Inpatient Psychiatric Facility Quality Reporting Program

Support Contractor

Overview of the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) Measure

Presentation Transcript

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Matt McDounough: Hello, and thank you for joining us for today's webinar. My name is Matt McDonough, and I am going to be your virtual host for today's event. Before we get started and turn things over to our speakers, I'd like to cover some event housekeeping items with you, so that you understand how today's event is going to work and also how you can interact with our speakers on today's call. As you can see on this slide, we are streaming our audio for today's call over ReadyTalk®'s Internet streaming service. If you are hearing my voice coming out of your speakers or headphones right now, then you are connected. This service means that no telephone line is required to listen to today's event. But, you do need to have those speakers or headphones plugged in and turned up to hear the streaming audio feed. If, for some reason, you are not able to stream audio today or you encounter issues with the streaming audio feed, we do have a limited number of dial-in lines available. Please just send us a chat message, if you need to dial in, and we will get that number out to you as soon as

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All of our attendees are in a listen-only mode today. But, that doesn't mean that you can't interact with our speakers today. We encourage you to submit any questions or comments you may have to our speakers at any

time today using the Chat with Presenter feature located in the bottom left corner of your screen. Simply type your question or comment into the Chat with Presenter box and click the Send button. Your feedback will be visible to all of our presenters on today's call. As time, resources and the availability of answers allows, we will address as many questions as possible either verbally or in the chat window. Please do note, however, that if we don't get to your question today, all questions submitted during today's event are being archived to be addressed in a future Q&A document. That is going to do it for my introduction. So, at this point, I'd like to hand things over to our first speaker. Thanks for your time, and enjoy today's event.

Evette Robinson: Hello, everyone, and welcome to today's IPFQR Program webinar. My name is Evette Robinson, and I am the project lead with the VIQR support contractor for the Inpatient Psychiatric Facility Quality Reporting Program. Before we begin today's webinar, I would like to remind those in attendance that 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 the Quality Reporting Center website at www.qualityreportingcenter.com. On the right side of the homepage, you will find 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. This session is being recorded, and the slides, transcript, webinar recording, and questions and answers for this presentation will be posted on the *QualityNet* and Quality Reporting Center website at a later date. In attendance with us today from CMS is Dr. Jeff Buck, the IPFQR Program Lead. At this time, I will turn it over to Dr. Buck, who will set the stage for today's webinar, which is entitled *Overview of the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility Measure*. Dr. Buck, the floor is yours.

Jeffrey Buck: Thank you, Evette. And thank all of you for attending this webinar on the new All-Cause Psychiatric Readmission measure that has been developed for use in the IPFQR Program. For several years, we have been stating

our intention to develop such a measure. And, additionally, other groups, such as the Measures Application Partnership that reviews quality measures for CMS Programs, have also urged us to develop such a measure. We believe the need for having a readmission measure is clear.

First, studies have shown that readmission rates for behavioral health disorders are as high, or higher, than other conditions for which CMS has already developed readmission measures. But, additionally, and at least as importantly, psychiatric readmissions appear to be unique and different from other conditions for which readmission measures have been developed, in that more than half of the readmissions, psychiatric readmissions, are for the same reason as the initial admission. In other words, unlike other conditions for which readmission measures have been developed, people who are readmitted after an initial treatment for a psychiatric disorder, when they do come back to the hospital, a majority – a large majority of them – are coming back again for a psychiatric – for treatment of a psychiatric diagnosis. This is unlike other conditions, in – where the majority of the readmissions for other conditions are for other reasons, even though people are still coming back to the hospital within 30 days. So, with that in mind, we have developed this measure. And, because we think that there may be a greater interest in this measure than many others that we have introduced in our program, this webinar goes beyond simply describing the specifications for the measure; and, instead – or, in addition – provides detail about how it was developed and tested. In particular, we hope that it will help you understand what went into the development of the risk adjustment methodology for the measure and what its likely impact will be on reported readmission rates. Thank you. Now, I will turn things back over to Evette.

Evette Robinson: Thank you, Dr. Buck. And, now, I would like to introduce our guest speaker for today's event, Dr. Kyle Campbell. Dr. Campbell is a pharmacist and health services researcher with expertise in quality measure development, project management and clinical pharmacy. As executive director of the Inpatient Psychiatric Facility Outcome and Process Measure Development and Maintenance Contract, he oversees all

aspects of the project and advises on measure development and specifications. He received a PharmD from the University of Florida. Dr. Campbell, the floor is yours.

