



**RPC VALUE BASED PAYMENT
AD HOC WORK GROUP EDUCATIONAL SERIES:
Care Transitions Network**

**July 12, 2017
1-2PM**



AGENDA

- Welcome
- Regional Planning Consortia
- VBP Ad Hoc Work Groups
- Care Transitions Network
- Q&A



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**Care
Transitions
Network**

for People with Serious Mental Illness

INTRODUCTIONS:



Samantha Holcombe

Director, Practice Improvement for the National Council for Behavioral Health



Nina Marshall

Senior Director of Policy and Practice Improvement at the National Council for Behavioral Health



Care Transitions Network

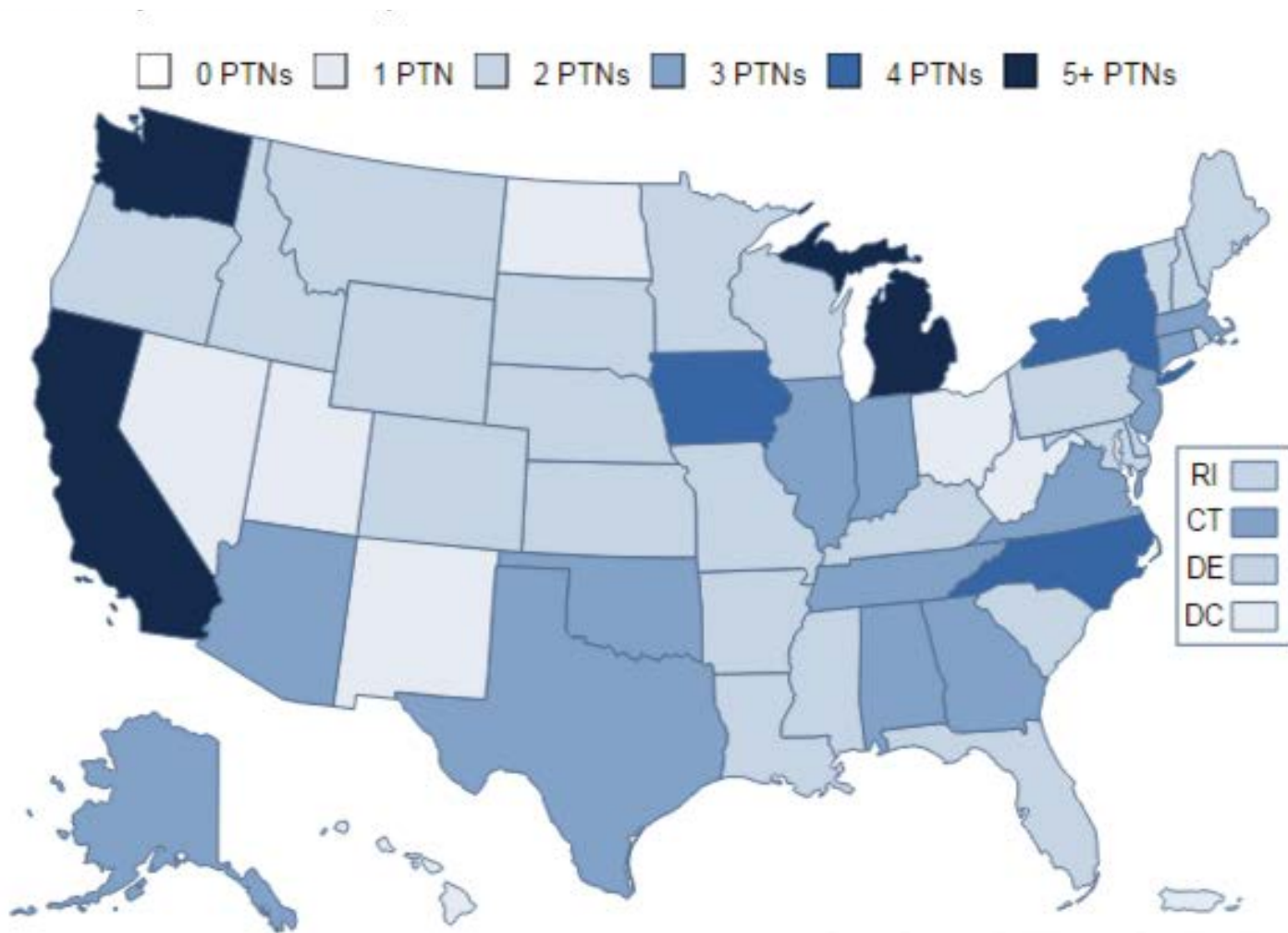
National Council for Behavioral Health
Montefiore Medical Center
Northwell Health
New York State Office of Mental Health
Netsmart Technologies



for People with Serious Mental Illness

Transforming Clinical Practice Initiative

29 Practice Transformation Networks (PTNs)



Source: Centers for Medicare & Medicaid Services

The Care Transitions Network is:

