

Bilateral Agreement between the Commonwealth and Western Australia

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 Western Australia (WA) 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 WA 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 the 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 WA.

Commencement, duration and review of the Agreement

6. The Agreement will commence from the date of the signing of this agreement.
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 WA's local needs and circumstances.
13. The Parties recognise that the activities, objectives and outcomes of the Agreement will link, where relevant, to progress longer term health reforms.

Data Collection and Analysis

14. 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 jurisdictional 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.

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 *aged care integration*, and *end of life care*.

Part 4 — Roles and responsibilities

18. The Parties agree to work together to implement, monitor, refine and evaluate coordinated care reform activities under the Agreement.
19. In respect of the joint commitment at Clauses 11 through 17, the Parties will: undertake all activities as outlined in the Schedules to the Agreement; develop and agree project plan/s 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; and
 - 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 WA 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, the 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 Western Australian 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.

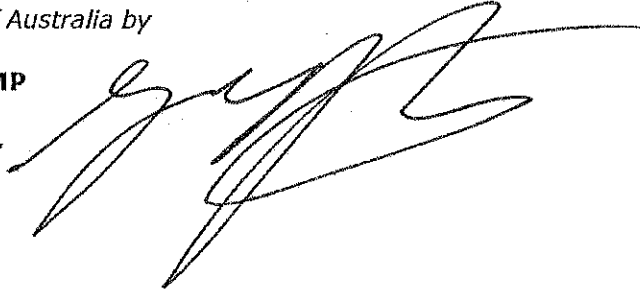
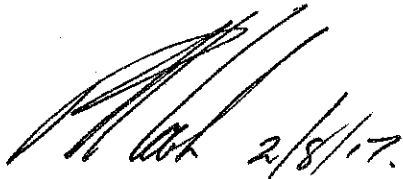
System Integration	Bringing together disparate systems either physically or functionally to act as a coordinated whole, including information technology, funding and organisational systems, that promote the delivery of coordinated or integrated care, centred around people's needs.
Care coordination	Connection 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).
Health Service Providers (HSPs)	A HSP is an organisation that provides public hospital services in accordance with the NHRA. A HSP can contain one or more hospitals, and is usually defined as a business group, geographical area or community.
Primary Health Networks (PHNs)	PHNs are independent organisations with regions closely aligned with those of HSPs. 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/HSP regional 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

Hon Greg Hunt MP
Minister for Health
Minister for Sport

A large, stylized handwritten signature in black ink, appearing to read 'Greg Hunt'.A handwritten signature in black ink, followed by the date '2/8/17'.

Signed for and on behalf of
Western Australia by

Hon Roger Cook MLA
Deputy Premier
Minister for Health; Mental Health

Implementation Plan

PART 1: Preliminaries

1. This Implementation Plan is a schedule to 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. The arrangements in this schedule will be implemented by the Parties.
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 National Health Reform Agreement: Revised Public Hospital Arrangements for 2017-18 to 2019-20* (NHRA Addendum).

PART 2: Terms of this Schedule

3. The implementation of this Schedule by the Parties will commence from the date of signing of this agreement, and expire on 31 December 2019, unless terminated earlier, in writing.
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 11-17 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 WA local needs and circumstances.

PART 3: Core Characteristics

Data Collection and Analysis

Objectives

7. Data collection and analysis activities will focus on Health Care Homes (HCH) patients and an appropriate comparison group, and will link data for these patients, to inform Commonwealth and Western Australian 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 deidentified patient data collection and linkage activities for this Agreement relate to patients with chronic and complex conditions, and include provision of Admitted Patient Care National Minimum Data Set (NMDS), Medicare Benefits Schedule (MBS) data, Pharmaceutical Benefits Schedule (PBS) data, Emergency Department NMDS and National Death Index data initially. Additional data will be included, where appropriate, by the Commonwealth and WA.
9. The Commonwealth will work with WA to identify a cohort of patients for the deidentified 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 WA legislation, confidentiality, privacy, ethics, data governance 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 WA, with the agreement that WA will be able to view linked, deidentified data for services provided in WA.
13. The Parties recognise that the data collection and analysis within this bilateral agreement does 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 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 an 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	Planned end date	Frequency	Responsibility
1.1	Ethics and data governance arrangements are in place to enable data collection	September 2017	N/A	Once	Commonwealth and WA
1.2	Identification of patient cohort and patient consent sought for data collection and analysis	October 2017	December 2019	Ongoing	Commonwealth

