

# **Bilateral Agreement between the Commonwealth and Victoria**

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 the State of Victoria (Victoria) 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 Victoria 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). Reforms are set out in Schedule A 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 Victoria.

### **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, or 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 the *NHRA Addendum*;
  - b. The *National Healthcare Agreement 2012*;
  - c. The *Intergovernmental Agreement on Federal Financial Relations 2008*; and
  - d. The *Agreement on Victorian Aboriginal and Torres Strait Islander Health and Wellbeing 2015-2020*.
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 *Addendum to the NHRA 2017-20* 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 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 Victoria’s local needs and circumstances, including aged care integration; end of life care; mental health; and multidisciplinary team care.
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 reforms will focus on patients with chronic and complex conditions, and will use linked data for these patients to inform Commonwealth and Victorian 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 Health Care Home (HCH) model;
  - c. supporting understanding of the impact of service change, to support improved population health outcomes and inform ongoing health system improvements; and
  - d. contributing to the evidence base for improving patient care.

### **System Integration**

15. System integration reforms 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, ambulatory care including specialist medical, nursing, allied health and aged care services, and through digital health opportunities; and
  - c. effectiveness and efficiency of collaborative commissioning arrangements.

## **Care Coordination Service**

16. Care coordination service reforms are aimed towards contributing to improvements over time, in:
  - a. care coordination capacity and capability;
  - b. cost effectiveness and efficiency through 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.

## **Part 4 – Roles and responsibilities**

17. The Parties agree to work together to implement, monitor, refine and evaluate coordinated care reforms under the Agreement.
18. In respect of the joint commitment at Clauses 12 through 16, the Parties will: undertake all as outlined in the Schedules to the Agreement; develop and agree project plan/s as relevant to support implementation; monitor achievement against milestones; and conduct evaluation of reform activities.

## **Part 5 – Monitoring progress and evaluation**

### **Monitoring Progress**

19. 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 reforms.
20. Monitoring reforms 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.
21. 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, upon commencement of the Agreement.
22. Where Victorian 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.

23. The Parties will work together to ensure that the HCH evaluation and the evaluation of the Agreement (in particular the evaluation of the model outlined in Schedule A) build upon and align with one another and are not duplicative, subject to relevant ethics approvals.
24. Where possible, the evaluation will acknowledge and consider existing national and local measures, and other broader policy changes that affect the operation of the Agreement.
25. Evaluation findings will be used to inform the development of advice to COAG Health Council prior to COAG in early 2019, in order to inform future reforms 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 reforms 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 reforms 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 Victorian 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 by giving six months' notice of its intention to do so, in writing, to 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.

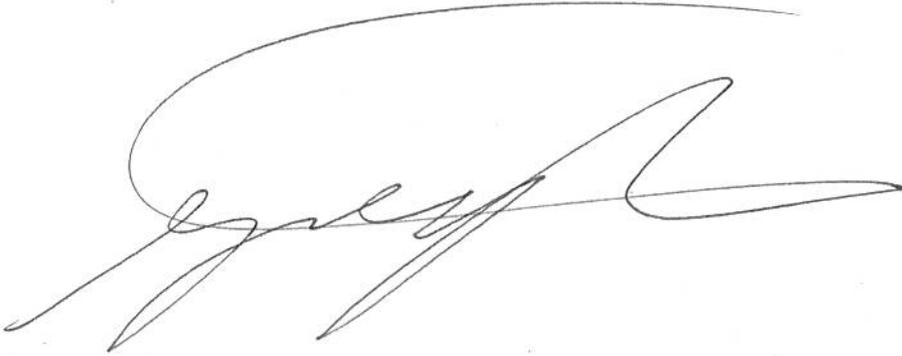
System Integration	Bringing together disparate systems either physically or functionally to act as a coordinated whole, including information technology, funding and organisational systems, that promote the delivery of coordinated or integrated care, centred around people's needs.
Care coordination	Connection 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 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.

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

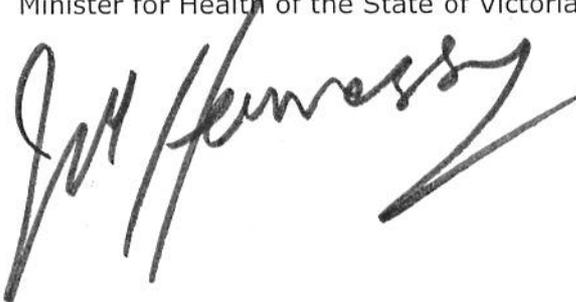
**Signed** for and on behalf of the  
Commonwealth of Australia by

**The Honourable Greg Hunt MP**  
Minister for Health of the Commonwealth of Australia

A handwritten signature in black ink, appearing to read 'Greg Hunt', with a large, sweeping flourish above the name.

**Signed** for and on behalf of  
the State of Victoria by

**The Honourable Jill Hennessy MP**  
Minister for Health of the State of Victoria

A handwritten signature in black ink, appearing to read 'Jill Hennessy', with a large, sweeping flourish below the name.

