

Bilateral Agreement between the Commonwealth and Tasmania

Coordinated care reforms to improve patient health outcomes
and reduce avoidable demand for health services

Part 1 — Preliminaries and Reform Intent

1. The Commonwealth of Australia (the Commonwealth) and Tasmania acknowledge that while Australia has a high performing health system, some patients with chronic and complex conditions experience the system as fragmented and difficult to navigate.
2. This Bilateral Agreement (the Agreement) recognises the mutual interest and investment of the Commonwealth and Tasmania in improving the delivery of care for patients with chronic and complex conditions, and reducing avoidable demand for health services.
3. The Agreement sets out a suite of reforms to progress the Council of Australian Government's (COAG) commitment to enhanced coordinated care, as articulated in the *Addendum to the National Health Reform Agreement (NHRA): Revised Public Hospital Arrangements for 2017-18 to 2019-20 (the NHRA Addendum)*. Activities that will progress these reforms are set out in Schedules to this Agreement (the Schedules).
4. The Agreement complements reforms relating to safety and quality, and Commonwealth funding mechanisms also articulated in the NHRA and existing national and local coordinated care measures.

Part 2 — Parties and Operation of Agreement

Parties to the Agreement

5. The Agreement is between the Commonwealth and Tasmania.

Commencement, duration and review of the Agreement

6. The Agreement will commence on the date of signing.
7. Review of the Agreement will commence from July 2018, to inform COAG's consideration of a joint national approach to enhanced coordinated care for people with chronic and complex conditions in early 2019.
8. The Agreement will expire on 31 December 2019, unless terminated earlier in writing. COAG will consider arrangements beyond this point.

Interoperability

9. The Agreement is to be considered in conjunction with:
 - a. The NHRA and the NHRA Addendum;
 - b. The *National Healthcare Agreement 2012*; and
 - c. The *Intergovernmental Agreement on Federal Financial Relations 2008*.
10. Schedules to this Agreement will include, but not be limited to:
 - a. Schedule A: Implementation Plan; and
 - b. Schedule B: Evaluation Framework.

Part 3 — Objective and Outcomes

11. The overarching objective of the Agreement is to support the implementation of coordinated care reforms, consistent with the principles outlined in the NHRA Addendum, that:
 - a. improve patient health outcomes; and
 - b. reduce avoidable demand for health services.
12. The Parties will contribute to the achievement of these objectives and outcomes through reform activities as specified in Schedule A to this Agreement, including;
 - a. data collection and analysis; system integration; and care coordination services, as critical underlying structures of joint coordinated care reform; and
 - b. in other priority areas relevant to Tasmania's local needs and circumstances.
13. The Parties recognise that the activities, objectives and outcomes of the Agreement, will link, where relevant, with longer term health reforms.

Data Collection and Analysis

14. Data collection and analysis activities are aimed towards creating a linked data set for patients with chronic and complex conditions to inform coordinated care reforms in order to:
 - a. understand patient service utilisation and pathways across the health system;
 - b. identify patients or patient characteristics that would benefit from better care coordination, including from the Health Care Homes (HCH) model;
 - c. understand the impact of service change, to support improved population health outcomes and inform ongoing health system improvements; and
 - d. contribute to the evidence base for improving patient care.

System Integration

15. System integration activities are aimed towards contributing to improvements over time, in:
 - a. regional planning and patient health care pathways, including providing better access and service delivery across systems;
 - b. integration of primary health care, acute care, specialist and allied health services, including through digital health opportunities; and
 - c. effectiveness and efficiency of collaborative commissioning arrangements.

Care Coordination Service

16. Care coordination service activities are aimed towards contributing to improvements over time, in:

- a. care coordination capacity and capability;
 - b. cost effectiveness and efficiency of targeting of available resources, while ensuring continuity of care for patients; and
 - c. patient empowerment, knowledge, skills and confidence to set goals and manage their health, with the support of their health and social care team.
17. The Parties will additionally contribute to the achievement of the objectives and outcomes of the Agreement through reforms in the priority areas of primary mental health care, end of life and multidisciplinary/anticipatory models of care.

Part 4 — Roles and responsibilities

18. The Parties agree to work together to implement, monitor, refine and evaluate coordinated care reforms under the Agreement.
19. In respect of the joint commitment at Clauses 12 through 17, the Parties will: undertake all activities as outlined in the Schedules to the Agreement; develop and agree project plans to support implementation, where relevant; monitor achievement against milestones; and conduct an evaluation of reform activities.

Part 5 —Monitoring progress and evaluation

Monitoring Progress

20. Progress will be monitored and reported in accordance with Schedule A (Implementation Plan). This will support early identification and/or resolution of implementation issues, inform refinement of the coordinated care reform activities and policy development, and support evaluation of Agreement activities.
21. Monitoring activities will include:
- a. Six-monthly status reports, on an exception basis against relevant milestones, by each Party, to relevant executive officers;
 - b. Quarterly bilateral officer-level discussions on implementation progress and emerging risks or issues;
 - c. Multilateral updates as required on implementation progress and emerging risks or issues through relevant committees; and
 - d. Ad hoc reporting, as agreed by the Parties.
22. The Parties will undertake an initial evaluation of the reforms including, where possible, the impact on patient outcomes and experience, as outlined in Schedule B (Evaluation Framework), consistent with Clauses 10 – 12 of the NHRA Addendum. The evaluation will consider the first 12 months of activity, from the commencement of the Agreement.
23. Where Tasmanian reforms build on or directly support the HCH model, the evaluation will recognise the collaborative partnership and its impact on the outcome of the HCH evaluation.

