QUESTIONS AND RESPONSES

FOR:

RFP: Patient Centered Medical Home Consultant

1. Where do the two clinics (internal medicine and pediatrics) currently stand with respect to the six NCQA/PCMH standards?
   a. **We are currently not meeting the six standards.**

2. To what extent should work plan proposals address internal medicine and pediatrics residency outpatient curricula to align them with NCQA/PCMH elements?
   a. **Would like the work plan to include revising the curriculum along the lines of PCMH training especially under systems based practices, practice based learning and improvement. Should include implementation of PI/QA projects involving residents.**

3. Do you plan to undertake other payment and delivery system reforms (e.g., ACOs) during this period that might impact the PCMHs?
   a. **We are not currently part of an ACO, however will continue to monitor and implement modified payment systems as part of healthcare reform.**

4. Is there an anticipated level of effort for this scope of work, or a target budget amount, and can it be specified?
   a. **We are leaving open depending on the initial RFP responses.**

5. What is the anticipated schedule (begin and end date) for the requested scope of work?
   a. **Hope to begin early spring 2013 for a 2-3 year engagement.**

6. Empanelment, i.e., assigning each provider a set number of patients, is thought to increase continuity for both patients and providers. Are the ambulatory care patients empanelled, and if so, are they empanelled to residents or attendings? A follow-up question is what software product is used to track the panels, and to what degree are performance improvement tools used within the panels?
   a. **Formal empanelment does not occur outside of managed care provider selection. Appointments are made at the resident level (residents and their attending are a care team) – we do not have a**
software product to track panels and we do not have much in the way of provider specific PI measures.

7. How many faculty physicians staff the internal medicine and pediatrics continuity clinics?
   a. Pedi-35 residents and 2.5 attendings, internal med 60 residents, 3 attendings.

8. Do the faculty physicians assigned to these clinics also see patients in other clinics?
   a. Internal med, yes at the community based practices

9. How many residents rotate into these clinics annually and approximately for what time period?
   a. Internal med rotates on a 4+1 schedule. 1 week of continuity clinic followed by 4 weeks of inpatient. There are 10-12 residents per block.

10. Do you anticipate any major changes in the number of patients that will be served by the NHCC clinics?
    a. Anticipate a 10-20% growth annually.

11. What internal resources will be available to the consulting team to support the development of the new care model as the consulting team and NHCC works together to design and transition the care model?
    a. There will be a steering committee.

12. Does a care management program exist currently within the resident practice? What is the model and how is it staffed
    a. No

13. How many practices? How many sites? What is the breakdown by specialty, location, and how many FQHCs or lookalikes?
    a. The RFP looks for a consultant to support the transformation of the Nassau University Medical Center’s hospital based clinics in pediatrics and internal medicine into 2011 NCQA level 2 or 3 PCMHs

14. When would the contract start?
    a. As soon as feasible. We hope late winter, 2013

15. Is the funding for this project from federal dollars?
    a. NY State
16. What is the main priority of this RFP? Is it to acquire Medical Home transformation facilitation? Is it primarily to acquire IT support for medical home transformation?
   a. To facilitate the transformation of “traditional” hospital based teaching clinics into FQHCs in which the pediatric and medicine housestaff obtain their ambulatory/continuity training

17. Do all practices use the same EMR? Is their electronic health information exchange with the hospital and specialists?
   a. No, the hospital and its onsite clinics use Allscripts Sunrise Clinical Manager. The FQHC’s are implementing Eclinical Works. For specialists on the same EMR there is capacity to exchange information via Secure Health Messaging.

18. What is the deadline for practices to submit their NCQA application and what is the deadline for achieving NCQA recognition at level 2 or 3?
   a. Deadline for achieving recognition is 12/31/13.

19. Will practices be submitting a multi-site or single site NCQA application?
   a. Single site

20. When do you expect all sites to have full EMR functionality? Will it support NCQA? Will there be care management functionality?
   a. 4th Quarter 2013 for Medicine clinic. The pediatric clinic is electronic now.

21. Have you identified the population management (registry) software? If so, what is it? What is the timeline for installation?
   a. No. There is an outstanding RFP request for this product.

