

# **Bilateral Agreement between the Commonwealth and Northern Territory**

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 Northern Territory (NT) 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 NT 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 NT.

### **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 for 2011* and its *2017-20 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 reforms activities specified in Schedule A to this Agreement;
  - 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 the NT'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 a Strategic Partnership between NT and Northern Territory Primary Health Network and improved health and care services for Vulnerable Older Territorians in Remote Communities.

## **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 16, the Parties will undertake all activities as outlined in Schedules to the Agreement; develop and agree project plans to support implementation, where relevant; monitor achievement against milestones; and conduct 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 NT 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, 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 NT 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

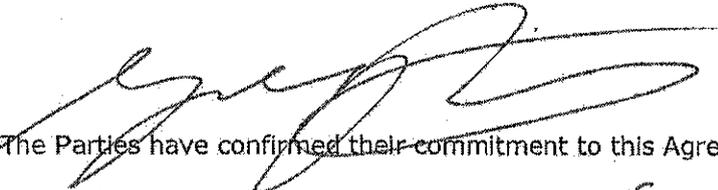
37. Either of the Parties may withdraw from the Agreement at any time by giving six months' notice of its intention to do so, in writing, to the other Party, the COAG Health Council and COAG.
38. Following notification of a Party's intention to withdraw from the Agreement, the terms of the withdrawal, 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.
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 Home (HCH)	An existing general 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.



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

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

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**The Hon Greg Hunt MP**  
Minister for Health  
Minister for Sport

Natasha

**Signed** for and on behalf of  
Northern Territory by

**Hon Natasha Fyles MLA**  
Attorney-General and Minister for Justice  
Minister for Health

10 OCT 2017

### 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 jointly implemented by the Parties.
2. The Agreement sets out a suite of reforms to be implemented from upon signing 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 on signing of the 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 11-16 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 NT 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 Home (HCH) patients, and will link data for these patients to inform Commonwealth and NT 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 de-identified 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, Pharmaceutical Benefits Schedule, Emergency Department NMDS and National Death Index data initially. Additional data will be included, where agreed, by the Commonwealth and NT.
9. The Commonwealth will work with NT to identify a cohort of patients for the de-identified 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 NT 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 by the AIHW Act 1987, and with oversight of the AIHW Ethics Committee.
12. Analysis projects using the linked data set will be undertaken by the Commonwealth and NT, with the agreement that the NT be able to view de-identified linked data for services provided in NT.
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 NT is committed to
  - a. Preparedness as an early adopter of the AIHW National data linkage project;
  - b. Improve linkages within our own linked data sets; including the SA/NT Data Link; and
  - c. Development of a data sharing agreement with the Northern Territory Primary Health Network (NT PHN).
17. NT will negotiate with the relevant parties and set-up any required agreements to enable aggregated analysis outputs (not patient level data) to be shared with the Primary Health Network (PHN) and/or HCHs in order to progress these objectives.
18. 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	Frequency	Responsibility
<b>Linkage of Health Data Sets</b>				
1.1	Identification of patient cohort, for data collection and analysis	October 2017	Ongoing	Commonwealth and NT
1.2	Ethics and data governance arrangements in place to enable data collection	October 2017	Once	Commonwealth and NT
1.3.	Provision of data to the data custodian	December 2017	Ongoing	Commonwealth and NT
1.4	Commence data linkage and enable jurisdictions to access linked data	January 2018	Ongoing	Commonwealth and NT
<b>Identification of additional datasets for linkage</b>				
1.5	Explore feasibility of extending the data set through expansion to all patients or 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 as part of enduring data linkage arrangements	September 2017	Ongoing	Commonwealth and NT
<b>Progression of a Primary Healthcare National Minimum Data Set</b>				
1.6	Monitor and progress activities towards establishing a primary health care National Minimum Data Set of de-identified information	August 2017	Ongoing	Commonwealth

## **System Integration**

### Objectives

19. 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.
20. The Parties agree that activities under this priority area will be progressed in conjunction with the Australian Digital Health Agency (ADHA) in accordance with its on-going policy responsibility for My Health Record (MHR).

