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Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor (SC)

Today’s Presentation
Webinar Chat Questions

Chat Tool

• Submit questions pertinent to today’s topic.
• Any unanswered questions will be responded to and published in the *QualityNet* Questions and Answers (Q&A) Tool at a later date.
Quality Improvement Organizations and Inpatient Psychiatric Facilities Working Together to Reduce Readmissions

July 18, 2019
Speakers

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Centers for Medicare & Medicaid Services (CMS)

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Senior Quality Consultant, MPRO

Moderator

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Program Lead
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor
Purpose

This presentation will provide the inpatient psychiatric facility (IPF) community with an overview of the QIO Program and demonstrate how collaborative relationships with QIOs can reduce IPF readmissions and enhance patient outcomes.
Learning Objectives

At the conclusion of the program, attendees will understand the following:

• The purpose of QIOs
• The benefits of working with QIOs on quality improvement initiatives
• Ways QIOs can support IPFs
• How to contact your QIO
What are Quality Improvement Organizations (QIOs)?
What are Quality Improvement Organizations (QIOs)?

• A Quality Improvement Organization (QIO) is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare.

• QIOs are led by the Centers for Medicare & Medicaid Services (CMS).
What is the purpose of a QIO?

- QIOs work with all health care providers across the care continuum, including the following:
  - Hospitals
  - Nursing homes
  - Home health associations
  - Rural health centers
  - Critical access hospitals (CAHs)
  - Inpatient psychiatric facilities (IPFs)

- QIOs bring local providers and community leaders together to work on improving the quality of health care and related community services.
QIN-QIO Regions

11th Statement of Work Quality Improvement Network
Quality Improvement Organization Program Contracts

- Great Plains Quality Innovation Network (QIN A QIO 4)
- TMF (QIN B QIO 13)
- Lake Superior Quality Innovation Network (QIN C QIO 8)
- Telligen (QIN D QIO 12)
- HealthInsight (QIN E QIO 6)
- Alliant Georgia Medical Care Foundation (QIN F QIO 1)
- atom Alliance (QIN G QIO 3)
- Mountain Pacific Quality Health Foundation (QIN H QIO 9)
- Atlantic Quality Improvement Network (QIN I QIO 2)
- Quality Insights Quality Innovation Network (QIN J QIO 11)
- HQI (QIN K QIO 14)
- QualisHealth (QIN L QIO 10)
- Health Services Advisory Group (QIN M QIO 7)
- Healthcentric Advisors (QIN N QIO 5)
Quality Improvement Organizations and Inpatient Psychiatric Facilities Working Together to Reduce Readmissions

Benefits of Working with a QIO
How can QIOs support you?

- Conduct learning sessions regarding evidence-based care coordination models and information about IPF quality reporting.
- Offer technical assistance for implementing evidence-based best practices and providing reports and analysis of your readmission and follow-up rates.
- Connect your IPF with other facilities, key stakeholders, community organizations, and nationally recognized experts to address behavioral health concerns and strategies.
QIO Accomplishments

- **63,335** underserved and at-risk beneficiaries have been educated through Diabetes Self-Management Education programs

- **713,856** Nursing Home residents avoided antipsychotic medications across the country

- **77,830** hospital readmissions were avoided among Medicare Fee-for-Service beneficiaries in recruited communities
Quality Improvement Organizations and Inpatient Psychiatric Facilities Working Together to Reduce Readmissions

QIO Success Stories with IPF Readmissions
Lake Superior QIN-QIO

- The Lake Superior QIN-QIO partners with MPRO in Michigan, Stratis Health in Minnesota, and MetaStar in Wisconsin.
- The QIN-QIO assists CMS in improving healthcare for Medicare beneficiaries by convening and connecting providers to share knowledge and spread best practices for:
  - Behavioral Health
  - Care Coordination
  - Quality Improvement Initiatives
  - Heart health
  - Diabetes
  - Nursing homes
  - Adverse Drug Events (ADEs)
  - Antibiotic stewardship
  - Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)
  - Adult immunizations

