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F5 Key
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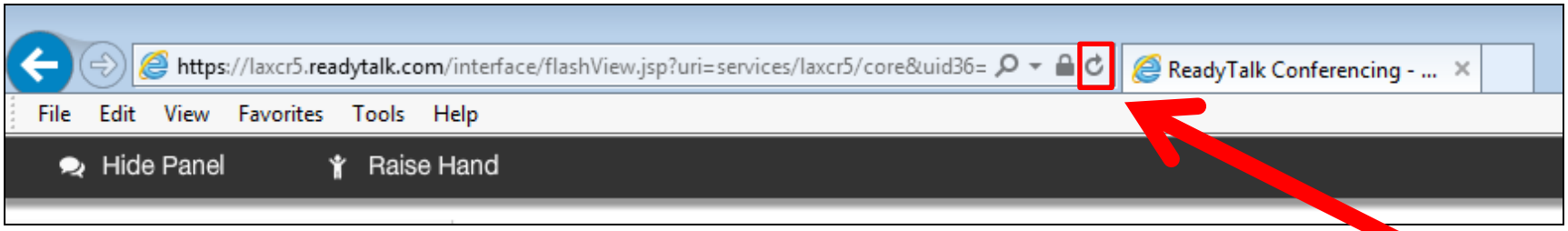

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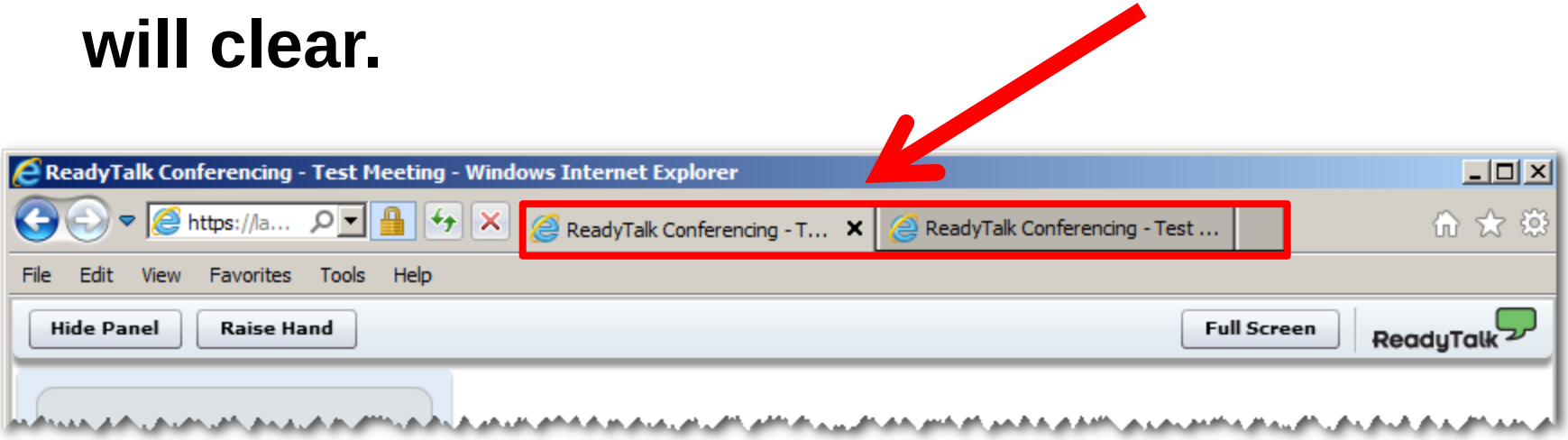