## Activities

21. 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;
  - 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 the PHN to support the above processes, as appropriate; and
  - f. 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.
22. 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.
23. 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, or alternatively not feasible or are being 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 (RACF) residents admitted to hospital; and
  - g. improving data systems and linkages between datasets.

24. A third area of focus for the NT is embedding the Integrated Social and Emotional Wellbeing (SEWB) program in primary health care service
25. Depression and anxiety are common comorbidities for people with chronic disease. Mental health issues and substance misuse may both interfere with effective self-management of chronic conditions. Improving access to appropriate therapeutic supports, coupled with culturally informed appropriate medical care, for this group of high risk patients will contribute to positive health outcomes for consumers and potential reduction in preventable hospitalisations.
26. This project will develop a social and emotional wellbeing service model based on a holistic model of primary health care that provides medical services, therapeutic care and cultural services to consumers with mental health and/or alcohol and other drug (AOD) issues in an integrated and coordinated manner. The model is integrated within comprehensive primary health care service delivery, incorporates community development, engagement and clinical components and is informed by the stepped care guidelines.
27. This project will also seek to improve funding equity and workforce distribution across primary health care services (provided by either NT Health or by Aboriginal Community Controlled Health Services - ACCHSs). This will be achieved through co-ordinated provision of consumer focused care for individuals with mental health and AOD related issues living in rural and remote Aboriginal communities. NT Health and ACCHSs are working in collaboration with the NT PHN, which has received new funding from the Australian Government for Indigenous mental health and Indigenous drug and alcohol support services. This funding model will support an integrated and multi-disciplinary approach which links these three streams of care:
- a. Medical stream – includes general practitioners, mental health and/or AOD nurses.
  - b. Therapeutic stream – includes access to therapeutic interventions by allied health clinicians and mental health nurses with specialist therapeutic skills and experience.
  - c. Social cultural stream – this includes Aboriginal leadership and a focus on culturally appropriate care by medical and therapeutic teams including Aboriginal mental health or AOD workers.
28. 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	Frequency	Responsibility
<b>Digital health reforms and increased use of MHR</b>				
2.1	Establish baseline and increase in the number of registrations for MHR in NT	August 2017	6 monthly	Commonwealth
2.2	Establish baseline and increase in the number of Advance Care Plan uploads on MHR in NT	August 2017	6 monthly	Commonwealth

2.3	Provision of training for public hospital staff on how to use MHR in relation to the NT electronic medical record systems	August 2017	Ongoing	Commonwealth and NT
2.4	Monitor and increase in percentage of automatic uploads on MHR for: discharge summaries; diagnostic imaging; and pathology	August 2017	6 monthly	Commonwealth and NT
2.5	Monitor and increase the viewing frequency of the MHR by healthcare providers	August 2017	6 monthly	Commonwealth and NT
2.6	Identify and implement approaches to improve the content and quality of discharge summaries on MHR	August 2017	Ongoing	Commonwealth and NT
<b>Identify opportunities to improve patient transitions between residential aged care and primary/acute settings</b>				
2.7	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	Ongoing	Commonwealth
2.8	Identify agreed priority areas for working group to investigate the transition of patients across acute, primary and aged care sectors	January 2018	Ongoing	Commonwealth and NT
<b>Improve the Integrated Social and Emotional Wellbeing (SEWB) program</b>				
2.9	Implementation of integrated SEWB model at an individual community and district level	July 2017	Once	NT
2.10	Development of therapeutic stream network with appropriate clinical and cultural supervision	September 2017	Once	NT
2.11	Finalisation of SEWB evaluation framework	January 2018	Once	Commonwealth and NT
2.12	Provision of individual therapeutic services to clients, with percentage of clients with chronic condition	November 2017	Ongoing	NT

