P8: Measure of patient experience of access to GP

This indicator has been retired from the Framework effective 1 September 2024.

The ABS Patient Experience Survey data was found to be insufficiently granular to use at the PHN level.

P9: Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	<p>The number of non-hospital Medicare-subsidised services for GP Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences in the PHN region.</p> <p>GP Health Assessments include MBS Group A14; Subgroups A7.5, A40.11, A40.12; Items 93470, 93479.</p> <p>GP Chronic Disease Management Plans include MBS Subgroups A15.1, A40.13, A40.14; Items 229, 230, 231, 232, 233, 93469, 93475.</p> <p>GP Multidisciplinary Case Conferences include MBS Items 235, 236, 237, 238, 239, 240, 243, 244, 735, 739, 743, 747, 750, 758.</p>
Purpose	<p>A Chronic Disease Management Plan (CDMP) offers patients with chronic conditions access to services that improve continuity and coordination of care between health care providers. There are several different types of CDMP available to health practitioners through the MBS. This indicator specifically reports the following services:</p> <ul style="list-style-type: none"> • GP Health Assessments • GP Chronic Disease Management Plans (which include Team Care Arrangements), and • GP Multidisciplinary Case Conferences. <p>While PHNs would not commission the team care arrangements, PHNs have capacity to influence GPs to consider the use of these services and improve linkages and communication to facilitate their use.</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>People in the PHN region receive coordinated, culturally safe services from local health care providers.</p>
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	AIHW - Medicare-subsidised GP, allied health and specialist health care across local areas.
Calculation	Sum of MBS services for GP Health Assessments, GP Chronic Disease Management Plans, and GP Multidisciplinary Case Conferences.
Limitations	This data does not provide information on the number of unique patients who received one or more of these services. As such, it is not feasible to calculate this indicator as a rate of patients per population.
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including P12.

P10: Cross views of My Health Record

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	Cross views of My Health Record (MyHR) by health professionals from organisations with different Healthcare Provider Identifier – Organisation (HPI-O). A cross view is when health providers from different organisations view the same MyHR for a patient.
Purpose	Cross views of MyHR by different HPI-Os suggests that health providers are working together to deliver coordinated care to a patient. As MyHR use increases, supported and encouraged by PHNs, it would be expected that cross views will also increase.
Outcome Theme: Coordinated Care	Outcome: People in the PHN region receive coordinated, culturally safe services from local health care providers.
Outcome Theme: Quality Care	Outcome: PHNs support health care providers to use digital health systems to improve patient care and communication.
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	ADHA – number of cross-views in general practices and pharmacies; number of general practices and pharmacies that are registered MyHR providers.
Calculation	Numerator: Number of cross-views in general practices/pharmacies. Denominator: Number of general practices/pharmacies that were registered MyHR providers in the PHN region at the end of financial year. Computation: Numerator / denominator, presented as a rate of cross-views per general practice/pharmacy in PHN region. Disaggregation: General practices and pharmacies.
Limitations	Data not available prior to My Health Record Expansion Program (MHREP) implementation (1 August 2018). Health providers within the same health care provider organisation who share a patient will not have their views of MyHR recorded.

Item	Description
Additional information	Data from this indicator will be used to interpret and provide context to other indicators.

P11: Rate of discharge summaries uploaded to My Health Record

This indicator has been retired from the Framework effective 1 September 2024.

There are linkage issues between the data sources for this indicator that could not be resolved.

P12: Rate of potentially preventable hospitalisations

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	<p>Rate of potentially preventable hospitalisations (PPH) in PHN region by all conditions, vaccine-preventable conditions, acute conditions, and chronic conditions.</p> <p>PPH are defined in accordance with the National Healthcare Agreement (NHA) indicator PI 18 - Selected potentially preventable hospitalisations. (See https://meteor.aihw.gov.au/content/740851 for more information.)</p> <p>Acute PPH: cellulitis; convulsions and epilepsy; dental conditions; ear, nose and throat infections; eclampsia; gangrene; pelvic inflammatory disease; perforated/bleeding ulcer; pneumonia (not vaccine-preventable); urinary tract infections, including pyelonephritis.</p> <p>Chronic PPH: angina; asthma; bronchiectasis; congestive cardiac failure; chronic obstructive pulmonary disease; diabetes complications; hypertension; iron deficiency anaemia; nutritional deficiencies; rheumatic heart disease.</p> <p>Vaccine preventable PPH: other vaccine-preventable conditions; pneumonia and influenza (vaccine-preventable).</p>
Purpose	PPH are admissions to hospital that may have been avoided by timely and effective health care, usually delivered in primary care and community-based care setting. Rate of PPH can indicate improvements in the effectiveness of prevention programs and/or accessibility and more effective management of selected conditions in the primary and community-based health care sector.
Outcome Theme: Longer Term	<p>Outcome:</p> <p>Patients in local region receive the right care in the right place at the right time.</p>
Outcome Theme: Addressing Needs	<p>Outcome:</p> <p>Fewer preventable hospitalisations in PHN region for people with chronic and vaccine preventable diseases.</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Fewer preventable hospitalisations in PHN region for older people.</p>

Item	Description
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	Australian Institute of Health and Welfare (AIHW).
Calculation	<p>Numerator:</p> <p>Number of potentially preventable hospitalisations.</p> <p>Denominator:</p> <p>Resident population of PHN region.</p> <p>Computation:</p> <p>100,000 x (numerator / denominator) presented as a rate per 100,000 population in PHN region.</p> <p>Disaggregation:</p> <p>People aged 0-64 and 65+, vaccine preventable, acute conditions and chronic conditions. The age-standardised rate is used for AIHW-supplied PHN groups of national, metropolitan, and regional only; all other comparisons must use the crude rate.</p>
Limitations	<p>It may be difficult to readily measure changes in rates for categories of PPH, especially acute events that can be attributed to the effect of PHNs. PPHs are only one measure of potentially avoidable hospitalisations and exclude hospitalisations for injury and poisoning that may also be considered potentially avoidable.</p> <p>PPHs exclude episodes of non-admitted patient care provided in outpatient clinics or emergency departments. Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.</p> <p>Reporting age-standardised rates at regional levels below state/territory depends on the availability of ABS population estimates, including age breakdowns, for the same geographical regions or for other regions that can be aggregated to align with the region of interest and PHN.</p> <p>The data quality and/or definition of categories used to refine PPH reporting (for example SEIFA, First Nations status) can vary over time and therefore could cause PHN performance levels between different time periods to not be directly comparable.</p> <p>Changes in ICD-10-AM coding standards may affect the interpretation of PPH trends over time. This has been evident in previously published PPH statistics and has led to the refinement of PPH definitions to account for changes such as excluding counts for additional diagnoses of Diabetes mellitus in the definition of the PPH 'diabetes' category. After refinement, it is likely historical PPH performance would need to be backdated to maintain consistent definitions over time and to remove the presence of coding change affects.</p>
Additional information	-