22. What is the expected impact of 18 month construction project on PCMH transformation?
   a. The two projects need to proceed in parallel. The newly constructed primary care center will be the new site in which ambulatory care is delivered, with increased capacity and access.

23. What is the level of consultation desired?
   a. What are the top priorities and what you would most like from your consultant? The bottom line deliverable is the NCQA designation. However, we need support in a) description of the job responsibilities
of the PCMH team, with a focus on each team member working to the maximum of their skill set. This would include NPs/Pas, nurses, nurses aides, social workers, transition care team, community outreach workers, etc; b) a training and education program consistent with (a); c) the required staffing patterns; d) an operational plan of the daily PCMH routine-team meetings, group visits, anticipatory calls to patients for needed health maintenance and chronic care management needs; e) a strategy for patient engagement and activation; f) a strategy for disease registry and “high utilizer” management.

24. Will this project be rolled-out to a larger group of practices after a period of time? If so, what at what time and how many practices?
   a. This is focused on the hospital based residency practices

25. RE: Quality measures reporting, are you interested in data aggregation to monitor not only individual practice’s progress, but also the progress of the entire project? Will practices have the functionality to track data for clinical quality measures?
   a. Yes
   b. The plan is to have reports come from the EMR to track CQM’s.

26. RE: Assessment and outcome reporting, are you interested in a larger evaluation that includes assessments of patient engagement, clinical quality, costs and utilization, for example?
   a. 100% compliance with QARR-HEDIS measures.

27. Are you incorporating PCMH training in residency curriculum and resident evaluations?
   a. Would like the consultant to address these issues.

28. What are milestones that determine continued funding?
   a. 1) attainment of NCQA 2011 PCMH level 2 or 3 designation
      2) Breast Cancer Screening (NQF 0031), Cervical Cancer Screening (NQF 0032) Diabetes: HbA1c Poor Control (NQF 0059), Diabetes: LDL Management & Control (NQF 0064), NQF 0062 Diabetes Urine Screening (2012)
      3) Coordination between the PCMH and specialists
      4) Qualitative changes in the pediatric and medicine residencies
      5) Success in two inpatient quality projects with resident participation.
29. Under the new patient centered medical home (PCMH) system, what metrics does NuHealth plan to be using to define success?
   a. 1) attainment of NCQA 2011 PCMH level 2 or 3 designation 2) Quality metrics utilized are those depicted in the NCQA’s PCMH Standard manual, including attainment of all “Must Pass” components with all maximum number of points achieved per standard as per NCQA. 3) Coordination between the PCMH and specialists 4) qualitative changes in the pediatric and medicine residencies 5) success in two inpatient quality projects with resident participation.

30. What are the most important success metrics to NuHealth in identifying and managing its patient population health initiative?
   a. 1) Attainment of PCMH Level 2 or 3 designation; 2) Successful attainment of all NCQA PCMH standards; 3) 100% QARR-HEDIS outcomes.

31. With the exception of identifying population health management software, what tools/procedures are already in place to help achieve disease prevention and management?
   a. We really don’t have anything in place.

32. How does NuHealth currently measure its operational performance? What key parameters does NuHealth use to capture its performance improvement?
   a. Operational performance measured by combination of open chart audit data and some reports from the electronic clinical system. QARR-HEDIS

33. What role does NuHealth envision a third party consultant playing in the rollout of its EMR system and in identifying a population health management software?
   a. The rollout of the EMR will be part of our IT departments function. The population health software is part of an RFP request.

34. How should we interpret the floor plan provided? For example, are we to work with the existing structure or the new Primary Care Center that will be constructed in the future?
   a. The new center will open in 2014, but we need to have the PCMH model fully operational in the current space by 12/31/13.
35. In the current clinics, what is the resident composition and staffing during normal operations?
   a. There is a range. In general for internal medicine there are 10-12 residents and 3 supervising attending in five ½ day sessions a week. For peds there are 4-6 residents with 2 attendings.

36. What is the budget for this patient centered medical home (PCMH) consultant contract?
   a. There is no upfront budgetary limit for this contract. We would like to see responses and evaluate the opportunities.