Kyle Campbell: Well, thank you, Jeff; and thank you, Evette. We are very excited this afternoon to talk to you about the overview of the 30-Day All-Cause Unplanned Readmission measure that our team has been developing.

The purpose for today's talk is to really teach you about the background of the All-Cause Unplanned Readmission measure: what we did in terms of the development process for the measure; and to help you better understand the final measure specification; and to really look at how the measure compares to existing readmission measures; and let you know about future plans for the measure.

And, that corresponds very directly to the learning objectives of the presentation, which are to explain the development process, interpret the final readmission measure specification, and describe our future plan.

We have included a slide in here for acronyms. So, in case there are any acronyms included in the slides that you are not familiar with, they are there for your reference.

So, the first thing I wanted to do was provide a background for you on really the business case for how we determined that this would be an important measure for the IPF setting.

The first thing is, we looked very carefully at the frequency of readmissions following IPF admissions and found that they were very common. In fact, more than 20 percent of IPF admissions were followed by a readmission within 30 days of discharge, using the 2012 and 2013 national Medicare dataset. We also found that there was a fairly wide variation in readmission rates between facilities. And, when we looked at the tenth percentile, which is really the highest-performing facilities. We found that they were about 12 percent, and the ninetieth percentile was about 27 percent. So, there was actually a 15-percent difference between

high- and low-performing facilities. And, we know from our experience in other programs that readmissions are very costly. And, in fact, in the IPF setting in 2012, the average admission costs Medicare nearly $10,000. And, we heard that readmissions are very undesirable outcomes for both patient and their caregivers. It represents a deterioration in the patient's condition, and it can definitely disrupt the recovery process.

The other thing with outcome measures that we have to evaluate very carefully is the potential for a provider to influence those outcomes. And, thankfully, there was ample literature both from the acute care setting, but also from – specific to the IPF setting – that IPFs around the country had established effective strategies to reduce readmission rates. And, they are listed here on the slide and include things like administering evidence-based treatment, connecting patients to post-discharge services and follow-up care, performing adequate medication reconciliation, providing appropriate communication between care providers, and providing discharge planning, including patient education.

So, starting with slide 12, I am going to explain to you the process for how we develop the measure specifications for this particular measure. And, to begin with, I just want to frame the conversation by discussing how CMS intends to use this measure.

It has been proposed for use in the Inpatient Facility Quality Reporting Program. And, as you know, this is a pay-for-reporting program. It is not a pay-for-performance program. The measure itself will be calculated using administrative claims data. So, we don't expect an additional data collection burden for facilities. We are actively working on an ICD-10 conversion process and are planning to conduct a national dry run with all facilities in the country in 2017. The measure is planned to be publicly reported on Hospital Compare in 2018 and have been submitted to NQF for endorsement consideration.

So, when we set out to develop this particular measure, there were a few things that we were particularly interested in. The first is, we wanted to

develop a 30-day readmission measure for IPFs for the initial index admission being a psychiatric diagnosis. And, we wanted the measure to be based on administrative claims data. Where reasonable, we wanted to align specifications with the existing measures that CMS has related to readmissions across other settings. And, we wanted to include readmissions for all causes. We were particularly interested in ensuring that the measure was risk adjusted appropriately. And, we wanted to be as inclusive in terms of the age range of beneficiaries as possible. So, we included beneficiaries that are 18 years of age and older.

The measure development process, if you are not familiar with CMS measure development processes, is guided by a comprehensive set of business processes called the Measure Management System Blueprint. And, in particular, the blueprint recommends or requires that measure developers use a technical expert panel that incorporates the perspective of both the patient and the caregiver as well as clinical and methodological experts. And in our case, we also used an expert workgroup composed of clinicians and billing experts in the IPF setting. And, the measure development process starts with the development of a business case, which is really a concise summary of the rationale for why we think that this would be an important quality measure to look at. Then, we spend quite a considerable amount of time in developing and testing both cohort and outcome definitions, some of which I am going to review with you. And, this is conducted, again, in the context with experts in various fields evaluating the results and providing feedback to us. Similarly, we develop and test a risk model. And, in the case, of this measure, we divided our risk model development into two phases. The first phase really focused on more traditional variables that we typically use in risk adjustment, such as clinical conditions and comorbidities. And, the second phase of the risk adjustment looks specifically at potential adjustment for sociodemographic status factors, which we will talk about today.

