Bilateral Agreement between the Commonwealth and South Australia

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

Part 1 — Preliminaries and Reform Intent

1) The Commonwealth of Australia (the Commonwealth) and South Australia (SA) 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 SA 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 SA.

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 to consider arrangements beyond this point.

Interoperability

9) The Agreement is to be considered in conjunction with:

   a. The *NHRA for 2011* and its 2017-20 *Addendum*;

   b. The *National Healthcare Agreement 2012*; and

   c. The *Intergovernmental Agreement on Federal Financial Relations 2008*.

10) Schedules to this Agreement will include, but not be limited to:

   a. Schedule A: Implementation Plan; and

   b. Schedule B: Evaluation Framework.

Part 3 — Objective and Outcomes

11) The overarching objective of the Agreement is to support the implementation of coordinated care reforms, consistent with the principles outlined in the NHRA Addendum that:

    a. improve patient health outcomes; and

    b. reduce avoidable demand for health services.

12) The Parties will contribute to the achievement of these objectives and outcomes through 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 SA's local needs and circumstances.

13) The Parties recognise that the activities, objectives and outcomes of the Agreement, will link, where relevant, with longer term health reforms.

Data Collection and Analysis

14) Data collection and analysis activities will focus on patients with chronic and complex conditions, including Health Care Homes (HCH) patients, to inform coordinated care reforms by:

    a. providing an understanding of patient service utilisation and pathways across the health system;

    b. identifying patients or patient characteristics that would benefit from better care coordination, including from the HCH model;

    c. supporting understanding of the impact of service change, to support improved population health outcomes and inform ongoing health system improvements; and

    d. contributing to the evidence base for improving patient care.

System Integration

15) System integration activities are aimed towards contributing to improvements over time, in:

    a. regional planning and patient health care pathways, including providing better access and service delivery across systems;

    b. integration of primary health care, acute care, specialist and allied health services, including through digital health opportunities; and

    c. effectiveness and efficiency of collaborative commissioning arrangements.

Care Coordination Service

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

a. care coordination capacity and capability;

b. cost effectiveness and efficiency of targeting of available resources, while ensuring continuity of care for patients; and

c. patient empowerment, knowledge, skills and confidence to set goals and manage their health, with the support of their health and social care team.

17) The Parties will additionally contribute to the achievement of the objectives and outcomes of the Agreement through reforms in the priority areas of:

a. PHN Engagement;

b. End of Life; and

c. Rural and Remote Service Delivery.

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 evaluation of reform activities.

20) The Parties will work collaboratively with the SA Primary Health Networks (PHNs) 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 activities, 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 SA reforms build on or directly support HCHs, the evaluation will recognise the collaborative partnership and its impact on the outcome of the HCH evaluation.

25) Where possible, evaluation will acknowledge and consider existing national and local measures, and other broader policy changes that affect the operation of the Agreement.

26) 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

27) The Parties agree that they will continually monitor, review and take necessary action to manage risks over the life of the Agreement.

28) Where agreed by both Parties, Schedule A will be updated to reflect any substantive changes or extension to activities to effectively manage identified risks.

29) 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.

30) The Commonwealth and SA will work collaboratively with the SA Primary Health Networks to support and encourage active participation in the relevant aspects of the bilateral.

31) 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

32) 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

33) Any Party may give notice in writing to the other Party of a dispute under the Agreement.

34) The Parties will attempt to resolve any dispute at officer-level in the first instance.

35) 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

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

Delegations

37) The Parties may delegate monitoring and reporting of progress on reform activities under this Agreement to appropriate senior Commonwealth and South Australian officials.

Enforceability of the Agreement

38) 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

39) 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.

40) 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

41) 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 (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 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

18:1:18

Signed *for and on behalf of South Australia by*

The Hon Peter Malinauskas MLC
Minister for Health

Implementation Plan

PART 1: Preliminaries

1. This Implementation Plan is a schedule to the *Bilateral Agreement on Coordinated Care Reforms to Improve Patient Health Outcomes and Reduce Avoidable Demand for Health Services* (the Agreement), and should be read in conjunction with that Agreement. The arrangements in this schedule will be 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 on signing of the Agreement, and expire on 31 December 2019, unless terminated earlier in writing.

