RFP (REQUEST FOR PROPOSAL) CARE COORDINATION SERVICE FOR ADULTS WITH CHRONIC DISEASE - SERVICE PROVIDER

Introduction

This document provides applicant/s with advice and guidance about submitting a proposal. Applicant/s are advised to carefully review the instructions and assessment criteria prior to completing the application form.

Background and context

PHNs are a Commonwealth Government health initiative, established in 2015 with the key objective of increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and improving co-ordination of care to ensure people receive the right care in the right place and at the right time.

To achieve these outcomes, PHNs need a deep understanding of the health care needs of their communities through analysis and annual planning. This deep understanding enables PHNs to identify and address service gaps and ensure services they commission deliver value for money and successfully contribute to health improvement outcomes for the community.

The need for care coordination

The Primary Health Care Advisory Group’s December 2015 report to the Australian Government on: Better Outcomes for People with Chronic and Complex Health Conditions, states that “Our current health system is not optimally set up to effectively manage long-term conditions.” This report also reveals that patients often experience:

- a fragmented system, with providers and services working in isolation from each other rather than as a team
- uncoordinated care
- difficulty finding services they need
- at times, service duplication and at other times, absent or delayed services
- a low uptake of digital health and other health technology by providers to overcome these barriers
- difficulty in accessing services due to lack of mobility and transport, plus language, financial and remoteness barriers, and
- feelings of disempowerment, frustration and disengagement.

The report highlights the need to strengthen primary health care, particularly to better manage the large numbers of patients with multiple chronic conditions and detailed a range of recommended improvements both within and external to primary care.

Addressing the Quadruple Aim – improving patient and provider experience, population health and reducing costs – is widely accepted as the way to improve health system performance.
Additionally, there have been recent aged care reforms that have resulted in older people, particularly vulnerable populations, being at risk of not being able to successfully navigate the system and get the support they need using self-directed care initiatives.

**Care coordination models**

Care coordination models are regarded as a feature of service level integration strategies and models of care. They are particularly suited to populations with complex, chronic biopsychosocial needs and examples include older people and vulnerable groups negatively impacted by social determinants of health and discriminatory health practices. Care coordination models have been trialled since the 1990s, are diverse in design and evaluations have not yet yielded consistent and conclusive outcomes. However, the field is rich in lessons learnt and offers growing and consistent advice on components for success. All models share a common objective: to facilitate “a more proactive approach to bringing care services together around the bio-psychosocial needs of service users”.

**The design of a care coordination model for chronic disease**

In recognition of the benefits of care coordination models in improving person centred approaches, consumer journeys and experiences through the health system, the Brisbane South PHN sought the development of a Care Coordination Model for persons with chronic disease. Delivery of the service described by the model will be targeted within the Logan region.

The model was designed in late 2018 and early 2019. The design focused on drawing together lessons learned and the evidence base from international models of care coordination. In addition, consumer feedback and input from local service providers - including health professionals - was sought, and market sounding was undertaken to determine whether the proposed model was feasible, viable and implementable. Brisbane South PHN expects that the resulting service model will be further refined and evolved in partnership with stakeholders following implementation.

**Procurement purpose**

Brisbane South PHN is seeking an experienced service provider to deliver care coordination services for persons with one to two chronic diseases and psychosocial risk factors, who are not frequently hospitalised. This group is considered to be at “rising risk” of hospitalisation and without appropriate support, may experience unnecessary and avoidable deterioration (see Attachment A for more information on "rising risk"). The model will support older persons (that is, not children or youth) and has been broadly defined as capturing those aged over 40 years and whose primary presenting medical condition is not mental health related.

**Service specifications**

**Outcomes sought**

The care coordination model seeks to guide service delivery and achieve a number of key outcomes for the target group including:

- improved self-efficacy and self-management for participants
- improved consumer experience for participants as they journey through the health system
- improved health literacy among participants in relation to their health condition(s) and their ability to understand and navigate relevant health and community services
- improved health outcomes (for example reductions in expected rates of hospitalisation, reduced polypharmacy risk)
- delayed entry of participants into the high risk category
• improved health and community linkages and networks in the Logan region
• positive health provider and practitioner experience (including freeing up GP capacity), and
• a sustainable and effective service that can meet the needs of the target population

Target Group

- Those eligible for the service will be people:
  - with one or two chronic conditions (where mental health is not the primary presenting condition)
  - experiencing bio-psychosocial risk factors
  - not frequently hospitalised
  - aged 40 years and over
  - who live within the specified SA3s

Geographic location

The Care Coordination Model will cover four areas (SA3’s) within the Logan region:

- Beenleigh,
- Browns Plains,
- Loganlea-Carbrook and
- Springwood –Kingston

Service Requirements

1. Functions and delivery requirements
2. The successful service provider will be expected to:
3. develop and deliver services in alignment with the attached Care Coordination Model (see Attachment B)
4. support and retain an appropriately trained workforce who are experienced in practices reflecting the principles of the PHN’s Person Centred Collaborative Care model (see Attachment C) and work within the scope of their practice
5. be consistent with relevant standards and legislative requirements and have the capacity and capability to:
   i. support program participants by providing evidence based care coordination approaches for people with chronic disease (focusing on holistic care and therefore including psychosocial factors) that:
      a. promote self-efficacy and self management
      b. provide logistics and navigation support
      c. support information flow between health providers involved in the consumer’s care
      d. coordinate service delivery with other health and support service providers
      e. assist people to navigate the health and aged care systems
      f. link consumers to services relevant to them (including other existing care coordination programs where they are more suited to their needs);
   ii. offer the right frequency and volume of services to meet consumers’ needs and goals
iii. develop tools and resources to support the commencement and sustainability of the program (for example referral forms, eligibility assessment processes, care coordination plan templates)

iv. support the roll out of a phased implementation approach of the care coordination model to meet demand

v. promote the care coordination service model amongst both clinical staff who will provide referrals (including GPs and pharmacists) and consumers in the Logan region

vi. develop strong inter-professional working relationships with professionals in the health, community, aged care and NGO sectors to complement and enhance existing GP and clinical services

vii. develop networks that support the social and community connections relevant to consumers and their biopsychosocial, cultural and other support needs

viii. support appropriate exit from the program when care coordination needs have been met or when efforts to support consumers have been unsuccessful

ix. support the evaluation and monitoring of the program during implementation, including use of data and analytics to drive continuous improvements

x. continue to explore/capture and communicate the issues, barriers and enablers experienced by vulnerable consumers, and family/carers, when accessing appropriate health and social support services (including aged care assessment and screening services where relevant) and

xi. contribute to the evidence for emerging care coordination models.

6. be adaptable and responsive to any changes required to the care coordination model over time

7. Within the agreed timeframe prepare

   i) a detailed project plan for the Initial Implementation Phase and
   ii) a high level service development and delivery plan to June 2021.

The Initial Implementation Phase is considered as a two part process. The first part will establish system, people and processes required prior to client intake. The second part is expected to be an initial patient intake period that will allow further refinement of processes involved. It is anticipated that this early patient intake may recruit between 50 to 100 clients. The project plan for the Initial Implementation Phase will therefore, outline how and when the services will be operationalised including:

- recruitment and orientation of workforce
- operational and governance structures established
- service model documented and establishment
- protocols for differing client needs developed, and
- quality and risk documentation developed
- continuous quality improvement activities
Transition implications

Brisbane South PHN expects that the initial implementation phase of the Care Coordination Model will be gradual and include a setting up phase and progressive building of service delivery capacity. This period will enable:

- development of referral pathways, processes and flows -initially from selected GP practices
- better estimates of the potential demand for the service
- better understanding of the maximum workload and capacity of the service
- better understanding of consumers' needs
- service monitoring to inform scaling up and risk management in later phases.

It is anticipated that 50-100 participants will be accepted into the Care Coordination Model during the Initial Implementation Phase. Brisbane South PHN will work closely with the service provider as an enabling agency.

Governance, quality systems and risk management

Applicants must demonstrate excellent clinical governance, staff and consumer engagement frameworks enabling effective management of individuals and services. Applicants are required to demonstrate alignment with any relevant standards and hold the appropriate level of accreditation commensurate to their scale and business.

**In addition to strong clinical governance, applicants are required to:**

- have robust financial and risk management strategies in place to manage safety, reputational, demand and financial risks and mitigate them through early action and identification
- have a demonstrated commitment to delivering services for the Aboriginal and Torres Strait Islander population
- ensure the secure transmission/communication of health information between service providers.

Out of scope

The care coordination service does not have a treatment function, and is not designed to duplicate or replace any clinical role of health professionals involved in the eligible person’s care. In addition, the service provider will not undertake the evaluation of the service model. The model will be evaluated by a separate organisation. However, the service provider will be expected to assist in the collection of information and data and actively participate in the quality improvement and refinement of the model.

Performance, reporting and evaluation

Successful applicants will be required to implement ongoing continuous improvement processes to ensure quality of care for people. Successful applicants will be required to regularly report their performance to Brisbane South PHN to inform future service provision.

