



Australian Government

Department of Health, Disability and Ageing

PHN Program Performance Measurement and Reporting Framework

Part B: Indicator Specifications – August 2025



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Coordinate Indicators

CO-01: Partnerships for system coordination or integration

Item	Description
Dimension	Progress
Description	<p>A description of partnership arrangements between PHNs and stakeholders directly related to system coordination or integration.</p> <ul style="list-style-type: none"> • Name of stakeholder organisation • Is the partnership formalised? How is this evidenced? • Is the partnership part of a co-commissioned arrangement or working towards one? • Is data shared between the PHN and this stakeholder?
Rationale	<p>PHNs have a role in coordinating and integrating local health care services in collaboration with local stakeholders, including state or territory government agencies and/or Local Hospital Networks (or equivalent) and others. This role requires PHNs to have enduring relationships with stakeholders to determine a shared approach and collaborate to enhance patient outcomes while reducing duplication. This measure is indicative of with whom and how PHNs are engaging and the relationships that exist with their stakeholders.</p>
Purpose	<p>To determine the extent to which PHNs are working or engaging with stakeholders to achieve strategically aligned goals. It additionally provides elementary insight into PHNs identifying opportunities to leverage available resources and pursue innovation.</p>
Indicator Definition	<p>Partnerships are a collaborative relationship between a PHN and stakeholder towards shared strategic goals, often through long-term commitments. Stakeholders may include LHNs (or equivalents), rural workforce agencies, universities, general practices, Aboriginal Medical Services, other PHNs and peak bodies. Examples of partnerships may include activities related to data linkage projects, joint regional needs assessments, or alliances with LHNs (or their equivalent) and Aboriginal Community Controlled Health Organisations (ACCHOs). Formalised partnerships refer to a documented agreement that recognises active and long-term collaboration between stakeholders. Agreements may be evidenced by Memoranda of Understanding, partnership agreements, joint strategies, and other documents which demonstrate accountability and alignment of collaborative efforts of the involved parties. Examples listed here are not exhaustive and may include other stakeholders, projects, initiatives and forms of evidence that reflect formalised partnerships</p> <p>This indicator aims to capture all current partnerships - formalised or informal - that PHNs are engaged in. PHN collaborations, unlike partnership, are typically more informal, short-term or are task-specific interactions that do not necessarily require documented agreements or long-term commitments. Examples of this include Communities of Practice, collaboratives or working groups and networks. As such, collaborations are excluded from this indicator. This indicator is also not intended to capture typical commissioned provider agreements, or general practice agreements expected for participation in incentive programs (e.g. PIP QI).</p> <p>Co-commissioning (or joint commissioning) refers to arrangements between a PHN and stakeholders (including other PHNs) where activities are jointly planned, funded and managed. Accountability and decision-making are shared, and outcomes collectively agreed upon. Co-commissioning often involves incremental progress; therefore, PHNs may be in a transitional phase - working towards co-commissioning - where partnerships exist but where joint planning, funding or management are not yet in place. This is distinct from active co-commissioning where these elements are already implemented.</p> <p>System coordination or integration involves activities that occur between stakeholders that are critical in ensuring a connected local health care system. This is done by strengthening the connection between public and private sectors, through care pathways, and models of care. Key stakeholders of system coordination or integration are primary care, mental health, aged care, disability, social and hospital services. These activities are focused on organised management and integration of patient care that contributes to the seamless and efficient delivery of health services.</p>

Item	Description
Dimension	Progress
	Data sharing refers to where data is exchanged between PHNs and stakeholders as part of the partnership arrangement. Data is inclusive of unit level or aggregate data that pertains directly to the system coordination or integration activity.
Performance Criteria	<ul style="list-style-type: none"> Where PHNs <u>have established</u> formal partnerships involving co-commissioning or data sharing, these partnerships should be maintained. Where formal partnerships <u>do not yet exist</u>, PHNs should work to strengthen relationships by entering formal arrangements, which may or may not include co-commissioning or data sharing. In areas where partnerships <u>are not yet established</u>, PHNs are actively identifying and developing meaningful partnerships aligned with local health priorities.
Reporting Frequency	Biennial (once every two years).
Data Source	PHN Reported
Calculation	<p>a) Provide the operating name of the stakeholder.</p> <p>b) Provide a 'Yes' or 'No' response, and select from one of the following if applicable:</p> <ol style="list-style-type: none"> Memoranda of Understanding Partnership agreement Joint strategy Other: please specify <p>c) Select from one of the following:</p> <ol style="list-style-type: none"> Yes, actively co-commissioning Working towards co-commissioning No, not co-commissioning <p>d) Select from one of the following:</p> <ol style="list-style-type: none"> Yes, data is shared No, data is not shared
Limitations	This indicator may not capture informal arrangements that exist between PHNs and stakeholders that have resulted in long term outcomes for the community.
Additional information	<p>A contextual field is included to provide PHNs an alternative format to demonstrate other outcomes of partnership arrangements (that are not data sharing or co-commissioning arrangements). In addition, PHNs will have the opportunity to provide a statement on their partnership experiences during the reporting period. This could include commentary on developing and establishing partnerships, in addition to maintaining partnerships.</p> <p>This indicator will also be used to capture details for the purpose of executing CO-03. This will include receipt of details for an appropriate representative for the organisation and their e-mail and/or telephone details.</p>

CO-02: Referral pathways

Item	Description
Dimension	Progress / Performance
Description	Count and characteristics of formal referral pathways, and their usage metrics by program area. <ol style="list-style-type: none"> Number of formal referral pathways available. Proportion of total referral pathways reviewed. Proportion of total referral pathways that are clinical. Proportion of total referral pathways targeted at consumers. Average number of page views per unique user.
Rationale	PHNs contribute to the development and accessibility of digital tools that assist clinicians in providing quality care to patients and consumers with service navigation. Development and promotion of the use of these contributes to a consistent and localised approach to management and understanding of patient journeys.
Purpose	To determine what formal referral pathways are available and used by primary health care providers and consumers.
Indicator Definition	<p>Referral pathways are online health resources designed for <u>primary health care providers</u> to use at point of care. Primary health care providers include general practitioners, nurses (practitioners, registered and enrolled), midwives, Aboriginal and Torres Strait Islander health workers or practitioners, allied health professionals and peer workforce. They provide structured information on how to assess and manage conditions and/or how to refer patients to local specialists and services.</p> <p>Clinical pathways are resources that are especially targeted at assessing, managing and referring a medical condition or diagnosis. Non-clinical pathways are resources that involve connecting patients with alternative supports that do not provide medical care.</p> <p>Referral pathways may also be designed specifically for consumers. These pathways provide structured information that supports people to navigate services appropriate to an individual's needs.</p> <p>The term formal is defined as approved, published and accessible to health practitioners.</p> <p>Review refers to the process of examining and revising the content of a referral pathway to ensure that the information accurately reflects and aligns with the local health system. Review may result in the consolidation of referral pathways.</p> <p>Page views refer to every instance a referral pathway has been loaded by a user. A unique user refers to an individual who accessed a referral pathway during the reporting period, identified by distinct login credentials or identifier (i.e. IP address). PHN staff and their page views are excluded.</p> <p>Program areas include population health, mental health and suicide prevention, alcohol and other drugs, aged care, and First Nations health. The measure includes all referral pathways activities described in the PHN Core Funding schedule, including Dementia Pathways (where specified).</p> <p>Saturation refers to the point at which growth in unique users or page views has plateaued over a two-year reporting period, indicating sustained engagement.</p>
Performance Criteria	<ul style="list-style-type: none"> A 5% increase in the number of unique users or 5% increase in the number of page views, across the sum of all formal referral pathways, OR Where saturation has occurred at ¹%, maintenance (-/+ 5%) of unique users and page views, across the sum of all formal referral pathways. <p>AND</p> <ul style="list-style-type: none"> At least 10% of referral pathways have been reviewed.

¹ Percentage to be determined.

Item	Description
Dimension	Progress / Performance
	It is noted that it is best practice to consolidate infrequently used pathways where appropriate. Therefore, where maintenance or an increase is not reported, PHNs may be requested to provide evidence of consolidation.
Reporting Frequency	Annual
Data Source	PHN Reported
Calculation	<p>Disaggregated by program area:</p> <ul style="list-style-type: none"> a) Count: Total number of formal referral pathways at time of reporting. b) Numerator: Referral pathways that were reviewed during reporting period. Denominator: Total formal referral pathways at time of reporting. Multiplied by 100. c) Numerator: Referral pathways that are clinical at time of reporting. Denominator: Total formal referral pathways at time of reporting. Multiplied by 100. d) Numerator: Referral pathways targeted at consumers at time of reporting. Denominator: Total formal referral pathways at time of reporting. Multiplied by 100. e) Numerator: Total number of page views in reporting period. Denominator: Total number of unique users.
Limitations	The use of referral pathways by primary health care providers and consumers is likely influenced by the incidence of conditions and the demographics of a local community. Usage metrics may also be influenced by the knowledge and confidence of the existing primary care workforce in referring and managing patients or certain condition in the local region.
Additional information	A contextual field is included to provide PHNs an opportunity to provide contextual information where they may not be meeting the performance criteria for the Department's consideration. Where PHNs have different referral pathways to accommodate for different LHD (or their equivalent), PHNs must report aggregate (the sum) of all referral pathways.