24. Where possible, evaluation will acknowledge and consider existing national and local measures, and other broader policy changes that affect the operation of the Agreement.
25. Evaluation findings will be used to inform the development of advice to COAG Health Council prior to COAG in early 2019, in order to inform future activities that will continue to build the evidence base for joint action on coordinated care.

Risk and Issues Management

26. The Parties agree that they will continually monitor, review and take necessary action to manage risks over the life of the Agreement.
27. Where agreed by both Parties, Schedule A will be updated to reflect any substantive changes or extension to activities to effectively manage identified risks.
28. Each Party agrees to provide the other Party with reasonable prior notice, in writing, on any implementation issues and risks that may impact on the progress or success of the reforms.
29. If risks eventuate at any time for either party, the Party with primary responsibility for the risk will work with the other Party to develop agreed mitigation proposals.

Part 6 — Stakeholders

30. To support appropriate linkages and embed Agreement activities within existing programs and services, the Parties will communicate as appropriate with key stakeholders throughout the life of the Agreement, including through existing communication channels, mechanisms and forums.

Part 7 — Governance of the Agreement

Disputes under the Agreement

31. Any Party may give notice, in writing, to the other Party of a dispute under the Agreement.
32. The Parties will attempt to resolve any dispute at officer-level in the first instance.
33. If the issue cannot be resolved at officer-level, it may be escalated to the relevant executive officers, Ministers and, if necessary, the COAG Health Council and COAG.

Variation of the Agreement

34. The Agreement and its Schedules may be amended at any time by agreement in writing by the Parties.

Delegations

35. The Parties may delegate monitoring and reporting of progress on reform activities under this Agreement to appropriate Commonwealth and Tasmanian officials.

Enforceability of the Agreement

36. The Parties do not intend any of the provisions of the Agreement to be legally enforceable. However, this does not lessen the Parties' commitment to the Agreement.

Termination of the Agreement

37. Either of the Parties may withdraw from the Agreement at any time by giving six months' notice of its intention to do so, in writing, to the other Party, the COAG Health Council and COAG.
38. Following notification of a Party's intention to withdraw from the Agreement, the terms of the withdrawal, including the date on which the Party will cease to be a Party, and any legislative changes and other arrangements that may be necessary as a consequence of the withdrawal, will be negotiated in good faith and agreed between the Parties, on a basis which aims to ensure continuity of support for patients with chronic and complex conditions.

Definitions

39. The following definitions are applicable throughout the Agreement and all Schedules to the Agreement.

System Integration	Bringing together disparate systems either physically or functionally to act as a coordinated whole, including information technology, funding and organisational systems, that promote the delivery of coordinated or integrated care, centred around people's needs.
Care coordination	Connection of patient care activities to enable the appropriate delivery of health care services (e.g. through communication and transfer of relevant information to ensure safe care transitions; processes to support team-based approaches, such as care plans, case conferences, assignment of a care coordinator role; facilitated access to services).
Local Hospital Networks (LHNs)	A LHN is an organisation that provides public hospital services in accordance with the NHRA. A local hospital network can contain one or more hospitals, and is usually defined as a business group, geographical area or community. Every Australian public hospital is part of a local hospital network.
Hospital and Health Service (HHS)	A HHS is an organisation that provides public hospital services in accordance with the NHRA. A HHS can contain one or more hospitals, and is usually defined as a business group, geographical area or community. Every Queensland public hospital is part of a HHS.
Primary Health Networks (PHNs)	PHNs are independent organisations with regions closely aligned with those of LHNs. They have skills-based boards, which are informed by clinical councils and community advisory committees. Their key objectives are to increase the efficiency and effectiveness of medical services for patients (particularly those at risk of poor health outcomes) and improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

Health Care Homes (HCH)	An existing practice or Aboriginal Community Controlled Health Service (ACCHS) that commits to a systematic approach to chronic disease management in primary care. It uses an evidence-based, coordinated, multi-disciplinary model of care that aims to improve efficiencies and promote innovation in primary care services.
Commissioning	A strategic approach to procurement that is informed by PHN/LHN baseline needs assessment and aims towards a more holistic approach in which the planning and contracting of health care services are appropriate and relevant to the needs of their communities.
Joint, coordinated or collaborative commissioning	Encompasses a variety of ways of working together, as locally appropriate, to make the best use of pooled or aligned budgets to achieve better outcomes for patients.