Providers will be monitored across a range of Key Performance Indicators (KPIs) and metrics in line with an agreed performance framework. The framework will include domains such as quality, value for money, efficiency, effectiveness, ability to service priority populations, client and stakeholder satisfaction.

Reporting requirements will include:
• submission of progress reports and collection of data for evaluation and performance purposes
• participation in a transparent evaluation of services
• meeting additional reporting needs of Brisbane South PHN, specifically concerning the collection and reporting of outcomes and service performance indicators
• collect and report consumer experience of service measures, as detailed by Brisbane PHN. Consumer, carer and stakeholder’s experience and/or satisfaction with service feedback may also be requested.

Budget and fees

There is an expected budget of approximately $500,000 for service operation and enhancement each financial year (2019/20 and 2020/21).

Activity to 30 June 2019 will be funded with a smaller amount of funding to be negotiated based on a proposed budget.

The service provider is expected to submit a budget that reflects activity required to establish the service to 30 June 2019 based on the Care Coordination Model (Attachment B). Budgets for the following two financial years must be presented separately.

The exact amount of funding available for the contract duration will be provided post selection process.

Evaluation methodology

Applications will be reviewed against the selection criteria and need to conform to the template provided (see Application Form RFP). Conflicts of interest of panel members must be declared and will be managed.

Brisbane South PHN reserves its right to:
• take into account any matter that Brisbane South PHN, in its absolute discretion, considers relevant (whether or not that matter forms part of the evaluation criteria) when evaluating responses
• develop and consider sub-criteria for any, or all, of the evaluation criteria
• take into account information provided in response to a particular criterion in the evaluation of any criterion
• take into account information from its own and other sources in evaluating RFP responses
• request additional information or clarifications in relation to any RFP responses, including via interview.

Following evaluation of all proposals, a shortlist of applicants will be invited to an interview. Applicants are requested to be available for interview from the 08/04/2019 to 09/04/2019.

Mandatory requirements and due diligence

Applicants are required to submit a declaration of eligibility confirming compliance with the mandatory criteria below with their application (or be ready to provide such as soon as they are notified as being shortlisted):
• ABN, GST registration
• current accreditation with ACHS or ISO or ISQua or NSMHS 2010 or QIC or NSQHS or similar
• Public Liability Insurance – Certificate of Currency (minimum $20 million per claim)
- Professional Indemnity Insurance – Certificate of Currency (minimum $10 million per claim)
- WorkCover – Certificate of Currency
- other certifications and insurances as appropriate to the nature of the services (e.g. volunteer insurance)
- list of accountable, legally-assigned office bearers, including names and position titles (e.g. directors, executive officer and company secretary)
- a completed Vendor Form, including bank details
- evidence of Goods and Services Tax (GST) status and registration date
- profit/loss statements for 2017/18
- indication of readiness to sign off on proposed Head Contract (Attachment D)

Brisbane South PHN will conduct due diligence on organisation/s.

**Evaluation criteria**

| SC1 | Demonstrated ability to undertake care coordination services in a health context (preferably chronic disease), including coordination services that address the needs of vulnerable populations consistent with the implementation approach detailed above. (800 words) | 25% |
| SC2 | Demonstrated ability to support contemporary approaches to person-centred care and consumer oriented care coordination (e.g. underpinning philosophy and in evidence-based tools and resources). (600 words) | 20% |
| SC3 | Demonstrated ability to build networks and relationships within a community, including social, community and health provider and practitioner networks. Demonstrated understanding of the Logan region and its population, including vulnerable groups. (500 words) | 15% |
| SC4 | A clear workforce model that supports the design of the model and are able to demonstrate professional excellence, agility in approach, and strengths in relationship management. Evidence of an ability to retain and support the workforce to support continuity of care. (500 words) | 15% |
| SC5 | Use of innovation in design and approach to support the Care Coordination Model. (300 words) | 10% |
| SC6 | Value for money including an outline of all key budget items (including workforce) (300 words) | 15% |

**Conflict of interest**

Conflict of interest refers to situations in which personal, occupational or financial considerations may affect, or appear to affect the objectivity, judgment or ability to act in the best interests of Brisbane South PHN in relation to the outcome of this procurement.