4. In implementing the projects identified in this Schedule, the Parties will identify relevant stakeholders and ensure there is an agreed communication approach.

5. The purpose of this Schedule is to guide implementation, provide the public with an indication of how the enhanced coordinated care reform project is intended to be delivered, and demonstrate the Parties' ability to achieve the outcomes of the Agreement.

6. In accordance with clauses 12-17 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 SA's local needs and circumstances.

PART 3: Core Characteristics

Data Collection and Analysis

Objectives

7. Data collection and analysis activities will focus on patients with chronic and complex conditions, including HCH patients, and will link data for these patients, to inform Commonwealth and jurisdictional reforms, by:

    a. providing an understanding of patient service utilisation and pathways across the health system;

    b. identifying patients or patient characteristics that would benefit from better care coordination, including from the HCH model;

    c. supporting understanding of the impact of service change, to support improved population health outcomes and inform ongoing health system improvements; and

    d. contributing to the evidence base for improving patient care.

Activities

8. The de-identified patient data collection and linkage activities for this Agreement relate to patients with chronic and complex conditions, and include provision of public hospital Admitted Patient Care National Minimum Data Set (APC NMDS), Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Schedule (PBS), Emergency Department NMDS and National Death Index data initially (additional data will be included, where agreed), by the Commonwealth and SA.

9. The Commonwealth will work with SA to identify whole of population data for the de-identified linked data set, which will include all patients enrolled in HCH as well as a comparison group of patients with chronic and complex conditions who are not enrolled in HCH.

10. The collection and use of data will be in accordance with relevant Commonwealth and State/Territory confidentiality, privacy, ethics and consent provisions.

11. The Australian Institute of Health and Welfare (AIHW) will undertake the data collection and linkage work in its capacity as a Commonwealth-accredited data integration authority, within the confidentiality provisions of the AIHW Act 1987, and with oversight by the AIHW Ethics Committee. SA may elect to utilise the services of SA/NT Datalink to facilitate the linkage process on their behalf. In the interests of improving efficiency and quality in the linkage process SA (and/or SA/NT Datalink) will receive back from the AIHW the relevant data to facilitate future linkage under this Agreement or as otherwise approved by the appropriate ethics and authorised by the relevant parties for the APC NMDS and the Emergency Department NMDS datasets.

12. Analysis projects using the linked data will be undertaken by the Commonwealth and SA, with the agreement that SA will be able to interact and analyse the linked de-identified data for services provided in SA. Analysis work will only commence once there is an agreed governance model between SA and the Commonwealth.

13. The Parties recognise that the data collection and analysis within this bilateral agreement does not supersede or alter the work of the National Data Linkage Demonstration Project (NDLDP) being undertaken by the AIHW under the auspice of the National Health Information and Performance Principal Committee (or equivalent replacement bodies as directed by the Australian Health Ministers' Advisory Council (AHMAC) if applicable) and AHMAC.

14. It is recognised that consideration and decision by AHMAC in relation to the future of the NDLDP will need to be taken into account in progressing the collection and linkage of data through this Agreement.

15. The Commonwealth will take a national lead role on work to develop a NMDS of de-identified information to help measure and benchmark primary health care performance at a local, regional and national level, which will also help to inform policy and identify region-specific issues and areas for improvement. This will be a staged, complex and multi-faceted work program, extending beyond the end of this Agreement. It will require collaboration and cooperation from a number of government and non-government sectors.

16. SA is committed to:

    a. Improve linkages within our own linked data sets; including leveraging the SA/NT Data linkage node or similar; and

    b. Develop a data sharing agreement with the SA PHNs.

17. SA Health will negotiate with the relevant parties and set-up any required agreements to enable aggregated analysis outputs (not patient level data) to be shared with the PHNs and/or HCHs in order to progress these objectives.

18. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 1.

