Care Transitions Network for People with Serious Mental Illness
Frequently Asked Questions

What is the Care Transitions Network?
The Care Transitions Network for People with Serious Mental Illness supports practice transformation for organizations that serve people with serious mental illness (SMI) in New York State. Funded by the Centers for Medicare and Medicaid Services (CMS), the Care Transitions Network aims to reduce all-cause re-hospitalization rates among people with SMI while, simultaneously, preparing organizations to transition into value-based payment arrangements.

The Care Transitions Network is the only CMS-funded Practice Transformation Network specifically designed to support behavioral health and primary care providers who serve people with SMI and other behavioral health disorders, including schizophrenia, bipolar disorder and chronic depression. When your behavioral health organization enrolls, you and your entire workforce will gain access to:

- Expert faculty who deliver free and individualized coaching, clinical consultation and organizational trainings to support patient and family-centered care, data-driven quality improvement and sustainable business operations
- A free web-based platform with utilization and financial data to enable enrolled organizations to track progress on key quality improvement indicators and confidently transition to value-based payment contracts
- Free training and technical assistance to help primary care and behavioral health organizations leverage financial incentives and reimbursement changes, and thrive as businesses in the context of value-based payments

Who supports Care Transitions Network implementation?
The National Council for Behavioral Health leads the Care Transitions Network with support from several partners: Montefiore Health Systems, Northwell Health, the New York State Office of Mental Health, and Netsmart Technologies to implement Care Transitions Network activities. Montefiore Health Systems provides short-term care transitions support; Northwell Health provides one-on-one clinical consultation; OMH ensures statewide synchronization and assists with quality improvement; and Netsmart Technologies provides web-based platforms to enable providers to track progress on key quality improvement indicators throughout the life of the project.

How will the Care Transitions Network support the Delivery System Reform Incentive Payment (DSRIP) and other New York state initiatives?
The aims of DSRIP and the Care Transitions Network are closely aligned: they both aim to reduce avoidable hospitalizations and support providers’ transition into payment arrangements that reward value over volume. The Care Transitions Network, and the data and technical assistance it provides enrolled organizations, focuses on service utilization of a specific population – people with serious mental illness. It will provide technical and financial support to meet the aims of both programs.
Enrollment Questions

Who is eligible to join?
Any inpatient or outpatient provider organization that serves people with serious mental illness is eligible to join. This includes behavioral health providers (mental health and addictions) and primary care providers.

Enrolled organizations must have at least one of the following clinician types:
- Licensed clinical social worker
- Licensed psychologist
- Physician
- Physician Assistant
- Nurse Practitioner

While the Care Transitions Network must track these clinicians for federal reporting purposes, your entire workforce can benefit from the Care Transitions Network learning community, expert consultation, quality improvement platform, coaching and technical assistance.

Who is ineligible to join?
- Provider organizations that are already participating in another Practice Transformation Network (PTN) are ineligible.
- A practice is ineligible to enroll in the Care Transitions Network if it also participates in a Medicare Shared Savings Program or Pioneer Accountable Care Organization (exception if the enrolled clinician has no patient attribution, such as may be the case for a practice’s behavioral health providers), the CMS Comprehensive Primary Care Initiative or the CMS Multi-payer Advanced Primary Care Practice demonstration.
- Clinicians who are not listed as Eligible Professionals under the Physician Quality Reporting System cannot be counted as “Eligible Clinicians” for reporting and incentive payment purposes. Eligible Professionals under the Physician Quality Reporting System include: Physicians, Nurse Practitioners, Physician Assistants, Clinical Psychologists, and Clinical Social Workers.
- Once the Department of Health launches enrollment for its Comprehensive Primary Care Initiative, organizations will have to choose to participate either in this initiative, or the Care Transitions Network.
- Practices that are not in full compliance with ICD-10.

What are the benefits of enrollment?

Enrollment benefits include:
- Up to $1,000 incentive payments to organizations for each eligible professional
- Technical support in the shift from fee-for-service to value-based payments under DSRIP
- Targeted coaching and training for the entire workforce
- Short-term care transitions support as clients transition out of inpatient settings
- Clinical consultation on evidence-based practices to treat complex cases, provided by
psychiatrists and internists with expertise in comorbid behavioral health and medical conditions

- Access to clinical and practice resources from organizations like the AMA and APA
- A web-based platform for accessing quality improvement dashboards and financial analysis to support movement into value-based contracts
- Free contact hours that contribute to CEUs and CMEs through online, interactive learning events
- Improved conversion rate for referrals from participating hospitals
- National recognition as a high performing practice that delivers excellent care and reduces all-cause hospital readmissions for people with SMI
- No minimum training requirements; resources available on demand

We are an inpatient facility. How will this program benefit us?
Inpatient facilities are working to ensure that its patients are connected to appropriate outpatient care, and research suggests that people with SMI are a particularly challenging population to connect to care. Further, some inpatient facilities do not have sufficient staff support to help with these transitions. The Care Transitions Network can help inpatient staff to bridge the gap between inpatient and outpatient care, and provide data to monitor progress over time.

