

Bilateral Agreement between the Commonwealth and Queensland

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 State of Queensland (Queensland) 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 Queensland 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 activities complement reforms relating to safety and quality and Commonwealth funding mechanisms also articulated in the NHRA Addendum; 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 Queensland.

Commencement, duration and review of the Agreement

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

Interoperability

9. The Agreement is to be considered in conjunction with:
 - a. The *NHRA for 2011* and its *2017-20 Addendum*;
 - b. The *National Healthcare Agreement 2012*; and
 - c. The *Intergovernmental Agreement on Federal Financial Relations 2008*.
10. Schedules to this Agreement will include, but not be limited to:
 - a. Schedule A: Implementation Plan; and
 - b. Schedule B: Evaluation Framework.

Part 3 – Objective and Outcomes

11. The overarching objective of the Agreement is to support the implementation of coordinated care reforms, consistent with the principles outlined in the *Addendum to the NHRA 2017-20* that:
 - a. improve patient health outcomes; and
 - b. reduce avoidable demand for health services.
12. The Parties will contribute to the achievement of these objectives and outcomes through 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 Queensland'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 HCH patients, and will link data for these patients, to inform Commonwealth and Queensland reforms, by:
 - a. providing an understanding of patient service utilisation and pathways across the health system;
 - b. identifying patients or patient characteristics that would benefit from better care coordination, including from the Health Care Homes (HCH) model;
 - c. supporting understanding 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 Queensland's overarching priority areas of care integration, coordination and access; joint end to end planning (including population health and social determinants); cross boundary data linkage and use; and clinical optimisation.

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 11 through 17, the Parties will: undertake all activities as outlined in the Schedules to the Agreement; develop and agree project plans to support implementation, where relevant; monitor achievement against milestones; and conduct an evaluation of reform activities.
20. The Parties will work collaboratively with the Queensland Primary Health Networks (PHNs) and Hospital and Health Services (HHSs) to support and encourage active participation in the relevant aspects of the Agreement.

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 between the Commonwealth and Queensland will include:
 - a. Six-monthly status reports, on an exception basis against relevant milestones, by each Party, to relevant executive officers;
 - b. Quarterly bilateral officer-level discussions on implementation progress and emerging risks or issues;
 - c. Multilateral updates as required on implementation progress and emerging risks or issues through relevant committees; and
 - d. Ad hoc reporting, as agreed by the Parties.

23. The Parties will undertake an initial evaluation of the reforms, including where possible, the impact on patient outcomes and experience, as outlined in Schedule B: Evaluation Framework, consistent with Clauses 10 – 12 of the NHRA Addendum. The evaluation will consider the first 12 months of activity from the commencement of the Agreement.
24. Where Queensland 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.
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, 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. 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

31. 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

32. Any Party may give notice, in writing, to the other Party of a dispute under the Agreement.
33. The Parties will attempt to resolve any dispute at officer-level in the first instance.
34. 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

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

Delegations

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

Enforceability of the Agreement

37. 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

38. Either of the Parties may withdraw from the Agreement by giving six months' notice of its intention to do so, in writing, to the COAG Health Council and COAG.

39. 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

40. The following definitions are applicable throughout the Agreement and all Schedules to the Agreement.

Australian Health Practitioner Regulation Agency (AHPRA)	AHPRA is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia.
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).
Commissioning	A strategic approach to procurement that is informed by PHN/HHS 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.
Comprehensive Aged Residents Emergency and Partners in Assessment, Care and Treatment (CARE-PACT)	Residential Aged Care Facility (RACF) patients through an emergency department (ED) telephone triage system are provided with onsite care by a Doctor or Nurse Practitioner, or telephone advice for RACF staff or general practitioners (GPs). A series of clinical pathways and supportive education has been developed to support the care of the most frequent attendances to EDs which are classified as avoidable.

Health Care Home (HCH)	A HCH is an existing practice or Aboriginal Community Controlled Health Services (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.
HealthPathways	An online portal for assessing evidence based information, assessment management, referral, and additional resources to aid decision making for specific health conditions for health practitioners, starting with GPs through to hospital clinicians.
Hospital and Health Service (HHS)	A HHS is an organisation that provides public hospital services in accordance with the NHRA. A HHS can contain one or more hospitals, and is usually defined as a business group, geographical area or community. Every Queensland public hospital is part of a HHS.
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.
Primary Health Networks (PHNs)	PHNs are independent organisations with regions closely aligned with those of HHSs. 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.
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.
The Viewer	The Viewer is a read-only web-based application that displays consolidated hospital-level clinical information sourced from a number of existing Queensland Health enterprise clinical and administrative systems. GPs will gain access to the Viewer through their AHPRA registration.