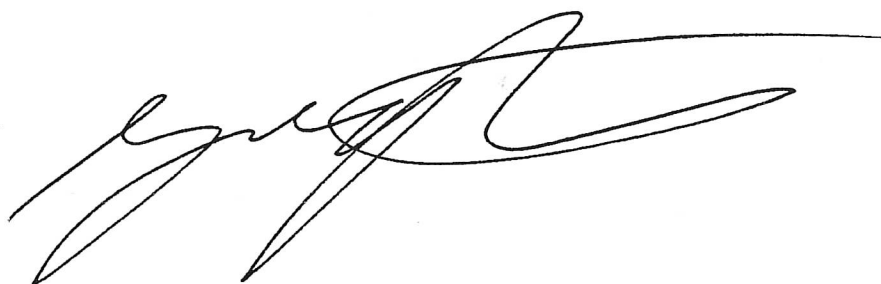
The Parties have confirmed their commitment to this Agreement as follows:

**Signed for and on behalf of the
Commonwealth of Australia by**

The Hon Greg Hunt MP

Minister for Health

Minister for Sport

A large, stylized handwritten signature in black ink, appearing to read 'Greg Hunt'.

**Signed for and on behalf of
Tasmania by**

The Hon Michael Ferguson MP

Minister for Health

Minister for Information Technology and Innovation

Leader of Government Business in House of Assembly

A handwritten signature in black ink, appearing to read 'M Ferguson'.

Implementation Plan

PART 1: Preliminaries

1. The arrangements in this Schedule will be implemented by the Parties as outlined in the *Bilateral Agreement on Coordinated Care Reforms to Improve Patient Health Outcomes and Reduce Avoidable Demand for Health Services* (the Agreement), and should be read in conjunction with that Agreement.
2. The Agreement sets out a suite of reforms to be implemented from the date of signing of the Agreement to progress the COAG's commitment to enhanced coordinated care, as articulated in the *Addendum to the NHRA for 2017-18 to 2019-20*.

PART 2: Terms of this Schedule

3. The implementation of this Schedule by the Parties will commence from the date of signing, and expire on 31 December 2019.
4. In implementing the projects identified in this Schedule, the Parties will identify relevant stakeholders and ensure there is an agreed communication approach.
5. The purpose of this Schedule is to guide implementation, provide the public with an indication of how the enhanced coordinated care reform project is intended to be delivered, and demonstrate the Parties' ability to achieve the outcomes of the Agreement.
6. In accordance with clauses 11-16 of the Agreement, the projects will comprise coordinated care reforms relating to the following priority areas:
 - a. data collection and analysis; system integration; and care coordination services; and
 - b. other areas relevant to Tasmania's local needs and circumstances.

PART 3: Core Characteristics

Data Collection and Analysis

Objectives

7. Data collection and analysis activities will focus on patients with chronic and complex conditions, including Health Care Homes (HCH) patients, and will link data for these patients to inform Commonwealth and Tasmanian reforms, by:
 - a. providing an understanding of patient service utilisation and pathways across the health system;
 - b. identifying patients or patient characteristics that would benefit from better care coordination, including from the HCH model;
 - c. supporting understanding of the impact of service change, to support improved population health outcomes and inform ongoing health system improvements; and
 - d. contributing to the evidence base for improving patient care.

Activities

8. The patient data collection and linkage activities for this Agreement will relate to patients with chronic and complex conditions, and will include provision of Admitted Patient Care National Minimum Data Set (NMDS), Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Schedule (PBS), Emergency Department NMDS and National Death Index data initially. Additional data will be included, where agreed, by the Commonwealth and Tasmania.
9. The Commonwealth will work with Tasmania to identify a cohort of patients for the linked data set, which will include all patients enrolled in HCH as well as a comparison group of patients with chronic and complex conditions who are not enrolled in HCH.
10. The collection and use of data will be in accordance with relevant Commonwealth and State/Territory confidentiality, privacy, ethics and consent provisions.
11. The Australian Institute of Health and Welfare (AIHW) will undertake the data collection and linkage work in its capacity as a Commonwealth-accredited data integration authority, within the confidentiality provisions of the AIHW Act 1987, and with oversight by the AIHW Ethics Committee.
12. Analysis projects using the linked data set will be undertaken by the Commonwealth and Tasmania, with the agreement that Tasmania will be able to view linked data for services provided in Tasmania.
13. The Parties recognise that the data collection and analysis within this bilateral agreement will not supersede or alter the work of the National Data Linkage Demonstration Project (NDLDP) being undertaken by the AIHW under the auspice of the National Health Information and Performance Principal Committee and the Australian Health Ministers' Advisory Council (AHMAC).
14. It is recognised that consideration and decision by AHMAC in relation to the future of the NDLDP will need to be taken into account in progressing the collection and linkage of data through this Agreement.
15. The Commonwealth will take a national lead role on work to develop a NMDS of de-identified information to help measure and benchmark primary health care performance at a local, regional and national level, which will also help to inform policy and identify region-specific issues and areas for improvement. This will be a staged, complex and multi-faceted work program, extending beyond the end of this Agreement. It will require collaboration and cooperation from a number of government and non-government sectors.
16. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 1.