## **Implementation Plan**

### **PART 1: Preliminaries**

1. This Implementation Plan is a schedule to the *Bilateral Agreement on Coordinated Care Reforms to Improve Patient Health Outcomes and Reduce Avoidable Demand for Health Services* (the Agreement), and should be read in conjunction with that Agreement. The arrangements in this schedule will be implemented jointly by the Parties.
2. The Agreement sets out a suite of reforms to be implemented 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 reforms 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 Clause 12 of the Agreement, the reforms will comprise coordinated care reforms relating to the following priority areas:
  - a. data collection and analysis; system integration; and care coordination services (Part 3 – Core Characteristics); and
  - b. aged care integration; end of life care; mental health; and multidisciplinary team care (Part 4 – Victoria's priorities).

### **PART 3: Core Characteristics**

#### **Data Collection and Analysis**

##### Objectives

7. Data collection and analysis reforms will focus on patients with chronic and complex conditions, and will use linked data for these patients to inform Commonwealth and Victorian reforms by:
  - e. providing an understanding of patient service utilisation and pathways across the health system;
  - f. identifying patients or patient characteristics that would benefit from better care coordination, including from the HCH model;
  - g. supporting understanding of the impact of service change, to support improved population health outcomes and inform ongoing health system improvements; and

- h. contributing to the evidence base for improving patient care.

## Reforms

8. The data collection and linkage reforms for this Agreement will relate to:
  - a. collection and linkage of de-identified health data sets for the entire Victorian population, including patients with chronic and complex conditions, and will initially include provision of Admitted Patient Care National Minimum Data Set (NMDS), Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Emergency Department NMDS, outpatient care data, aged care (residential aged care, home care packages and transition care program) and National Death Index data. Additional data will be included, where appropriate, by the Commonwealth and Victoria;
  - b. the provision of relevant personal information about HCH patients in Victoria (with patient consent) to the Victorian Department of Health and Human Services to improve delivery of coordinated and multidisciplinary care for HCH patients within the relevant Local Health Networks in the South Eastern Melbourne PHN region, where HCHs are being rolled out; and
  - c. developing a de-identified Victorian HCH patient dataset (dependent on relevant approvals) linking HCH patients' service use across the various settings in which they access care (including in public hospitals and their HCH practice), to inform improvements to service funding, management, planning and evaluation on how best to coordinate care for HCH patients. This dataset will also be used to inform the development and implementation of the integrated model that spans across care settings and aligns with or builds on the HCH model under "System Integration".
9. The Commonwealth will work with Victoria to identify a cohort of patients within the linked de-identified 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 HCHs in Victoria.
10. The collection and use of data under this Agreement will be in accordance with relevant Commonwealth and State/Territory confidentiality, privacy, ethics and consent provisions and legislation.
11. The Australian Institute of Health and Welfare (AIHW) will undertake the data collection and linkage work in its capacity as a Commonwealth-accredited data integration authority, within the confidentiality provisions of the *AIHW Act 1987*, with oversight of the AIHW Ethics Committee.
12. Analysis projects using the linked data set will be undertaken by the Commonwealth and Victoria, noting an intention for each to be able to view and access linked data for services provided in Victoria.
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), in which Victoria and New South Wales will continue to participate, in concert with the AIHW under the auspice of 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. In addition to health data reforms described at Clause 8 of Schedule A, the Parties commit to investigate data collection and analysis opportunities that enable a better understanding of social determinants of health and patient pathways across health and social care services.

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.
17. The Parties will monitor progress on the reforms 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 data sets by AIHW</b>				
1.1	Identification of patient cohort, for data collection and analysis	Start of agreement	Ongoing	Commonwealth
1.2	Ethics and data governance arrangements approved and in place to enable data collection for the duration of this Bilateral Agreement which will, among other things: <ul style="list-style-type: none"> <li>a. include access protocols and controls to ensure that data is only accessible by trusted and cleared people consistent with privacy requirements; and</li> <li>b. ensure any data that allows re-identification of people is not published</li> </ul>	Start of agreement	Once and/or ongoing as appropriate	Commonwealth (lead) and Victoria (support)
1.3	Provision of data to the data custodian	Start of agreement	Ongoing	Commonwealth and Victoria
1.4	Explore the need for legislative or other arrangements, including governance arrangements, to support enduring data collection, linkage and analysis beyond the term of this Bilateral Agreement	Start of agreement	Ongoing	Commonwealth and Victoria
1.5	Commence data collection, linkage and analysis on the data outlined at Clause 8 and in accordance with Clauses 8 through 13 of Schedule A for all Victorian patients, noting that the Commonwealth and Victoria will have access to the data for analysis and monitoring	Start of agreement	Ongoing	Commonwealth and Victoria
1.6	Explore feasibility of extending the data set through inclusion of additional data sets, such as disability and National Disability Insurance Scheme (NDIS) data, allied health data and Mental health data collected through the PHN program as part of enduring data linkage arrangements	Start of agreement	Ongoing	Commonwealth and Victoria

1.7	Identify opportunities to improve the integrity of, and share additional data, including community health data and clinical mental health data as part of establishing enduring data linkage arrangements over time and to support system planning, improved analytics and monitoring of reforms	Start of agreement	Ongoing	Victoria
1.8	Share experience with data linkage and analysis	Start of agreement	Ongoing	Commonwealth and Victoria
1.9	Work collaboratively to develop, and where feasible within the time frame, evaluate, common clinical and patient reported outcomes measures and the appropriate tools for measurement to deliver better quality and high value care	Start of agreement	Ongoing	Commonwealth and Victoria
<b>Health Care Homes data linkage with Victorian Health datasets</b>				
1.10	Work collaboratively to ensure data governance arrangements are in place to enable data collection and linkage (contingent on relevant approvals) to inform: <ul style="list-style-type: none"> <li>• coordination of care for HCH patients; and</li> <li>• improvements to service funding, management, planning and evaluation</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria
<b>National Minimum Dataset</b>				
1.11	Monitor and progress activities towards establishing a primary health care National Minimum Data Set of de-identified information	Start of agreement	Ongoing	Commonwealth
<b>Linkage of datasets to better understand social determinants of health</b>				
1.12	Explore the feasibility of linking Victorian health and human services datasets with other Victorian datasets in order to analyse care pathways and socio-environmental determinants of health for people who have chronic and complex conditions	Start of agreement	Ongoing	Victoria

