MY CARE PARTNERS CARE COORDINATION PROCUREMENT – Request for Proposal

South Western Sydney PHN

Expression of Interest for:	**My Care Partners Care Coordination**
Issue Date:	23/04/2024
Submission Due Date:	17/05/2024
Place for lodgment:	http://www.tenderlink.com/swsphn/

Respondents are advised to register at the tenders page of SWSPHN's Tenders website http://www.tenderlink.com/swsphn/ in order to receive any further information such as amendments, addenda, and further conditions that may apply to this RFP/EOI.

The respondent's Response must be submitted electronically via http://www.tenderlink.com/swsphn/

Document Contents

Associated Attachments (Provided on Tenderlink)

Attachment 1 - SWSPHN Commissioned Services Agreement - Contract Terms and Conditions

Attachment 2 – My Care Partners Program Model of Care

Attachment 3 – Information Session Invitation

Attachment 4 – References

Attachment 5 – Risk Identification and Management Matrix Template (to be uploaded with submission)

Attachment 6 - SWSPHN Activity Work Plan Template (to be uploaded with submission)

Attachment 7 - SWSPHN Budget Template (to be uploaded with submission)

PART A – Invitation and Bid Rules

1. Invitation

Interested parties are invited to express interest to South Western Sydney Primary Health Network (SWSPHN) in accordance with the instructions outlined in this document for MY CARE PARTNERS CARE COORDINATION PROCUREMENT.

2. Background

2.1 SWSPHN Background

SWSPHN is a not-for-profit organisation that is funded by the Australian Government, Department of Health and Aged Care (DoHAC) with the key objective of increasing the efficiency and effectiveness of medical primary care services, particularly for those at risk of poor health outcomes, and improving coordination of care to ensure patients/clients receive the right care in the right place at the right time.

SWSPHN's region services seven Local Government Area's (LGAs) of Bankstown (pre-amalgamation), Camden, Campbelltown, Fairfield, Liverpool, Wingecarribee and Wollondilly (see Figure 1), with an estimated total population of 1,057,080 in 2021.

The population living in SWS is culturally, linguistically, and socioeconomically diverse and it also has the largest urban Aboriginal community in metropolitan Sydney. For further information please see, Health of Our Region: http://www.swsphn.com.au/healthofourregion.

SWSPHN would like to acknowledge the Dharawal, Gundungurra and Darug Aboriginal people as the Traditional custodians of the land within South Western Sydney and pay respects to Elders both past and present. SWSPHN acknowledges Aboriginal and/or Torres Strait Islanders as the first people of Australia.

Figure 1 – SWSPHN catchment area

2.2 Overview of Priority Area

Background – MCP and the issue of chronic disease in SWS

Patients who have complex health needs typically suffer from multiple chronic health conditions, functional limitations and unmet social needs[1]. These individuals often experience fragmented care characterised by clinicians working in isolation from each other rather than as a coordinated team. As a result, effective communication between the health 'team' can be challenging and inconsistent, which leads to concern regarding the quality and safety of patient care[2]. Furthermore, these patients often account for a disproportionate share of health care spending[1], and potentially preventable hospitalisations (PPH).

The South Western Sydney Integrated Care Collaborative (SWSICC) during its time stated a readiness to innovate and test initiatives that reduce care fragmentation for patients. South Western Sydney PHN (SWSPHN) and South Western Sydney Local Health District (SWSLHD) have built on current integrated activities to develop My Care Partners, a 'medical neighbourhood' model of care, to address PPH of at-risk patients in south western Sydney. A PPH is an admission to hospital for a condition where the hospitalisation could potentially have been prevented through the provision of appropriate individualised preventative health interventions and early disease management, usually delivered in primary care and community-based care settings[3].

A 'medical neighbourhood' represents a collective approach to the Person-Centred Medical Home (PCMH) model of care and incorporates it into the coordination of care between the medical home, primary and community health services, and acute care. Key features of the PCMH align with the '10 Building Blocks of High Performing Primary Care' with a strong focus on providing care that is person-centred, accessible, coordinated, and continuous, comprehensive, and practices quality and safety[4]. Generally, this encompasses GP-led multidisciplinary care coordination built on risk stratification, patient tracking, integrated information, and communication technology (ICT), and systematic approaches to continuous quality improvement and self-management strategies. The goals of the Medical Neighbourhood are to improve patient safety, experience, quality evidence-based care, while also reducing cost and unnecessary duplication of services[5].