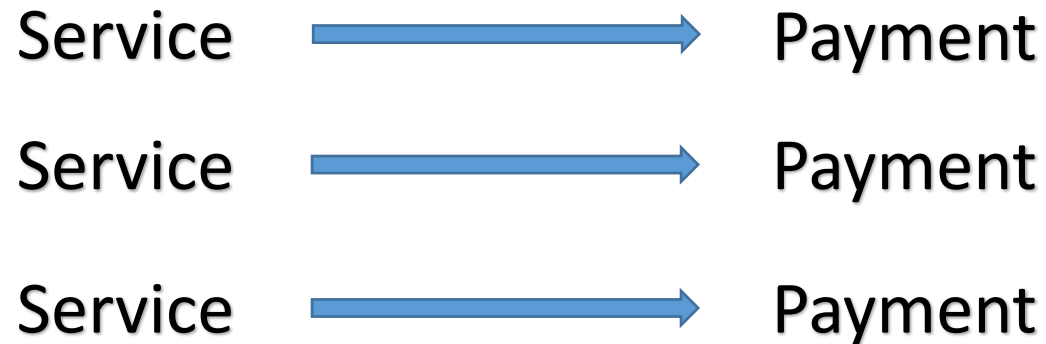
- The only PTN focused on supporting clinicians who serve people with serious mental illness
- One of three project options for OMH's 2016 Continuous Quality Improvement Initiative



for People with Serious Mental Illness

Fee For Service

Incentive for Volume

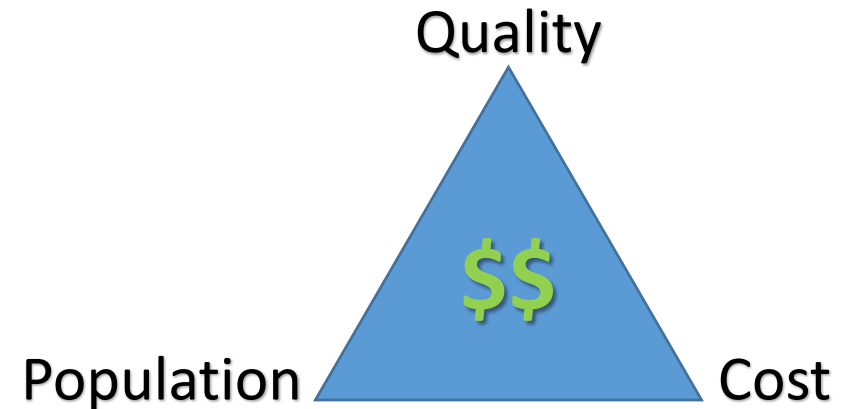


Metrics to track:

- Unit of care
- Volume

Value-Based Payments

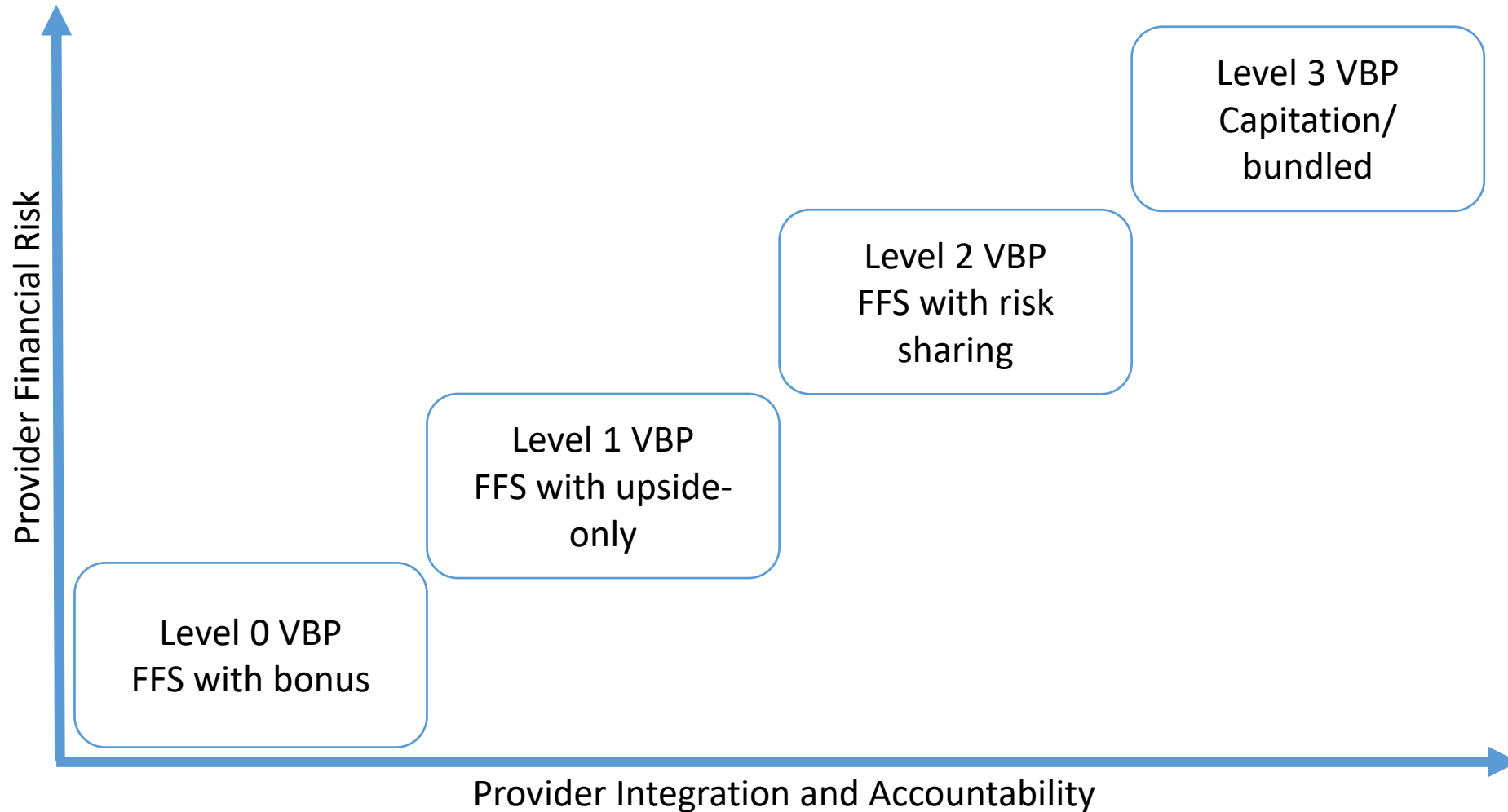
Incentive for Results



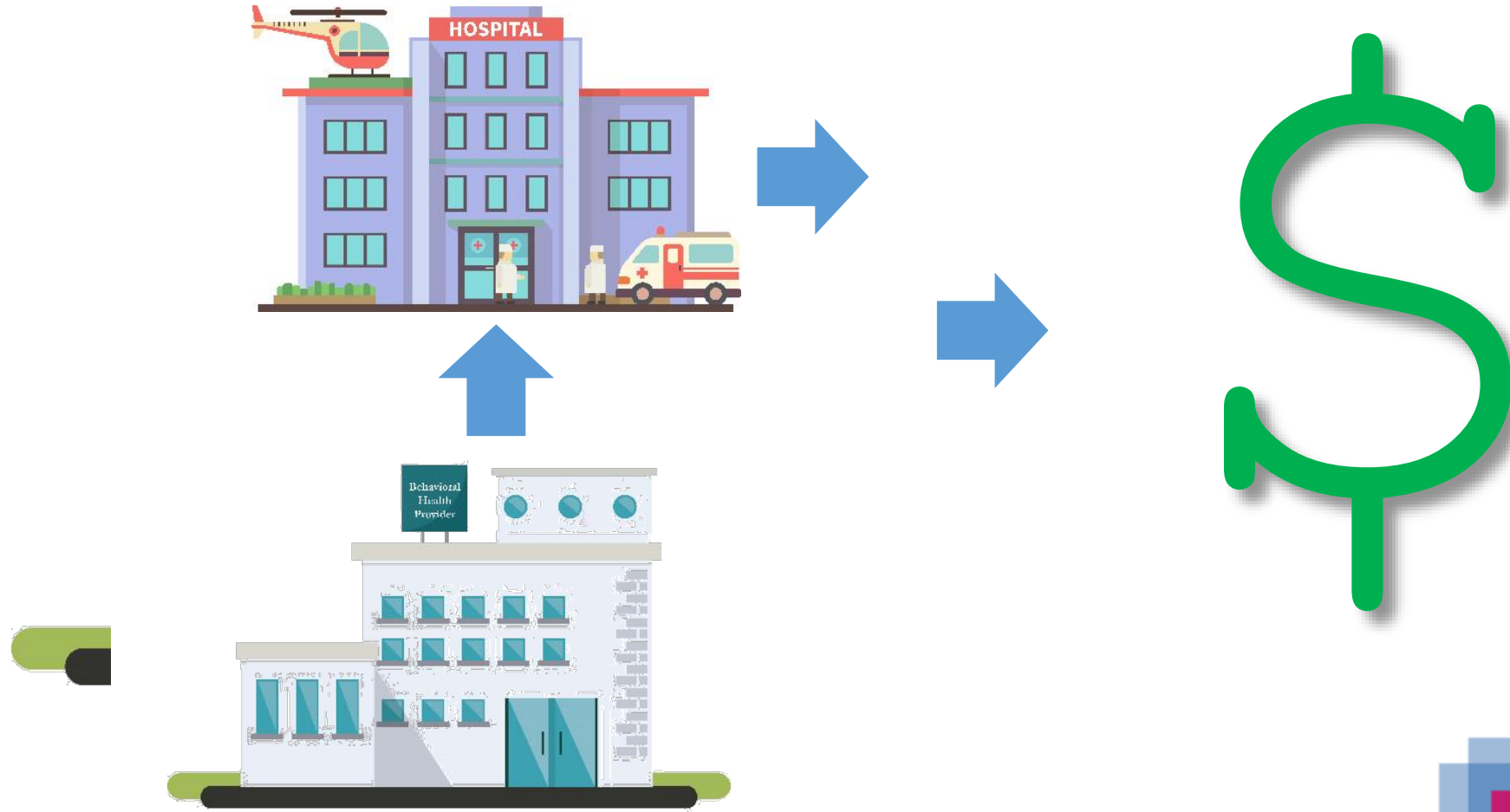
Metrics to track:

- Clinical outcomes/best practices
- Population
- Total cost

Payments Continuum



Contracting with a Payer



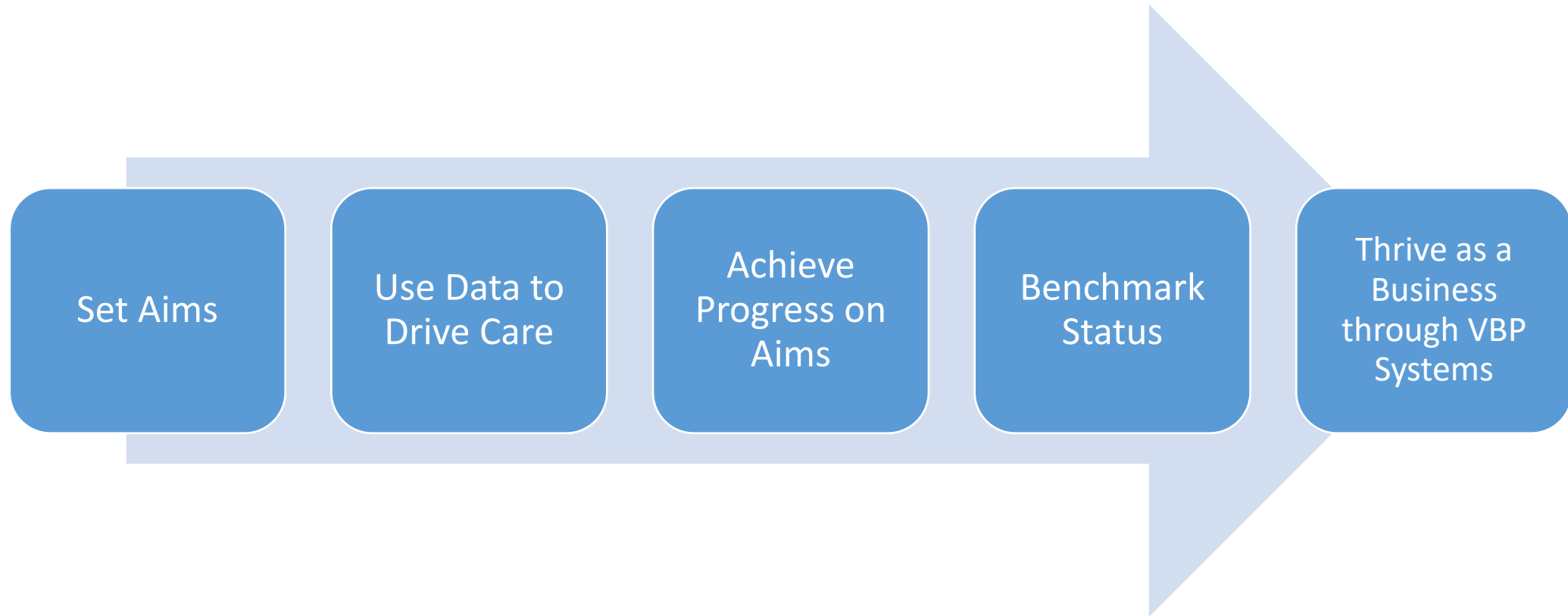
Value-Based Payment Readiness

Patient- and
Family-
Centered
Care Design

