

Bilateral Agreement between the Commonwealth and New South Wales

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 New South Wales (NSW) 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 NSW 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 NSW.

Commencement, duration and review of the Agreement

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

Interoperability

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

Part 3 – Objective and Outcomes

11. The overarching objective of the Agreement is to support the implementation of coordinated care reforms, consistent with the principles outlined in the NHRA Addendum that:
 - a. improve patient health outcomes; and
 - b. reduce avoidable demand for health services.
12. The Parties will contribute to the achievement of these objectives and outcomes through reform activities as specified in Schedule A to this Agreement, including:
 - a. data collection and analysis; system integration; and care coordination services, as critical underlying structures of joint coordination and reform; and
 - b. in other priority areas relevant to New South Wales' 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 reforms will use linked data for the NSW population to inform Commonwealth and NSW 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

16. Care coordination activities are aimed towards contributing to improvements over time, in:
 - a. care coordination capacity and capability;
 - b. cost effectiveness and efficiency of targeting of available resources, while ensuring continuity of care for patients; and
 - c. patient empowerment, knowledge, skills and confidence to set goals and manage their health, with the support of their health and social care team.
17. The Parties will additionally contribute to the achievement of the objectives and outcomes of the Agreement through reforms in the priority areas of aged care integration, palliative and end of life care, mental health, multidisciplinary team care, and rural and remote service delivery.

Palliative and End of Life Care

18. Palliative and end of life care activities aim to ensure patients are central to their own care planning and receive the right care, in the right place and at the right time. To enable this, the system of care needs to provide seamless, effective and efficient care by:
 - a. Ensuring that the roles and responsibilities between the Commonwealth and NSW are clear across care settings;
 - b. Building whole of workforce skills and capability in palliative and end of life care across all care settings;
 - c. Improving the uptake and use of Advance Care Planning across care settings; and
 - d. Improving the collection, sharing and use of palliative care outcomes data.

Multidisciplinary Team Care

19. Multidisciplinary team care activities are aimed towards building the capability of health care professionals to work together and deliver comprehensive patient-centred care that:
 - a. Improves health outcomes and patient satisfaction;
 - b. Make more efficient and effective use of resources; and
 - c. Enhances job satisfaction for health care professionals.
20. Multidisciplinary team care activities also aim to improve and better understand the evidence base for multidisciplinary approaches.

Aged Care

21. Aged care activities are aimed towards developing a system of aged care service delivery that is sustainable and integrated with the wider health system, including:
 - a. Improved sharing of patient information across primary health care, acute care and aged care services, including through digital health enablers; and
 - b. Supporting the health and care needs of older people to reduce avoidable hospital demand.

Rural and Remote

22. Rural and remote activities are aimed towards improving the delivery of health services in rural and regional communities by:
 - a. Strengthening rural ehealth infrastructure; and
 - b. Enhancing the rural health workforce.

Mental Health

23. Mental health activities are aimed towards improving and integrating mental health services and support across health systems to deliver person-centred care by:
 - a. Improving Commonwealth and NSW government information and coordination, particularly in terms of mental health funding and programs; and
 - b. Improving workforce capabilities in mental health across the primary health, acute health and aged care sectors.

Part 4 — Roles and responsibilities

24. The Parties agree to work together to implement, monitor, refine and evaluate coordinated care reforms under the Agreement.
25. In respect of the joint commitments at Clauses 14 through 23, the Parties will: undertake activities as outlined in the Schedules to the Agreement; develop and agree project plans to support implementation, where relevant; monitor achievement against milestones; and conduct an evaluation of reform activities.

Part 5 —Monitoring progress and evaluation

Monitoring Progress

26. 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.
27. Monitoring activities will include:
 - a. Six-monthly status reports, on an exception basis, against relevant milestones by each Party, to relevant executive officers;

- b. Quarterly bilateral officer-level discussions on implementation progress and emerging risks or issues;
 - c. Multilateral updates as required on implementation progress and emerging risks or issues through relevant committees; and
 - d. Ad hoc reporting, as agreed by the Parties.
28. 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.
29. Where NSW 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.
30. Where possible, evaluation will acknowledge and consider existing national and local measures, and other broader policy changes that affect the operation of the Agreement.
31. 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

32. The Parties agree that they will continually monitor, review and take necessary action to manage risks over the life of the Agreement.
33. Where agreed by both Parties, Schedule A will be updated to reflect any substantive changes or extension to activities to effectively manage identified risks.
34. 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.
35. 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

36. 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

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

38. The Parties will attempt to resolve any dispute at officer-level in the first instance.
39. 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

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

Delegations

41. The Parties may delegate monitoring and reporting of progress on reform activities under this Agreement to appropriate Commonwealth and NSW officials.

Enforceability of the Agreement

42. 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

43. 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, to the COAG Health Council and COAG.
44. 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

45. 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 Districts	A LHD is an organisation that provides public hospital services in accordance with the NHRA. A local hospital

(LHDs)	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 LHDs. 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 Services (ACCHS) that commit 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/LHD baseline needs assessment and aims towards a more holistic approach in which the planning and contracting of health care services are appropriate and relevant to the needs of their communities.
Joint/coordinated or collaborative commissioning	Encompasses a variety of ways of working together, as locally appropriate, to make the best use of pooled or aligned budgets to achieve better outcomes for patients.