Table 1: Data Collection and Analysis Milestones

No.	Key Milestone	Planned start date	Frequency	Responsibility
1.1	Ethics and data governance arrangements in place to enable data collection.	September 2017	Once (anticipate ethics approval by January 2018)	Commonwealth And SA
1.2	Identification of patient cohort and patient consent sought for data collection and analysis.	October 2017	Ongoing	Commonwealth
1.3	Explore feasibility of inclusion of additional data sets, such as residential and community aged care data, My Aged Care data, and Mental health data collected through the PHN program.	September 2017	Ongoing	Commonwealth and SA
1.4	Monitor and progress activities towards establishing a primary health care National Minimum Data Set of de-identified information.	August 2017	Ongoing	Commonwealth
1.5	SA Health Admitted and Emergency datasets are linked into the AIHW national data linkage set.	January 2018	June 2019 (based on evaluation)	SA
1.6	The Mental Health Enhanced Patient Journey data set is developed.	January 2018	December 2018 (and ongoing)	SA
1.7	SA Health and PHNs agreed data sharing mechanism is built, tested and implemented.	January 2018	December 2018 (and ongoing)	Commonwealth and SA

System Integration

Objectives

19. System integration activities are aimed towards contributing to the broader system integration objective of achieving improvements over time, in:

    a. regional planning and patient health care pathways, including providing better access, and service delivery across systems;

    b. integration of primary health care, acute care, specialist and allied services, including through digital health enablers; and

    c. effectiveness and efficiency of collaborative commissioning arrangements.

20. The Parties agree that activities under this priority 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

21. In addition to the national roll-out of MHR on an opt-out basis, a key focus for the Commonwealth and SA is improved uptake, and more effective and efficient use of the MHR, initially targeting PHNs in which HCHs are located, and with a view to expanding more broadly where possible over time, including through:

    a. promoting targeted training-provided by the ADHA to hospital staff;

    b. progressing the automatic uploading of discharge summaries, in conjunction with ADHA;

    c. promoting and increasing the frequency of "viewing" of the MHR by healthcare professionals;

    d. increasing MHR content of uploaded documents;

    e. continued rollout of electronic referrals providing general practices, specialists and other care providers accurate, timely and up-to-date information on patients and their interaction with the acute sector;

    f. identifying ways to work with PHNs to support the above processes, as appropriate; and

    g. Progressing towards the uploading of pathology and diagnostic imaging.

22. A second area of focus is improving the transition of patients between residential aged care and primary/acute settings, a critical time when a patient's health status can be adversely impacted. A Commonwealth and inter-jurisdictional working group will be established with the aim to investigate issues, and identify policy opportunities and solutions for COAG consideration on coordinated care in 2019.

23. While the working group will be best placed to determine its areas of focus, opportunities for exploration could include:

    a. the use of, and movements between, health settings including whether these movements are appropriate; not feasible; or are being inappropriately prevented;

    b. improving the evidence base to inform understanding of access to health care services for aged care recipients;

    c. improving the evidence base for older people with chronic and complex health conditions, particularly older people with dementia and associated severe behavioural and psychological symptoms;

    d. establishing aligned reporting requirements for aged care services across the care continuum;

    e. clarifying the roles and responsibilities between the Commonwealth and jurisdictions in providing aids and equipment, and where relevant, link with the work of the State and Territory Aged and Community Care Officials Committee;

f. explore mechanisms to improve identification of Residential Aged Care Facility residents admitted to hospital; and

g. improving data systems and linkages between datasets.

24. The area of focus for SA is the development of system integration initiatives in areas of high volume transitions such as between hospital and the community and for people with more specialised service needs where close service coordination is critical to patient outcomes. The focus of SA will be these areas:

a. The development of an evidence based alcohol and other drug treatment services system framework for SA government, non- government, SA PHNs and primary health sector. The framework will enable greater transparency in treatment planning, improved service coordination and reduced duplication and include outcome measures and service pathways. The framework will support individuals with complex and chronic needs to entering and transitioning between services and will benefit both the individuals accessing the system and funders; enabling greater service coordination and planning, reduced duplication and clearly defined evidence-based health services.

b. Undertake a trial of proof of concept for integrated hospital avoidance and supported discharge service model of care which links residential and community aged care, general practice, Emergency Departments, Ambulance service with a new rapid assessment clinic to ensure safe care transitions and facilitated access to specialist advice and services.

c. Develop an integrated approach to the provision of community Mental Health services through the development of a collaborative funding and shared model of care with the SAPHNs.

