



Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Support Contractor

A Community Approach to Follow-Up Care

Presentation Transcript

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Evette Robinson: To maximize the usefulness of the summarized questions-and-answers document for this webinar, we will consolidate the questions received during this event and focus on the most important and frequently asked questions. If you have a question that is not related to today's webinar topic, we recommend that you go to the *QualityNet* Q&A tool by clicking on the link on this slide. There, you can 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 previously published summary of webinar questions-and-answers document.

Hello, everyone and welcome to today's Inpatient Psychiatric Facility Quality Reporting Program webinar. My name is Evette Robinson, and I am the Project Lead with the VIQR Support Contractor for the IPFQR Program. I would like to welcome you to today's event, *A Community Approach to Follow-Up Care*. This presentation is a case study of one hospital's community approach to follow-up care and is provided for potential interest and general educational value for IPFQR Program participants. CMS aims to share some of the strategies used at Behavioral Health Charlotte to inspire stakeholders of the IPFQR Program to address challenges that may impact follow-up care for psychiatric patients. The presentation's content is provided by Behavioral Health Charlotte. The material and opinions that are included in this webinar are those of Behavioral Health Charlotte, not necessarily those of CMS.

We are fortunate to have as our guest speakers for today's webinar, Victor Armstrong and Allison Wolfe. Victor Armstrong is Vice President of Behavioral Health with Atrium Health, based in Charlotte, North Carolina, and serves as Facility Executive of Behavioral Health Charlotte. As such, he is responsible for operational and strategic oversight of the 66 inpatient beds, the psychiatric emergency department, and 10 provider-based, outpatient behavioral health programs on the BHC campus. Prior to his role with Atrium, at Behavioral Health Charlotte, Victor served as Behavioral Health Medicine Program Manager with the Cone Health System. Victor has worked on the payer side of behavioral health through the Medicaid Managed Care Organizations, as well as in community

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mental health. He currently serves on the Board of Directors of National Council for Behavioral Health, American Foundation for Suicide Prevention North Carolina, i2i Center for Integrative Health, and is a former Board President for the National Alliance on Mental Illness, North Carolina. Additionally, Victor serves on the Mecklenburg County Mental Health Task Force and the Mecklenburg Provider Council Executive Board, among many other committees and subcommittees. Victor graduated Magna Cum Laude with a degree in Business Administration from North Carolina Central University and received his graduate degree in Social Work from East Carolina University. Allison Wolfe is the Director of Social Work Services for Atrium Health, Behavioral Health Charlotte. She has the responsibility for the mental health clinicians, the discharge coordinators, and peer support teammates throughout the psychiatric hospital. Allison has over 15 years of clinical experience, working with individuals in a variety of inpatient and outpatient settings. She earned her undergraduate degree in psychology in 2000, as well as her Master of Social Work degree in 2003 from Virginia Commonwealth University. Allison utilizes a trauma-informed and recovery-oriented approach to treatment. She is a member of the National Association of Social Workers, National Alliance on Mental Illness, and the International Association of Peer Supporters. Again, my name is Evette Robinson, and I will serve as one of the moderators for today's event, along with Dr. Jeffrey Buck, who is the Program Lead for the IPFQR Program and the Senior Advisor for Behavioral Health in the Center for Clinical Standards and Quality in the Centers for Medicare & Medicaid Services.

In this presentation, our guest speakers will share information about Behavioral Health Charlotte strategies for successful patient transitions into the community post-discharge from an IPF, the importance of establishing and maintaining community partnerships in the optimization of patient follow-up care, and the key outcome metric used to track and improve transitions that are directly attributed to the community partnership.

By the end of this presentation, participants will be able to describe strategies for successful patient transitions into the community post-

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discharge from an IPF, community partnerships and their role in the optimization of patient follow-up care, as well as key outcome measures to track and improve transitions in care.

This slide lists the acronyms that will be referenced during today's presentation.

