# Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

**Support Contractor**

## Quality Improvement Organizations and Inpatient Psychiatric Facilities Working Together to Reduce Readmissions

## Presentation Transcript


### Speakers

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**Evette Robinson:** Before we proceed with today's webinar, I would like to cover a few housekeeping items specific to IPFQR Program webinar events. As a reminder, we do not recognize the raised-hand feature in the chat tool during webinars. Instead, you can submit any questions pertinent to the webinar topic to us via the chat tool. Any unanswered questions will be responded to and published in the *QualityNet* Questions and Answers, or Q&A, tool at a later date. Any questions received that are not related to the topic of the webinar will not be answered in the chat tool. Instead, we recommend that you go to the *QualityNet* Q&A tool to search for posted question-and-answer pairs, as well as submit any new questions to us that are not already addressed in the Q&A tool or in a previously published summary of questions and answers. The slides for this presentation were posted to the *Quality Reporting Center* website prior to the event. If you did not receive the slides beforehand, please go to *QualityReportingCenter.com* in your web browser and, on the bottom left of the screen, you will see a list of upcoming events. Click on the link for this event, scroll down to the bottom of the page, and there you will find the presentation slides available for download.

Hello everyone and welcome to today's presentation. My name is Evette Robinson, and I am the Program Lead for the IPFQR Program. I would like to introduce you to our speakers for today's presentation titled, *Quality Improvement Organizations and Inpatient Psychiatric Facilities Working Together to Reduce Readmissions*.

Our first guest speaker for today's presentation is Christina Goatee, who is a nurse consultant at CMS. She has been with CMS for over five years, where she is the Subject Matter Expert for the QIN-QIO Behavioral Health Task. She also serves as the QIN-QIO Subject Matter Expert for the Care Transitions Task. Prior to joining the QIN-QIO Program, she led the Community-Based Care Transitions Program in CMMI. Ms. Goatee holds Bachelor and Master of Science degrees in nursing from the University of Maryland and Walden University. Barbra Link is a Senior Quality Consultant at MPRO QIO, part of Lake Superior QIN, for over three years, where she works on spreading best practices and quality

improvement for behavioral health and care transitions projects in the state of Michigan. Ms. Link is a Licensed Master Social Worker and has over 25 years of experience in the field of aging and disabilities. She has worked in a variety of healthcare settings, from geriatric primary care to providing in-home care management to people living with dementia and their family members. Before coming to MPRO, Miss Link was the director of care transitions with the Area Agency on Aging 1B in Southfield, Michigan. Miss Link received her master's degree in social work from the University of Chicago, School of Social Service Administration. At this time, I will turn to presentation over to our first speaker, Christina Goatee.

**Christina Goatee:** Thank you, Evette. The purpose of today's webinar is to provide the IPF community with an overview of the Quality Improvement Organization Program, we call it the QIO Program, and demonstrate how collaborative relationships with IPFs can reduce IPF readmissions and enhance patient outcomes.

At the conclusion of this webinar, attendees will understand what a QIO does, the benefits of working with QIOs on quality improvement initiatives, and we'll also see some specific examples of how QIOs can support IPFs and how to contact your local QIO.

Let's start by discussing what a Quality Improvement Organization is.

A Quality Improvement Organization is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. QIOs are contracted to and led by the Centers for Medicare & Medicaid Services, CMS.

So, QIOs work with all healthcare providers across the care continuum, including hospitals, nursing homes, home health associations, rural health centers, critical access hospitals, inpatient psychiatric facilities, and others. Additionally, QIOs bring local providers and community leaders together to work on improving the quality of healthcare and related community services.

Here's a map of the QIO regions across the country. The QIOs are structured in networks known as Quality Innovation Networks. Each color on this map represents a QIO network or region. There's a QIO in every state and US territory. Throughout this presentation, you may hear Quality Innovation Network, Quality Improvement Organizations, or, as we call them, the QIN-QIOs. We use those terms interchangeably.

Now I'm going to discuss some of the benefits of working with a QIO.

You may be wondering, "How does this impact my organization? What can QIOs do for IPFs?" There are a few examples of the ways that QIOs can support you. They conduct learning sessions regarding evidence-based care coordination models and information about inpatient psychiatric facility quality reporting. They offer technical assistance for implementing evidence-based practices and providing reports and analyses of the readmissions and follow up rates. Lastly, they connect your IPF with other facilities, key stakeholders, community organizations, and nationally recognized experts to address behavioral health concerns and strategies.