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

Table 2: System Integration Milestones

No.	Key Milestone	Planned start date	Frequency	Responsibility
Effective and efficient use of MHR				
2.1	Establish baseline and increase in the number of registrations for MHR in SA.	August 2017	6 monthly	Commonwealth
2.2	Establish baseline and increase in the number of Advanced Care Directives uploads on MHR in SA.	August 2017	6 monthly	Commonwealth
2.3	SA will improve the awareness and understanding of Advanced Care Directives and its availability on MHR with health professionals in LHNs.	November 2017	Ongoing	SA
2.4	Provision of training for public hospital staff on how to use MHR in relation to the SA electronic medical record systems.	December 2018	Ongoing	Commonwealth and SA

2.5	Monitor and increase in percentage of uploads on MHR for discharge summaries.	June 2018	6 monthly	Commonwealth and SA
2.6	Develop and implement a plan to increase the capacity of SA Health services to view MHR.	August 2017	August 2018	Commonwealth and SA
2.7	Investigate and implement approaches to reduce the number of errors in uploading discharge summaries.	July 2018	June 2019	Commonwealth and SA
2.8	Commence investigations to design and plan for the upload of • diagnostic imaging; and • pathology	July 2018; December 2018	Ongoing	Commonwealth and SA
Improving patient transitions between residential aged care and primary/acute settings				
2.9	Commonwealth and inter-jurisdictional working group to investigate the transition of residential and community aged care patients across acute, primary and aged care sectors.	September 2017	Ongoing	Commonwealth and SA
2.10	Identify agreed priority areas for working group to investigate the transition of patients across acute, primary and aged care sectors.	January 2018	Ongoing	Commonwealth and SA
The development of system integration initiatives in areas of high volume transitions				
2.11	Evidence based agreed Alcohol and other Drug Treatment Services Framework for stakeholders including SA PHNs that includes treatment outcomes measures that can be included in contracts for services and as service deliverables.	December 2017	August 2018	Commonwealth and SA
2.12	The SA Ministerial Clinical Advisory Council Group (MCAG) to endorse an integrated hospital avoidance and supported discharge model of care for implementation across SA Health.	January 2018	June 2019	SA
2.13	Development of a collaborative funding and shared model of care in collaboration with the SA PHNs for the provision of community based Mental Health services.	July 2017	June 2019	Commonwealth and SA

Care Coordination Services

Objectives

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

a. care coordination capacity and capability;

b. cost effectiveness and efficiency of targeting of available resources, while ensuring continuity of care for patients; and

c. patient empowerment, knowledge, skills and confidence to set goals and manage their health, with the support of their health and social care team.

Activities

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

28. HCHs will provide care to up to 65,000 patients across 200 sites. HCHs will initially be implemented in ten geographical regions based on PHN boundaries. The regions within SA include:

- Adelaide PHN
- Country SA PHN

29. A training program and educational resources will support implementation and adoption of the HCH model. Learning material describes the philosophy and approaches required to achieve cultural shift to create high functioning HCHs.

30. Stage one HCH will be evaluated to establish what works best for different patients and practices and in different communities with different demographics. The evaluation will include consultation with SA stakeholders and will examine the implementation process as well as the impact of the model, including any jurisdiction-specific impacts and opportunities.

31. SA will support State programs to link with HCHs, to support HCH patients over the life of the Agreement. This includes linking up with the Commonwealth funded Integrated Team Care program (ITC) to support eligible Aboriginal and Torres Strait islander people with chronic disease to access comprehensive coordinated care in a timely manner.

32. SA's contribution to care coordination services is through the implementation and linking of the HealthPathways South Australia program, with the Adelaide and Country SA PHNs (which includes Commonwealth funding support), and the HCH practices. Through the use of a web based health information portal, Health Pathways enhances patient care through establishing standard pathways and state-wide referral criteria for local services, including SA Health specialist outpatient services.