CO-03: Partnership experience measure

Item	Description
Dimension	Performance
Description	Percentage of PHN stakeholders reporting a positive partnership experience.
Rationale	PHNs have a role in coordinating and integrating local health care services in collaboration with local stakeholders, including state or territory government agencies and/or Local Hospital Networks (or equivalent). A positive partnership experience is reflective of an effective and productive working relationship between engaged parties. This includes strong goal alignment, problem resolution, and sustainability of joint activities. This measure is indicative of how PHNs are engaging with partners in facilitating coordination within their local health system.
Purpose	To determine the extent to which PHNs are fostering positive, collaborative relationships with partners to achieve shared goals.
Indicator Definition	Survey tool to be determined. Partners in scope of this measure are those identified in CO-01.
Performance Criteria	To be determined based on survey tool and following collection of baseline data.
Reporting Frequency	Biennial (once every two years).
Data Source	Independent survey.
Calculation	To be determined based on survey tool.
Limitations	To be determined based on survey tool.
Additional information	Not applicable

Capacity-Build Indicators

CB-01: Significant interactions with primary health care providers

Item	Description
Dimension	Progress
Description	<p>Significant interactions and their characteristics between PHNs and local primary health care providers directly related to capacity building activities.</p> <ol style="list-style-type: none"> Topic area Interaction type Health care provider or support staff type Number of significant interactions Attendance or participation rate
Rationale	<p>PHNs support general practices and other health care providers in their region. This is to ensure that health professionals can respond appropriately and confidently to the health needs of their region and improve their service delivery. This indicator measures the opportunities PHNs are providing to local health care providers to engage in clinical professional development or other targeted support activities.</p>
Purpose	<p>To determine how PHNs are engaging with primary health care providers to contribute to meaningful capacity-building for the local workforce.</p>
Indicator Definition	<p>For the purpose of this indicator, a significant interaction is a formal engagement between PHNs and primary health care practitioner/s or administrative staff that is documented and contributes to capacity building. Specifically, capacity building activities must have an articulated learning outcome. Primary health care providers include the following list of practitioners: general practitioners, nurses (practitioners, registered and enrolled), midwives, Aboriginal and Torres Strait Islander health practitioners, and allied health professionals. In some cases, support staff such as practice managers and administrative employees who are critical in delivery of services also receive capacity-building support from PHNs and as such are included in this measure.</p> <p>Types of significant interactions are categorised as continuous quality improvement (CQI) sessions, clinical professional development (CPD) activities and other training or capacity-building activities. It does not include informal engagements, such as administrative conversations, emails, newsletters or general announcements. Interactions could include different formats, including in-person workshops or online webinars. Significant interactions are likely to be documented through an agenda, attendee or participant register and have targeted outcomes.</p> <ul style="list-style-type: none"> • CQI activities: refer to structured, iterative processes designed to support practices in identifying, testing, and implementing changes that lead to better patient care and system performance. These sessions are directly related to Practice Incentive Program Quality Improvement (PIP QI). CQI may involve a range of initiatives that focus on data quality, service delivery processes, or patient engagement. Improving patient outcomes through data-driven quality improvement is the intended primary learning outcome. • CPD activities: events which contribute points towards a clinician's Continuing Professional Development as recognised by the Australian Health Practitioner Regulation Agency (AHPRA) or the associated professional peak body. Enhancing professional skills, knowledge and competencies is the intended primary learning outcome. • Other training or capacity-building activities: Are all other sessions, events or activities that do not constitute as CQI or CPD. These may be one-off training activities delivered by PHNs. Examples of these activities may include education on responding to emergencies, accreditation, culturally safe practices, digital tools, or practice management improvement. <p>Topic areas for these interactions should be categorised as one of the following:</p>

Item	Description
	<ul style="list-style-type: none"> • general practice support, • population health, • aged care, • digital health, • workforce development, • First Nations health, • mental health and • emergency management or response. <p>Participation rate refers to the number of unique people who were present at the interaction. It also includes unique people who subsequently accessed and completed all requirements of the training or education (e.g. workshop recordings). This rate is calculated as a proportion of those who were invited or expected to attend.</p>
Performance Criteria	To be determined following collection of baseline values.
Reporting Frequency	Annual
Data Source	PHN Reported
Calculation	<p>For each relevant topic area (a):</p> <ul style="list-style-type: none"> b) Select the relevant interaction type: <ul style="list-style-type: none"> i. continuous quality improvement ii. continuous professional development iii. other training or capacity-building activities c) Select the relevant providers or support staff who participated in the interaction: d) Total number of significant interactions delivered. e) Numerator: Number of people we were present or accessed the interaction Denominator: Number of unique people who were invited or expected at the interaction Multiplied by 100.
Limitations	No current limitations identified; subject to future review.
Additional information	Optional: PHNs may provide additional narrative with this indicator to provide further context.

CB-02: Proportion of general practice demonstrating improvements following continuous quality improvement activities

Item	Description
Dimension	Performance
Description	Proportion of general practice demonstrating improvements following PHN-supported continuous quality improvement activities.
Rationale	PHNs support general practices in their region. This is to ensure that health professionals can respond appropriately and confidently to the health needs of their region and improve their service delivery. This indicator measures the number of general practices demonstrating such improvements, expressed as a proportion of all general practices that participated in PHN-supported CQI activities during the reporting period.
Purpose	To determine the extent to which PHN-supported continuous quality improvement activities in general practice are effective.
Indicator Definition	<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 whole person health care to individuals and families in their communities.” These entities are eligible for accreditation under the Australian Commission on Safety and Quality in Health Care’s National General Practice Accreditation Scheme. General practices are therefore inclusive of Aboriginal Medical Services and Aboriginal Community Controlled Health Services. The total count of general practices in a PHN region are inclusive of those who are not accredited.</p> <p>Continuous quality improvement (CQI) activities refer to structured, iterative processes designed to support practices in identifying, testing, and implementing changes that lead to better patient care and system performance. These sessions are directly related to Practice Incentive Program Quality Improvement (PIP QI). CQI may involve a range of initiatives that focus on data quality, service delivery processes, or patient engagement. A general practice is demonstrating improvement when it has participated or actively received PHN-supported CQI activities and has shown measurable, positive change in <u>the selected measure of that reporting period</u>. Positive change is considered any measurable gain or increase from a baseline figure. Improvement must be evidenced through comparative data (e.g. baseline vs follow-up) or other verifiable sources.</p> <p>Selected measures:</p> <ul style="list-style-type: none"> • Quality Improvement Measures (QIMs) – all ten measures collected from data captured from general practice clinical information systems. The measures represent status of patients’ lifestyle behaviours and areas of significant health burden. See information published by the Australian Institute of Health and Welfare for more details. • PIP QI eligible data set quality – as part of data submission to the AIHW, the PIP eligible data is screened and tested for data quality. It is expected that data quality issues are addressed, and that all PIP QI practices are submitting their data for reporting purposes. • Others to be determined.
Performance Criteria	To be determined following collection of baseline values.
Reporting Frequency	Annual
Data Source	PHN Reported
Calculation	<p>Quality Improvement Measures (<i>to be determined</i>):</p> <ul style="list-style-type: none"> • Numerator: Number of general practices that have shown improvement in at least 8 of the ten QIMs. • Denominator: Total number of general practices participating in PIP QI. • Multiplied by 100

Item	Description
	<p>PIP QI eligible data set quality:</p> <ul style="list-style-type: none"> • Numerator: Number of general practices submitting PIP eligible data set • Denominator: Total number of general practices participating in PIP QI • Multiplied by 100 <p>Numbers used for the calculations above should aggregate quarterly figures to produce a total annual figure.</p>
Limitations	No current limitations identified; subject to future review.
Additional information	<p>To facilitate targeted practice support and drive CQI, reporting on selected measures will rotate annually. Each reporting year focuses on one specific area of CQI. The rotating roster of focus areas is outlined below:</p> <ul style="list-style-type: none"> • Year 1: QIMs • Year 2: PIP QI eligible data set quality <p>Data will be validated against AIHW Progress Reports and the PIP QI National Report.</p>