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

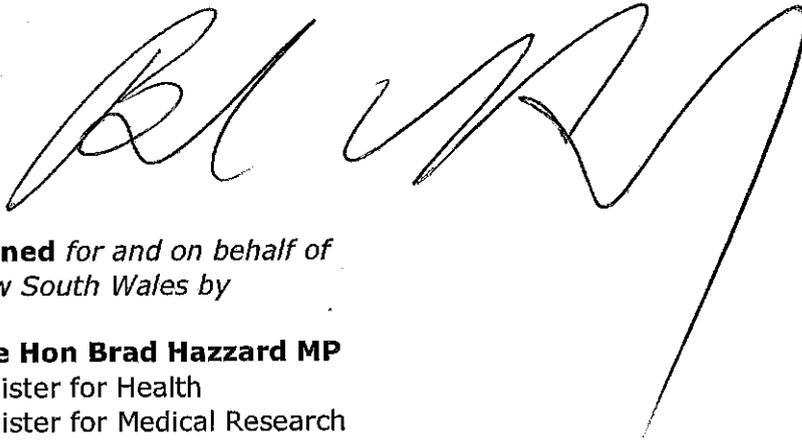
**Signed for and on behalf of the
Commonwealth of Australia by**

The Hon Greg Hunt MP
Minister for Health
Minister for Sport

A handwritten signature in black ink, appearing to read 'Greg Hunt', written over a horizontal line.

**Signed for and on behalf of
New South Wales by**

The Hon Brad Hazzard MP
Minister for Health
Minister for Medical Research

A handwritten signature in black ink, appearing to read 'Brad Hazzard', written over a horizontal line.

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. This Schedule 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, or unless terminated earlier, consistent with Clauses 43-44 of the Agreement.
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 14-23 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 NSW's local needs and circumstances.

PART 3: Core Characteristics

Data Collection and Analysis

Objectives

7. Data collection and analysis reforms will use linked data to inform Commonwealth and NSW 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 patient data collection and linkage activities for this Agreement will relate to:
 - a. Collection and linkage of de-identified health datasets for the NSW population, including patients with chronic and complex conditions, and will include provision of Admitted Patient Care National Minimum Data Set (NMDS), Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Schedule (PBS), Emergency Department NMDS, outpatient care, aged care (residential aged care, home care packages and transition care program), and National Death Index data initially. Additional data will be included, where appropriate, by the Commonwealth and NSW.
 - b. The provision of relevant personal information about Health Care Home patients in NSW, with patient consent) to NSW Health to facilitate coordinated, multidisciplinary care for NSW HCH patients within their relevant Local Health District.
 - c. Developing a de-identified NSW 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
9. The AIHW will undertake the data collection and linkage work outlined in Clause 8a, in its capacity as a Commonwealth-accredited data integration authority, within the confidentiality provisions of the AIHW Act 1987, and with oversight of the AIHW Ethics Committee.
10. Analysis projects using the linked data set outlined in Clause 8a will be undertaken by the Commonwealth and NSW, noting an intention for each to be able to view and access linked data for services provided and patients in NSW.
11. The collection, analysis and use of any of any health datasets under this Agreement will be in accordance with relevant Commonwealth and State/Territory confidentiality, privacy, governance, ethics, consent provisions and legislation.
12. 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) which Victoria and New South Wales will continue to participate in, in concert with the AIHW under the auspice of the National Health Information and Performance Principal Committee (NHIPPC) and the Australian Health Ministers' Advisory Council (AHMAC).
13. 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.
14. The Commonwealth will take a national lead role on work to develop a de-identified National Minimum Data Set (NMDS) of information for people with complex and

chronic conditions 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.

15. NSW has been working with Western Sydney PHN to develop and test data linkage with general practices in the Western Sydney region. The Western Sydney General Practice Data Linkage project represents the first time in NSW that data have been extracted from the electronic health records of general practices, transferred to NSW Health and linked to state health system records including emergency department, hospital and mortality records. The project aims to understand patient care across general practices and acute health services to inform health system planning.
16. The Parties will work together to investigate opportunities to expand the Western Sydney General Practice Data Linkage project. This will include identifying opportunities to expand to other regions, link additional data sets and strengthen linkage capability and governance, and develop joint risk stratification models to identify factors that can predict individual patient deterioration and acute health service use.
17. The Parties will also investigate the feasibility of future data collection and analysis opportunities that enable better understanding of social determinants of health and patient pathways across health and social care services for people with chronic and complex conditions. The Parties recognise that this will require collaboration and cooperation from a number of government departments and agencies.
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	Planned end date	Frequency	Responsibility
<i>Linkage of Data Sets by the AIHW</i>					
1.1	Ethics and data governance arrangements in place to enable data collection and linkage for the duration of this Agreement	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
1.2	Provision of data to the data custodian and commence data collection, linkage and analysis	October 2017	December 2019	Ongoing	Commonwealth and NSW
1.3	Share experience with data linkage and analysis	October 2017	December 2019	Ongoing	Commonwealth and NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
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 Agreement	January 2018	December 2019	Ongoing	Commonwealth and NSW
Health Care Homes data linkage with NSW Health datasets					
1.5	Ethics and data governance arrangements in place to enable data collection and linkage for the duration of this Agreement	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
1.6	Provision of relevant NSW HCH data to NSW Health to commence data collection, linkage and analysis, for the purposes of: <ul style="list-style-type: none"> • Coordinating patient care for HCH patients; and • <i>(contingent on relevant approvals)</i> Informing improvements to service funding, management, planning and evaluation 	Upon signing of the Agreement and in line with DHS reporting capacity	December 2019	Ongoing	Commonwealth and NSW
Identification of Additional Data Sets for Potential Linkage					
1.7	Explore feasibility of including additional relevant health datasets in future linkage arrangements, including: <ul style="list-style-type: none"> • NSW-held public hospital allied health data • Commonwealth-held private/community allied health data and any additional aged care data 	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
1.8	Where possible, additional health datasets collected and included in data linkage arrangements (dependant on ethics and governance requirements)	Jan 2018	December 2019	N/A	Commonwealth and NSW
<i>Progression of Primary Health Care NMDS</i>					
1.9	Monitor and progress activities towards establishing a de-identified primary health care National Minimum Data Set	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth
<i>General Practice Data Linkage</i>					
1.10	Explore opportunities to expand the Western Sydney General Practice Data Linkage pilot study, including: <ul style="list-style-type: none"> • expansion to other regions; • linking additional data sets, where possible; • testing encrypted linkages; • reviewing data governance processes for expansion; and • developing risk stratification models to predict individual patient pathways 	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
<i>Data enablers for better integration of health and social services</i>					
1.11	Identify feasibility of future data collection, analysis and linkage between health and social services data, considering: <ul style="list-style-type: none"> Commonwealth-held datasets including NDIS data, PHN commissioned mental health data, ABS measures of socioeconomic disadvantage and social security (Department of Social Services) data NSW-held datasets including mental health data and NSW family and community services data (child protection, social impact investment) 	Upon signing of the Agreement	September 2018	Once	Commonwealth and NSW