Chronic disease is prevalent in South Western Sydney (SWS) and significantly contributes to the disease burden in the region. About one in two (49%)[6] of South Western Sydney residents reported having a chronic health condition such as cancer, cardiovascular disease, mental health conditions, chronic obstructive pulmonary disease, chronic kidney disease, asthma and diabetes. South Western Sydney residents are also at higher risk of chronic disease due to having on average elevated rates of behaviours that have been linked to poorer health status and chronic disease prevalence. Additionally, this chronic disease burden is projected to increase due to the expected population growth. The number of people aged 65+ in SWSLHD is expected to increase by 80% between 2016-2031[7].

Growth in the number of people aged 65 years and older will increase demand for chronic care provision in the region and burden on the healthcare system. To illustrate, recent data shows the highest diabetes prevalence in SWSLHD (between 10% and 25%) is in people aged 50-79 years[7].

The overarching goal of My Care Partners is to reduce PPH and care fragmentation for patients at risk of hospitalisation due to chronic disease through a patient-centred integrated healthcare neighbourhood in South Western Sydney.

References: Attachment 4.

2.3 Scope

Overview of Procurement

SWSPHN and SWSLHD have entered into a Joint Venture Deed (JVD) to deliver the My Care Partners Program in South Western Sydney. My Care Partners commenced as a joint collaborative initiative with SWSLHD in June 2019. Patient enrolments commenced in November 2021. South Western Sydney PHN has been delivering care enabling, capacity building and support of general practice as well as administration of contracts and payments. Care Coordination and Care Navigation services have been delivered by SWSLHD Keeping Well in Community (KWIC) team. As at March 2024, 121 patients from 23 general practices are currently enrolled in the My Care Partners program across all regions in South Western Sydney.

In order to further scale the program to more practices and patients, a change is required to the delivery of the program. This will involve the introduction of commissioning a service provider (separate to SWSPHN and SWSLHD) to deliver the care coordination, care navigation and care enabling components of the My Care Partners program.

The remaining components of capacity building and support of general practice as well as administration will continue to be delivered by SWSPHN. SWSPHN will provide dedicated staff to support My Care Partners participating general practices, iRAD interoperability software and POLAR (Population Level Analysis & Reporting Tool) software to the commissioned supplier.

SWSPHN is seeking to commission a supplier to deliver the care enabling/facilitation and clinical services (care coordination/care navigation) key components of the My Care Partners program, to patients who have complex health needs, unmet social needs and are identified as at risk of potentially preventable hospitalisations.

Service Objectives

- Deliver chronic care interventions including care coordination and care navigation services to at-risk patients accessing MCP in SWS.
- Deliver care enabling services to assist general practice in facilitating patient enrolment and activities.
- Improve provider access to accurate and reliable patient information and improve communication between members of the patient care team (GPs, nurses, allied health, specialists, ED) through relationship building and usage of digital health tools.
- Improve 'shared care' of targeted at-risk patients between general practice, primary and community health services and acute care.
- Improve patient reported experience of targeted at-risk patients.
- Improve patient activation and quality of life of targeted at-risk patients.
- Reduce potentially preventable hospitalisation, ED presentations and hospital bed days of targeted at-risk patients.
- Enhance quality of care for patients in SWS suffering from chronic disease.
- Increased uptake of team-based care and communication between members of the patient care team.

Service Outcomes

- The My Care Partners program will be led by SWSPHN in conjunction with GPs, with input from a commissioned service provider to support the delivery of patient interventions and practice engagement through care coordination, care navigation and care enabling services.

- Establish a multidisciplinary team likely to exist of experienced clinical nursing, allied health and medical administration workforce with skills in chronic disease management including the ability to address complex psychosocial and environmental needs.

- Patients have access to effective health management in the form of care coordination, care navigation and care enabling services.
- Patients have better self-management strategies in place to manage chronic diseases.
- Patients have access to supplementary services funding (SSF).
- Patients are more empowered to make positive changes to their health and advocate for themselves.
- Improved communication pathways between general practice and patient healthcare providers.
- Improved information sharing between multidisciplinary care teams, primary, secondary and tertiary health care services through usage of digital health tools and team-based care.