We are a health home. How will this program benefit us?
The Care Transitions Network aims to increase health home enrollment. It also aims to reinforce existing relationships between Medicaid beneficiaries and their health homes. The Care Transitions Network will look up all clients admitted to participating inpatient units and either notify the health home of the client’s admission so that the health home can contact the client when she or he is in a stable environment, or facilitate enrollment in an area health home.

How does my organization enroll?
Enrollment is easy!
- Complete an Enrollment Agreement.
- Provide information regarding specific clinicians within the organization (Physicians, NPs, PAs, PsyDs, LCSWs) within 30 days of receiving your fully executed enrollment agreement.
- Complete CMS’s Practice Assessment Tool (PAT) within 30 days of enrollment. The PAT is completed at the practice level.
- Contact CareTransitions@theNationalCouncil.org with any questions along the way.

What is the Practice Assessment Tool?
Designed by CMS, the Practice Assessment Tool allows each organization to assess and evaluate its readiness for and progress toward value-based service delivery. The Practice Assessment Tool can be completed by a practice manager in less than an hour, and should be completed within 30 days of enrollment, and every six months for the duration of the project.

Your practice’s PAT score will determine its location along CMS’s five “phases of transformation.” CMS defines the phases of transformation as the change points for a provider organization as it prepares for value-based payment systems. Participating organizations will receive payments of up to $1,000 per enrolled eligible clinician as they move through these phases.
**What happens after our organization enrolls?**
The organization’s designated point of contact will:

1. Provide NPIs, license numbers, and email addresses for their eligible credentialed providers. Individual providers will receive emails from CMS and the Care Transitions Network, including invitations to live webinars that offer free CEUs and CMEs for clinical staff.
2. Receive a welcome packet with additional information about the Care Transitions Network, and share it with practice leaders and decision-makers.
3. Attend a one hour welcome webinar for recently enrolled practices, which explains how the Care Transitions Network can help each enrolled practice improve patient and family-centered care design, use data to drive continuous quality improvement, and build sustainable business operations.
4. Complete CMS’s Practice Assessment Tool (PAT) and submit it to the Care Transitions Network.
5. Participate in a one hour, practice-level teleconference to review the practice’s PAT scores, collaborate to determine up to three practice transformation goals, and identify appropriate resources that will support the practice to achieve these goals and progress through the phases of transformation.

**Does the Care Transitions Network only benefit the specific clinicians identified?**
Care Transitions Network resources will be available to your **entire workforce** – this includes all clinicians, as well as administrative and other support staff. We ask for information about specific types of clinicians (physicians, NPs, PA, PsyDs., LCSWs) because CMS is tracking this information across all practice transformation networks nationwide.

**Short-term Care Transition Support**

**What is short-term care transition support?**
The Care Transitions Network builds the capacity of behavioral health practices to strengthen care transitions and achieve our goal to reduce re-hospitalization rates among people with SMI by at least 50%.

To support transparency, the Care Transitions Network will make referral rate information publicly available on a quarterly basis.

**Enrolled psychiatric inpatient units** will notify Care Transitions support staff of qualifying
patients upon admission (using criteria determined by the inpatient unit’s expressed needs). While the patient is on the unit, Care Transitions staff will determine the patient’s Health Home status and help to connect with a Health Home in one of two ways:

(1) If a patient is currently enrolled in a Health Home, staff will notify the patient’s Care Manager of the patient’s admission;
(2) If a patient is eligible but not currently enrolled in a Health Home, staff will facilitate their enrollment in a Health Home through the bottom up referral process. This will help connect patients with care management services that will address physical, behavioral health, and social service needs on an ongoing basis.

As the patient approaches discharge, Care Transitions Support staff will support the inpatient staff (and the patient’s Health Home Care Manager, if applicable) to coordinate necessary outpatient appointments. The Care Transitions staff can offer referrals as needed to outpatient medical and behavioral health providers, regardless of provider enrollment status in the PTN. Care will be made to prioritize pre-existing clinical relationships, and referral recommendations will incorporate factors such as geography, insurance, and ability to provide timely appointments following discharge.

Following discharge, Care Transitions Support staff will engage each patient by telephone to review discharge instructions and to address barriers to medication adherence or treatment attendance. This may include appointment reminders, rescheduling missed outpatient appointments, and engaging other levels of care as necessary. Staff will also coordinate with the outpatient providers to confirm that the patient attends outpatient appointments, and will continue to re-engage the patient if necessary for at least the first 30 days following discharge.

Who needs to be involved within my organization?
The Care Transitions Support team will work with you to determine the optimal work flow that works for your organization, and to build your organization’s care transitions capacity to ensure long-term sustainability of outcomes.

For inpatient units, we ask for a point of contact to notify us of inpatient admissions, to communicate around discharge planning, and to provide the finalized discharge plan with relevant appointment information for the purpose of our telephonic follow-up (this may be one or more people involved in these processes on the unit).