System Integration

Objectives

19. System integration activities are aimed towards contributing to the broader system integration objective of achieving improvements over time, in:
- regional planning and patient health care pathways, including providing better access, service delivery and patient transitions across systems;
 - integration of primary health care, acute care, specialist and allied services, including through digital health enablers; and
 - effectiveness and efficiency of collaborative commissioning arrangements.

20. The Parties agree that activity under this priority will be progressed in conjunction with the Australian Digital Health Agency (ADHA), in accordance with its remit and agreed work-plan for My Health Record (MHR).

Activities

21. In addition to the national roll-out of the MHR on an opt-out basis, a key focus is more effective and efficient use of the MHR, initially targeting whole PHNs regions 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, general practices, aged care clinicians and community health providers on how to use MHR;
 - b. In conjunction with the ADHA progressing the automatic uploading of discharge summaries, pathology and diagnostic imaging;
 - c. Promoting and increasing the frequency of “viewing” of the MHR by healthcare professionals;
 - d. Increasing MHR content of uploaded documents;
 - e. Identifying ways to work with PHNs to support the above processes, as appropriate; and
 - f. Continued rollout of secure messaging and electronic referrals; providing GPs, specialists and other care providers with accurate, timely and up-to-date information on patients and their interaction with the acute sector.
22. Interoperability between MHR and digital health systems at a State and local level will be crucial to system integration. The Parties commit to regularly share information on respective digital health systems with a view to long-term interoperability across platforms and potential co-investment in eHealth initiatives.
23. All HCH patients will have a Shared Care Plan. Health Care Home practices will be encouraged to upload a copy of the Shared Care Plan to MHR, recognising electronic record sharing is critical to enable coordinated care.
24. 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.
25. 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 by older people 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 about care for older people with chronic and complex health conditions, particularly older people with dementia and associated severe behavioural and psychological symptoms;
 - d. establish aligned reporting requirements for aged care services across the care continuum;
 - e. clarify the roles and responsibilities between the Commonwealth and jurisdictions in providing aids and equipment, and where relevant link, with the work of the State and Territory Aged and Community Care Officials Committee;

- f. explore mechanisms to improve identification of Residential Aged Care Facility (RACF) residents admitted to hospital;
- g. explore options for developing an agreed definition of “adverse events” and “avoidable hospital admissions’ for residential and community aged care clients, including an appropriate application and monitoring mechanisms; and
- h. improving data systems and linkages between datasets.

26. The Parties recognise the value of the National Health Services Directory (NHSD) in enabling health professionals and consumers 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 plan.

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

Table 2: System Integration Milestones

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
<i>Digital Health Reforms and Increased use of MHR</i>					
2.1	Establish baseline for MHR in NSW and increased number of registrations for MHR in NSW, targeting a 20% year on year growth based on current registrations	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth and NSW
2.2	Establish baseline and increased number of Advance Care Plans in NSW	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth and NSW
2.3	Provision of training for public hospital staff on how to use MHR in relation to the NSW electronic medical record systems	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
2.4	Monitor and increase in percentage of uploads on MHR for: <ul style="list-style-type: none"> • discharge summaries; • diagnostic imaging; and • pathology 	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
2.5	Monitor and increase the MHR viewing frequency by healthcare providers, including in public hospitals	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth and NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
2.6	Identify and implement approach to improved content of uploaded document on MHR, including discharge summaries, pathology and diagnostic imaging reports	Upon signing of the Agreement	December 2019	Annually	Commonwealth and NSW
2.7	Data and information on MHR system updates, usage and approaches to improve uptake and use are shared	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
<i>Towards digital health systems interoperability</i>					
2.8	Improved sharing of eHealth information and resources	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
2.9	Consultation and coordination occurs between the Commonwealth and NSW on development of MHR and State and local digital health initiatives, including secure messaging, e-referrals, shared care planning, patient reported measures, and other relevant integrated care technology solutions between hospital services, GPs, specialist medical services and community health services	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
2.10	Opportunities for co-investment in eHealth initiatives of mutual benefit are identified	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
<i>Improving patient transitions between residential aged care and primary/acute settings</i>					
2.11	Commonwealth and jurisdictional working group established to investigate the transition of residential aged care patients across acute, primary and aged care sectors	September 2017	November 2019	Once	Commonwealth and NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
2.12	Agreed priority areas for Working Group to investigate the transition of patients across acute, primary and aged care sectors identified	January 2018	March 2018	Once	Commonwealth and NSW
<i>Improving service information through the National Health Services Directory (NHSD)</i>					
2.13	Active promotion of the NHSD and registration of service provider details in public hospitals, community health, primary and aged care	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
2.14	Monitor registrations and use of NHSD	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth and NSW

Care Coordination Services

Objectives

28. 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

29. 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 seeks to establish more effective partnerships across the health system, including hospitals, allied health and primary health sectors.
30. HCHs will provide care to up to 65,000 patients across 200 sites. HCHs will initially be implemented in ten geographical regions based on Primary Health Network (PHN) boundaries. NSW regions include:
- Western Sydney PHN
 - Hunter New England and Central Coast PHN
 - Nepean Blue Mountains PHN.