- Reduced care fragmentation for patients at risk of potentially preventable hospitalisation.
- Patients have reduced presentation and admission to hospital for potentially preventable reasons.
- Patients have improved health outcomes.

2.4 In Scope

The service provider will deliver care enabling services, care coordination and care navigation for My Care Partners patients enrolled in the program. The purpose of these pathways is to provide interventions that help support patients with chronic diseases in staying safe and well at home. Activities undertaken directly reflect the needs of the patient to identify and bridge gaps in care. They will help patients access additional support to address managing their chronic conditions and any unmet needs, such as linking them to community support and services, allied health and specialists who will tailor care to achieve their health goals.

Care Navigation helps patients navigate the health system, helping them identify and access health services and other organisations. The goal is to improve the patient's health and wellbeing and reduce their risk of further hospital admission.

Care Coordination helps patients to address the psychological, social and behavioural factors that can impact the progression of chronic illness, prevent the effective self-management strategies and reduce access to treatment.

Care enabling services facilitate the implementation of My Care Partners through oversight of the patient journey and liaison with the patient's care team to ensure patient needs and project deliverables are met. They work closely with general practice and care coordination services, primarily to facilitate new patient referrals into the program, track patient enrolment, monitor hospitalisations, support the practice team with completion of patient activities including case conferencing, facilitate communication between stakeholders, and identify gaps in patient care. A small proportion of patients may require care enabling support alone, through a care pathway that provides enhanced usual care.

For further information on the My Care Partners model of care, please refer to Attachment 2.

2.5 Out of scope

The following are considered out of scope for this Request for Proposal:

- Services that are not aligned to the My Care Partners Program Model of Care (Attachment 2), objectives, outcomes and scope;

- Mental health or residential aged care services, the program is not intended to take on new patients who have a mental health condition as the sole diagnosis, or live in a residential aged care facility;
- Palliative care services, the program is not intended to take on new patients who are acutely unwell, or at end of life, but may continue to support existing patients through these situations;
- Capital works, including purchasing and refurbishment of assets above $5000.00;
- Services that replicate or duplicate existing service provision(s);
- Activity that is more appropriately funded through other funding bodies;
- Activity that is not supported by clinical evidence;
- Any costs associated with research.

3. Eligible Organisations

Submissions are sought from Private, Non-Government, or Community based organisations with demonstrated capacity and capability to deliver care coordination services for the My Care Partners program, in accordance with this RFP.

Services could be existing services that have been enhanced, or new services. Organisations with demonstrated skills, experience, and expertise in coordinating care for people living with chronic and complex disease will be scored favourably, however organisations that do not currently provide these services are also encouraged to apply.

For services that are applying in partnership or consortia, one organisation will be identified as the Supplier for the purpose of the RFP, and if successful, the contract.

4. Contract Term

Funding will be provided through a formal funding agreement.
The contract term is 1 August 2024 – 21 July 2025 including the following:

- Establishment and embedding: 1 August 2024 – 30 November 2024
- Full implementation and service delivery: 1 December 2024 – 31 July 2025

Funding will be for 12 months, with the possibility of extension subject to funding.

5. Funding

The maximum contract value / available funding for 12 months is $510 000

The funding outlined above is exclusive of GST, GST is payable.

Respondents are asked to demonstrate how the funds will be allocated across the financial year and provide a detailed budget using the budget templates provided.

SWSPHN may propose an alternative allocation of these funding amounts across financial years depending on the budget and activities submitted.

Funds will be expended in accordance with the indicative cost caps in the table below.

Component	% Cost Cap
Indirect support and administration costs/operating costs including the following: - rent, utilities, telecommunications, recruitment, contract management and administration costs	10-20% ($85 000)
Direct service/salary costs	80% ($425 000)
Total	100% ($510 000)

6. Information Session

Respondents are invited to attend an information session to be held on **Wednesday 1 May, 2024, at 12:30PM** see Attachment 3: Information Session Invitation. The purpose of the meeting is to provide an overview of the RFP/EOI. Outcomes sought, the process for submission and to allow potential respondents to ask questions.