P13: Numbers of health professionals available

Item	Description
Assessment	PHN Program
Reporting	<p>Twelve monthly by PHN.</p> <p>Twelve monthly by Department from healthdirect and National Health Workforce Data Set (NHWDS).</p>
Definition	<p>Numbers of primary health care professionals (GPs and selected allied health professionals) available within the PHN region.</p> <p>These include:</p> <ul style="list-style-type: none"> • Number of general practices in region • Number of GPs • Number of GP full time equivalents • Number of GP services • Number of nurses working in general practice • Number of occupational therapists • Number of optometrists • Number of pharmacists • Number of physiotherapists • Number of podiatrists, and • Number of psychologists. <p>A general practice is defined by the Royal Australian College of General Practitioners as an entity which 'provides person centred, continuing, comprehensive and coordinated wholeperson health care to individuals and families in their communities.' Therefore, practices which do not provide 'wholeperson' or mainstream health services should be excluded from the count. This would include skin clinics and travel doctors etc.</p>
Purpose	<p>This indicator is required to provide data for other indicators.</p> <p>Numbers of primary health care professionals is core information in assessing the capacity of a region to meet its primary health care needs, with improving trends over time providing indications of success in meeting potential service gaps.</p> <p>Findings will be used for individual performance assessments and to calculate other indicators, but will not be published separately in the PHN Program Annual Performance Report.</p>
Outcome Theme: Longer Term	<p>Outcome:</p> <p>Patients in local region receive the right care in the right place at the right time.</p>
Performance Criteria	<p>This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.</p>

Item	Description
Data Source	<p>PHNs provide the number of general practices, GPs and nurses.</p> <p>The Department provides number of occupational therapists, optometrists, pharmacists, physiotherapists, podiatrists, and psychologists from NHWDS.</p> <p>The Department also provides supplementary data from healthdirect.</p>
Calculation	Number of primary health care professionals in the PHN per 100,000 population.
Limitations	-
Additional information	<p>Data from this indicator will be used to interpret and provide context to other indicators including:</p> <p>P3, P5, P6, DH2 and DH3.</p>

Mental Health indicators

MH1: Rate of regional population receiving PHN commissioned low intensity psychological interventions

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs.
Definition	<p>Percentage of the regional population who received one or more low intensity episodes of care provided by an organisation or an individual service provider commissioned by the PHN.</p> <p>Low intensity services include cognitive behavioural therapy and other evidence-based interventions that may be delivered by health professionals or non-mental health workers who have received specific training and work in a supervised arrangement with a qualified mental health professional. These services should be easy to access, high quality services that people can access directly, with or without needing a referral, and are generally provided at a lower cost than more traditional forms of mental health treatment.</p> <p>Services can be provided individually or in groups either face-to-face, by telephone or online.</p> <p>Particular groups in the region may be targeted for low intensity services.</p>
Purpose	A driving factor underpinning the development of low intensity mental health services is to increase overall community access to evidence based psychological interventions for people with, or at risk of, mild mental illness who do not require traditional services. Increasing access to low intensity services is fundamental to building a stepped care model of mental health service delivery.
Outcome Theme: Improving Access	<p>Outcome:</p> <p>People in PHN region access mental health services appropriate to their individual needs.</p>
Performance Criteria	At least 5% growth in number of people accessing low intensity episodes compared with previous year, or where service capacity has been reached, a maintenance of the previous year's rate.
Data Source	<p>MH Schedule reporting – Indicator Acc-1.</p> <p>Constructed from PMHC MDS (numerator) and ABS Estimated Resident Population (denominator).</p>

Item	Description
Calculation	<p>Numerator:</p> <p>Number of people who received one or more episodes of care classified as low intensity from a PHN commissioned organisation or individual service provider.</p> <p>Denominator:</p> <p>Total population residing in the region in the reporting period.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$.</p> <p>*May be presented as a rate per targeted age cohort in PHN region.</p>
Limitations	<p>Unique counting of persons and episodes is at the Provider Organisation level, not region. It is possible therefore that a person receiving an episode of care by more than one organisation within the region, or from another PHN region, will be counted more than once.</p> <p>PHNs may fund services for individuals who live in other regions. The indicator specification does not adjust for this.</p> <p>This indicator looks only at service provision funded by the PHN and does not take account of the role of other primary care funding streams in overall service delivery to the regional population. The role of mental health treatment accessed through the MBS is the most significant, and to a lesser extent, service delivery by specialist mental health services funded by state and territory governments.</p>
Additional information	See PMHC-MDS Data Specification .

MH2: Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs.
Definition	<p>Percentage of the regional population who received one or more psychological therapy episodes of care provided by an organisation or an individual service provider commissioned by the PHN.</p> <p>Psychological therapies are delivered by qualified mental health professionals. Referral from a GP, psychiatrist or paediatrician is usually required, but service provision may commence with a provisional referral. These may have been provided face-to-face (either individually or in a group), by telephone or online on the proviso that this was a personalised service.</p>

Item	Description
Purpose	<p>Flexible funding has been provided to allow PHNs to reduce service gaps and inequities across the region by commissioning mental health services targeting selected underserved populations. These services are to be provided both where there are limited or not easily accessible Medicare Benefits Schedule subsidised psychological services or to particular subpopulations that are not accessing available services to the same extent as the general population.</p> <p>These services are primarily focussed on people with mild and moderate mental illness, who are not clinically suited to lower intensity services, and also people with severe mental illness who may benefit from psychological therapy as part of their care.</p> <p>Groups that may be targeted include traditionally hard-to-reach subpopulations, such as people experiencing or at risk of homelessness, people living in more remote communities, First Nations people, Culturally and Linguistically Diverse (CALD) people, those who have experienced trauma or abuse, and women experiencing perinatal depression. Determination of target groups will depend upon local needs and prioritisation of activity within regions.</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>People in PHN region access mental health services appropriate to their individual needs.</p>
Performance Criteria	At least 5% growth in number of people accessing psychological therapy episodes compared with previous year, or where service capacity has been reached, a maintenance of the previous year's rate.
Data Source	<p>MH Schedule reporting – Indicator Acc-2.</p> <p>Constructed from PMHC MDS (numerator) and ABS Estimated Resident Population (denominator).</p>
Calculation	<p>Numerator:</p> <p>Number of people who received one or more episodes of care classified as psychological therapy from a PHN commissioned organisation or individual service provider.</p> <p>Denominator:</p> <p>Total population residing in the region in the reporting period.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$.</p>

Item	Description
Limitations	<p>Unique counting of persons and episodes is at the Provider Organisation level, not region. It is possible therefore that a person receiving an episode of care by more than one organisation within the region, or from another PHN region, will be counted more than once.</p> <p>PHNs may fund services for individuals who live in other regions. The indicator specification does not adjust for this.</p> <p>This indicator looks only at service provision funded by the PHN and does not take account of the role of other primary care funding streams in overall service delivery to the regional population. The role of mental health treatment accessed through the MBS is the most significant, and to a lesser extent, service delivery by specialist mental health services funded by state and territory governments.</p>
Additional information	See PMHC-MDS Data Specification .

MH3: Rate of regional population receiving PHN commissioned clinical care coordination services for people with severe and complex mental illness

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs.
Definition	<p>Percentage of the regional population who received one or more clinical care coordination episodes of care provided by an organisation or an individual service provider commissioned by the PHN.</p> <p>Services provided may include direct client contact, either face-to-face or by telephone, and also contact with families and carers, other service providers and agencies on the consumer's behalf.</p>
Purpose	<p>PHNs are required to commission clinical mental health services to meet the needs of people with severe mental illness, whose care can be appropriately managed in a primary care setting. This will include making optimal use of the available and new mental health nursing services funding to support clinical coordination.</p> <p>Fragmentation of care is particularly problematic for people with severe and complex mental illness who require services from multiple agencies.</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers in PHN region have an integrated approach to mental health care and suicide prevention.</p>
Performance Criteria	At least 5% growth in number of people accessing care coordination episodes compared with previous year, or where service capacity has been reached, a maintenance of the previous year's rate.