This slide shows a few of the major accomplishments achieved as a result of QIOs working with local healthcare providers and patients on quality improvement initiatives. As you can see, working with a QIO can lead to improved outcomes and results.

The next part of this presentation is to highlight successes of the QIO program and hear from a QIO team member about how their team supports IPFs in their region and some of the outcomes of their work together. I'm going to turn this presentation over to Barbra Link.

**Barbra Link:** Thank you so much, Chris. I want to thank CMS and IPFQR for providing me this opportunity to talk about how Quality Innovation Networks can support and work together with IPFs to reduce readmissions and provide quality care for their patients.

As stated earlier in the presentation, I am a Senior Quality Consultant with MPRO, a Quality Improvement Organization in Michigan, in the Lake Superior QIN that includes Stratis Health in Minnesota and MetaStar in

Wisconsin, as well. As you'll see from this slide, we provide quality improvement targeting certain conditions and processes to improve the quality of care for Medicare fee-for-service beneficiaries through our contract with CMS.

I work in the behavioral health task and the care coordination task. These tasks fit well together, as both are focused on reducing all-cause readmissions in the hospital setting. The behavioral health task is working on this through our work with the IPFs in the IPF setting. With this goal in mind, the Lake Superior QIN has developed standardized quarterly reports, technical assistance tools, opportunities for sharing best practices [and] sharing community resources, and networking opportunities for IPFs in care coordination community coalitions, all of which I will expand on in this presentation.

First, I'd like to talk about how data supports our quality improvement work. Much of the work we do is through data-driven decision making. Through interviews with recruited IPFs, the Lake Superior QIN developed a standardized data report that provides information to IPFs through the use of Medicare fee-for-service claims data. The report includes data such as all-cause readmissions, emergency room utilization rates, and comparison against statewide rates for the specific IPF for which we are providing technical assistance. Though the information is aggregate on the graphs that include IPFs outside their health system, many IPFs find this data to be very useful because it gives them a picture of their readmission rates, including other IPFs and other hospitals, including critical access and acute care hospitals. From IPF feedback, MPRO also developed a readmission report that separated these readmission rates so IPFs could see if their population was readmitting for a psychiatric condition or for a physical condition. This was helpful in assessing where they needed to focus training for their staff. These reports also assisted in targeting where the IPFs needed to develop support resources after discharge. For example, one of the recruited IPFs found, through data that we provided them, that many of their patients were being discharged without any services, and this population was also a high readmission rate population.

Upon further internal analysis, they found that this population was disproportionately homeless and, thus through referral and networking, they developed a collaboration where their health system was able to provide mobile medical services to a local shelter in exchange for a bed hold designation, thus assisting in a readmission reduction. Another IPF saw a critical rise in readmissions and, when a root cause analysis was conducted, they were able to connect it directly to the closing of their onsite psychiatric crisis unit. They are now working with us on connecting with other IPFs in their area, as well as local community resources, to lower the impact of the closing of this unit on their patients.

This graph is included in the set of standardized reports and highlights the 30-day readmission rates for specific IPFs and its ED utilization rate with regards to readmissions. This particular IPF saw the large variation in readmissions from their ED and decided to institute an ED psychiatric nurse care manager program in their emergency department, or ED. Upon providing this graph at a site visit, they were pleased to see that, from the time of implementing the program to date, they saw a drastic decline in readmissions from their emergency department that was 4.7%, as shown at the end of the graph from Quarter 3, 2017, through Quarter 3, 2018. Even though their ED visits increased during this time period, they felt that the psychiatric nurse care manager program in the emergency department was one of the factors that decreased readmissions from the emergency department. They plan to bring this information back to their hospital administration for supporting continuation of the program. So, Chart 3 shows the IPF 30-day readmission rate decrease by 4.7% from Quarter 3, 2017, to Quarter 2, 2018, in acute care hospitals for Medicare fee-for-service beneficiaries, compared to Quarter 4, 2017, through Quarter 3, 2018, but the Michigan statewide IPF 30-day readmission rate increased by 1.1 from Quarter 3 2017, through Quarter 2, 2018, in any acute care hospital for Medicare fee-for-service beneficiaries. That’s compared to Quarter 4, 2017, through Quarter 3, 2018. Chart 3 also shows both the IPF and statewide IPF ED visit rates increased by 2.2% and 1.1% respectively for Quarter 3, 2017, through Quarter 2, 2018, for Medicare fee-for-service beneficiaries. That’s compared to Quarter 4, 2017, through Quarter 3,

2018. So, on the X-axis, the trend graph has two methods. One is by quarter data, and the other is by rolling quarter data. The rolling quarter data means that we delete the earlier quarter data and add the new quarter data each time. Comparing the previous data each time, it has three quarters of overlap.