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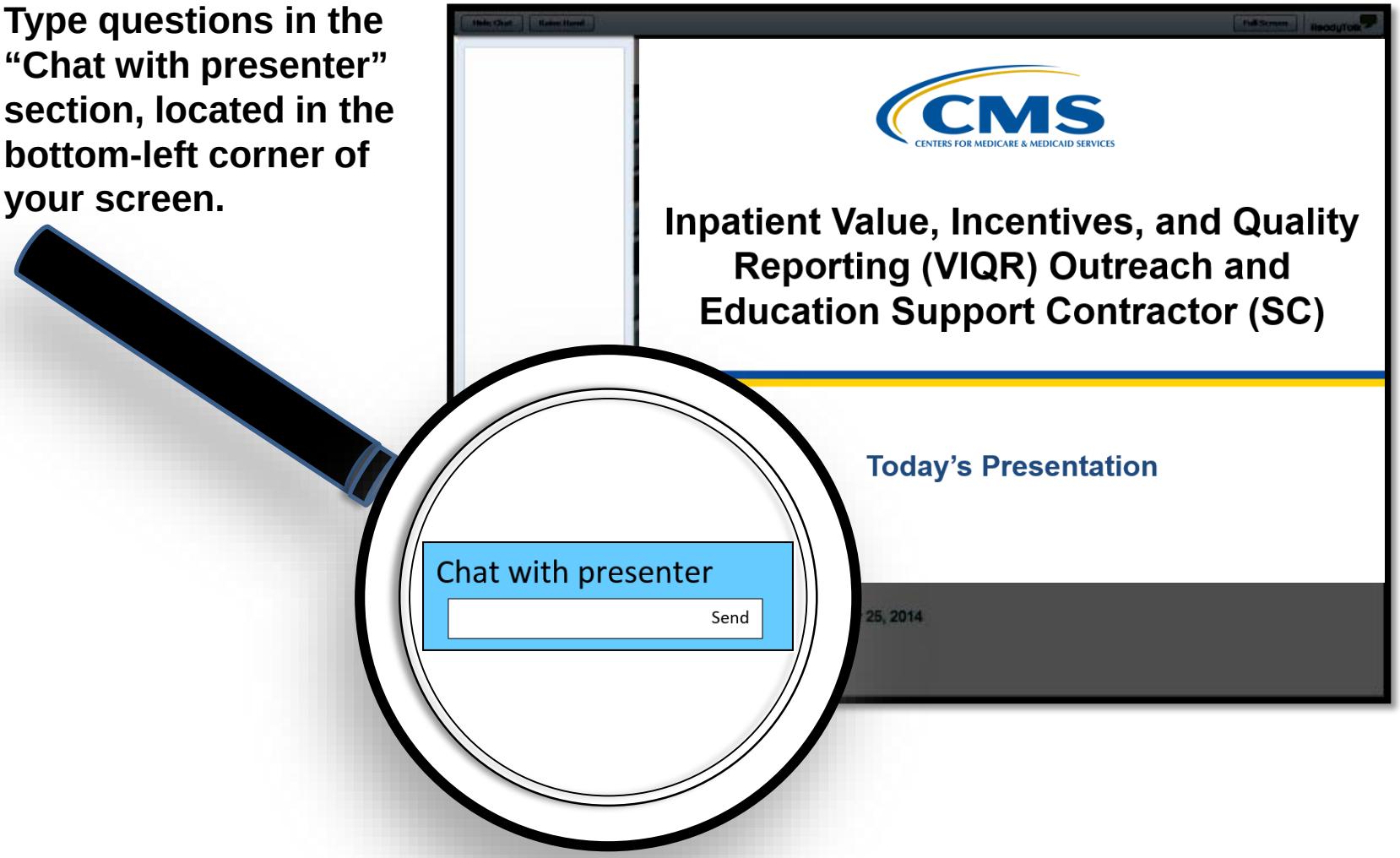


Webinar Chat Questions

Chat Tool

- Submit questions pertinent to today's topic.
- Any unanswered questions will be responded to and published in the *QualityNet* Questions and Answers (Q&A) Tool at a later date.

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

July 18, 2019

Speakers

Christina Goatee, MSN, RN
Quality Innovation Network-Quality Improvement Organization (QIN-QIO)
Subject Matter Expert
Centers for Medicare & Medicaid Services (CMS)

Barbra Link, LMSW, CIRS-A/D
Senior Quality Consultant, MPRO

Moderator
Evette Robinson, MPH
Program Lead
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor

Purpose

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

Learning Objectives

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

- The purpose of QIOs
- The benefits of working with QIOs on quality improvement initiatives
- Ways QIOs can support IPFs
- How to contact your QIO

What are Quality Improvement Organizations (QIOs)?