33. HealthPathways South Australia will enhance the way hospitals and general practice share the care and management of patients in the most appropriate setting. The implementation of Health Pathways across SA will:

a. Foster positive working relationships and open communication between SA Health services and primary care providers;

b. Provide greater opportunities for integrated healthcare resulting in seamless continuity of care between primary and acute sectors;

c. Better support primary sector health practitioners to assess, manage and treat patients in the community by following localised, evidence-based, referral pathways for specific clinical conditions;

d. Provide patients with a seamless and predicted patient journey;

e. Reduce waiting times for both primary and secondary health care services;

f. Assist people to stay well in a community setting for longer;

g. Increase patient involvement in care management and increase capacity for health literacy through access to information and educational resources related to specific clinical conditions available in the HealthPathways South Australia portal;

h. Ensure patients receive timely and appropriate treatment which supports better health outcomes;

i. Improve the experience for patients within the SA health care system;

j. Standardise care across the state; and

k. Assist in the identification of system and service redesign opportunities.

34. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 3.

Table 3: Care Coordination Services Milestones

No.	Key Milestone	Planned start date	Frequency	Responsibility
HCH Implementation				
3.1	Contract general practices/ACCHS to participate in HCHs	August 2017	Once	Commonwealth
3.2	Commence training of participating PHNs and HCHs	August 2017	Ongoing	Commonwealth
3.3	Commence patient enrolment	October 2017	Ongoing	Commonwealth
3.4	Commence HCH Evaluation (including established data baseline)	October 2017	Ongoing	Commonwealth
3.5	Share HCH implementation learnings and contribute to the evidence base for future coordinated care approaches.	October 2017	Ongoing	Commonwealth
Linking of the HealthPathways South Australia program				
3.6	Establishment of HealthPathways South Australia operational and clinical governance structures in collaboration with PHNs and other stakeholders.	July 2017	December 2017	Commonwealth and SA
3.7	Identification and prioritisation of clinical pathways for localisation in SA in partnership with PHNs and SA Health experts.	January 2018	Ongoing	Commonwealth and SA
3.8	Rolling localisation of 700 pathways based on prioritising by SA Health and SA PHNs.	July 2018	June 2019	Commonwealth and SA

3.9	Co-design of the HealthPathways South Australia program in partnership with PHNs, general practice and HCH practices.	January 2018	Ongoing	Commonwealth and SA

PART 4: SOUTH AUSTRALIAN PRIORITIES

Priority Area 1: Collaboration and coordination

Objectives

35. Improved collaboration and coordination between the SA Department of Health and Ageing (DHA) and the SA PHNs.

Activities

36. The development of a Memorandum of Understanding (MoU) between DHA and the SA PHNs will articulate the agreed intent and nature of the relationship and provide an overarching governance structure for cooperation and collaboration.

37. The MoU will:

    a. establish a common purpose;

    b. facilitate high level strategic discussions and decisions;

    c. encourage communication and information sharing;

    d. address barriers and risks to service delivery; and

    e. provide the foundation for individual cooperative initiatives and collaborative activities including the parties and the LHNs.

38. The MoU will establish an overarching strategic partnership committee with DHA, PHNs and some LHN representation that will develop an agreed work plan that will facilitate collaboration, joint planning and commissioning and decision making.

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

Table 4: Priority Area 1

No.	Key Milestone	Planned start date	Frequency	Responsibility
4.1	Provisional governance structure for strategic partnership committee developed.	July 2017	Once	Commonwealth and SA
4.2	Memorandum of Understanding signed (MoU).	December 2017	Once	SA
4.3	Implementation of Work plan as agreed by the Partnership committee.	December 2017	Ongoing	Commonwealth and SA

4.4	Review of the MoU and work plan progress.	July 2018	December 2018	SA

Priority Area 2: End of Life Care

Objectives

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

41. This work will also be informed by, and align with, the work of AHMAC in the end of life space, being undertaken by the inter-jurisdictional end of life care working group which reports through the Community Care and Population Health Principal Committee (or equivalent replacement bodies as directed by AHMAC if applicable).

42. This priority area forms a key part of the development of a comprehensive strategy to improve end of life care to South Australians. It will focus on supporting end of life care within, and transitions between, primary health care, acute care, specialist palliative care services, residential and community aged care through strong collaborative relationships and reducing barriers.

