Gippsland PHN

COMMISSIONED SERVICES

PROGRAM GUIDELINES

Table of Variations

Ref	Variation Type	Variation

Contents

1. Purpose of the Operational Guidelines

The purpose of the Operational Guidelines is to provide operational advice, expectations and guidance and should be read with reference to the Service Order for the delivery of the Gippsland PHN commissioned service and the individual Program Guidelines as applicable.

2. Overview of Gippsland PHN

Gippsland PHN is a not for profit organisation that works at a regional level to achieve improved whole of system health care. We work with general practice, allied health, hospitals and other primary and community health providers; to drive, support and strengthen primary health in Gippsland to meet the needs of local communities.

Gippsland PHN is consumer focused and established to reduce fragmentation of care by integrating and coordinating health services and supporting general practice. Our primary support is GPs/local doctors, allied health professionals and other community services to provide coordinated, efficient and effective medical services to patients, particularly for those at risk of poor health outcomes.

Gippsland PHN works at a regional and local level to achieve better whole of system care. We drive, support and strengthen primary healthcare in Gippsland. We leverage and administer health program funding from a variety of sources to commission flexible services to realise our vision of a measurably healthier Gippsland.

3. Commissioning role

Gippsland PHN is a commissioning, not service delivery, organisation. This means, that to successfully secure outcomes, priority setting is based on needs assessments and planning and a market that can understand, interpret, respond and deliver effectively.

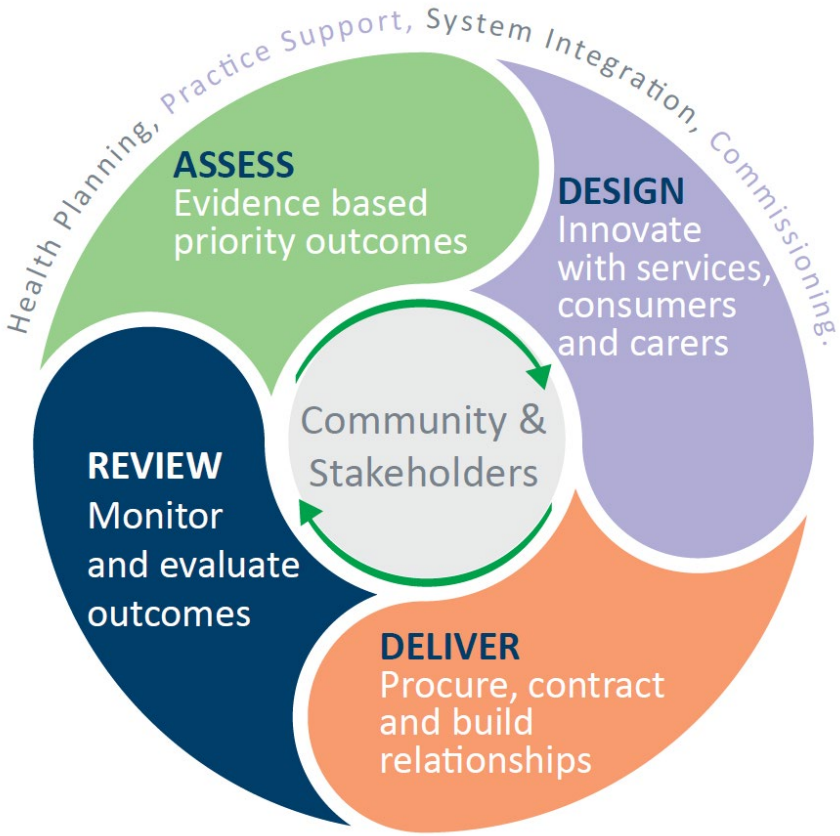
Gippsland PHN has developed a Commissioning Model based on models developed by the Commissioning of Public Services, 2013 model from The Scottish Government and the Commonwealth Department of Health PHN Needs Assessment Guide. The model is structured across four themes that ensure an approach of continuous quality improvement.

1.1 Commissioning

Gippsland PHN defines commissioning as a continuous and collaborative process of strategic planning that involves needs assessment, service design, procurement, monitoring and evaluation.