*Examples of “conflict of interest” include but are not limited to the following:*
- existing relationships with Brisbane South PHN either as members (board or collaborative partners), related parties, intermediaries and/or service providers
- acceptance or provision of gratification from/to customers, intermediaries or potential service providers
- disclosing confidential information received in the course of the procurement activity in order to obtain personal benefit for the individual or for any other person or entity related to the procurement
- provides services or competes in some way for the services tendered by Brisbane South PHN
- financial interest in outside activities, other employment and directorships without disclosing to Brisbane South PHN
- insider trading
- negotiating on behalf of the Brisbane South PHN with parties in which there is financial interest and no formal disclosure
- acceptance of substantial gifts or entertainment (including non-monetary inducements) that may influence behaviour in a way that conflicts with the interests of Brisbane South PHN.

To manage any perceived, potential or actual conflicts, all applicants must complete the Conflict of Interest declaration on the RFP Application Form.

**Selection process**

Applications will be reviewed against the selection criteria. Conflicts of interest of panel members will be declared and managed appropriately.

Please refer to section Declaration and general conditions for applications and funded programs for further information on the PHN’s process.

**Eligibility criteria**

Organisation/s eligible to apply include, but are not limited to, the following current legislations and their subordinate legislation or regulations as may be amended from time to time:

- Associations Incorporation Act 1981 (Qld)
- Religious, Educational and Charitable Institutions Act 1861 (Qld)
- Cooperatives Act 1997 (Qld)
- Corporations Act 2001 (Cth)
- Aboriginal Councils and Associations Act 1976 (Cth)
- Community Services Act 2007 (Qld)
- Local Government Act 2009 (Qld)
- Corporations (Aboriginal and Torres Strait Islander) Act 2006 (Cth)
- Education (General Provisions) Act 2006 (Qld) (including Parent and Citizens Associations)
- private allied health practices.

Applications are welcome from a single organisation or a collaboration of organisations, however the lead organisation must satisfy the mandatory and eligibility conditions.

**Submitting your proposal**

Proposals are due before 12:00pm, Wednesday 3 April 2019

Proposals are to be submitted electronically:

tenders@bsphn.org.au

- documents need to be in PDF or Word documents format only
- strict word limits apply, please note relevant word limits as outlined in the application form
- attachments are to be no larger than 10MB in total but can be sent in separate emails. Please ensure all attachments are identified (named) adequately

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<th>Stage</th>
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<td>EOI/RFP</td>
<td>EOI released to market</td>
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Responses received | 03/04/2019
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Interviews conducted with shortlisted applicants | 8 and 9 April 2019

| Contract stage | Due diligence and contract preparation with preferred applicant | 11 to 27 April 2019
| Contract Execution | 30 April 2019
| Start of Initial Implementation Phase | 1 May 2019

**Questions**
The Brisbane South PHN website contains extensive information relating to this opportunity and can be accessed via http://bsphn.org.au/tenders/

Questions will be received in writing. If you have any questions or require further information throughout the process, please email your question (and how to best contact you) to tenders@bsphn.org.au.

A nominated project officer will contact you. Please be aware that any new information provided in addition to this RFP will be made available to all via the Brisbane South PHN website.

**Declaration and general conditions for applications and funded programs**

- The successful applicant will be offered a contract with Brisbane South PHN comprising the Brisbane South PHN’s Contract Terms and Conditions and a Program Schedule. The Contract Terms and Conditions passes on clauses to providers from our Deed of Agreement with the Australian Government Department of Health.
- The following conditions apply to the application process:
  - incomplete or ineligible applications cannot be processed or considered
  - this RFP does not create a legal or binding commitment, arrangement or understanding between Brisbane South PHN and the recipient of the Invitation to Tender. Any such commitment will be the subject of further negotiation and documentation
  - completion and submission of the Request for Proposal Application Form will not necessarily result in funding
  - this RFP may be reviewed and amended at any time
  - the applicant unconditionally agrees to bear all expenses and costs associated with preparing their application.
- Brisbane South PHN reserves the right to:
  - seek clarification and additional information in relation to applications in writing or verbally
– vary the process or any part at any time before or after receipt of an application; and/or
– accept or reject any or all applications.
– Brisbane South PHN may share the information received through the application process with any member of the assessment panel and within Brisbane South PHN.

• The following conditions apply to funded programs:
  – successful applicant (lead) organisation will be asked to sign an agreement with Brisbane South PHN outlining the specific program deliverables, timeframe, agreed budget and reporting requirements
  – Brisbane South PHN may attach special conditions to a service. Any special conditions applied to the service will be agreed with the applicant and outlined in the Program Schedule
  – successful applicant is requested to submit tax invoices in order for payment to be processed.

Brisbane South PHN reserves the right to undertake quality assurance checks on all lead organisations to ensure funding is spent in accordance with the Contract Terms and Conditions and Program Schedule.