31. 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.
32. 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 New South Wales' stakeholders, and will examine the implementation process, as well as the impact of the model, including any jurisdiction specific impacts and opportunities.
33. In addition to targeted funding for Local Health Districts (LHDs) in Stage 1 HCH implementation regions in the 2016-17 NSW Budget, NSW is supporting the HCH model through additional resourcing, capability and capacity building for productive LHD-PHN partnerships and engagement with HCH practices, and sharing of good practice resources and information at all levels of governance.
34. The Parties recognise each other's expertise in designing and implementing approaches to improve care coordination for people with chronic and complex conditions, and commit to actively sharing their experiences and knowledge to contribute to the evidence base for best practice care coordination.
35. The Commonwealth also provides funding under the 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. NSW PHNs are funded to manage this program, and have commissioned Aboriginal Community Controlled Health Services and mainstream health services to deliver the program across NSW.
36. NSW is currently implementing its Leading Better Value Care (LBVC) program, focusing on best practice clinical pathways for people with diabetes, people with chronic obstructive pulmonary disease, and people with chronic heart failure. The Parties agree to support engagement at the State and local level across NSW under the LBVC program, given the shared focus on these patient cohorts, some of whom may be HCH enrolled patients.
37. The Parties agree to build on the Leading Better Value Care (LBVC) program in NSW by exploring ways to build the evidence base to understand patient service use and articulate best practice cycles of care for three cohorts: people with diabetes, people with chronic obstructive pulmonary disease, and people with chronic heart failure.
38. Based on this evidence, the Parties will explore options to support local development of pathways and/or integrated models of care across the state for the three cohorts. Options will consider opportunities for flexible funding approaches across health care settings in line with the patient journey, and key enablers (e.g. workforce capability, clinical leadership and governance) to facilitate scale up and sustainability of best practice models. This will link with work underway through PHNs and LHDs where relevant.
39. The Parties agree to develop a collaborative commissioning framework that provides guidance for NSW PHNs and LHDs to collaboratively plan and purchase services, particularly in rural and remote areas and for high-risk patients. This work will be important to establish a robust foundation for future national rollout, including shared governance approaches and/or joint or pooled funding arrangements.
40. To support collaborative work, monitoring, evaluation and future policy development, the Parties agree, 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 LHDs. This work is contingent upon the agreed involvement of all Australian jurisdictions, and could build on existing work being undertaken, and will be captured in the report to COAG for further consideration.

41. The Parties recognise that some people with or at risk of chronic and complex health conditions also have a disability, and these individuals require supports from a range of sectors, both within and outside the primary and acute health systems, including the National Disability Insurance Scheme (NDIS), community and social services and mental health services. The Parties commit to explore opportunities with authorities responsible for NDIS policy and service delivery to improve the early identification and coordination of support for patients with or at risk of chronic and complex health conditions who also have a disability. This could enable health services, NDIS providers and others to respond more effectively to significant declines in health, to manage chronic or complex conditions, and to prevent avoidable hospitalisations.
42. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 3.

Table 3: Care Coordination Services Milestones

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
Implementation of Health Care Homes					
3.1	Contract GP practices/ACCHS to participate in HCH	Upon signing of the Agreement	N/A	Ongoing	Commonwealth
3.2	Commence training of participating PHNs and HCHs	Upon signing of the Agreement	N/A	Ongoing	Commonwealth
3.3	Commence patient enrolment	October 2017	December 2019	Ongoing	Commonwealth
3.4	Commence HCH Evaluation (including established data baseline)	October 2017	December 2019	Ongoing	Commonwealth
3.5	Share HCH implementation learnings and contribute to the evidence base for HCH and future coordinated care approaches	October 2017	December 2019	Ongoing	Commonwealth and NSW
3.6	Consider and evaluate aligned risk stratification tools and patient selection algorithms that effectively identify patients with chronic and complex conditions	October 2017	December 2019	Ongoing	Commonwealth and NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
3.7	Support HCH Stage 1 implementation in NSW, including through: <ul style="list-style-type: none"> resource allocation to LHDs in engagement with selected HCH practices capability and capacity building for productive LHD-PHN partnerships sharing of good practice resources and information at all levels of governance 	October 2017	December 2019	Ongoing	NSW
3.8	Engage NSW state and local entities to participate in HCH evaluation, as appropriate	October 2017	December 2019	Ongoing	Commonwealth and NSW
<i>Leading Better Value Care for people with chronic disease</i>					
3.9	Share NSW evidence and experience in the development of clinical models for the three cohorts	October 2017	December 2019	Ongoing	NSW
3.10	Undertake analysis to define and understand patient characteristics, expenditure and activity patterns of the target population of the LBVC program and NSW HCH practices (dependant on ethics and governance requirements), leveraging available linked data	October 2017	December 2019	Ongoing	NSW
3.11	Identify local partners (PHNs, LHDs, HCH practices) interested in supporting LBVC	October 2017	December 2017	N/A	NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
3.12	Work with local partners to: <ul style="list-style-type: none"> • undertake cost data collection through sampling, with appropriate ethics approvals in place and based on available NSW funding support • co-design integrated pathways and/or models of care for the three cohorts, leveraging other relevant work (co-commission, NSW integrated care initiatives, HCHs and PHNs), including any flexible funding approaches to support models of care 	December 2017	June 2018	N/A	Commonwealth and NSW
3.13	Recommendations (to be included in the report to COAG) developed for: <ul style="list-style-type: none"> • integrated pathways and/or models of care for the three cohorts • possible funding and payment methods; and • key enablers (e.g. workforce capability, clinical leadership and governance) that facilitate scale up and sustainability of best practice models 	June 2018	September 2018	N/A	Commonwealth and NSW
<i>Strengthening capability in joint service commissioning</i>					
3.14	In conjunction with PHNs and LHDs, map current coordinated commissioning efforts in NSW and identify gaps to support people with chronic and complex conditions, including consideration of rural and remote and mental health services	Upon signing of the Agreement	December 2017	Once	Commonwealth and NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
3.15	Develop guidance on joint service planning and purchasing for NSW LHDs and PHNs in the form of a collaborative commissioning framework, defining target population/s and setting out principles and mechanisms for co-commissioning, including in the areas of governance, funding, purchasing and service delivery	January 2018	June 2018	Ongoing	Commonwealth and NSW
3.16	Share with the Commonwealth work to date on common terminology for care coordination	October 2017	October 2017	Once	NSW
3.17	In conjunction with other jurisdictions, develop a shared understanding of key care coordination terms	December 2017	January 2018	Once	Commonwealth and NSW
3.18	Trial application of collaborative commissioning framework in a rural and remote area of NSW	July 2018	December 2019	Ongoing	Commonwealth and NSW
<i>Improving care coordination for people with chronic and complex conditions who also have a disability</i>					
3.19	Identify partners (including PHNs, LHDs, and relevant NDIS policy or service delivery authorities) interested in conducting analysis on service gaps between the NDIS and health services, with respect to people with or at risk of chronic and complex health conditions who also have a disability	Upon signing of the Agreement	December 2017	Once	Commonwealth and NSW

