phn EASTERN MELBOURNE

An Australian Government Initiative

E023 Tender Briefing Questions and Answers

For the provision of Mental Health Stepped Care Model – Outer East

14 February 2018

Questions from the floor:

	Question / comment	Response
1.	How will tenderers demonstrate the provision of low intensity services in Stepped Care such as self-help online services, in terms of KPIs such as contacts, sessions or episodes of care?	Integration and collaboration with other available services are important aspects of the stepped care model. This funding cannot be used to develop or support eHealth/online and phone applications of mental health services (e.g. *moodgym* or *myCompass*). Instead, the funding is for clinicians and/or peer workers time to assist clients in utilising those online services. EHealth services are important components in EMPHN's Stepped Care Model. Where appropriate, clients should be directed to this service type or supported in their use, as part of an appropriate, overall planned intervention. For example, if a health worker is seeing a client and 15 minutes of that session includes supporting the client to access/use an online service or phone application, then this time is within the funding scope for this tender. This is referred to as moderated or clinician assisted eHealth support. Similarly, if the worker is supporting the GP of a client to implement/facilitate use of an eHealth support, and spends 15-30 minutes doing this work, then that can be included as a contact in relation to the management of that particular client. This type of support may also be delivered by the successful tenderer's intake team and should be acquitted against that intake staff member if that is the case. There is a wide range of emerging eHealth services that can support management of clients. There may be instances where unmoderated eHealth is an appropriate management strategy, although these services should not be an opt-out for good clinical care, where clients require support from a health worker. Service offerings must be clinically appropriate above all else.
2.	Is the Dual Diagnosis funding part of the $1.3M, and if so, will that be a separate amount that has to be reported on?	Within the current indicative funding, there is a small proportion of funding (less than 8%) to address dual diagnosis or co-occurring mental illness and substance use disorders. This funding is not solely for the treatment of AOD issues. Although this will be a small component of the service delivery, tenderers still need to include this in their proposed service model. The amount of dual diagnosis funding should be reflected in the service profile of the tenderers response i.e., 50% of the funding cannot be

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		dedicated to this service type. Services delivered as dual diagnosis will need to be reported as such and would likely include additional Alcohol and Other Drug outcome measures.
3.	Is the $1.3M a fixed or indicative figure and do tenderers need to provide episode of care costs?	The $1.3 million is the anticipated amount for the purposes of the tender. Unit costs do need to be provided so that tender evaluators can make value for money comparisons. In the RFT, there are two attachments: 1. *Attachment 5: Pricing Schedule* - The budget template requiring details of expenditures against staffing/workforce (FTEs). 2. *Attachment 7: Workforce Plan* - detailing the workforce types and the unit costs of their service model in terms of episodes of care or service contact. The methodology for calculating unit cost is clearly detailed in this attachment.
4.	In terms of eHealth mental health services as part of stepped care, if an organisation has an opportunity to deliver value for money services to people who can benefit from but wouldn't otherwise access these services, can this be included in the budget? Clearly these mental health apps will incur a cost so can these costs be included as part of Budget line items for telehealth services, the latter covering video conferencing and teleconferencing? Examples include consumer based applications that can link back into other existing client information management systems so that the end user can record their daily activity e.g. Chin Up!	The eHealth aspects of this funding pertains to the health worker moderation such as video conferencing and teleconferencing which would assist in reaching hard to reach groups such as people in rural populations in the Yarra Ranges. The development and support of eHealth software applications is out of scope for this tender. As previously mentioned, this tender can fund workers' time in helping clients use existing e-health applications within the limits outlined. Funding of video and phone conferencing services and relevant worker time is within the scope of this tender. These strategies may assist access to services for hard to reach target groups, which is an important objective for the mental health stepped care model.