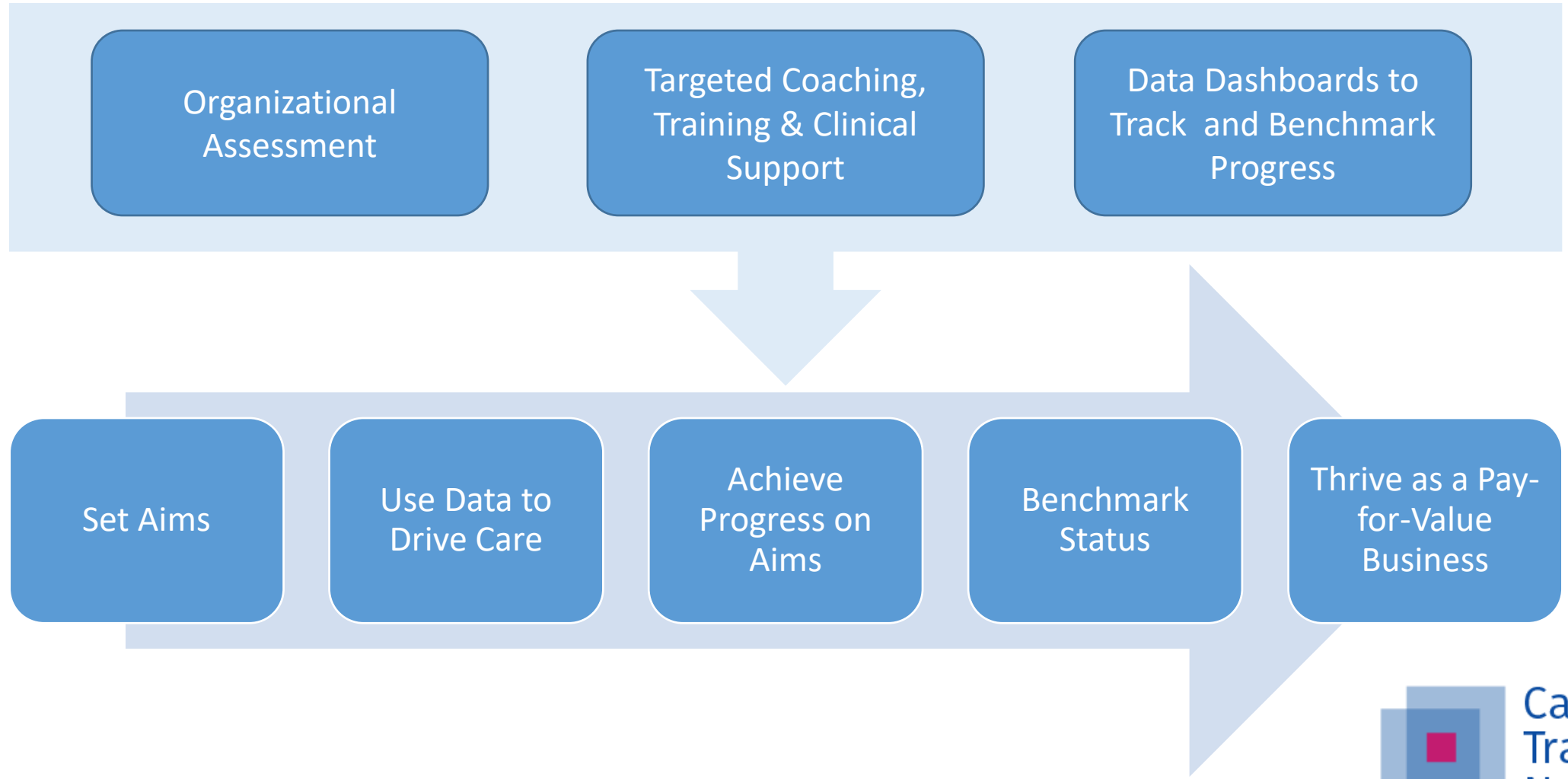
Data-driven
Quality
Improvement

Sustainable
Business
Operations

Readiness for Value-based Payments

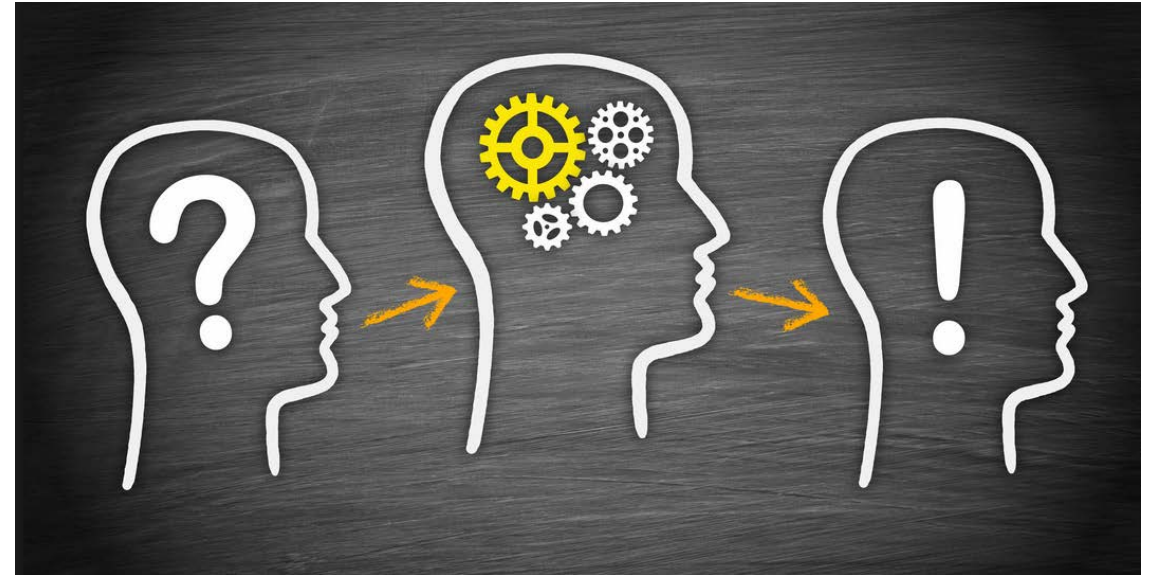


Approach