Item	Description
Data Source	MH Schedule reporting – Indicator Acc-3. Constructed from PMHC MDS (numerator) and ABS Estimated Resident Population (denominator).
Calculation	Numerator: Number of people who received one or more episodes of care classified as clinical care coordination from a PHN commissioned organisation or individual service provider. Denominator: Total population residing in the region in the reporting period. Computation: $100 \times (\text{numerator} / \text{denominator})$.
Limitations	Estimates of the number of people in the region with severe and complex mental illness and those that could be managed in a primary care setting are required to better gauge access to these services. Numbers using care coordination services will, however, provide an indication of activity and changes over time. Unique counting of persons and episodes is at the Provider Organisation level, not region. It is possible therefore that a person receiving an episode of care by more than one organisation within the region, or from another PHN region, will be counted more than once. PHNs may fund services for individuals who live in other regions. The indicator specification does not adjust for this. This indicator looks only at service provision funded by the PHN and does not take account of the role of other primary care funding streams in overall service delivery to the regional population. The role of mental health treatment accessed through the MBS is the most significant, and to a lesser extent, service delivery by specialist mental health services funded by state and territory governments.
Additional information	See PMHC-MDS Data Specification .

MH4: Formalised partnerships with other regional service providers to support integrated regional planning and service delivery

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department.
Definition	Agreements (both formal and informal) with other regional entities that support integrated regional planning and service delivery, including delineation of the role of services, referral pathways and other processes related to the access to PHN commissioned services and the transition of consumers according to their needs between different levels of care and service types.

Item	Description
Purpose	<p>PHNs are undertaking a broader role in the provision of mental health and suicide prevention service delivery by assessing regional needs and planning services, as well as commissioning services in identified regions of need. Services commissioned by PHNs must fit within a complex framework of current mental health, suicide prevention and related services, supplementing services provided by a broad variety of other service providers including those delivered by states and territories.</p> <p>Coordinated service delivery by multiple agencies is also essential to identify needs and gaps and reduce duplication and inefficiencies.</p> <p>PHNs are required under the Primary Mental Health Care (PMHC) Schedule and National Mental Health and Suicide Prevention Agreement and Bilateral PHN Program Schedule to develop a comprehensive and evidence based Joint Regional Mental Health and Suicide Prevention Plan. New or updated joint regional plans will build on, and strengthen, the work already undertaken by PHNs under the PMHC Schedule and the Fifth National Mental Health and Suicide Prevention Plan. It is intended that the joint regional plans will be iterative documents, to be reviewed at intervals and updated as needed.</p> <p>When reporting, PHNs are to provide detail on the work undertaken to develop, implement and review either the foundational regional plan or a new regional plan including: collaboration with stakeholders including the relevant state or territory local hospital networks (LHNs) or equivalent; governance arrangements; monitoring or evaluation activities; and implementation of initiatives under the Bilateral Agreement.</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers in PHN region have an integrated approach to mental health care and suicide prevention.</p>
Performance Criteria	Comprehensive regional mental health and suicide prevention plans to be jointly developed with local hospital networks (LHN).
Data Source	MH Schedule reporting – Indicator Regional Integration.
Calculation	Department of Health and Aged Care will assess the qualitative information provided by the PHN.
Limitations	-
Additional information	Comprehensive and evidence based Joint Regional Mental Health and Suicide Prevention Plan to be jointly developed with LHNs or equivalent and other stakeholders. Unless agreed as otherwise by the Commonwealth, new or updated joint regional plans are to be developed within the timeframes listed in the National Agreement Bilateral Schedules.

MH5: Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral

Item	Description
Assessment	Individual PHN

Item	Description
Reporting	Twelve monthly by Department from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs.
Definition	Proportion of people referred to PHN commissioned services where suicide risk was identified at referral and were followed up within 7 days of referral.
Purpose	<p>PHNs are to take a lead role in planning and commissioning community-based suicide prevention activities.</p> <p>There is a particular imperative to improve follow-up for people in the high risk period following a suicide attempt. Individuals are known to be particularly vulnerable in the period between leaving hospital and transitioning to community mental health care.</p> <p>Planning should be undertaken in partnership with local hospital networks (LHN) and other local organisations to ensure there are no gaps in services and that referral pathways are clearly defined.</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers in PHN region have an integrated approach to mental health care and suicide prevention.</p>
Performance Criteria	100% of people referred to PHN commissioned services followed up within 7 days of referral.
Data Source	<p>MH Schedule reporting – Indicator App-3.</p> <p>Constructed from PMHC MDS.</p>
Calculation	<p>Numerator:</p> <p>Number of episodes that commenced in the reporting period where the Suicide Referral Flag was recorded as 'Yes' and where the first Service Contact was recorded as occurring within 7 days or less of the Referral Date.</p> <p>Denominator:</p> <p>Number of episodes that commenced in the reporting period where the Suicide Referral Flag was recorded as 'Yes'.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$.</p>
Limitations	<p>This indicator represents a proxy of the underlying concept of prompt response and follow up for people at risk of suicide or who have made a recent attempt.</p> <p>Estimates of the number of people attempting suicide in the region and those presenting for treatment of injuries as a result of an attempt are required to better gauge the effectiveness of and access to services.</p> <p>Referral arrangements and information exchange with other regional service providers are also required to ascertain the effectiveness of services in following up all referrals. In the interim the numbers of people receiving appropriate follow up provide an indication of net activity and allows for tracking changes over time.</p>
Additional information	See PMHC-MDS Data Specification .

MH6: Outcomes Readiness - Completion rates for clinical outcome measures

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs.
Definition	The proportion of mental health care episodes delivered by PHN commissioned organisations or individual service providers with valid clinical outcome measures at both baseline and follow-up.
Purpose	<p>A key objective of funding PHNs is to commission mental health services to improve outcomes for those receiving mental health and suicide prevention services in primary care.</p> <p>Standardised outcome measures, collected at the first and last occasions of service at a minimum, provide the means for assessing effectiveness of services and are included in the PMHC MDS as mandatory requirements.</p> <p>The purpose of indicator MH6 is to monitor the implementation progress of outcome measurement within regions. Completion rates will point to whether the coverage of outcome measurement is sufficient to enable meaningful and valid indicators to be constructed from the outcomes data.</p>
Outcome Theme: Quality Care	Outcome: PHN commissioned mental health services improve outcomes for patients.
Performance Criteria	70% of completed episodes of care have recorded valid outcome measures at Episode Start and Episode End.
Data Source	MH Schedule reporting – Indicator Out-3. Constructed from PMHC MDS.
Calculation	<p>Numerator:</p> <p>Number of completed episodes of mental health care which have valid outcome measures recorded for Episode Start and Episode End within the reference period.</p> <p>Denominator:</p> <p>Number of completed episodes of mental health care delivered by PHN commissioned organisations or individual service providers within the reference period.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$</p> <p>Coverage/Scope is all completed episodes of care in the reporting period that have a 'matched pair' of valid outcome measures collected at Episode Start and Episode End.</p>

Item	Description
Limitations	<p>Clinical outcomes do not necessarily reflect the client experience of service delivery.</p> <p>Development of a consumer experience of services measure suitable for the primary mental health care sector, based on the Your Experience of Service instrument, is ongoing work for future implementation.</p>
Additional information	<p>For purposes of this indicator, a valid clinical outcome measure is defined as one where the number of items completed meets minimal threshold requirements. Translated to individual rating scales this means:</p> <ul style="list-style-type: none"> • For the K10, a minimum of 9 of the 10 items • For the K5, a minimum of 5 items (nil missing data) • For the SDQ, a minimum of 3 items for each of the 5 subscales. <p>See PMHC-MDS Data Specification.</p>