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5.	1. If an organisation has a client information management system that can deliver the minimum data set requirements in an acceptable way to the Commonwealth, can this system be used instead of FIXUS? 2. If the tenderer uses FIXUS, can they obtain reports from the data they have entered in FIXUS?	1. At this stage, service providers are required to use FIXUS as this provides EMPHN with up to date information on how services are performing and links with the information collected by EMPHN's Referral and Access Team. 2. There are some basic reports that some current commissioned services can already access through FIXUS and EMPHN is reviewing the need to generate additional service delivery reports.
6.	Are there any learnings that you can share with us about the roll out of stepped care in the north east?	Working with our current and outgoing service providers to conduct a comprehensive clinical review of their clients and to refer them onto more appropriate other services and not just stepped care has been a challenge. The EMPHN Referral and Access team has been working with service providers to consider more appropriate services based on the identified needs of the clients, particularly since there are existing (e.g. MBS Better Access if clients can afford the gap payment) and new services that are available. EMPHN has learnt that there is a need to allocate more time for transition to support clients, referrers and service providers. We have also highlighted to our service providers, individuals and organisations, their contractual obligations, to ensure appropriate transition care arrangements. As with north east providers, EMPHN will deliver comprehensive communication about the need for transition planning with not only contracted service providers, but also consumers, families and other service providers in particular referrers such as GP clinics, GPs and psychiatrists. The transition and review activities we have undertaken has shone a light on some undesirable practices that do not meet good clinical guidelines or standards such as people not being reviewed, holding onto clients for long

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		periods of time, or having unacceptably large and unsafe number of clients in their caseloads.
7.	Based on the implementation of stepped care in the north east, are you able to give an indication of how many clients you are expecting to transition from the old programs into the new programs?	To date, the Referral and Access team has received 130 transition summaries for the north east and more are still trickling in. Of those, approximately 40% or less will go into stepped care. In terms of clients coming from the Mental Health Nursing Services (formerly MHNIP), as of early December 2017, there were approximately 500 active clients in the north eastern region. However, there was only a small percentage that ended up needing to be referred to the Referral and Access Team for a possible transition into stepped care. The rest were well enough to refer back to their respective GPs or to other more appropriate service providers. For a number of the Psychological Strategies clients (formerly ATAPS), their providers have elected to continue to see them under MBS Better Access or to complete their episode of care rather than transition them to a new provider. So at this time, EMPHN are unable to give details on specific transition numbers although the North East transition process suggests that the number will not be large.
8.	In terms of sub-contractual arrangements, what services can potentially be sub-contracted? What is the difference between partnerships and sub-contracting? What are the advantages and disadvantages of each?	In setting up the new model, EMPHN intentionally did not prescribe the workforce employment arrangements. Options may include: • One provider/ large organisation that can deliver the whole model with directly employed staff. • A partnership arrangement with a lead organisation with a couple of other organisations. Partner organisations may deliver the model in different parts of the catchment or deliver different components. • A mixed work force where the workforce may be directly employed and sub-contractors. • A purely sub contractual arrangement with other organisations or individual providers There are pros and cons to each of these models. However, whether it is a partnership, consortium, or sub-contractual model, EMPHN expects the tenderer to clearly explain how its proposed clinical governance framework

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		will operate in their model, including fulfilment of credentialing requirements of directly employed and/or subcontracted staff. Regardless of model, it is also pertinent that integration and collaboration between services is a component of service delivery.
9.	Why is the funding only for 12 months?	This funding is for 12 months because PHNs have only been assured of funding until June 2019. We do not anticipate that our funding will cease after that but we need to await official confirmation. The RFT for the stepped care model inner east will be for 6 months. EMPHN, like all PHNs, is hoping to receive a longer term commitment of funding from the Commonwealth.
10.	Does that mean that the successful tenderers for the stepped care model will have their contracts automatically extended?	The performance of contracted agencies will be regularly and comprehensively monitored and evaluated. EMPHN acknowledges that the implementation of the stepped care model is a huge investment and a significantly disruptive undertaking. Unless the new service was not performing and there were significant issues we would not seek to disrupt any further.