Note: 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



Signed for and on behalf of
Queensland by

The Honourable Dr Steven Miles MP
Minister for Health and Minister for Ambulance Services



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 upon signing of the Agreement to progress the COAG's commitment to enhanced coordinated care, as articulated in the 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 activities identified in this Schedule, the Parties will identify relevant stakeholders and ensure there is an agreed communication approach.
5. The purpose of this Schedule is to guide implementation, provide the public with an indication of how the enhanced coordinated care reform project is intended to be delivered, and demonstrate the Parties' ability to achieve the outcomes of the Agreement.
6. In accordance with clauses 11-17 of the Agreement, the projects will comprise coordinated care reforms relating to the following priority areas:
 - a. data collection and analysis, system integration; and care coordinated services; and
 - b. other areas relevant to Queensland'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 Queensland 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 deidentified patient data collection and linkage activities for this Agreement will relate to patients with chronic and complex conditions, and will include provision of Admitted Patient Care National Minimum Data Set (NMDS), Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Emergency Department NMDS and National Death Index (NDI) data initially. Additional data will be included, where appropriate, and as agreed by both Parties.
9. The Commonwealth will work with Queensland to identify a cohort of patients for the deidentified 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 Queensland 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 of the AIHW Ethics Committee.
12. Analysis projects using the linked data set will be undertaken by the Commonwealth, and Queensland, with the agreement that Queensland will be able to view linked data for services provided in Queensland.
13. Queensland remains the data custodian of all hospital data provided to the AIHW, as the original collecting jurisdiction. Any use of the data outside of the agreed linkage activities set out in this Agreement, must first be approved by Queensland.
14. The Parties recognise that the data collection and analysis within this bilateral agreement will not supersede or alter the work of the National Data Linkage Demonstration Project (NDLDP) being undertaken by the AIHW under the auspice of the National Health Information and Performance Principal Committee (NHIPPC) and the Australian Health Ministers' Advisory Council (AHMAC).
15. It is recognised that consideration and decision by AHMAC in relation to the future of the NDLDP will need to be taken into account in progressing the collection and linkage of data through this Agreement.
16. The Commonwealth will take a national lead role on work to develop a NMDS of de-identified information to help measure and benchmark primary health care performance at a local, regional and national level, which will also help to inform policy and identify region-specific issues and areas for improvement. This will be a staged, complex and multi-faceted work program, extending beyond the end of this Agreement. It will require collaboration and cooperation from a number of government and non-government sectors.
17. The Commonwealth will provide relevant personal information about HCH patients in Queensland with patient consent, to Queensland Department of Health to identify HCH patients in their hospital systems to better facilitate the coordination of care for these patients.
18. In addition to health data activities described above, the Parties commit to investigate data collection and analysis opportunities to better understand the social determinants of health and patient pathways across health and social care services for people with chronic and complex conditions.

19. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 1. The planned start and completion dates are indicative only and may vary where appropriate.

Table 1: Data Collection and Analysis Milestones

No.	Key Milestone	Planned start date	Planned completion date	Frequency	Responsibility
Linkage of Health Data Sets					
1.1	Ethics and data governance arrangements are in place to enable data supply, collection, storage and use.	Upon signing of the Agreement	March 2018	Once	Commonwealth and Queensland
1.2	Identification of patient cohort, and HCH patient consent sought for data collection and analysis	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and Queensland
1.3	Subject to the establishment of agreed data governance arrangements that set out the supply, collection, storage and use of data, Queensland admitted patient and emergency department data for a period to be agreed by both parties, will be provided for HCH patients and a suitable comparison group to enable linkage with MBS, PBS and NDI data	December 2017	December 2019	Ongoing	Commonwealth and Queensland
1.4	AIHW commence data linkage and enable jurisdictions to access linked data set	January 2018	December 2019	Ongoing	Commonwealth and Queensland
Health Care Homes data linkage with Queensland datasets					
1.5	Work collaboratively to ensure data governance arrangements are in place to enable data collection and linkage (contingent on relevant approvals) to inform: <ul style="list-style-type: none"> • coordination of care for HCH patients; and • improvements to service funding, management, planning and evaluation 	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and Queensland

