Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Support Contractor

IPFQR Program: Review of ISRs for CBM

Presentation Transcript

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Evette Robinson: Hello everyone and welcome to today's webinar. My name is Evette Robinson and I am the Program Lead for the [Hospital Inpatient] VIQR [Outreach and Education] Support Contractor for the Inpatient Psychiatric Facility Quality Reporting Program. Before we proceed with today's webinar, I will cover a few housekeeping items specific to the IPFQR Program's webinar events. As a reminder, we do not recognize the raised-hand feature in the chat tool during webinars. Instead, you can submit any questions pertinent to the webinar topic to us via the chat tool. To maximize the usefulness of the Summarized Questions and Answers document, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. Any questions received that are not related to the topic of the webinar will not be answered in the chat tool nor in the Summarized Questions and Answers document for any IPFQR Program events. We recommend that you go to the *QualityNet* Q&A tool by clicking the link on this slide to search for posted question-and-answer pairs as well as submit any new questions to us that are not already addressed in the Q&A tool or in a published Summary of Questions and Answers. The slides for this presentation were posted to the *Quality Reporting Center* website prior to the event. If you did not receive the slides beforehand, please go to *QualityReportingCenter.com* in your web browser, and, on the right side of the screen, you will see a list of upcoming events. Click on the link for this event, scroll down to the bottom of the page, and there you will find the presentation slides available for download.

Now, I would like to introduce our speaker for today's presentation, titled *IPFQR Program: Review of ISRs for CBMs*, Meghan Keenan. Megan Keenan is the Executive Director of the Inpatient Psychiatric Facility Measure Development Contract for HSAG. The contract is responsible for the development, maintenance, and implementation of quality measures for the CMS IPFQR Program. Megan has expertise in quality measure development and project management. She holds a master's degree in Health Policy and Administration from the Yale School of Public Health.

At this time, I will turn the presentation over to our speaker. Megan, the floor is yours.

Megan Keenan: Thanks, Evette. Today, I'll discuss two new reports that CMS is providing to inpatient psychiatric facilities prior to public reporting in February 2019. These reports contain confidential information on the two claims-based measures in the Inpatient Psychiatric Facility Quality Reporting Program. Unlike the chart abstracted measures, where facilities calculate their own results and send them to CMS, claims-based measures are calculated by CMS using data that are not always available to facilities. This can include things like health care provided after the patients leave their inpatient stay. The reports, referred to as IPF-Specific Reports, contains both results that will be made publicly available and other information that will not be made publicly available so that facilities have more data to inform targeted quality improvement activities.

There are two claims-based measures in the IPFQR Program. The first is the Follow-up After Hospitalization for Mental Illness measure. This measure has been publicly reported in the IPFQR Program since December 2016. However, this is the first year that CMS is providing an IPF-Specific Report to facilities for this measure. You'll note that this is Version 2.0 of the measure because several updates have been applied since the measure was last publicly reported. A list of those updates is available in the Claims-Based Measure Specification Manual on the *Quality Reporting Center* web site. The second measure is the 30-day All Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility measure. CMS conducted a confidential dry run of the measure in October of 2017, and this will be the first year that the measure is publicly reported. Facilities that downloaded their IPF-Specific Reports during a dry run will notice that the IPF-Specific Reports provided this year are very similar to those you received previously. This measure has also been updated since the dry run to Version 1.2, and those updates are also listed in the Claims-Based Specifications Manual on the *Quality Reporting Center* web site.

So, the purpose of today's presentation is to provide information on how to download your facility's IPF-Specific Report, if you haven't accessed it prior to this call, and we'll also refer to content of each IPF-Specific Report and provide tips on how to review and interpret your facility's data. Each IPF-Specific Report is accompanied by a user guide that also provides tips on how to review and interpret your facility's data.