Please follow the instructions on the Information Session Invitation to register.

All questions and answers as well as PowerPoint slides, will be posted on Tenderlink within one (1) week of the meeting.

7. Contact Procedures

Any questions in relation to this RFP/EOI should be lodged, in writing, through the Tenderlink portal. Questions will be sent to SWSPHN to be addressed and the response will be posted on the portal. All

respondents will see the question and answer however, all identifying information of the organisation will be removed.

8. Submission Lodgement

Respondents must submit their RFP/EOI through the Tenderlink portal www.tenderlink.com/swsphn

Application submissions via any other means aside from the Tenderlink portal will not be considered and will be returned to the Respondent.

To use the Tenderlink Portal system, you must first be a registered provider. Visit www.tenderlink.com/swsphn then select the Registration Tab and complete the form. Once confirmed, you will be able to submit applications through the e-tender box facility. There is no charge to register with Tenderlink.

Once registered, you will be able to access a video tutorial on how to use the Tenderlink website and for Technical Assistance you can contact the Tenderlink support help desk on 1800 233 533 or email support@tenderlink.com

The Closing Time for RFP/EOI submission is Friday 17 May 2024, at 5PM.

Respondents are encouraged to begin entering information on the portal well before the submission date, to familiarise themselves with Tenderlink.

All electronic copies of files to be attached must be virus checked by the respondent before lodgement.

Once an application has been submitted via the Tenderlink portal, modifications to the application can be made up until the Closing Time.

Respondents are encouraged to lodge their proposal via Tenderlink at least two hours before the proposal closing time, and ensure they are familiar with Tenderlink well before the submission date.

9. Last Queries Date

If there are parts of the document that respondents do not understand, respondents should lodge their questions on the Tenderlink portal before the last queries date.

The Last Queries Date is Tuesday 14 May 2024, 5PM (3 business days before close).

10. Timeline

The below table provides indicative timelines for this procurement:

Activity	Date
RFP/EOI open	23 April 2024

Information session	1 May 2024, 12:30PM
Last queries date	14 May 2024, 5PM
RFP/EOI Closing date	17 May 2024, 5PM
Evaluation period	20 May – 31 May 2024
Recommendations to SWSPHN board and executive	June 2024
Successful applicant notified and contract negotiations	June-July 2024
Unsuccessful applicants notified	1 August 2024

11. Evaluation Process

Proposals will be evaluated for full compliance with any mandatory requirements identified in *Part A Invitation and Bid Rules* and Part B Specifications and Requirements.

Respondents are reminded that any requirements identified as mandatory are considered to be of fundamental importance to the satisfactory delivery of the goods and/or service, and a fully compliant response is required.

11.1 Proposal shortlist process

SWSPHN reserves the right to short-list a limited number of respondents, based on its initial assessment and continue detailed evaluation of this smaller group of respondents to the exclusion of all others.

If SWSPHN chooses to include a shortlisting stage in its evaluation process, it is not, at any time, required to notify respondents or any other person or organisation interested in submitting a proposal.

11.2 Secondary evaluation process

There are occasions when a secondary evaluation process is required. SWSPHN may request further, where appropriate, of the bid but need not make the same request of all respondents. This may occur as a part of the original plan or be necessary to differentiate between short listed submissions.

A secondary process may include, but not be limited to:

- Clarification of particular aspects of the submission.
- Additional information on some aspect of the proposal;
- Responses to additional requirements;

- Negotiations on personnel, project delivery, milestones and price; Or
- Short listed providers will be notified of the secondary process.

12. Evaluation Criteria

SWSPHN will accept one submission per grant arrangement. Respondents that wish to apply for multiple grants must submit multiple applications. Respondents will be evaluated and scored against the following general criteria.