No.	Key Milestone	Planned start date	Planned completion date	Frequency	Responsibility
Identification of Additional Data Sets for Potential Linkage					
1.6	Explore feasibility of inclusion of additional data sets, such as residential and community aged care data, My Aged Care data, allied health data, and mental Health data collected through the PHN program	December 2017	December 2018	Ongoing	Commonwealth and Queensland
Progression of Primary Health Care NMDS					
1.7	Monitor and progress activities towards establishing a primary health care National Minimum Data Set of de-identified information.	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and Queensland

System Integration

Objectives

20. 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 health services, including through digital health enablers; and
- c. effectiveness and efficiency of collaborative commissioning arrangements.

21. 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).

22. The parties recognise that in Queensland, primary health care provision in some areas is supported by HHSs, particularly in rural and remote settings. Regional planning will be a joint responsibility to ensure a stable GP workforce and enable redesign of services to chronic and complex disease management where appropriate.

Activities

23. In addition to the national roll-out of MHR on an opt-out basis, a key focus is more effective and efficient use of MHR, initially targeting Queensland's HCH location (Brisbane North PHN) and the priority areas within this Agreement, with a view to expanding more broadly where possible over time including through:

- a. promoting targeted training provided by the ADHA to hospital staff on the use of MHR;

- b. progression of the automatic uploading of discharge summaries, pathology and diagnostic imaging in conjunction with the ADHA;
 - c. promoting and increasing the frequency of viewing of the MHR by healthcare professionals;
 - d. increasing MHR content of uploaded documents;
 - e. continued rollout of 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; and
 - f. Identifying ways to work with PHNs to support the above processes, where appropriate.
24. Queensland has introduced GP access to the Viewer which improves the flow of information between HHSs and GPs, and helps to facilitate timely sharing of discharge summaries. Opportunities to increase awareness and promote usage of the Viewer amongst GPs will also be explored through the PHNs in Queensland.
25. 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.
26. The Parties agree to commit to integration between systems and the MHR, building on Queensland's current Enterprise Discharge Summary capability of sending discharge summaries to MHR, with a view to investigate additional views (such as pathology and diagnostic imaging).
27. The Parties will work together to improve 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.
28. While the working group will be best placed to determine its areas of focus, opportunities for exploration could include:
- a. The use of, and movements between, health settings, including whether these movements are appropriate, or potentially preventable;
 - 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. Working collaboratively to align reporting requirements and accreditation arrangements 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 facilities (RACF) residents admitted to hospital; and
- g. Improving data systems and linkages between other datasets.

29. Queensland specific priorities for system integration include:

- a. working with the Commonwealth to support joint planning and governance arrangements between HHSs and PHNs, to provide a solid foundation for partners to move towards coordination of investments and ultimately, a pooling of funds for joint commissioning of coordinated care programs into the future; and
- b. investigating and exploring potential future opportunities for coordinated commissioning efforts between HHSs and PHNs to support people with chronic and complex conditions in areas such as mental health services and alcohol and other drugs services.

30. The Parties agree to participate in development of a national collaborative commissioning framework, building on existing work. This Framework will guide PHNs and HHSs to collaboratively purchase and or co-commission services. 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.

31. The Parties will monitor progress on the activities against the milestones and timelines outlined in Table 2. The planned start and completion dates are indicative only and may vary where appropriate.

Table 2: System Integration Milestones

No.	Key Milestone	Planned Start Date	Planned Completion Date	Frequency	Responsibility
Digital Health Reforms and Increased Use of MHR					
2.1	Establish a baseline and increase in the number of registrations for MHR in Queensland	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth
2.2	Establish a baseline and increase in the number of advance care plan uploads to MHR in Queensland	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth
2.3	Promotion of targeted training provided for hospital staff by the ADHA on how to use MHR	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and Queensland
2.4	Monitor the percentage of uploads on MHR for discharge summaries; diagnostic imaging; and pathology	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth and Queensland
2.5	Monitor and increase the viewing frequency of MHR by healthcare providers	Upon signing of the Agreement	December 2019	Six-monthly	Commonwealth and Queensland

