phn EASTERN MELBOURNE

An Australian Government Initiative

# Questions and Answers

## Tender Briefing: For the provision of Mental Health Stepped Care Model – North East

04 / 10 / 2017

| | Question / comment | Response |
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| **Reference #** | **Questions from Stepped Care email or website** | |
| 1. | Are individual allied health practitioners eligible to tender for the Stepped Care model? | This is an open tender. In line with our commissioning framework, tenderers need to address all the pre-qualification requirements, and at the same time provide a whole Stepped Care model in compliance with the requirements of the tender. |
| 2. | Will Stepped Care replace Medicare Benefits Schedule (MBS) program? | It will not replace the current MBS Better Access program. At this stage we have not received any formal communication from the Commonwealth regarding any changes to the MBS Better Access Program. |
| | **Questions from the floor:** | |
| 3. | Will each successful tenderer be given funding that reflects the nature of the mental illness continuum or the patient journey, recognising some patients will travel through all phases of a Stepped Care model? | We would expect a capable service provider could respond to client needs along the continuum of care. We are looking for a whole of model response. The funding should accommodate the response to a client's needs. |
| 4. | The second part of the submission is hidden behind the pre-qualification. So it's not clear what's going to be in the submission after pre-qualification. Can we get visibility to what's in that next part? We know what the evaluation criteria are, but previous tenders sometimes have surprises around attachments etc. Because we only have a week from pre-qualification to submission, it would be nice to have visibility on that next part. | Tenderers need to complete pre-qualification to be able to access all the criteria within the tender document online.<br><br>Responses can only be text (no bullets, no bold, no italics). You can copy and paste from another document into the online response form.<br><br>If your response is within the recommended word limit but includes tables, please upload these in PDF form. Document formats that can be attached include Word, PDF, Excel, and JPEG.<br><br>Please note there are two mandatory attachments:<br>Criterion 4 - Completed Risk Table template<br>Criterion 5 - Completed Budget template<br><br>These templates are provided in the RFT documents. Under Criterion 2 you have the option to provide additional information such as an implementation plan. It may also be helpful to attach a diagram detailing your Stepped Care Model or client flow.<br><br>Screenshots of Part E - Online Response Schedule E2 have been added in eProcure as part of Addendum 3. They clearly indicate character / page limits for each criteria response and those criteria responses which require/allow you to upload additional information. |

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| 5. | Page limits – what does five pages mean? Will the online form cut off beyond a certain point? | This refers to the equivalent amount of text that would fit on 5 pages in a Word document. This would be approximately 500 words per page, using Arial font, size 10.<br><br>There are character / page limits for each criteria response.<br><br>**Well-constructed, concise descriptions of what you are proposing are highly recommended.** |
| 6. | 1. E-Procure submission: Are there any contingency measures for bugs, glitches, server drop outs, etc. for tenders being submitted at 3.55pm on the last day.<br><br>2. Risk table – are there any particular attachments or paperwork that clarify the criteria that you're wanting to consider for reporting in those template documents? E.g. word counts, OHS attachments A-Z<br><br>3. If we have policies, procedural guidelines and protocols, do you prefer those are attached as part of the application, or do you not want attachments A-Z and have to read through all of that. | 1. The best strategy is to be prepared and try and submit ahead of time. E-Procure has a support line for technical questions. If you have questions regarding content please contact EMPHN. Allow plenty of time for uploading documents, to minimise the risk of any late technical issues. If you have glitches/difficulties **before** the cut off time, let EMPNN know prior to 4pm.<br><br>2. We are looking to gain a strong understanding of your organisation's approach to risk management, including detail regarding high level risks.<br><br>3. Details of your organisation's risk management policies, procedures and protocols do not necessarily need to be attached in full in your application. |
| 7. | 1. Catchment area and location of services: North East (NE) region – do tenderers have to be all from NE region or will tenderers from outside the catchment be accepted?<br><br>2. Staged implementation and tendering approach: How will that be balanced with a successful provider who sits in the NE, and another who wants to tender for Outer East or Inner East? Will the successful tenderer/s for the NE have an advantage if they have already delivered the service? Would that be looked on favourably, or will there be a level playing field? | 1. Tenderers need not be from the North East region, as long as they have established links and can deliver services within the North East catchment and address the tender requirements. EMPHN is seeking whole of catchment coverage. Consumer choice is a very important element in the delivery of services.<br><br>2. We would seek to establish a level playing field. Choice, good coverage and access for clients are the most important factors. Being a successful tenderer in one region does not always indicate that you will also be the successful tenderer in another region. Each proposal will be taken on its own merit. |