2.39 Million Medicare Fee for Service Beneficiaries
Steps to Reducing All-Cause Readmissions in IPFs

The Lake Superior QIN-QIO assisted IPFs by:

- **Providing** technical assistance for implementing evidence-based best practices and providing reports and analysis
  - Example 1: Standardized quarterly reports of an IPFs readmission and follow-up rates
  - Example 2: Providing technical assistance tools
- **Conducting** learning sessions on evidence-based care coordination models and information about IPF quality reporting
  - Example 3: Conducting Stakeholder Sharing Calls
  - Example 4: Sharing community resources
- **Connecting** IPFs with other facilities, key stakeholders, community organizations, and nationally recognized experts to address behavioral health concerns and strategies
  - Example 5: Including IPFs in care coordination community coalitions
Standardized Quarterly Reports

- Review all-cause readmission data
- Compare recruited IPFs
- Provide IPFs with emergency department (ED) utilization and readmission rates
  - ED psychiatric nurse care manager justification
  - Termination of psychiatric crisis unit impact
  - Homeless shelter collaboration

Quarterly Inpatient Psychiatric Facility (IPF) Readmissions Report

Name of Hospital
XXXXXX Hospital

Centers of Medicare & Medicaid Services (CMS) Certification Number (CCN)
XXXXXX

State
WI

Overall Data Timeframe
Q4 2014 - Q3 2017

This material was prepared by Lake Superior Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The materials do not necessarily reflect CMS policy.
Standardized Quarterly Reports

Outcome of implementing an ED psychiatric nurse care manager program at an IPF

Chart 3: 30 Day Readmission Rates For IPF and ED Utilization
Rolling Year Inpatient Psychiatric Facility (IPF) Readmissions Report

Name of Hospital:
CCN:
Overall timeframe: Q4 2015 - Q3 2018

Chart 3 displays the rate of acute care visits within 30 days of discharge from for the MI Medicare FFS beneficiaries. The time periods are denoted by quarter number and year (e.g., Q1 2010). See Table 4 for detailed data.

The patients represented in this table were discharged from your IPF (discharges eligible for readmission) and could have readmitted to an inpatient facility (any acute care 30 day readmission) or been admitted for an ED visit (but not subsequently admitted as an inpatient).
Providing Technical Assistance Tools

Examples of technical assistance tools QIN-QIOs use to support IPFs include the following:

- READMIT: A Clinical Risk Index to Predict 30-day Readmission After Discharge from IPFs
- Best practices flyer
- Depression stop light tool for self monitoring
Providing Technical Assistance Tools: READMIT Tool

• READMIT is a clinically useful risk index, administered before discharge, for determining the probability of psychiatric readmission within 30 days of hospital discharge for general psychiatric inpatients.

• The researchers who developed the READMIT tool used population-based, socio-economic, and health data to develop this predictive model.

• Each 1 point increase in READMIT score increases the odds of 30-day readmission by 11 percent.

Factors associated with IPF readmission include:

- Past Readmissions
- Emergent Admissions, such as harm to self and others
- Age
- Diagnoses (such as psychosis, bipolar, and personality disorders), and unplanned discharge
- Medical co-morbidity
- Prior service use Intensity
- Time in hospital
Providing Technical Assistance Tools: READMIT Tool

- Each 1 point increase in READMIT score increased the odds of 30-day readmission by 11 percent
- Lake Superior QIN (MetaStar QIO) developed an easy-to-use scoring sheet to assist IPFs with using the READMIT tool.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Variable</th>
<th>Value</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;R&quot; Repeat Admission</td>
<td>Number Prior to Index</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;E&quot; Emergent Admission</td>
<td>Threat to Others</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Threat to Self</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to Care for Self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;A&quot; Age</td>
<td>Age Group (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;D&quot; Diagnosis and Discharge</td>
<td>Primary Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any Personality Disorder</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Unplanned Discharge</td>
<td></td>
<td></td>
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<tr>
<td>&quot;M&quot; Medical Morbidity</td>
<td>Charlson Comorbidity Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;I&quot; Intensity (past year)</td>
<td>Outpatient Psychiatric Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Department Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;T&quot; Time in Hospital</td>
<td>Length of Stay (days)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Risk of Readmission**
- Low