Table 1: Data Collection and Analysis Milestones

No.	Key Milestone	Planned start date	End date	Frequency	Responsibility
Linkage of Health Data Sets					
1.1	Ethics and data governance arrangements in place to enable data collection	October 2017	N/A	Once	Commonwealth and Tasmania
1.2	Identification of patient cohort, and patient consent sought for data collection and analysis	October 2017	N/A	Ongoing	Commonwealth

1.3	Provision of data to the data custodian	December 2017	December 2019	Ongoing	Commonwealth and Tasmania
Identification of additional datasets for potential linkage					
1.4	Explore feasibility inclusion of additional data sets, such as residential and community aged care data, My Aged Care data, and Mental health data collected through the PHN program	September 2017	December 2019	Ongoing	Commonwealth and Tasmania
Data collection and reporting					
1.5	The Commonwealth and Tasmania to view, analyse and report on collection of patient-level de-identified linked public hospital, MBS, PBS and National Death Index data for services provided in Tasmania	December 2017	December 2019	Annually	Commonwealth
1.6	Explore feasibility of providing relevant data from the Community Rapid Response Service project pilot and from the trial of an anticipatory care project implemented within a HCH to the Australian Government as required for purposes of HCH evaluation.	December 2017	December 2019	Once	Tasmania
Progression of Primary Healthcare National Minimum Data Set					
1.7	Monitor and progress activities towards establishing a primary health care National Minimum Data Set of de-identified information	August 2017	December 2019	Ongoing	Commonwealth

System Integration

Objectives

17. System integration activities are aimed towards contributing to the broader system integration objective of achieving improvements over time, in:
- a. regional planning and patient health care pathways, including providing better access, and service delivery across systems;
 - b. integration of primary health care, acute care, specialist and allied services, including through digital health enablers; and
 - c. effectiveness and efficiency of collaborative commissioning arrangements.

Activities

18. In addition to the national roll-out of My Health Record (MHR) on an opt-out basis, a key focus is improved uptake, and more effective and efficient use of the MHR, initially targeting the PHN regions in which HCHs are located, and with a view to expanding more broadly where possible over time, including as part of the broader joint Department of

Health and Human Services (DHHS)/Tasmanian Health Service (THS) Diagnostics to the MHR Project, through:

- a. promoting targeted training provided by the Australian Digital Health Agency (ADHA) to hospital staff;
 - b. progressing the automatic uploading of discharge summaries, pathology and diagnostic imaging, in conjunction with the ADHA;
 - c. promoting and increasing the frequency of viewing of the MHR by healthcare professionals in Tasmanian public hospitals;
 - d. increasing MHR content of uploaded documents;
 - e. Continued rollout of electronic referrals providing GPs, specialists and other care providers, accurate, timely and up-to-date information on patients and their interaction with the acute sector; and
 - f. Identifying ways to work with PHNs to support the above processes, as appropriate.
19. The Parties agree that this activity will be progressed in conjunction with the ADHA, in accordance with their remit and agreed work plan for MHR.
20. A second area of focus is improving the transition of patients between residential aged care and primary/acute settings, a critical time when a patient's health status can be adversely impacted. A Commonwealth and inter-jurisdictional working group will be established with the aim to investigate issues, and identify policy opportunities and solutions for COAG consideration on coordinated care in 2019.
21. While the working group will be best placed to determine its areas of focus, opportunities for exploration could include:
- a. the use of, and movements between, health settings including whether: these movements are appropriate; are not feasible; or are being inappropriately prevented;
 - b. improving the evidence base to inform understanding of access to health care services for aged care recipients;
 - c. improving the evidence base for older people with chronic and complex health conditions, particularly older people with dementia and associated severe behavioural and psychological symptoms;
 - d. establishing aligned reporting requirements for aged care services across the care continuum;
 - e. clarifying the roles and responsibilities between the Commonwealth and jurisdictions in providing aids and equipment, and where relevant, link with the work of the State and Territory Aged and Community Care Officials Committee;
 - f. explore mechanisms to improve identification of Residential Aged Care Facility residents admitted to hospital; and
 - g. improving data systems and linkages between datasets.
22. A third area of focus in Tasmania is improved collaboration and coordination between DHHS, THS and Tasmania's PHN, particularly in relation to joint planning and commissioning. This will occur through the Memorandum of Understanding between

DHHS/Tasmania PHN/THS for Improving the Health Outcomes of Tasmanians, through the joint establishment of a Health Consumer Organisation for Tasmania, and identification of future co-commissioning opportunities, commencing with mental health services.

23. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 2.