1.13	Explore the feasibility of linking Victorian health and human services datasets with national datasets (such as Centrelink and ATO data) that can be used to generate reliable and universal individual-level proxies of socioeconomic status, with which Victoria can analyse socioeconomic determinants of adverse system pathways and poor health outcomes	Start of agreement	Ongoing	Commonwealth and Victoria
1.14	Where possible progress towards linking Victorian health and human services datasets with Commonwealth datasets (e.g. MBS, PBS and NDIS datasets) in order to analyse patient pathways from primary through to tertiary health care, and in this way identify significant gaps in care continuity and access, predictors of adverse health outcomes and avoidable downstream health system utilisation	Start of agreement	Ongoing	Commonwealth and Victoria
1.15	Where possible progress towards using linked Victorian and Commonwealth datasets to analyse and determine the extent to which social determinants of health (such as socioeconomic status) are an important predictor of access gaps and adverse health outcomes for people with chronic and complex conditions. If socioeconomic status proves an important predictor: <ul style="list-style-type: none"> <li>consider inclusion of social determinants of health when designing measurement and evaluation of relevant bilateral reforms, informed by findings from linkage and measure testing when these are available</li> <li>Victoria will explore with the Commonwealth the feasibility of developing a nationally congruent approach to measuring and recording social determinants of health</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria
1.16	Use the results of the analyses of linked datasets to provide PHNs and health providers with reports on the broad morbidity, service utilisation and social need profiles of local populations (contingent on ethics approval to do so)	Start of agreement	Ongoing	Victoria

## **System Integration**

### Objectives

18. System integration reforms 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; effectiveness and efficiency of collaborative commissioning arrangements; and
- c. investigate opportunities for the Victorian community health service platform to be considered in scope for future chronic disease health care reforms, in particular, providing a broader platform to deliver integrated services to disadvantaged people living with chronic illness.

19. The Parties agree that activities under this priority area 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).

### Reforms

20. In addition to the national roll-out of the MHR on an opt-out basis, a key focus is improved uptake, more effective and efficient use of the MHR, and improved interoperability between MHR and digital health systems at a State and local level, including through:

- a. provision and promotion of on-going targeted training to hospital staff, General Practices, aged care clinicians and community health providers on how to use MHR by the ADHA;
- b. progressing the automatic uploading of discharge summaries, with extension to pathology and diagnostic imaging reports, in conjunction with the Digital Health Agency;
- c. promoting and increasing the frequency of viewing of MHR by healthcare professionals;
- d. identifying ways to work with PHNs to support the above processes, as appropriate; and
- e. further investigation of the suitability of the current electronic referrals standards and solutions aimed at providing General Practices, specialists and other care providers, with accurate, timely and up-to-date information on patients and their interaction across the health sector.

21. All HCH-enrolled patients will have a Shared Care Plan. HCH practices will be encouraged to actively share the HCH patient's shared care plans via MHR with relevant health professionals to coordinate care for their patients.

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, State and Territory 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; 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 residents admitted to hospital;
  - g. explore an agreed definition of "adverse events" for residential aged care clients and determine monitoring mechanisms of appropriate application; and
  - h. improving data systems (including aged care data systems) and linkages with other datasets.
24. The Parties recognise the value of the National Health Services Directory (NHSD) in enabling health professionals and consumers to access 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.
25. A fourth focus area, is the development of an integrated model that spans across care settings, aligns with or builds on the HCH model and will need to be negotiated with relevant State and Commonwealth entities which may impact on the exact design of the governance and funding arrangements. Key elements of the model include:
- a. pooling of Commonwealth and State public hospital funding for an enrolled cohort (likely the HCH cohort) under clauses A18 to A20 of the NHRA, and a percentage of the relevant PHN's flexible or innovation funding (subject to negotiation with the relevant PHN and continued Commonwealth funding to PHNs beyond 2017-18) encouraging integration and joint care planning across care settings;
  - b. collaborative commissioning by fund holders, including the LHNs, PHNs and primary care providers for the enrolled cohort, with joint accountability for outcomes and shared goals;

- c. creating a provider Alliance that understands local care pathways, community need and the broader system, to help inform decisions made by commissioners on a “best for system and patient” basis.