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
3.20	<p>Conduct service gap analysis and identify priority areas for improved care coordination, which may include:</p> <ul style="list-style-type: none"> co-designed local health pathways and/or integrated models of care tools and strategies to enable early identification of health issues for people with a disability. 	January 2018	June 2018	Once	Commonwealth and NSW
3.21	Drawing on the priority areas identified in the service gap analysis, work with LHDs and PHNs to develop guidance, tools and supports for acute health services and general practices to navigate the interface between health services and the NDIS	July 2018	December 2019	Ongoing	Commonwealth and NSW

PART 4: NSW PRIORITIES

Projects and project information

43. The Parties agree the key milestones and roles and responsibilities outlined in this Schedule (Part 4) for coordinated care reforms relating to: palliative care and end of life care, multidisciplinary team care, aged care, rural and remote health service delivery and mental health.

Palliative and End of Life Care

44. The Parties recognise the importance of palliative and end of life care services to support people suffering terminal illness and their families. Palliative and end of life care aims to improve the quality of life of patients with an active, progressive disease that has little or no prospect of a cure.

45. Strengthened and coordinated palliative and end of life health services can better support people with chronic and complex conditions to receive the right care, in the right place and at the right time, with greater participation in their care. To enable this, the Parties agree to a set of activities including integration, workforce support and Advance Care Planning, and data, as follows.

46. The Parties will identify opportunities for better coordination of palliative and end of life care services across the primary, acute and residential and community aged care sectors for people with chronic and complex conditions. This will include clear articulation of the roles and responsibilities of the Commonwealth, NSW and other parties in relation to palliative and end of life care.
47. Advance Care Planning is important for patients, families and healthcare professionals to ensure patients receive the care that they want, if they become too unwell to make their own health decisions. The Parties agree to work collaboratively to develop workforce support and improve Advance Care Planning in palliative and end of life care across all care settings by:
- a. Establishing a joint working group to identify workforce support needs and agree approaches to improve whole of workforce capacity in managing end-of-life and palliative care;
 - b. Contingent on recommendations from the joint working group, developing and implementing workforce support and training tools on end of life care for all healthcare workers across care settings, building on current state and national initiatives including the National Palliative Care Projects;
 - c. The Parties agree to promote the uptake and use of Advance Care Planning across the acute, primary and aged care sectors by promoting the use of Advance Care Planning in public hospitals and NSW funded community palliative care services;
 - d. Incorporating Advance Care Planning into community and residential aged care policy and practice; and.
 - e. Incorporate accessible and easy to use electronic Advance Care Plans into MHR and provide change management support to clinicians in using electronic Advance Care Plans.
48. The Parties commit to improve the evidence base on palliative care and Advance Care Planning, including information on patient outcomes collected through the Palliative Care Outcomes Collaboration. The Parties agree to:
- a. encourage hospital and community palliative care and residential and community aged care providers funded by the Commonwealth or NSW to participate in the National Palliative Care Outcomes Collaboration program
 - b. Share findings on the use of Advance Care Planning in HCHs as captured in the HCH evaluation.
49. In addition to these activities, the Parties agree to support the multi-jurisdictional AHMAC End of Life project with the aim of providing advice to COAG Health Council by end of June 2018 on:
- a. pre-service and continuing education;
 - b. raising community and clinician awareness and engagement;
 - c. support end of life care conversations happening in primary care and a wider range of community settings such as aged care; and

- d. examining opportunities to have a common language and tools to support good practice.
50. The Parties agree that activities under this priority area will, where relevant, link with the National Palliative Care Strategy, and the National Palliative Care Projects funded by the Commonwealth.
51. NSW is investing an additional \$100 million over four years from 2017-18 in palliative care. This will include training for 300 nurses and allied health staff, 300 scholarships for rural and regional staff to enhance palliative care skills and 30 additional nurses in hospitals, homes and nursing homes.
52. Under the Commonwealth funded National Palliative Care Projects, opportunities for education and training will be available to palliative care staff in NSW, including any additional staff employed as a result of the 2017 NSW Budget measure.
53. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 4.