Table 2: System Integration Milestones

No.	Key Milestone	Planned start date	End date	Frequency	Responsibility
Digital Health reforms and increased use of My Health Record					
2.1	Establish baseline and increase the number of registrations for MHR in Tasmania	August 2017	December 2019	6 monthly	Commonwealth
2.2	Establish baseline and increase in the number of Advanced Care Plan uploads on MHR	August 2017	December 2019	6 monthly	Commonwealth
2.3	Provision of training for public hospital staff on how to use MHR in relation to the Tasmania electronic medical record systems	August 2017	December 2019	Ongoing	Commonwealth and Tasmania
2.4	Monitor and increase in percentage of automatic uploads on MHR for: discharge summaries; diagnostic imaging; and pathology	August 2017	December 2019	6 monthly	Commonwealth and Tasmania
2.5	Monitor and increase the viewing frequency of the MHR by healthcare providers	August 2017	December 2019	6 monthly	Commonwealth and Tasmania
2.6	Identify and implement approaches to improve the content of discharge summaries on MHR	August 2017	December 2019	Ongoing	Commonwealth and Tasmania
2.7	Introduce capability for clinicians in Tasmanian public hospitals to view the MHR	August 2017	December 2019	N/A	Tasmania
Identify opportunities to improve patient transitions between residential aged care and primary/acute settings					
2.8	Commonwealth and jurisdictional working group to investigate the transition of residential and community aged care patients across acute, primary and aged care sectors	September 2017	December 2019	Ongoing	Commonwealth
2.9	Identify agreed priority areas for working group to investigate the transition of patients across acute, primary and aged care sectors	January 2018	March 2018	Ongoing	Commonwealth and Tasmania

Strengthening capability in joint planning and service commissioning					
2.10	Expand Memorandum of Understanding between DHHS/Tasmania PHN/THS for Improving the Health Outcomes of Tasmanians	October 2017	December 2019	Ongoing	Commonwealth and Tasmania
2.11	Establish a Health Consumer Organisation to support joint planning and commissioning activity in Tasmania.	October 2017	February 2018	Once	Tasmania
2.12	Identify opportunities for regional planning between PHN and LHN	July 2017	December 2019	Ongoing	Commonwealth and Tasmania

Care Coordination Services

Objectives

24. Care coordination service activities are aimed towards contributing to improvements over time, in:
- a. care coordination capacity and capability;
 - b. cost effectiveness and efficiency of targeting of available resources, while ensuring continuity of care for patients; and
 - c. patient empowerment, knowledge, skills and confidence to set goals and manage their health, with the support of their health and social care team.

Activities

25. HCHs are a key Commonwealth contribution to care coordination services under this Agreement. HCHs are a 'home base' that will coordinate the comprehensive care that patients with chronic and complex conditions need on an ongoing basis. Under this model, care is integrated across primary and hospital care as required and establishing more effective partnerships across the health system, including hospitals, allied health and primary health sectors.
26. HCHs will provide care to up to 65,000 patients across 200 sites. HCH will initially be implemented in ten geographical regions based on PHN boundaries. These regions include Tasmania PHN.
27. A training program and educational resources will support implementation and adoption of the HCH model. Learning material describes the philosophy and approaches required to achieve cultural shift to create high functioning HCHs.
28. Stage one HCH will be evaluated to establish what works best for different patients and practices and in different communities with different demographics. The evaluation will include consultation with Tasmanian stakeholders and will examine the implementation process as well as the impact of the model, including any jurisdiction-specific impacts and opportunities.
29. The Commonwealth also provides funding under the Integrated Team Care program to support eligible Aboriginal and Torres Strait Islander people with chronic disease to access comprehensive coordinated care in a timely manner. Tasmania PHN is funded to manage

this program, and has commissioned Aboriginal Community Controlled Health Services and mainstream health services to deliver the program across Tasmania.

30. Subject to future decisions with respect to Tasmania's Community Rapid Response Service (The Service) and the location of Tasmanian HCH, The Service will engage the HCH as a referring practice, permitting it access to state funded services designed to reduce preventable hospital emergency department presentations. In undertaking this engagement, the Service will work collaboratively with the PHN to ensure effective coordination of activity.
31. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 3.

Table 3: Care Coordination Services Milestones

No.	Key Milestone	Planned start date	End date	Frequency	Responsibility
Implementation of Health Care Homes					
3.1	Commence training of participating PHNs and HCHs	August 2017	December 2019	Ongoing	Commonwealth
3.2	Commence patient enrolment	October 2017	December 2019	Ongoing	Commonwealth
3.3	HCH site baseline measured for evaluation	October 2017	July 2018	Ongoing	Commonwealth
3.4	Share HCH implementation learnings	October 2017	December 2019	Ongoing	Commonwealth
Linkage of Tasmanian health programs with PHN and HCH sites					
3.5	HCH sites identified for relevant program linkage, clinicians informed of available Tasmanian Health services	October 2017	December 2019	Ongoing	Tasmania
3.6	Include Tasmania's HCHs as a referring practice to the State's Community Rapid Response Service (as applicable)	December 2017	December 2019	Ongoing	Tasmania
3.7	Commence support for eligible HCH-identified patients as per referral pathways identified through milestones 5 and 6.	October 2017	December 2019	Ongoing	Tasmania

PART 4: TASMANIAN PRIORITIES

Priority Area 1: Primary Mental Health Care

Objective

32. All activities undertaken under this priority area to achieve milestones will align with the priorities and objectives of the Fifth National Mental Health and Suicide Prevention Plan.
33. The Parties recognise that there are a number of programs of work and collaborations already underway, including local partnership approaches between Local Health Districts and PHNs, and national focus on coordinated commissioning of through the AHMAC Mental Health and Drug and Alcohol Principal Committee.
34. Complementary to existing activities, and to inform service planning and future policy approaches for people with chronic and complex conditions, the Parties commit to certain

actions to improve coordination of mental health services and supports across care settings.