The ISR Reports were distributed to facilities and QIOs by December 4, 2018, and that marks the start of the 30-day confidential review period. Facilities are encouraged to review their IPF-Specific Reports and send questions or comments on those reports to the *QualityNet* Help Desk no later than January 3, 2019. To download your IPF-Specific Reports, log into your *QualityNet* Secure Portal and open your AutoRoute inbox. Once there, you'll see a zip file that contains your IPF-Specific Report Excel file and PDF of the user guide, and you should receive those for each measure. Highlight that file and click Download. Facilities without an active CMS Certification Number will not receive an IPF-Specific Report zip file. If you don't see a file in your AutoRoute inbox and believe your facility should've received the file, please contact the *QualityNet* Help Desk for assistance.

Next, we'll review the IPF-Specific Report for Version 2.0 of the Follow-Up After Hospitalizations for Mental Illness measure.

Because the purpose of the IPF-Specific Report is to provide information to facilities to inform targeted quality improvement activity, I'd like to spend a minute orienting everyone to the goals of the Follow-Up measure. We recognize that there are many factors that can influence follow-up after psychiatric hospitalization, and some of those are beyond the control of the IPF facility. However, there is evidence that the inpatient facilities can and do influence follow-up rates in the outpatient setting. So, this measure is really meant to improve follow-up rates to the extent possible and produce variation in follow-up rates between facilities. That ensures that patients receive the same high-quality care at any inpatient psychiatric facility across the country.

This slide lists some examples of proven intervention and those include things like communicating discharge plans to patients and their caregivers, establishing contact with outpatient providers, discussing potential barriers to follow-up with a patient, you know, providing telephone or written reminders to patients, and then acting as a resource for patients between discharge and that first outpatient appointment. However, we also recognize that not all interventions to promote follow-up care are appropriate for every facility or every patient, and we encourage facilities to review their data in the IPF-Specific Report and develop interventions that best meet the needs of your patient populations.

With that, let's review the contents of the IPF-Specific Report for this measure. The report consists of five worksheets listed on this slide, and we'll review each in more detail on a subsequent slide.

When you first open your IPF-Specific Report for the Follow-Up measure, you'll open it to Worksheet 1 to review the summary. This includes your IPF name, CMS Certification Number, and state. If you notice discrepancies in any of your facility information, we ask that you please contact the *QualityNet* Help Desk before continuing to review your IPF-Specific Report. As a reminder, we ask that you do not email the IPF-Specific Report because it includes Personally Identifiable Information and Protected Health Information.

If all of the information on your Summary Worksheet is correct, you then open Worksheet 2 to review the information that will be publicly reported for this measure. So, you'll see in row 6 in Table 1, we provide the number of eligible discharges from your facility during the one-year performance period spanning July 1, 2016 through June 30, 2017. In this example, a facility had 85 discharges that met all measure inclusion and exclusion criteria. Row 8 shows what percentage of eligible discharges had their follow-up visit within 7 days of leaving a facility and row 9 shows what percentage of eligible discharges had a follow-up visit within 30 days of leaving a facility.

Rows 11 and 12 provide the 7- and 30-day follow-up rate among eligible patients discharged from inpatient psychiatric facilities nationwide. In this example, you can see that the fictional facility has higher percentages of patients that received follow-up within seven and 30 days than patients nationally. If your facility has fewer than 11 cases in row 6 the rates on rows 8 and 9 will not be publicly reported because of the small sample size. For more information on this worksheet, you would refer to pages 3 and 4 of your user guide. Then, as a reminder, information on the remaining worksheets that we'll cover are provided confidentially for each facility's benefit and will not be publicly reported like the information on this slide.

Worksheet 3 shows the national distributions of 7- and 30-day follow-up rates for facilities across the country. In this example, you can see that 1483 facilities had publicly reportable 7- and 30-day follow-up rates. Among those facilities, the minimum 7-day rate was zero percent and the maximum 7-day rate was almost 97 percent. Because this fictional facility's 7-day rate from the previous worksheet is 31.8 percent, which is higher than the rate of 28 percent for the 50th percentile, row 7 shows that this facility is in the 61st percentile. This means that 61 percent of facilities had a lower 7-day follow-up rate than this facility or, stated differently, this facility performs better than 61 percent of facilities on their 7-day follow-up rate. Rows 8 and 9 contain comparable information for the 30-day follow-up rate. For more information on this worksheet, you would refer to pages 4 and 5 of the user guide.