Without further ado, I will turn the presentation over to our first speaker, Victor Armstrong.

Victor Armstrong: Thank you, Evette.

The Behavioral Health Charlotte campus is at the center of behavioral health service delivery in Mecklenburg County, North County, and the surrounding areas. The volume of patients seen combined with the service array uniquely positions Behavioral Health Charlotte to leverage relationships with our managed care organization and with community providers.

The history of Behavioral Health Charlotte is unique in that BHC was once the county hospital, and as such, this facility has traditionally been the destination for the uninsured and served as a safety net for the community. In addition, Atrium Health opened a second behavioral health hospital approximately 30 miles from BHC in May of 2014. The new facility was designed to be a mood disorder facility and BHC was designated as the thought disorder facility. The ratio of patients with a diagnosis of psychosis versus patients without a diagnosis of psychosis increased as a result of opening the second behavioral health hospital. In addition, there was a decrease in availability of state-operated beds due to staffing issues at state hospitals.

From 2014 to 2016, there was a 41 percent increase in the number of psychiatric patients presenting to acute care emergency departments within the Atrium system. During the same time frame, Atrium EDs experienced a 48 percent increase in the number of psychiatric patients waiting more than 120 hours for inpatient admissions due to limited resources and increasing acuity. During inpatient care, challenges persisted with discharge planning, contributing to as high as a 24 percent

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increase in length of stay at our behavioral health facilities. This further perpetuates backlog in the system, particularly with throughput in acute care emergency departments.

BHC has a total of 66 inpatient beds; 44 adult, 22 child and adolescent. We generally run at or near capacity year-round, only closing beds for construction or due to acuity or programming. For example, we sometimes have transgender patients that we may end up providing a single room for that patient. We operate the only psychiatric emergency department in the Southeast, staffed 24/7 with board-certified psychiatrists. Our observation unit really functions much like a facility-based crisis with an average length of stay of about three days.

Slide 16 depicts the payer mix for Behavioral Health Charlotte. BHC is again, historically, the county hospital. In addition, the facility's 66 inpatient beds include 22 child and adolescent beds. These factors combine to create a consistently high volume of Medicaid patients. The higher volume of Medicaid is an added incentive for our managed care organization to partner with us to manage transitional care in that our MCO Cardinal Innovations manages the Medicaid dollars and the funds for the uninsured in our area.

In comparing the first six months of each year, 2014, 2015, 2016, BHC saw an increase in the ratio of adult patients experiencing systems of psychosis. For behavior to be identified as psychotic, it must be grossly disorganized and the patient lack the insight into its nature. These patients, primarily diagnosed with schizophrenia, are often not in touch with reality and require longer inpatient hospitalizations to stabilize. They also inherently pose greater difficulty with discharge as external resources are limited. These patients have often exhausted resources, such as housing and family support, which increases the difficulty of engaging them in enhanced services.

In comparing inpatient psychiatric data for 2014, 2015, 2016, BHC saw an increase in the number of patients with a diagnosis of intellectual and developmental disabilities, as well, and patients on the autism spectrum.

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These patients inherently pose greater difficulty with discharge, and external resources, again, are limited. In addition, many of these patients are dually diagnosed with mental health and IDD. There are also often family dynamics and guardianship issues that can interfere with discharge. At this point, I'm going to turn it over to my colleague, Allison, and she's going to tell you a little bit more about our process.