CB-03: My Health Record: Rate of uploads by general practices

Item	Description
Dimension	Performance
Description	My Health Record: Rate of uploads by general practices per 100,000 population.
Rationale	PHNs encourage and support primary health care providers in the full implementation of My Health Record. Use of My Health Record will enhance co-ordination and continuity of care for patients. This indicator can suggest the effectiveness of support provided by PHNs to general practice in adopting and maintaining the use of My Health Record.
Purpose	To determine the extent to which PHNs are providing support to general practice in utilising My Health Record.
Indicator Definition	<p>My Health Record is a national digital platform that collates electronic records of an individual's health information. The platform can be accessed by different healthcare professionals involved in a person's care.</p> <p>My Health Record provides a range of functionalities including the upload of documents and accessing of targeted views to allow health care providers and consumers access to healthcare information. Uploads occur when health information documents are transferred by healthcare providers into My Health Record.</p> <p>For the purpose of this indicator, only uploads performed by general practice, denoted by their Healthcare Provider Identifier-Organisation (HPI-O), are considered. Additionally, uploads only include shared health summaries, event summaries and eHealth prescription records – as these clinical records are those typically generated by general practitioners.</p>
Performance Criteria	Suggested benchmark will be informed by available data.
Reporting Frequency	Annual
Data Source	<p>Department Reported</p> <p>Numerator: Australian Digital Health Agency</p> <p>Denominator: Australian Bureau of Statistics (TableBuilder); 2021 Census – counting persons, place of enumeration, by PHN 2023 Boundaries</p>
Calculation	<p>Numerator: Total uploads performed by general practice</p> <p>Denominator: Estimated residential population</p> <p>Multiplied by 100,000</p>
Limitations	Health Legislation Amendment “Modernising My Health Record – Sharing by Default” commenced in 2025. As part of this legislation, diagnostic imaging and pathology reports will be required for upload into My Health Record by healthcare providers. It is therefore anticipated that rate of uploads for these documents will be high in compliance with this requirement. As such it is excluded from this indicator.
Additional information	Not applicable

CB-04: My Health Record: General practice cross views

Item	Description
Dimension	Performance
Description	Rate of general practice cross views per 100,000 population.
Rationale	PHNs encourage and support primary health care providers in the full implementation of My Health Record. Use of My Health Record will enhance co-ordination and continuity of care for patients. Cross views of My Health Records by different healthcare provider organisations suggests that health providers are working together to deliver coordinated care to a patient. As My Health Record use increases, supported and encouraged by PHNs, it would be expected that cross views will also increase. This indicator can suggest the effectiveness of support provided by PHNs to primary healthcare providers in adopting and maintaining the use of My Health Record.
Purpose	To determine the extent to which PHNs are providing support to general practice in utilising My Health Record.
Indicator Definition	<p>My Health Record is a national digital platform that collates electronic records of an individual's health information. The platform can be accessed by different healthcare professionals involved in a person's care.</p> <p>My Health Record provides a range of functionalities including the upload of clinical documents and accessing of targeted views to allow health care providers and consumers access to healthcare information. Cross views occur when a document uploaded by a healthcare provider organisation is viewed by a different healthcare provider organisation. Documents may include shared health summaries, discharge summaries, prescription and dispense records, pathology reports, diagnostic imaging reports, specialist letters and event summaries.</p> <p>For the purpose of this indicator, only views performed by general practices – denoted by their Healthcare Provider Identifier-Organisation (HPI-O) – of documents uploaded by any other health care organisation are included.</p>
Performance Criteria	<ul style="list-style-type: none"> A 5% increase in the rate of cross views in My Health Record by general practice. Where the rate of cross views is xx², the rate is maintained (-/+5%). This benchmark will be informed by available data.
Reporting Frequency	Annual
Data Source	Department Reported Numerator: Australian Digital Health Agency Denominator: Australian Bureau of Statistics (TableBuilder); 2021 Census – counting persons, place of enumeration, by PHN 2023 Boundaries
Calculation	Numerator: Total cross views performed by general practices Denominator: Estimated residential population Multiplied by 100,000
Limitations	No current limitations identified; subject to future review.
Additional information	Not applicable

² Rate to be determined

CB-05: Primary healthcare provider-reported experience

Item	Description
Dimension	Performance
Description	Primary healthcare provider experience measure.
Rationale	PHNs are expected to deliver quality capacity building opportunities to their local primary care workforce. It is important to understand whether capacity building activities delivered by PHNs are meeting the needs and expectation of participants. It provides insights that can inform further continuous improvement and build a stronger understanding towards positive provider experience in delivering care.
Purpose	This measure determines whether the local health workforce report positive experiences of PHN-delivered capacity building interactions.
Indicator Definition	<p>Standardised survey tool to be determined.</p> <p>A primary health care provider includes the following list of practitioners: general practitioners, nurses (practitioners, registered and enrolled), midwives, Aboriginal and Torres Strait Islander health practitioners, and allied health professionals. In some cases, support staff such as practice managers and administrative who are critical in delivery of services also receive capacity-building support from PHNs. Support staff are included in this measure.</p> <p>Providers in scope of this measure are those identified as attendants or participants in CB-02. A separate indicator (CM-07) exists for measuring commissioned service provider experience.</p> <p>Provider experience is feedback received using a nationally standardised tool that focuses on seeking the practitioner's perspective on their engagement with PHN-delivered capacity building activities identified in CB-02. Experience is collected through a formal survey on the participants' perceptions of the relevance, quality, and effectiveness of the activity.</p>
Performance Criteria	To be determined based on survey tool and following collection of baseline data.
Reporting Frequency	Annual
Data Source	PHN Reported
Calculation	To be determined based on survey tool.
Limitations	Participation rates in provider-reported experience surveys may vary. This could prevent achieving a global measure of workforce experience in receiving PHN-delivered capacity building activities.
Additional information	Not applicable

CB-06: Case study: demonstrate change or improvements in practice

Item	Description
Dimension	Progress / Performance
Description	Case study: demonstrate change or improvements in practice.
Rationale	PHNs support local healthcare providers based on their respective capacity-building needs. Due to the variability that exists between communities PHNs may take different approaches in delivering activity. This indicator provides PHNs the flexibility to showcase a successful change or improvement in healthcare provider practice following capacity-building activities.
Purpose	To provide PHNs the ability to showcase diversity of approaches and outcomes following capacity building activities. This indicator is designed to gain a richer understanding of activities and promote peer learning.
Indicator Definition	<p>A general practice is demonstrating change or improvement when it has participated in PHN-supported continuous quality improvement activities and has shown measurable, positive change in at least one agreed quality indicator. Change or improvement must be evidenced through comparative data (e.g. baseline vs follow-up), clinical audits, or other verifiable sources.</p> <p>Continuous quality improvement (CQI) activities refer to structured, iterative processes designed to support practices in identifying, testing, and implementing changes that lead to better patient care and system performance. These sessions are directly related to Practice Incentive Program Quality Improvement (PIP QI). CQI may involve a range of initiatives that focus on data quality, service delivery processes, or patient engagement.</p> <p>The case study must adhere to providing information against an evaluative framework, consisting of:</p> <ul style="list-style-type: none"> • What was the identified issue? • What objective/s did the PHN have to address the issue? • What processes or activities were implemented to address the issue? • What was the outcome and how is this evidenced? • What were lessons learned? • What are future implications and opportunities?
Performance Criteria	Not applicable, however PHNs are expected to fulfill the requirements of the provided template, including provision of supporting data.
Reporting Frequency	Annual
Data Source	PHN Reported
Calculation	Not applicable. A case study template will be provided by the Department.
Limitations	No current limitations identified; subject to future review.
Additional information	<p>Only one case study is required for each reporting period.</p> <p>To facilitate targeted submissions of case studies, reporting on selected priority or reform areas will rotate annually. Each reporting year focuses on one specific area. The rotating roster of focus areas is outlined below:</p> <ul style="list-style-type: none"> • Year 1: Prevention and early intervention • Year 2: Equity • Year 3: Digital and technology • Year 4: Integrated systems

Commission Indicators

CM-01: Evidence that commissioned activities address identified health needs or gaps

The Department will continue to internally develop this indicator to ensure it is fit-for-purpose and provides meaningful insight into PHN performance, in line with program expectations. As such, details have been included where possible to convey the intent and broad purpose of the indicator.

Item	Description
Dimension	Progress
Description	Evidence that commissioned activities address identified health needs or gaps.
Rationale	Activities delivered by PHNs are underpinned by a continual and iterative cycle described as the PHN Commissioning Framework. PHNs identify health needs or gaps within their communities and are responsible for designing and delivering locally tailored interventions that address these. PHNs should therefore be able to demonstrate a direct relationship between the strategic planning, and monitoring and evaluation phases of the commissioning cycle.
Purpose	To demonstrate that PHNs actively implement the full commissioning cycle, demonstrating a clear relationship between identified needs and delivery of measurable outcomes.
Indicator Definition	To be determined.
Performance Criteria	To be determined.
Reporting Frequency	To be determined.
Data Source	To be determined.
Calculation	To be determined.
Limitations	PHNs deliver some programs/activities in response to needs identified by the department, e.g. in response to an identified national health priority, rather than those identified through the HNA or other internal PHN process. To preserve the integrity of the strategic planning stages involved in commissioning, this indicator is intended to apply to flexibly funded activities in the first instance. The Department will consider how program-specific Health Needs Assessments may contribute to ongoing development of this indicator.
Additional information	Currently, PHNs can link the relationship between their Health Needs Assessment and Activity Work Plans. However, there is no clear mechanism that demonstrates the link between strategic planning with the outcomes measured in the monitoring and evaluation stages.