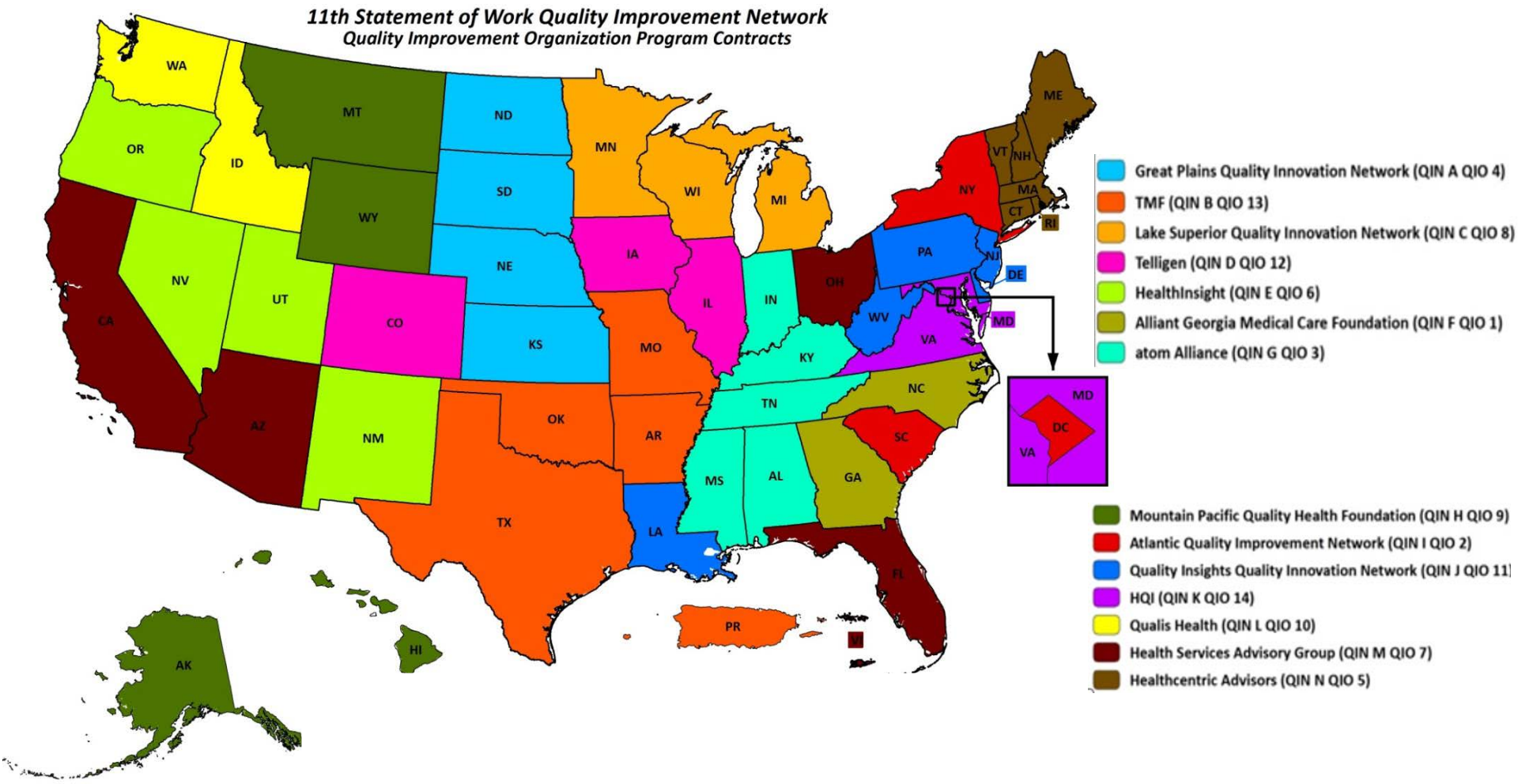
What are Quality Improvement Organizations (QIOs)?

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

What is the purpose of a QIO?

- QIOs work with all health care providers across the care continuum, including the following:
  - Hospitals
  - Nursing homes
  - Home health associations
  - Rural health centers
  - Critical access hospitals (CAHs)
  - Inpatient psychiatric facilities (IPFs)
- QIOs bring local providers and community leaders together to work on improving the quality of health care and related community services.

QIN-QIO Regions



Benefits of Working with a QIO

How can QIOs support you?