## **Care Coordination Services**

### Objectives

29. 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

30. HCHs are a key 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.
31. 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 Northern Territory PHN.
32. 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.
33. 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 NT stakeholders and will examine the implementation process as well as the impact of the model, including any jurisdiction-specific impacts and opportunities.
34. NT will link Territory and local programs with HCHs where relevant, to support HCH patients over the life of the Agreement with a focus on improving local access to coordinated care for remote patients with chronic conditions through strengthening the outreach services model.
35. The NT PHN is funded through the Australian Government under the previous Indigenous Chronic Diseases Program (ICD) funding to provide visiting outreach services to remote communities from allied health professionals including dietitians, diabetes educators, exercise physiologists, cardiac educators, optometrists and podiatrists, to contribute to chronic disease management.
36. The Specialist Outreach Northern Territory (SONT) program coordinates visiting medical specialists, some of whom manage patients with chronic diseases, and whose work is complemented by the services provided by the allied health staff. SONT is funded by the NT Government and the Australian Government through specific funding, for example the Rural Health Outreach Fund and Visiting Optometry Scheme.

37. Current outreach services have significantly improved access to specialist medical and allied health services that in urban and regional centres are conventionally offered on a hospital outpatient basis. There is scope to further strengthen the outreach services model in NT Health to reduce patient waiting times, improve access to individual clinicians, and be more family-and community-centric in approach.
38. Harnessing the full benefits of an outreach services model requires systematic organisation and co-ordination of multiple service streams. Not only will this provide greater opportunity for delivery of team-based care, but it will also improve timely access to services by avoiding the need for clients to make separate visits (often on different days) to multiple providers. This project will shift the emphasis to a more place-based approach and client-centred care.
39. The NT will develop and implement a care coordination model to effectively meet increasing client demand and more complex needs to:
- reduce the need for multiple separate patient visits to multiple separate providers;
  - increase family engagement in provision of client-centred care; and
  - increase joint consultations and introducing more group sessions.
40. 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	Frequency	Responsibility
<b>Implementation of HCHs</b>				
3.1	Contract GP practices/ACCHS to participate in HCH	August 2017	Once	Commonwealth
3.2	Commence training of participating PHNs and HCHs	August 2017	Ongoing	Commonwealth
3.3	Commence patient enrolment	October 2017	Ongoing	Commonwealth
3.4	Commence HCH evaluation (including established data baseline)	October 2017	Ongoing	Commonwealth
3.5	Share HCH implementation learnings and contribute to the evidence base for future coordinated care approaches	October 2017	Ongoing	Commonwealth
<b>Linkage/expansion of NT programs with PHNs/HCHs</b>				
3.6	Identify care coordination programs or services that could support HCH providers and patients	August 2017	Ongoing	Commonwealth and NT
3.7	Put in place agreed arrangements to support HCH providers and patients	August 2017	Ongoing	Commonwealth and NT

<b>Specialist Outreach Northern Territory (SONT) program</b>				
3.8	Establish an Outreach Services Model Improvement Steering Group and Working Groups	September 2017	Ongoing	NT
3.9	Identify gaps and duplication in outreach service delivery within NT	October 2017	Once	NT
3.10	Develop a coordinated service model for NT outreach services	December 2017	Once	NT
3.11	Develop and implement an agreed and coordinated approach, between NT Health and NT PHN to schedule travel for allied health services and SONT outreach services	March 2018	Ongoing	NT

## **PART 4: NORTHERN TERRITORY PRIORITIES**

### **Priority Area 1: Strategic Partnership**

#### Objectives

41. The NT will look to develop a strategic partnership between NT Health and NT Primary Health Network to strengthen collaboration, particularly in relation to joint planning for the development of new health services and initiatives.
42. NT Health has operated under a devolved governance arrangement since July 2014, with the Department of Health responsible for system management and the two Health Services having responsibility for service delivery.
43. This partnership will look to expand and formalise a more strategic and collaborative approach to deliver greater health benefits for Territorians, provide valued opportunities for the health workforce, and improve the overall efficiency and cost-effectiveness of the NT health system.
44. A strategic partnership framework will include:
  - a. a statement of commitment by NT Health and NT PHN to pursue regional health services planning supported by data sharing in key priority areas;
  - b. the context for continued collaboration on existing shared projects, and for identifying, prioritising and progressing collaboration on new exercises; and.
  - c. consideration of collaborative regional commissioning in particular circumstances.
45. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 4.