CM-02: Program episodes or service contacts

Item	Description
Dimension	Progress
Description	Number of episodes or service contacts delivered to eligible clients.
Rationale	PHNs contribute to the accessibility and delivery of targeted care to address population health needs and/or gaps. Measuring the number of episodes or service contacts delivered provides insight into operational efficiencies, client engagement and overall service impact. This measure is indicative of the volume and capacity of services that PHNs are achieving through their commissioned activities.
Purpose	To provide context to service volume of commissioned activities at a program level. On its own this indicator is not a performance measure but is intended for triangulation with other Commissioning Indicators in the Framework.
Indicator Definition	<p>Service contacts are defined as the provision of a service (or intervention) by a PHN-commissioned service provider for a client. The nature of the service would normally warrant a dated entry in a Client (or Clinical) Management System. Service provision is only regarded as a service contact if it is relevant to the condition or health needs of the client. This means that it does not include services of an administrative nature.</p> <p>Episodes are defined as a continuous period of contact between a client and a commissioned service that starts at the point of first contact and concludes at discharge. Episodes comprise a series of one or more service contacts</p> <p>Service contacts may be delivered as different modalities and are inclusive of face-to-face communication, telephone, video or other forms of direct communication.</p> <p>Eligible clients are defined as recipients of a service who fulfil specific criteria that qualify them to access or participate in a program or service. Eligible clients may include family and carers. Factors may include demographics, health status, or geographic location. Eligible clients are typically specified in Departmental program or service requirements. In other circumstances, PHNs may be identifying eligible clients based on their strategic planning processes.</p> <p>A commissioned service (or intervention) refers to any PHN organised activity or set of activities designed to meet the health needs or address gaps in service. Services may be clinical or non-clinical and co-commissioned with other stakeholders. Commissioned services are inclusive of medical services provided in a primary, allied, or aged care setting, and include alternative services such as service navigation, preventative care, care coordination, and psychosocial or workforce support.</p> <p>A commissioned service may also be provided at different levels of intensity. Service intensity refers to the degree of support or engagement a client receives from a service. Where applicable, episodes may be disaggregated by service intensity to demonstrate differences in service delivery or models of care.</p>
Performance Criteria	Nil – this will be interpreted with other measures.
Reporting Frequency	Annual
Data Source	Various
Calculation	Count of episodes or service contacts delivered to eligible clients. This count may be disaggregated by modality and service intensity.
Limitations	No current limitations identified; subject to future review.
Additional information	Delivery of episodes or service contacts is commensurate to funding provided to PHNs to deliver activities. This data will contribute to better understanding models of care that are in place.

CM-03: Commissioned service clients and positive outcomes

Item	Description
Dimension	Performance
Description	Proportion of commissioned service clients who demonstrate a positive outcome.
Rationale	PHNs seek to improve the health outcomes of their communities through effective commissioning. Demonstrating positive outcomes in clients receiving commissioned services is evidence of quality care. It can also be used to guide continuous quality improvement activities and offer insights that build a stronger understanding of factors that contribute to a positive consumer experience when receiving care.
Purpose	To determine the extent to which services or interventions are delivering positive outcomes which improve the health and wellbeing of clients.
Indicator Definition	<p>A commissioned service (or intervention) refers to any PHN organised activity or set of activities designed to meet the health needs or address gaps in service. Services may be clinical or non-clinical and co-commissioned with other stakeholders. Commissioned services are inclusive of medical services provided in a primary, allied, or aged care setting, and include alternative services such as service navigation, care coordination, and psychosocial or workforce support.</p> <p>Clients are recipients of a commissioned service. These clients may or may not have eligibility requirements specified. Clients who were actively receiving services during the reporting period are included in the counts of this measure.</p> <p>Positive outcomes refer to the beneficial and measurable results achieved through systematic efforts to enhance care and/or overall health. These outcomes are assessed by the service or provider, using metrics that are meaningful to the client and the service received. A positive outcome may include reduced symptoms, clinical or functional improvement, client engagement, or improved quality of care such as reduced wait times and referral to other appropriate services. A positive outcome is not limited to clinical measures alone - it encompasses broader aspects of well-being.</p> <p>Maintenance of health status (or outcomes) is also acknowledged as a positive outcome for some conditions where stability is a key goal. Maintenance refers to the sustained health and wellbeing of a client over time. Health status (or outcome) maintenance is defined by the health condition and respective tool used. "Maintenance" must therefore be determined at the time an outcome tool is selected.</p> <p>A positive outcome (improvement or maintenance) must be demonstrated from the commencement of a service to a defined endpoint. An endpoint may include discharge, transition to other care or at point of last contact.</p>
Performance Criteria	Performance criteria will be determined on a program-level basis. This is to ensure alignment with the program objectives, intervention and target population. Performance criteria will consider outcome trends (e.g. rolling averages) in line with expectation and stage of program delivery, rather than a target figure.
Reporting Frequency	Annual
Data Source	Various
Calculation	<p>Disaggregated by health status:</p> <ul style="list-style-type: none"> • Numerator: Number of clients who <u>demonstrated positive outcomes</u>. • Denominator: Total number of clients who received a service with an outcome measure Multiplied by 100. <ul style="list-style-type: none"> • Numerator: Number of clients who <u>maintained their health status</u> • Denominator: Total number of clients who received a service, with an outcome measure Multiplied by 100.

Item	Description
Limitations	This indicator may not be appropriate for application in short-term interventions where clients may only receive a single occasion of service.
Additional information	This indicator is a measure of service effectiveness, that aims to demonstrate that the service or intervention is producing the desired outcome (effectiveness) in clients. This contrasts with patient-reported outcome measures (CM-06) which focuses on patient-centred care and their personal perceptions.

CM-04: Cost per health improvement

The Department will continue to internally develop this indicator to ensure it is fit-for-purpose and provides meaningful insight of PHN performance, in line with program expectations. As such, details have been included where possible to convey the intent and broad purpose of the indicator.

Item	Description
Dimension	Performance
Description	Cost per health improvement.
Rationale	PHNs should commission activities that provide value for money. Value for money may be demonstrated by the cost of delivering a service relative to client outcomes. Value for money may also provide insights into an activity's sustainability. This measure helps understand costs associated with patient outcomes and maximising investments.
Purpose	To determine the extent to which commissioned services are achieving value for money.
Indicator Definition	Value for money refers to the optimal use of resources to achieve the best possible outcomes for the target population. Value for money is not simply about delivering services at the lowest value, but about the quality, appropriateness and effectiveness of what the investment has provided.
Performance Criteria	To be determined.
Reporting Frequency	Annual
Data Source	Various
Calculation	To be determined.
Limitations	No current limitations identified; subject to future review.
Additional information	The determination of this indicator is heavily reliant on the client cohorts, models of care, remoteness, service provider availability and the desired outcomes of a program. The Department will consider preliminary approaches that set foundations in measuring value for money, that is sensitive to nuances, equity and reduces misinterpretation.

CM-05: Proportion of commissioned services delivered to target population

Item	Description
Dimension	Performance
Description	Proportion of commissioned services delivered to target population.
Rationale	PHNs aim to increase the efficiency and effectiveness of primary health care services, particularly for people at risk of poor health outcomes. This measure demonstrates how effectively PHNs are tailoring services to reach and engage with target populations to achieving equity in service delivery. It also provides evidence of whether services are accessible and meeting the needs of the target population.
Purpose	To determine the extent to which PHN commissioned services are accessible to the target populations.
Indicator Definition	<p>A commissioned service (or intervention) refers to any PHN organised activity or set of activities designed to meet the health needs or gaps of clients. Services may be clinical or non-clinical. These are inclusive of medical services provided in a primary, allied, or aged care setting, or alternative supports such as service navigation, care coordination, and psychosocial support.</p> <p>A target population refers to a cohort of individuals that are the intended recipients of a service or program. Target populations are identified based on eligibility criteria and align with the intended goal of the service being delivered. These characteristics may include people with specific health conditions, demographics, socioeconomic status, place of residence or vulnerability. Target populations will be specified in Departmental program or service requirements.</p> <p>When a target population is not specified by the Department for a national program (e.g. where PHNs are commissioning services from their flexible funds), PHNs must describe the target population within their Activity Work Plans. Target populations may include the following cohorts:</p> <ul style="list-style-type: none"> • First Nations • culturally and linguistically diverse, • socioeconomically disadvantaged, • other <p>This indicator is a measure of service contacts, and the proportion of total services delivered to the target population, <u>not</u> as a measure of total clients. Service contacts are defined as the provision of a service (or intervention) by a PHN-commissioned service provider for a client. The nature of the service would normally warrant a dated entry in a Client (or Clinical) Management System. Service provision is only regarded as a service contact if it is relevant to the condition or health needs of the client. This means that it does not include services of an administrative nature.</p>
Performance Criteria	Performance criteria will be determined on a program-level basis. This is to ensure relevance to the program objectives, intervention and target population
Reporting Frequency	Annual
Data Source	Various
Calculation	<p>Disaggregated by each target population (if multiple apply):</p> <ul style="list-style-type: none"> • Numerator: The number of services delivered to the target population. • Denominator: The total number of services delivered. • Multiplied by 100. <p>In some circumstances the count may be calculated to determine the reach of the service as a rate of the target population (where appropriate):</p> <ul style="list-style-type: none"> • Numerator: The number of services delivered to the target population. • Denominator: Estimated residential population of the target population. • Multiplied by 100,000

Item	Description
Limitations	No current limitations identified; subject to future review.
Additional information	Not applicable.