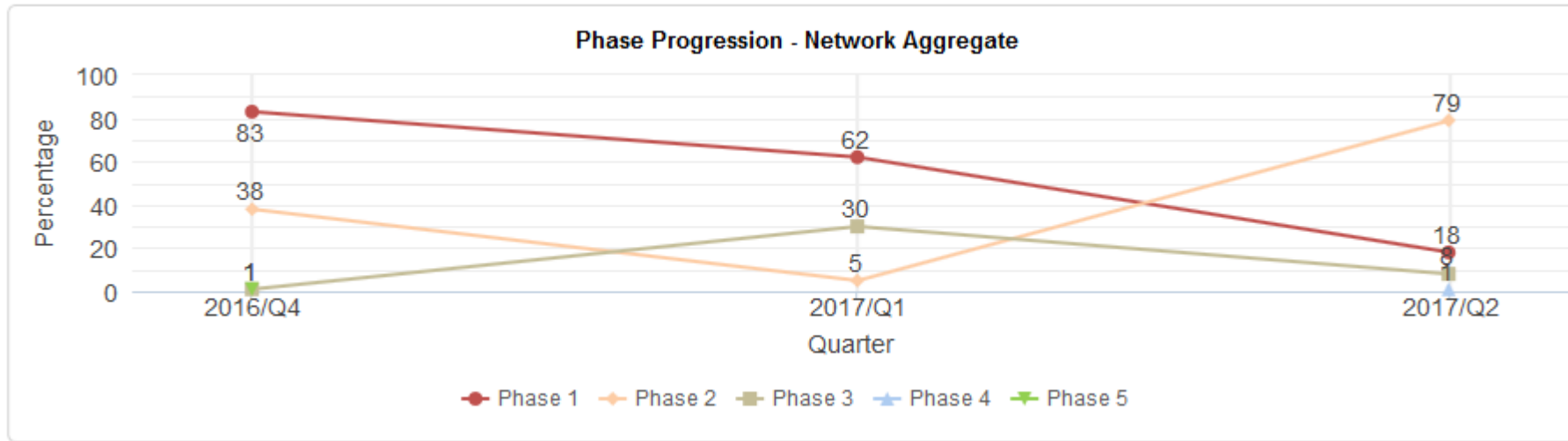
Individualized Coaching and Clinical Support

- Support to assess practice and set individualized goals
- Training and consultation to implement evidence-based practices
- Tele-consultations with subject matter experts