Another way QINs support IPFs is through the development and provision of technical assistance tools. I would like to highlight just a few that we developed, as well as views from other QINs. They are the READMIT, A Clinical Risk Index to Predict 30-day Readmission After Discharge from IPFs; a best practices flyer that was initially developed by Health Insights QIN and tailored to our region; and a depression stop light tool for self-monitoring adapted from the TMF QIN alcohol stop light tool.

As Chris highlighted in the beginning of the program, we have used the READMIT Tool throughout our project to assist IPFs in developing risk stratification to target those patients at risk for readmitting. I thought I would just take a minute to talk about how our QIN actualized this tool for IPFs from a journal article based on the development of this criteria for the tool. This article was found through a subcommittee that MPRO and a recruited IPF developed after the IPF decided they wanted to have a better way of addressing high-risk patients from readmission at admission.

So, the physicians that developed the READMIT Tool found that the listed factors were highly associated with IPF readmissions. So, listed on this slide are R, repeat admissions; E stands for emergent admissions, examples are harm to self or others; A stands for age; D stands for diagnosis, examples such as psychosis, bipolar and/or personality disorder, and unplanned discharge; M stands for medical co-morbidity; I stands for prior service use intensity; and T stands for time in hospital. Most people know it as length of stay.

The wonderful team from our Wisconsin Quality Improvement Organization, our partners at MetaStar, part of the Lake Superior Quality Innovation Network, developed an easy-to-use spreadsheet that provides the numerical value for each readmission factor so IPFs can easily

calculate a given patient's risk score for readmission. We have introduced this tool to the majority of the IPFs we work with. We are still in the implementation phase to see if it assists with their readmission reduction work. One IPF stated that, currently, they use a risk stratification tool focused on medical conditions, and it is little to no use for them in their setting. They are excited to introduce this tool to their administration because it is tailored to the IPF setting and much more applicable to them. They see that it could be easily added to their electronic medical record to assist them in helping to focus their efforts on high-risk patients for readmission from day one and help them through their stay to discharge. The information needed to complete the tool can be acquired by patient interview, or through chart review, and takes about 20 minutes to complete.

Specific assistance on implementing the READMIT Tool may not be available through your regional QIN. However, your regional QIN does have access to all QIN-QIO technical assistance tools. If you would like assistance or more information about the READMIT Tool, or any other tools referenced during this presentation, you can contact your regional QIN and let them know that these tools are from the Lake Superior QIN. Your regional QIN then can contact us directly for support or access the information through our website.

We also developed a patient self-management stoplight tool for depression management. This originated as a tool for primary care physicians to use in the outpatient clinic setting, but we decided to include it with site visit information for IPFs. IPFs we work with not only thought it would be useful for their patient population but for family and caregiver education as well. So, a patient's extended informal support system would also have education on the signs and symptoms of depression, so they could support their family member and intervene if they had concerns about their family member's condition.

Another way QINs support IPFs is through connecting them with other IPFs and providing opportunities for sharing best practices as well as challenges. Some examples of topics addressed on these calls are listed on this slide, including an overview of the READMIT Tool, which I covered

in earlier slides. Another example is the integration of high-utilization, interdisciplinary team structures that included an IPF, a sheriff's department, local department of mental health, and a judge to assist in addressing the needs of high-readmitting patients. Another example includes channeling funds to a transportation program to help patients that reside in remote locations return home safely after discharge, instead of having to extend their stay in the IPF because they did not have their own transportation to their home. Sharing calls are structured with an IPF-driven agenda format, provide IPFs with ways to look at challenging situations in a new way, and either adapt or adopt the program to their setting. The frequency of sharing calls vary depending on the need and/or interest of the sharing call participants, and we have also held stakeholder sharing calls that specifically address strategies for readmission reduction, which I will describe in more detail on the next slide.