No.	Key Milestone	Planned Start Date	Planned Completion Date	Frequency	Responsibility
2.6	Identify and implement approaches to improve the content of discharge summaries on MHR	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and Queensland
2.7	Promote and increase utilisation of the GP Viewer by HCH sites and priority areas in the Agreement	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and Queensland
2.8	Consultation and coordination occurs between the Commonwealth and QLD 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 and GPs	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and Queensland
Strengthening partnerships					
2.9	Explore and identify joint planning initiatives for regions with high growth and/or high or complex health need across PHNs	Upon signing of the Agreement	October 2018	Ongoing	Commonwealth and Queensland
Moving towards Joint commissioning					
2.10	Share learnings of the co-investment model in primary and community providers and services in five locations in Western Queensland	Upon signing of the Agreement	June 2019	Ongoing	Commonwealth and Queensland
2.11	Share learnings from collaborative initiatives that deliver quality outcomes through improved integration of care	Upon signing of the Agreement	July 2018	Annually	Commonwealth and Queensland

No.	Key Milestone	Planned Start Date	Planned Completion Date	Frequency	Responsibility
2.12	Participate in development of a national collaborative commissioning framework that defines target population/s and sets out principles and mechanisms for co-commissioning, including in the areas of: <ul style="list-style-type: none"> governance funding purchasing service delivery 	Upon signing of the Agreement	June 2018	Ongoing	Commonwealth and Queensland
2.13	Explore potential opportunities for coordinated commissioning efforts between HHSs and PHNs to support people with chronic and complex conditions in areas such as mental health services and alcohol and other drugs services	Upon signing of the Agreement	June 2019	Ongoing	Commonwealth and Queensland
Improving patient transitions between residential aged care and primary/acute settings					
2.14	Commonwealth and inter-jurisdictional Aged Care Working Group established to investigate the transition of residential and community aged care patients across acute, primary and aged care sectors	Upon signing of the Agreement	November 2019	Ongoing	Commonwealth and Queensland
2.15	Identify agreed priority areas for working group to investigate the transition of patients across acute, primary and aged care sectors	January 2018	March 2018	Once	Commonwealth and Queensland

Care Coordination Services

Objectives

32. 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

33. HCH is the Commonwealth's primary 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, establishing more effective partnerships across the health system, including hospitals, allied health and primary health sectors.
34. HCHs will provide care for up to 65,000 patients across 200 sites. HCHs will initially be implemented in 10 geographical regions based on PHN boundaries. Queensland's HCH region is the Brisbane North PHN region.
35. Queensland and the Commonwealth will work together to identify and link up State and local programs with Queensland's HCH practices, to support HCH patients for this region.
36. A Commonwealth led 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.
37. Stage one of HCH will be evaluated to establish what works best for different patients and practices, and in different communities with different demographics. The evaluation will be undertaken in consultation with Queensland stakeholders, and will examine the implementation process, as well as the impact of the model, including any Queensland specific impacts and opportunities.
38. Queensland has made a significant investment in integrated care through Queensland Health's Integrated Care Innovation Fund (ICIF). The ICIF funds activities to deliver better coordination of services through the introduction of new models of care, addressing fragmentation in services, and providing value based healthcare across Queensland. The projects funded under this program will provide a wealth of information and data to support the HCH project.
39. In addition, Queensland will address priority areas of clinical care optimisation, care integration, care coordination, and care access, through the introduction of specific ICIF projects and HealthPathways. Queensland priority areas of interest include (but are not limited to) Aboriginal and Torres Strait Islander health and aged care.
40. HealthPathways are a source of assessment, management and referral information for General Practitioners and other community healthcare providers. Activities to support HealthPathways include:

- a. Implementation of a web based system which will enable primary care physicians to plan patient care through primary, community and secondary health care systems.
- b. A state-wide supported roll out of HealthPathways will promote awareness and require workforce development to encourage increased use in a primary care setting.
- c. Communicating learnings from the implementation and use of HealthPathways where they are being used in conjunction with Clinical Prioritisation Criteria to reduce the number of inappropriate referrals and improve the quality of referrals from General Practice into the HHSs.

41. The Parties agree to develop a collaborative commissioning framework that provides guidance for Queensland PHNs and HHSs 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.
42. 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.
43. The Parties will monitor progress on these activities against the milestones and timelines outlined in Table 3. The planned start and completion dates are indicative only and may vary where appropriate.