Allison Wolfe:

The purpose of this Harvey Ball diagram was to help our senior leadership analyze options on how to respond to the increase in length of stay and the increase of patients presenting with psychosis and intellectual disabilities, or having autism spectrum disorder. This was not only happening at BHC but across all of our acute care hospitals. So, we needed to identify options of tackling these issues. So, on the left-hand side, you see our identified options. One was, increase our interaction with care management, or our community partners, to ensure patients have the community to support their needs. The second one was to increase patient bed capacity in the hopes of decreasing the wait time in the EDs for an inpatient bed. The third is to increase outpatient services that might divert patients from the hospital. And, fourth is, create programming or units specific to the population where we see the increase in volumes. These options are being cross-referenced by the impact they would make. For instance, when you look at the overall population, the demand for care management or coordination of care, is far greater than the need for a specialized unit for patients with autism or intellectual disabilities. However, patients with autism or intellectual disabilities are extremely difficult to place, so they end up in acute care EDs for an extensive time. So, taking all of this information into account, it was decided that while seeing the trend with certain populations was important, the impact of targeting special programming for this population would not give us the most impact for our overall need, which is keeping patients stabilized in their communities. Therefore, we chose to look at who we can utilize among external stakeholders, including the MCOs, to help with care management.

At BHC, we realized that so much of the health outcomes of the patients we serve is driven by social determinants. There is growing recognition

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that social and economic factors shape the ability of individuals to engage in healthy behaviors. We further realized that only a fraction of those determinants can be impacted by our facility. We needed to be able to address social determinants while in the inpatient setting, as well as partner with our external stakeholders that understand the holistic needs of our patients and can work with our patients when they are discharged from the hospital.

Our next step was how to engage our community stakeholders to share the responsibility of care management for the patients we have in common. Three specific methods were used for accurate and timely identification of needs and to get the involvement of community stakeholders. First, within 24 hours of admission, to facilitate the biopsychosocial assessment and really focus on identifying all current and past community providers and care managers, as well as the patient's natural support. Second, a treatment team that includes professionals that understand the whole patient, like having a pharmacist who can identify what medication will work to meet the needs of the patient and also that they can afford. A peer support specialist that can discuss social determinants impacting the trajectory of wellness, and what community resources will be needed to meet those challenges, like needing a food bank, for instance. Third, timely discharge planning, starting at admission, and looking at engaging the community stakeholders as early as possible that would be providing post-hospital services.

Victor Armstrong: Taking all that into account, the next question is, how do we get there? Slide 22, you see there a diagram of the resource care management strategies during a psychiatric hospital stay. Addressing the social determinants in order to provide whole person care required that we identify the partners needed to address the patient's needs, both in and outside our facility, and then to build and/or enhance those relationships. This diagram from Robert Wood Johnson's County Health Rankings outlines the complexity of care management. We try to keep in mind that patients don't operate and don't live in a vacuum, but they're impacted by things that we generally don't have control over in an inpatient setting.

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So, taking all those things into account, what is the end game? What is it that we're trying to accomplish? The goal of the whole person care is the coordination of health, behavioral health, and social determinants in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. As you can see in the diagram, we're looking at physical well-being, spiritual, occupational, and all the other components of a person's overall health as opposed to just focusing on healthcare.

Allison Wolfe: This is a list of some of the support services that we connect patients to. In the next several slides, we'll provide you with an overview of a few of these programs.

At Behavioral Health Charlotte, we made the decision several years ago to move toward the recovery model of care, which focuses more on holistic care rather than primarily being medical-focused. Despite there not being a service definition for peer support in the hospital setting, there was growing evidence to support that peer support specialists are an essential ingredient for recovery-oriented programs. Therefore, BHC hired three peer support specialists for our adult inpatient unit and emergency room. This slide shows the standard four functions of peer support originated for outpatient peers. BHC adopted this model to fit in the inpatient setting.

So, what is peer support? Peer support specialists have lived experience with symptoms of mental illness or addictive disease. They must be in recovery from the illness and have gone through a certification process to be employed in our inpatient unit and provide services to our patients. The peer support specialists on the inpatient unit facilitate support groups, as well as talks individually with patients to assess needs that they may not have discussed with their medical providers. The peer support specialist's focus is on the social determinants that we know impact the trajectory of illness, such as needing a stable home, food, employment, sobriety, and social support. Peer support specialists, due to their lived experiences, are often able to gain more personal information from patients that is important to their healthcare and treatment plans. This information is shared during treatment teams and is used to identify what community

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resources are going to be needed to help with the care management of the patients. In addition, a large part of their service has to do with providing hope and encouragement. Because without hope and belief in a better tomorrow, individuals are less likely to follow through with their treatments.