Worksheet 4 shows how the mix of patients in your denominator compares to the mix of patients nationwide. The first column lists principal discharge diagnosis categories. To help with the ease of interpretation, we've used clinically and meaningful groupings or ICD-10 codes created by the Agency for Health Care Research and Quality called Clinical Classification Software, or CCS, categories. The next four columns list the number and percent of eligible denominator discharges that had each of the principal discharge diagnoses and show the 7- and 30-day follow-up rate for patients with each of those principal discharge

diagnoses. In this example, 26 of the facilities' 85 denominator cases had a principal discharge diagnosis of schizophrenia or psychotic disorder. Those patients account for over 30 percent of their eligible discharges, whereas, nationally, almost 40 percent of the eligible discharges had a diagnosis of schizophrenia or psychotic disorder. You'll see that this facility has higher 7- and 30- day follow-up rates for those patients compared to similar patients nationwide. However, within this facility, their patients with schizophrenia or psychotic disorders have lower 7- and 30-day follow-up rates than their patients with principal mood disorders. Therefore, this fictional facility could potentially use the data to justify additional resources toward interventions specifically targeted at addressing the needs of their patients with schizophrenia or psychotic disorders. You'll notice that some cells contain the letters NQ. When you see that, that indicates that the facility did not have any qualifying cases with the diagnosis type listed in that row. In this example, the fictional facility did not treat any patients with principal antibody disorders and several other conditions listed. For more information on this worksheet, you would refer to pages 5 and 6 of your user guide.

Worksheet 5 contains more granular detail on each of the discharges that are included in your facility's denominator. Each row represents a unique discharge and is assigned an ID Number in the first column. In the example we've been discussing, this facility would have index admissions with ID Numbers 1 through 85 because they had 85 eligible discharges in the measure population. The next column lists the ID for the facility that treated the patient. This should always be your facility's ID. If you see any cases in the second column that do not have your facility's ID in this column, we ask again that you please contact the *QualityNet* Help Desk for further instruction. As a reminder, we ask that, if you do encounter any issues, that you please not attach the IPF-Specific Report or mention any of the PII or PHI in your inquiry. Once you've confirmed that all discharges were from your facility, the next five columns list the patient HIC number, medical record number, patient date of birth, and admission and discharge dates, so that you can link back to the medical record for more information if needed. Facilities can sort by the patient information

to see if there are types of patients who have been treated more than once during a performance period and who may need more personalized support to prevent a return to the hospital. The next four columns show the principal discharge diagnosis for the visit including both the ICD-10 code and higher-level diagnosis grouping, or CCS category, and whether the discharge is followed by a 7-or 30-day visit. Facilities can sort by diagnoses or by follow-up status to identify patterns or areas for improvement. In this example, the worksheet has been sorted so that the discharges with 7- and 30-day follow-ups are at the top as indicated by the Yes in those columns. The follow-up information is particularly informative because facilities may not always have known for sure whether their patients attended their follow-up appointments. So, this data can hopefully shine a light on which patients need the most support and whether existing interventions to improve follow-up rates have been effective. For more information on this worksheet, you would refer to pages 6 and 7 of your user guide. That concludes our summary of the IPF-Specific Report for the Follow-Up measure.

Next, we will review the IPF-Specific Report for the IPF Readmission measure.

Now, similar to the Follow-Up measure, the goal of the IPF Readmission measure is to improve overall rate and reduce variation rates between facilities to ensure that patients receive the same high-quality care at any inpatient psychiatric facility across the country. While there are factors beyond a facility's control that can impact the readmission rate, we also know that inpatient facilities can and do influence readmission rate. The five listed examples of interventions that have proven effective at reducing readmission rates and these include things like administering evidence-based treatments during a stay, connecting patients to post-discharge services, performing medication reconciliation at discharge, communicating with outpatient providers and, you know, really focusing on that discharge planning and patient education. However, again, we also recognize that not all the admission reduction strategies are appropriate for every facility or for every patient, and we encourage facilities to review

their data on the IPF-Specific Report and develop interventions that best meet the need of their patient population.