1.2 Commissioning Cycle

The Commissioning Cycle has four iterative segments which revolve around collaboration with the Gippsland community and stakeholders. The Commissioning Cycle is supported by Gippsland PHN's strategic functions of Health Planning, Practice Support, System Integration and Commissioning.



As a commissioner, Gippsland PHN, has a role to play in supporting the development of markets so that they are sustainable, and provide scalable solutions that leverage local workforces. Gippsland PHN need to ensure that in partnership with stakeholders and providers, it can appropriately support local primary health care needs.

Historically, planning and delivery of services has traditionally focused on an output/throughput approach (volume of activity). This has not translated in health improvement nor has it stimulated innovation. Instead it has often closed opportunities and isolated services and providers.

Commissioning promotes an outcomes approach that promotes improved health, positive impact where it matters and allows the person to be the centre of care. An outcome and values approach to primary care in Gippsland is best achieved via implementing an internationally recognised evidence-based model.

Commissioning activity at Gippsland PHN is underpinned by the Quadruple Aim framework, designed to help health services improve patient outcomes and the quality of care provided. It enables team-based

integrated care, encompassing health care outcomes, patient satisfaction, provider work/life experience, and the cost of care.[1]

The subsequent benefits of high-quality care will ensure that the quadruple aim is met, through implementing the following features:

- **Patient centred care** ensuring an ongoing relationship between the patient and their provider.
- **Continuous and coordinated care** providing a centralised point of coordination and integration targeting patients who will most benefit and ensuring high levels of patient satisfaction and experience, lowering rates of hospitalisation and mortality.
- **Comprehensive or team-based care** being accountable for the requirements of the patient, their carer's and other significant partners.
- **Quality care** encompassing participation by the entire practice team focusing on leadership, safety, clinical governance and quality improvement.
- **Accessible care** incorporating alternative type of clinical encounters for patients who are unable to attend the practice and that the care provided is culturally safe, sensitive and responsive.

[1] Christian, E., Krall, V., Hulkower, S., & Stigleman, S. (2018). Primary care behavioral health integration: Promoting the Quadruple Aim. NC Medical Journal, 79(4), 250-255.