First Nations Health indicators

FN1: Numbers of Integrated Team Care services delivered by PHN

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>Integrated Team Care (ITC) services comprise of care coordination services, supplementary services, clinical services and other services.</p> <p>Care coordination services relate to each occasion of care provided to an ITC client.</p> <p>Supplementary services relate to support to access approved medical aids or specialist and/or allied health service appointments.</p> <p>Clinical services are appointments organised for an ITC patient.</p> <p>‘Other’ can be any other services delivered which are within the ITC Guidelines.</p>
Purpose	This indicator counts the number of services the PHN is delivering under ITC. It will assist in understanding how PHNs deliver ITC services to First Nations people.
Outcome Theme: Addressing Needs	<p>Outcome:</p> <p>PHNs address needs of First Nations people in their region.</p>
Performance Criteria	Services are being delivered across the range of services allowed within ITC Guidelines.
Data Source	<p>PHN – number and type of organisations engaged with.</p> <p>ABS – estimated resident First Nations population of the PHN region, for use in the PHN Program Annual Report only.</p>

Item	Description
Calculation	<p>Care coordination services delivered.</p> <p>Supplementary services delivered.</p> <p>Clinical services delivered.</p> <p>Other services.</p> <p>Total services.</p> <p>The Department will assess the qualitative information provided by the PHN.</p> <p>For use in the PHN Program Annual Report only:</p> <p>Numerator:</p> <p>Count of services delivered of each type.</p> <p>Denominator:</p> <p>Resident First Nations population of the PHN region.</p> <p>Computation:</p> <p>$1000 \times (\text{numerator} / \text{denominator})$ presented as a rate per 1,000 First Nations population in PHN region.</p> <p>Disaggregation:</p> <p>Care coordination services, supplementary services, clinical services, and other services.</p>
Limitations	-
Additional information	-

FN2: Types of organisations delivering ITC services

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>ITC program funds are used to deliver services across a range of organisations, including Aboriginal Medical Services (AMS), mainstream organisations and sometimes from the PHN, noting PHNs may engage Aboriginal and Torres Strait Islander Health Project Officers (ATSIHPOs) to undertake ITC activities.</p> <p>AMS means a health service funded principally to provide services to First Nations people. Aboriginal Community Controlled Health Service (ACCHS) refers to primary care services initiated and operated by the local First Nations community to deliver holistic, comprehensive, and culturally safe health care. This care targets and addresses the needs of the community, which control it through a locally elected Board of Management. Mainstream organisations are any primary health care provider that serves the whole population and is not an ACCHS or AMS.</p> <p>PHN – the PHN may retain some funding for ATSIHPO workforce activities.</p>

Item	Description
Purpose	This indicator counts the number and type of organisations that the PHN is engaging with in the delivery of ITC services. It will assist in understanding how the services are being delivered across the PHN region.
Outcome Theme: Addressing Needs	Outcome: PHNs address needs of First Nations people in their region.
Performance Criteria	A range of organisations are engaging in ITC programs.
Data Source	PHN – number and type of organisations engaged with.
Calculation	Number of AMS. Number of mainstream organisations. PHN activities. The Department will assess the information provided by the PHN.
Limitations	-
Additional information	-

FN3: Evidence that all drug and alcohol commissioned services are culturally safe for First Nations people

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department.
Definition	Evidence that all drug and alcohol commissioned services are culturally safe for First Nations people.
Purpose	PHNs aim to provide tailored and culturally safe treatment for First Nations people. PHNs will report on how mainstream and First Nations services have been delivered in recognition of the six domains and focus areas of the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-26.
Outcome Theme: Quality Care	Outcome: Local health care providers provide culturally safe services to First Nations people. Local workforce has suitable cultural and clinical skills to address health needs of PHN region.
Performance Criteria	PHN supplies evidence that commissioned drug and alcohol services are culturally safe.

Item	Description
Data Source	Drug and Therapeutic Information Service – Indicator 4.2.
Calculation	Department of Health and Aged Care will assess the qualitative information provided by the PHN.
Limitations	-
Additional information	-

FN4: Proportion of PHN commissioned mental health services delivered to the regional First Nations population that were culturally safe

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department from Primary Mental Health Care (PMHC) Minimum Data Set (MDS) Standard Reports accessed by PHNs.
Definition	<p>Proportion of PHN commissioned mental health services delivered to First Nations clients where the service was provided by service providers that can demonstrate the delivery of culturally safe services as evidenced by:</p> <ul style="list-style-type: none"> • behaviours, attitudes, policies, practices and physical structures that are respectful and tailored to First Nations people; and/or • the inclusion of First Nations staff; and/or • delivery by providers appropriately skilled in the delivery of culturally safe services.
Purpose	<p>PHNs are funded to increase access to integrated, culturally safe mental health services for First Nations peoples. This funding supplements that provided to PHNs for services in other key areas.</p> <p>Culturally safe and competent care is a key strategy for improving access to mental health services and also mental health outcomes for First Nations peoples. Services can be provided through Aboriginal Community Controlled Health Services (ACCHSs) or mainstream services.</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Local health care providers provide culturally appropriate services to First Nations people.</p> <p>Local workforce has suitable cultural and clinical skills to address health needs of PHN region.</p>
Performance Criteria	At least 5% growth on proportion of previous year, or maintenance of the level where all services were culturally safe.
Data Source	<p>MH Schedule reporting – Indicator App-2.</p> <p>Constructed from PMHC MDS.</p>

Item	Description
Calculation	<p>Numerator:</p> <p>Number of PHN commissioned mental health service contacts provided to First Nations people where the service provider is either:</p> <ul style="list-style-type: none"> recorded as of Aboriginal and/or Torres Strait Islander origin; or employed by an Aboriginal Community Controlled Health Service; or has indicated they have completed a recognised training programme in the delivery of culturally safe services to First Nations peoples. <p>Denominator:</p> <ul style="list-style-type: none"> Total number of PHN commissioned mental health service contacts provided to First Nations clients. Computation: 100 x (numerator / denominator), presented as a percentage in PHN region.
Limitations	<p>Accuracy of this indicator is dependent on the integrity of data reported by service providers on their First Nations status and First Nations Cultural Training.</p> <p>Further work is required on approaches to identifying the delivery of culturally safe services to First Nations people from routine datasets.</p>
Additional information	See PMHC-MDS Data Specification .

FN5: ITC improves the cultural safety of mainstream primary health care services

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>ITC commissioned services work to improve the cultural safety of mainstream primary health care services through a variety of activities, including but not limited to:</p> <ul style="list-style-type: none"> delivering or organising cultural awareness training for staff encouraging uptake of relevant MBS items, and helping practices create a more welcoming environment for First Nations people. <p>Mainstream primary care means any primary health care service provider that is not an Aboriginal Medical Service (AMS) or an Aboriginal Community Controlled Health Service (ACCHS).</p>
Purpose	This indicator provides an opportunity for PHNs to describe the work undertaken as part of ITC to improve the cultural safety of mainstream primary care services.

Item	Description
Outcome Theme: Quality Care	Outcome: Local health care providers provide culturally safe services to First Nations people. Local workforce has suitable cultural and clinical skills to address health needs of PHN region.
Performance Criteria	PHN provides evidence that as part of ITC it is working to improve cultural safety of mainstream primary health care services.
Data Source	Short description of activities undertaken to improve cultural safety of mainstream primary health care services.
Calculation	Department of Health and Aged Care will assess the qualitative information provided by the PHN.
Limitations	-
Additional information	-

FN6: PHN provides support for First Nations health workforce

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	PHN provides formal/informal support to improve the capability, capacity and proportion of First Nations identified health workforce. Support may include general activities or a workforce strategy/plan which outlines the planned approach by the PHN to improve the First Nations identified health workforce. It may be part of a broader workforce strategy/plan for the PHN or separate.
Purpose	Improving the capacity, capability and proportion of First Nations identified health workforce should result in an improvement in the quality of services offered to First Nations people and also improve the accessibility and cultural safety of services for First Nations people.
Outcome Theme: Quality Care	Outcome: First Nations identified health workforce capability and capacity matches needs of regions.
Performance Criteria	PHN supplies evidence of support provided to First Nations identified workforce in its region.
Data Source	PHN supplies short description of formal/informal support activities provided to First Nations identified health workforce and/or provision of a workforce strategy/plan addressing capability, capacity and proportion of First Nations identified health workforce.