You'll notice that the IPF-Specific Report for the Readmission measure contains some of the same information as the IPF-Specific Report for the Follow-Up measure. However ,given the additional complexity of risk-adjusted measures like this one, the Readmission IPF-Specific Report contains additional information, and, while the IPF-Specific Report for the Readmission measure is similar to the one that was provided during the dry run last year, we recognize that not everyone on this call participated in the dry run webinar and those who did participate may want a refresher. So, we'll spend a little time reviewing each of the 11 worksheets on subsequent slides.

Worksheet 1 contains the same type of information as in your Follow-Up measure IPF-Specific Report. Again, if you notice discrepancies in any of your facility information, including your facility name or state, we ask that you please contact the *QualityNet* Help Desk before you continue to review your IPF-Specific Report. As a reminder again, we can't reiterate enough, please do not email your IPF-Specific Report because it includes that Personally Identifiable Information and Protected Health Information.

Worksheet 2 contains your facility's performance relative to the national readmission rate, and this is the information that will be publicly reported for the Readmission measure. Measure scores are presented as Risk-Standardized Readmission rates, or RSRRs, in row 8. Confidence intervals in rows 9 and 10 are calculated around each RSRR to determine whether the score is statistically different from the national readmission rate in row 11. If the national readmission rate falls between the lower and upper limit of the confidence interval, the facility's performance is considered no different than the national rate. That would be listed in row 6. Because lower rates are better for this measure, if the national rate was lower than the lower limit in row 9, then the facility performance would be statistically worse than the national rate and that would be indicated in row 6. Conversely, if the national rate was higher than the upper limit in row 10, then the facility performance would be statistically better than the

national rate and that would be indicated in row 6. So, you can see in this example the facility performance was worse than the national readmission rate because its confidence interval spans from approximately 21 percent to 26 percent and the national readmission rate is approximately 20 percent, so it's lower than that range. If the number of admissions in the measure population shown here in row 7 is less than 25, rows 8, 9, and 10 will not contain rates and no rates will be publicly reported due to the small sample size. For more information on this worksheet, you would refer to pages 3 and 4 of your user guide, and, similar to your Follow-Up [measure] ISR, the information on the remaining worksheet is provided confidentially for each facility's benefit and will not be publicly reported like the information on this worksheet.

Worksheet 3 provides an overview of how other facilities nationwide and within your state performed relative to the national readmission rate. So, in this example, row 7 shows that most facilities nationwide perform no different than the national readmission rate, and row 12 shows that most facilities in a fictional facility's state also performed no different than the national readmission rate. Row 6 shows how many facilities nationwide performed statistically better than the national rate, and row 8 shows how many facilities nationwide performed statistically worse than the national rate. Rows 11 and 13 provide the same information at the state level. Finally, rows 9 and 14 show the number of facilities with fewer than 25 cases in their measure population. In this example, there are 81 facilities nationwide and four facilities in the fictional facility's state that had fewer than 25 cases during the measurement period and those facilities were not assigned a performance category. For more information on this worksheet, you would refer to page 5 of your user guide.

Worksheet 4 is intended to provide more information on how the RSRR is calculated. First, the observed readmission rate in row 8 is calculated by dividing the number of unplanned readmissions in row 7 by the total number of index admissions in row 6. In this example, the observed readmission rate for the fictional facility is 28 percent. Next, the risk adjustment is applied to obtain a facility's standardized risk ratio, or SRR,