35. The Parties support the strategy to test and lead coordinated commissioning of mental health services between PHNs and state and territory government bodies focused on severe and complex needs, agreed by the COAG Health Council in October 2016. Milestones relating to this work are included within this Agreement as System Integration activities.
36. DHHS/THS to work with Tasmania PHN to develop a mental health consultation liaison model for GPs within HCHs. The model will allow GPs access to timely, specialised information and advice on the management of patients with a mental health condition, strengthening the capacity of the primary health sector to meet growing demand for services. This work will be led by the Mental Health, Drug and Alcohol Directorate in the DHHS in collaboration with THS.

Activities

37. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 4.

Table 4: Priority Area 1 - Primary Mental Health Care

No.	Key Milestone	Planned start date	End date	Frequency	Responsibility
Mental health consultation liaison					
4.1	Develop model for mental health consultation liaison	July 2017	December 2017	Once	Tasmania
4.2	Implement model for mental health consultation liaison	January 2018	June 2018	Once	Tasmania
4.3	Review and evaluate model for mental health consultation liaison	July 2019	December 2019	Once	Tasmania
Mental health coordinated commissioning					
4.4	Develop and implement a strategy to test coordinated commissioning and co-commissioning of mental health services between State government bodies and Tasmania PHN, with a focus on people with severe and complex mental health needs.	July 2017	December 2019	Ongoing	Commonwealth and Tasmania

Priority Area 2: Chronic condition management using multidisciplinary/anticipatory models of care

Objective

38. Enhance the care of people with chronic condition(s) such as diabetes and related risk factors (like obesity) through the identification and trial of a model of anticipatory care in a Tasmanian Health Care Home.
39. Anticipatory care is risk based prevention in general practice that is based on principles which includes regular consultations, assertive follow up, ongoing relationships and sharing information.

40. This work will build on work currently underway as part of the Healthy Tasmania initiative, a 5 year strategic plan to improve the health of Tasmanians.

41. The trial will be overseen by a Chronic Conditions Working Group consisting of representatives from Tasmania PHN, Public Health Services and the Community Planning and Strategy unit within the DHHS who will co-design a model and develop an implementation plan with HCH(s) and other relevant stakeholders/subject matter experts as appropriate.

Activities

42. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 5.

Table 5: Priority Area 2 - Chronic condition management using multidisciplinary /anticipatory models of care

No.	Key Milestone	Planned start date	End date	Frequency	Responsibility
Development of multidisciplinary anticipatory models of care					
5.1	Workshop/s to clarify conceptual foundations of anticipatory care and its applications in the primary health care context	July 2017	August 2017	Once	Tasmania
5.2	Identify and select a proposed model of anticipatory care in consultation with HCHs and Tasmania PHN, for potential implementation within HCH	September 2017	December 2017	Once	Commonwealth and Tasmania
5.3	Develop a project proposal to support implementation, for consideration and agreement from HCH practices and Tasmania PHN	December 2017	April 2018	Once	Commonwealth and Tasmania
5.4	Implement trial of model in accordance with project plan	April 2018	October 2018	Once	Tasmania
5.5	Evaluate Trial to determine effectiveness of model	December 2018	June 2019	Once	Tasmania

Priority Area 3: End of Life Care

Objective

43. The Parties recognise that activities under this priority area will link where relevant with the National Palliative Care Strategy, and the National Palliative Care Projects funded by the Commonwealth.

44. This work will also be informed by, and align where relevant with, the work of AHMAC in the end of life space, being undertaken by the inter-jurisdictional end of life care working group which currently reports through the Community Care and Population Health Principal Committee.

45. This work will enhance end of life care in Tasmania by building the capacity of the health and community sector to promote and participate in advance care planning. This priority is an action area of Compassionate Communities, Tasmania's Palliative Care Policy Framework, 2017-21. It seeks to introduce a standardised approach to advance care

planning including tools, information and education resources for service providers. The project will be undertaken by the DHHS and be oversighted by the Partners in Palliative Care Reference Group comprising palliative care stakeholders from around the state.

Activities

46. The Parties will monitor progress against the activities in Table 6.

Table 6: Priority Area 3 - End of Life Care

No.	Key Milestone	Planned start date	End date	Frequency	Responsibility
Increase workforce capacity and skill					
6.1	Support the development of a consistent approach to end of life care through the delivery of a Tasmanian End of Life Care Policy Statement with application across all health and community care settings.	August 2017	December 2017	Once	Tasmania
6.2	Develop and make available a suite of resources to support advance care planning including tools such as Advance Care Directives, Medical Goals of Care standardised training resources with state and system wide application.	September 2017	January 2018	Once	Commonwealth and Tasmania
6.3	Work with in collaboration with key stakeholders, and Tasmanian HCH to identify strategies and resources support HCH to deliver end of life care in accordance with the Tasmanian End of Life Care Policy Statement. This includes accessing and utilising the suite of resources developed to support advance care planning.	November 2017	January 2018	Once	Commonwealth and Tasmania
6.4	Review and evaluate the HCH uptake and implementation the Tasmanian End of Life Care Policy Statement.	April 2018	September 2018	Once	Tasmania

Evaluation Framework

PART 1: Preliminaries

1. This Schedule should be read in conjunction with the *Bilateral Agreement on Coordinated Care Reforms to Improve Patient Health Outcomes and Reduce Avoidable Demand for Health Services* (the Agreement).