Item	Description
Calculation	Department of Health and Aged Care will assess the qualitative information provided by the PHN.
Limitations	This indicator does not consider the impact the support or workforce strategy/plan has on improving the capability, capacity and proportion of First Nations identified health workforce.
Additional information	This indicator will be adjusted over time to measure effectiveness of the support and/or workforce strategy/plan.

FN7: ITC processes support First Nations people enrolled in the program to access coordinated care

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>ITC processes include:</p> <ul style="list-style-type: none"> • Referral – the processes to identify possible patients of the ITC program • Intake – the processes to accept and assess the patients of the ITC program, and • Discharge – the processes by which patients leave the care of the ITC program.
Purpose	This indicator provides information on the referral, intake and discharge processes which are supporting First Nations people receiving care under the ITC program.
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>First Nations people with chronic conditions enrolled on the ITC program receive coordinated care.</p>
Performance Criteria	PHN provides evidence of its ITC processes.
Data Source	Short description of referral, intake and discharge processes of ITC program.
Calculation	Department of Health and Aged Care will assess the qualitative information provided by the PHN.
Limitations	-
Additional information	-

FN8: Rate of population receiving specific health assessments

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	Proportion of First Nations population receiving health checks (MBS items 715, 228, 92004, 92011, 92016, and 92023) for children aged 0-14; adults aged 15-54; adults aged 55 years and over.
Purpose	<p>This indicator shows the degree to which First Nations people are accessing a range of primary health care services designed to both identify and prevent health care problems, and to plan and manage treatment in a multidisciplinary manner.</p> <p>PHNs will have a role to inform practices and patients of the value of these services and encourage their use.</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>First Nations people are able to access primary health care services as required.</p>
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	AIHW – proportion of First Nations population receiving health assessments.
Calculation	<p>Data retrieved from the data source is already calculated to show an uptake percentage in the PHN region. For reference the calculation is provided below.</p> <p>Numerator:</p> <p>Number of patients who received a health check in the year.</p> <p>Denominator:</p> <p>First Nations population at the end of the year.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$ presented as an uptake percentage in PHN region.</p> <p>Disaggregation:</p> <p>Children aged 0-14; adults aged 15-54; adults aged 55 years and over.</p>
Limitations	This indicator does not reflect the quality of assessment or effectiveness of ongoing care.
Additional information	-

Population Health indicators

PH1: Rate of children fully immunised at 5 years

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	<p>Childhood immunisation coverage is an indicator of the Australian Governments' objective to achieve high immunisation coverage for children to prevent selected vaccine preventable diseases. Childhood immunisation rates are a well-established performance indicator and reported in national health care agreements and frameworks.</p> <p>Childhood immunisation is defined as the number of children who are fully immunised in the Australian Immunisation Register (AIR) at 5 years.</p> <p>'Fully immunised' at 5 years (60 to <63 months) of age is defined as a child having a record on the AIR of 4 doses of a DTP-containing vaccine; 4 doses of polio vaccine; and 2 doses of an MMR-containing vaccine.</p>
Purpose	<p>There is evidence of a link between immunisation and better health outcomes. Rates are also reported internationally, which allows local comparisons to be made with Organisation of Economic Cooperation and Development (OECD) countries.</p> <p>This indicator appears to be sensitive to change over time and it is possible to report at the PHN and sub-PHN level to detect any variations and identify regional hotspots.</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>PHNs support health care providers to address factors impacting population health.</p>
Performance Criteria	<p>The national childhood immunisation target is 95%, which is considered when interpreting results.</p> <p>Otherwise, this item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.</p>
Data Source	Quarterly AIR data published on the Department of Health and Aged Care website.

Item	Description
Calculation	<p>Data retrieved from the data source is already calculated to show rate. For reference the calculation is provided below.</p> <p>Numerator:</p> <p>Children who turned 5 years of age in the reference year who were recorded as fully vaccinated on the Australian Immunisation Register in the reference year.</p> <p>Denominator:</p> <p>Number of children 5 years in the reference year registered on AIR.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$ presented as a percentage of children vaccinated in PHN region.</p>
Limitations	PHNs' capacity to directly influence childhood immunisation rates may be affected by service delivery arrangements and incentive schemes.
Additional information	<p>Nationally consistent immunisation data are available 3 months after the period that providers submit immunisation records after providing the service (December, March, June and September).</p> <p>Standard coverage reports for all children, and for First Nations children, are produced on a regular basis at the postcode and Statistical Area Levels 2 and 3. Coverage at these geographical levels is grouped within state and territory boundaries (e.g. postcodes for South Australia, SA3 for Western Australia).</p>

PH2: Cancer screening rates for cervical, bowel and breast cancer

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	<p>Cancer screening rates are participation rates in breast, bowel and cervical cancer screening programs.</p> <p>Screening population cohorts are:</p> <ul style="list-style-type: none"> Breast – women aged 50 to 74 years who undertake screening every 2 years. Bowel – people aged 50 to 74 years who are invited to screen in a 24 month period who returned a completed test within this period or the following 6 months. Cervical – women and people with a cervix aged 25 to 74 years who undertake the Cervical Screening Test every 5 years.
Purpose	<p>Screening programs are effective in the early detection of cancers in people with no symptoms. This allows for the early treatment of discovered cancers and reduces death rates. Participation in screening programs is the single most important factor in achieving these outcomes and can be measured and reported for target populations.</p> <p>PHNs can help to improve participation rates in the national breast, bowel and cervical cancer screening programs, particularly in regions with low screening participation rates.</p>

Item	Description
Outcome Theme: Quality Care	Outcome: PHNs support health care providers to address factors impacting population health.
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	AIHW; Breast Screen Australia Monitoring Report, National Bowel Cancer Screening Program (NBCSP) Monitoring Report and National Cervical Screening Program (NCSP) Monitoring Report.
Calculation	<p>Data availability differs between each cancer screening program due to the methods of collection and monitoring:</p> <ul style="list-style-type: none"> National Cervical Screening Program data is published annually however is only available for aggregate years at PHN level. In addition, delays in the completeness of some data impacts on calculation of performance indicators and how soon data can be used. <p>Numerator: Participants in screening.</p> <p>Denominator: Estimate of persons in screening population cohort.</p> <p>Computation: 100 x (numerator / denominator) presented as a percentage in PHN region.</p>
Limitations	<p>First Nations populations and culturally and linguistically diverse populations are not routinely identified in all cancer screening registers.</p> <p>First Nations population data is only available at PHN level for breast screening participation.</p> <p>Due to the introduction of the Cervical Screening Test and the change to the screening population, there will be no baseline data available for the Cervical Screening Program.</p>
Additional information	<p>Future developments:</p> <p>From 1 July 2024, people aged 45-49 years old became eligible to screen through the NBCSP and can now request their first bowel cancer screening kit be sent to them. Due to the 'opt in' nature of their engagement with the NBCSP, the calculation of participation of the new 45-49 year old cohort is being refined. People aged 50-74 years old will continue to receive a bowel cancer screening kit in the post. People receiving a screening kit will continue to do so every 2 years.</p> <p>A Cervical Screening Test is undertaken every five years in women and people with a cervix 25-74 years of age, using a primary human papillomavirus (HPV) test with partial genotyping and liquid-based cytology triage.</p> <p>From 1 July 2022, anyone eligible for a Cervical Screening Test is given a choice of HPV testing either through self-collection of a vaginal sample or clinician-collection of a sample from the cervix.</p>