37. What are the names of the other organizations who have submitted questions for this RFP?
   a. We are prohibited from providing this information.

38. How many clinic sites will be involved in the PCMH project?
   a. This RFP is looking to transform the East Meadow hospital based residency clinics in Medicine and Pediatrics. Parallel to this there will be changes at two FQHCs which are used for residency training, but that is outside the scope of this proposal.

39. How many practitioners total (including residents, physicians, physician assistants, and advanced nurse practitioners) will be involved in the PCMH project at each site?
   a. Hempstead 3.5 FTE doctor
      1 FTE PA
      3-4 residents (1 peds, 2-3 internal med depending on the block)
      New Cassel 4 FTE doc
      6 FP residents
      Roosevelt 5 FTE doc
      No residents at this time
      Omni med 3 FTE docs
      50 IM residents
      Omni peds 2.5 FTE doc
      30 residents

40. Please describe if NHCC has a preference for the modality of the consulting services (e.g., on-site visits, telephone consultation, webinars, e-mail communication, and so forth).
   a. We would prefer, at least for the initial phases, to have on site visits/evaluations/focus groups, etc. We would anticipate that
milestones and performance indicators, once developed, could be reported and discussed via telephone or the internet. However, we would expect periodic on site follow up.

41. Please describe what the involvement will be, if any, with the Nassau University Medical Center and the A. Holly Patterson Extended Care Facility.
   a. The resident continuity clinics are located at Nassau University Medical Center. There is no involvement with A. Holly Patterson.

42. The RFP indicates that there is a construction project planned to construct a new Primary Care Center. Is this new Center expanding access/capacity, or will it just replace the current facility? How will the new Center be involved in this project? Please explain.
   a. This new center will be the new physical plant in which the residents will train and will provide increased capacity and access.

43. It appears from the RFP that the focus of this consulting engagement is on outpatient clinics. However, there is also mention of other settings of care and practice settings. Please clarify whether the focus of this PCMH consulting engagement is solely focused on outpatient clinics or if it includes other practice settings.
   a. The focus is on the resident practices and the transformation to certified PCMHs.

44. Please indicate if there are other consultants or vendors (e.g., IT consultants) who the PCMH consultant will need to work with on this engagement.
   a. The consultant would be working with on site staff.

45. Please explain any information NHCC has received from key payers regarding the required or preferred outcome reporting that will be expected from PCMHs.
   a. The payer requires that we achieve level 2 or 3 designation by 12/31/13. Successful attainment of all NCQA PCMH standards, including attainment of all “Must Pass” components with all maximum number of points achieved per standard as per NCQA. 100% QARR-HEDIS outcomes.

46. Please describe any initial activities or projects that NHCC has already implemented related to PCMH practice transformation (e.g., such as care transitions, health coaching, patient navigators, and so forth).
   a. We have one patient navigator per health center, none in the resident clinics at the hospital
47. Has a steering committee or similar team been formed to help guide and direct the PCMH initiative at NHCC? If so, please describe who the members are of this group, such as job titles, facility location, and so forth.
   a. Executive Vice President for Business Development and Ambulatory Services
      Chairman, Department of Ambulatory & Community Medicine
      Administrator, Ambulatory & Community Medicine
      Vice President for Quality Management
      Vice President, Executive Staff Operations

48. Is there a timeframe goal to achieve NCQA recognition? If so, please describe it.
   a. AS ABOVE, 12/31/13

49. Please describe the current structure of the residency program. For example, is this an apprenticeship model, rotating model, or other model of residency? What is the average length of time the residents are practicing in the NHCC clinic?
   a. Internal Medicine residency is based on a 4+1 model. During the plus one week (ambulatory block) residents are assigned to the Specialty clinics in the morning while they attend their Continuity clinic in the afternoon. Each resident is assigned an attending who serves as their preceptor for the three years in training. About 15 residents are in the (+1) plus one week at any given time. About 10-12 residents have their continuity clinic in the hospital, called Omni clinic. The rest of them are assigned to Hempstead Health Center. Each resident in the categorical track of the internal medicine residency program gets to do about 10 to 12 weeks of ambulatory block each year.