26. As part of this integrated model the Parties would be required to:

- a. convert relevant financial contributions, equivalent to the expected service utilisation by an enrolled cohort, for inclusion and scoped for the purposes of clause A19(d) of the NHRA;
- b. include the relevant financial contributions for the cohort in the Independent Hospital Pricing Authority’s National Efficient Cost Determination A19(d), and the Administrator of the National Health Funding Pool would be required to make necessary adjustments to the calculation of National Health Reform contributions, including funding and payment mechanisms so that Parties are no worse off under this arrangement;
- c. convert the quantum of funding for a relevant financial year, determined and agreed by the Parties following data analysis and patient enrolments;
- d. agree that this funding will not be subject to Safety and Quality Adjustments under the *2017-20 NHRA Addendum*; and
- e. agree that any additional funding provided by the Commonwealth for programs out of the scope of the NHRA (that may be subsequently paid through the National Health Reform funding arrangements) will not be considered by the Administrator of the National Health Funding Pool for the purposes of calculating the 6.5% funding cap referred to in Clause I10 of the *NHRA Addendum*.

27. A fifth area of focus is the development and trial of shared indicators for prevention and early intervention at a local level, noting that if successful, the results of the trial may lead to using both State and Commonwealth funding to drive collective efforts across care settings to achieve population level change. This approach would:

- a. help to focus funding and support a multiple risk factor approach;
- b. support initiatives at a scale that will impact a broader number of people; and
- c. embed public reporting against agreed population health targets and outcomes.

28. The approach may lead to modification to funding formulas or arrangements, placing greater emphasis on funding for prevention and early intervention in the longer term, and could expand to include broader aged care and social services.

29. The sixth area of focus is improving the interface between the health system and the social care system, including the NDIS. The Parties commit to explore opportunities with authorities responsible for NDIS policy and service delivery to improve, where possible, the integration and seamless transitions for people moving between the NDIS and the health system, including age appropriate accommodation and supports for people under 65 years in community settings, avoiding the risk of premature admission to residential aged care services.

30. The Parties also agree to explore establishing agreed priorities for joint efforts and directions to develop broader platforms for service delivery and system integration to

support people with chronic conditions. This may include broader state-based platforms for the delivery of integrated primary care services, such as Community Health.

31. The Parties will monitor progress on the reforms 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 Victoria	Start of Agreement	6 monthly	Commonwealth
2.2	Establish baseline and increase in the number of Advanced Care Plan uploads on MHR in Victoria	Start of agreement	6 monthly	Commonwealth and Victoria
2.3	Promote and encourage development of Advance Care Plans (including identification of substitute decision maker) for patients (including for HCH patients, if the patient agrees) and upload these plans to MHR.	Start of agreement	6 monthly	Commonwealth and Victoria
2.4	Increase in percentage of uploads on MHR for: discharge summaries; with extension to pathology and diagnostic imaging reports; and pathology	Start of agreement	Ongoing	Commonwealth and Victoria
2.5	Implement mechanisms to promote and increase the "viewing" frequency of the MHR by healthcare providers, including in public hospitals	Start of agreement	6 monthly	Commonwealth and Victoria
2.6	Share data and information on MHR system updates, usage and other approaches being taken to improve MHR uptake and use	Start of agreement	Ongoing	Commonwealth and Victoria
2.7	Consult with Victoria on development of Commonwealth digital health infrastructure and MHR in respect of secure messaging, eReferrals, Shared Care Planning, Patient Reported Measures and other integrated care technology solutions between hospital, General Practices, specialist medical and community health services	Start of agreement	Ongoing	Commonwealth
2.8	Collaborate to promote greater interoperability of digital health systems to support seamless care delivery across system settings and enable improved care coordination	Start of agreement	Ongoing	Commonwealth and Victoria
2.9	Share experience and knowledge of state-wide rollout of digital health and integrated care technology solutions	Start of agreement	Ongoing	Victoria

<b>Improving transitions between residential aged care and primary/acute settings</b>				
2.10	Commencement of Commonwealth and inter-jurisdictional aged care working group to investigate the transition of residential aged care patients across acute, primary and aged care sectors	Start of agreement	Ongoing	Commonwealth and Victoria
2.11	Identify agreed priority areas for the working group to investigate the transition of patients across acute, primary and aged care sectors	Start of agreement	Ongoing	Commonwealth and Victoria
2.12	Provide advice on policy opportunities and solutions to COAG in 2019 as outlined in clause 25 of the Agreement	2019	Once	Commonwealth and Victoria
<b>Improving service information through the National Health Services Directory (NHSD)</b>				
2.13	Active promotion of the NHSD and registration of service provider details in public hospitals, community health, primary and aged care, as appropriate and with consideration of service provision and usability limitations	Start of agreement	Ongoing	Commonwealth and Victoria
2.14	Support increase in registrations and use of NHSD, as appropriate and with consideration of service provision and usability limitations	Start of agreement	Ongoing	Commonwealth and Victoria
<b>Integrated model/s</b> (Note: the exact model is subject to negotiation with relevant State and Commonwealth entities which may impact on the exact design of the governance and funding arrangements)				
2.15	Undertake data analysis to inform the development of a model that will align with or build on the HCH model. This should inform: <ul style="list-style-type: none"> <li>Victoria and the Commonwealth about the target patient cohort</li> <li>subject to relevant approvals, Victoria and the Commonwealth use of linked data to establish a funding baseline for the model and analysis of service use, patient pathways and potential overlap with other patient cohorts already involved with service reforms (e.g. HealthLinks: Chronic Care)</li> <li>subject to relevant ethics approvals, future data analyses that inform funding and support collaborative commissioning arrangements, and/or using the linked dataset outlined in Clause 8a of Schedule A.</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria (with Victoria to lead on data analytics)