PART 2: Terms of this Schedule

2. The implementation of this Schedule by the Parties will commence from on signing of the agreement, and expire on 31 December 2019.
3. The purpose of this Schedule is to provide a framework to guide Commonwealth, State and Territory evaluation activity.
4. The objective of the Evaluation Framework is to outline the key evaluation questions and indicators that will be used to measure the success of the bilateral agreement activity on coordinated care and demonstrate the Parties' intended outcomes of the Agreement.
5. The Evaluation Framework is a staged design, which covers monitoring and short term evaluation with consideration of longer term evaluation over the life of the agreement.
6. Evaluation activity will examine the process of implementation of the bilateral agreements as well as the impact the activities have on the health workforce, processes, systems and the care provided to patients. The effect of these changes on patients will also be measured where available.
7. Where the Parties' reforms build on or directly support the HCH model, these will be considered by the HCH evaluation, which is being undertaken separately by the Commonwealth.
8. The results of the coordinated care bilateral agreement evaluations, covering the first 12 months of bilateral agreement activity, and the initial stage of the HCH evaluation will be drawn together to inform advice to COAG through the COAG Health Council in early 2019.
9. The report to the COAG Health Council will capture both the reporting on the agreed milestones in Part 5, Clause 20 of the agreement and Schedule A to the agreement and the indicators for the Evaluation Framework, where possible and as appropriate for each jurisdiction.
10. Reporting beyond this will be contingent upon COAG Health Council consideration of the report on the first 12 months. The Evaluation Framework set out in this Schedule may be modified by the Parties (in line with Part 7, Clause 33 of the agreement) to reflect direction from COAG or the COAG Health Council on the focus or content of the evaluation beyond the first 12 months.

PART 3: Evaluation Framework

Project approach

11. This Framework will be implemented by all jurisdictions (including the Commonwealth), collectively drawing on the agreed evaluation questions and indicators as appropriate to the Parties to the agreement.
12. Each Party agrees to provide qualitative and quantitative data (as appropriate to the Parties) to report on the relevant indicators by 1 October 2018, to enable data compilation and analysis and the drafting of a report to the COAG Health Council. The report is intended to inform future activities that will continue to build the evidence base for joint action on coordinated care.
13. The Evaluation Framework is based on a pre/post design. For some indicators, baseline data will be able to be collected at the commencement of the activity (for example, routinely collected data), while for other indicators, the data collected at the 12 month point will form the baseline for comparison at the end point.
14. All Parties will participate in the development of, and agree on, the report to the COAG Health Council which will outline the progress against each of the evaluation questions, based on compilation and analysis of the qualitative and quantitative data provided by individual jurisdictions.
15. The Evaluation Framework includes:
 - o key evaluation questions;
 - o a number of agreed indicators, as appropriate to each Party, for each core and priority area; and
 - o reporting on activities through the bilateral agreements to support the Stage 1 roll out of the HCH model.
16. The report to the COAG Health Council will include, but is not limited to:
 - o an overview of the current health system on coordinated care, at the commencement of the bilateral agreement;
 - o qualitative sections on each core and priority area; and
 - o an assessment against each of the key evaluation questions, drawing on implementation reports and the qualitative and quantitative data collected by jurisdictions.
17. In applying the Evaluation Framework against activities, the following principles will apply:
 - o The Framework has been developed at a national level and it is acknowledged that not all dimensions or indicators will be relevant to all jurisdictions and therefore reporting will vary for each jurisdiction.
 - o Core and priority activities for all Parties will be assessed against the Framework;
 - o The evaluation questions and indicators enable joint reflection and support consistent data collection across jurisdictions and aggregated data analysis and reporting;
 - o All Parties will ensure appropriate privacy, ethics, consent and data security requirements are addressed as part of any evaluation activity. In some cases this may require joint approvals;
 - o The primary focus is on outputs at the patient, workforce and system levels, reflecting that changes in outcomes can take time to be demonstrated through evaluation;
 - o The Framework does not limit or dictate the level and complexity of evaluation activities undertaken by each jurisdiction;

- Data will be collected and reported through a variety of existing methods as well as through specific evaluation activity undertaken at the local level by jurisdictions, which can be both quantitative and qualitative.
- Where appropriate the Commonwealth will provide data collected at a national level (for example, usage of My Health Record); and
- Where possible and appropriate, validated evaluation tools will be used in evaluating activities.