50. How standardized are the clinics across the NHCC system?
   a. Not very. There is more standardization among the community based centers though they still need work. Their work flows and processes are different than the teaching clinics though they share policies (for the most part)

51. Is the EMR that is used for the clinics the same as the EMR being used in the hospital and extended care facility? How will there be communication and information sharing between clinics, hospital, and extended care facility? Please explain
   a. The extended care facility has no EMR. IT is working on an interface strategy for ambulatory and hospital systems.

52. How does this engagement integrate with the new Centers for Medicare & Medicaid Services (CMS) award to NHCC to support the Hospital-Medical Home Demonstration Project?
   a. It is funded by IT.
53. What is the involvement, if any, of the Long Island FQCH in this PCMH project?
   a. NONE

54. What is the number of practice sites/providers at each site that are planned to be included?
   a. 2 hospital based primary care practices (internal med with 3 attendings and 60 residents and ped is with 2.5 attendings and 35 residents). Also 2 community based practices- one with 5 providers, one with 4.5 providers

55. We note that NHCC plans to roll out functionality of an EMR using Allscripts, including the patient portal. We also noted that the pediatric sites have a different EMR. Will the contemplated PCMH sites share a common electronic record?
   a. The hospital based clinics all run the same EMR Allscripts sunrise. The FQHC’s have Eclinical works. There are peds clinics at both sites.

56. Will they share a common population health management tool? Will the pediatric sites also have a Patient Portal?
   a. The population health management tool has not been selected yet. This is currently going through an RFP process. The intention is to use a single tool that can unify data from disparate systems. Yes, the pediatric sites will also have a patient portal.

57. A floor plan for the proposed Primary Care Center was to be annexed to the RFP, but the document we received did not have that floor plan. May we see that floor plan?
   a. The floor plan is posted on NuHealth.net website under “doing business with NuHealth”

58. What is the budget for this project?
   a. There is no fixed budget at this time.

59. Is this project being funded from the CMS grant? If so, what percentage of this grant is being allocated to this project versus other initiatives?
   a. No, this is funded from state funds.

60. What is the scope or limitations of the grant as it relates to technology in your facilities for this project?
   a. There is support for a report writer as part of the grant

61. What is the pediatrics EMR environment? Is that Allscripts as well?
   a. Yes
62. What is your current approach to integrating EMR data?
   a. Demographic data will be shared with both EMR’s via MPI. We are in
      the process of integrating laboratory, radiology and EKG
      information from Allscripts Sunrise into Eclinical Works. A phase 3
      project will involve passing information such as medications, allergies
      and problem lists via CCD. But this is not going to occur during the
      timeframe of the project.

63. Does the scope include the FQHCs in addition to the continuity clinics?
   a. No, just the hospital based clinics.

64. As part of this project, is there an expectation to review the ambulatory center
    design and make recommendations regarding patient flow and potential facilities
    layout for PCMH care processes?
   a. By the time the consultant is engaged much of the architectural
      planning will be finalized. However, within that constraint advice will
      be solicited.

65. Have you identified your demonstration facility and have you established a rollout
    schedule to other facilities, or do you expect this to be part of the planning
    process?
   a. Part of the planning process.

66. Does the scope of this project include implementing master patient information or
    enterprise master patient identifier functionality as part of the solution, or should
    we assume it is already there?
   a. It is already in place.

67. Does your organization have a strategy to implement an accountable care
    organization (ACO)? Will the PCMH strategy for continuity clinics be rolled out
    to a broader physician network?
   a. There are very preliminary discussions re: creating a Medicaid ACO

68. What is the approach to population health—outsource or own internally? Which
    vendors are being considered?
   a. We have not selected a population health vendor. Until that selection
      is complete, we cannot provide that information.
69. What resources will NHCC provide for this project, e.g. project manager, physicians, policy and procedures SMEs, etc.?
   a. Steering committee, a PCMH administrator.

70. Have you initiated the NCQA application process, or is that part of this project?
   a. We have initiated PCMH process in that we are doing a gap analysis on hospital based primary care clinics. We have PCMH recognition under 2008 standards at our 4 community based (and largely non-teaching) practices.