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| 8. | 1. Timelines: With contracts expected to be signed in December, commencing on 1 January and service commencing 10 working days after that, are you expecting a fully-fledged service on 15 January?<br><br>2. What are the recording systems going to be so that we can make provision in the budget for them?<br><br>3. Do the Referral and Access Team use an e-Referral system? If so, what is it? | 1. As per the Request for Tender, service delivery should commence on 15th January 2018. Given the time frames, we have transition arrangements in place internally. For example, we have provided change agreements for our existing services in Mental Health Nursing Services and Psychological Strategies to assist with the transition. This will act as a buffer to assist the successful tenderer/s in establishing and commencing services. We are seeking a collaborative approach to the transition for clients, ensuring a good level of service is maintained.<br>2. Currently we are closely looking at Client Information Management System development. EMPHN will take on the development cost; however, tenderers need to make provisions for licencing costs for the Client Information Management System. At this point in time, we are only advocating that our Client Information Management System capture sessions, finance and Minimum Data Set (MDS) information. Tenderers need to make provisions for clinical notes to be stored separately to EMPHN's system.<br>3. EMPHN's Referral and Access Team currently uses a paper based system through secure e-fax. We are asking tenderers to give us proposals for their own intake system. While EMPHN's Referral and Access Team is one entry point for the Stepped Care Model, we would expect that that the successful provider has a robust intake system and team of their own. If part of your proposed model is that you will be using an e-based referral system, then the proposal should articulate that. |
| 9. | 1. There are statements in the tender about the Clinical system to be used. If a tenderer can create a new Minimum Data Set (MDS) using their own clinical system, therefore not having to use one system for clinical notes and another for reporting, how does that fit with PHN future plans?<br>2. Are you looking at further development of FIXUS to allow the clinical side to potentially be used in FIXUS. As a tenderer, you're left | 1. Our aim is for the PHN to have an integrated system where we have visibility and access to all the Minimum Data Set (MDS) information so we can undertake activities such as population health planning and improve our systems, as well as comply with our Commonwealth reporting requirements. We also require a seamless system that can allow us to facilitate referrals (similar to the system currently in place using FIXUS – EMPHN Client Information Management System).<br>2. EMPHN needs access to information required for reporting (e.g. MDS); however, we do not |

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| | with two options. One is you've got a reporting system that EMPHN is using at the moment that doesn't quite allow you to enter the clinical side of things. But on the other hand, there are lots of other clinical systems out there you could use, but that would separate out the two, so the PHN view on the future on what they're going to do, needs to guide that a bit more. | require visibility of clinical client information (e.g. case notes).<br><br>As part of the implementation of the Stepped Care Model, we want to work with the service sector to develop good referral pathways, with systems in place that support the client journey and facilitate good service delivery.<br><br>We are currently exploring Client Information Management System development and potential links to centralised e-health records. |
| 10. | Will tendering for services aim to try and provide more opportunity for multiple services, to make a more competitive model, as opposed to one or two mega services that may be over-represented in regions, and thus, almost monopolising or subcontracting out to other services? | The key premise and underlying principle is we want a system that provides integrated coordinated care for consumers. We want them to have choice and good access. We want capable providers. |
| 11. | Will this end up looking like what has happened in primary healthcare that you end up with a mental health super clinic or three mental health super clinics because it feels like that's what will end up happening?<br><br>$2.5 million is about $800 per client according to your figures and that will give you about 10 sessions with Medicare so that's not a lot of money. | There are many ways to get a system working, and we would encourage partnership approaches to ensure good client access, capable service provision and choice for clients. This is about the client journey, it is a person centred approach and there are many ways to effect that. We have a lot of faith in the sector that they are able to do that.<br><br>In terms of budget, if you read our tender documentation you will know that need far outstrips the resources that we have. We are looking for a different way of working and we are looking for the use of other modalities to meet a growing need in our community. The resources are what they are. We sought to distribute those equitably across our catchment. |
| 12. | 1. I'd like to ask a clinical question around clinical staging and I'm just trying to clarify the difference between that and what the UK NICE guidelines have outlined as the Stepped Care model and whether there are distinct differences or tools or criteria that you are using specifically? | 1. It's important to understand that Stepped Care is not the same as Clinical Staging. Stepped care, like that outlined in the NICE Guidelines, is a population level framework for re-designing services. In the UK, the evidence shows that patient pathways and the interventions provided varied greatly under the stepped care arrangements both between different sites and within sites involved in evaluations. |

