

Bilateral Agreement between the Commonwealth and the Australian Capital 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 Australian Capital Territory (ACT) 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 the ACT 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 the ACT.

Commencement, duration and review of the Agreement

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

Interoperability

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

Part 3 – Objective and Outcomes

11. The overarching objective of the Agreement is to support the implementation of coordinated care reforms, consistent with the principles outlined in the NHRA Addendum, that:
 - a. improve patient health outcomes; and
 - b. reduce avoidable demand for health services.
12. The Parties will contribute to the achievement of these objectives and outcomes through reform activities as specified in Schedule A to this Agreement, including;
 - a. data collection and analysis; system integration; and care coordination services, as critical underlying structures of joint coordinated care reform; and
 - b. in other priority areas relevant to the ACT'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, where possible, focus on patients with chronic and complex conditions, 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;
 - 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 mental health, and after hours primary care.

Part 4 – Roles and responsibilities

18. The Parties agree to work together to implement, monitor, refine and evaluate coordinated care reforms under the Agreement.
19. In respect of the joint commitment at Clauses 12 through 17, the Parties will: undertake all activities as outlined in the Schedules to the Agreement; develop and agree project plans to support implementation, where relevant; monitor achievement against milestones; and conduct an evaluation of reform activities.
20. The Parties will work collaboratively with the ACT Primary Health Network (PHN) to support and encourage active participation in the relevant aspects of the bilateral.

Part 5 – Monitoring progress and evaluation

Monitoring Progress

21. 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.
22. 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.
23. 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.
24. Where possible, evaluation will acknowledge and consider existing national and local measures, and other broader policy changes that affect the operation of the Agreement.

25. Evaluation findings will be used to inform the development of advice to COAG Health Council prior to COAG in early 2019, in order to inform future activities that will continue to build the evidence base for joint action on coordinated care.

Risk and Issues Management

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

Part 6 – Stakeholders

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

Part 7 – Governance of the Agreement

Disputes under the Agreement

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

Variation of the Agreement

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

Delegations

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

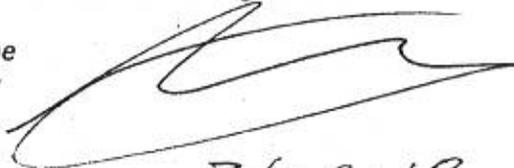
System Integration	Bringing together disparate systems either physically or functionally to act as a coordinated whole, including information technology, funding and organisational systems, that promote the delivery of coordinated or integrated care, centred around people's needs.
Care coordination	Connection 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 Homes (HCH)	An existing practice or Aboriginal Community Controlled Health Service that commits to a systematic approach to chronic disease management in primary care. It uses an evidence-based, coordinated, multi-disciplinary model of care that aims to improve efficiencies and promote innovation in primary care services.

Commissioning	A strategic approach to procurement that is informed by PHN/LHN baseline needs assessment and aims towards a more holistic approach in which the planning and contracting of health care services are appropriate and relevant to the needs of their communities.
Joint, coordinated or collaborative commissioning	Encompasses a variety of ways of working together, as locally appropriate, to make the best use of pooled or aligned budgets to achieve better outcomes for patients.

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

Signed for and on behalf of the
Commonwealth of Australia by

The Hon Greg Hunt MP
Minister for Health
Minister for Sport



31:5:18



Signed for and on behalf of
the ACT by

10/5/2018

Meegan Fitzharris MLA
Minster for Health and Wellbeing

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 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 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 11–17 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 the ACT's local needs and circumstances.

