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# THE 30 DAY TRANSITIONS OF CARE (TOC) PROJECT PARTICIPATION OPPORTUNITY APPLICATION

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## Background & Project Participation Opportunity

OneCity Health is issuing this Project Participation Opportunity (PPO) to select Partner(s) to provide 30-day care transition support for patients at high-risk of readmission post-discharge from inpatient care. “Care Transitions” can be broadly defined as the transfer and longitudinal support of a patient from one setting of care or one set of providers to another during the course of an episode of care. This is an interdisciplinary, proactive care model addressing needs of patients at highest risk for poor outcomes post-discharge.

A leading cause of avoidable readmissions is noncompliance with discharge regimens. Noncompliance is a result of many factors including health literacy gaps, language issues and lack of engagement with the community health care system. This intervention targets patients prior to the time of discharge from inpatient units who have been flagged as “high risk” based on clinical criteria and a history of past potentially avoidable admissions and/or avoidable ED use. The high-risk flag integrates evidence-based clinical and social determinants of health (SDOH) factors known to contribute to avoidable readmissions and poor outcomes, including poorly controlled chronic conditions, behavioral health comorbidities and unmet social needs (such as food insecurity and housing instability).

To address these challenges in 2017, the OneCity Health Performing Provider System (PPS) implemented the 30-Day Care Transitions Program. Preliminary analyses of patients enrolled in Care Transitions model programs have shown promising reductions in admissions and cost across all care settings. Building on the program’s success, OneCity Health is seeking to refine, implement and provide infrastructure supports to improve and sustain the intervention.

# Program Goals and Requirements

The program's goals are to reduce avoidable ED and IP visits and admissions, and improve patient care and well-being by connecting patients to primary care and needed social services. Key components of the intervention include responsibilities that occur prior to discharge by the referring hospital and responsibilities that Partners<sup>1</sup> will complete post discharge.

## ROLES AND RESPONSIBILITIES

### Referring Hospital

The referring hospital will be responsible for the following:

Task	Description
Patient Identification	Identify patients at high-risk of readmission.  (Patients are identified from a defined algorithm for high-risk which is flagged in the electronic medical record.)
Patient Consent	Obtain necessary consent from patients who agree to participate in the Transitions of Care program
Patient Referral	Refer patients to the Partner with a discharge plan during a warm hand-off in the care setting. A primary care physician (PCP) will be assigned at time of discharge.

### Transitions of Care Partner

The Partner will designate a care team comprised of a community health liaison (CHL), registered nurse (RN)<sup>2</sup>, social worker (SW) and a peer if appropriate. A partner may propose a combination of team members with assigned roles and responsibilities. Preferably the care team will be comprised of all team members; however, only the RN role is mandatory. Team members will be co-located at the site of the referring hospital as well as in the community. The selected partner will work closely with OneCity Health to design and implement operational details of this intervention, including following the discharge plan received by the referring hospital, engaging and monitoring the patient, and documenting all notes within GSI. The RN will supervise the CHL and other members of the TOC team and provide communication to the referring hospital. At a minimum, the Partner will be required to maintain a case load of 50 patients per team.

<sup>1</sup> For the purposes of this PPO the term "Partner" is defined as an entity providing services in the community in accordance with this PPO who also has a signed a Phase IV Comprehensive Schedule B Agreement with OneCity Health

<sup>2</sup> RN is mandatory

The Transitions of Care Partner will be responsible for the following tasks:

Task	Description
Enrollment	An initial assessment must be completed for all referrals. (All referrals will be entered in GSI prior to or at time of discharge.)
Care Plan Initiation	<p>At the time of Enrollment, Partner must complete at least one care plan domain in GSI with an associated goal and intervention prior to or at time of discharge.</p> <p>Partner must address the remaining five domains within seven days of discharge and include associated goals and interventions.</p> <p>(The six required domains are: medication reconciliation, caregiver stress, self-education, adherence to appointments, social support and services, medical diagnosis.)</p>
Care Plan Updates	The Partner will update a minimum of one care plan issue per week in GSI during the 30 day transition period.
Notification to PCP	The nurse supervisor will notify the patient's PCP if a patient relapses or if a patient is non-compliant and the Partner is unable to resolve the issue.
Linkage to and completion of PCP visit(s)	Arrange a patient appointment with the patient's assigned PCP and follow-up through completion of visit, incorporating PCP directives as needed. Must document patient visit(s) in GSI.
Graduation	<p>If the patient successfully completes the 30-day program, the Partner must address and close (de-activate) all issues in GSI on or before the 30-day target.</p> <p>If the patient does not complete the program, The partner must address and close (change patient to inactivate and fully document why) all issues in GSI within 48 hours, and document the reason(s) for case closure.</p>
Reporting	Timely completion of summary reports and metrics for review.