and that's relative to the national readmission rate, which has a standardized risk ratio of 1. In this example, the facility's standardized risk ratio in row 9 is more than 1 because it is worse than the national readmission rate. If a facility's rate was better than the national readmission rate, it would have a standardized risk ratio of less than 1. Next, the facility's standardized risk ratio is multiplied by the national readmission rate in row 8 to obtain the risk standardized readmission rate, or RSRR, in row 12. The same is done for the standardized risk ratios in the lower and upper interval estimates in rows 10 and 11, and that helps you to obtain the confidence intervals for the RSRRs in rows 13 and 14. You'll note that the RSRRs and interval estimates are not listed for the national data. This is because the national data set includes the entire eligible patient population, so there isn't uncertainty around the national rate or a need for risk adjustment. The individual facility rates are risk adjusted relative to the national data since each facility is a sample of the eligible patient population. For more information on this worksheet, you would refer to pages 5, 6, and 7 of your user guide.

In regard to your IPF-Specific Report for the Follow-Up measure, Worksheet 5 shows the distribution of facility rates on the IPF Readmission measure. Further, instead of displaying 7- and 30-day rates, Table 4 lists the distributions of observed readmission rates and with standardized readmission rates. In this example, you can see that 1611 facilities had publicly reportable readmission rates. Among those facilities, the minimum RSRR was 11.4 percent and the maximum RSRR was almost 36 percent. Because this fictional facility's RSRR from the previous worksheet is 23.7 percent, which is slightly lower than the rate of 23.8 percent for a 90th percentile, row 9 shows that this facility is in the 89th percentile. This means that 89 percent of facilities have a lower RSRR than the facility or, stated differently, that this facility performs worse than 89 percent of facilities on their RSRRs since lower RSRRs are better. For more information on this worksheet, you would refer to pages 7 and 8 of your user guide.

Table 5 on Worksheet 6 shows information on the most common diagnoses of index admissions and their specific readmission rate. The top of the table shows information for your facility and the bottom of the table shows national information for comparison. Similar to the previous IPF-Specific Report we reviewed, principal discharge diagnosis ICD-10 codes are grouped into clinically and meaningful PCS categories on the first column. The next two columns show the count and percent of index admissions of each diagnosis. So, in this example, the fictional facility treats a lower proportion of patients with psychosis than many facilities nationwide, as indicated by the blue boxes. The last two columns provide information on the observed readmission rates for patients with each diagnosis. One rate shows the readmission for any cause and the other shows readmission with a diagnosis that matches the index admission. So, in the example of patients with psychosis, that last column would indicate patients who were readmitted with a diagnosis of psychosis. In this example, you can all see that patients with psychosis have higher readmission rates at the fictional facility than patients with psychosis nationwide. The facility could use this information to target readmission reduction strategies to best meet the needs of their patients with psychosis, particularly around treatment of comorbid conditions because many of those patients are now being readmitted for psychosis. For more information on this worksheet, refer to pages 8 and 9 of the user guide.

Worksheet 7 helps facilities better understand their readmissions compared to facilities nationwide. Table 6 shows the total number of readmissions in row 7. In this example, a facility had 204 index admissions that were followed by an unplanned readmission. Among those readmissions, row 10 shows that 85 returned to their facility, and row 12 shows that 119 were readmitted to another facility. So, prior to this measure, the fictional facility may only have been aware of the 85 readmissions to their own facility; but, with this report they can see the additional readmissions that are occurring at other facilities. This report further breaks down the 119 readmissions to other facilities in rows 15 through 18 by showing that 71 readmissions were to other IPFs and 48 readmissions were to acute care hospitals. So, facilities could use this

information, you know, to reach out to other acute care hospitals or IPFs in their area to better coordinate care when their patients are readmitted after discharge. For more information on this worksheet, you would refer to page 9 of the user guide.

Table 7 in Worksheet 8 provides more information on readmissions at the patient level compared to patients nationwide. In this example, you can see that the facility has 728 index admissions in row 6 but only 472 patients in row 7, and that's because some patients may have had multiple index admissions during a performance period. In rows 9 and 10, you can see that the facility had 204 readmissions but only 138 patients because again patients may have had multiple index admissions that were followed by readmission during a performance period. This table further breaks down the readmissions by showing the number of patients who were only readmitted once and another of patients who were readmitted multiple times during a performance period. Now, in this example the fictional facility had 36 patients who were readmitted multiple times in the performance period, and that accounts for a slightly smaller percentage of patients with multiple readmissions than was observed nationwide in row 15. This facility could use this information in the table to find patients with multiple readmissions in the Discharge Level worksheet and they can use that to target readmission reduction interventions for patients that are at higher risk of readmission. For more information on this worksheet, you would refer to pages 9 and 10 of your user guide.