Table 4: Palliative and End of Life Care milestones

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
<i>Improving integration</i>					
4.1	Identify common areas of concern / potential areas for improved coordination between the Commonwealth and NSW in palliative and end of life care, including for people interacting with the aged care system	Upon signing of the Agreement	February 2018	Once	Commonwealth and NSW
4.2	Develop and implement strategies to improve care coordination and remedy areas of concern	March 2018	December 2019	Ongoing	Commonwealth and NSW
4.3	Determine feasibility of analysis to map people who use palliative and end of life, and aged care services, considering HCH points and broader coordinated care cohort in NSW (dependent on data linkage work)	Upon signing of the Agreement	December 2018	Ongoing	Commonwealth and NSW
<i>Workforce development and support</i>					
4.4	Establish joint Working Group on end-of-life and palliative care workforce development and support	Upon signing of the Agreement	December 2017	Once	Commonwealth and NSW

4.5	Joint working group identifies and agrees approaches to improve workforce capacity in managing end-of-life and palliative care	December 2017	December 2018	Ongoing	Commonwealth and NSW
Advance care planning					
4.6	Joint change management approach developed to support clinicians using electronic Advance Care Plans	Upon signing of the Agreement	December 2017	Once	Commonwealth and NSW
4.7	Advance Care Planning is incorporated into residential aged care, policy and practice	Upon signing of the Agreement	December 2018	Ongoing	Commonwealth
4.8	Increased use of Advance Care Planning in public hospitals and NSW funded community palliative care services	Upon signing of the Agreement	December 2019	6 monthly	NSW
Improving the evidence base					
4.9	Increased data and benchmarking of patient outcomes in palliative care	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and NSW
COAG Health Council – End of Life Project					
4.10	Contribute to AHMAC report to COAG Health Council on: <ul style="list-style-type: none"> • pre-service and continuing education • raising community and clinician awareness and engagement • support EOLC conversations happening in primary care and a wider range of community settings such as aged care • examining opportunities to have a common language and tools to support good practice 	July 2018	December 2018	Ongoing	Commonwealth and NSW

Multidisciplinary Team Care

54. Multidisciplinary team care is an essential requirement for enhanced care coordination for people with chronic and complex conditions.
55. The Parties agree to collaborate on building the capability of health care professionals to work together to deliver comprehensive patient-centred care. This collaboration aims to improve health outcomes and patient satisfaction, make more efficient and effective use of resources, and enhance job satisfaction for health care professionals.
56. This will involve jointly identifying, developing and implementing workforce support and tools to enable a multidisciplinary team based approach for people with chronic and complex conditions. There will be a focus on clinical leadership in HCH and services that support HCH and the NSW Integrated Care for People with Chronic Conditions (ICPCC) model. The Parties will draw on relevant work in local and national fora.
57. The Parties also agree to share experience, evaluation results and lessons on multidisciplinary team care, where possible, including experience and data on clinical workforce models through NSW's Integrated Team Care program and the Commonwealth's HCH initiative. This information will build the evidence base for best practice multidisciplinary approaches.
58. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 5.

Table 5: Multidisciplinary Team Care milestones

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
<i>Supporting our workforce to deliver multidisciplinary team based care</i>					
5.1	Identify gaps and opportunities in workforce support and training tools to enable a multidisciplinary team based approach	Upon signing of the Agreement	June 2018	Once	Commonwealth and NSW
5.2	Contingent on the findings, explore opportunities to jointly develop supports and approaches to enable a multidisciplinary team based approach, and begin implementation of strategies as appropriate	July 2018	December 2019	Ongoing	Commonwealth and NSW
<i>Building the evidence base for best practice multidisciplinary approaches</i>					

No.	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
5.3	Share with NSW available information from HCH practices, where possible, to inform best practice multidisciplinary care, including: <ul style="list-style-type: none"> task distribution between clinical and non-clinical workforce service utilisation patient experience and outcomes 	Early 2019 (as part of HCH evaluation)	N/A	Once	Commonwealth
5.4	Share experience and lessons on multidisciplinary team care from NSW integrated care initiatives	Upon signing of the Agreement	December 2019	Initially by December 2017 and then ongoing	NSW

Aged Care

59. Many older people have chronic and complex health conditions, and access services from the aged care system as well as the health system. The Parties commit to two areas to improve health outcomes for people with chronic and complex conditions, as follows.

60. The Parties commit to improving the use of MHR in Residential Aged Care Facilities, acknowledging the importance of digital platforms in supporting coordinated care for older people.

61. The Parties will explore opportunities to expand on current initiatives in NSW that aim to reduce avoidable hospital demand from Residential Aged Care Facilities. These are the Geriatric Flying Squad, the Aged Care Emergency (ACE) program, and the Geriatric Rapid Acute Care Evaluation (GRACE) model of care.

62. This Agreement does not seek to change roles and responsibilities for aged care. The Parties recognise that:

- a. 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;
- b. there are a number of aged care programs that are jointly funded and regulated by the Commonwealth and State and Territory governments, including the Multi-Purpose Services Program and the Transition Care Program;

- c. the Commonwealth is responsible for subsidising and regulating aged care services, such as residential aged care, home care packages and Commonwealth Home Support; and
- d. in line with their responsibilities as approved providers of transition care, NSW will continue to manage the day-to-day operations of the Transition Care Programme in their jurisdiction, to ensure quality care is delivered to eligible care recipients immediately following a period of hospitalisation.

63. All activities undertaken under this priority area will align with the Aged Care Act 1997 (Commonwealth) and the Australian Aged Care Quality Agency Act 2013 (Commonwealth), their Principles, relevant program guidelines, manuals and agreements and the Commonwealth's aged care quality regulatory framework, which 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.