This slide identified more specifically what a peer is responsible for. For example, a patient diagnosed with schizophrenia might enjoy reading. One of their recovery goals may be to obtain a library card, identify a nearby library, and come up with a weekly schedule that includes trips to the library for recreation and socialization. Or, if the depressed patient enjoys music, the peer can help them identify inspiring music and the goal can be to make a playlist that helps them get out of bed in the morning. These may seem like trivial goals but to someone struggling with the symptoms of a mental illness or addictive disease, identifying coping skills such as reading and music that create joy and productivity are crucial to wellness and recovery, as well as the avoidance of negative patterns of thinking and behavior. Peer support specialists help build confidence by sharing their own story of recovery. They take pride in not sharing the mess of their story but instead the message. They focus on overcoming obstacles, believing in themselves, and finding the strength to pursue their recovery. Finally, they help to find appropriate services and ensure that patients get there, like driving someone with an addictive disease to their local AA or NA meeting.

This slide highlights in practical terms how peers can help in the recovery of patients living with mental illness. When patients are able to interact and receive support from people who have walked in their shoes, it elevates hope of recovery. It creates an environment where patients are more likely to engage in programming and partnering with clinical staff in their recovery. It empowers the patient to take ownership of their own recovery, and it reduces the likelihood of readmission.

As a result of the community's shared investment in stabilizing individuals in the community and the shared understanding that timely follow-up care is essential to sustained wellness, the Peer Bridger Program was established. Involved stakeholders include BHC; Cardinal Innovations,

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our MCO; and community providers. The goal is to improve outcomes related to patients discharging from the hospital and linking to community providers. The first step in the Peer Bridger Program is to identify patients eligible for the program. Then a peer support specialist on the inpatient unit will discuss their role with the patient and how a peer support specialist in the community could then serve their needs. If the patient is agreeable to the program, a referral will be made to a participating provider.

During the second step, the participating outpatient peer support specialist will meet the patient on the inpatient unit. This will help to establish a therapeutic rapport and collect all necessary information. Depending on the length of time the patient is on the inpatient unit, there could be another visit prior to discharge, or the outpatient peer support specialist will meet the patient the day and time of discharge. The outpatient peer support specialist will transport the patient home in an effort to further their relationship, as well as meet the people in the home of the identified patient. These relationships will prove to be helpful in continuing to engage the patient in the community.

After discharge, there is communication between the hospital and the outpatient provider to ensure that the shared consumer made it to their follow-up appointment. If the shared consumer was not able to be engaged in the community and missed the follow-up appointment, the outpatient provider will try to call the patient and reengage them. If that doesn't work, then they will send mobile engagement to the patient's home as another attempt to engage in outpatient services.

In addition to the components put into place in our facility and partnerships put into place for a handoff to community partners, we recognize the need for partners downstream. The next few slides highlight some of those collaborative partnerships, and Vic will speak to those.

Victor Armstrong: One of the services that we talked about was mobile engagement. Mobile engagement is an extension of a mobile crisis team. We use mobile engagement in non-crisis situations for follow-up if the post-discharge appointment is missed. The community provider agency can contact the

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mobile crisis provider agency to request follow-up if the appointment is missed.

Community members can also utilize Atrium Health 24/7 help line. This line is staffed with clinicians who are able to do things from assess individuals in crisis with suicide risk to educating families on behavioral health community resources. They also schedule appointments for community members in our Behavioral Health Charlotte outpatient clinics.