Table 8 in Worksheet 9 provides information on the most common diagnoses of readmissions with their counts and percentages amongst all readmissions. The top of the table shows this information for your facility and the bottom of the table shows national information for comparison. In this example, the rows and the blue boxes show that the facility has a higher percentage of patients readmitted for schizoaffective disorder than patients nationwide. This could be due to the fact that, as we saw in Worksheet 6, this facility treats more patients with schizoaffective disorders than many facilities nationwide. This facility could use the information to perhaps target readmission reduction strategies towards

patients with schizoaffective disorder to bring down their overall readmission rate. For more information on this worksheet, you would refer to pages 10 and 11 of your user guide.

Worksheet 10 shows how your facility's case mix of patients compares to patients nationwide. The example on this slide is truncated, but Table 9 in your IPF-Specific Report should include the full list of risk factors included in the measure. To interpret this information, let's look first at the risk factor for gender in row 8. This table indicates that approximately 55 percent of the fictional facility's 728 index admissions were for male patients. The fictional facility has a slightly higher percentage of male patients than was observed nationwide, which is only around 49 percent male patients. Looking next at age in this example, the facility has a slightly younger population than was observed nationwide. You can see they have higher percentages for the younger age groups than the national discharges. Moving down to the principal discharge diagnosis, you'll notice that some cells have the letters NQ instead of a percent. So, similar to what we saw in other worksheets, this indicates that none of the 728 index admissions had the risk factor in that row. The information in this worksheet may help facilities better understand their patient population relative to other IPFs, and that can help inform readmission reduction interventions that best meet the needs of very unique patient populations. For more information on this worksheet refer to pages 11 and 12 of the user guide.

Finally, Table 10 in Worksheet 11 provides more granular discharge-level data on each eligible index admission included in the measure population at your facility. Similar to IPF-Specific Report for the Follow-Up measure, each row represents the unique index admission and assigns an ID number in the first column. So, again, in this example, this facility would have index admissions of ID Numbers 1 through 728 because they have 728 index admissions in their measure population. The next column lists the ID for the facility that treated the patient, and, again, this should always be your facility's ID. If you see any cases in the second column that do not have your facility's ID, we ask that you please contact the *QualityNet*

Help Desk for further instruction. As one final reminder, we ask that you do not attach the IPF-Specific Report or mention any of the PII or PHI included in this worksheet when you send your inquiry. Once you have confirmed that all of the discharges were from your facility, the next five columns list the patient HIC number, medical record number, patient date of birth, and admission and discharge dates so that you can link back to the medical record for more information as needed. The next three columns show that principal discharge diagnosis for the visit including both the ICD-9 or ICD-10 code and higher-level diagnosis grouping, or CCS category. Then, it lists whether the discharge is followed by an unplanned readmission within 30 days of discharge. Facilities can sort by diagnoses or by readmission status to identify patterns or areas for improvement. In this example, the worksheet has been sorted so that index admissions followed by a readmission are at the top as indicated by the Yes in that column. So, this slide here is a continuation of the table in Worksheet 11. The remaining columns in this worksheet provide additional information on the readmissions that occurred, including the readmission date, discharge date, ICD-9 or ICD-10 code, and higher-level CCS condition category for the principal discharge diagnosis, whether the readmission occurred at your facility or another provider, whether the readmission was to an IPF, and finally the provider ID of the readmitting facility. So, this information can be used in the context of information provided on the previous worksheet to identify areas for quality improvement and specific types of patients who may require more targeted readmission reduction intervention. This information also allows facilities to identify other facilities in their area where patients are being readmitted and that can help improve care coordination. So, for more information on this worksheet you would refer to pages 12 and 13 of your user guide. With that, that concludes the summary of IPF-Specific Reports for the Readmission measure, and it also concludes our presentation on the IPF-Specific Reports in general. So, as a reminder, we would encourage everyone to download and review your report. If you have any questions or comments, please contact the *QualityNet* Help Desk by January 3, 2019. With that, I'll hand it over to Evette to close out today's webinar.