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| | 2. In relation to your outline of integrated care, is that integrated between mental and physical and the physical is provided by the other parts of the primary care community, or is this whole model of service that you're talking about really talking about the integration of mental health providers or the whole of a person's health needs. | Stepped care frameworks provide the first level of guidance. Clinical staging provides more clinical guidance for assessment and staging interventions (based on evidence). The assessment is using validated tools for a comprehensive initial assessment and depending on the results, more specific assessment tools for particular conditions.<br><br>The World Health Organization Disability Assessment Scale (WHODAS), Global Assessment of Functioning (GAF) and Social and Occupational Functioning Assessment Scale (SOFAS) are all comprehensive and validated tools for the initial assessment. All of them assess level of functioning and therefore offer avenues for interventions (e.g. vocational and educational, social and family functioning, alcohol and other drug harm reduction, suicide risk reduction, physical health and so on).<br><br>Further information about clinical staging is available on our website, see the discussion paper developed by ConNetica Consulting (MH Stepped Care Model: Discussion paper August 2017).<br><br>2. The primary element is the 'whole of a person health needs', taking into account mental health, physical health and social needs, and using an opportunity to deliver integrated services. We are taking two former funding streams and collapsing those into one bucket so we can respond along that continuum of intensity or complexity. |
| 13. | I like the idea of the system being connected, seamless as well as a person-cantered system but I cannot see how you can achieve that because as you say there is a need for mental health, physical health, housing, social as well as work. How can all these different service providers actually become connected and still be providing services on their own, not connected at all? Please explain. | We would be looking at some governance and other processes to enable the development of collaborative/shared care plans. For example, development of a collaborative care plan between the GP, social worker, psychologist, together with the client, and their carer or other advocate. A collaborative plan to detail what care will look like, with everyone on the same page about what they are doing. That will be the start of joining that system, and we will see where we go from there. |

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| 14. | 1. Can you please clarify the age that is in scope? Is it 0 years plus or is it something more rigid than that?<br><br>2. Just to clarify, so you are looking for a tenderer you can apply the Stepped Care model to all age groups?<br><br>3. Just to clarify, in the RFT document you mentioned the role of Partners In Recovery and the transitioning into NDIS, will other federally funded programs be part of the Stepped Care model such as headspace or other existing federally funded programs? | 1. The Stepped Care Model is an all of age model. Tenderers are encouraged to use their knowledge about the sector and what particular services are going to be appropriate for a particular age group when developing their model. Refer to the Request for Tender for further details.<br><br>2. Yes, absolutely those are the service types we predicate. There are many ways that could be proposed to offer this service. We know that we have a sector which delivers a range of services, often in isolation, so there is the opportunity to form partnerships to ensure delivery of a comprehensive Stepped Care Model.<br><br>3. As you know PIR is funded until June 2019 and providing continuity of support for people who may not access NDIS. We recognise that Stepped Care will exist and is rolling out at about the same time as the NDIS so we are looking for providers of Stepped Care who really understand NDIS and understand the needs of people with severe and enduring mental health needs. This includes an understanding of consumers accessing NDIS, and consumers who may be accessing PIR or mental health nursing programs at the moment who may struggle or not be able to access NDIS. We also have youth services which currently sit alongside Stepped Care, in terms of the headspace services across the catchment. We have one in each of the areas, as well as newly funded youth complex mental health services which are being rolled out this year so they will sit alongside and complement the Stepped Care model. |
| 15. | 1. With regard to the partnership potential I imagine in this room there are people who might be going alone or they might want to collaborate with others. In order to help facilitate that is it possible to let us know who's in the room and who might be wanting to be on a list where we might communicate with each other?<br><br>2.Could you organise this for the next meeting? Or could the probity question be asked when we sign up | 1. EMPHN has made arrangement to make this venue available for an extra hour at the end of this briefing as an opportunity for attendees to network.<br><br>For confidentiality and potential privacy reasons, EMPHN does not propose to release the names of interested Tenderers.<br><br>2. EMPHN may decide to explore this as an option for future tendering processes, via incorporating a consent process for parties willing to share their contact information. |