Activities

43. This activity will focus on:

    a. strengthening key partnership arrangements with primary healthcare and other key stakeholders;

    b. the subsequent use of the partnership arrangements to address barriers to seamless and responsive care, and improve the consumer outcomes and transitions between care settings; and

    c. working together with the Commonwealth through the AHMAC end of life working group.

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

Table 5: Priority Area 2

No.	Key Milestone	Planned start date	Frequency	Responsibility
5.1	Round table discussions with key stakeholders across the broader end of life care sector.	September 2017	February 2018	SA
5.2	Development and finalisation of the SA End of Life Care strategy.	September 2017	April 2018	SA

5.3	Building and strengthening collaborative approaches with but not limited to PHNs, general practices, acute sector, LHNs, private and public sectors and Residential and Community aged Care sector and emergency services including ambulance services.	September 2017	Ongoing	Commonwealth and SA
5.4	Participating in the AHMAC working group on end of life.	Upon signing of the Agreement	Ongoing	Commonwealth and SA

Priority Area 3: Innovative Rural and Remote Service Integration Framework

Objectives

45. To improve health service integration for the high population of chronic and complex health needs in the remote setting of Ceduna.

Activities

46. The development of a service integration framework between the Country Health SA LHN operated Ceduna Hospital and Health Service, Ceduna Family Medical Clinic, and Ceduna Koonibba Aboriginal Health Service (CKAHS).

47. This framework will include the development and testing of a range of strategies with a focus on information sharing, discharge planning and chronic disease management and utilising Virtual Clinical Care (VCC) home telemonitoring approaches to enhance outcomes in a remote setting.

48. It is proposed to capture data from within the general practice, Consolidate Country Client Management Engine (CCCME) and the VCC database to measure the coordination of clients, chronic conditions outcomes and utilisation of the VCC.

49. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 6.

Table 6: Priority Area 3

No.	Key Milestone	Planned start date	Frequency	Responsibility
6.1	Agreed data management and sharing protocols are established	December 2017	December 2017	Commonwealth and SA
6.2	Identification of opportunities for joint partnership and planning/commissioning of services across the primary health care services	December 2018	June 2019	Commonwealth and SA
6.3	Evidence that demonstrates how clients improved coordination and integration of service	December 2017	December 2018	Commonwealth and SA

Evaluation Framework

PART 1: Preliminaries

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

PART 2: Terms of this Schedule

2. The implementation of this Schedule by the Parties will commence from the date of signing the Agreement, and expire on 31 December 2019.

3. The purpose of this Schedule is to provide a framework to guide Commonwealth, State and Territory evaluation activity.

4. The objective of the Evaluation Framework is to outline the key evaluation questions and indicators that will be used to measure the success of the bilateral agreement activity on coordinated care and demonstrate the Parties' intended outcomes of the Agreement.

5. The Evaluation Framework is a staged design, which covers monitoring and short term evaluation with consideration of longer term evaluation over the life of the agreement.

6. Evaluation activity will examine the process of implementation of the bilateral agreements as well as the impact the activities have on the health workforce, processes, systems and the care provided to patients. The effect of these changes on patients will also be measured where available.

7. Where the Parties' reforms build on or directly support the HCH model, these will be considered by the HCH evaluation, which is being undertaken separately by the Commonwealth.

8. The results of the coordinated care bilateral agreement evaluations, covering the first 12 months of bilateral agreement activity, and the initial stage of the HCH evaluation will be drawn together to inform advice to COAG through the COAG Health Council in early 2019.

9. The report to the COAG Health Council will capture both the reporting on the agreed milestones in Part 5, Clause 20 of the agreement and Schedule A to the agreement and the indicators for the Evaluation Framework, where possible and as appropriate for each jurisdiction.

10. Reporting beyond this will be contingent upon COAG Health Council consideration of the report on the first 12 months. The Evaluation Framework set out in this Schedule may be modified by the Parties (in line with Part 7, Clause 33 of the agreement) to reflect direction from COAG or the COAG Health Council on the focus or content of the evaluation beyond the first 12 months.