We also conduct a national public comment, once we have developed a methodology report and a summarized testing result and a draft specification, so that we can receive input from national stakeholders.

And then, we – once we complete that process, we submit the measure for NQF endorsement consideration. And, this particular measure is scheduled for NQF review in June of 2016.

So, with the target population, as I mentioned, we started with the idea of focusing on principal psychiatric diagnoses. And for the definition, we used the ARHQ Clinical Classification Software, which helps us to group ICD-9 codes. And, you can see for this particular measure, the grouping that we focused on ranged from CCS' of 650 to 670. What we have done here for you in the data is to bold those conditions for which we had the greatest proportion of admissions coded. And, you can see those are delirium, dementia, and other cognitive disorders, mood disorders, and schizophrenia and other psychiatric disorders – or psychotic disorders, rather.

On slide 17, we describe our target population development. And here, we have patients identified that are aged 18 years of age and older. It does require that patients are enrolled in Medicare Parts A and B. And that is because we use a lookback period of 12 months prior to the measure to identify risk factors using both the Part A and B data. And, it should be noted that patients younger than 65, with severe mental illness, can qualify for Medicare due to disability and, therefore, we were able to set the measure age criteria of 18.

In terms of exclusions, we looked to exclude patients that were discharged against medical advice, those for which we had unreliable vital status data, patients that were transferred. So, if a patient is transferred to an acute care setting, we felt that the intervening readmission could potentially influence readmission rates; and, therefore, didn't want to hold the IPF accountable. And, we also had a unique situation within the billing practices of the IPF, known as the interrupted stay. And, for this issue, the IPF billing procedures combines readmission into the same claim as an initial admission, if the patient is readmitted to the same IPF within three days of discharge. So, essentially, anything less than three days, we

cannot identify using the administrative data as a readmission and, therefore, we excluded those admissions from readmission considerations.

In terms of the target population development summary, then what we have is, across our dataset looking January 1, 2012, to December 31, 2013, is about 782,000 discharges. And, you can see that very few of those are excluded due to unreliable data. There are more that are excluded due to the transfer and interrupted stay issue and, then, about one percent for discharges against medical advice. The final – excuse me – the final cohort that we are using for our testing dataset represents about 716,000 discharges.

Moving on now to the outcome development, as we mentioned, we were interested in an all-cause readmission measure. And there are several reasons for that. Perhaps, the most important is that we want to foster innovative treatments that really look at the patients as a whole across both psychiatric and medical settings. And, we believe, by having an all-cause readmission measure that this type of practice is fostered. Secondly, the readmission relationship between readmission and admission diagnoses is very complex. It's difficult to discern, let's say, if a patient was admitted for schizophrenia and then they had a hip fracture and were admitted to an acute care facility. The relationship between that diagnosis and the readmission could have, in fact, been because of the medication prescribed for schizophrenia. And, if you look at all the various complex diagnoses and relationships that could occur between an index admission and a readmission, it is very difficult to make that consideration. And so, we think, for that reason, it's best to focus on all-cause readmissions. Another thing that we mentioned at the outset is, we are attempting to harmonize and align measures across various settings of care within CMS, and all the other measures that focus on readmission focus on all-cause readmission. And, we think that focusing on all-cause readmission really allows IPFs to implement a broader range of quality improvement initiatives and foster that innovative care and quality improvement that we are really looking for.

To describe for you just the breakdown of the readmissions, we have included on this slide that about 76 percent of readmissions are for psychiatric diagnoses, and only about a quarter of the readmissions are for non-psychiatric diagnoses. And, we have broken down here for you the sort of the frequency distribution of the diagnoses that were identified. And, you can see far and away that schizophrenia and mood disorders represent sort of the highest frequency of readmissions. And, you can see that the non-psychiatric readmissions would appear much lower on the list.

Another consideration in the development of the outcome is planned readmissions. So, there are certain times when the physician is interested in bringing a patient back to the facility for a specific treatment, which is considered planned. And, we looked very carefully at how this particular process is address in the Acute Care Hospital-wide readmission measure. And, we also worked very closely with our expert workgroup to potentially consider scenarios that would be unique to the IPF setting. And, the experts recommended in the end that we harmonize directly with the planned algorithm for the hospital-wide readmission measure. And, you see here that the frequency of planned readmission measures is pretty rare in the IPF setting.