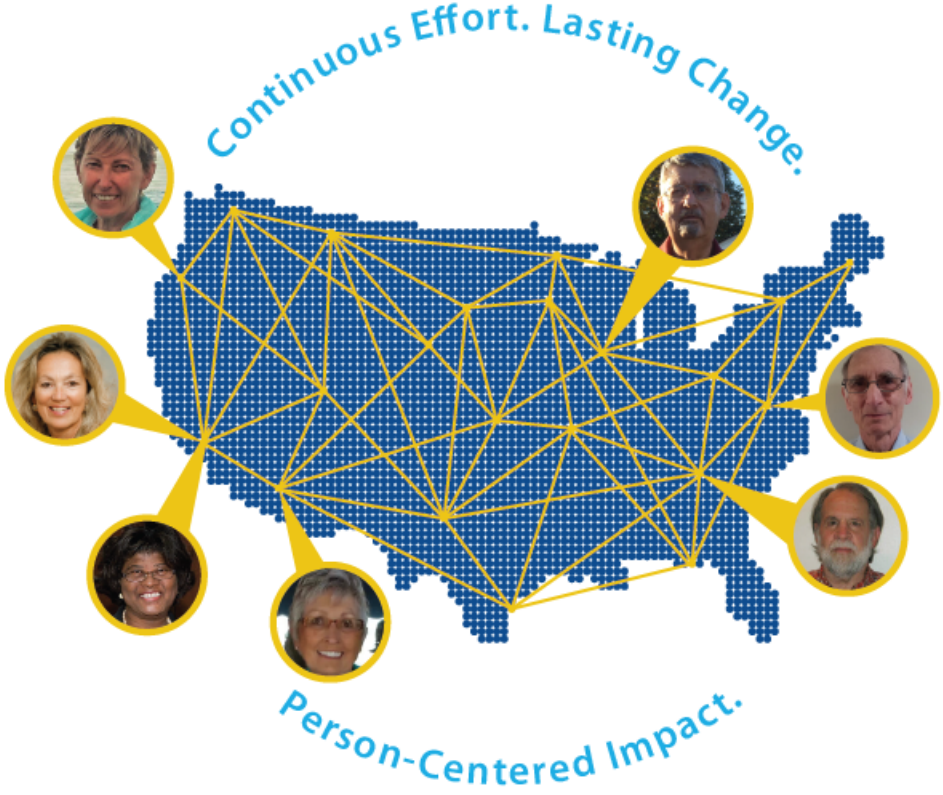
- Conduct learning sessions regarding evidence-based care coordination models and information about IPF quality reporting.
- Offer technical assistance for implementing evidence-based best practices and providing reports and analysis of your readmission and follow-up rates.
- Connect your IPF with other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

QIO Accomplishments

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

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

77,830 hospital readmissions were avoided among Medicare Fee-for-Service beneficiaries in recruited communities



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

QIO Success Stories with IPF Readmissions

Lake Superior QIN-QIO

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

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2.39 Million
Medicare Fee for Service Beneficiaries