As a payer for Medicaid patients and those patients who are uninsured, a partnership with Cardinal Innovations, our local managed care organization, MCO, was critical. They're also a major driver in being able to engage community providers who receive payment for Medicaid services through Cardinal. When Cardinal Innovations assumed the role of the MCO, they also created a 24/7 help line, however it was catering primarily to the Medicaid consumers. Like Behavioral Health Charlotte, Cardinal Innovations also offers a 24-hour crisis service line. Although they operate independently of one another, each will also make referrals to the other. For example, Cardinal may receive a call from a BHC patient who has private insurance. As Cardinal is not the payer for privately insured patients, that patient may be referred to BHC. In addition, the patient may be a recipient of outpatient services in our BHC campus.

One of the other services that we provide on our BHC campus is what we call our Eagle Program. The Eagle Program is actually a first-episode psychosis program. It's an evidence-based program that provides wraparound services to young adults, ages 15 to 30, and their families, who live in Mecklenburg County and who have dealt with psychosis in the past three years. This program was started in 2017 with a grant funded by SAMHSA. So, the criteria are that the person must be age 15 to 30, must be a resident of Mecklenburg County, and the first episode of psychosis must have occurred within the past three years. No previous diagnosis of neurodevelopmental disorder or intellectual disability can exist, and IQ has to be above 70. Substance use disorder is not the primary diagnosis, and psychosis was not solely substance-induced in order for them to qualify for the first-episode psychosis or Eagle's program.

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The next few slides will describe some of the key outcome metrics at Behavioral Health Charlotte.

Slide 38 depicts the outpatient services located on the BHC campus, to which we refer patients and track outcome metrics. We show you this slide for a couple of reasons. One is that it helps give you an idea of what type of outpatient programs we run here that we're referring patients to. It also helps to really clarify, I think, for anyone who is looking at the services we provide, how we're able to leverage both the MCO and our community providers because of the volume of services that we provide here at our BHC campus.

In March 2015, Behavioral Health Charlotte began tracking the scheduling of post-discharge hospital follow-up appointments for patients that were on our inpatient unit, as well as the show rate for those appointments. The table in this slide reflects data collected, starting in calendar year 2016 through the first quarter of 2018. The top line shows the percentage of patients that left the inpatient unit with a hospital follow-up appointment with a community provider within five business days. The bottom line shows the percentage of patients that showed up to that appointment. It's worth noting that we also increased the number of outpatient providers we refer to and track each year. Now, let's take a look at how readmission rates have improved over the years as a result of implementing some of the transitional care process described earlier in today's presentation.

Behavioral Health Charlotte also measures readmissions of psychiatric patients by tracking the number of patients discharged from our inpatient psychiatric units in which the patient presents for readmission for psychiatric purposes within 30 days of discharge. Readmission rates within 30 days of discharge fell from 7.56 percent at the end of 2015 to 5.77 percent at the end of 2017 at Behavioral Health Charlotte. The readmission rates listed on this slide represent the readmissions for psychiatric reasons only. That concludes this portion of today's webinar. I'll turn things back over to Evette at this point.

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Evette Robinson: Thank you, Victor and Allison, for sharing with us Behavioral Health Charlotte's community approach to follow-up care. Now, I would like to switch gears and turn the presentation over to Dr. Jeffrey Buck, who has a few questions for you both about the information you shared with us today.

Dr. Jeffrey Buck: Thanks, Evette. Victor and Allison, you mentioned a number of components that you think contributed to your improvement. Which of these do you consider to be the most important?

Allison Wolfe: Jeff, I think communication between everybody involved was one of the most important things. We found if we didn't have good communication between our frontline staff, as well as our management staff, then the systems wouldn't work well together. We really needed to understand each other's workflow and understand how to get in touch with each other when there was change in patient care or changes in different systems. So, communication was key. Another part is really understanding that the hospital is just one little piece to a wider system that the patient engages in. So, at any given moment in this patient's life, so many different systems are touching them. So again, communication and the realization that we are all in this together for this patient was really helpful for us to understand.