In terms of the incidence period, we did settle on the 30-day incidence period. And, there are a number of reasons for that, the first of which, again, is consistency with the other NQF-endorsed measures across the other settings of care. This timeframe or incidence period is supported by the literature as an indicator of quality of care. And, efforts already in practice – you know, some of the interventions that we described to you earlier in the presentation, really focus on reducing 30-day readmission rates. And, we should note that multiple readmissions within the 30-day period are only counted once.

Now, I want to move on to – we have described for you the definitions related to the cohort and the outcome. Now, I want to move on for you to the risk model development. And, so, this little bar chart here just

describes for you the various factors that go into the variation in measure rates between when we compare facilities nationally. And, what we are most interested in identifying is sort of this box shown here in orange, which is the performance differences between facilities. And, there are things known as random factors that we really can't do anything about. And, we presume or assume that those random factors stay random for a facility, for example, in California compared to a facility in Florida. But, there are other things related to the case mix of the patient and patient-identified characteristics that we hope that we can potentially risk adjust for. And, that is where we are going to spend our time talking about in the next few slides.

So, there are some general considerations that we think about in terms of risk model development for CMS measures. The first is, we focus on those variables that would be considered patient characteristics. So, we are not interested in the characteristics of the IPF or the system at large. We are interested in those variables that really describe for us the condition of the patient. And, these variables must be present at the start of care. We were not interested in variables that could potentially occur during the process of care. We are interested in things that have happened prior to the start of care. And, we want to ensure that those variables don't include anything that might be reflective of the quality of care provided. And, we will talk about that in this presentation a little bit. And, the variables need to be related to the outcome conceptually and empirically. And, they also need to be available in national datasets. So, there are many things that could potentially be considered for variables that might not be available for all the patients within our data. And, then, we also look for risk factors to be as parsimonious as possible.

So, in the risk model development shown here on slide 26, we evaluated in phase one the typical variables to be evaluated. And, those include demographic variables, the principal discharge diagnoses of the index admissions, the comorbidities that had been identified for the patient and other psychiatric-specific risk factors that were identified in the literature. We'll talk about phase two, which was the identification of

sociodemographic status variables and their subsequent evaluation in just a little bit.

So, the risk model development for phase one – I am going to share with you the results. We identified gender and age in seven groupings, as well as principal discharge diagnoses, comorbidities that were identified from the hierarchical condition categories grouping in ICD-9, including 13 psychiatric CCs and 25 non-psychiatrics CCs and, then, other variables that we identified 12 months prior to admission from the literature and in consultation with our expert workgroup and our technical expert panel. And, those include having a history of being discharged against medical advice, having a history of suicide attempt or self-harm and a measure to identify potential aggression. So, those are the variables that were included in the risk model development phase one.

In phase two, as I mentioned, we looked very comprehensively at what sociodemographic status risk variables could be considered. And, to identify these variables, we did a comprehensive literature review. We look at variables – SDS variables that were being considered by other measure developers. And, we solicited input from our workgroup and technical expert panel. We then took all of that information and looked at the available data and the variables that were available on the data, such as the claims data, the census, American Community Survey, data available from HRSA and the national provider files and constructed variables for consideration. From these variables, we then performed various statistical techniques to identify empirically their associations with readmission. And, then, in the end, for those variables that went through this process, we looked at the impact of including them in our risk model that have been prior-developed.

So, here on slide 29, you can see the variables that were considered. And, I will say that this was a very comprehensive look across a number of different sociodemographic status variables. However, I will point out that some of the variables, in fact many of the variables, could only be identified at the neighborhood level. So, what that means, for example, to

contrast for you – so, Medicaid enrollment is an example of a variable that we had identified unique to each individual patient. Unemployment, the variable listed here, is something that we could essentially impute from the area or census area for which the patient resided in. So, within their neighborhood, we could say in general that unemployment was high or was low. And those relationships may, in fact, not represent the – you know, the true status of the patient. They serve at this point as a proxy, and are the best that we can do in terms of attempting to assign sociodemographic status variables to patients. So, that is an important limitation of this work.

