

PROJECT PARTICIPATION OPPORTUNITY



Updated as of 7/18/19

This Frequently Asked Questions resource answers partner questions about the OneCity Health 30-Day Transitions of Care Program PPO. If a partner has additional questions about the PPO or Phase IV contracting that are not addressed in this document, they can contact the OneCity Health Support Desk at ochsupportdesk@nychhc.org.

30-Day Transitions of Care Funding

Q: Does OneCity Health have a maximum amount of funding and a maximum number of proposals they will fund?

A: There is no maximum amount of funding for this program. As part of the application process, organizations should develop a budget that covers all costs associated to deliver this service. Funding will be based on the proposal scope and information that partners provide in their applications, and will be determined in the negotiation process between the partner and OneCity Health.

Q: Is OneCity Health looking to impact only adult metrics or also considering pediatrics?

A: The 30-Day Transitions of Care program is focused exclusively on adult patients 18 years and older, who are being discharged from inpatient medical /surgical unit.

Q: What is the expected program completion/graduation rate? Is funding based on FTE/costs or metrics (completed program)?

A: OneCity Health will work with partners to determine reasonable targets for this program. Compensation is based on the partner's proposed budget inclusive of all costs required to deliver a successful intervention model. Partners have an opportunity to receive additional incentives by meeting targets related to specified quality metrics.

Q: What is the distinction between this program and the previous OneCity Health Care Transitions program?

A: The OneCity Health Care Transitions program has been ongoing at selected sites. The 30-Day Transitions of Care (TOC) program, under Phase IV contracting, has been redesigned to incorporate important lessons learned from the first iteration. OneCity Health will work with partners to transition their current patients into the new 30-Day Transitions of Care program.

Q: Are patients who are in long term care programs but who need intensive care transitions support eligible for this program?

A: Patients enrolled in this TOC program cannot be simultaneously enrolled in long term transitional care programs.

Q: Are all patients (i.e. those covered by Medicaid, Medicare, commercial insurance, as well as uninsured) eligible for TOC services at this time?

A: Partners can serve all patients who meet qualifying enrollment criteria to receive transitions of care services, regardless of insurance status and payer type.

Q: The PPO states that the team should maintain a caseload of 50 patients at all points during the contract period. Is there any ramp up period or is the team expected to have a caseload of 50 patients from day 1?

A: Our expectation is that within 30 days of implementation each team will carry a cohort of 50 patients.

Q: Is there any cost associated with use of GSI for this program?

A: There will be no charge associated with GSI for the partner. OneCity Health will provide both the technology and support for use of GSI as part of the TOC program.

Q: What will be the process for teams to register for GSI and receive training?

A: OneCity Health will provide a contact who will ensure that GSI registration and training occurs in a timely fashion.

Q: Does associated program delivery costs include IT support?

A: IT support is provided via GSI and there is no cost to the partner. Other IT costs should be included in the proposed budgets to be covered by OneCity Health.

Q: Regarding the required skill set, will OneCity Health continue to offer relevant trainings (i.e. care management, ethics training, and motivational interviewing) or should the applicant offer/pay for those trainings themselves?

A: Individuals who provide TOC services are expected to meet all of the training needs of their contracted employees. With the exception of GSI trainings (which OneCity Health will provide), any and all trainings required to ensure staff are operating effectively and within their scope of practice, should be provided by the partner organization to whom they report. The OneCity Health Learning Management System (LMS) has extensive on demand trainings, including all of the topics listed above, available free of charge to our PPS partners.

Q: What is the payment structure for the project? Are there start-up funds? Will payments after that be made quarterly?

A: Payments will be based on Partners' proposed program budget for a 12-month contract term, inclusive of personnel and associated program delivery costs. There will be no advance payment. Frequency of payment will be determined as part of contract negotiation.

Partners will have an opportunity to receive additional incentives by meeting targets related to the following key quality metrics:

- Demonstrate that a certain percentage of patients enrolled in the program have a least one care plan update completed during each week of enrollment
- Schedule a Primary Care Provider appointment for a certain percentage of patients enrolled in the program within seven days of discharge
- Conduct a minimum telephone and/or in-person patient encounters for a certain percentage of enrolled patients
- Achieve a certain program completion/graduation rate for patients who were enrolled into the program

Targets will be set in collaboration with selected partners.

Conversely, failure to meet minimum quality and productivity targets may result in financial penalties.

30-Day Transitions of Care Team Structure

Q: Is there flexibility in the 50 patient caseload if we can show evidence that we can make a significant impact with a high utilizer population that is medically complex?