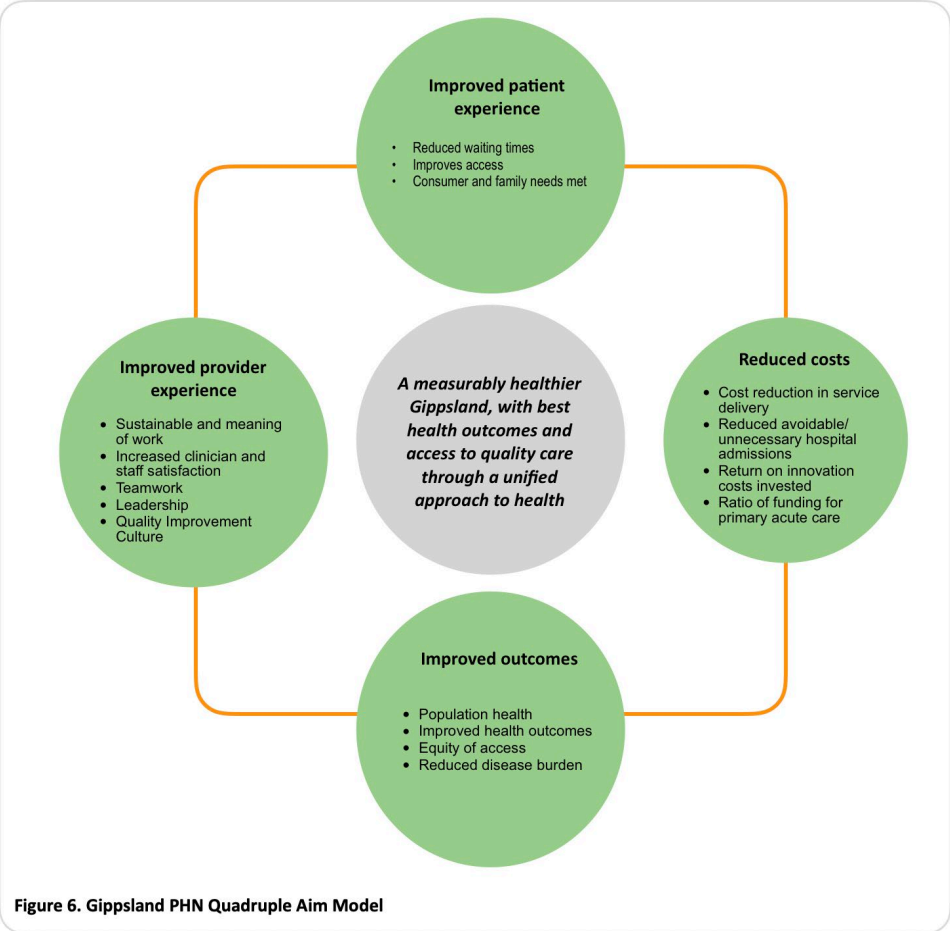


Figure 6. Gippsland PHN Quadruple Aim Model

Gippsland PHN is committed to the Quadruple Aim guiding future work to achieve a contemporary, quality health system that is outcomes-focused and values-based. In doing so, we want to be considered a trusted and credible source of information, a vehicle for collaboration, and strong advocate, essential to local decision making and capability building.

3.1 Priority area of focus

Health Services have some flexibility in the targeting population groups, however service must be based on local needs, with consideration to gaps in service availability and funding limitations. Health Services may choose to develop stricter eligibility criteria for their service, provided this is developed with appropriate clinical input, and remains within the scope and intent of the commissioned service Program.

Health Services will provide services aligned to Gippsland PHN Priorities:

Gippsland PHN Priorities 2022-25
Aboriginal and Torres Strait Islander health and wellbeing
People 65 years and over
Children and young people (0-25 years)
People with a disability
Alcohol and other drugs
Cancer
Mental health and wellbeing, including suicide prevention
Chronic disease
Dementia
Reproductive and sexual health
Health workforce
Digital health
Access to care that meets people's needs
Family violence
Factors affecting health (social determinants; housing, income, social connections)
Healthy and safe environment (climate change, pandemics, natural disasters)

Further information regarding Gippsland PHN's identified priorities, the role of PHN's in Australia's healthcare system and population health resources is available at: https://gphn.org.au/

2. Stepped Care Model Guidelines

In 2014 the National Mental Health Commission undertook a review of Commonwealth programmes and services across the government, non-government and private sectors. The review was released in June 2015 and highlighted the existing complexity, inefficiency and fragmentation of the mental health system.[2] It recommended three components to improve the longer-term sustainability of the mental health system. These include:

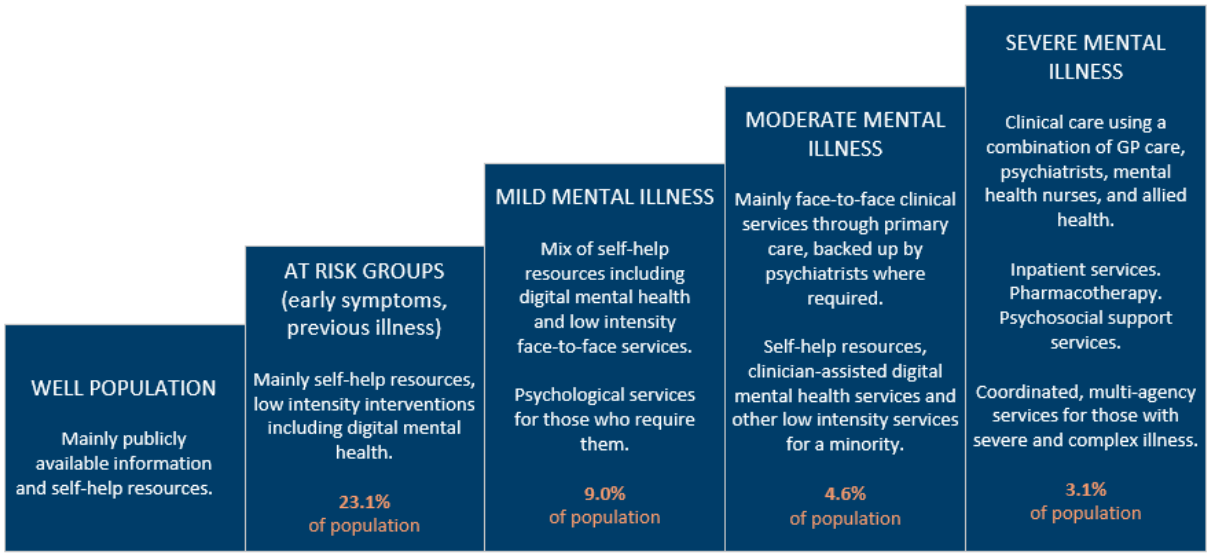
- Person-centred design principles.
- A new system architecture.