71. How many clinics comprise the continuity clinics, both primary and specialty? Are all clinics in scope? If not, which are in scope and which are out of scope?
   a. We have 81 hospital based primary care and specialty clinics. PCMH recognition is being sought for the primary care practices in internal medicine and pediatrics only.

72. To what extent will the LEAN Organizational Improvement project, if any, have on this effort? Will this other project be responsible for developing the process flows relevant to the population health solution to be selected by NHCC? Will this project also look at optimizing the new facility being constructed? What vendor did you select? Has this effort started?
   a. The LEAN effort, facilitated by Simpler, is responsible for developing flows. It will be too late to impact on the facility design.

73. Will the population health solution vendor handle all outcomes and quality reporting required by NHCC?
   a. Yes

74. If not, what specific requirements do you have above and beyond the PCMH Level 3 reporting requirements? Do you expect this vendor to project manage all aspects of the population health environment (functional and technical)?
   a. Yes

75. Will the selected population health solution vendor assess your current infrastructure to support the new population health solution, or do you assume this will be done as part of this engagement?
   a. This will be part of the PCMH engagement.

76. Does this scope include establishing the organizational governance to meet PCMH requirements?
   a. Yes
77. What are the expectations for the Assessment phase? Is this the NCQA certification process or an assessment of the PCMH performance (which is much longer term in nature)?
   a. The expectations are a) NCQA process and 2) 1-2 year assessment of PCMH performance.

78. Are you looking for PMO support throughout the three year initiative?
   a. Yes

79. How will you determine the success of this project?
   a. The primary end point is NCQA Certification. However we also wish to develop PCMH metrics to follow.

80. Section C.3. asks for documentation demonstrating that the Proposer is licensed and authorized to do business in the State of New York and Nassau County – is there specific documentation requested here? Our firm has done work with multiple clients in the State of New York and has a regional office in New York City.
   a. They vendor should submit whatever documentation they deem appropriate to address this item and if selected, NHCC may request additional information if appropriate.

81. What is meant by the following statement on p.3 of the RFP: “Floorplan for the proposed Primary Care Center is annexed hereto and make a part hereof.”?
   a. We have funding from NY State of construct a new physical facility. The floor plans were shared fyi, and are available on our web site in the RFP section.

82. Is NHCC interested in support for the All Scripts implementation, or should the proposer assume this is out of scope?
   a. Yes, we are interested in support for the Allscripts EMR to achieve PCMH status.

83. Section D-2 appears to be requesting a list of all projects we’ve done in the past 18 months – as many of our client engagements are confidential, is it sufficient to provide a list of relevant clients/projects which may serve as references, or is there additional information that would be helpful?
   a. We request a list of relevant clients with a brief statement regarding the project.

84. What is the timeframe for selecting a vendor and starting the engagement? A Jan 2, 2013 press release seems to indicate that all sites must be at NCQA-level 2 by the end of 2013.
   a. We hope to select a vendor in February.
85. What is the timeline for the All Scripts implementation rollout?
   a. The current go live date for the medical omni clinic is September. Pediatrics is electronic already but has not achieved PCMH status. The FQHC’s rollout of Eclinical Works is slated for 3rd quarter 2013.

86. What tools and/or platform, if any, are currently being used for Quality Measurement and Performance Improvement?
   a. Premier Warehouse for CM data; Keystats

87. Is there a desire to have a common EHR platform for all providers? Do all providers have an ATCB Certified EHR?
   a. 1) Hospital based clinics run Allscripts and FQHC’s run Eclinical Works.
      2) Yes

88. What percentage of eligible providers who have achieved stage 1 Meaningful Use?
   a. None

89. What is the patient total served by NHCC?
   a. In total we have 23,000 annual discharges and 250,000 ambulatory visits.

90. How many residency / primary care sites is NHCC looking to have level 3-certified?
   a. A single physical site; medicine and pediatric residency continuity clinics.

*NHCC received questions pertaining to the RFP Schedule “B” – Standard Clauses for NHCC Contracts. In depth discussion of contract language at this stage of the procurement process is premature. Vendors may raise issues related to the boilerplate contract language in their proposal and NHCC will consider such during the selection and contract drafting stages as appropriate.”