The results of the SDS risk factors testing were surprising to us in a few different ways. The first is that some of the risk factors that we identified had associations with readmission that were opposite of the effect that we had identified in the literature. And, a very good example of this is the provider-to-patient ratio. So, we hypothesized that, and the literature told us that, readmissions would potentially be lower in areas where there were a larger number of providers that could provide adequate ambulatory services to patients. And, conversely, those areas that were maybe more rural and have fewer providers would have higher readmission rates because those patients didn't have appropriate support services to help prevent readmissions. And what we found, in fact, was exactly the opposite. So, the urban areas and the areas with the higher density of providers actually had higher rates of readmission than the rural areas. The second that was interesting in our findings was that there was a correlation between SDS and clinical variables, which really limited the ability of the SDS variables to describe the association with readmission. And, what I mean was – is specifically that our standard model that we started out with in phase one, was really adequately describing the risk of patients and the influence on readmission. And, when we added the SDS variables into the model, most of that risk had already – an association had already been accounted for. And, we will show you a little bit about that here in a moment. And, then, the third thing was: one of the things that I mentioned at the outset of the talk is, we are particularly concerned that

we don't insert risk variables that could potentially adjust away differences in quality. And we are particularly sensitive to the fact that we don't want to risk adjust away disparities – the potential disparities in care. And, what we found when we looked across race and ethnicity and disabled was that disabled black and Hispanic patients had significantly lower odds of readmissions at hospitals with higher performance than those hospitals with lower performance. And, that association was linear as we compared sort of the various quartiles of performance. And, one of the potential explanations for that is that adjustment for those variables could partially adjust for IPF quality and/or potentially a disparity in care. And, even though that is not the only explanation, it gave us significant cause and rationale for excluding those potential variables from consideration.

So, I show you here the model performance with the original model and the model adding in the SDS risk factors. And, one of the primary statistics that is used to describe a risk model is the C-statistic, which you see here on this slide. And, you could see that the two are nearly or virtually identical between the original model and the original model with the SDS factors added in. So, they did not, in any way, improve the model performance; and, therefore, they were not recommended for inclusion.

So, what I'd like to round out the presentation with for you is: just sharing with you reference slides for the final measure specifications, and describing to you the testing results that we found when we looked at the 2012-2013 data, the national dataset.

So, as we talked about before, here on slide 33, the target population includes all those 18 years of age and older. Patients have to be discharged alive and they must be enrolled in Medicare Part A and B according to those criteria listed. And, this measure does exclude admissions for patients that don't have psychiatric principal discharge diagnoses, those that were discharged against medical advice, where there is unreliable data, and this issue related to interrupted stay that we discussed earlier.

The outcome, then, is a facility-level risk-standardized readmission rate within 30 days of discharge from the IPF. Readmission is defined as an unplanned subsequent inpatient admission to an IPF or a short-stay acute care hospital. And this is inclusive of critical access hospitals for any cause. There is a 24-month performance period. And, the reason for this is that we wanted to ensure that the case volume was adequate to include the majority of IPFs so that the measure could be reported. And you should note that readmissions are also eligible as a subsequent index admission, as long as they meet all the other eligibility criteria.

Risk adjustment, we just reviewed with you. So, that is gender, age, principal discharge diagnoses, the comorbidities listed here, and those other variables present from 12 months prior to admission.

And, here are the results looking across approximately 1,700 IPF facilities in the country. And, you can see that the observe rate, the mean is about 19.4 percent, and the risk-standardized rate is about 21 percent. The variation in performance, if we look again at the 10th percentile – so, these would be the highest-performing facilities, their risk-standardized rate is about 17.3, and the 90th percentile for them about 24.95. So, still a substantial difference between high-performing and low-performing hospitals. And, you can see on the graph that risk adjustment has the tendency to pull all of the facility scores towards that mean. And that is represented by the curve in red. And the curve in blue is representative of unadjusted rates.

The other thing we wanted to share with you is how performance categories looked across the national dataset. So, we had approximately 8.3 percent of IPFs that would be classified better than the national rate, the vast majority being no different than the national rate. But, we had about 13.4 percent of facilities that were worse than the national rate. And, the other thing to note on this slide is that we used to cut off in testing fewer than 25 cases during the performance period to exclude IPFs. Using those criteria, we would exclude approximately 4.2 percent of IPFs.