Workforce indicators

W1: Rate of drug and alcohol treatment service providers with suitable accreditation

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department.
Definition	Number of commissioned service providers which have completed or are completing accreditation.
Purpose	<p>PHN aims to promote quality improvement approaches and support health professionals through education and training. PHN also facilitates evidence based treatments.</p> <p>PHN will need to maintain records of commissioned services providers' accreditation status.</p> <p>It is the Department's expectation that all specialist drug and alcohol treatment service providers are accredited or are working towards accreditation.</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>Local workforce has suitable cultural and clinical skills to address health needs of PHN region.</p>
Performance Criteria	All specialist drug and alcohol treatment service providers have or are working towards accreditation.
Data Source	Drug and Therapeutic Information Service (DATIS) reporting – Indicator 3.2.
Calculation	<p>Numerator:</p> <p>Number of commissioned service providers which have completed or are working towards accreditation.</p> <p>Denominator:</p> <p>Total number of commissioned drug and alcohol service providers in PHN region.</p> <p>Computation:</p> <p>100x (numerator / denominator) presented as a percentage of service providers.</p>
Limitations	-
Additional information	-

W2: PHN support for drug and alcohol commissioned health professionals

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department.

Item	Description
Definition	Support provided by PHN to drug and alcohol commissioned health professionals including number of education/training modules delivered.
Purpose	PHN aims to promote quality improvement approaches and support health professionals through education and training. This indicator will reflect how PHNs demonstrate support for health professionals in the management of drug and alcohol dependence and related morbidities.
Outcome Theme: Quality Care	Outcome: Local workforce has suitable cultural and clinical skills to address health needs of PHN region.
Performance Criteria	PHN supplies evidence of support provided to drug and alcohol commissioned health professionals.
Data Source	Drug and Therapeutic Information Service (DATIS) reporting – Indicator 3.1.
Calculation	Number and type of completed education and/or training modules for health professionals, relating to the management of drug and alcohol dependence and related morbidities.
Limitations	-
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including P4.

W3: PHN Commissioning Framework

Item	Description
Assessment	Individual PHN
Reporting	PHN - Twelve monthly by PHN
Definition	<p>The PHN has a Commissioning Framework that is structured around three broad phases of strategic planning, procuring services, and monitoring and evaluation. It also includes consideration of cultural appropriateness and stakeholder engagement at every stage of the process</p> <p>Cultural appropriateness refers to ways of working with people of different cultural backgrounds with an understanding of their cultural differences, needs and respect.</p> <p>See PHN Commissioning Resources for further information: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHNCommissioningResources </p>
Purpose	<p>Under the PHN Program model, PHNs use commissioning to address the prioritised needs of their region.</p> <p>A Commissioning Framework is a tool which assists PHNs to fulfil their commissioning role in a strategic way.</p>

Item	Description
Outcome Theme: Quality Care	Outcome: Local workforce has suitable cultural and clinical skills to address health needs of PHN region.
Outcome Theme: Capable Organisations	Outcome: The PHN uses commissioning cycle processes to identify, plan, procure, monitor and evaluate services to respond to the prioritised health needs of its region.
Performance Criteria	The PHN has a Commissioning Framework which includes strategic planning, procuring services and monitoring and evaluation phases, with cultural appropriateness and stakeholder engagement considered throughout the process.
Data Source	Copy of the PHN's Commissioning Framework
Calculation	Department of Health and Aged Care will assess the qualitative information provided by the PHN.
Limitations	This indicator does not include an assessment of the quality of the Commissioning Framework or its ability to commission high quality, effective services.
Additional information	As the Program and Framework matures, this indicator will be amended to consider the quality and effectiveness of the Commissioning Frameworks.

Digital Health indicators

DH1: Rate of health care providers informed about My Health Record

Item	Description
Assessment	Individual PHN
Reporting	My Health Record Expansion Program (MHREP) Schedule reporting by the Department.
Definition	<p>Rate of health care providers informed about My Health Record (MyHR). Health care providers include general practice, community pharmacy, private specialist practice and allied health services.</p> <p>Informed about MyHR describes activities funded under MHREP to improve awareness.</p>
Purpose	<p>PHNs are required to inform health care providers about MyHR including encouraging ongoing adoption and use of the MyHR.</p> <p>PHNs are required to deliver MyHR awareness and training to health care providers.</p>
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers are aware of digital health systems and technologies.</p>
Performance Criteria	100% of general practices are aware of and provided with access to MyHR education.
Data Source	MHREP reporting – Indicators 1-4
Calculation	<p>Numerator:</p> <p>The total number of general practices/community pharmacy/private specialist practice/allied health service receiving information about use of MyHR by the PHN.</p> <p>Denominator:</p> <p>The total number of general practices/community pharmacy/private specialist practice/allied health service in PHN region.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$ presented as a percentage in PHN region.</p>
Limitations	-
Additional information	-

DH2: Rate of health care providers using specific digital health systems

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>Rate of general practices in PHN region using smart forms; e-referrals and telehealth digital health systems.</p> <p>Smart forms are electronic forms issued by receiving providers that sending providers use to extract information from their client management system and assemble that information into an e-referral or other communication.</p> <p>E-referrals describe the reliable, secure transfer of referral information from one provider's client management system to another provider's client management system. E-referrals are a leading indicator of the use of secure electronic messaging for other types of clinical exchange.</p> <p>Telehealth describes where health care is provided remotely by means of telecommunications technology.</p>
Purpose	<p>PHNs provide support to general practices to adopt digital systems which improve the delivery and experience of health care for provider and patients. This indicator can provide a measure of how effective this support has been in encouraging the use of these systems.</p> <p>The use of telehealth is also a good measure of access, particularly for people in rural/remote parts of PHN regions. PHNs can encourage the use of these technologies to improve access for people at risk of poor outcomes.</p>
Outcome Theme: Quality Care	<p>Outcome:</p> <p>PHNs support general practices to use digital health systems to improve patient care and communication.</p>
Performance Criteria	<p>Increase in the rate of general practices using smart forms, e-referrals and/or telehealth.</p> <p>Where the rate has been stable for at least 3 years, the performance criteria is to maintain the existing rate of using specific digital health systems.</p>
Data Source	PHN - number of health care providers using the specified systems.
Calculation	<p>Numerator: Number of general practices in the PHN region which are using the specified digital health systems.</p> <p>Denominator: Number of general practices in the PHN region.</p> <p>Computation: $100 \times (\text{numerator} / \text{denominator})$ presented as a percentage in PHN region.</p> <p>Disaggregation: Smart forms, e-referrals and telehealth.</p>
Limitations	-

Item	Description
Additional information	<p>As new digital systems are developed, relevant definitions may be added to this specification.</p> <p>The Department will investigate nationally consistent methods of counting health care providers by PHN region. This will provide more accurate data and reduce PHNs' reporting burden.</p> <p>Note: PHNs may choose to provide information on individual or all digital health systems being used in their region.</p>

DH3: Rate of accredited general practices sharing data with PHN

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>Rate of accredited general practices involved in sharing data with PHN.</p> <p>A general practice is defined by the Royal Australian College of General Practitioners (RACGP) as an entity which 'provides person centred, continuing, comprehensive and coordinated wholeperson health care to individuals and families in their communities.' Therefore, practices which do not provide 'wholeperson' or mainstream health services should be excluded from the count. This would include skin clinics and travel doctors etc.</p> <p>An accredited general practice is one which is accredited or registered for accreditation against the RACGP Standards for general practices.</p> <p>Sharing data describes where a general practice is actively sharing their practices' data with the PHN.</p>
Purpose	General practices are being encouraged to share their data with the PHN as part of quality improvement activities. PHNs can offer support and analysis to improve delivery and experience of health care. PHNs can also use the data to inform their Needs Assessments.
Outcome Theme: Quality Care	<p>Outcome:</p> <p>General practices and other health care providers use data to improve care.</p>
Performance Criteria	<p>At least 5% growth on rate of accredited general practices sharing data with the PHN each year.</p> <p>Where the rate is over 60%, the performance criteria is to maintain the existing rate.</p>
Data Source	PHN - number of accredited general practices involved in sharing data and total number of accredited general practices.