Available to all eligible professionals
in each enrolled practice

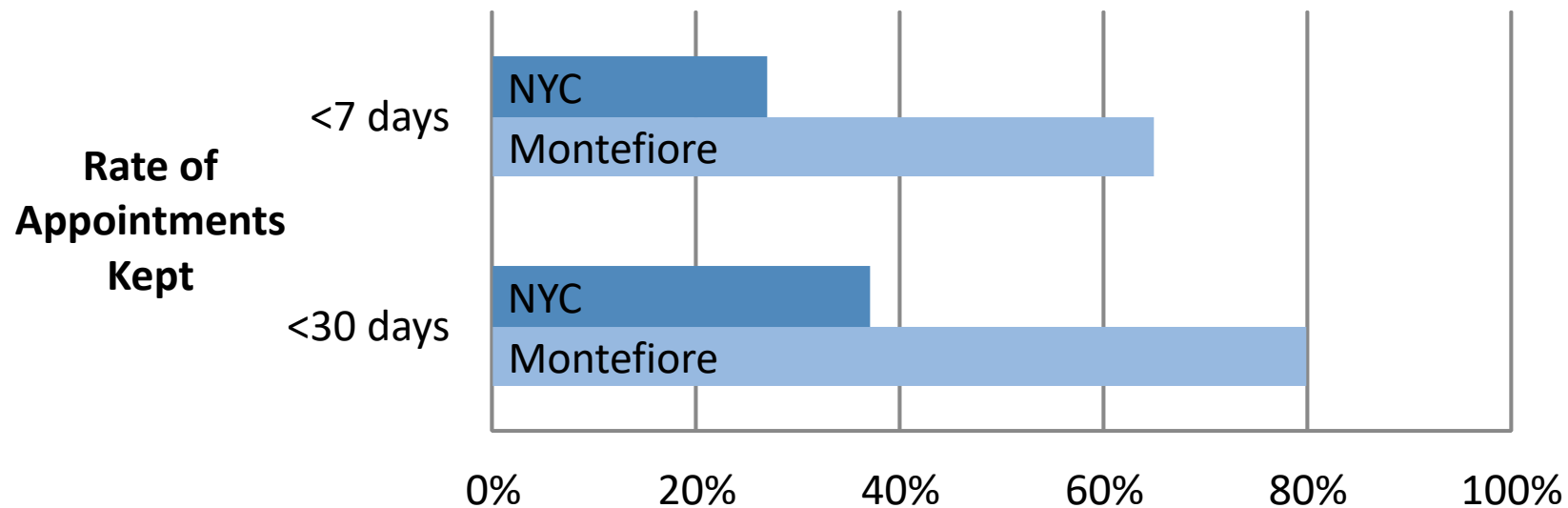
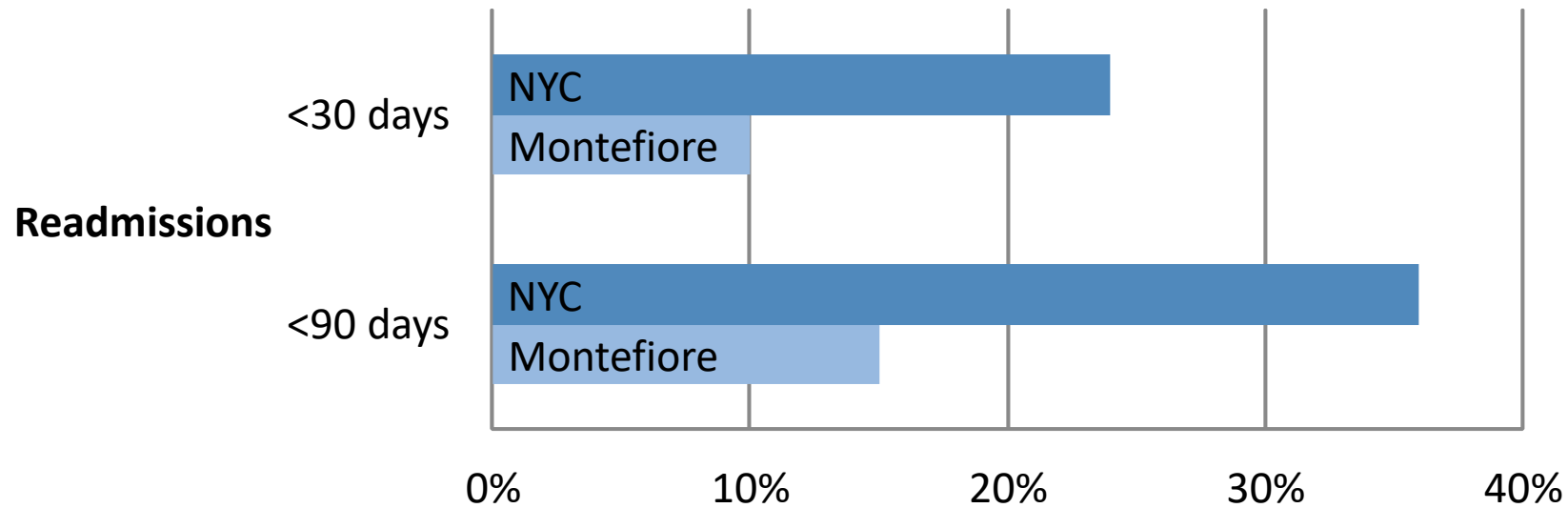
Dashboards to Track and Benchmark Progress