We also include here, as we mentioned – we worked very close with CMS and some of the other developers of the measures for the other settings to harmonize. And, we wanted to include for you a reference to how the measure is aligned and what the differences are between our measure and the hospital-wide readmission measure. A couple of things to point out is: the 24-month performance period, again, because of the case volume in the IPFs. Also to note is the model performance, which is essentially at the upper end of the range of model performance, when compared to the hospital-wide readmission measure. And, you can see in the facility classification that we have more IPFs that are better than the national rate; but, we also have many more that are worse than the national rate. And, that would be expected given that this measure is – hasn't been reported to date and, you know, the hospital-wide readmission measure has previously been reported and has been a focus of targeted quality improvement.

So, just in summary of the public comments we received: so, all of this information – it was summarized in a methodology report and testing report and draft specifications, and those were put out for public comment. And, we heard from the national stakeholders were that the majority of commenters were very supportive of the measure and felt it addressed an important quality concept. We did receive some key considerations that we felt like we have addressed, through the testing process and the literature review. One of those was related to the preventability of readmissions and attribution to the IPF. We know that not all readmissions that are classified in this measure are preventable. But, we also know from the literature that a number of them are, and there are clear evidence-based interventions that can be used to prevent readmissions in the IPF setting. There was a note of a shortage of mental health services, which we did note and provide to CMS. There was a request to evaluate adjustment for sociodemographic factors, which we feel that we did very comprehensively, and a desire to ensure that measures are harmonized, which we discussed. And, the issue of trying to match readmission diagnoses with their subsequent or prior admission diagnoses, as we discussed, is something that is not done in the other

readmission measures and would be exceedingly difficult to do in the measure specification. The measure was submitted by CMS to the Measures Application Partnership, which is convened by the NQF to advise HHS on the potential inclusion of measures in reporting programs. And, this measure was conditionally supported for the IPFQR. And, we heard from the MAP that they would like to see the evaluation of SDS risk factors, which, as we discussed, is completed.

So, finally, I will just describe to you the future plans for the measure, where we are in the process.

The measure, as I mentioned, is scheduled for NQF review in June of 2016. The NQF looks very carefully at some key criteria related to the measure. They look at how important the measure is. They look at scientific acceptability in terms of reliability and validity. And, we have included some of those results in the reference slides here available to you. They look at the feasibility of the measure and also the usability.

And, the steering committee, this time, will evaluate very carefully the testing results that we have shown you on the sociodemographic status variables, as NQF is considering the potential inclusion of these variables. And, so, any recommendations that could come from this committee would be considered in future updates to the measure. And, following the endorsement process, should the measure be endorsed, the measure would be scheduled to be updated annually and submitted for full re-endorsement consideration every three years.

We also will be very carefully monitoring the measure specifications and will be updating them annually based on updates to the code sets. As we mentioned, the transition from ICD-9 to ICD-10 will need to be incorporated. We will evaluate very closely any recommendations we receive from stakeholders concerning the implementation and the use of the measure, once it is released. And, any new empirical evidence or changes to clinical practice that might necessitate a change in the measure, all of that will be carefully monitored by the team at HSAG.

And, I just want – a finalize teh presentation just acknowledging the group of folks both from Health Services Advisory Group…

… and the University of Florida, who really made this measure possible and did all the hard work to bring it to fruition.

We also had an excellent technical expert panel representing a diverse set of stakeholders across the country, nationally recognized…

… And, we want to acknowledge their contribution to this measure.

And on slide 48, I just wanted to acknowledge the broad base support that we have received from CMS across various divisions and, in particular, thank Vinitha and Lein, Judy and Jeff, who have provided continuous feedback and support throughout the development process, as well as other contractors developing measures related to readmission, specifically Yale and RTI, who also provided support to us as we developed the measure.

So, with that, I want to close and hand it over to my colleague, Evette, who is going to provide for you some helpful links and resources that you can use to find further information on this measure. So, thank you, all, for your attention today, and we really appreciate the opportunity to present this measure to you. Thank you.

Evette Robinson: Thank you, Dr. Campbell, for providing those resources that relate to the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF measure. The next few slides contain information pertinent to the IPFQR Program as a whole.