[2] National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services Summary. Sydney: NMHC, p.6-7

- Shifting funding to more efficient and effective upstream services and supports.

To achieve system reform, the National Mental Health Commission's Review outlined 25 recommendations across nine interconnected areas of reform. One of these reforms was **'Refocusing primary mental healthcare programs and services to support a stepped care model.'** Primary Health Networks have been tasked with implementing this reform in parallel with the commissioning of locally relevant mental health services. In addition, each PHN is required to undertake the development of a comprehensive Regional Mental Health and Suicide Prevention Plan in collaboration with service providers underpinned by the stepped care approach.

"Stepped care is an evidenced-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional step, but rather offer a spectrum of service interventions."[3] The aim is to start at the lowest intensive level that meets their needs, but people can move up and down the levels as required.



According to the Commonwealth Department of Health, there are four key elements to a stepped care approach to mental health. These include:

1. Stratification of the population into different needs groups.
2. Setting interventions for each group.
3. Defining a comprehensive menu of evidence-based services required to respond to spectrum of need.

[3] Australian Government Department of Health. *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance.* 2015. P.2

4. Matching service types to treatment targets and deliver services accordingly.

4. Funding guidelines

A Service Order (Contract) between Gippsland PHN and the eligible Health Service will define the terms and conditions to be performed by both parties to the agreement and define the specifications of the Program to be delivered by the Health Service.

4.1 Service planning and population and health profile

The Program has a focus on increasing access to a broad range of primary and allied health services and activities. When planning and developing for primary and allied health programs, Health Services are to consider models that are responsive to the health needs of their community, that utilise available and skilled workforce and align to the aim and objectives of the Program. It is expected that Health Services will adopt broad processes when planning and delivering primary and allied health service such as:

- Engaging with Gippsland PHN Health Planning Program to access and/or assist in the interpretation of health and population data and other statistical information to assist to identify community needs
- Identifying and engaging with local stakeholders and community members to plan and implement services to improve access to primary health care for the community.
- Consult and liaise with other local health and other community services to assist in integrating services, including identifying complementary services whilst avoiding duplication.

Refer to https://gphn.org.au/ for assistance.

4.2 Workforce arrangements

Health Services may have employment models that vary from full-time salaried engagement of the Program, which may lead to sharing of staff/contractor time across multiple programs. Where this occurs, organisations must ensure that time/services are properly attributed to each program. Organisations must also clearly delineate between Program funds (and their use) and funds received from other sources.

Program funding should not be used to create a situation where existing primary health care is 'crowded out' or made less profitable.

Measures should be taken to ensure that if professionals are recruited from an existing local service, this service is not left under resourced because the position cannot be backfilled.

Program funding should not be used to pay for services funded under other programs such as the Victorian State Government funding, the Better Access to Psychiatrists, Psychologists and General Practitioners, Psychological Therapies to Underserviced Groups.

4.3 Service delivery model

When planning for the Program, Health Services can consider a range of flexible service delivery models to support greater access to health services within communities including:

- **Cluster:** service provision provided to multiple communities from a variety of service providers located in different communities with the cluster;

- **Hub and spoke:** service provision provided both in the central town and by the service provider travelling to outlying communities;
- **Outreach:** service provision provided to outlying communities by service providers travelling to those communities from a larger town;
- **Region:** service provision to a region which could include several communities who travel to the central point for service provision;
- **Town:** service provision to a single town only; and
- **Telehealth:** service provision using technology that focuses on connecting the client and health professional for the delivery of clinical care.

Services delivered under the Program is defined as:

- **Direct** – A direct face to face, telephone or video consultation. The contact has clinical significance in that it monitors or updates a person's care, risk profile or plan. It includes time related to preparation and closure of the consultation. The contact can be defined as a 1:1 session with an individual person or as a group session with more than two people.
- **Indirect** – A consultation with other health professionals or community service providers to discuss and/or review plans of care, and liaison with carers and/or family members. The contact should be of a clinical nature and include relevant preparation and closure time.