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

Table 6: Aged Care Milestones and Indicators

No.	Key Milestone/Indicator	Planned start date	Planned end date	Frequency	Responsibility
<i>Smarter use of digital health to support health and aged care service integration</i>					
6.1	Share data with NSW to inform strategies to increase uptake and use of MHR by older people (for 65-74 year olds, and people aged 75 and over)	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth
6.2	Share relevant experience of HealthNet implementation in NSW and its connectivity with aged care platforms	Upon signing of the Agreement	June 2018	N/A	NSW
<i>Right care, right place, right time – reducing avoidable hospital demand</i>					

No.	Key Milestone/Indicator	Planned start date	Planned end date	Frequency	Responsibility
6.3	Opportunities are identified to build on the initiatives currently in place in NSW to reduce avoidable hospital admissions from Residential Aged Care Facilities (Geriatric Flying Squad, Aged Care Emergency (ACE) and Geriatric Rapid Acute Care Evaluation (GRACE) models of care)	January 2018	December 2018	Ongoing	Commonwealth and NSW

Rural and Remote

65. It is often more difficult for people with chronic and complex conditions to access the care they need in rural and remote areas. The Parties agree to work together to enhance coordination of care for these communities by focussing on digital health and workforce improvements.
66. Strong eHealth infrastructure in rural and remote areas can enable the sharing of information and resources, supporting patients receiving care as close to home as possible in a coordinated way. The Parties commit to increase the use of digital health across the acute, primary and aged care sectors in rural and remote area, including through the implementation of the National Digital Health Strategy.
67. A sustainable, effective workforce is fundamental to improving health services for rural and remote communities. To support this, the Parties will work to strengthen the rural and remote workforce by:
- a. Identifying workforce gaps, duplications and priority areas for collaboration;
 - b. Developing joint workforce strategies for priority areas, including post-graduate workforce pathways to retain people in rural and remote communities post-training, and considering shared employment arrangements; and
 - c. Promoting training opportunities in Aboriginal Medical Services with a focus on better support for people with chronic and complex conditions.
68. Joint activities in this area will be consistent with existing respective policies and frameworks, including:
- a. Commonwealth programs using the network of Rural Workforce Agencies;
 - b. Commonwealth support for rural undergraduate training through the Rural Health Multidisciplinary Training Program; and
 - c. the NSW Rural Health Plan: Towards 2021 and the NSW Health Professional Workforce Plan 2012-2022.
69. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 7.

Table 7: Rural and Remote Service Delivery Milestones

No	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
<i>Stronger digital health for rural and remote communities</i>					
7.1	Opportunities to increase the use of digital health across the acute, primary and aged care sectors in rural and remote areas are identified	Upon signing of the Agreement	June 2018	Ongoing	Commonwealth and NSW
7.2	Strategies to strengthen digital health are developed and implemented as appropriate	July 2018	December 2019	Ongoing	Commonwealth and NSW
<i>Sustainable, effective rural and remote workforce</i>					
7.3	Joint workforce mapping conducted and workforce gaps and/or duplication in NSW identified	Upon signing of the Agreement	June 2018	Once	Commonwealth and NSW
7.4	Joint workforce strategies developed, including to retain post-graduates in rural and remote communities post-training, and considering shared employment arrangements in thin markets	Upon signing of the Agreement	December 2018	Once	Commonwealth and NSW
7.5	Promote available training for clinicians in Aboriginal Medical Services	Upon signing of the Agreement	December 2018	Ongoing	Commonwealth and NSW

Mental Health

70. The Parties commit to certain actions to improve coordination of mental health services and supports across care settings. The Parties recognise that these activities will be complementary to a number of programs of work and collaborations already underway, including:

- a. local partnership approaches between LHDs and PHNs;
- b. implementation of the Fifth National Mental Health and Suicide Prevention Plan; and
- c. national focus on coordinated commissioning through the AHMAC Mental Health and Drug and Alcohol Principal Committee.

71. The Parties will work together to improve understanding of policy and service gaps for people with complex mental health support needs across the spectrum of care. This will involve regular collaboration on planning for future policy and program

settings to enable better coordination of mental health services, including suicide prevention initiatives. Information sharing will enable mapping of referral pathways to better support navigation of mental health services.

72. The Parties agree to develop and test coordinated commissioning of mental health services, with a focus on people with severe and complex mental health needs. This work will involve development of a mental health specific Co-Commissioning Framework considering shared governance and aligned funding opportunities, and for the Framework to be trialled for a discrete population as agreed between the Parties.

73. The Parties recognise workforce capability as a key factor in improved coordination of mental health care. The Parties will work together to improve training and supports across the primary health, acute health and aged care sectors to increase whole-of-sector knowledge about mental health.

74. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 8.

Table 8: Mental Health Milestones

No	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
<i>Improved coordination in mental health service and policy planning</i>					
8.1	Establish a mechanism to regularly share information between NSW and the Commonwealth about planning for future policy and program settings to enable better coordination of mental health services, including suicide prevention activities	September 2017	December 2017	Once	Commonwealth and NSW
8.2	Share information about mental health funding, policy and program settings	September 2017	December 2019	Ongoing	Commonwealth and NSW
8.3	Map referral pathways for people with complex mental health support needs	Upon signing of the Agreement	July 2018	Ongoing	Commonwealth and NSW
<i>Co-commissioning mental health services</i>					
8.4	Develop a mental health Co-Commissioning Framework to guide PHNs and LHDs in testing co-commissioning approaches for mental health services, with an initial focus on people with severe and complex needs	Upon signing of the Agreement	June 2018	Ongoing	Commonwealth and NSW

No	Key Milestone	Planned start date	Planned end date	Frequency	Responsibility
8.5	Co-Commissioning Framework is trialled for a discrete population and evaluated	July 2018	December 2019	Ongoing	Commonwealth and NSW
<i>Strengthening mental health care capability in the workforce</i>					
8.6	Develop and implement joint workforce support and training tools on mental health for all healthcare workers across the acute, primary and aged care sectors	September 2017	December 2019	Ongoing	Commonwealth and NSW

Evaluation Framework

Commonwealth and New South Wales Enhanced Coordinated Care Bilateral Agreement

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).