PART 3: Core Characteristics

Data Collection and Analysis

Objectives

7. Data collection and analysis activities will, where possible, focus on patients with chronic and complex conditions and will link data for these patients to inform Commonwealth and ACT 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;
 - 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 will relate to patients with chronic and complex conditions, and include provision of Admitted Patient Care National Minimum Data Set (NMDS), Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Schedule (PBS), Emergency Department NMDS, outpatient care, aged care (residential aged care, home care packages and transition care program) and National Death Index data initially. Additional data would be included, where appropriate, by the Commonwealth and the ACT.
9. The ACT recognises and acknowledges the value of deidentified patient data collection and linkage activities. Where possible, the ACT will work towards participating in data linkage activities. Data collection and analysis will commence as soon as data is made available from the ACT.
10. Once data is made available, the Commonwealth will work with ACT to identify a cohort of patients for the deidentified linked dataset.
11. The collection and use of data would be in accordance with relevant Commonwealth and ACT legislation, confidentiality, privacy, ethics, data governance, and consent provisions.
12. The AIHW would 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, with oversight of the AIHW Ethics Committee.
13. Analysis projects using the linked data set would be undertaken by the Commonwealth, and the ACT, with the agreement that the ACT would be able to view linked, deidentified data for services provided in the ACT.
14. The Parties recognise that the data collection and analysis within this bilateral agreement does not supercede 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).
15. 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.
16. 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.

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
1.1	Ethics and data governance arrangements in place to enable data collection	Upon availability of the data	Once	Commonwealth and ACT
1.2	Where possible, provision of data to the data custodian	Upon availability of the data	Ongoing	Commonwealth and ACT
1.3	Where possible, explore feasibility of extending the data set through inclusion of additional data sets, such as residential and community aged care data, and Mental health data collected through the PHN program as part of enduring data linkage arrangements	Once initial data is available	Ongoing	Commonwealth and ACT
Progression of Primary Health Care NMDS				
1.4	Monitor and progress activities towards establishing a primary health care National Minimum Data Set of de-identified information	Upon signing of the Agreement	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 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 the PHN to support the above processes, as appropriate; and
 - f. continued roll-out of electronic referrals providing general practitioners (GPs), specialists and other care providers, accurate, timely and up-to-date information on patients and their interaction with the acute sector.
20. A second area of focus is improving the transition of patients between residential aged care and primary/acute settings, a critical time when a patient's health status can be adversely impacted. A Commonwealth and inter-jurisdictional working group will be established with the aim to investigate issues, and identify policy opportunities and solutions for COAG consideration on coordinated care in 2019.
21. While the working group will be best placed to determine its areas of focus, opportunities for exploration could include:
- a. the use of, and movements between, health settings including whether: these movements are appropriate; are not feasible; or are being inappropriately prevented;
 - b. improving the evidence base to inform understanding of access to health care services for aged care recipients;
 - c. improving the evidence base for older people with chronic and complex health conditions, particularly older people with dementia and associated severe behavioural and psychological symptoms;
 - d. 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.
22. 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.
23. Parties agree to develop a national collaborative commissioning framework, building on existing work. This framework will guide PHNs and LHNs to collaboratively purchase and/or co-commission services, particularly in rural and remote areas and for high-risk patients to better address local needs. 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.

24. 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
My Health Record				
2.1	Establish baseline and increase in the number of registrations for MHR in ACT	Upon signing of the Agreement	6 monthly	Commonwealth
2.2	Establish baseline and increase in the number of Advance Care Plan uploads on MHR	Upon signing of the Agreement	6 monthly	Commonwealth
2.3	Provision of training for public hospital staff on how to use MHR in relation to the ACT electronic medical record systems	Upon signing of the Agreement	Ongoing	Commonwealth and ACT
2.4	Monitor and increase in percentage of uploads on MHR for: discharge summaries; diagnostic imaging; and pathology	Upon signing of the Agreement	6 monthly	Commonwealth and ACT
2.5	Monitor and increase the viewing frequency of the MHR by healthcare providers	Upon signing of the Agreement	6 monthly	Commonwealth and ACT
2.6	Identify and implement approaches to improve the content of discharge summaries on MHR	Upon signing of the Agreement	Annually	Commonwealth and ACT
Improving service information through the NHSD				
2.7	Active promotion of the NHSD and registration of service provider details in public hospitals, community health, primary and aged care	Upon signing of the Agreement	Ongoing	Commonwealth and ACT
2.8	Monitor and increase in registrations and use of NHSD	Upon signing of the Agreement	Ongoing	Commonwealth and ACT
Improving patient transitions between residential aged care and primary/acute settings				
2.9	Commonwealth and Jurisdictional working group to investigate the transition of residential and community aged care patients across acute, primary and aged care sectors	Upon signing of the Agreement	Ongoing	Commonwealth and ACT
2.10	Identify agreed priority areas for working group to investigate the transition of patients across acute, primary and aged care sectors	Upon signing of the Agreement	Ongoing	Commonwealth and ACT