Evette Robinson: Thank you, Megan, for providing us with an overview of the ISRs for both of the IPFQR Program's claims-based measures. Now, we would like to take this opportunity to find out from our audience a bit of information regarding your plans for the ISRs. On your screen you should see a poll question. We have two for today's event. For this first one, we ask that you respond by selecting one of the options presented here on this screen that applies to you. So, the question: Prior to today's webinar did your IPF receive and download the ISRs? Select A if a representative from your IPF received and downloaded the ISRs. Select B if a representative from your IPF received but has not yet downloaded the ISRs. Select option C if no one from your IPF received the ISRs or select D if this question is not applicable to you because, for example, you may be representing a vendor or an agency or another such entity. So, I see that several responses have already come in. We'll give everyone about 15 more seconds or so to make their selection. Again, there's no right or wrong answer for this question. We're just really interested in getting an idea of the activities that occurred prior to today's webinar with regard to receipt and download of the ISRs for the claims-based measures. All right, we'll give everyone about ten more seconds. It does look like the responses are slowing down but give it a few more seconds here. All right, it does look like the majority of those who responded did receive and download the ISRs, more than half of those who responded. Then, about a little – almost 11 percent – received the ISRs, but they have not downloaded them yet. Almost the same percentage stated that no one at their IPF received the ISRs, and a little over 20 percent of you replied that this is not applicable to you. For those of you who represent an IPF that did not receive the ISRs, but you do believe that you should have received one, again, I'll remind you, as Megan mentioned, to contact the *QualityNet* Help Desk for assistance with that. So, let's move onto the next question.

How does your IPF plan to use the ISRs to inform quality improvement? For this question, you may select all that apply. You are not limited to selecting one answer. So, I'll just go through each of these options briefly and, as time goes on, we'll then look at a summary of all that have responded. So, you'll select option A if your IPF plans to evaluate the

current quality improvement activities that are going on there at your IPF; option B if your IPF plans to identify high-risk populations; and select option C if your IPF aims to use these ISRs to improve care coordination for patients and that can include of course care coordination for your patient with other providers in your area. Select option D if your IPF intends to use these ISRs to pursue other quality improvement activities that are not already described in options A, B, or C. Option D is for those who believe that the ISRs will not inform [those] quality improvements at their IPF [but will inform other activities]. Choose option E if your IPF is currently undecided regarding plans for the ISRs as they pertain to quality improvement or choose option [F] if this question is not applicable again because you may be representing a vendor, an agency, or another such entity. All right, so I know for our first question we had just over 200 participants respond. It looks like we're getting close to that number here. So, I'll wait a few more seconds for you to respond to this polling question. Again, there are no right or wrong answers. We are interested in learning more about what IPFs plan to do with these ISRs, and, again, we'll give everyone a few more seconds to respond to make your selection. All right, it looks like the responses are slowing down. So, we'll take a look at our overall results here. Okay, it looks like close to half of those who responded do plan to evaluate their current quality improvement activities. Then, another 39.2 percent are going to identify high-risk populations using these ISRs. Okay, a little over 48 percent of you plan to improve your care coordination for your patients using these ISRs. Then, there's also 22.6 percent who have other quality improvement activities in mind that were not already described. Okay, and then, there are about 27 percent who are undecided about their plans for their use of the ISRs, and another 14.1 percent for whom this is not applicable. Well, we just want to thank everyone who participated in the polling questions. This is very helpful information for us as we continue to proceed through this review period. With that, we'll continue for the remainder of today's presentation. Next slide, please.