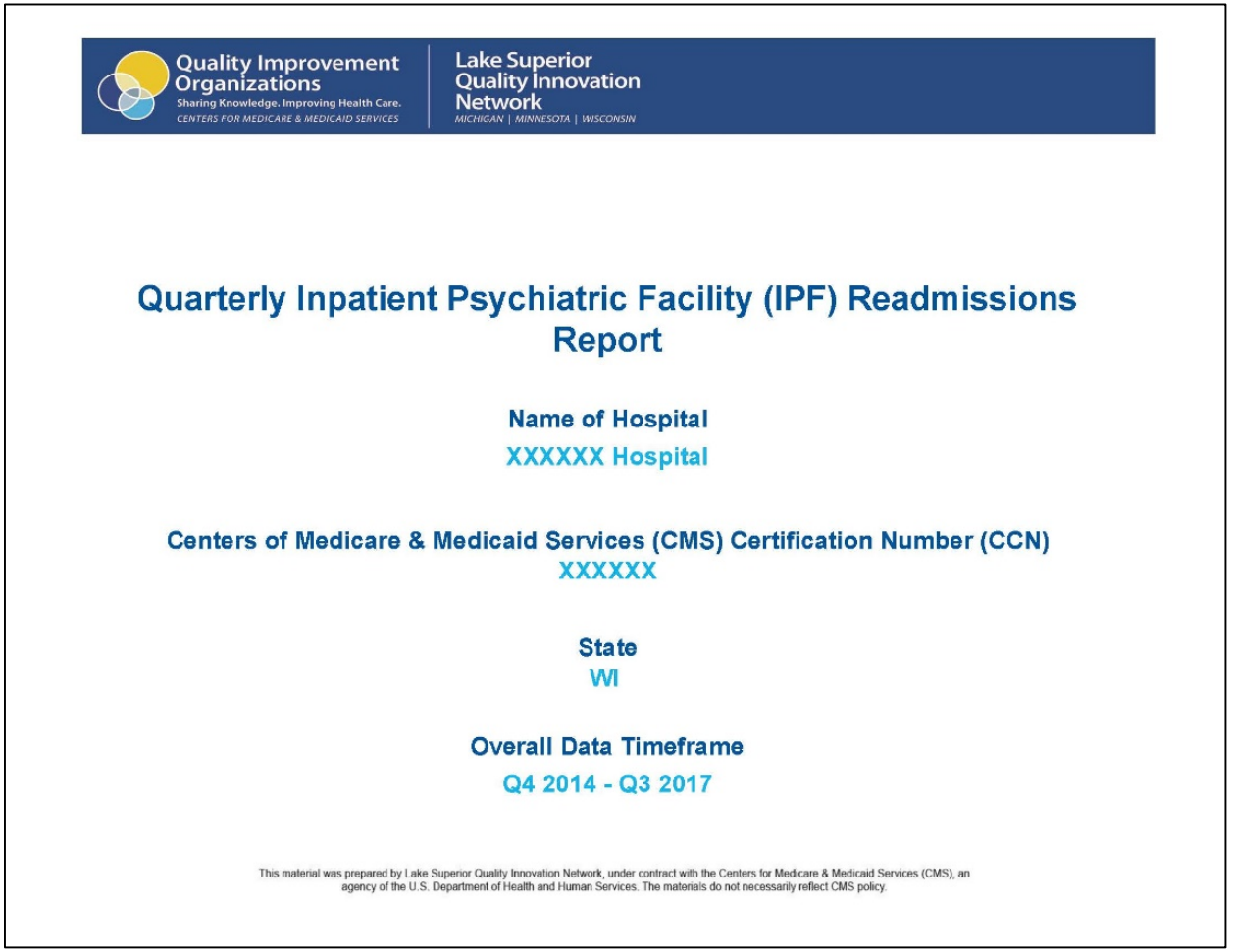
Steps to Reducing All-Cause Readmissions in IPFs

The Lake Superior QIN-QIO assisted IPFs by:

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

Standardized Quarterly Reports

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



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Quarterly Inpatient Psychiatric Facility (IPF) Readmissions Report

Name of Hospital
XXXXXX Hospital

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

State
WI

Overall Data Timeframe
Q4 2014 - Q3 2017

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

Standardized Quarterly Reports

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

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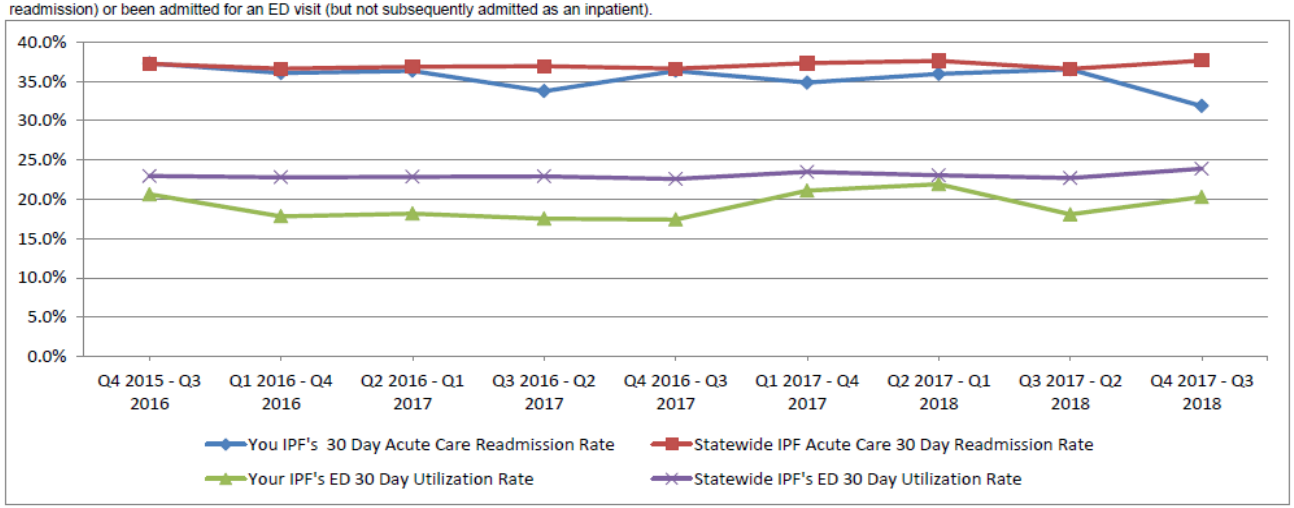
Chart 3: 30 Day Readmission Rates For IPF and ED Utilization