Item	Description
Calculation	<p>Numerator:</p> <p>Number of accredited general practices involved in sharing data with PHN.</p> <p>Denominator:</p> <p>The number of all accredited general practices in the PHN.</p> <p>Computation:</p> <p>$100 \times (\text{numerator} / \text{denominator})$ presented as a percentage in PHN region.</p>
Limitations	-
Additional information	This does not include Aboriginal Community Controlled Health Services (ACCHS). The denominator data will be sourced from indicator P3.

Aged Care indicators

AC1: Rate of MBS services provided by primary care providers in residential aged care homes

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	<p>Rate of MBS services provided by primary care providers in residential aged care homes (RACH) per patient who received at least one Medicare-subsidised GP attendance in a RACH.</p> <p>MBS groups and items for services provided in residential aged care include: Group A35; Items 232, 249, 731, 772, 776, 788, 789, 829, 869, 881, 892, 903, 2125, 2138, 2179, 2220, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267, 92102, 92071, 92058, 92027.</p>
Purpose	<p>Primary health care can be difficult to obtain in RACH, and when medical care cannot be obtained patients depend on the hospital system which is less appropriate for the patient and a cost to the system.</p> <p>PHNs have opportunities through their networks and commissioning to take steps to facilitate the minimisation of these problems.</p> <p>This indicator will reflect whether access to appropriate MBS health services for people aged 65 and over in RACH has improved.</p>
Outcome Theme: Improving Access	<p>Outcome:</p> <p>Older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home.</p>
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	AIHW; Medicare-subsidised GP, allied health and specialist health care across local areas.
Calculation	<p>Numerator:</p> <p>Number of specific MBS items provided in residential aged care homes.</p> <p>Denominator:</p> <p>Number of GP residential aged care patients.</p> <p>Computation:</p> <p>Numerator / denominator, presented as a rate of attendances per patient in PHN region.</p>
Limitations	-
Additional information	Data from this indicator will be used to interpret and provide context to other indicators including P4, P12 and AC2.

AC2: Rate of people aged 65 and over with a GP health assessment

Item	Description
Assessment	PHN Program.
Reporting	Twelve monthly by Department.
Definition	Rate of people aged 65 and over with a GP health assessment. GP health assessment includes MBS groups, subgroups, and items: Group A14; Subgroups A7.5, A40.11, A40.12; Items 93470, 93479.
Purpose	This indicator will reflect whether access to appropriate GP health services for people aged 65 and over has improved. This indicator will provide information on trends in usage of GP services by older people to identify gaps and weaknesses in the systems which PHNs may be able to influence.
Outcome Theme: Improving Access	Outcome: Older people in the PHN region are supported to access primary health care services that meet their needs including self-care in the home.
Performance Criteria	This item does not have performance criteria or a target. It provides context for other indicators and a reference to the healthcare landscape in which PHNs are operating.
Data Source	AIHW – Medicare-subsidised GP, allied health and specialist health care across local areas.
Calculation	Numerator: Number of specific MBS items provided to people aged 65 and over. Denominator: Population of the PHN aged 65 and over for the most recent year available. Computation: 100 x (numerator / denominator) presented as a percentage in PHN region.
Limitations	-
Additional information	A health assessment for people aged 65 years and older is an assessment of a patient's health and physical, psychological and social function for the purpose of initiating preventive health care and/or medical interventions as appropriate. This indicator targets the population of those aged 65 years and over. Data from this indicator will be used to interpret and provide context to other indicators including P4, P12 and AC1.

Alcohol and Other Drugs indicators

AOD1: Rate of drug and alcohol commissioned providers actively delivering services

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by Department.
Definition	Rate of providers commissioned to deliver drug and alcohol services and actively delivering services. Actively delivering means that patients are being referred and accessing services.
Purpose	PHNs are helping to address demand for treatment services through commissioning providers to deliver services. This indicator measures how successful the PHN and commissioned providers are in moving from design to delivery of services.
Outcome Theme: Improving Access	Outcome: People in PHN region are able to access appropriate drug and alcohol treatment services.
Performance Criteria	Rate of drug and alcohol commissioned providers actively delivering services increases or remains the same.
Data Source	Bi-annual commissioning reports from PHNs.
Calculation	Numerator: Number of providers commissioned to deliver drug and alcohol services actively delivering services within reporting period. Denominator: Number of providers commissioned to deliver drug and alcohol services. Computation: $100 \times (\text{numerator} / \text{denominator})$ presented as a rate. Disaggregation: First Nations Specific Services.
Limitations	-
Additional information	-

AOD2: Partnerships established with local key stakeholders for drug and alcohol treatment services

Item	Description
Assessment	Individual PHN.

Item	Description
Reporting	Twelve monthly by Department.
Definition	<p>Partnerships and collaborations established with local key stakeholders including Non-Government Organisations (NGO) (including specialist drug and alcohol treatment services), local health networks, state government, peak bodies and primary health services in relation to the delivery of drug and alcohol services.</p> <p>Evidence of formalised partnerships and collaboration includes strategies to facilitate collaboration, establishment of governance structures, joint service planning and delivery and Memorandum of Understanding between service providers that have been facilitated by the PHN.</p>
Purpose	This indicator measures the range of partnerships established in the PHN region in relation to the delivery of drug and alcohol services. PHNs promote linkages with other health services and improve integration and quality of services.
Outcome Theme: Coordinated Care	<p>Outcome:</p> <p>Health care providers in PHN region have an integrated approach to drug and alcohol treatment services.</p>
Performance Criteria	A range of organisations are involved in delivering drug and alcohol services.
Data Source	Drug and Therapeutic Information Service (DATIS) reporting Indicator 1.3 and 1.4.
Calculation	The Department will assess the information provided by the PHN.
Limitations	-
Additional information	-

Organisational indicators

O1: PHN has an independent and diverse skills-based Board

This indicator has been retired from the Framework from 1 September 2024 (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O2: PHN Clinical Council and Community Advisory Committee membership

This indicator has been retired from the Framework from 1 September 2024 (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O3: PHN Board considers input from committees

This indicator has been retired from the Framework from **1 September 2024** (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O4: Record of PHN Board member attendance at meetings

This indicator has been retired from the Framework from 1 September 2024 (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O5: PHN Board has a regular review of its performance

This indicator has been retired from the Framework from **1 September 2024** (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O6: PHN Board approves strategic plan

This indicator has been retired from the Framework from **1 September 2024** (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O7: Variance report of scheduled activities