Note: Time taken by a clinician to travel to an outreach location is not considered a component of service delivery hours.

For an individual or group session, service delivery includes:

1. Face to face time with the patient;
2. Telephone calls with or on behalf of the patient;
3. Completing clinical notes or other communication notes relating to the patient;
4. Any discussion required with other health clinicians or care service relating to the patient;
5. Time required for follow up care and/or coordination of services for the patient.

The service target will be 1,307 hours per annum per EFT or part thereof. Service delivery hours are based on providing 43 weeks of service per annum which equates to 1,307 hours of service calculated as follows:

Weeks of service	Days of service	Hours of Service
43	215	1,634
Allow 80% for service delivery	172	1,307

4.4 Intake, referral and feedback pathways

The Program has a focus on increasing access to a broad range of primary and allied health services and activities. Referrals to the Program will increase opportunities for collaborative work by multidisciplinary teams, the use of care planning and case conferencing and will promote better continuity of care.

Access to primary and allied health services will be by referral from a General Practitioner, Registered Nurse or other allied health professional or through self-referrals or from family and carers.

All referrals will be subject to an intake process where an assessment is undertaken prior to acceptance or onward referral to the appropriate service.

Continuity of care will be achieved through written or electronic communication between an individual's allied health practitioner or primary care nurse and their General Practitioner should occur and in accordance to national privacy principles.

Consumer access to services should not be impeded by the absence of a referral from a General Practitioner. Health Services will be required to facilitate early access to the client's usual General Practitioner and provide appropriate feedback and request for referral to the ensure continuity of mental and primary health care and service provision.

Health Services are required to maintain improved pathways and intake, triage and demand management processes within available resources so that referrals are accepted throughout the contracted period. They must ensure feedback to General Practitioner or other referrer during and at the completion of the client's service, or more frequently for long term clients. While repeated referrals may not be required where possible/appropriate Health Services will provide a feedback report to the General Practitioner or referrer midway through the client's initial episode of care including forecasting total number of therapeutic sessions required and outlining client's key health and social issues.

Service integration is a requirement of the service. Health Services will be required to provide evidence of health system development as outlined in the Service Order. Evidence of collaboration and integration with other health providers including general practitioners. Evidence of a report sent to the patient's own primary care provider, general practitioner or other referrer.

Community sector engagement is another requirement of the service. Health Services will be required to provide evidence of community understanding of appropriate access to the service(s) and evidence of engagement and partnership with health and human services sector including Aboriginal Services and other vulnerable groups. Health services are required to put the necessary protocols and procedures in place to ensure services are delivered in a culturally appropriate manner.

4.5 Fees and charges

Health services funded under the Program should be provided free of charge to consumers.

Special circumstances may require that fees are charged for consumables and services e.g. if a Program funded allied health or nursing service is provided in a setting where a nominal fee was charged under a former program. Services wishing to seek a nominal fee from patients accessing the service must first obtain written approval from Gippsland PHN. The approval request should address how the following principles will be maintained:

- The expectation that an inability to pay fees will not result in an inability to access the Program service e.g. additional concessions may need to be provided for pensioners and Health Care Card holders.
- People with high frequency health care needs are not charged more than a specified maximum amount in a given period.
- Revenue from fees will be used to enhance/expand the level of Program service provision and will not result in an individual or agency receiving a financial gain i.e. cost recovery basis.

4.6 Clinical governance

Sound clinical governance structures are an essential component of the Program and ensures accountability and transparency across all disciplines of health care, supporting staff to ensure patients and the community receive high standards of quality care and service provision, and quality improvements are continuously reviewed, monitored and implemented.

Good clinical governance ensures that the community and the health service organisation can be confident that systems are in place to deliver safe and high-quality care and continuously improve services.

The Gippsland PHN Clinical Governance Framework[4] and associated policies and procedures are the system of safeguards that govern clinical practice within programs commissioned by Gippsland PHN.