Rolling Year Inpatient Psychiatric Facility (IPF) Readmissions Report

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

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

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



Providing Technical Assistance Tools

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

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

Providing Technical Assistance Tools: READMIT Tool

- READMIT is a clinically useful risk index, administered before discharge, for determining the probability of psychiatric readmission within 30 days of hospital discharge for general psychiatric inpatients.
- The researchers who developed the READMIT tool used population-based, socio-economic, and health data to develop this predictive model.
- Each 1 point increase in READMIT score increases the odds of 30-day readmission by 11 percent.

Source: Vigod, Kurdyak, Seitz, et al. “READMIT: a clinical risk index to predict 30-day readmission after discharge from acute psychiatric units”, Journal of Psychiatric Research. 2015 Feb;61:205-13. doi: 10.1016/j.jpsychires.2014.12.003. Epub 2014 Dec 13.

Providing Technical Assistance Tools: READMIT Tool

Factors associated with IPF readmission include:

- Past **R**eadmissions
- **E**mergent Admissions, such as harm to self and others
- **A**ge
- **D**iagnoses (such as psychosis, bipolar, and personality disorders), and unplanned discharge
- **M**edical co-morbidity
- Prior service use **I**ntensity
- **T**ime in hospital

Providing Technical Assistance Tools: READMIT Tool

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

Risk Factor	Variable	Value	Points
"R" Repeat Admission (lifetime)	*Number Prior to Index*		
"E" Emergent Admission	*Threat to Others*		
	Threat to Self		
	Unable to Care for Self		
"A" Age	*Age Group (years)*		
"D" Diagnosis and Discharge	*Primary Diagnosis*		
	Any Personality Disorder		
	Unplanned Discharge		
"M" Medical Morbidity	*Charlson Comorbidity Score*		
"I" Intensity (past year)	*Outpatient Psychiatric Visits*		
	Emergency Department Visits		
"T" Time in Hospital	*Length of Stay (days)*		