This is an example of a sharing call topic on three different strategies that IPFs could use to target their readmission work. A sharing call is facilitated by the QIN and the IPFs are invited to attend with the framework of a general topic to kick off the call, this one being various readmission reduction programs. Then, the majority of the time is spent by allowing the IPFs to discuss the topic, challenges they would have implementing the intervention, and solutions that they or the other IPFs in attendance have found to address these issues. Many times, emails and phone numbers are exchanged at the end of these calls because attendees have found the connections they made with the other IPFs during the call to be so helpful to their work. If you're interested in learning more about the strategies listed on this slide, there are links provided in the inpatient psychiatric facility resource flyer referenced on slide 26.

Lastly, QINs provide a unique opportunity for IPFs to expand their community resource referral lists and network by providing community resources tailored to their needs. For example, we have a link to local, state, and federal behavioral health resources on our website referenced here. We also provide IPFs with the opportunity to attend our Care Coordination Community Collaborative. These are locally formed groups

that include a variety of organizations through the continuum of care that come together on a regular basis to address readmissions, admissions, and to increase patients staying in the community settings longer. Many times when IPF staff are able to attend these meetings, they find organizations that are more than willing to assist them with service provision once a patient is discharged from their facility. One such example was a community home visiting program that was targeted at specifically providing behavioral health service, along with intensive care management, to older adults in their home. Though this program did not have a large budget for advertising their unique services, they were able to present their program at a collaborative meeting and many IPFs in the area, that did not know of this service, now had a direct name and contact number for referrals for their patients. This all came from attending a collaborative meeting. So, through provision of data to make decisions, technical assistance tools to support their work, networking and connecting with other IPFs and community partners, QINs provide a variety of ways to improve and support the quality of care IPFs provide to their patient population. I hope you found this information to be helpful, and the next time you are interested or in need of assistance regarding readmission work or quality improvement in general at your facility, you reach out to the QIN in your area. They can provide a wealth of information, data, and support, all free of charge.

At this point, you're probably thinking, "How can I contact my QIO to take advantage of the support, expertise, and resources?" To locate the contact information for the QIO in your region, visit https://qioprogram.org/locate-your-qio, and select your state from the dropdown menu. QIN-QIOs can provide a wealth of knowledge and can connect you to other resources in your region that can support the important work that you do.

This is a list of acronyms that were referenced during the presentation. This concludes my portion of today's webinar. I will now turn the presentation back over to Evette.

**Evette Robinson:** I want to thank our guest speakers for today's presentation, Christina Goatee and Barbra Link, for their willingness to share with us information about QIOs and how they can collaborate with IPFs to reduce readmissions. In the next several slides, I will review helpful resources pertaining to this topic, as well as the IPFQR Program in general.

This slide lists some of the future webinar topics that will be covered in the next several months. We use the IPFQR Program Listserve to notify subscribers of future webinar information.

CMS recommends that IPFs refer to the updated IPFQR Program manual for information pertaining to the IPFQR Program. The manual is located on the *QualityNet* and *Quality Reporting Center* websites, which can be accessed by clicking on the icons on this slide. The IPFQR Program manual contains information about program requirements, program measures, and various tools pertinent to the IPFQR Program.

We encourage you to keep us up to date with points of contact at your facility by sending the completed Contact Change Form to us whenever there are staff changes relevant to the IPFQR Program or other quality reporting programs. We also recommend that you sign up for the IPFQR Program Listserve, if you have not already, by clicking on the Listserve registration icon on this slide. Once enrolled in the IPFQR Program Listserve, you will receive communications pertaining to the IPFQR Program webinars, program updates, and other announcements. Information about upcoming webinars can be viewed by clicking on the upcoming webinars icon. We encourage everyone to leverage the Find An Answer function in the *QualityNet* Q&A tool to find information about program requirements and measures, or, if not found, submit your inquiries to us via the tool. We also welcome your recommendations for future webinar topics via the Q&A tool, which you can access by selecting the Q&A tool icon. You can click on the email support icon to send an email to us at IPFqualityreporting@hcqis.org regarding eligibility, such as next steps for a newly-eligible provider or notification that an IPF is or will be closing. Contact the VIQR support contractor via phone at (866) 800-8765 or secure fax at (877) 789-4443.

This concludes the content portion of today's webinar titled, *Quality Improvement Organizations and Inpatient Psychiatric Facilities Working Together to Reduce Readmissions*. We thank you for your time and attention.