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| | for the next meeting so that can then be released? | |
| 16. | 1. If you add it up there is about 3,000 people that you mentioned would be eligible for service in that catchment. How was this calculated?<br><br>2. Is $2.5 million the total budget of all the mental healthcare that's going to pay for services for the approximately 3000 people? | 1. Regarding eligibility, the eligibility criteria are detailed in the tender specifications and I'd refer you to those (RFT Section 5.7.2, p. 20).<br><br>The targets we've outlined have been estimated based on historical service utilisation and the National Mental Health Service Planning Framework (NMHSPF, http://www.nmhspf.org.au/) tool.<br><br>2. We have taken for our model two previous funding streams and we have collapsed them and we have done an allocation based on population. $2.5 million is an allocation we had made to that part of the catchment.<br><br>If you read our tender documentation you will know that need far outstrips the resources that we have. We are looking for a different way of working and we are looking for the use of other modalities to meet a growing need in our community. The resources are what they are. We sought to distribute those equitably across our catchment. |
| 17. | Just to follow on from the potential partnership model, given the probity advice that has been given already, is it possible to get a list of current service providers or is there any way to understand what might be publicly available in terms of the service providers in the region? Is it possible to get a list of current service providers? Is there any way to find out what's available in area? | In terms of current contracted services, EMPHN's Psychological Strategies directory includes every single provider currently delivering psychological strategies, and is on a public directory on our website.<br><br>As EMPHN is not subject to an external procurement regime (e.g. Commonwealth Procurement Rules) that requires it to publish contract information, it will not release contact information pertaining to its existing contracts. |
| 18. | 1. Do providers need to communicate their own intake process in the tender application or is this developed by EMPHN?<br>2. Is using the EMPHN intake the best use of funding? Clinical staff and GP's may be well placed | 1. Part of the proposal and the model is for the tenderer to have their own intake team. EMPHN's Referral and Access Team will be one of the access points for the Stepped Care Model. We are envisioning that the EMPHN Referral and Access team will work in partnership with the tenderer's intake system. |

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| | with certain suitability for services also. | 2. The EMPHN Referral and Access Team is an important centralised access point for the Stepped Care Model. The team have a wealth of knowledge about the sector, about services and pathways. They have clinical knowledge so they can assist our various stakeholders with clinical discussions and triage discussions. |
| 19. | Around eligibility, one of the components of the mandatory requirements is to have financially audited statements and for many companies it is not a requirement to have audited statements but they do have financial statements. I'm just wondering whether there is an alternate option for other companies who are not 'not for profit' organisations etc.? For example, allowing use of forecasting summaries? | The prequalification process requires tenderers to submit "copies of the last two years' audited financial statements".<br><br>If tenderers are unable to comply fully with this requirement, the following alternatives are acceptable to the PHN:<br>• For organisations which can only provide non-audited financial statements for this period, these will be accepted by the PHN in lieu of audited statements.<br>• For organisations which are relatively new and therefore cannot provide financial statements for the past two years, financial forecasting summaries for the next two years will be accepted by the PHN.<br><br>In relation to consortia, if the lead agency cannot comply with the audited statements requirement, it must be able to comply with one of the above alternatives. Financial statements provided only by consortium partners and not the lead agency will not be accepted by the PHN.<br><br>Therefore, when responding to the audited financial statements requirement in the online prequalification form, please submit the documentation most relevant to your organisation's circumstances as per the advice above.<br><br>Please note that, as the tender is active, it is not possible to amend the wording in the online prequalification form in relation to 'audited financial statements'. Evaluation of all pre-qualification information is done by the PHN team. The eProcure system will not restrict you from submitting your pre-qualification information. |
| 20. | In terms of the physical location, and the physical spaces themselves, did you have a picture in your mind of approximately how many centres or | An important principle is access for consumers, and therefore offering models of care that can facilitate access to service. This model is likely multi-model, utilising e-technology, face-to-face and other flexible |

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| | places? Are you talking a hundred or one? | arrangements. eHealth will also be an important component of future service delivery across our whole catchment. |
| 21. | Can you explain how the model will work when there is already existing services being delivered in the North East that sit within similar services to the Stepped Care model that may overlap as well. What's the view on this? How does this interact with existing services that provide very similar types of interventions? | We know that need for MH services outstrips resources within the catchment. Our hope is that the service system works together in a coordinated way to ensure a person-centred approach to client care. As we have mentioned in the RFT, when services are provided by other part of the service sector, these services should not be duplicated by primary care. |
| 22. | Has the PHN defined the various nuances applicable to the stages of Stepped Care so what constitutes a low care need versus what constitutes high care needs? | That information is in the Request for Tender, Part B, Figure 2 on page 10, and also in the Mental Health Stepped Care Model Discussion Paper, Figure 1 on page 12 on our website. |
| 23. | If tenderers have uploaded the prequalification questionnaire, and realised that they have missed uploading one file, can the tenderer modify the submission and add another file? | Tenderers who have uploaded the questionnaire cannot modify your response to Part E - Response Schedule E1 - Prequalification criteria.<br><br>However, once the tenderer receives notification that they have not qualified including the reasons why, they can then resubmit their response with the additional information at any time up until the closing date/time for prequalification. |