2.16	<p>Determine and agree the governance and operation of an agreed funding pool, including payment mechanisms (into and from the pool), quantum of the prospective funding pool, and monitoring arrangements (including reconciliation of funds pooled). The funding pool will:</p> <ul style="list-style-type: none"> <li>include the Commonwealth's and Victoria's relevant contribution (admitted, sub-acute, other program funds if relevant) for the cohort and is to be included in the Independent Hospital Pricing Authority's National Efficient Cost Determination A19d of the NHRA (as outlined in clause 26 of Schedule A)</li> <li>be applied by the Administrator of the National Health Funding Pool, with necessary adjustments made to the calculation of the National Health Reform contributions, to ensure that parties are no worse off than under the National Health Reform Agreement</li> <li>include a percentage of the relevant PHN's flexible or innovation funding (subject to negotiation with the relevant PHN and continued Commonwealth funding to PHNs beyond 2017-18)</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria
2.17	<p>Develop and agree an implementation plan in concert with the relevant LHN(s) and PHN, which details the operational elements of the integrated model and clear time lines, and includes the:</p> <ul style="list-style-type: none"> <li>catchment area for collaborative commissioning</li> <li>quantum of funding contributions from the Commonwealth and from Victoria and any relevant Commonwealth funding from the PHN based on data and analytics and expected service utilisation of enrolled patients, as well as the operation of the funding pool including reconciliation</li> <li>roles and establishment of the LHN(s) and PHN as collaborative commissioners, and local Alliance (comprising key representatives from across the health system at</li> </ul>	Start of agreement	Once	Commonwealth and Victoria

	<p>local level), and how this will build on current arrangements on the ground</p> <ul style="list-style-type: none"> <li>workforce development and digital health infrastructure reforms and funding contributions (including in kind)</li> <li>evaluation, including outcome and output measures for which the commissioners are responsible</li> <li>communications strategy</li> </ul>			
2.18	<p>Develop a Commonwealth-Victoria co-commissioning framework that defines target cohorts and sets out principles and mechanisms for co-commissioning including:</p> <ul style="list-style-type: none"> <li>governance</li> <li>funding</li> <li>purchasing</li> <li>service delivery</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria
2.19	<p>Develop and agree on collaborative commissioning arrangements and governance framework (with an Alliance framework), including legal arrangements and relevant guidance and/or training materials for commissioning and operations</p>	Start of agreement	Ongoing	Commonwealth and Victoria (with Victoria to lead)
2.20	<p>Undertake actions to enable pooling of funds (including as outlined at clause A26), including to:</p> <ul style="list-style-type: none"> <li>allow, subject to negotiation with the relevant PHN and continued Commonwealth funding to PHNs beyond 2017-18, an amount of Commonwealth funds to be contributed via the relevant PHN; direct the Independent Hospital Pricing Authority to include the Commonwealth's contribution (admitted, sub-acute, other program funds if relevant) as per clause A19(d) of the NHRA;</li> <li>implement a system to identify and flag enrolled patients to support reconciliation of activity through the pool;</li> <li>direct the Administrator of the National Health Funding Pool to make necessary adjustments to the growth calculation so that Parties are no worse off under this arrangement</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria
2.21	<p>Determine the funding pool and contribute relevant shares of funds to the funding pool</p>	Start of agreement	Ongoing	Commonwealth and Victoria

2.22	Implement workforce development and digital health infrastructure reforms (including through in-kind investment in workforce education and digital health infrastructure reforms, including MHR development and uptake)	Start of Agreement	Ongoing	Commonwealth and Victoria
2.23	Monitor, evaluate and refine the model, including through tracking MBS and PBS over time, as well as Community Health data	Start of agreement	Ongoing	Commonwealth and Victoria
2.24	Facilitate collaboration between PHNs, LHNs and other service providers across Victoria to improve the integration of care across care settings, from acute to primary and community health care	Start of agreement	Ongoing	Commonwealth and Victoria
2.25	Share tools, early learnings and evaluation of HealthLinks: Chronic Care and other integrated care efforts with the Commonwealth to inform future reform efforts and implementation of the model	Start of agreement	Ongoing	Victoria
<b>Shared accountability measures</b>				
2.26	Develop and prioritise shared indicators for prevention and early intervention for State and Commonwealth health funding, based on the indicators in the National Strategic Framework for Chronic Conditions, and agree monitoring systems to capture progress against the indicators.	Start of agreement	Ongoing	Commonwealth and Victoria
2.27	Trial shared indicators for prevention and early intervention in select local government areas across Victoria, and based on findings from the trial, commence negotiations with the Commonwealth on a new agreement for further roll out	July 2018	Ongoing	Commonwealth and Victoria
<b>NDIS and health interface</b>				
2.28	Develop resources, solutions and models to improve the interface between the health system and NDIS, and implement as appropriate. This joint work will cover: <ul style="list-style-type: none"> <li>• upskilling and educating the primary and community care and disability sectors in early identification and management of complex disability and health issues (preventive health)</li> <li>• tailoring integrated solutions for younger people (under 65 years) who: <ul style="list-style-type: none"> <li>○ remain in acute care and are</li> </ul> </li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria

	<p>at risk of premature admission to residential aged care services due to high levels of complexity that cannot be managed appropriately in community settings</p> <ul style="list-style-type: none"> <li>○ are NDIS eligible, who must remain in residential aged care or acute care because there are no appropriate alternative accommodation options in community settings, or for those who choose to remain in residential aged care so that their care is commensurate to that received by NDIS clients living in community settings</li> <li>• developing alternative integrated model(s) so that people aged under 65 years can transition out of acute care as early as possible, or out of residential aged care if appropriate, into the most appropriate setting</li> </ul>			
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## **Care Coordination Services**

### Objectives:

32. Care coordination service reforms are aimed towards contributing to improvements over time, in:
- a. care coordination capacity and capability, including the development of care plans, health literacy, chronic disease management, goal setting and cultural safety;
  - 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.