Most recent measure information.

Measure	Indicator	Standard	+/-	Current Quarter Percentage	Network Average	
1	All-cause 30-day readmission rate following MH inpatient discharge.	NYS	-	23%		
2	30-day MH re-admission.	NYS	-	19%		
3	Follow-Up After Hospitalization for Mental Illness, 7 Days.	NQF 0576 PQRS 391 HEDIS FUH-A	+	50%		

Customized Short-term Care Transitions Support





**IMPROVED
HEALTH
OUTCOMES**



for People with Serious Mental Illness

Current and Upcoming Technical Assistance

- Innovation Communities
 - Risk Stratification
 - Long-Acting Injectables
- Community Partnerships and Developing Your Value Proposition
- Transitions of Care
- Resources
 - Value-based Payment Toolkit
 - Measures Crosswalk
 - Engagement of Patients and Families during Discharge

Additional Benefits

- Up to **\$1,000 incentive payment** per eligible clinician
- **Free contact hours** that contribute to CMEs and CEUs for clinical staff
- Access to **on-demand resources**, including clinical and practice modules and training from Network affiliates
 - The Center for Practice Innovations
 - American Medical Association
 - American Psychiatric Association
 - American Association of Nurse Practitioners

Minimal Investment

- Signed enrollment agreement
- Provide licensure, NPI, contact information of all enrolled clinicians
- Designated leadership to engage team in continuous quality improvement



Select Eligibility Criteria

- ✓ Inpatient and outpatient
- ✓ Behavioral health and primary care
- ✓ Urban or rural
- ✓ Must include at least one physician, NP, PA, PhDs/PsyDs, LCSW



Next Steps

- Sign the enrollment agreement and join the network!

www.CareTransitionsNetwork.org

- Direct any additional questions to:

CareTransitions@TheNationalCouncil.org



Questions?



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Thank you!

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