1.3	Provision of data to the data custodian	October 2017	December 2019	Ongoing	Commonwealth and WA
1.4	Explore feasibility of inclusion of additional data sets, such as residential and community aged care data, My Aged Care data, and Mental health data collected through the Primary Health Network (PHN) program	September 2017	December 2019	Ongoing	Commonwealth and WA
1.5	WA and the Commonwealth to view, analyse and report on collection of patient-level linked public hospital, MBS, PBS and National Death Index data for services provided in WA	December 2017	December 2019	Annually	Commonwealth and WA
1.6	Monitor and progress activities towards establishing a primary health care NMDS 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.
18. The Parties agree that activities under this priority will be progressed in conjunction with the Australian Digital Health Agency (ADHA), in accordance with their remit and agreed work plan for My Health Record (MHR).

Activities

19. In addition to the national roll-out of MHR on an opt-out basis, a key focus is improved uptake, and more effective and efficient use of the MHR, initially targeting PHNs in which HCHs are located, and with a view to expanding more broadly where possible over time, including through:
- a. promoting targeted training provided by the 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;
 - d. increasing MHR content of uploaded documents;
 - e. identifying ways to work with PHNs to support the above processes, as appropriate; and
 - f. Continued rollout of electronic referrals providing General Practitioners (GP), specialists and other care providers, accurate, timely and up-to-date information on patients and their interaction with the acute sector.
20. WA will also establish relevant infrastructure and authorisation to enable automatic uploading of pathology and diagnostic imaging to MHR.
21. 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 affected. A Commonwealth and inter-jurisdictional working group will be established to investigate issues, and identify policy opportunities and solutions for COAG consideration on coordinated care in 2019.
22. 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. establish aligned reporting requirements for aged care services across the care continuum;
 - e. clarify 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 (RACF) residents admitted to hospital; and
 - g. improving data systems and linkages between datasets.
23. The Parties recognise the value of the National Health Services Directory (NHSD) in enabling health professionals' and consumers' access to reliable and consistent information about health services and commit to its promotion, including encouraging health providers to register their service details with the NHSD, and including digital health and coordinated care initiatives in the NHSD annual work.
24. In addition, WA will undertake the following activities to support system integration, in collaboration with the WA Primary Health Alliance (WAPHA), which operates the WA PHNs:

- a. Continue implementing the *Partnership Agreement between WA Department of Health (DoH), Health Service Providers (HSPs) and WA Primary Health Alliance (WAPHA) to Develop Health Pathways for Western Australia* to ensure pathways are developed and localised for WA, with the key focus of improving integration between primary, secondary and tertiary care, especially in Perth North HCHs.
- b. Use the *Deed of Agreement for the Transfer of Data* (between DoH and WAPHA), which establishes principles and governance for undertaking needs analysis, services planning and performance monitoring and evaluation, to support connections between Perth North HCHs and associated WA Health (i.e. Department of Health WA and HSP) services.
- c. Apply the principles and governance established by the DoH-WAPHA Memorandum of Understanding (which undertakes to explore practical means by which to strengthen their cooperation and collaboration) to support connections between Perth North HCHs and WA Health.
- d. Continue convening the WA's Primary Health Care Reference Group, comprising representatives from DoH, HSPs and WAPHA, to identify opportunities to improve coordination of care between these sectors.

25. 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	Planned end date	Frequency	Responsibility
2.1	Establish baseline and increase in the number of registrations for MHR in WA	August 2017	December 2019	6 monthly	Commonwealth
2.2	Establish baseline and increase in the number of Advance Care Plan uploads on MHR	August 2017	December 2019	6 monthly	Commonwealth and WA
2.3	Provision of training for public hospital staff on how to use MHR in relation to the WA electronic medical record systems	August 2017	December 2019	Ongoing	Commonwealth and WA
2.4	WA infrastructure and authorisation in place for automatic uploads of diagnostic imaging and pathology to MHR	December 2017	December 2019	NA	WA
2.5	Monitor and increase automatic uploads of discharge summaries to MHR	August 2017	December 2019	6 monthly	Commonwealth and WA
2.6	Monitor and increase the viewing frequency of the MHR by healthcare providers	August 2017	December 2019	6 monthly	Commonwealth and WA
2.7	Identify and implement approaches to improve the content of discharge summaries on MHR	August 2017	December 2019	Ongoing	Commonwealth and WA