A: Successful evidence-based models show that the ideal case load per team is 50 patients. However, OneCity Health welcomes all detailed proposals of how implementation and case management is proposed to occur. Applicants should demonstrate in their proposals how selected patients will benefit from more intensive care from the same team composition. Please be sure to specify the roles and responsibilities of the team members so that the use of resources are made clear.

Q: Are there any responsibilities which the RN MUST provide independently, or are services provided under the supervision of an RN acceptable?

A: In this evidence based model, the RN is the team member ultimately responsible for ensuring that the care management plan is being followed. The RN is also responsible for managing the individuals who compose the TOC team and ensuring that all members of the team are working within the appropriate scope and providing the high level of quality care that their role requires.

Q: Does the RN on the team have to be a BSN or are Associate's level RN's acceptable?

A: The RN can be a registered nurse of either level (associates, bachelors, masters, etc.), but cannot be an LPN.

Q: Are home visits required for every patient or can telephone encounters be utilized for appropriate patients?

A: The intent of the TOC program is to be actively and aggressively engaged with patient in the 30 day post discharge period. This evidence based model requires a personalized care plan that includes a minimum of one home visit, telephone encounters and other tailored support as required by the individual patient and care plan.

Q: Does the social worker have to be licensed?

A: The social worker on the TOC team does not have to be licensed.

30-Day Transitions of Care Metrics and Workflow

Q: Does the PCP appointment need to occur within 7 days of discharge or just be scheduled within that time frame?

A: The PCP visit must be scheduled within 7 days of discharge.

Q: Is the case load of 50 patients at any point in time?

A: Ideally each team will carry 50 patients at any point in time.

Q: Given our past experience with care transitions, we have often seen many patients that are jointly enrolled in Health Home (or HARP) at the same time as being in the Care Transitions program. Are you now saying they should not be in more than one?

A: Patients who are enrolled in TOC should not simultaneously be enrolled in a health home or related programs. At the completion of the 30-day TOC period, it may be appropriate to refer patients to these services at that time.

Q: I am understanding that if the patient is enrolled in long term care programs (Health Homes, FIDA, MAP, HARP, etc.) that we are unable to work with them for 30 days transitional care?

A: The intent of this program is to ensure a warm handoff to TOC for those patients who are otherwise not currently supported by a program which addresses their transitional care needs at time of discharge.

Q: Does each hospital facility require additional onboarding in order to work on site?

A: OneCity Health, in partnership with referring inpatient facilities will work with partners to ensure that facility access is provided as required by the TOC program.

Q: What is the anticipated start date of this project?

A: OneCity Health anticipates the 30-Day Transitions of Care services will launch in September 2019.

30-Day Transitions of Care Referrals

Q: Is the expectation that all clients are also enrolled in a Health Home for Care Coordination? If so, is Care Coordination billable during enrollment in the 30-day Transitions of Care program?

A: TOC patients should not simultaneously be enrolled in a health home. Referrals for patients who are deemed appropriate for the TOC program will be made by the referring facility who will also be aware of other transitional services patients may be receiving.

Q: Is the expectation that a Partner covers all NYC boroughs or only specific ones?

A: Applicants are encouraged to include specific borough or facility preferences in their proposals, along with the number of referrals they can accommodate. During the contracting process partners will be matched to referring facilities. No one partner is required to service all boroughs; a minimum of one site must be serviced by a partner.

Q: Who will identify the clients/patients for referral to this program? Who will decide whether to accept the referral? Is there eligibility requirement of which should be aware while writing the proposal?

A: Care teams at the referring facilities will be responsible for identifying patients who will benefit from TOC prior to the patients' discharge. Pending consent from the patient, it is expected that the partner will accept all referrals. In your response to the PPO, please demonstrate your familiarity with high-risk patients who are likely to be referred from medical/surgical units.

Q: Will there be patient consent to participate during discharge from the hospital?

A: The referring facility will determine if a patient is appropriate for referral to TOC and obtain patient consent if the patient indicates their interest in the program. The partner will engage the patient in a formal enrollment that includes an additional consenting process.

Q: Are we responsible for developing the relationship with an acute care facility in which to imbed, or will OneCity Health facilitate this process?

A: OneCity Health will work with both the referring facilities and the selected partners to establish and support a working relationship for the warm handoff and completion of the referral.

Q: Can we as applicants suggest the facility we can have the most impact with and with whom we already have a relationship?

A: Yes, OneCity Health welcomes all partner suggestions as part of their PPO applications.