### Reforms:

33. HCHs are a key Commonwealth contribution to care coordination services under this Agreement. HCHs are a 'home base' that will coordinate the comprehensive care that patients with chronic and complex conditions need on an ongoing basis. Under this model, care is integrated across primary and hospital care as required and establishing more effective partnerships across the health system, including hospitals, allied health and primary health sectors.

34. HCHs will provide care to up to 65,000 patients across 200 sites. HCHs will initially be implemented in 10 geographical regions based on PHN boundaries. The Victorian region is **South Eastern Melbourne PHN (SEMPHN)**. 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.
35. Stage one HCHs 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 Victorian stakeholders and will examine the implementation process as well as the impact of the model, including any jurisdiction-specific impacts and opportunities.
36. In addition to the roll out of the HCHs, areas of focus to improve care coordination services include:
- a. identifying and linking State and local programs with HCHs, to support HCH patients over the life of the Agreement;
  - b. in-principle, to work towards developing a shared understanding of definitions used by different stakeholders for key care coordination terms. Terms may include, but not be limited to care navigation, health coaching, functions described in HCH practices, and other services and integrated care models in PHNs and LHNs. This work is contingent upon the agreed involvement of all Australian jurisdictions, and could build on existing initial work being undertaken and will be captured in the report to COAG for further consideration; and
  - c. strengthening the capability and capacity of the health workforce for HCHs.
37. The Parties will monitor progress on the reforms against the milestones and timelines outlined in Table 3.

**Table 3: Care Coordination Services Milestones**

No.	Key Milestone	Planned start date	Frequency	Responsibility
<b>Health Care Homes</b>				
3.1	Contract General Practices/ACCHS to participate in HCH	July 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	Implement and compare risk stratification models that effectively identify patients with chronic and complex conditions (such as HealthLinks: Chronic Care) with the HCH model	Start of agreement	Once	Commonwealth and Victoria
3.5	Commence HCH evaluation (including establishment of baseline data)	October 2017	Ongoing	Commonwealth

3.6	Share preliminary and final reports and any other relevant evaluation data, findings and outcomes in relation to the roll out of the HCHs in the SEMPHN region, where possible	October 2019	Ongoing	Commonwealth
3.7	Work together to ensure that the HCH evaluation and the evaluation of the Agreement (in particular the evaluation of the integrated model) build upon and align with one another and are not duplicative, subject to relevant ethics approvals	Start of agreement	Ongoing	Commonwealth and Victoria
<b>Common language for care coordination</b>				
3.8	In conjunction with other jurisdictions, develop a shared understanding of key care coordination terms	Start of agreement	Ongoing	Commonwealth and Victoria
<b>Strengthening the capability and capacity of the health workforce for HCHs</b>				
3.9	Work with the Commonwealth and relevant Victorian service providers to determine if there are services or programs (including care coordination) that could assist in supporting HCH providers and patients, and if so: <ul style="list-style-type: none"> <li>• promote these with HCH providers and patients</li> <li>• facilitate opportunities for regional planning and joint or aligned funding arrangements</li> </ul>	Start of agreement	Ongoing	Victoria and Commonwealth
3.10	Develop capacity and capability for ACCHS and the Aboriginal Health Workforce to manage increasing demand for culturally-safe services and to introduce, embed and/or collaborate with HCH sites, in consultation with the Victorian Advisory Council on Koori Health	Start of agreement	Ongoing	Commonwealth and Victoria
3.11	Establish change management support to develop capacity of key stakeholders in implementing new systems and models of service and to understand the benefits of the HCH model and its operation.	Start of agreement	Ongoing	Commonwealth and Victoria

## PART 4: VICTORIA'S PRIORITIES

### Priority Area 1: End of life care

#### Objectives and Reforms:

38. The Parties recognise that activities under this priority area will link where relevant with the National Palliative Care Strategy, and the National Palliative Care Projects funded by the Commonwealth.
39. This work will also be informed by, and align where relevant with, the work of AHMAC in end of life care, being undertaken by the inter-jurisdictional end of life care working group which currently reports through the Community Care and Population Health Principal Committee.
40. Reforms focused on the end of life and palliative care services are aimed towards contributing to improvements over time, in:
- a. supporting patients in preparing for end of life;
  - b. increasing the capability of health professionals across all care settings in identifying, managing and preparing patients, their families and carers for end of life care, including making end of life care conversations and planning part of everyday practice; and
  - c. increasing the uptake of best practice advance care plans that can be shared across the health system to improve patient care and consistency in care at end of life.
41. The Parties will monitor progress against the reforms in Table 4.