CM-06: Patient-reported experience and outcome measure

Item	Description
Dimension	Performance
Description	Patient-reported experience and outcome measure.
Rationale	PHNs seek to improve the health outcomes and service experience of their communities through effective commissioning. Patient reported experience and outcome measures (PREMs & PROMs) are a valuable and holistic means to measure patient-centred care. This measures patient perception of care received from PHN-commissioned activities. It can identify areas for continuous quality improvement.
Purpose	To determine the extent to which PHNs are commissioning services that result in a positive patient-reported experience and outcome.
Indicator Definition	<p>A suite of agreed survey tools to be determined, suitable for use across different services, health conditions and populations.</p> <p>Patient-reported experience and outcome measure refers to tools used to capture a patient's perspective on their health care experience and outcomes of the care they received.</p> <p>The measure of patient-reported experience (PREMs) focusses on how well a service is perceived to have been delivered. It can explore of any of the following aspects of care: communication, cultural safety, access, and self-empowerment. PREMs are collected following receipt of care.</p> <p>The measure of patient-reported outcomes (PROMs) focuses on the perceived impact of care received on a patient's health status. Patients self-assess improvements in their symptoms, physical functioning, wellbeing and quality of life. PROMs are collected at the commencement and conclusion of care (at minimum).</p>
Performance Criteria	To be determined based on each survey too and following collection of baseline data.
Reporting Frequency	Annual
Data Source	Various
Calculation	To be determined.
Limitations	Participation rates in patient-reported experience and outcome surveys may vary. This could prevent achieving a global measure of patient experience and outcome in receiving PHN-commissioned activities.
Additional information	This indicator is a measure of patient perception, that aims to demonstrate that the service is patient centred. This contrasts with commissioned service-reported outcome measures (CM-03) which are an objective assessment of whether a service is producing its desired outcomes.

CM-07: Commissioned provider experience measure

The Department will continue to internally develop this indicator to ensure it is fit-for-purpose and provides meaningful insight of PHN performance, in line with program expectations. As such, details have been included where possible to convey the intent and broad purpose of the indicator.

Item	Description
Dimension	Progress
Description	Proportion of commissioned providers reporting a positive experience.
Rationale	PHNs procure services from local health providers as part of their commissioning approach. An effective procurement process, and monitoring and management of contracted providers is important in delivering successful commissioning. Measuring commissioned provider experience seeks to understand how well PHNs are performing their role as commissioners and engaging with providers to facilitate delivery of quality care.
Purpose	To determine the extent to which PHNs provide a positive commissioning experience to commissioned service providers.
Indicator Definition	<p>Standardised survey tool to be determined.</p> <p>A commissioned service provider is the business entity that the PHN has contracted to provide a specific service or intervention. For the purposes of this indicator, commissioned service providers in scope are those listed in a PHNs submitted Commissioned Services Report from the previous 12 Month Performance Report. This includes all service providers who had delivered services during the reference period, regardless of whether they have been de-commissioned. This list is used solely to identify eligible participants for the survey. The actual delivery of surveys and the collection of responses should occur within the current reporting period, ensuring that responses reflect recent service experiences.</p> <p>Provider experience is feedback received using a nationally standardised tool that focuses on seeking the commissioned provider's views on their engagement with the PHNs commissioning practices from an organisational perspective. This indicator is not intended to collect the views of individual clinicians. Key areas of focus of the survey include co-design, procurement, and continuous quality improvement.</p>
Performance Criteria	To be determined based on survey tool and following collection of baseline data.
Reporting Frequency	Annual
Data Source	Various
Calculation	To be determined.
Limitations	No current limitations identified; subject to future review.
Additional information	Survey responses should be provided by the representative of the commissioned provider who holds accountability for the delivery of the commissioned service (e.g. Executive Manager) Note: For providers who are commissioned by a PHN to deliver more than one program, it may be appropriate for a different or the same representative to provide the response, depending on the organisation's structure and responsibilities. One response is required from each commissioned program.

Compliance Indicators

CP-01: Financial reporting obligations

Item	Description
Dimension	Compliance (Financial management, planning and reporting)
Description	PHNs have met their financial responsibilities and obligations, including: <ol style="list-style-type: none"> Provision of annual audited income and expenditure statements to the required standard. Provision of other annual financial documentation (where applicable). Expenditure of funding in alignment with executed funding agreements and approved carryovers.
Rationale	PHNs are responsible for the management of funds provisioned under program schedules and their respective funding agreements. This indicator ensures transparency and accountability in the use of funds, by demonstrating funds are being used for intended purposes. This indicator supports the broader objective of ensuring PHNs, as commissioners, deliver value for money and achieve intended health outcomes within their communities.
Purpose	To assure PHNs are fulfilling financial reporting obligations and maintaining accountability of income and expenditure.
Indicator Definition	Annual audited income and expenditure statements are formal financial documents that summarise a PHNs financial performance over a fiscal year. They are reviewed and verified by an independent auditor. These statements must align with the format requested by the Department provided in July each year and as outlined in the 12 Month Finance Reporting Guide. Other annual financial documentation includes reporting on: ‘ <i>Other income</i> ’ ‘ <i>Interest earnings</i> ’, ‘ <i>Carryover and movement of funds,</i> ’ any identified ‘ <i>recoups</i> ’ and ‘ <i>Income and expenditure variance advice.</i> ’ This information is provided on templates which the Department issues annually or input to fields in PPERS.
Performance Criteria	<ol style="list-style-type: none"> <u>All</u> financial documents have been submitted in an acceptable format and in accordance with prescribed requirements by the Department by the specified due date in that financial year (typically 30 September). Content of financial documents is complete and provided to the requested level of detail.
Reporting Frequency	Annual
Data Source	PHN Reported – Submission of financial documents or information.
Calculation	Compliance status is determined based on whether all performance criteria have been fully satisfied.
Limitations	No current limitations identified; subject to future review.
Additional information	Refer to “PHN 12 Month Performance Report Financial Reporting Guidance” for additional detail on reporting requirements.

CP-02: ACNC Reporting

Item	Description
Dimension	Compliance (Financial management, planning and reporting)
Description	PHNs have completed their reporting obligations to the Australian Charities and Not-for-profits Commission (ACNC).
Rationale	PHNs are required to provide financial reports and annual information statements to the ACNC, prepared in accordance with the ACNC Act and Regulations. These reports are for the purpose of providing an added level of assurance about not-for-profit operations and financial affairs. Meeting this obligation is required for PHNs to maintain their registration as a not-for-profit organisation.
Purpose	To assure PHNs are completing their reporting requirements with the ACNC.
Indicator Definition	<p>At a minimum, large charities (those with annual revenue over \$3 million) must provide the following key information as part of ACNC reporting requirements:</p> <ul style="list-style-type: none"> • Annual Information Statement • Annual Financial Report <p>An Annual Information Statement (AIS) is a description of a charity's operations and finances over a twelve-month reporting period. The AIS typically includes information on basic charity information, key management personnel, finances, charity programs and outcomes, and compliance declarations.</p> <p>An Annual Financial Report (AFR) is a detailed description of a charity's finances and is usually provided as a General Purpose Financial Statement for reporting entities. The AFR typically includes a statement of profit or loss, a statement of financial position, and an auditor's or reviewer's report. The AFR must comply with Australian Accounting Standards.</p> <p>Failure to meet reporting obligation can result in publication of an overdue statement on the ACNC's Charity Register, issue of penalty notices and possible revocation of registration.</p> <p>Reports to the ACNC are due six months after the end of a charity's reporting period, which is typically from 1 July to 30 June for PHNs. Refer to ACNC's published guides for further detail on reporting requirements.</p>
Performance Criteria	<p>a) PHNs have confirmed that ACNC reporting has been completed and submitted to the ACNC by the ACNC required due date in that financial year.</p> <p>b) In instances where reports have not yet been submitted, the PHN must inform the Department once submission has been completed.</p>
Reporting Frequency	Annual
Data Source	Annual Information Statements and Annual Financial Reports will be sourced directly from the ACNC website by the Department.
Calculation	Compliance status is determined based on whether all performance criteria have been fully satisfied
Limitations	It is acknowledged that statements and reports to the ACNC are typically presented at a PHNs Annual General Meeting (AGM) which are generally held in October or November. This is likely to impact on reporting against this indicator.
Additional information	Not applicable