Table 3: Care Coordination Services Milestones

No.	Key Milestone	Planned start date	Planned completion date	Frequency	Responsibility
Implementation of Health Care Homes					
3.1	Contract GP practices/ACCHS to participate in HCH	October 2017	December 2017	Once	Commonwealth
3.2	Commence training of participating PHNs and HCHs	October 2017	December 2019	Ongoing	Commonwealth
3.3	Commence patient enrolment	October 2017	December 2019	Ongoing	Commonwealth
3.4	Commence HCH evaluation (including establishing data baseline)	October 2017	July 2018	Ongoing	Commonwealth
3.5	Share HCH implementation learnings and contribute to the evidence base for future coordinated care approaches	December 2017	December 2019	Ongoing	Commonwealth and Queensland

No.	Key Milestone	Planned start date	Planned completion date	Frequency	Responsibility
HealthPathways – Linkage/expansion of local programs					
3.6	Statewide access to HealthPathways is rolled out	Upon signing of the Agreement	July 2018	Ongoing	Queensland
3.7	Communicate and share the learnings from the implementation and use of HealthPathways with all HHSs and PHNs in Queensland.	Upon signing of the Agreement	January 2018	6 monthly	Queensland
3.8	Localise and update the pathways through local agreement between the PHNs and HHSs.	Upon signing of the Agreement	October 2018	Ongoing	Commonwealth and Queensland
Common language for care coordination					
3.9	In conjunction with other jurisdictions, develop a shared understanding of key care coordination terms	December 2017	January 2018	Ongoing	Commonwealth and Queensland

PART 4: Queensland Priorities

Priority Area 1 - Better Aged Care Access and Integration

Objectives

44. The Parties recognise that the Commonwealth is responsible for subsidising and regulating aged care services, such as residential aged care, home care packages and Commonwealth Home Support.
45. The Parties recognise that aged care services are operated by a mix of not-for-profit, private and government organisations, and can be delivered in a number of different care settings.
46. There are a number of aged care programs that are jointly funded and regulated by the Commonwealth and State and Territory governments, these include the Multi-Purpose Services Program and the Transition Care Program.
47. The Parties recognise that all activities undertaken under this priority area to achieve the milestones outlined in Table 4 will align with the Aged Care Act 1997 (Cth) and the Australian Aged Care Quality Agency Act 2013 (Cth), their Principles, relevant program guidelines, manuals and agreements and the Commonwealth's aged care quality regulatory framework. The Commonwealth Department of Health is responsible for the quality regulatory framework policy. The framework includes:
 - a. assessment and monitoring against quality standards by the Australian Aged Care Quality Agency
 - b. the Aged Care Complaints Commissioner, who responds to concerns raised by anyone regarding the quality of care and services and

- c. the Commonwealth Department of Health’s compliance powers, including sanctions, where a provider is not meeting its legislative obligations.

48. In line with their responsibilities as approved providers of transition care, Queensland 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

49. Residents in residential aged care facilities who have chronic and/or complex conditions would benefit from improved care coordination activities through addressing access to non-acute health services and medical advice in RACFs, thereby reducing avoidable hospital presentations.

Activities

50. Queensland-run programs aimed at the co-ordinated care of RACF residents, and individuals with chronic and complex conditions, including the frail elderly, are predominately coordinated from public hospital emergency departments (EDs). As there is shared responsibility between Queensland and the Commonwealth, the Parties commit to work together to improve care coordination for this cohort.

51. The activities under this priority area include:

- a. The expansion of the demonstrator program CARE-PACT, targeting patients with chronic and complex diseases, including the frail elderly;
- b. Queensland to improve identification of RACF residents attending EDs in ED databases;
- c. Queensland to adapt the CARE-PACT model to local settings to reduce ED attendance of RACF residents;
- d. The Commonwealth and Queensland to increase uptake of Advance Care Plans across RACFs; and
- e. Additional coordinated projects under the ICIF are aimed at supporting the frail elderly in the community to assist with reducing hospital admissions and total length of stay.

52. The Parties will monitor progress against these activities in line with the milestones described in Table 4 below. The planned start and completion dates are indicative only and may vary where appropriate.