Improving service information through the National Health Services Directory (NHSD)					
2.8	Active promotion of the NHSD and registration of service provider details in public hospitals, community health, primary and aged care	August 2017	December 2019	Ongoing	Commonwealth and WA
2.9	Monitor and increase in registrations and use of NHSD	August 2017	December 2019	Ongoing	Commonwealth and WA
Improving patient transitions between residential aged care and primary/acute settings					
2.10	Commonwealth and Jurisdictional working group established to investigate the transition of residential and community aged care patients across acute, primary and aged care sectors	September 2017	November 2019	Once	Commonwealth and WA
2.11	Identify agreed priority areas for working group to investigate the transition of patients across acute, primary and aged care sectors	January 2018	March 2018	Once	Commonwealth and WA
HealthPathways					
2.12	350 HealthPathways localised and promoted across the Perth North PHN region and HCH practices	August 2017	June 2018	Ongoing	WA
2.13	25% increase in webpage views	August 2017	June 2018	Annually	WA
2.14	Provide a minimum of four Continuing Professional Development events and 50 unique GP attendances to support uptake and awareness of HealthPathways	August 2017	June 2018	Annually	WA
Strategic Alliances					
2.15	Partnership Committee report on activity and continued operation of the WAPHA-DoH <i>Memorandum of Understanding</i>	August 2017	December 2019	Ongoing	WA
2.16	Implement opportunities to improve coordination identified by the WA Primary Health Care Reference Group	January 2018	December 2019	Annually	WA

Care Coordination Services

Objectives

26. 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

27. 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 more effective partnerships are established across the health system, including hospitals, allied health and primary health sectors.
28. 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. Perth North PHN is the participating PHN in WA.
29. 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.
30. 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 WA and relevant jurisdictional stakeholders and will examine the implementation process as well as the impact of the model, including any jurisdiction-specific impacts and opportunities.
31. 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. WA PHNs are funded to manage this program, and have commissioned Aboriginal Community Controlled Health Services (ACCHS) and mainstream health services to deliver the program across WA.
32. The Parties agree to develop a Collaborative Commissioning Framework, building on existing work. This Framework will guide PHNs and HSPs to collaboratively purchase and or co-commission services. This work will be important to establish a robust foundation for future national rollout, including shared governance approaches and/or joint or pooled funding arrangements.
33. WA will also contribute to care coordination by linking the following WA programs with the Perth North PHN region and HCH practices. These programs will be:
 - a. Complex Needs Coordination Team (CoNeCT) – This program provides metropolitan community case management support for clients identified as frequent users of acute hospital services, at constant risk of poor health outcomes. The objective is for

patients with chronic and complex conditions to become – with tailored and coordinated support in the community – less reliant on emergency department and acute hospital services.

- b. Healthy Lifestyle Program - This Program supports people at risk of, or newly diagnosed with, a chronic disease to improve the management of their health and wellbeing, via an early intervention approach with a multi-disciplinary allied health team.
- c. Homeless Healthcare Program – This program provides a mobile, community-based primary health service for people with chronic and complex conditions experiencing, or at risk of, homelessness at a time and place that meets clients’ needs. It supports people with complex health conditions, including comorbidities, to experience an integrated and connected health service, and improves their health outcomes.

34. Another activity for coordinated care will be the exploration of opportunities for regional planning and/or joint or aligned funding arrangements to bring together PHNs and HSPs that support care coordination services.

35. WA will also work with WAPHA, the Perth North PHN and its HCHs to ensure the WAPHA-Silver Chain Peri-End of Life dedicated primary care practice is connected to WA Health services. This will enable better management of these patients in their community/homes by providing integrated non- and medical care, aligned with patients’ preferences, at the right time, and in the right place.