CP-03: Board composition and contribution

Item	Description
Dimension	Compliance (Governance and decision-making processes)
Description	<p>A description of PHN Board composition and evidence of skills audit or review.</p> <ul style="list-style-type: none"> • Director name • Qualification/s • Director role/s • Commencement date
Rationale	<p>PHNs are required under their funding agreements to establish and maintain robust governance structures, including a skills-based Board. The Board holds ultimate accountability for the PHN's performance and outcomes, overseeing key areas such as clinical governance, financial management, risk, strategic planning, legal compliance, and business operations. An effective Board is composed of individuals who bring a diverse mix of skills, experience, and independence. This indicator demonstrates that PHNs are guided by strong strategic leadership and is well-positioned to deliver on its objectives with financial integrity, operational efficiency, and responsiveness to community needs.</p>
Purpose	To assure PHN Board composition is skills-based and is subject to regular review or audit.
Indicator Definition	<p>A skills-based board is one that brings together a diverse range of core competencies and expertise. This includes clinical expertise, health system knowledge, governance and risk management, financial and audit expertise, community and consumer engagement, strategic planning, performance monitoring, and innovation. A description of board composition should include the following details for each individual:</p> <ul style="list-style-type: none"> • Qualification: The formal academic qualifications, certifications, and professional credentials that an individual on the board holds, which support their ability to contribute effectively to governance and oversight. • Role: The specific position, office or function an individual on the board holds within the board and sub-committee structure, such as Director, Chair, Deputy/Co-Chair. <p>Commencement date: The official date at which the individual was formally appointed to the Board.</p> <p>A skills audit refers to a systematic process to assess the collective capabilities and experience of the board against a set of competencies. A skills review is broader and determines whether there are identified gaps, future needs and opportunities to improve board effectiveness. PHNs should provide a summary of what framework, criteria and process was used to undertake the skills audit or review, and the subsequent actions taken or planned in response to the findings. This may include the selection process for new Directors.</p>
Performance Criteria	<p>a) PHNs have provided information on Board composition in alignment with the indicator definition.</p> <p>b) PHNs have indicated that a skills audit or review was conducted (and the date completed), and have provided a brief (300 word) summary of outcomes or actions to a satisfactory level.</p>
Reporting Frequency	Biennial (once every two years)
Data Source	<p>a) PHNs to provide a hyperlink to their website listing details of Board composition. Board composition is validated by Financial Reports submitted to the Australian Charities and Not-for-profits Commission.</p> <p>b) PHN Reported</p>
Calculation	<p>a) For each individual on the Board, provide:</p> <ul style="list-style-type: none"> • Name: Title or honorific and full name • Qualifications: <ul style="list-style-type: none"> Academic qualifications (e.g MBBS, PhD, etc) <ul style="list-style-type: none"> ○ Professional certifications or registrations (e.g. CPA, FRACGP, etc) ○ Relevant governance credentials (e.g GAID, etc) • Role: PHNs describe the official role title of the individual

Item	Description
Dimension	Compliance (Governance and decision-making processes)
	<ul style="list-style-type: none"> • Commencement date in dd/mm/yyyy format <p>b) PHNs should provide a summary of the framework, criteria and process used to undertake the skills audit or review, and the subsequent actions taken or planned in response to the findings. Compliance status is determined based on whether all performance criteria have been fully satisfied.</p>
Limitations	No current limitations identified; subject to future review.
Additional information	PHNs are expected to ensure that updated Board composition details are published on their website by the reporting due date. As part of a validation process, the Department will present information collected for this indicator back to each PHN, to qualify that details are true and correct. This will also be an opportunity to request details that may not be published (e.g. commencement date).

CP-04: Culturally safe practices

Item	Description
Dimension	Compliance (Organisational capacity)
Description	Evidence that PHNs engage in practices that support cultural safety and that these are embedded in organisational policies and procedures.
Rationale	PHNs are expected to demonstrate culturally safe workplace practices that foster a positive and supportive environment for First Nations staff. Under Commonwealth and jurisdictional Workplace Health and Safety legislations (or equivalent), PHNs are legally required to provide a workplace free from risks to health, including psychosocial and cultural harm. It requires organisations to address systemic issues that may affect marginalised staff, and to implement preventative measures such as training, inclusive policies and culturally safe practices. This indicator demonstrates that PHNs have implemented policies and procedures that contribute to providing a safe and inclusive workplace.
Purpose	To assure PHNs are committed to supporting cultural safety for staff in the workplace.
Indicator Definition	<p>A culturally safe workplace is one in which individuals, especially those belonging to marginalised or diverse cultural groups, feel respected, valued and free from discrimination. Embedding cultural safety is taking deliberate actions that actively recognise, respect and support the cultural identity of a person while meeting their needs, expectations and rights.</p> <p>Reconciliation Action Plans (RAPs) are a formal commitment by organisations to sustainably and strategically support First Nations self-determination through the advancement of reconciliation. RAPs are developed with the collaborative support of Reconciliation Australia and are designed to suit an organisation's reconciliation journey across four stages: <i>Reflect</i>, <i>Innovate</i>, <i>Stretch</i> and <i>Elevate</i>. RAPs must proceed through a conditional and formal endorsement process with Reconciliation Australia. Refer to Reconciliation Australia for more information.</p>
Performance Criteria	<p>a) PHNs provide a progress update on development and implementation of their RAP, including:</p> <ul style="list-style-type: none"> • RAP type: Reflect, Innovate, Stretch or Elevate • RAP status and date endorsed by Reconciliation Australia • RAP deliverables and their traffic light status <p>b) PHNs provide a (300 word) summary of progress, achievements and challenges experienced in the development and implementation of their RAP during the reporting period.</p>
Reporting Frequency	Annual
Data Source	PHN Reported – Submission of relevant documents or statement.
Calculation	Compliance status is determined based on whether all performance criteria have been fully satisfied.
Limitations	No current limitations identified; subject to future review.
Additional information	This indicator is concerned specifically with the cultural safety within the PHN's workplace. The application of principles of cultural safety in commissioning processes and those implemented by contracted providers, whilst important, is not the focus of this indicator.

CP-05: Procurement methods

Item	Description
Dimension	Compliance (Probity and commissioning practices)
Description	Description of procurement methods used to commissioned services.
Rationale	PHNs are required to procure and contract services in a way that achieves value for money, using open and transparent processes that are appropriate to the scale and scope of the procurement. Competitive, merit-based procurement methods can achieve better outcomes and value with relevant money. Such processes should be used for commissioning new services wherever possible. However, in some circumstances such as thin markets, it may be appropriate to use a procurement method that is tailored to capability-development, sustainability, and market maturity. In these cases, the reason for using another approach should be documented. This indicator identifies patterns in a PHN's probity, accountability and commissioning practices, demonstrating alignment with Commonwealth expectations.
Purpose	To assure PHN procurement practices and market engagement methods.
Indicator Definition	<p>There are several procurement methods that could be used to secure a commissioned service. These include:</p> <ul style="list-style-type: none"> • Continuing Service Provider/Contract extension: When an existing commissioning arrangement expires within the reporting period and is extended (by variation) without a procurement process undertaken (as permitted under contractual arrangements). • Direct Engagement - providers are invited to apply or provide a proposal for a particular service that is assessed in isolation on its own merits against the selection criteria. • Open Tender - a procurement approach with nominated open and close dates, with applications assessed against the nominated selection criteria (eligibility and assessment criteria) and against the comparative merits of other applications. • Other Approach - all other procurement methods not described above, such as targeted or restricted competitive processes. In some cases, PHNs may use a split approach to develop markets that have limited providers. In the circumstance of thin markets, PHNs may choose models that leverage partnership-based and capacity-building commissioning. These are denoted under this method. <p>All service providers that were commissioned for the respective reporting period are in scope for this indicator, regardless of whether for a new or ongoing activity.</p>
Performance Criteria	<p>a) PHNs have procured services in accordance with the Commonwealth Grants Rules and Principles 2024 and relevant Grant Opportunity Guidelines.</p> <p>b) Any exceptions to the Department's required or expected approach have been documented, justified and if applicable, approval from the Department provided.</p>
Reporting Frequency	Annual
Data Source	PHN Reported - Commissioned Services Report
Calculation	<p>a) PHNs indicate the procurement method used for each service provider listed in the Commissioned Services Report.</p> <p>b) PHNs provide justification and where applicable, approval, for all exceptions to a required or preferred procurement approach.</p> <p>Compliance status is determined based on whether all performance criteria have been fully satisfied.</p>
Limitations	No current limitations identified; subject to future review.
Additional information	PHNs are required to report on their planned procurement method through their Activity Work Plans. This indicator focuses on the actual method used.