Future webinars will be posted on the events calendar found on the Quality Reporting Center website. Information about the upcoming webinars can be accessed from the qualityreportingcenter.com homepage under the events calendar. And, of course, we encourage you to sign up for the IPFQR Program ListServe, so that you have notifications of upcoming events and other program-related topics delivered directly to

your email inbox. We plan to present the next two educational webinars during the month of May. These webinars will include one in which we will provide a thorough of the fiscal year 2017 IPF PPS proposed rule, followed by a webinar entitled *IPFQR Program 101 and Advanced Directives*. And, in the latter webinar, we aim to address commonly-asked questions, as well as misconceptions about the IPFQR Program, in addition to providing responses to questions pertaining to the advanced care plan element of the Transition Record Measures. In June, we plan to hold a webinar entitled *Keys to Successful Data Submission* in preparation for the upcoming data submission period. Again, we strongly recommend that all attendees sign up for the IPFQR Program ListServe, if you have not already done so to ensure that you receive notifications about these events. And we also encourage you to monitor the events calendar on the Quality Reporting Center website for updates, registration fliers and links to webinar slides.

This slide includes active links that you can click on to send us your questions about the IPFQR Program. We encourage you to use the Q&A tool. And we also recommend that, if you have any questions that you would like to address through our inpatient live chat, to use the link indicated in the top right of this slide. We also offer e-mail and phone support. And, you can certainly contact us via secure fax, if needed, at the fax number in the bottom of this slide. We also encourage you to utilize all available resources that are currently housed on the *QualityNet* and Quality Reporting Center websites. On the *QualityNet* website, you would go to the Inpatient Psychiatric Facilities dropdown menu. And, there, you will find updated information pertaining to the program requirements and deadlines.

As with previous webinars, we will cover all questions that were provided through the chat tool in an upcoming questions and answers transcript. And, that will be published within the next couple of weeks.

We will not have a live Q&A session for today's session due to lack of time. But, we do encourage you to monitor your emails, and we will

announce when the Q&A transcript is available. And now, I will turn the presentation over to Deb Price, who will discuss the CE credit process for this webinar.

Deb Price: Well, thank you very much. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider. And, as such, all nurses report their own credits to their board using the national provider number 16578. It is your responsibility to submit this number to your own accrediting body for your credits.

We now have an online CE certificate process. You can receive your CE certificate two ways. First way is if you register for the webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. We will also be sending out the survey link in an email to all participants within the next 48 hours. If there are others listening to the event that are not registered in ReadyTalk®, please pass the survey to them. After completion of the survey, you will notice at the bottom right hand corner a little gray box that says "Done." You will click the Done box, and then, another page opens up. That separate page will allow you to register on our Learning Management Center. This is a completely separate registration from the one that you did in ReadyTalk®. Please use your personal email for this separate registration, so you can receive your certificate. Healthcare facilities have firewalls that seem to be blocking our certificates from entering your computer.

If you do not immediately receive a response to the email that you signed up with the Learning Management Center, that means you have a firewall up that is blocking the link into your computer. Please go back to the new user link and register a personal email account. Personal emails do not have firewalls up. If you can't get back to your new user link, just wait 48 hours because, remember, you are going to be getting another link and another survey sent to you within 48 hours.

OK. This is what the survey will look like. It will pop up at the end of the event and will be sent to all attendees within 48 hours. Click "Done" at the bottom of the page when you are finished.

This is what pops up after you click Done on the survey. If you have already attended our webinars and receive CEs, click Existing User. However, if this is your first webinar for credit, click New User.

This is what the New User screen looks like. Please register a personal email like Yahoo! or Gmail or ATT, since these accounts are typically not blocked by hospital firewalls. Remember your password, however, since you will be using it for all of our events. You will notice you have a first name, a last name and the personal email. And, we are asking for a phone number in case we have some kind of back side issues that we need to get in contact with you.

This is what the Existing User slide looks like. Use your complete email address as your user ID and, of course, the password you registered with. Again, the user ID is the complete email address, including what is after the @ sign. OK. Now, I am going to pass the ball back to your team lead to end the webinar and to go over any questions that came in. Thank you for taking the time spent with me.

Evette Robinson: Thank you, everyone, for joining us today for the webinar. And just, once again, I want to let you all know that, if we did not get to your questions during this session, as a reminder, all questions will be researched and posted to the Quality Reporting Center website within the next couple of weeks in the Q&A transcript for this event. Thank you again for your time. And this ends today's webinar. Have a great day.

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