Strengthening capability in joint service commissioning				
2.11	Development of a national collaborative commissioning framework that defines target population/s and sets out principles and mechanisms for co-commissioning, including in the areas of: <ul style="list-style-type: none"> • governance • funding • purchasing • service delivery 	Upon signing of the Agreement	Ongoing	Commonwealth and ACT

Care Coordination Services

Objectives

25. 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

26. 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 establishes more effective partnerships across the health system, including hospitals, allied health and primary health sectors.
27. The ACT commits, as far as possible, to preparing for implementation of HCH within the ACT in collaboration with the ACT's PHN.
28. Care coordination service activities will focus on the Transitions of Care Project, the Chronic Heart Failure Project, and Health Literacy.
29. Transitions of Care Project

The Transition of Care Project is a joint project between ACT Health and the ACT PHN. The project includes co-design, development and implementation of a proof of concept service model to improve patient focussed transitions of care between hospital and primary health care and community settings for targeted (risk stratified) chronic and complex hospital in-patients (ie: potentially avoidable public emergency department (ED) presentations and hospitalisations).
30. Chronic Heart Failure Project

The Chronic Heart Failure (CHF) project is a joint project between ACT Health and the ACT PHN. The objective of this project is to develop and implement a comprehensive and systematic approach to the management and palliation of CHF that involves evidence-based, multi-disciplinary and patient-centred care. It will utilise the National Heart Foundation of Australia CHF Consensus Statement (2013) as a framework and will be whole-of-system and whole-of-person focused.

31. Health Literacy

ACT Health, in partnership with other relevant organisations, will undertake a range of coordinated projects to improve the health literacy of consumers. This will include provision of information through a range of mediums, which aim to provide consumers with information to assist them to gain advice from their clinicians, and make more informed choices about their treatment. Efforts to improve health literacy will also be implemented through direct self-management support in the Transitions of Care and Chronic Heart Failure projects.

ACT Health will also focus on organisational health literacy, ensuring that clinicians and other relevant staff incorporate health literacy principles in all communication with consumers, and support consumers in becoming active partners in their health care.

32. The Parties will monitor progress against the activities in Table 3.

Table 3: Care Coordination Services Milestones

No.	Key Milestone	Planned start date	Frequency	Responsibility
Transitions of Care Project				
3.1	Establish governance for the project including partnership arrangements between ACT Health and the ACT PHN.	Upon signing of the Agreement	Once	Commonwealth and ACT
3.2	Identify gaps and opportunities in current transitions of care between hospital and primary health care and community care settings	Upon signing of the Agreement	Ongoing	Commonwealth and ACT
3.3	Co-design, consult and develop a proof of concept service model	Upon signing of the Agreement	Once	Commonwealth and ACT
3.4	Implement the proof of concept service model	Upon signing of the Agreement	Ongoing (to 30 June 2018)	Commonwealth and ACT
3.5	Evaluate the proof of concept service model and revise the model as appropriate.	June 2018	Ongoing (to 30 June 2018)	Commonwealth and ACT
Chronic Heart Failure Project				
3.6	Establishment of project governance arrangements including the steering group and Clinical Leadership Forum establishment and stakeholder engagement strategies.	Upon signing of the Agreement	Once	Commonwealth and ACT