CP-06: Value for money in commissioning

Item	Description
Dimension	Compliance (Probity and commissioning practices)
Description	PHNs conduct a 'value for money' assessment throughout their commissioning process.
Rationale	PHNs are expected to achieve value for money in accordance with the Commonwealth Grants Rules and Principles 2024 . This principle should underpin PHN purchasing and outcomes-based commissioning practices and is inclusive of both financial and non-financial costs and benefits. Measuring value for money throughout the commissioning cycle ensures that PHN activities are fit for purpose, support a competitive market, and promote transparent and accountable decision-making, which are key elements of probity.
Purpose	To assure PHNs have assessed value for money as part of their commissioning cycle processes.
Indicator Definition	<p>Value for money is a judgement based on the grant proposal representing an efficient, effective, economical and ethical use of public resources and determined from a variety of considerations³. Factors that contribute to an assessment of value for money include, but are not limited to:</p> <ul style="list-style-type: none"> • fitness for purpose; • a potential supplier's experience and performance history; • flexibility, including innovation and adaptability; and • whole of life costs <p>Regular assessments of value for money are expected to occur at least triennially (every three years) for ongoing programs or activities (in line with standard contract duration) and at the commencement of a new activity. Assessment refers to a methodical process of determining whether defined criteria or factors have been met. It is expected that PHNs systematically review relevant information, apply agreed measures and form a documented judgement on value for money.</p> <p>A program refers to a structured and related set of services or interventions commissioned by the PHN to achieve a specific health outcome. Programs may encompass multiple activities under a common objective or funding stream. An activity refers to a distinct intervention or service commissioned by the PHN. Activities typically implement a component of a broader program. A new activity is the commencement of a distinct service not previously commissioned or delivered by the PHN under a new or existing funding stream. It may include a new model of care, service type, or delivery method. <u>This indicator is only relevant to Core and Mental Health Flexible funded programs.</u></p> <p>Evidence of value for money assessments should be embedded within commissioning policy and procedure documents. This may include value for money assessment templates, procurement toolkits, business case reports, and service performance reviews. These documents are then operationalised throughout the continuum of the commissioning cycle and are kept as records of decisions.</p> <p>For the purpose of this indicator, the commissioning cycle consists of three main stages: strategic planning (needs assessment and annual planning), procurement (co-designing and contracting), and monitoring and evaluation (managing performance and evaluation).</p>
Performance Criteria	<p>PHNs regularly assess value for money as part of the commissioning cycle and have conducted an assessment over the lifecycle of each program and activity.</p> <p>Compliance status is determined based on whether all performance criteria have been fully satisfied</p>
Reporting Frequency	Annual
Data Source	PHN Reported – Commissioned Services Report
Calculation	PHNs indicate which programs or services they deliver have undergone a 'value for money' assessment, and at what stage of the commissioning cycle during the reporting period.

³ Department of Social Services – Community Grants Hub - Glossary

Item	Description
Dimension	Compliance (Probity and commissioning practices)
	<p>In addition, PHNs provide one representative case study (300 words) that demonstrates how it assesses value for money at a particular stage in the commissioning cycle.</p> <p>The case study must provide information consisting of:</p> <ul style="list-style-type: none"> • The stage of the commissioning cycle in which the assessment was performed. • The criteria used to assess value for money • The processes or activities that formed the assessment • The outcome of the assessment
Limitations	<p>Grant opportunity guidelines may contain some requirements that limit a PHN's ability to have a significant effect on value for money in service delivery.</p> <p>The Department has not prescribed a specific set of measures for PHNs to use when assessing value for money as part of commissioning. Subsequently, there is expected variability in how PHN's perform a value for money assessment. While PHNs may not explicitly label their processes as 'value for money' assessments, the underlying principles are likely embedded throughout their commissioning practices. This indicator focuses on confirming that value for money assessments has been conducted, rather than specifying how they have been performed. Information reported through this indicator may be used to inform future development of the indicator.</p>
Additional information	<p>Refer to "12 Achieving Value with Relevant Money" in the Commonwealth Grants Rules and Principles 2024 for more information.</p> <p>This indicator differs from CM-04, as it is concerned with demonstrating that PHNs systematically assess value for money within the commissioning processes. CM-04 seeks to determine the efficiency of achieving outcomes in a service or activity.</p>

CP-07: Conflicts of interest and related party transactions

Item	Description
Dimension	Compliance (Probity and commissioning practices)
Description	Evidence of policies and procedures to manage conflicts of interest and related party transactions.
Rationale	PHNs are responsible for appropriately managing conflicts of interest and related party involvement throughout commissioning and program delivery. In line with Commonwealth Grant Rules and Principles and the Terms and Conditions of funding agreements, managing conflicts of interest and related parties promotes transparency, accountability and equitable practices. This indicator examines PHN probity and transparency, demonstrating alignment with Commonwealth expectations.
Purpose	To assure PHNs effectively manage conflicts of interest and related party transactions and have notified the Department in applicable circumstances.
Indicator Definition	<p>Conflict of interest (or conflict) - means any matter, circumstance, interest or activity involving or affecting the PHN or the PHNs personnel, which may, or may not appear to impair the PHNs ability to perform its responsibilities diligently, fairly and independently⁴.</p> <p>Related parties - Any individual or organisation that has a pre-existing relationship with the PHN and who may be in a position to influence or benefit from decisions made by the PHN. This includes but is not limited to:</p> <ol style="list-style-type: none"> i. An entity that the PHN controls or has significant influence over; ii. A member of the PHN's board or governing body; iii. A member of the board of any related entity; iv. A member of the PHN's personnel acting outside their capacity as an employee; v. A spouse or immediate family member of any of the individuals listed above. <p>Organisational policies and procedures are formal documents that guide how a business operates and how staff are expected to behave. They help ensure consistency, transparency, legal compliance and alignment with the organisation's values and goals. Policies and procedures provide a clear framework for decision-making and instructions on how to implement organisational practices</p> <p>Review refers to the process of examining and revising the content of policies and procedures to ensure that the information is comprehensive and accurately reflects management of conflicts of interest and related party transactions. PHNs are not necessarily expected to review policies and procedures on a biennial basis, but in line with the organisation's risk-appetite and established review cycles.</p>
Performance Criteria	<ol style="list-style-type: none"> a) PHNs have provided their policies and procedures related to the management of conflicts of interest and related party transactions. b) PHNs have indicated that their policies and procedures related to the management of conflicts of interest and related party transactions have been reviewed, and the date new versions (if any) were published. c) Where applicable, the PHN has notified the Department of conflicts and the PHN's proposed management/mitigation strategies, and/or sought consent of Related Party transactions in accordance with PHN obligations and requirements set out in the funding agreement terms and conditions and the PHN Conflicts and Related Party Policy.
Reporting Frequency	<ol style="list-style-type: none"> a) and b) biennial (once every two years). c) PHNs notify the Department as conflicts arise – refer to xxx⁵ for details on this process.
Data Source	<p>PHN Reported – Submission of relevant documents and information.</p> <p>Related party transaction may be validated by Financial Reports submitted to the Australian Charities and Not-for-profits Commission.</p>

⁴ Commonwealth Grant Rules and Principles: "A conflict of interest arises where a person makes a decision or exercises a power in a way that may be, or may be perceived to be, influenced by either material personal interests (financial or non-financial) or material personal associations".

⁵ Document to come.

Item	Description
Dimension	Compliance (Probity and commissioning practices)
Calculation	Compliance status is determined based on whether all performance criteria have been fully satisfied.
Limitations	No current limitations identified; subject to future review.
Additional information	Clauses 9.4 and 9.5 of the Funding Agreement outline the requirements to notify the department in case of conflicts and related party transactions. The Department may refine expectations of what conflicts are reported by PHNs, based on receipt of existing policies and procedures.

CP-08: Information security management

Item	Description
Dimension	Compliance (Data management and governance)
Description	ISO27001:2022 certification, and the number, description and remediation of non-conformities.
Rationale	PHNs are required to have Information Security Management Systems (ISMS) that are certified against ISO27001:2022 international standards. Certification means that PHNs have been formally audited and have been assessed as meeting requirements. These requirements include a range of controls that manage information security risks that meet the principles of confidentiality, information integrity and data availability. This indicator confirms PHNs are certified and if they have experienced any non-conformities.
Purpose	To ensure PHNs are certified to ISO27001 and are monitoring controls accordingly.
Indicator Definition	Non-conformities refer to a deviation or lapse to the implementation of management controls established as part of ISO27001 certification. In accordance with ISO guidelines, conformity is considered as the demonstration that specified requirements relating to a product, process, service, person, system or body are fulfilled. Controls are measures that maintains and/or modifies risk. Controls include, but are not limited to, any process, policy, device, practice or other conditions and/or actions which maintain and/or modify risk. Refer to ISO for more information.
Performance Criteria	a) PHNs are ISO27001:2022 certified. If certified, PHNs indicate that they have commenced or are undertaking a Surveillance Audit or Recertification. b) PHNs provide a summary (300 words) of the number and controls affected by non-conformities against ISO27001:2022 standards and how non-conformities were remediated.
Reporting Frequency	Annual
Data Source	PHN Reported
Calculation	Compliance status is determined based on whether all performance criteria have been fully satisfied.
Limitations	No current limitations identified; subject to future review.
Additional information	Not applicable