PART2: Terms of this Schedule

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

PART 3: Evaluation Framework

Project approach

11. This Framework will be implemented by all jurisdictions (including the Commonwealth), collectively drawing on the agreed evaluation questions and indicators as appropriate to the Parties to the agreement.
12. Each Party agrees to provide qualitative and quantitative data (as appropriate to the Parties) to report on the relevant indicators by 1 October 2018, to enable data compilation and analysis and the drafting of a report to the COAG Health Council. The report is intended to inform future activities that will continue to build the evidence base for joint action on coordinated care.
13. The Evaluation Framework is based on a pre/post design. For some indicators, baseline data will be able to be collected at the commencement of the activity (for example, routinely collected data), while for other indicators, the data collected at the 12 month point will form the baseline for comparison at the end point.
14. All Parties will participate in the development of, and agree on, the report to the COAG Health Council which will outline the progress against each of the evaluation questions, based on compilation and analysis of the qualitative and quantitative data provided by individual jurisdictions.
15. The Evaluation Framework includes:
 - key evaluation questions;
 - a number of agreed indicators, as appropriate to each Party, for each core and priority area; and
 - reporting on activities through the bilateral agreements to support the Stage 1 roll out of the HCH model.
16. The report to the COAG Health Council will include, but is not limited to:
 - an overview of the current health system on coordinated care, at the commencement of the bilateral agreement;
 - qualitative sections on each core and priority area; and
 - an assessment against each of the key evaluation questions, drawing on implementation reports and the qualitative and quantitative data collected by jurisdictions.
17. In applying the Evaluation Framework against activities, the following principles will apply:
 - The Framework has been developed at a national level and it is acknowledged that not all dimensions or indicators will be relevant to all jurisdictions and therefore reporting will vary for each jurisdiction.
 - Core and priority activities for all Parties will be assessed against the Framework;
 - The evaluation questions and indicators enable joint reflection and support consistent data collection across jurisdictions and aggregated data analysis and reporting;
 - All Parties will ensure appropriate privacy, ethics, consent and data security requirements are addressed as part of any evaluation activity. In some cases this may require joint approvals;
 - The primary focus is on outputs at the patient, workforce and system levels, reflecting that changes in outcomes can take time to be demonstrated through evaluation;
 - The Framework does not limit or dictate the level and complexity of evaluation activities undertaken by each jurisdiction;

- Data will be collected and reported through a variety of existing methods as well as through specific evaluation activity undertaken at the local level by jurisdictions, which can be both quantitative and qualitative.
- Where appropriate the Commonwealth will provide data collected at a national level (for example, usage of My Health Record); and
- Where possible and appropriate, validated evaluation tools will be used in evaluating activities.

18. The Parties agree that any changes in implementing the activities outlined in Schedule A will need to ensure that they continue to support the Evaluation Framework outlined below:

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

System Integration			
<p>How has the sharing of health information across the system changed?</p> <p>How has service delivery across the system changed?</p> <p>Have there been improvements in patients' access to health services?</p> <p>What is patient experience and satisfaction of health system improvements?</p> <p>Have changes resulted in improved patient and clinical outcomes?</p>	<ul style="list-style-type: none"> • Coordination between health providers and systems • Multi-disciplinary team based care • Patient reported satisfaction/experience and outcomes • Patient continuity of care • Workforce experience and engagement • Changes to service utilisation patterns 	Intermediate	<ul style="list-style-type: none"> • Number, type and coverage of activities • Development of regional planning activities • Development of patient care pathways • Collaborative commissioning arrangements • Increased use of MHR <ul style="list-style-type: none"> - Number of MHRs - Increased number of views/updates - Number of uploaded discharge summaries - Increased number of health professionals viewing/uploading to MHR
		Longer term	<ul style="list-style-type: none"> • Cost of delivering services • Patient outcomes and experience/satisfaction (using PROMs and PREMs)** • Number and type of regional planning or commissioning models across care settings • Use of health services (MBS, ED presentations, hospital admissions) • Referral rates • Waiting times
Coordinated Care			

<p>How has the management of patients with chronic and complex disease improved?</p> <p>What is patient experience and satisfaction with care provision?</p> <p>Have changes resulted in improved patient and clinical outcomes?</p>	<ul style="list-style-type: none"> • Service provider and workforce practices • Systems and processes that enable sharing and coordination • Patient health literacy and/or engagement • Patient reported experience and outcomes • Clinical outcomes 	Intermediate	<ul style="list-style-type: none"> • Number, type and coverage of activities • Increased engagement of health workforce in coordinated care • Increased information sharing and communication between health professionals (eg 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)
Jurisdictional priority areas			
<p>What impact did the activities have on system integration, service delivery or patient experience/outcomes?</p>	<ul style="list-style-type: none"> • Collaboration in planning and implementation • Appropriately skilled workforce • Patient health literacy and/or engagement • Patient reported experience and outcomes • Clinical outcomes 	Intermediate	<ul style="list-style-type: none"> • Number, type and coverage of discretionary projects • Collaboration between Commonwealth and jurisdictions in reforms or delivery of care • Increased staff capability • Information/resource developed for, and used by, patients and carers

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

* 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.