Total Possible Score 0
Providing Technical Assistance Tools: Best Practices Flyer

The Inpatient Psychiatric Facility Resources flyer includes the following:

- Information on readmission reduction models
- Webinars dedicated to innovative strategies for regional IPFs used to reduce readmissions

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**Inpatient Psychiatric Facility Resources**

Lake Superior Quality Innovation Network’s behavioral health initiative has compiled this inpatient psychiatric facility resource list to provide best practices, learning sessions, tools and journal articles targeted at reducing all-cause readmissions within the inpatient psychiatric facility context.

**The Bridge Model**


The Bridge Model is a person-centered, social work-led, interdisciplinary model of transitional care. Bridge emphasizes collaboration among hospitals, community-based providers, and the Aging Network in order to ensure a seamless continuum of health and community care access settings.

**Care Transition Interventions in Mental Health**


This article addresses three main questions regarding care transitions as related to psychiatric readmissions within existing frameworks. Interventions to improve care transitions were evaluated to determine if they could be adapted for the behavioral health population.

**An Effective Model to Reduce Psychiatric Readmissions**


One hospital’s behavioral health performance improvement committee monitored 30-day psychiatric readmissions and examined variables related to patient population, diagnostic profile, payer source and the interdisciplinary team members providing care. This document outlines the outcomes they developed regarding strategies for reducing readmissions specific to IPFs.

**Interdisciplinary Meetings and Mental Health Treatment Orders**


Presentation by Michelle Baker and Hen, John D. Tomlinson at the 2017 Care Coordination Summit on the importance of community partnerships in addressing mental health.

**Medicare Psychiatric Patients and Readmissions in the Inpatient Psychiatric Facility Prospective Payment System**


This article focuses on readmission analysis regarding the discrete issues raised by the admission and readmission patterns for IPFs paid under the Medicare IPPS Prospective Payment System (IPPS).

**Project RED (Re-engineered Discharge Toolkit)**

[https://www.uab.edu/collegenationalsystems/transitioncare/toolkit/howto.html](https://www.uab.edu/collegenationalsystems/transitioncare/toolkit/howto.html)

This program was developed and tested by the Boston University Medical Center and this toolkit was put together with their help to assist hospitals, especially ones serving diverse populations, reduce readmissions. This toolkit is very comprehensive and covers an extensive amount of information related to implementation, delivering services, follow-up and monitoring outcomes.

**RARE (Reducing Avoidable Readmissions Effectively)**


This material was prepared by the Lake Superior Quality Innovation Network, in partnership with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. The material does not necessarily reflect CMS policy. [180/01/17-AO-201407]
Providing Technical Assistance Tools: Zone Tool

Self-Management for Depression Zone Tool

- Patients and caregivers use the tool to monitor symptoms of depression.
Conducting Stakeholder Sharing Calls

The Lake Superior QIN-QIO hosts stakeholder sharing calls to discuss best practices and address topics such as:

- READMIT Tool overview
- High utilization interdisciplinary team structure and success
- Step-down program integration into IPFs
- Care Transitions Models adapted to IPFs
# Sharing Community Resources: Strategies for Readmission Reduction