## A. Skills and Training Requirements

- All participating Partners must be trained to use and document notes in the GSI Health Management platform
- The TOC team members must possess sufficient professional skills relevant to the defined care management activities of this intervention, such as:
  - » Nurse care management skills and principles;
  - » Community Health Liaison skills;
  - » Familiarity with social determinants of health;
  - » Ethics training community based care; and
  - » Complex care management models and activities.
- Hospital teams may be trained for view-only access in GSI upon request

## B. Data and Infrastructure Requirements

- Partner(s) will be required to use GSI to coordinate and manage patient care

## C. Partner(s) must work with OneCity Health to demonstrate the efficacy and impact of the TOC program based on the program's objectives, targets, and outcomes measures.

In addition to the awarded amount, bonus financial incentives may be based on the following process metrics<sup>3</sup>:

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

<sup>3</sup> Process metrics are subject to change and will be finalized prior to contracting

# Application Information

## ELIGIBILITY AND CRITERIA

Organizations must have an executed Phase IV Comprehensive Schedule B with OneCity Health and fully meet these minimum criteria to be considered eligible:

- Documentation of successful evidence-based practice and experience in implementing services in a care-coordinated model to improve patient care and well-being
- Ability to scale-up and efficiently implement a TOC Program at each assigned facility and health care organization while maintaining a minimum case load of 50 patients per team
- Internal capacity in place to address the needs of patients as identified by the social determinants of health screen and to connect patients to in-house and external resources
- Internal infrastructure to ensure data is collected and reported through GSI in a timely manner
- Experience collaborating in complex health environments

## AWARD INFORMATION

Awards will be commensurate with the proposed scope of work and discussed with each awardee separately. See application process.

### Selection Criteria and Weighting

Selection Criteria	Weight
Experience: Demonstrated experience, capability, and evidence-based practice implementing the TOC and other programs for high-risk populations.	20%
Proposed Approach: Proposed plan is feasible to gain buy-in for short-and long-term sustainability, including care-coordination and integration at each facility and community provider setting.	25%
Organizational Capacity: Demonstrated personnel and management to scale-up by beginning of the contract period.	20%
Cost: Budget is reasonable and aligns with the proposed approach, staff, and patient caseload.	35%

# Application Process and Timeline

## APPLICATION COMPONENTS

Partners interested in applying to the “30-Day Transitions of Care Program” should submit a proposal, not to exceed seven (7) pages (exclusive of any desired and applicable appendices), that includes the following:

- Documentation of experience and capability as described under “Eligibility and Criteria”;
- A proposed program budget for the 12-month contract period, inclusive of personnel, patient caseload, and associated program delivery costs, that is responsive to the requirements and deliverables of the TOC Program model, as outlined in this PPO; and
- Documentation of required organizational data capacity and experience with reporting on operational process measures and longitudinal patient tracking.
- A collaborative care management workflow that is patient-centered and longitudinal for transitional care processes during the 30-day transition period from time of discharge from an In-Patient unit through 30 days post-discharge back to a community-based setting (i.e. patient home).

## APPLICATION SUBMISSION

- Applications must be submitted by close of business on August 1, 2019, to the OneCity Health Support Desk ([ochsupportdesk@nychhc.org](mailto:ochsupportdesk@nychhc.org)), with the subject line “30-Day Transitions of Care Program.”
- This initiative will begin upon execution of a Schedule B and run for a 12-month period, beginning September 1, 2019.

## ONECITY HEALTH CONTACT INFORMATION

Please submit any questions to the OneCity Health Support Desk ([ochsupportdesk@nychhc.org](mailto:ochsupportdesk@nychhc.org)), with the subject line “**30-Day Transitions of Care Program.**” We will respond to your inquiries promptly.