Health Services, funded through the Program, are required to provide evidence of adequate Clinical Governance inclusive of the five domains of clinical governance as outlined in the Gippsland PHN Clinical Governance Framework which are:

1. Leadership and culture.
2. Consumer directed care and partnership.
3. Clinical risk management.
4. Clinical effectiveness and appropriateness.
5. Effective workforce and staff education.

Within the five domains, key systems and practices are required to support safe, effective, person-centred care for every consumer.

The domains are interrelated and integrated into the organisations broader governance arrangements (for example clinical risk management is a component of broader risk management, leadership and culture is a component of the organisations purpose and culture governance framework).

The following principles will guide effective clinical governance systems and are adopted from the Victorian Clinical Governance Framework (Safer Care Victoria)[5].

- **Excellent consumer experience**
    - Commitment to providing a positive consumer experience

[4] https://gphn.org.au/wp-content/uploads/files/pdf/Clinical-Governance-Framework-1.pdf

[5] Delivering high-quality healthcare, Victorian clinical governance framework, Safer Care Victoria, DHHS, June 2017

- **Clear accountability and ownership**
    - Accountability and ownership displayed by all staff
    - Compliance with legislative and appropriate departmental policy requirements
- **Partnering with consumers**
    - Consumer engagement and input is actively sought and facilitated
- **Effective planning and resource allocation**
    - Staff have access to regular training and educational resources to maintain skill set
- **Strong clinical engagement and leadership**
    - Ownership of care processes and outcomes is promoted and practised by all staff
    - Health service staff actively participate and contribute their expertise and experience
- **Empowered staff and consumers**
    - Organisational culture and systems are designed to facilitate the pursuit of safe care by all staff
    - Care delivery is centred on consumers
- **Proactively collecting and sharing critical information**
    - The status quo is challenged, and additional information is sought when clarity is required
    - Robust data is effectively understood and informs decision making and improvement strategies
- **Openness, transparency and accuracy**
    - Health service reporting, reviews and decision making are underpinned by transparency and accuracy
- **Continuous improvement of care**
    - Rigorous measurement of performance and progress is benchmarked and used to manage risk and drive improvement in the quality of care

4.7 Risk management

Health Services, funded through the Program, will be required to demonstrate robust and effective implementation of risk management as a crucial component of the organisation's operating practice. The effective management of risk is vital to the continued development and success of the Program.

When undertaking risk assessment for the Program, Health Services will use the best available information, data and research and will engage and consult to identify issues and seek feedback to inform the risk assessment process. The risk assessment process will involve three steps, risk identification, risk analysis and risk evaluation.

- Risk assessment is traditionally structured and assessed for likelihood and consequence on a rating of low to high.

- Risk identification is the process of identifying key risks and involves analysing the sources of risks, potential hazards, possible causes and the potential exposure.
- Risk assessment involves consideration of the source of the risk, determining the consequence of the outcome of the risk, and the likelihood that those consequences may occur, and then understanding the controls that are currently in place and how effective they are.
- An evaluation of each risk is undertaken to determine those risks that are acceptable and those that require further treatment.

A Risk Assessment will be provided to Gippsland PHN prior to services commencing and will consider risks related but not limited to access, workforce, funding, service delivery, infrastructure and resources.

5. Financial guidelines

Strong financial management is essential under the Program, with specific financial management responsibilities set out in the Service Order. Funding under the Program is as follows:

5.1 Unit Price

Gippsland PHN has developed unit pricing to determine the value to deliver one hour of service. Unit pricing is based on the number of hours available to deliver the service and the total cost to employ a suitably qualified professional to deliver the service. Refer to the Unit Price Model Guidelines for assistance.

Unit pricing for an hour of service includes:

- Annual salary
- Salary on-costs
- Organisation support

If the unit price does not cover all costs, additional funding may be provided where costs are demonstrated by the provider and approved by Gippsland PHN.

Examples of additional costs include:

1. Over the award payments or a higher hourly rate to attract contracted staff;
2. Overnight accommodation for providing the service in a location other than the central site (e.g. an outreach service);
3. Travel expenses/time to and from the central site for **contracted** staff;
4. Flight costs for service providers to travel to the central site of service;
5. Additional or extraordinary travel or vehicle expenses additional to vehicle cost covered in Organisation Support to visit the site of service or patients or to provide a travel service.

The funding will be in addition to the unit price and will be included in the Service Order.