The evaluation criteria are set out below:

1) Demonstrated extensive experience in providing evidence-based chronic disease management and care coordination services in the community (25%)
2) Detail how the service will align with the My Care Partners Model of Care, paying particular attention to the principles and schedule of care in Attachment 2 (15%)
3) Demonstrated ability to establish an experienced, multidisciplinary clinical workforce with skills in chronic disease management including the ability to address complex psychosocial and environmental needs (10%)
4) Detail how the organisation will establish and maintain effective partnerships with key stakeholders (10%)
5) Demonstrated knowledge of the needs of the My Care Partners target population in South Western Sydney (10%)
6) Comprehensive Risk Identification and Management Matrix that outlines risk management and all governance procedures (Attachment 5) (10%)
7) Comprehensive Activity Work Plan that aligns with this RFP (Attachment 6) (10%)
8) Comprehensive budget that clearly aligns with the activities presented in the Activity Work Plan that represents value for money (Attachment 7) (10%)

Unscored criteria

- $20 million public liability and
- $10 million professional indemnity
- Workers compensation
- Evidence of relevant accreditations
- Agreement with the standard terms and conditions
- References will be included as part of the evaluation process. Please provide contact information for at least two (2) referees (name, title, organisation, email, phone).

Bids will be evaluated based on value for money.

Respondents shall provide supporting information to enable these criteria to be assessed, by completing every section of the request for proposal response.

General Required Criteria contribute to 100% of the total assessment, all of the criteria must be satisfactorily addressed.

Unscored criteria need to be addressed but will not be individually scored. An applicant who does not address the unscored criteria may not be considered for evaluation.

13. Additional bid rules

SWSPHN will not be held accountable for any costs incurred in responding to the Expression of Interest, including responding to any secondary evaluation processes.

SWSPHN reserves the right to:

- Invite any person or entity to submit a bid;
- Extend the bid closing date;
- Vary the statement of requirement and/or the specifications at any time, subject to first giving each tenderer the opportunity to respond to the variations;
- Allow a tenderer to change its bid before the completion of evaluation of tenders, but only if the same opportunity is given to all tenderers;
- Exclude from consideration a bid that has not been submitted by the closing time;
- Consider or accept (at SWSPHN's sole discretion) any tender including without limitation a late tender or the tender of a tenderer who has failed to submit in accordance with these bid rules
- Abandon this invitation process at any time;
- Clarify any aspect of a bid after the closing date;
- Seek the advice of external consultants to assist in the evaluation or review of bids;
- Make enquiries of any person or entity to obtain information about the tenderer and its bid;
- Seek information from any tenderer;
- Following evaluation of bids, invite revised bids from one or more tenderers;
- Following evaluation of bids, negotiate with one or more tenderers;
- Negotiate with a tenderer for the provision of any part of the requirement, and to negotiate with any other tenderer with respect to the same or other parts of the requirement, and to enter into one or more contracts for all or any part of the requirements;

- Discontinue negotiations at any time with any tenderer; and
- Propose revised or replacement contract terms at any stage in this procurement process in substitution for, or in addition to, the terms and conditions included.

Respondents can expect that SWSPHN will:

- Preserve the confidentiality of your confidential information;
- Afford every respondent the opportunity to compete fairly;
- Subject to SWSPHN's right to terminate this process, consider a bid which is submitted in accordance with these rules by a tenderer who has:

    - Complied with expectations as to probity;
    - Provided the information required in this stage of the process as set out in this Invitation;
    - Co-operated with bid rules; and
    - Submitted its bid by the Closing Time

14. Complaints

If at any time during the tender process, a respondent considers that it has been unfairly treated, the respondent must first notify the Contact Officer in writing. If the matter is not resolved, the respondent may then contact the nominated procurement complaints officer below, and request in writing for the issue to be addressed.

Name: Amy Prince via Melissa McIntyre
Title: Director of Planning and Performance
Address: Level 2, 1 Bolger Street Campbelltown NSW 2560
Email: Melissa.McIntyre@swsphn.com.au
Phone: (02) 4632 3000

15. Feedback

Feedback may be provided to unsuccessful respondents upon request. Feedback will only be provided at the end of the process following tender award, debrief or contract execution.

PART B – Specifications and Requirements

1. Specifications

1.1 Target Population

The target population for the My Care Partners program is any person within SWS who is living with chronic or complex conditions with complex/unmet needs and is identified as at risk of frequent and potentially preventable hospitalisations.