**Table 4: End of life care**

No.	Key Milestone	Planned start date	Frequency	Responsibility
<b>Workforce development and support</b>				
4.1	Support and upskill primary, community health, acute and aged care providers (including General Practices, disability service providers, disability group homes and aged care facilities/services) to improve and make end of life care conversations and planning part of everyday practice through a range of actions, including: <ul style="list-style-type: none"> <li>• identifying approaches to, and increasing provision of secondary supports into primary care, community health and aged care (e.g. increased access to palliative care physicians)</li> <li>• providing education and training to increase knowledge and skills in end of life care and planning, including communication training for having and managing difficult conversations</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria

	<ul style="list-style-type: none"> <li>developing principles for communicating with patients and carers around preparing for end of life</li> </ul>			
<b>Increasing the uptake of Advance Care Plans</b>				
4.2	Review and update hospital referral and discharge templates and care plans, and Community Health care plans to include references to advance care planning and identification of a substitute decision maker	Start of agreement	Once	Victoria
<b>Supporting patients in preparing for end of life</b>				
4.3	Investigate actions to improve culturally appropriate end of life care	Start of agreement	Ongoing	Commonwealth and Victoria
4.4	Promote harmonisation across jurisdictions on managing end of life and palliative care, by ensuring models of care are informed by agreed uniform data collection and benchmarking, to ensure consistent patient management	Start of agreement	Ongoing	Commonwealth and Victoria
4.5	Clarify the roles and responsibilities between the Commonwealth and Victoria in palliative and end of life care, with a focus on people in the aged care system	Start of agreement	Ongoing	Commonwealth and Victoria
4.6	Integrate Advance Care Planning into community and residential aged care policies and practice	Start of agreement	Ongoing	Commonwealth and Victoria

## **Priority Area 2 Aged care integration**

### Objectives and reforms:

42. 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.
43. 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.
44. 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.
45. 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.

46. In line with their responsibilities as approved providers of transition care, Victoria will continue to manage the day-to-day operations of the Transition Care Programme in its jurisdiction, to ensure quality care is delivered to eligible care recipients immediately following a period of hospitalisation.

47. Reforms focused on aged care integration are aimed towards contributing to improvements over time, in:

- a. outcomes for aged care patients through earlier intervention and treatment, in particular through increased primary care support to, and strengthened links with, Residential and Community Aged Care settings. This would help to reduce:
  - i. the trauma and risk of adverse events associated with being unnecessarily transferred to a hospital from a Residential and Community Aged Care service; and
  - ii. unplanned presentations, admissions and readmissions, and unnecessary transfer to hospital for death.
- b. cost effectiveness and efficiencies of services being delivered to aged care patients through reductions in unnecessary emergency department and acute presentations, and consideration of options for collaborative commissioning of, and more flexible funding for providing health care to Residential and Community Aged Care consumers;
- c. the capability of, and consistency in, service provision across the aged care sector by Residential and Community Aged Care services and General Practice, including through developing the capability of the aged care and primary care workforce; and
- d. identifying options for collaborative commissioning of, and more flexible funding for, providing health care to Residential and Community Aged Care consumers.

48. The Parties will monitor progress against the reforms in Table 5.

**Table 5: Aged care integration**

No.	Key Milestone	Planned start date	Frequency	Responsibility
<b>Collaborative commissioning options for aged care</b>				
5.1	Develop a proposal and explore opportunities to implement a collaborative commissioning model between Victorian, Commonwealth funded, and other providers at a local level which: <ul style="list-style-type: none"> <li>• supports flexible use of funds to focus Residential In Reach services on the highest acuity patients and increase provision of primary care services to residential aged care residents</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria

	<ul style="list-style-type: none"> <li>increases the skills of primary care service providers in targeting the needs of older persons</li> <li>maintains strong links with hospital based clinicians to best manage patients' needs, including those that present to an emergency department or are admitted to hospital</li> </ul>			
<b>Strengthening links between aged care and other health care providers</b>				
5.2	<p>Support relevant PHNs to:</p> <ul style="list-style-type: none"> <li>work with General Practice to increase access of residents to General Practitioners and multi-disciplinary care, including participation in medication reviews, to better respond to and manage their health needs and respond to deterioration in their health</li> <li>work with residential aged care services to increase their workforce's skills and participate in quality improvement activities (e.g. Raise the Bar, Quality use of medicines)</li> <li>assist aged care providers in ensuring they have skilled nurses available and on site to respond to residents' care needs</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria
<b>Improving the quality of care to aged care residents</b>				
5.3	<p>Support LHNs to explore opportunities to establish increased secondary supports into aged care services (which could be collaboratively commissioned), such as:</p> <ul style="list-style-type: none"> <li>centralised telephone triage and advice services for residential aged care services and General Practitioners</li> <li>aged care link nurses in LHNs to build the clinical capacity of aged care nurses, to improve and update their assessment skills of older people</li> <li>models of care supporting greater access to comprehensive geriatric assessment and use of technology</li> </ul>	Start of agreement	Ongoing	Victoria

5.4	Explore options to establish common output and outcome measures for residential aged care service providers for residents with chronic and complex conditions and any collaborative commissioning of aged care health services	Start of agreement	Ongoing	Commonwealth and Victoria
5.5	Explore options to establish aligned reporting requirements for aged care services across the care continuum	Start of agreement	Ongoing	Commonwealth and Victoria
5.6	Commence process to introduce a "flag" in Victoria's emergency department and inpatient datasets to capture the place of residence of residential aged care facility residents	Start of agreement	Ongoing	Victoria