3.7	Model of Care development (Including Palliative Care Services Review), Outcomes Framework development & associated minimum data set (MDS)	Upon signing of the Agreement	Once	Commonwealth and ACT
3.8	Development and implementation of a system wide change and adoption strategy(ies)	Upon signing of the Agreement	Ongoing (to June 2018)	Commonwealth and ACT
3.9	Development and delivery of a whole of system multi-disciplinary workforce development plan	Upon signing of the Agreement	Ongoing (to June 2018)	Commonwealth and ACT
3.10	Formative evaluation of the processes, system wide change and adoption strategy(ies), and multi-disciplinary workforce development plan	Upon signing of the Agreement	Ongoing (to June 2018)	Commonwealth and ACT
Health Literacy				
3.11	Develop and endorse Organisational Health Literacy Improvement Plan 2018-2020 and Health Literacy Policy	Upon signing of the Agreement	Once	ACT
3.12	Annual report on activity proposed in the Improvement Plan	Upon signing of the Agreement	Annually by 1 September each year	ACT

PART 4: ACT PRIORITIES

Mental Health

33. All activities undertaken under this priority area to achieve milestones will align with the priorities and objectives of the Fifth National Mental Health and Suicide Prevention Plan.
34. The Parties recognise that there are a number of programs of work and collaborations already underway, including local partnership approaches between Local Health Networks and Primary Health Networks, and national focus on coordinated commissioning of through the AHMAC Mental Health and Drug and Alcohol Principal Committee.
35. Complementary to existing activities, and to inform service planning and future policy approaches for people with chronic and complex conditions, the Parties commit to certain actions to improve coordination of mental health services and supports across care settings.
36. The Parties agree to develop and test coordinated commissioning of mental health services, with a focus on people with severe and complex mental health needs. This work will involve development of a mental health specific Co-Commissioning Framework considering shared governance and aligned funding opportunities, and for the Framework to be trialled for a discrete population as agreed between the Parties.
37. ACT Health and the ACT PHN will jointly develop an ACT Regional Mental Health Services Plan (RMHSP). The purpose of this plan is to provide a strategic and coordinated

approach to the provision of mental health and suicide prevention services across the ACT. In particular, the RMHSP will work towards a system whereby organisations interact and provide coordinated services and coherent care. The plan will take a patient-centred approach and will aim to clarify roles and responsibilities between ACT Health and ACT PHN in relation to mental health services in the ACT.

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

Table 4: Mental health milestones

No.	Key Milestone	Planned start date	Frequency	Responsibility
Co-commissioning mental health services				
4.1	Develop a mental health Co-Commissioning Framework to guide the ACT PHN and ACT Health in testing co-commissioning approaches for mental health services, with an initial focus on people with severe and complex needs	Upon signing of the Agreement	Ongoing	Commonwealth and ACT
ACT Regional Mental Health Services Plan				
4.2	Establish governance arrangements including working group.	Upon signing of the Agreement	Ongoing	Commonwealth and ACT
4.3	Development of Background Paper	Upon signing of the Agreement	Once	Commonwealth and ACT
4.4	Undertake Stakeholder Consultation	November 2017	Ongoing	Commonwealth and ACT
4.5	Development of the Regional Mental Health Services Plan	Upon signing of the Agreement	Ongoing—to August 2018	Commonwealth and ACT
4.6	Finalisation and endorsement of the Regional Mental Health Services Plan	September 2018	First version to be completed by December 2018	Commonwealth and ACT

After hours care

39. Provision of after hours care

ACT Health and ACT PHN will undertake a joint planning and commissioning approach to support targeted and cost effective after hours primary health care services. Planned work includes:

- Commissioning of Aboriginal and Torres Strait Islander after hours primary health care services;

- A scoping study to determine a model that would support the integration of ambulance services into primary health care networks to more effectively support more appropriate after hours service provision in the ACT;
- A scoping study to investigate GP/ED integration including paediatric streaming, the role of Aboriginal Health Workers, and/or GP employment within ED to address primary care type presentations;
- An approach to the market for the provision of innovative solutions to the provision of after hours radiology services in the ACT for primary care providers;
- Development of a targeted and nuanced communication and social media strategy to increase awareness amongst specified cohorts of the availability and utilisation of after hours primary health care services as appropriate alternatives to ED;
- A cross-service observational study of all patients presenting to after hours services in the ACT, to explore reasons for the encounter and the choice of service.