**Table 4: Strategic Partnership Milestones**

No.	Key Milestone	Planned start date	Frequency	Responsibility
<b>Strategic partnership between NT Health and NT Primary Health Network</b>				
4.1	Establish a Project Working Group	March 2017	Ongoing	NT
4.2	Undertake a mapping exercise to identify various 'touch-points' of engagement between NT Health and NT PHN	May 2017	Once	Commonwealth and NT
4.3	Develop the strategic partnership framework and statement of commitment between NT Health and NT PHN	July 2017	Once	Commonwealth and NT
4.4	Identify key priority projects for collaboration	August 2017	Ongoing	NT

## **Priority Area 2: Aged Care**

### Objectives

46. 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.
47. 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.
48. 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.
49. The Parties recognise that all activities undertaken under this priority area to achieve the milestones outlined in Table 5 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 Department of Health's compliance powers, including sanctions, where a provider is not meeting its legislative obligations.

50. The NT will implement activities to improve health and care services for vulnerable older Territorians in remote communities noting that:
- a. Commonwealth Home Care Packages (HCPs) assist older Australians to remain in their home and community through the provision of supports and services. There are four levels Of HCPs with level 1 being for low care needs through to level 4 for high care needs.
  - b. As part of the Commonwealth’s aged care reforms, effective from February 2017 HCPs follow the consumer where by an older person is approved by the Aged Care Assessment Team as eligible for a level 3 or 4 home care package, funding will be available for the individual – wherever they live - to purchase that level of care from an approved aged care provider.
51. In recognition that access to services for high care and specialised aged care needs has been historically restricted in remote communities, the NT in partnership with the NT PHN will implement a two phased approach to address the lack of capability of current aged care providers, operating in NT remote communities, to provide nursing and allied health care.
52. This project will be undertaken in two phases:
- a. **Phase 1** will involve a high level health needs assessment of older Territorians with a particular focus on remote residents, identifying service gaps and opportunities to improve health and wellbeing outcomes including through improved aged care. This will be undertaken by the NT PHN, as part of its commitment to the national Aged Care Reform Agenda, in partnership with the DoH.
  - b. **Phase 2** will identify linkages to support the development of client care pathways across primary and acute settings focusing on services delivered to older Territorians in remote communities who are receiving or are eligible for high level HCPs (level 3 and 4). This will ensure approved clients receive the appropriate level of care, including nursing and allied health care.
53. This project will also explore opportunities for service linkage that could be available through the National Disability Insurance Scheme (NDIS).
54. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 5.

**Table 5: Aged Care Milestones**

No.	Key Milestone	Planned start date	Frequency	Responsibility
<b>Health and care services for vulnerable older Territorians in remote communities</b>				
5.1	Establish a combined NT Health/NT PHN Working Group, and further scope the project including undertaking preliminary research and consultations	July 2017	Ongoing	Commonwealth and NT
5.2	Conduct needs assessment and gap analysis	February 2018	Once	NT

5.3	Development of care pathways for clients in remote communities	June 2018	Once	NT
5.4	Trial the new care pathways in selected remote communities	September 2018	Ongoing	Commonwealth and NT
5.5	Evaluate the trial	September 2019	Once	NT

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## **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 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 the Northern Territory.
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 Parties, 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 the Northern Territory.
  - 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 all 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;
  - o 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*	
<b>Bilateral Partnership</b>			
<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"> <li>• Bilateral partner collaboration in planning and implementation</li> <li>• Shared knowledge and information amongst bilateral partners</li> <li>• Complementarity of bilateral activities</li> </ul>		<ul style="list-style-type: none"> <li>• 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)</li> <li>• Qualitative analysis of implementation reporting and monitoring data</li> </ul>
<b>Data Collection and Analysis</b>			
<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"> <li>• Timeliness of data contribution and availability</li> <li>• Data completeness and quality</li> <li>• Data fit-for-purpose</li> <li>• Ease of access</li> <li>• Use of linked data</li> <li>• Understanding of patient utilisation of services and pathways through the system</li> </ul>	Intermediate	<ul style="list-style-type: none"> <li>• Mechanisms established for linkage of Commonwealth and Jurisdictional data sets, including agreed governance and access arrangements</li> <li>• Range of data sets (e.g. MBS, PBS, hospital data) linked, or in the process of being linked</li> <li>• Number of Jurisdictions contributing linked data</li> </ul>
		Longer term	<ul style="list-style-type: none"> <li>• Progress towards establishing enduring linked data sets</li> <li>• Use of linked data for planning/commissioning activities</li> <li>• Use of linked data to inform policy development/reforms</li> <li>• Use of linked datasets to track/analyse the patient journey across care settings</li> </ul>