### **Priority Area 3: Mental Health**

#### Objectives and reforms:

49. All reforms undertaken under this priority area to achieve the milestones should be aligned with the priorities and objectives of the Fifth National Mental Health, Suicide Prevention Plan and Victoria's 10-year mental health plan.
50. The Parties recognise that there are a number of programs of work and collaborations already underway, including local partnership approaches between LHNs and PHNs, and national focus on coordinated commissioning through the AHMAC Mental Health and Drug and Alcohol Principal Committee.
51. Complementary to existing reforms, 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.
52. Reforms focused on integration of mental health services are aimed towards contributing to improvements over time, in:
- a. identification and treatment of mental health and physical health issues across acute and primary care settings, and improving outcomes for, people with mental health conditions, including those with severe and complex needs;
  - b. more seamless, high quality and earlier mental health care, including through building the capacity and capability of the health workforce in mental health services and ensuring clear pathways for those patients across the system; and
  - c. the efficiency and effectiveness of mental health services across care settings, including through coordinated commissioning and sharing information to enable better coordination of mental health services and suicide prevention.
53. The Parties will monitor progress against the reforms in Table 6.

**Table 6: Mental health**

No.	Key Milestone	Planned start date	Frequency	Responsibility
<b>Sharing information</b>				
6.1	Share information about policy and program settings in mental health to enable better coordination of, or joined up response to, mental health services, including suicide prevention	Start of agreement	Ongoing	Commonwealth and Victoria
<b>Building capacity and capability of the health workforce in mental health</b>				
6.2	Provide education and training to the primary and aged care sectors to better manage mental health comorbidity, with an initial focus on General Practitioners or Aboriginal Medical Services and care-coordinators in HCH program to be rolled out more broadly	Start of agreement	Ongoing	Commonwealth and Victoria
<b>Developing more seamless and effective mental health services</b>				
6.3	Clarify and reinforce the role of primary health care services and General Practice in maintaining the physical health of people with severe and complex mental health conditions	Start of agreement	Ongoing	Commonwealth and Victoria
6.4	Develop and implement a strategy to test coordinated commissioning of mental health services between State and Territory government bodies and PHNs, with a focus on people with severe and complex mental health needs.  This work should build on, and be facilitated by, the work of the Mental Health Drug and Alcohol Principal Committee and align with the Fifth National Mental Health Plan.	Start of agreement	Ongoing	Commonwealth and Victoria
6.5	Explore and implement opportunities for joint work to: <ul style="list-style-type: none"> <li>• build capacity of General Practices and other health care providers to improve treatment and support for patients with mental illness</li> <li>• provide clear pathways into and out of specialist mental health services (including Area Mental Health Services and private psychiatry)</li> <li>• work with PHNs to map and agree clear mental health referral pathways across PHN regions, including those suitable for Aboriginal people</li> <li>• increase the capacity of the primary healthcare sector to implement preventive strategies</li> </ul>	Start of agreement	Ongoing	Commonwealth and Victoria

	<ul style="list-style-type: none"> <li>increase the capacity of the primary healthcare sector to link people with social support services, including alcohol and other drug services</li> <li>embed cultural knowledge and capability into all aspects of clinical and community care, including pathways in and out of services</li> </ul>			
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## **Priority Area 4 – Multidisciplinary team care**

### Objectives and reforms:

54. Reforms focused on multidisciplinary team care are aimed towards contributing to improvements over time, in the capability of the health workforce to deliver new integrated care models and work as part of a multidisciplinary team across care settings.

55. These reforms are addressed through a range of the Core and other Priority areas outlined in the Agreement.

56. The Parties will monitor progress against the reforms in Table 7.

**Table 7: Multidisciplinary team care**

<b>No.</b>	<b>Key Milestone</b>	<b>Planned start date</b>	<b>Frequency</b>	<b>Responsibility</b>
<b>Building the capability of the workforce to deliver integrated care</b>				
7.1	Identify new workforce models and the competencies and capabilities required in the broader health workforce to support integrated care and consistent care across settings, with particular focus on the chronic care workforce	Start of agreement	Ongoing	Commonwealth and Victoria
7.2	Identify and implement approaches to support health professionals to operate in multidisciplinary teams including in the new HCH model of service	Start of agreement	Ongoing	Commonwealth and Victoria
7.3	Identify barriers to multidisciplinary team care for the management of chronic conditions	Start of agreement	Ongoing	Commonwealth and Victoria
7.4	Identify opportunities to develop a self-assessment tool for consumers with no diagnosed chronic disease to detect and prevent chronic diseases earlier in general (medical) practice. This self-assessment tool would support primary care educating patients in better understanding chronic diseases and their risk factors	Start of agreement	Ongoing	Commonwealth and Victoria

7.5	Promote uptake of the integrated health check as agreed with PHNs, through education, systems support, creating linkages with relevant prevention services, and develop measurement, reporting and evaluation via quality improvement programs	Start of agreement	Ongoing	Commonwealth and Victoria
7.6	Explore and promote opportunities for Victorian Community Health Services to collaborate with HCHs, to provide the multi-disciplinary care required by patients with complex and chronic conditions, enhancing integration of the system and service delivery	Start of agreement	Ongoing	Commonwealth and Victoria

### 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 upon signing, 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*	
<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>	<p>Intermediate</p> <p>Longer term</p>	<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> <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 (e.g. 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>
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"> <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 jurisdictions 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.