Eligibility and Exclusion Criteria

Essential Criteria – to be eligible for referral to MCP, the patients must be	**Exclusion Criteria** – patients who meet any of the following criteria are not considered eligible for referral to the MCP Program
• Aged 16+ • At risk of hospitalisation • Living with a chronic or complex condition with complex/unmet needs • Living within South Western Sydney LHD • Available to engage for the entirety of the intervention period and committed to 12 months of engagement in My Care Partners	• Currently living in a residential aged care home • Pregnant • Actively receiving Palliative Care services • Mental Health as sole diagnosis • Current inpatient at the time of referral • Currently in the care of a correctional facility • No fixed address
Criteria for Case-by-case Consideration Patients eligible for referral into MCP, who also meet one or more of the following, are eligible for referral into the program and will be assessed on a case-by-case basis.	
• Active enrolment in other Care Coordination Services • Mental health diagnosis, where the patient also has a diagnosis of a chronic/complex condition(s) • Residing in a group home • Level 4 Home Care Package recipient • NDIS participant • DVA Gold Card recipient • Any other diagnosis that does not fit the essential inclusion / exclusion criteria.	

1.2 Key Principles

The My Care Partners Program has been designed to improve patient health outcomes and quality evidence-based care, while also reducing cost and unnecessary duplication of services.

Guiding Principles	Definition
Confidentiality and privacy	Maintain confidentiality of information accessed. Platforms are secure, and information practices address the privacy and confidentiality concerns of consumers and providers.
Evidence-informed best practice and continuous quality evaluation	Services promote reflective practice, clinical reasoning and evidence-based practice in the context of coordinating care.
Clinical governance and accountability	Appropriate governance to ensure quality standards and clinical competence, and appropriate clinical escalation pathways are in place.
Person-centred care	Care planning and delivery places the person at the centre of the process and actively involves people, their families and carers through shared decision making. Individuals are empowered to direct their care journey according to their needs and aspirations, supported by clear information about the services they need and timely access to those services.
Primary-based care	Care is coordinated through primary health care providers where appropriate to the person's needs.
Targeted	Resources which support the integration of care are targeted where they are most needed. There is equity in access to and delivery of care.
Partnering	Partnering (with the consumer, carer(s), GP, and services/supports)
Continually improved	Care operates in a flexible environment, where innovation and integration is supported. There is a focus on learning from experiences and continuous improvement
Collectively accountable	All service providers and clinicians share responsibility for the person's wellbeing when integrating care. Integrating care is multidisciplinary and interdisciplinary. Service providers, clinicians and other system participants act with trust and confidence, and there is mutual benefit.
Shared information	Robust information sharing processes are in place to support rapid communication between sectors, organisations, teams and clinicians, including a single record gathered from a shared assessment. Planning and monitoring systems are in place.

Comprehensive care	A schedule of care is developed that prioritises patient consent, is person-centred and driven in engagement and consultation with the patient eg: working to achieve goals set with them.
Technology	There is an increased use of technologies that allow more seamless and accessible care to be delivered. This may involve remote monitoring, delivery by a single provider or multidisciplinary team or case conferencing between providers.

The commissioned organisation must have resources, training, and ongoing technical support to ensure the successful implementation of My Care Partners Model of Care across the region. The commissioned organisation will be assessed by SWSPHN, which will evaluate their functioning and fidelity to the My Care Partners model. This will enable SWSPHN to identify strengths as well as areas that require improvement and drive continuous improvement in the delivery of care across the region.

1.3 Service Model Elements

The commissioned service provider will deliver the Care Coordination services of the My Care Partners program in accordance with the My Care Partners Model of Care (Attachment 2). It is expected that the service will commence establishing and embedding the service from 1 August 2024, with full implementation and service delivery by 1 December 2024.

2. Requirements

2.1 Technology

The successful respondent, must commit to the following operational requirements:

- Supplier to obtain, install and use iRAD-compatible medical software – Best Practice, or Medical Director.
- Supplier to obtain, install and use a secure messaging system – such as HealthLink.
- Supplier to use software provided by SWSPHN including iRAD and POLAR.

2.2 Partnerships and collaborations

Collaborations and partnerships are intended to enable an integrated approach to care coordination for patients who may require referral to other services. Clear protocols will be developed by the commissioned service provider, with the SWSPHN My Care Partners project team, SWSLHD community nursing team, and General Practices participating in My Care Partners, to enable information sharing and transfer of patient care as required.