As we wind down the remainder of today's webinar, I will briefly review some helpful resources we have available pertaining to the IPFQR Program in general as well as this review period for the ISRs. Next slide, please.

As Megan mentioned earlier in the presentation, there are resource documents available to facilities on the *Quality Reporting Center* web site in the IPFQR Program Resources and Tools tab. These resources are also now available on the *QualityNet* web page under Public Reporting of Data, the IPF Public Reporting of Data, section. The first of these items that we wanted to just highlight here is the Claims-Based Measure Specifications Manual, and the second item we want to highlight here is the Quick Reference Guide for the ISR Confidential Review Period. Be sure to go to this site that's listed here. You can click on that hyperlink in the PowerPoint presentation that you may have down – or in the presentation that you may have downloaded earlier today – and access these references there on *Quality Reporting Center*. Next slide, please.

CMS recommends that IPFs refer to the updated IPFQR Program Manual for information pertaining to the program. The latest version that's currently published on the *QualityNet* and *Quality Reporting Center* web sites contains information about program requirements, program measures, [and] various tools pertinent to the program. An updated version of the manual actually is in progress and we aim to publish that in the near future. Availability of that updated version of the manual will be announced via the IPFQR Program ListServe. Next slide, please.

As you can see, there [are] several hyperlinks available on this slide. You can actually click on the title of the table to access the IPFQR Program Resources page on the *QualityNet* web site. Additional active links on this slide are available for you to send us your questions about the program. We encourage everyone to use the *QualityNet* Q&A tool in particular because it does provide us the best means to track questions and answers, and it also delivers our responses directly to your email inbox. It's also an excellent way for you to let us know what kinds of questions and topics you would like for us to address in future webinars. We also recommend that you sign up for the IPFQR Program ListServe if you've not already

done so, as this is the way that we send communications to the IPFQR community pertaining to webinars, program updates, and other announcements. You can sign up to be added to the ListServe on the *QualityNet* ListServe Registration page. We encourage you to utilize available resources that are found on the *QualityNet* web site in the Inpatient Psychiatric Facilities dropdown menu to ensure appropriate knowledge of the IPFQR Program requirements and deadlines. This concludes the content for our webinar titled *IPFQR Program: Review of ISRs for CBMs*. I will now turn the presentation over to Deb Price, who will describe the continuing education process for this event.

Deb Price: Thank you very much, Evette. Today's webinar has been approved for one continuing education unit for the following boards. Next slide, please.

At the end of these slides, a survey will automatically pop up. The survey will take you to your certificate. Next slide, please.

Okay, if you do not immediately receive an email to the address, to the email address that you registered, this means that there's some kind of block on your email. What we recommend is that you go back to the link, the survey, go back to the link that says New Registration and start over. Next slide, please.

Okay, this is what the end of the survey will look like. As soon as our slides are done, this is what's going to pop up. At the bottom right hand side, you see a little Done button, so you take the survey. Click the Done. Next slide.

This page will pop up. There are two links on the slide. The first link is the New User link. So, if you've had any problems getting your certificates, please click on the New User link. If you have not had any problems, click the Existing User link. Now, I want to caution that you can use the Existing User link, but, if you don't get that automatic email, that means that, since you used this process, you now have a block on your email. So, now, what we're asking is go back. Use the New User link, and then you register. Next slide, please.

Okay, so this is what's going to pop up when you click on the New User link. We ask you put your first name, last name, and use a different email than the one that is getting blocked. Google, Yahoo, any personal email do not get blocked. The phone number, if you have a work phone number and that is associated with your work email, they're both blocked. Please use a different phone number. Next slide, please.

Okay, this is what pops up when you click on the Existing User. Your user name is your entire email including what's after the @ sign. So, for me, it'd be Dprice@gmail.com. Put the entire email address and then whatever password you use. Now, if you don't remember your password, click in that box and you'll be moved to where you can designate a new password. Next slide, please.

Okay. Now, we'd like to thank everyone for their time, and we hope to see all of you at our next event. Good-bye everyone.