Dr. Jeffrey Buck: Thank you. I have another question. Of all the changes you made, which do you think were the hardest; and in particular, which were the most challenging to get staff to adapt to?

Victor Armstrong: I think, Jeff, probably the hardest was changing the hospital culture. You can change processes, but changing culture is a whole lot more difficult, and it was a matter of changing hospital culture to not just focus on the medical treatment of the person, but also that the social determinants impact the trajectory of the illness. In looking at changing the culture though, we had to look at changing the culture both internally and externally. A lot of it involved having our providers and our staff here at Behavioral Health Charlotte to begin to look differently at the patient, look at the whole patient, look at, including family, look at what impacted that person's ability to get to services outside our facility. But it also involved changing the culture and the way that we interact with folks outside of our

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facility. Hospitals, a lot of times by nature, particularly behavioral health hospitals, are not always accustomed to trusting external entities for the care of patients. And, what was happening in large part with us was that, once we discharged that patient, we didn't necessarily trust the folks in the community, but we didn't really have a structured way of having any communication with them. So, we had to have, really had to have a cultural shift in how we were not only relating to the patient and the patient's environment, but also how we were responding and reacting, communicating with those folks outside of our facility.

Dr. Jeffrey Buck: Thank you. And so, maybe a final question. Based on your experience, what would be the most important things you would share with other inpatient psychiatric facilities that are seeking to improve transitions in care as they relate to follow-up and readmission rates?

Victor Armstrong: So, Allison and I have talked about this, and I think we've identified several things. One, I'll start with identifying the gaps. You have to be able to look at what's impacting the care of that patient and identify where those gaps in services are, identify what is missing from your service array, understand that you can't be all things to that patient, and then realizing that you have to be able to identify what it is that's missing, and then how you make those connections.

Allison Wolfe: And that leads into identifying what community partners can fill in those pieces. For example, if we're on a treatment team looking at what medication this person is leaving with and what they can afford, we also need to know what pharmacies can work with our patients to ensure that they have the medication they can afford. Another example is, you know, we found through our peer support that some of our readmitted folks were readmitted, not because they weren't taking their medication, but because they weren't taking their medication with food because there was no food in the house. So, the community partner might be a food bank so that we can ensure that our patients are taking their medication with food.

Victor Armstrong: Yeah, and I think that leads into really developing a collective plan. Because you've got to look at, once you identify where the gaps are and

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identify who the community partners are, then you've got to figure out, how do I get these players at the table? How do I get the right people at the table and how do I get them to take interest in what we're doing? And I think, for a lot of us, that becomes the challenge because looking at the MCO, looking at the community providers, we often operate in our own silos, and we're not really thinking about it collectively in terms of how do we work together to serve the patient. That, in part, means that you have to have a really honest assessment of yourself and realize, not only what you think that you're doing in the community, but how you're perceived in the community. So, part of that collective plan really involves us taking a look at ourselves and recognizing that we were not always the best community partners ourselves. And then, taking the time to try to understand, what is it that the community needs? What does the MCO need? What does our Department of Social Services need? What do the community partners need? And then, how can we help them to be able to meet their needs, while they're also looking at how they can help us meet our need, and coming at it from more of a collective partnership.

Allison Wolfe: And, I'm going to talk a little bit about how measuring outcomes fits into that. So obviously, measuring outcomes is, then we know if it works for our patients or not, right? Because it all comes back to, are we serving the needs of our patients? One thing that we found is, one of the providers that we were tracking the readmissions with and if they're following up at their hospital follow-up appointments, we found that one was falling short. And, what we found was, if we had their admission paperwork, and we could help the patient work on that admission paperwork while they're here in the hospital, ready to be being discharged, then we found that that handoff worked a lot smoother; and those outcomes started to increase in the right way. So, measuring outcomes leads to further action planning to further help reach the goals that we're looking for.