36. 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	Planned end date	Frequency	Responsibility
Health Care Homes					
3.1	Contract GP practices/ACCHS to participate in HCH	August 2017	December 2019	Once	Commonwealth
3.2	Commence training of participating PHNs and HCHs	August 2017	December 2017	Ongoing	Commonwealth
3.3	Commence HCH patient enrolment	October 2017	December 2019	Ongoing	Commonwealth
3.4	Commence HCH Evaluation (including established data baseline)	October 2017	July 2018	Ongoing	Commonwealth
3.5	Share HCH implementation learnings and contribute to the evidence base for future coordinated care approaches	October 2017	December 2019	Ongoing	Commonwealth
Linkage of WA Health programs with Perth North PHN region and HCH sites					
3.6	HCH sites identified for relevant program linkage, clinicians informed of available WA Health services	August 2017	December 2019	Ongoing	WA

3.7	Commence support for eligible HCH-identified patients	August 2017	December 2019	Ongoing	WA
Strengthening capability in joint service commissioning					
3.8	Development of a Collaborative Commissioning Framework that defines target population/s and sets out principles and mechanisms for collaborative commissioning, including in the areas of: <ul style="list-style-type: none"> • governance • funding • purchasing • service delivery 	October 2017	June 2018	Ongoing	Commonwealth and WA
3.9	Identify opportunities for regional planning between Perth North PHN and HSPs	August 2017	December 2019	Ongoing	Commonwealth and WA

PART 4: WA PRIORITIES

Priority Area 1: Aged care integration

Objectives

37. The Parties recognise that the Commonwealth is responsible for subsidising and regulating aged care services, such as residential aged care, home care packages and Commonwealth Home Support.
38. The Parties recognise that aged care services are operated by a mix of not-for-profit, private and government organisations, and can be delivered in a number of different care settings.
39. There are a number of aged care programs that are jointly funded and regulated by the Commonwealth and State and Territory governments. These include the Multi-Purpose Services Program and the Transition Care Program.
40. The Parties recognise that all activities undertaken under this priority area to achieve the milestones outlined in Table 4 will align with the *Aged Care Act 1997 (Cth)* and the *Australian Aged Care Quality Agency Act 2013 (Cth)*, their Principles, relevant program guidelines, manuals and agreements and the Commonwealth's aged care quality regulatory framework. The Commonwealth Department of Health is responsible for the quality regulatory framework policy. The framework includes:
- a. assessment and monitoring against quality standards by the Australian Aged Care Quality Agency;
 - b. the Aged Care Complaints Commissioner, who responds to concerns raised by anyone regarding the quality of care and services; and
 - c. the Commonwealth Department of Health's compliance powers, including sanctions, where a provider is not meeting its legislative obligations.

41. In line with their responsibilities as approved providers of transition care, the Department of Health WA will continue to manage the day-to-day operations of the Transition Care Program in that jurisdiction, to ensure quality care is delivered to eligible care recipients immediately following a period of hospitalisation.
42. WA will continue to implement coordinated care reforms relating to aged care integration to ensure better coordination of services for older people to improve patient outcomes and reduce avoidable demand on acute services.
43. The aim of this activity will be to continue better connecting State- and Commonwealth-funded services to improve older people's health and wellbeing outcomes through provision of the programs outlined below.

Activities

44. Aged care will be further integrated in the Perth North PHN region and HCH practices via the following programs:
- a. Interim Hospital Packages (IHPs) – This program enables appropriate patient discharge to metropolitan community services, to prevent unnecessary hospitalisation and associated functional decline. Information about HCHs will be provided to HSP IHP Coordinators so they can be included in planning the transition of patients to appropriate community services.
 - b. Residential Care Line – This resource improves staff capability in Commonwealth-funded RACFs to provide assessment and required care in situ, and associated hospital avoidance outcomes for residents, via:
 - i. a 24 hour, 7 day per week triage and advice telephone line; and
 - ii. an aged care specialist nursing outreach and education service, providing expertise and support in an integrated and collaborative style for RACF staff, GPs, and other specialist services (including allied health), while primary carers retain governance.
45. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 4.

Table 4: Aged Care Integration Milestones

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
Interim Hospital Packages					
4.1	Eligible cohort identified within PHN region, including HCH cohort	August 2017	December 2019	Ongoing	Commonwealth
4.2	Sites identified for relevant program linkage, clinicians informed of available WA Health services	August 2017	December 2019	Ongoing	WA
4.3	Number of patients discharged with a completed IHP in the HCH catchment	August 2017	December 2019	Ongoing	WA
WA Health program linkage with aged care sector					
4.4	Promotion of Residential Care Line across the Perth North PHN region	August 2017	December 2019	Ongoing	WA

4.5	New RACFs and transition care providers in the Perth North PHN region are given access to the Residential Care line	August 2017	December 2019	Ongoing	WA
4.6	Number of outreach and education services provided to RACFs and transition care providers in the Perth North PHN region by Residential Care Line	August 2017	December 2019	Ongoing	WA