Examples of partnerships required to develop strong levels of integration include:

- SWSPHN My Care Partners project team
- SWSLHD Primary & Community Health
- My Care Partners participating General Practices, inclusive of general practitioners, practice nurses and practice managers
- Local Allied Health Professionals
- Local Medical Specialists (public and private)
- Local equipment suppliers for supplementary services delivery
- Other social or clinical support services, including government services and those commissioned by SWSPHN
- Services that support diverse communities, including people who identify as LGBTIQA+, Culturally and Linguistically Diverse Communities (CALD) and Aboriginal and Torres Strait Islander people

2.3 Insurances

The successful respondent, must maintain insurances of:

- $20 million public liability;
- $10 million professional indemnity; and
- Workers compensation.

2.4 Governance Requirements

The successful respondent will develop and implement operational and clinical governance.

The commissioned organisation will ensure appropriate policies, procedures and systems are embedded, including:

- Referral pathways and handovers
- Shared care arrangements and joint case review as part of effective collaboration with patients/carers and General Practitioners
- Appropriate confidentiality and privacy arrangements in accordance with relevant legislation, whilst ensuring appropriate information sharing is in place between services involved in a care pathway to support quality care
- Support for the appropriate use of the Privacy Act 1988 and the Australian Privacy Principles
- Clear communication mechanisms

- Quality systems and quality improvement
- Complaints handling
- Risk identification and mitigation
- Incident management
- Financial management
- Reporting and evaluation
- Resources and innovation

2.5 Data and Reporting

Data collection and reporting requirements are still to be determined and will be set out in a Contract Schedule. However, the supplier will be required to collect qualitative and quantitative data to ensure outcomes are being achieved and to help inform an iterative, ongoing evaluation of service effectiveness to ensure needs are being met.

Indicators may include:

- Number of patients enrolled
- Number of service contacts provided
- Outcome measures

To collect this data, the following systems will be required:

- Secure patient information tracking system
- The commissioned organisation will maintain its own in-house electronic medical record software for clinical information

Other data administrative and reporting duties may include:

- Other reporting requirements for the purpose of service monitoring and evaluation

PART C – Response Schedule

Part C contains the questions that require a response in order for submission to be considered. Please note that strict word limits apply to the responses and responses should focus on the central points in the questions.

A template is provided for the workplan and budget. These templates should be completed with the inclusion of all the relevant financial components that are in scope for funding.

Only responses submitted via the online form in Tenderlink will be considered for evaluation. Please note, you will not be able to upload a word version of your submission.

Questions to be responded to that address the evaluation criteria:

Criteria Question 1:
Describe in detail, your organisation's experience in providing evidence-based chronic disease management and care coordination services in the community.
(1000 words)

Criteria Question 2:
Describe in detail, how the service your organisation will provide will align with the My Care Partners Model of Care, paying particular attention to the principles and schedule of care in Attachment 2.
(1000 words)

Criteria Question 3:
Provide a detailed description of how your organisation will successfully establish an experienced, multidisciplinary clinical workforce with skills in chronic disease management including the ability to address complex psychosocial and environmental needs.
(750 words)

Criteria Question 4:
Describe in detail how your organisation will establish and maintain effective partnerships with key stakeholders to deliver the Care Coordination services of the My Care Partners program.
(750 words)

Criteria Question 5:
Describe in detail, how your organisation would target your services towards the My Care Partners patient population, based on the need in South Western Sydney.
(750 words)

Criteria Question 6:

Please provide a comprehensive completed Risk Identification and Management Matrix (Attachment 5) which details potential risks to service establishment and implementation, and how these will be managed.

(Please attach)

Criteria Question 7:

Provide a completed Activity Work Plan that aligns with this RFP (Attachment 6).

(Please attach)

Criteria Question 8:

Provide a proposed itemised budget that aligns with the activities presented in the Activity Work Plan that represents value for money (Attachment 7).

(Please attach)

Unscored criteria

- Certificate of currency to the value of $20 million for public liability and $10 million for professional. indemnity in a single occurrence
- Workers compensation certificate
- Evidence of relevant accreditations
- Contact information for at least two (2) referees (name, title, organisation, email, phone).

Respondents will also be required to indicate their agreement with the standard terms and conditions, citing any departures.