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"> <li>• Coordination between health providers and systems</li> <li>• Multi-disciplinary team based care</li> <li>• Patient reported satisfaction/experience and outcomes</li> <li>• Patient continuity of care</li> <li>• Workforce experience and engagement</li> <li>• Changes to service utilisation patterns</li> </ul>	Intermediate	<ul style="list-style-type: none"> <li>• Number, type and coverage of activities</li> <li>• Development of regional planning activities</li> <li>• Development of patient care pathways</li> <li>• Collaborative commissioning arrangements</li> <li>• Increased use of MHR               <ul style="list-style-type: none"> <li>- Number of MHRs</li> <li>- Increased number of views/updates</li> <li>- Number of uploaded discharge summaries</li> <li>- Increased number of health professionals viewing/uploading to MHR</li> </ul> </li> </ul>
		Longer term	<ul style="list-style-type: none"> <li>• Cost of delivering services</li> <li>• Patient outcomes and experience/satisfaction (using PROMs and PREMs) **</li> <li>• Number and type of regional planning or commissioning models across care settings</li> <li>• Use of health services (MBS, ED presentations, hospital admissions)</li> <li>• Referral rates</li> <li>• Waiting times</li> </ul>

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"> <li>• Service provider and workforce practices</li> <li>• Systems and processes that enable sharing and coordination</li> <li>• Patient health literacy and/or engagement</li> <li>• Patient reported experience and outcomes</li> <li>• Clinical outcomes</li> </ul>	Intermediate	<ul style="list-style-type: none"> <li>• Number, type and coverage of activities</li> <li>• Increased engagement of health workforce in coordinated care</li> <li>• Increased information sharing and communication between health professionals (eg increased case conferencing, specialist advice to GPs, recording of referrals in clinical software, reports back to GPs, and e-discharge)</li> <li>• Information resources developed for, and used by, patients and carers</li> <li>• Number and type of joint/coordinated or collaborative commissioned or joint activities</li> <li>• Health professionals report increased information sharing and communication (e.g. increase in case conferencing, team care arrangements and multidisciplinary care)</li> </ul>
		Longer term	<ul style="list-style-type: none"> <li>• Patient and health professionals' use of MHR</li> <li>• Patient outcomes and experience/satisfaction (using PROMs and PREMs)**</li> <li>• Relevant clinical measures (e.g. HbA1c, blood pressure)</li> <li>• Use of health services (MBS, ED presentations, hospital admissions)</li> </ul>
Northern Territory 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"> <li>• Collaboration in planning and implementation</li> <li>• Appropriately skilled workforce</li> <li>• Patient health literacy and/or engagement</li> <li>• Patient reported experience and outcomes</li> <li>• Clinical outcomes</li> </ul>	Intermediate	<ul style="list-style-type: none"> <li>• Number, type and coverage of discretionary projects</li> <li>• Collaboration between Commonwealth and Northern Territorys in reforms or delivery of care</li> <li>• Increased staff capability</li> <li>• Information/resource developed for, and used by, patients and carers</li> </ul>

		Longer term	<ul style="list-style-type: none"> <li>• Patient outcomes and experience/satisfaction (using PROMs and PREMs)**</li> <li>• Use of health services (MBS, ED presentations, hospital admissions)</li> <li>• Relevant clinical measures (e.g. HbA1c, blood pressure)</li> </ul>
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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.