Table 4: Better aged care access and integration

No.	Key Milestone	Planned start date	Planned completion date	Frequency	Responsibility
Patient transitions					
4.1	Explore opportunities to establish employment, training and career pathways for the aged care sector	Upon signing of the Agreement	June 2019	Ongoing	Commonwealth and Queensland

No.	Key Milestone	Planned start date	Planned completion date	Frequency	Responsibility
4.2	Explore and where possible implement opportunities to increase collaboration between hospital psychogeriatric teams and the Commonwealth's Severe Behavioural Response Teams (SBRTs) and Specialist Dementia Care Units (currently under development)	Upon signing of the Agreement	October 2018	Ongoing	Commonwealth and Queensland
Advance Care Planning					
4.3	Support and promote Advance Care Plans across RACFs, primary healthcare and HHSs.	Upon signing of the Agreement	December 2019	Ongoing	Commonwealth and Queensland
4.4	Integrate Advance Care Planning into community and residential aged care policy and practice.	Upon signing of the Agreement	June 2019	Ongoing	Commonwealth
Data linkage					
4.5	Investigate the potential to link My Aged Care records with MHR and where feasible, explore opportunities to make improvements to the My Aged Care online interface for ease of use.	Upon signing of the Agreement	July 2018	Ongoing	Commonwealth and Queensland
4.6	Introduce a "flag" into Emergency Department databases to capture RACF residents.	Upon signing of the Agreement	December 2018	Once	Queensland
4.7	Use local data for demonstrator sites to adapt CARE-PACT model to local need in four HHSs.	Upon signing of the Agreement	January 2018	Ongoing	Commonwealth and Queensland
eHealth					
4.8	GPs visiting RACFs have access to the Viewer to improve information sharing between HHSs, and GP services.	Upon signing of the Agreement	October 2018	Ongoing	Commonwealth and Queensland

Priority Area 2 - Better Care for Aboriginal and Torres Strait Islander People

53. The Better Care for Aboriginal and Torres Strait Islander people priority area includes a focus on:
- a. Aboriginal and Torres Strait Islander clinical care pathways; and
 - b. Better care coordination for Aboriginal and Torres Strait Islander people with an acute mental health condition.
54. Activities undertaken that focus on mental health under this priority area will align with the priorities and objectives of the Fifth National Mental Health and Suicide Prevention Plan.
55. The Parties recognise that there are a number of programs of work and collaborations already underway, including local partnership approaches between HHSs and PHNs and national focus on coordinated commissioning through the AHMAC Mental Health and Drug and Alcohol Principal Committee.
56. Complementary to existing activities, and to inform service planning and future policy approaches for people with chronic and complex conditions, the Parties commit to certain actions to improve coordination of the mental health services and supports across care settings.
57. The Queensland Aboriginal and Torres Strait Islander Health Partnership (QATSIHP) is an important point of consultation. QATSIHP includes senior representation from the State, Commonwealth, Queensland Aboriginal and Islander Health Council (QAIHC), PHNs and HHSs. The QATSIHP is established under an Agreement signed by the State and Commonwealth Ministers for Health and the Chair of QAIHC.
58. The activities required by the Commonwealth and Queensland under this priority area are to:
- a. Provide easy access to evidence-based information on clinical risk factors experienced by the Aboriginal and Torres Strait Islander population that may influence the care pathway, in particular, the timing of screening and/or intervention services, to empower primary care and specialist clinicians;
 - b. Integrate care pathways for health conditions and/or services that are an agreed priority for the Aboriginal and Torres Strait Islander population;
 - c. Promote care pathways across primary health care, acute care, specialist and allied health services, and culturally appropriate integrated models of care;
 - d. Trial new approaches to improve continuity of care and identify opportunities for the development, sharing and use of single care plans that link patients' physical and mental health clinical care needs with any required community based social services and disability support services in scope under the National Disability Insurance Scheme;
 - e. Establish Indigenous mental health liaison roles in facilities with the highest volumes of Aboriginal and Torres Strait Islander inpatients to plan and manage the transition of care and support on entry and discharge from hospital; and

- f. Raise awareness among primary health care clinicians, including those in Aboriginal and Torres Strait Islander Community Controlled Health Services, of mental health specific MBS item numbers.

59. The Parties will monitor progress against these activities in line with the milestones described in Table 5. The planned start and completion dates are indicative only and may vary where appropriate.