Priority Area 2: End of life care

Objectives

46. 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.
47. This work will also be informed by – and, where relevant, align with – AHMAC’s work in end of life care, being undertaken by the inter-jurisdictional end of life care working group which currently reports through the Community Care and Population Health Principal Committee.
48. WA Health will continue to implement coordinated care reforms relating to end of life care to provide quality end of life care in more appropriate settings. The aim will be to:
- a. increase awareness of end of life legislation and training/education/resources available for clinicians;
 - b. improve connectivity across the PHN by engaging more GPs in end of life care;
 - c. reduce emergency department presentations and avoidable hospital admissions.
49. To achieve these aims, WA will implement the following activities within the Perth North PHN region, and link with HCH practices where possible:
- a. Specialist Palliative Care Consultancy Service (SPCCS) – this service will be positioned, at the interface between RACFs and public hospitals, as a key liaison and consultation mechanism to ensure that residents in facilities receive appropriate palliative care and are not unnecessarily admitted to hospital. Note: *for the purpose of this activity, residential facilities serviced include: RACFs, disability facilities, mental health and psychogeriatric facilities, correctional facilities and ACCHSs.* The following supports will also be part of this program:
 - i. A mobile specialist palliative care team for residents of RACFs and other at-risk populations;
 - ii. provision of support and ‘in-house’ education for residential facilities’ care workforce, particularly in RACFs, to provide optimal palliative and end of life care within their facilities
 - iii. capacity-building with GPs and consultants working in residential facilities; and hospital staff engaged in discharge planning for patients transferring to a facility or institution.

- b. Talking about End of Life (TAEOL) training program
 - i. The TAEOL program works, in conjunction with the SPCCS (as outlined above) to build RACF staff skills and capacity to care for people at the end of life and in their place of residence, if appropriate. In 2017-18, the program will initially focus on engaging with GPs in the region around managing end of life care.
- c. Home Palliative Care Program
 - i. Promotion of a 24 hour, 7 day a week in-home specialist palliative care service, provided by a multidisciplinary team with a core workforce of specialist palliative care nurses supported by specialist medical staff, GPs, and a clinical governance framework.
 - ii. Patient and informal carer/s could also be supported by a range of other health care professionals and volunteers during an episode of care.
- d. In-home Palliative Care Respite
 - i. This program provides temporary care and support in the home, to enable informal carers to have a break.
- e. Palliative Care Specialist Nurse Consultation Service
 - i. This service is provided in the Perth metropolitan areas, by phone or as a nursing intervention.
- f. 24 hour Telephone Advisory Service for health professionals providing palliative care in rural areas.
- g. Palliative Care referral and admission resources
 - i. These resources will assist with decision-making about whether specialist palliative care is required, and if so, which service best suits the patient's needs.
 - ii. Resources will include information on: referral criteria; triggers for referral and reasons for referral; guide to specialist palliative care services; resources and patient referral scenarios for GPs.

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

Table 5: End of Life Care Milestones

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
5.1	Promotion of end of life legislation and training/education/resources	August 2017	December 2019	Ongoing	WA
5.2	Provision of training and resources to health professionals within the PHN region	August 2017	December 2019	Ongoing	Commonwealth and WA
Linkage of WA Health programs with Perth North PHN region					
5.3	PHN region and HCH sites provided with information on linking with WA programs	August 2017	December 2019	Ongoing	WA
5.4	PHN and HCH sites identify patients for relevant program linkage/support	August 2017	December 2019	Ongoing	Commonwealth

5.5	Commence support for eligible HCH-identified patients	August 2017	December 2019	Ongoing	Commonwealth and WA
5.6	Monitor uptake of WA end of life care programs within PHN and HCH sites	August 2017	December 2019	Annually	WA
5.7	Development and circulation of palliative care referral and admission resources across PHN and HCH sites	August 2017	December 2019	Ongoing	WA
5.8	Promotion of Specialist Palliative Care Service to the RACFs	August 2017	December 2019	Ongoing	WA
5.9	Frequency of access to Specialist Palliative Care Service, including education and training provided to RACFs	August 2017	December 2019	Ongoing	WA

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 the date of signing 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 HSP/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			
<p>What impact did the activities have on system integration, service delivery or patient experience/outcomes?</p>	<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)
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* 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.