Victor Armstrong: One thing I would add, too, is that we decided to take a proactive approach. One thing that we did early on was, we began to invite people into our facility. We would host community meetings where we invited social services, we invited community providers, we invited the MCO. We

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even invited a local elected official, county commissioners, and a couple of state representatives. We invited local judges, and we brought people into our facility and began to look at how we were collectively failing our patients. And, that caused everyone to take some ownership. And then, from there, it was a matter of, now what do we put in place and how do we move toward having a more structured approach to how we serve our patients? Now, the good thing about that is, is that leads us to one of the final things I want to talk to you about and that is spreading the news of positive results. Because when you—now, when we talk to folks in the community, they feel like they're partners in this with us. So, we start talking about how we're providing better care for our patients. It is more easy for us to involve those and engage those community providers in helping to spread the word about what positive things we're doing here because they feel like they've been partners in it with us. And so, one way that we're able to continually grow this process and perpetuate the progress that we've made is by sharing and spreading the positive news about the results that we're getting. And, when we're talking about the providers that have partnered with us and how valuable their partnership is, it makes other providers also want to partner with us. That also, though, goes to spreading positive results internally with our teammates, too. When we're talking about the positive results that we've had, I'd mentioned earlier that our teammates internally oftentimes weren't trusting of the external environment. Where now, as we're talking about the positive things that we've done to be able to impact the care of our patients, we're also able to talk about the impact that our teammates have had; our peer support specialists, our social workers, our nurses, our providers. And, they take some pride also in knowing that they were a huge piece in making these positive results come about. I think, in conclusion, the key takeaways are: partner with your community providers; establish relationships with both your patients and your provider community; and, in establishing those relationships with the patient, also realize that the patients' families have to be included in that and key stakeholders in the patients' lives. And then also, participate in programs that have patient navigators with peers because navigating one's healthcare has become increasingly challenging. And so, the more that you can have folks with lived experience and folks that know how to navigate these systems, the

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more successful you're going to be in helping that person to have the best health outcome as possible. Thank you.

Dr. Jeffrey Buck: Well, thank you. That's very informative, and I want to thank both of you again, for all the time you've taken to share this information with us today.

Allison Wolfe: Thank you.

Victor Armstrong: Thank you.

Dr. Jeffrey Buck: And now, I'm going to return things over to Evette.

Evette Robinson: Once again, I would like to thank our guest speakers, Victor Armstrong and Allison Wolfe, for presenting today's topic, *A Community Approach to Follow-Up Care*. I'd also like to thank Dr. Jeffrey Buck for engaging our guest speakers in a round-table discussion. In the next two slides, we will review some helpful resources pertaining to the IPFQR Program overall.

CMS recommends that IPFs refer to the most recent IPFQR Program Manual for information pertaining to the IPFQR Program. The manual is located on the *QualityNet* and *Quality Reporting Center* websites, and it contains information about program requirements, program measures for the upcoming payment-determination year, as well as links to helpful optional paper tools pertinent to the data-submission process.

You can click on the title of the table on this slide to access the IPFQR Program Resources page on the *QualityNet* website. Additional active links on this slide are available for you to send us your questions about the IPFQR Program. We encourage you to use the Q&A tool in particular because it provides the best means by which we can track questions and answers and also delivers our responses directly to your email inbox. Additionally, this is a great way for you to let us know what types of questions and topics you would like for us to address in future webinars. We recommend that you sign up for the IPFQR Program ListServe if you have not already done so, so that you can receive communications that we send out to the IPFQR community, pertaining to webinars, program updates, and other announcements. You can sign up to be added to the

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ListServe on the *QualityNet* ListServe Registration page. We encourage you to utilize available resources found on the *QualityNet* website in the Inpatient Psychiatric Facilities drop-down menu to ensure appropriate knowledge of the IPFQR Program requirements and deadlines.

This concludes the content portion of the webinar titled, *A Community Approach to Follow-Up Care*. We thank you for your time and attention.