For outpatient organizations, we ask for a point of contact to accept referrals of mental health patients recently discharged from psychiatric inpatient units and to report back on patient attendance during the first 30 days following discharge.
Technical Assistance and Clinical Consultation

What type of Technical Assistance does the Care Transitions Network provide?
The Care Transitions Network offers a wide range of technical assistance and clinical support to enrolled organizations, including:

- Live, online learning opportunities that offer free CMEs and CEUs for clinical staff
- In-person events that address the transition from fee-for-service to value-based payments
- Tele-consultation with subject matter experts
- Support to assess practice and set individualized goals
- Clinical and training expertise in evidence-based treatments
- Online presentations
- Discussion boards

The Care Transitions Network also offers access to free online dashboards, which show Medicaid claims-derived financial and utilization data so enrolled practices can track their progress through the phases of transformation. These dashboards will also enable practices to benchmark their progress against other enrolled practices across New York State.

What if I can’t find the technical assistance resources I need?
Can’t find the resources you need on the Care Transitions Network website? Not a problem! You can complete the Technical Assistance form to get one-on-one assistance to support your organization’s practice transformation efforts. Our team can answer your questions, help you locate resources, and connect you with subject matter experts.

What is Clinical Consultation?
Clinical consultation builds provider capacity to develop treatment plans for especially challenging cases, including patients who have co-morbid conditions, and those who use multiple medications and long acting injectables. Clinical consultations are based on best practices and should not be construed as telemedicine.

What kind of consultation will the Care Transitions Network provide?
Clinicians from enrolled organizations can email clinical experts via the Care Transitions Network website. Clinicians can also access clinical resources 24/7 on the Care Transitions Network website.

Who will have access to Clinical Consultation?
Clinicians enrolled in the Care Transitions Network, including physicians, nurse practitioners, registered nurses, and physician assistants will have access to clinical consultations.

What types of topics will Clinical Consultation address?
Many patients with serious mental illness also have complex medical co-morbidities, and may not respond or adhere to antipsychotic medication. That’s why the Care Transitions Network offers clinical consultation through its partner, Northwell Health. Northwell Health faculty include psychiatrists and an internist who will initially focus on two key areas: patients who have been hospitalized for psychiatric...
illness, and patients who have serious medical comorbidities, which lead to increased use of medical services and decreased life spans. As faculty member Dr. Delbert Robinson explains, “the overall goal of clinical consultation is to help clinicians manage patients with serious mental illness...we will give your clinicians the help and support they need to provide better clinical management for this complex patient population.”

Dr. Robinson notes that the Care Transitions Network’s clinical consultation service is “not a typical consult” in that Northwell faculty do not interview the patient, and don’t provide specific diagnostic or treatment plans. Instead, faculty “give your clinicians ultimate flexibility, because they provide evidence-based guidelines for a particular condition, and enrolled clinicians can apply those guidelines as they see fit.”

Your practice’s enrolled clinicians can request individual consultations with these faculty members by email or telephone. They can also access information about best practices directly from the Care Transitions Network website, 24/7.

How quickly can providers expect a response?
Providers should expect a response within 1-2 business days. Please note that this is not an emergency service.

Quality Improvement

What kind of data does the Care Transitions Network collect?
The Care Transitions Network will primarily use Medicaid claims data to track access to different types of care, but is currently working with CMS to explore options to access Medicare data as well as data from private plans. There will be opportunities for participating providers to link their own non-claims data to gain a better picture of their progress, but this is not a requirement for enrollment.

What measures does the Care Transitions Network track?
In 2016, the Care Transitions Network will track the following Medicaid claims-based measures:

1. Follow-Up After Hospitalization for Mental Illness, 7 Days
2. Follow-Up After Hospitalization for Mental Illness, 30 Days
3. Use of Antipsychotic Drug Clozapine for Schizophrenia
4. Use of antipsychotic long acting injectable (LAIs) for schizophrenia
5. 14-day initiation and engagement of alcohol and other drug (AOD) dependence treatment (14 days)
6. 30-day initiation and engagement of AOD dependence treatment
Do enrolled practices need to do data entry?
No. Provider organizations do NOT need to conduct data entry in order to participate in the Care Transitions Network. All QI dashboards and evaluation summaries will be based on Medicaid and Medicare claims data.

Incentive Payments for Practice Transformation

What are the Incentive Payments?
The Care Transitions Network will use the Practice Assessment Tool to measure each practice’s progress over time. An initial incentive payment will be distributed upon enrollment; additional incentive payments will be distributed as practices progress through the phases of transformation. Incentive payment amounts are $200 for each eligible clinician from the enrolled practice and for each of the five phases of transformation. For example, if an enrolled organization with 10 eligible clinicians is in Phase 1 at enrollment and then progressed to Phase 2 at its next assessment, the organization would earn $2,000 at enrollment ($200 x Phase 1 status x 10 clinicians) and $2,000 at its next assessment ($200 x 1 phase change from Phase 1 to Phase 2 x 10 clinicians). Enrolled practices are eligible to earn up to $1000 per eligible enrolled clinician throughout the life of the project. “Eligible clinicians” for purposes of the incentive payments are: [list them out].