<table>
<thead>
<tr>
<th>Timeline</th>
<th>RARE Components</th>
<th>Project RED</th>
<th>Bridge Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During Stay</strong></td>
<td><strong>Patient/Family Engagement</strong></td>
<td>• Review patient information</td>
<td>Patient Engagement</td>
</tr>
<tr>
<td></td>
<td>Educate patient and family or caregivers (teach back)</td>
<td>• Confer with medical team</td>
<td>Assessment of patient needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Educate patient/caregivers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review how to respond to problems (teach back)</td>
<td></td>
</tr>
<tr>
<td><strong>Medication Management</strong></td>
<td>• Medication reconciliation at each care transition</td>
<td>• Identify correct medications</td>
<td>Coordinated Care</td>
</tr>
<tr>
<td></td>
<td>• Patient educated on medications (teach back)</td>
<td>• Confirm medication plan</td>
<td>Ongoing assessment of patient needs</td>
</tr>
<tr>
<td></td>
<td>• Address special populations</td>
<td>• Follow up on labs</td>
<td></td>
</tr>
<tr>
<td><strong>Transition/Discharge Process</strong></td>
<td><strong>Transition Planning</strong></td>
<td>• Provide a written patient-centered transition plan</td>
<td>Primary Care Integration</td>
</tr>
<tr>
<td></td>
<td>• ID a crisis management plan</td>
<td>• Create after hospital care plan</td>
<td>Use of Community Resources</td>
</tr>
<tr>
<td></td>
<td>• Educate patient and family on care transition providers</td>
<td>• Organize post-discharge services and equipment</td>
<td>• Establish plan of care collaboration</td>
</tr>
<tr>
<td></td>
<td>• Notify primary care and mental health providers</td>
<td>• Makes post-discharge follow up appointments</td>
<td>• Provide referrals to community resources</td>
</tr>
<tr>
<td></td>
<td>• Send discharge summary</td>
<td>• Provide patient with discharge plan; teach the plan, assess understanding</td>
<td>• Educate caregiver on community resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of AHCP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transmits discharge summary</td>
<td></td>
</tr>
<tr>
<td><strong>Post-Discharge Support</strong></td>
<td><strong>Transition Care Support</strong></td>
<td>• Calls to reinforce discharge plan within 48 to 72 hours</td>
<td>Community Resources</td>
</tr>
<tr>
<td></td>
<td>Contact the patient within 72 hours</td>
<td>• Staff the patient help line</td>
<td>• Contact patient/caregivers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 2-day, 2-week, and 30-day assessments</td>
</tr>
</tbody>
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7/18/2019
Including IPFs in Care Coordination

Community Coalitions

https://www.lsquin.org/initiatives/behavioralhealth/
How can I find my QIN-QIO?

Locate and contact your QIN-QIO here:
https://qioprogram.org/locate-your-qio
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADE</td>
<td>adverse drug event</td>
</tr>
<tr>
<td>APM</td>
<td>Alternative Payment Model</td>
</tr>
<tr>
<td>APU</td>
<td>annual payment update</td>
</tr>
<tr>
<td>CAH</td>
<td>critical access hospital</td>
</tr>
<tr>
<td>CE</td>
<td>continuing education</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>ED</td>
<td>emergency department</td>
</tr>
<tr>
<td>IPF</td>
<td>inpatient psychiatric facility</td>
</tr>
<tr>
<td>IPFQR</td>
<td>Inpatient Psychiatric Facility Quality Reporting</td>
</tr>
<tr>
<td>MIPS</td>
<td>Merit-Based Incentive Payment System</td>
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<tr>
<td>PPS</td>
<td>prospective payment system</td>
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<tr>
<td>QIN</td>
<td>Quality Innovation Network</td>
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<td>Quality Improvement Organization</td>
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<td>Value, Incentives, and Quality Reporting</td>
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</tbody>
</table>
Quality Improvement Organizations and Inpatient Psychiatric Facilities Working Together to Reduce Readmissions

Helpful Resources
Future Webinar Topics

FY 2020 IPF PPS Final Rule and APU Determination
- Overview of changes to the IPFQR Program, as outlined in the FY 2020 IPF PPS Final Rule
- Summary of the APU determination and reconsideration processes

FY 2020 IPFQR Program Data Review
- Review national-level data submitted during the summer 2019 data submission period

Future webinar titles, dates, and times will be communicated via the IPFQR Program ListServe.
Helpful Resources

IPFQR Program Webpages (Click the Icons)

Quality Reporting Center

QualityNet
Helpful Resources

Stay up to date….

…and get answers to your questions.
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Thank You
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