6. Milestone Payment Thresholds

A standardised approach to milestone payment amounts will apply to all service providers to align with Key Performance Indicators (KPI's) within the Schedule to the Service Order. Payment amounts will be contingent upon the service providers ability to meet KPI's and deliverables (if any) as outlined within the Schedule to the Service Order.

7. Reporting guidelines

Health Services funded through the Program are required to submit reports periodically to Gippsland PHN as specified in the Schedule to the Service Order to:

- Support effective contract performance and management.
- Enable Gippsland PHN to evaluate the system transformation achieved by the implementation of the Program and to inform future commissioning decisions.
- Fulfil Gippsland PHN's reporting requirements to funding bodies.
- Inform any independent review, evaluation or audit process initiated by Gippsland PHN's funding bodies.

Gippsland PHN will request quantitative and qualitative data and other evidential information to measure the performance and effectiveness of service outlined in the approved Work Plan provided by the Health Service.

Key Performance Indicators (KPIs) are set in the Schedule to the Service Order as a contractual agreement between Gippsland PHN and the Health Service. KPI's are focussed on achieving outcomes-based commissioning and the Quadruple Aim.

All reports must be provided on reporting templates supplied, or as approved, by Gippsland PHN and submitted electronically by the dates outlined in the Schedule to the Service Order.

7.1 Work Plan

Health Services, funded through the Program, are required to provide a Work Plan to Gippsland PHN. The Work Plan will be based on the details of services to be delivered outlined in the Service Order. The components of the Work Plan may include comprehensive details and evidence of:

- The community's population and health profile including information supporting priority population groups.
- Service planning methodology and stakeholder engagement
- Workforce utilisation and employment models and evidence of their competencies and regulatory compliances.
- Service delivery profiles and referral pathways that support greater community access to services.
- Sound clinical governance and risk management processes and practices.
- Sound financial management practices including a budget outlining staff salary pertaining to service delivery costs and business and operational costs supporting the service.

The Program Work Plan will require the approval of Gippsland PHN. In assessing the Work Plan, Gippsland PHN will consider:

- How well the Work Plan meets the aim and objectives of the Program.
- The adequacy of coverage and sustainability of the service delivery model to ensure services are maintained in existing communities.
- Whether the Work Plan meets the requirements of the Service Order and the Program Guidelines.
- Whether the proposed plan complies with Gippsland PHN's Clinical Governance Framework.
- Whether the budget items are reasonable to the staffing profile and operational and business costs and are cost-effective and in line with the Program Guidelines.

Gippsland PHN may request a Health Service to update the Work Plan to capture changes in service delivery or funding at any time during the contract period.

7.2 Quantitative data

Health Services are required to submit quantitative data, under the compliant Minimum Data Set (MDS) file, to Gippsland PHN. Health Services agree to ensure that any data is collected, used and stored as required by the Privacy Act 1988.

Quantitative data is to be submitted to Gippsland PHN as specified in the Schedule to the Service Order.

7.3 Qualitative reports

Gippsland PHN seeks information pertaining to progress against activities articulated in the Work Plan or at quarterly Project Management Meetings and other reporting processes seeking evidence of adequate clinical governance practices inclusive of the five domains of the Gippsland PHN Clinical Governance Framework.

Health Services will also be assessed to ensure a range of services are available to meet the needs of individuals and population groups, and that the best use of available workforce and technology has been achieved. Periodical reports to Gippsland PHN will seek evidence of health system development including but not limited to:

- Localised planning and development with relevant stakeholders promoting system redesign, co-design and service integration working towards a stepped care model.
- Evidence of patient reported outcomes and experience measures, including quality improvement activities relevant to survey results.
- Regular updating of the National Health Services Directory.
- Utilisation of digital health platforms and systems used by the Supplier or provided by Gippsland PHN.
- Utilisation of My Health Record.
- Utilisation and contribution to the development of HealthPathways.
- Contribution to population health planning, i.e. Gippsland PHN Needs Assessment.

7.4 Financial reports

Health Services are required to provide **Program specific** financial reports (using accrual accounting) as specified in the Schedule to the Service Order. Where a Health Service is funded for multiple programs, funds must be separately reported to Gippsland PHN in the financial statements and reports submitted by the funded organisation as specified in the Schedule to the Service Order.