Table 5: Better Care for Aboriginal and Torres Strait Islanders

No.	Key Milestone	Planned start date	Planned completion date	Frequency	Responsibility
Aboriginal and Torres Strait Islander Care Pathways					
5.1	In consultation with QATSIHP, agree to priority health conditions and/or service areas for focus	December 2017	March 2018	Once	Commonwealth and Queensland
5.2	In consultation with QATSIHP, identify the key barriers to the delivery of integrated care pathways for the agreed priority areas, including patient and system impact, and develop recommendations for improvement	December 2017	July 2018	Once	Commonwealth and Queensland
5.3	Up to three pathways developed or reviewed and updated at pilot sites (to be identified) to ensure: <ul style="list-style-type: none"> Where necessary, appropriate flags for early screening/intervention are in place; and Inclusion of information on local and/or national Aboriginal and Torres Strait Islander health services, programs and initiatives 	July 2018	July 2019	Once	Commonwealth and Queensland
5.4	Increase the uptake of online clinical decision support tools, particularly in Aboriginal and Torres Strait Islander Community Controlled Health Services, General Practice, and by private and non-government outreach service providers through promotion and education	July 2018	December 2019	Ongoing	Commonwealth and Queensland

No.	Key Milestone	Planned start date	Planned completion date	Frequency	Responsibility
5.5	Identify, with a view to increasing, local data sharing arrangements between primary care providers, particularly Aboriginal and Torres Strait Islander Community Controlled Health Services, PHNs and local HSSs	July 2018	December 2019	Ongoing	Commonwealth and Queensland
Better care coordination for Aboriginal and Torres Strait Islander people with an acute mental health condition					
5.6	An Indigenous mental health liaison role is established in each of the facilities with the highest volumes of Indigenous inpatients – Cairns, Toowoomba, Townsville, Royal Brisbane and Women’s, Logan, and Princess Alexandra Hospitals	Commenced September 2016	December 2017	Once	Queensland
5.7	Opportunities are investigated and identified to utilise eHealth technology for the development, sharing and use of single care plans – agreed to by key stakeholders as best practice and culturally appropriate	July 2018	December 2019	Ongoing	Queensland
5.8	<p>New approaches are trialled to improve continuity of care in the following location: <u>Townsville project:</u></p> <ul style="list-style-type: none"> • Individualised case management support; • Coordination and assistance to young Indigenous people transitioning from mental health services; and • Improve access to appropriate community-based services. 	Upon signing of the Agreement	June 2018	Once	Queensland

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).

PART2: Terms of this Schedule

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

PART 3: Evaluation Framework

Project approach

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

- Where appropriate the Commonwealth will provide data collected at a national level (for example, usage of My Health Record); and
- Where possible and appropriate, validated evaluation tools will be used in evaluating activities.

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

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

System Integration			
<p>How has the sharing of health information across the system changed?</p> <p>How has service delivery across the system changed?</p> <p>Have there been improvements in patients' access to health services?</p> <p>What is patient experience and satisfaction of health system improvements?</p> <p>Have changes resulted in improved patient and clinical outcomes?</p>	<ul style="list-style-type: none"> • Coordination between health providers and systems • Multi-disciplinary team based care • Patient reported satisfaction/experience and outcomes • Patient continuity of care • Workforce experience and engagement • Changes to service utilisation patterns 	<p>Intermediate</p> <p>Longer term</p>	<ul style="list-style-type: none"> • Number, type and coverage of activities • Development of regional planning activities • Development of patient care pathways • Collaborative commissioning arrangements • Increased use of MHR <ul style="list-style-type: none"> - Number of MHRs - Increased number of views/updates - Number of uploaded discharge summaries - Increased number of health professionals viewing/uploading to MHR • 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 	<p>Intermediate</p>	<ul style="list-style-type: none"> • Number, type and coverage of activities • Increased engagement of health workforce in coordinated care • Increased information sharing and communication between health professionals (e.g. increased case conferencing, specialist advice to GPs, recording of referrals in clinical software, reports back to GPs, and e-discharge) • Information resources developed for, and used by, patients and carers • Number and type of joint/coordinated or collaborative commissioned or joint activities • Health professionals report increased information sharing and communication (e.g. increase in case conferencing, team care arrangements and multidisciplinary care)

		Longer term	<ul style="list-style-type: none"> • Patient and health professionals' use of MHR • Patient outcomes and experience/satisfaction (using PROMs and PREMs)* • Relevant clinical measures (e.g. HbA1c, blood pressure) • Use of health services (MBS, ED presentations, hospital admissions)
Jurisdictional priority areas			
What impact did the activities have on system integration, service delivery or patient experience/outcomes?	<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.