40. The Parties will monitor progress against the activities in Table 5.

Table 5: After-hours care milestones

No.	Key Milestone	Planned start date	Frequency	Responsibility
5.1	Indigenous after hours service implemented	Upon signing of the Agreement	Ongoing (to June 2019)	Commonwealth and ACT
5.2.	Development and conduct of the Ambulance/Primary Health Care Integration scoping study	Upon signing of the Agreement	Once	Commonwealth and ACT
5.3	Implement the model identified in the Ambulance/Primary Health Care Integration scoping study	TBA	TBA	Commonwealth and ACT
5.4	Development and conduct of the Primary Health Care/ED Integration scoping study	Upon signing of the Agreement	Once	Commonwealth and ACT
5.5	Implement the model identified in the Primary Health Care/ED Integration scoping study	TBA	TBA	Commonwealth and ACT
5.6	Development and implementation of After Hours radiology services	Upon signing of the Agreement	Once (to January 2019)	Commonwealth and ACT
5.7	Development and delivery of the After Hours social media strategy	Upon signing of the Agreement	Ongoing (to June 2019)	Commonwealth and ACT
5.8	Evaluation of the social media strategy	June 2019	One off	Commonwealth and ACT
5.9	Cross-service observational study of after hours presentations	Upon ethics approval	One off	Commonwealth and ACT

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

PART 3: Evaluation Framework

Project approach

11. This Framework will be implemented by all jurisdictions (including the Commonwealth), collectively drawing on the agreed evaluation questions and indicators as appropriate to the Parties to the agreement.
12. Each Party agrees to provide qualitative and quantitative data (as appropriate to the Parties) to report on the relevant indicators by 1 October 2018, to enable data compilation and analysis and the drafting of a report to the COAG Health Council. The report is intended to inform future activities that will continue to build the evidence base for joint action on coordinated care.
13. The Evaluation Framework is based on a pre/post design. For some indicators, baseline data will be able to be collected at the commencement of the activity (for example, routinely collected data), while for other indicators, the data collected at the 12 month point will form the baseline for comparison at the end point.
14. All Parties will participate in the development of, and agree on, the report to the COAG Health Council which will outline the progress against each of the evaluation questions, based on compilation and analysis of the qualitative and quantitative data provided by individual jurisdictions.
15. The Evaluation Framework includes:
 - key evaluation questions;
 - a number of agreed indicators, as appropriate to each Party, for each core and priority area; and
 - 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:
 - an overview of the current health system on coordinated care, at the commencement of the bilateral agreement;
 - qualitative sections on each core and priority area; and
 - 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:
 - 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.
 - Core and priority activities for all Parties will be assessed against the Framework;
 - The evaluation questions and indicators enable joint reflection and support consistent data collection across jurisdictions and aggregated data analysis and reporting;
 - 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;

- 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;
 - The Framework does not limit or dictate the level and complexity of evaluation activities undertaken by each jurisdiction;
 - Data will be collected and reported through a variety of existing methods as well as through specific evaluation activity undertaken at the local level by jurisdictions, which can be both quantitative and qualitative.
 - Where appropriate the Commonwealth will provide data collected at a national level (for example, usage of My Health Record); and
 - Where possible and appropriate, validated evaluation tools will be used in evaluating activities.
18. The Parties agree that any changes in implementing the activities outlined in Schedule A will need to ensure that they continue to support the Evaluation Framework outlined below:

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

System Integration			
<p>How has the sharing of health information across the system changed?</p> <p>How has service delivery across the system changed?</p> <p>Have there been improvements in patients' access to health services?</p> <p>What is patient experience and satisfaction of health system improvements?</p> <p>Have changes resulted in improved patient and clinical outcomes?</p>	<ul style="list-style-type: none"> • Coordination between health providers and systems • Multi-disciplinary team based care • Patient reported satisfaction/experience and outcomes • Patient continuity of care • Workforce experience and engagement • Changes to service utilisation patterns 	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Intermediate</p>	<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
		<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Longer term</p>	<ul style="list-style-type: none"> • Cost of delivering services • Patient outcomes and experience/satisfaction (using patient reported outcome measures—PROMs and patient reported experience measures—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