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>A variance report of scheduled activities of the PHN tracking achievement and spend is produced.</p> <p>Scheduled activities are those that are included in the PHN Activity Work Plan (AWP).</p> <p>Achievement is measured against milestones/indicators developed by PHN.</p>
Purpose	<p>This indicator is required for compliance purposes.</p> <p>There will be some variance between projected achievement and spend and actual achievement and spend on activities. A variance report helps to keep track of this spend and can identify where there may be significant barriers to delivery of an activity or an over or underspend. This can suggest whether the PHN is delivering as expected or it is experiencing problems. This information would be supported by contextual information from the PHN on whether variance is expected and/or plans to address variances.</p> <p>Findings will be used for individual performance assessments but will not be published in the PHN Program Annual Performance Report.</p>

Item	Description
Outcome Theme: N/A	-
Performance Criteria	All variations are accounted for by PHN.
Data Source	Variance report on scheduled activities.
Calculation	The Department of Health and Aged Care will assess information provided in Variance Report (O7) against PHN Needs Assessment, PHN AWP and national priority areas. The Variance Report comprises a list of individual PHN activities pre-populated from AWPs where PHNs are to detail expected spend by reporting period against actual spend, identify the related need or priority area and assign a risk rating.
Limitations	-
Additional information	-

O8: Quality management system

This indicator has been retired from the Framework from **1 September 2024** (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O9: Staff satisfaction

This indicator has been retired from the Framework from **1 September 2024** (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O10: Performance management process

This indicator has been retired from the Framework from **1 September 2024** (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O11: Cultural awareness training

This indicator has been retired from the Framework from **1 September 2024** (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O12: Rate of contracts for commissioned health services that include both output and outcome performance indicators

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>The PHN includes both output and outcome performance indicators in its active contracts with commissioned service providers</p> <p>Active contracts are those commenced, continuing or ceased during the financial year.</p> <p>Output performance indicators measure the services and/or products delivered by the process or activity that was funded.</p>

Item	Description
	Outcome performance indicators measure the impact of the services and/or products delivered.
Purpose	PHNs are encouraged to include both output and outcomes performance indicators in their contracts with commissioned service providers. This will allow the PHN to demonstrate the impact of their commissioning over time towards the PHN Program outcomes.
Outcome Theme: Addressing Needs	Outcome: PHN activities and initiatives address local needs.
Performance Criteria	Increase in the number of contracts containing both output and outcome performance indicators.
Data Source	PHN provides number of contracts and extracts of output and outcome measures from contracts.
Calculation	<p>Numerator:</p> <p>Number of active contracts with output and outcome measures.</p> <p>Denominator:</p> <p>Number of total contracts executed.</p> <p>Computation:</p> <p>100 x (numerator / denominator) presented as a percentage of total contracts in PHN region.</p>
Limitations	-
Additional information	It is noted that PHNs construct the most appropriate performance indicators for each service they commission. For some contracts it will be most appropriate to include output performance indicators initially.

O13: Annual Report and audited financial statements

Item	Description
Assessment	Individual PHN.
Reporting	Twelve monthly by PHN.
Definition	<p>Annual Report and audited financial statements are submitted to the Department and are lodged in accordance with the Corporations Act 2001.</p> <p>PHN Full-Time Equivalent (FTE) staff is also to be provided. Contextual information may also be included to support FTE numbers if necessary.</p>
Purpose	<p>This indicator is required for compliance purposes.</p> <p>PHNs are contractually required to provide their Annual Report and audited financial statements as the Department has a responsibility to account for the spending of public money.</p>

Item	Description
	Findings will be used for individual performance assessments but will not be published in the PHN Program Annual Performance Report.
Outcome Theme: N/A	-
Performance Criteria	Annual Report meets requirements. Audited financial reports have unqualified auditor statement.
Data Source	PHN supplies Annual Report and audited financial statements.
Calculation	The Department will assess the qualitative information provided by the PHN.
Limitations	-
Additional information	-

O14: PHN stakeholder engagement

This indicator has been retired from the Framework from 1 September 2024 (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

O15: Engaging with complaints

This indicator has been retired from the Framework from 1 September 2024 (not required to be reported on commencing with the 2021-22 Twelve Month Performance Report).

Version History

Version	Description of change	Author	Effective date
1.0	Initial release version	Department of Health and Aged Care	1 / 7 / 18
1.1	Addition of Version History, Creative Commons licence notification, clarification of performance criteria wording for indicators MH1, MH2 & MH3, and the collapse of Mental Health indicators MH6 and MH7 into a single performance indicator.	Department of Health and Aged Care	1 / 9 / 18 (applies to annual reports up to and including 2020-21)
1.2	<p>Updated assessment and reporting practices:</p> <p>P1: updated reporting cadence; removed Capable Organisations outcome theme.</p> <p>P3: removed performance criteria.</p> <p>P4: removed Capable Organisations outcome theme.</p> <p>P5: removed performance criteria; updated data source; removed pharmacies and allied health service practices from the indicator.</p> <p>P6: clarified wording in purpose; removed performance criteria; updated data source; revised limitations.</p> <p>P7: updated name & terminology; updated definition and purpose; removed performance criteria; updated calculation; revised limitations.</p> <p>P8: indicator retired from Framework.</p>	Department of Health and Aged Care	1 / 9 / 24 (applies to the Primary Health Network Program Annual Performance Report 2021-22)

Version	Description of change	Author	Effective date
	<p>P9: renamed; updated definition and purpose; revised wording in outcome theme; removed disaggregation by First Nations status; removed performance criteria; updated data source; updated calculation; revised limitations and additional information.</p> <p>P10: clarified definition; removed performance criteria; updated data source; clarified calculation; updated limitations and additional information.</p> <p>P11: indicator retired from Framework.</p> <p>P12: updated definition; removed disaggregation by First Nations status and Coordinated Care outcome theme; removed performance criteria; updated data source and calculation; revised limitations; removed additional information.</p> <p>P13: slightly updated definition text; updated purpose; removed performance criteria; updated data source.</p> <p>Updated additional information in all Mental Health (MH) indicators.</p> <p>MH4: updated purpose and performance criteria.</p> <p>Updated names of all Indigenous Health (IH) indicators to First Nations (FN).</p> <p>FN1: slightly updated definition text; updated</p>		

Version	Description of change	Author	Effective date
	<p>data source and calculation.</p> <p>FN2: updated definition; clarified performance criteria.</p> <p>FN3: renamed.</p> <p>FN4: clarified calculation.</p> <p>FN5: renamed; slightly updated definition text.</p> <p>FN8: updated definition; removed performance criteria; updated data source; updated calculation.</p> <p>PH1: updated performance criteria; clarified data source and calculation.</p> <p>PH2: updated definition; removed performance criteria; updated data source; updated calculation; updated limitations.</p> <p>W1: clarified calculation.</p> <p>DH1: clarified reporting.</p> <p>DH2: revised indicator to only use general practice data; updated data source, calculation, and additional information.</p> <p>AC1: updated name & terminology throughout; updated definition; removed performance criteria; updated data source; clarified calculation.</p> <p>AC2: changed age group from 75+ to 65+; updated definition; removed performance criteria; updated data source; updated calculation; updated additional information.</p>		

Version	Description of change	Author	Effective date
	<p>AOD1: updated data source.</p> <p>Indicators O1-O6, O8-O11, and O14-O15 - indicators retired from Framework.</p> <p>O7: updated definition, purpose, performance criteria, data source, and calculation; removed outcome theme.</p> <p>O12: updated definition; changed outcome theme; clarified calculation.</p> <p>O13: updated purpose; removed outcome theme.</p> <p>Updated terminology from Aboriginal and Torres Strait Islander to First Nations peoples throughout; updated Department of Health to Department of Health and Aged care, or the Department.</p>		



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