18. The Parties agree that any changes in implementing the activities outlined in Schedule A will need to ensure that they continue to support the Evaluation Framework outlined below:

Evaluation questions	Dimensions	Indicators*	
Bilateral Partnership			
<p>Has there been improved collaborative and coordinated policy, planning and resourcing of coordinated care reforms?</p> <p>What were the barriers and enablers?</p> <p>What could be improved going forward??</p>	<ul style="list-style-type: none"> • Bilateral partner collaboration in planning and implementation • Shared knowledge and information amongst bilateral partners • Complementarity of bilateral activities 		<ul style="list-style-type: none"> • Number and types of joint activity or coordination across sectors (e.g. Joint/coordinated or collaborative commissioning, shared LHN/PHN planning, joint governance and other types of collaboration) • Qualitative analysis of implementation reporting and monitoring data
Data Collection and Analysis			
<p>To what extent has a linked national data set been achieved?</p> <p>To what extent has access to data been improved?</p> <p>To what extent has the quality of data been improved?</p> <p>How has the use of data to inform policy, planning and targeting of resources improved?</p>	<ul style="list-style-type: none"> • Timeliness of data contribution and availability • Data completeness and quality • Data fit-for-purpose • Ease of access • Use of linked data • Understanding of patient utilisation of services and pathways through the system 	Intermediate	<ul style="list-style-type: none"> • Mechanisms established for linkage of Commonwealth and jurisdictional data sets, including agreed governance and access arrangements • Range of data sets (e.g. MBS, PBS, hospital data) linked, or in the process of being linked • Number of jurisdictions contributing linked data
		Longer term	<ul style="list-style-type: none"> • Progress towards establishing enduring linked data sets • Use of linked data for planning/commissioning activities • Use of linked data to inform policy development/reforms • Use of linked datasets to track/analyse the patient journey across care settings

System Integration			
<p>How has the sharing of health information across the system changed?</p> <p>How has service delivery across the system changed?</p> <p>Have there been improvements in patients' access to health services?</p> <p>What is patient experience and satisfaction of health system improvements?</p> <p>Have changes resulted in improved patient and clinical outcomes?</p>	<ul style="list-style-type: none"> • Coordination between health providers and systems • Multi-disciplinary team based care • Patient reported satisfaction/experience and outcomes • Patient continuity of care • Workforce experience and engagement • Changes to service utilisation patterns 	Intermediate	<ul style="list-style-type: none"> • Number, type and coverage of activities • Development of regional planning activities • Development of patient care pathways • Collaborative commissioning arrangements • Increased use of MHR <ul style="list-style-type: none"> - Number of MHRs - Increased number of views/updates - Number of uploaded discharge summaries - Increased number of health professionals viewing/uploading to MHR
		Longer term	<ul style="list-style-type: none"> • Cost of delivering services • Patient outcomes and experience/satisfaction (using PROMs and PREMs)** • Number and type of regional planning or commissioning models across care settings • Use of health services (MBS, ED presentations, hospital admissions) • Referral rates • Waiting times

Coordinated Care			
<p>How has the management of patients with chronic and complex disease improved?</p> <p>What is patient experience and satisfaction with care provision?</p> <p>Have changes resulted in improved patient and clinical outcomes?</p>	<ul style="list-style-type: none"> • Service provider and workforce practices • Systems and processes that enable sharing and coordination • Patient health literacy and/or engagement • Patient reported experience and outcomes • Clinical outcomes 	Intermediate	<ul style="list-style-type: none"> • Number, type and coverage of activities • Increased engagement of health workforce in coordinated care • Increased information sharing and communication between health professionals (e.g. increased case conferencing, specialist advice to GPs, recording of referrals in clinical software, reports back to GPs, and e-discharge) • Information resources developed for, and used by, patients and carers • Number and type of joint/coordinated or collaborative commissioned or joint activities • Health professionals report increased information sharing and communication (e.g. increase in case conferencing, team care arrangements and multidisciplinary care)
		Longer term	<ul style="list-style-type: none"> • Patient and health professionals' use of MHR • Patient outcomes and experience/satisfaction (using PROMs and PREMs)** • Relevant clinical measures (e.g. HbA1c, blood pressure) • Use of health services (MBS, ED presentations, hospital admissions)

Jurisdictional priority areas			
What impact did the activities have on system integration, service delivery or patient experience/outcomes?	<ul style="list-style-type: none"> • Collaboration in planning and implementation • Appropriately skilled workforce • Patient health literacy and/or engagement • Patient reported experience and outcomes • Clinical outcomes 	Intermediate	<ul style="list-style-type: none"> • Number, type and coverage of discretionary projects • Collaboration between Commonwealth and jurisdictions in reforms or delivery of care • Increased staff capability • Information/resource developed for, and used by, patients and carers
		Longer term	<ul style="list-style-type: none"> • Patient outcomes and experience/satisfaction (using PROMs and PREMs)** • Use of health services (MBS, ED presentations, hospital admissions) • Relevant clinical measures (e.g. HbA1c, blood pressure)

* Reporting on indicators is subject to Clauses 12, 13 and 17 of Schedule B.

** Examples of potential instruments include SF-12 (Quality of Life), EQ-5D (Quality of Life), PQS (Patient satisfaction), and PACIC (Quality of patient centred care).

Note: Evaluation activity over the life of the agreement will shift the focus to the overall objectives of the Bilateral Agreements and where feasible will assess progress against the longer term indicators. Evaluation questions, dimensions and indicators for longer term evaluation are indicative only and subject to COAG and COAG Health Council consideration of the report on the first 12 months of activity.