Impact Indicators

IM-01: Potentially preventable hospitalisations

Item	Description
Dimension	Impact
Description	Rate of potentially preventable hospitalisation per 100,000 people.
Rationale	The cumulative efforts of PHNs in care coordination, capacity building and commissioning services within their regions, aim to strengthen the efficiency and effectiveness of primary health care services, particularly for people at risk of poor health outcomes. This indicator reflects the potential cumulative outcome of all PHN activities that, over time, contributes to a reduction in potentially preventable hospitalisations.
Purpose	To explore the extent to which the PHN Program may be reducing potentially preventable hospitalisations through delivery of its core functions.
Indicator Definition	<p>Potentially preventable hospitalisations (PPH) are hospital separations that potentially could have been prevented by timely and adequate health care in the primary and community setting. In total there are 18 conditions that are categorised as either⁶:</p> <ul style="list-style-type: none"> • acute: conditions that usually come on suddenly, and may not be preventable, but may not result in hospitalisation if timely and adequate care had been received in the community • vaccine-preventable: hospitalisations due to conditions that can be prevented by vaccination • chronic: conditions that are persistent and long-lasting but may be preventable through lifestyle change and can also be managed in the community to prevent worsening of symptoms or hospitalisation. <p>Primary and community health care can effectively manage and treat many health conditions. Primary care provides an opportunity for early intervention, that can help to reduce the risk of a person developing a disease, their symptoms worsening, or complications developing. Refer to AIHW for more information.</p>
Performance Criteria	<p>This indicator is assessed at a national level and disaggregated as per the below.</p> <ul style="list-style-type: none"> • National trend: A 1≥% reduction in the national rate of total PPH. <p>Disaggregation:</p> <ul style="list-style-type: none"> • PHN • people aged 0-64 and 65+ year • vaccine preventable, • acute conditions, and • chronic conditions.
Reporting Frequency	Annual
Data Source	Data will be sourced directly from the Australian Institute of Health and Welfare by the Department.
Calculation	<p>For each disaggregation:</p> <ul style="list-style-type: none"> • Numerator: Number of potentially preventable hospitalisations. • Denominator: Estimated residential population. • Multiplied by 100,000 <p>Where available, age-standardised rates will be the preferred unit for all analyses to ensure comparability. In instances where age-standardised rates are not available, crude rates will be used as an alternative.</p> <p>The Department may also consider select potentially preventable conditions for analysis purposes.</p>

⁶ Australian Institute of Health and Welfare (2025) [Potentially preventable hospitalisations in Australia by small geographic areas: 2017–18 to 2022–23](#), AIHW, Australian Government, accessed 06 August 2025

Limitations	<p>PHNs may have limited ability to affect this rate. 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. 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>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> <p>However, there are many other reasons why an area or group of people may have higher rates of PPH – including higher rates of disease, lifestyle factors and other risks, or a genuine need for hospital services. Some PPH may not be avoidable, such as for patients with complex illness, or patients having procedures as follow-up to primary care⁷.</p>
Additional information	Not applicable

⁷ Australian Institute of Health and Welfare (2025) [Potentially preventable hospitalisations in Australia by small geographic areas: 2017–18 to 2022–23](#), AIHW, Australian Government, accessed 06 August 2025

IM-02: Lower urgency care presentations

Item	Description
Dimension	Impact
Description	Rate of lower urgency emergency department presentations per 1,000 people.
Rationale	The cumulative efforts of PHNs in coordinating care, capacity building and commissioning services within their regions, aims to strengthen the efficiency and effectiveness of primary health care services, particularly for people at risk of poor health outcomes. This indicator reflects the potential cumulative outcome of all PHN activities, that over time, contributes to a reduction in lower urgency care presentations at emergency departments.
Purpose	To explore the extent to which the PHN Program may be reducing lower urgency care presentations through delivery of its core functions.
Indicator Definition	<p>Lower urgency emergency department presentations are defined as presentations at formal public hospital emergency departments where the person:</p> <ul style="list-style-type: none"> had a type of visit to the ED of Emergency presentation had a triage category of semi-urgent (triage category 4: should be seen within 60 minutes) or non-urgent care (triage category 5: should be seen within 120 minutes) 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>Presentations are inclusive of in hours and after hours presentations:</p> <ul style="list-style-type: none"> in hours: weekdays from 8:00 am to 7:59 pm and Saturdays from 8:00 am to 12:59 pm. after hours: Sundays, public holidays, weekdays before 8:00 am and from 8:00 pm, and Saturdays before 8:00 am and from 1:00 pm. <p>Lower urgency ED presentations are sometimes used as a proxy measure of access to primary health care because some patients presenting in these categories may be better managed elsewhere in the health system. Refer to AIHW for more information.</p>
Performance Criteria	<p>This indicator is assessed at a national and PHN level, and for the below disaggregates.</p> <ul style="list-style-type: none"> National trend: A 1≥% reduction in all hours lower urgency ED presentations. PHN trend: match or exceed the reduction in the national rate of all hours lower urgency ED presentations. <p>Disaggregation:</p> <ul style="list-style-type: none"> in hour presentations after hours presentations
Reporting Frequency	Annual
Data Source	Data will be sourced directly from the Australian Institute of Health and Welfare by the Department.
Calculation	<p>For each disaggregation:</p> <ul style="list-style-type: none"> Numerator: Number of lower urgency ED presentations. Denominator: Estimated residential population. Multiplied by 1,000 <p>Where available, age-standardised rates will be the preferred unit for all analyses to ensure comparability. In instances where age-standardised rates are not available, crude rates will be used as an alternative.</p>
Limitations	PHNs may have limited ability to affect this rate. The establishment of Medicare Urgent Care Clinics from 1 July 2023 may also influence these trends as they are intended to reduce pressure on hospital and emergency departments. In addition, state health departments may also provide alternative services (e.g. the Minor Injury and Illness Clinics in Queensland) that offer services for illnesses and injuries not anticipated to be life-threatening in nature. Other market factors also contribute to people attending emergency departments, including the availability and accessibility of general practice care.

Additional information	Not applicable
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IM-03: Patient coordination of care

Item	Description
Dimension	Impact
Description	Proportion of persons reporting that general practitioners helped most in coordinating their care.
Rationale	PHNs support general practices in their region. This is to ensure that health professionals can respond appropriately and confidently to the health needs of their region and improve their service delivery, including coordinated care. This indicator provides information on patient experience in receiving coordinated care from their general practitioner
Purpose	To explore the extent to which the PHN Program may be supporting general practice in providing coordinated care to patients, through delivery of its core functions.
Indicator Definition	Persons reporting that general practitioners helped most in coordinating their care, is derived from Patient Experience Survey respondents who saw three or more health professionals for the same condition. Responses collected as part of the Patient Experience Survey collects information from people about their experiences with selected aspects of the health system in the 12 months before their interview, including access and barriers to a range of healthcare services. It is conducted via telephone interview for people aged 15 years and over who were usual residents of private dwellings. The survey method collects responses from a sample population which are then processed to create estimates and manage non-sampling error. Refer to ABS for more information.
Performance Criteria	This indicator is assessed at a national level, and for the below disaggregates. <ul style="list-style-type: none"> National trend: A 0.5% increase in persons reporting that general practitioners helped coordinate care most Disaggregation: <ul style="list-style-type: none"> self-assessed health long term health conditions
Reporting Frequency	Annual
Data Source	Data will be sourced directly from the Australian Bureau of Statistics (Patient Experience Survey) by the Department.
Calculation	For each disaggregation: <ul style="list-style-type: none"> Proportion of persons reporting that general practitioners helped coordinate care most. (calculated proportion already provided in the ABS data release).
Limitations	PHNs may have limited ability to affect this rate.
Additional information	Information was collected on respondents' perceptions of their health status and experiences with services. Perceptions are influenced by several factors and can change quickly. Care should therefore be taken when analysing or interpreting the data.

Appendix

Acronyms and Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Organisation
ACNC	Australian Charities and Not-for-profits Commission
AFR	Annual Financial Report
AGM	Annual General Meeting
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AIS	Annual Information Statement
CB	Capacity-Build indicator
CM	Commission indicator
CO	Coordinate indicator
CP	Compliance indicator
CPA	Certified Practising Accountant
CPD	Continuing Professional Development
CQI	Continuous Quality Improvement
ED	Emergency Department
FRACGP	Fellow of the Royal Australian College of General Practitioners
GAID	Graduate of the Australian Institute of Directors
HNA	Health Needs Assessment
HPI-O	Healthcare Provider Identifier Organisation
ICD	International Classification of Diseases
IM	Impact Indicators
ISMS	Information Security Management Systems
LHD/LHN	Local Health District or Local Health Network
MBBS	Bachelor of Medicine, Bachelor of Surgery
OAIC	Office of the Australian Information Commissioner
PHN	Primary Health Network
PIP	Practice Incentives Program
PPERS	PHN Performance and Evaluation Reporting System
PPH	Potentially Preventable Hospitalisations
PhD	Doctor of Philosophy
QI	Quality Improvement
QIMs	Quality Improvement Measures
RACGP	Royal Australian College of General Practitioners
RAP	Reconciliation Action Plan

Version History

Version	Description of change	Author	Effective date
1.0	Initial release version	Department of Health, Disability and Ageing	August 2025

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All information in this publication is correct as at August 2025