PART 3: Evaluation Framework

Project approach

11. This Framework will be implemented by all jurisdictions (including the Commonwealth), collectively drawing on the agreed evaluation questions and indicators as appropriate to the Parties to the agreement.

12. Each Party agrees to provide qualitative and quantitative data (as appropriate to the Parties) to report on the relevant indicators by 1 October 2018, to enable data compilation and analysis and the drafting of a report to the COAG Health Council. The report is intended to inform future activities that will continue to build the evidence base for joint action on coordinated care.

13. The Evaluation Framework is based on a pre/post design. For some indicators, baseline data will be able to be collected at the commencement of the activity (for example, routinely collected data), while for other indicators, the data collected at the 12 month point will form the baseline for comparison at the end point.

14. All Parties will participate in the development of, and agree on, the report to the COAG Health Council which will outline the progress against each of the evaluation questions, based on compilation and analysis of the qualitative and quantitative data provided by individual jurisdictions.

15. The Evaluation Framework includes:
    - 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 MHR); 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			
Has there been improved collaborative and coordinated policy, planning and resourcing of coordinated care reforms? What were the barriers and enablers? What could be improved going forward??	• Bilateral partner collaboration in planning and implementation • Shared knowledge and information amongst bilateral partners • Complementarity of bilateral activities		• 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			
To what extent has a linked national data set been achieved? To what extent has access to data been improved? To what extent has the quality of data been improved? How has the use of data to inform policy, planning and targeting of resources improved?	• 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	• 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	• 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			
How has the sharing of health information across the system changed? How has service delivery across the system changed? Have there been improvements in patients' access to health services? What is patient experience and satisfaction of health system improvements? Have changes resulted in improved patient and clinical outcomes?	• Coordination between health providers and systems • Multi-disciplinary team based care • Patient reported satisfaction/experience and outcomes • Patient continuity of care • Workforce experience and engagement • Changes to service utilisation patterns	Intermediate	• Number, type and coverage of activities • Development of regional planning activities • Development of patient care pathways • Collaborative commissioning arrangements • Increased use of MHR - Number of MHRs - Increased number of views/updates - Number of uploaded discharge summaries - Increased number of health professionals viewing/uploading to MHR
		Longer term	• Cost of delivering services • Patient outcomes and experience/satisfaction (using PROMs and PREMs)** • Number and type of regional planning or commissioning models across care settings • Use of health services (MBS, ED presentations, hospital admissions) • Referral rates • Waiting times

Coordinated Care			
How has the management of patients with chronic and complex disease improved? What is patient experience and satisfaction with care provision? Have changes resulted in improved patient and clinical outcomes?	• 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	• 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	• Patient and health professionals' use of MHR • Patient outcomes and experience/satisfaction (using PROMs and PREMs)** • Relevant clinical measures (e.g. HbA1c, blood pressure) • Use of health services (MBS, ED presentations, hospital admissions)
Jurisdictional priority areas			
What impact did the activities have on system integration, service delivery or patient experience/outcomes?	• Collaboration in planning and implementation • Appropriately skilled workforce • Patient health literacy and/or engagement • Patient reported experience and outcomes • Clinical outcomes	Intermediate	• Number, type and coverage of discretionary projects • Collaboration between Commonwealth and jurisdictions in reforms or delivery of care • Increased staff capability • Information/resource developed for, and used by, patients and carers

		Longer term	• Patient outcomes and experience/satisfaction (using PROMs and PREMs)** • Use of health services (MBS, ED presentations, hospital admissions) • Relevant clinical measures (e.g. HbA1c, blood pressure)

* Reporting on indicators is subject to Clauses 12, 13 and 17 of Schedule B.
** Examples of potential instruments include SF-12 (Quality of Life), EQ-5D (Quality of Life), PQS (Patient satisfaction), and PACIC (Quality of patient centred care).
Note: Evaluation activity over the life of the agreement will shift the focus to the overall objectives of the Bilateral Agreements and where feasible will assess progress against the longer term indicators. Evaluation questions, dimensions and indicators for longer term evaluation are indicative only and subject to COAG and COAG Health Council consideration of the report on the first 12 months of activity.