Clear All Values

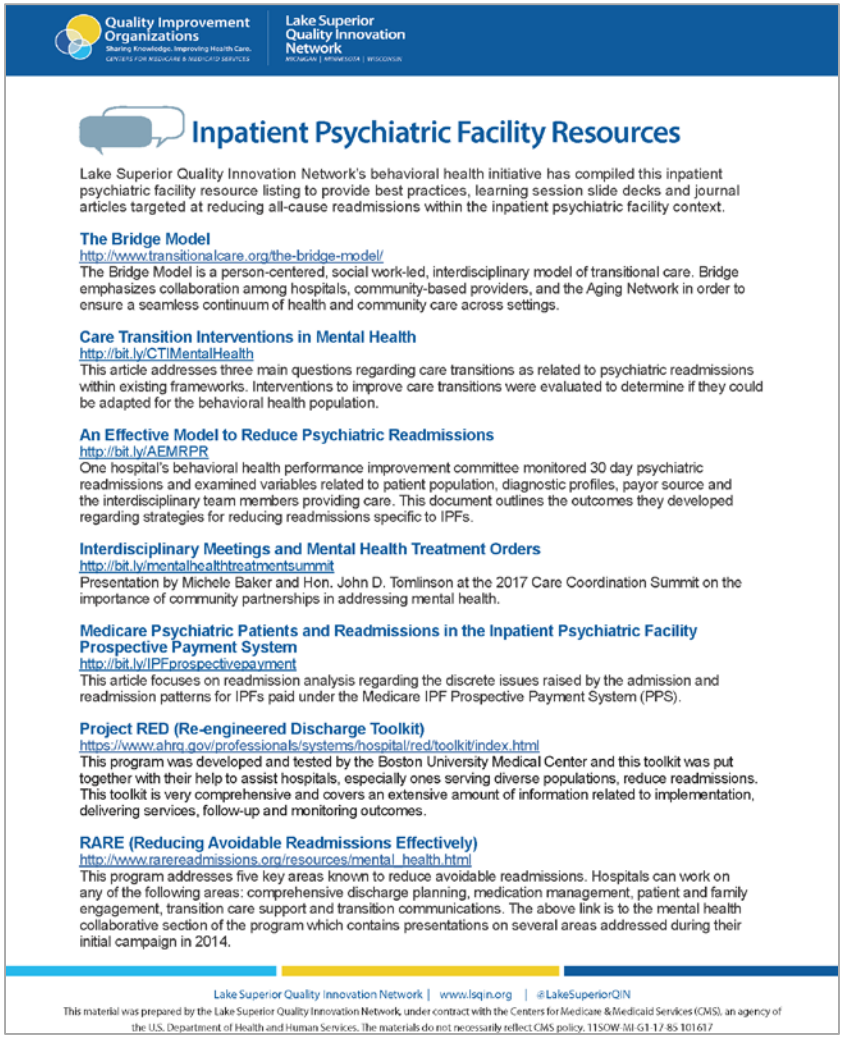
Total Possible Score 0

Risk of Readmission Low

Providing Technical Assistance Tools: Best Practices Flyer

The Inpatient Psychiatric Facility Resources flyer includes the following:

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



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Inpatient Psychiatric Facility Resources

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

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

Care Transition Interventions in Mental Health
http://bit.ly/CTIMentalHealth
This article addresses three main questions regarding care transitions as related to psychiatric readmissions within existing frameworks. Interventions to improve care transitions were evaluated to determine if they could be adapted for the behavioral health population.

An Effective Model to Reduce Psychiatric Readmissions
http://bit.ly/AEMRPR
One hospital's behavioral health performance improvement committee monitored 30 day psychiatric readmissions and examined variables related to patient population, diagnostic profiles, payor source and the interdisciplinary team members providing care. This document outlines the outcomes they developed regarding strategies for reducing readmissions specific to IPFs.

Interdisciplinary Meetings and Mental Health Treatment Orders
http://bit.ly/mentalhealthtreatmentsummit
Presentation by Michele Baker and Hon. John D. Tomlinson at the 2017 Care Coordination Summit on the importance of community partnerships in addressing mental health.

Medicare Psychiatric Patients and Readmissions in the Inpatient Psychiatric Facility Prospective Payment System
http://bit.ly/IPFprospectivepayment
This article focuses on readmission analysis regarding the discrete issues raised by the admission and readmission patterns for IPFs paid under the Medicare IPF Prospective Payment System (PPS).

Project RED (Re-engineered Discharge Toolkit)
https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html
This program was developed and tested by the Boston University Medical Center and this toolkit was put together with their help to assist hospitals, especially ones serving diverse populations, reduce readmissions. This toolkit is very comprehensive and covers an extensive amount of information related to implementation, delivering services, follow-up and monitoring outcomes.

RARE (Reducing Avoidable Readmissions Effectively)
http://www.rarereadmissions.org/resources/mental_health.html
This program addresses five key areas known to reduce avoidable readmissions. Hospitals can work on any of the following areas: comprehensive discharge planning, medication management, patient and family engagement, transition care support and transition communications. The above link is to the mental health collaborative section of the program which contains presentations on several areas addressed during their initial campaign in 2014.

Lake Superior Quality Innovation Network | www.lsqin.org | @LakeSuperiorQIN

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Providing Technical Assistance Tools: Zone Tool

Self-Management for Depression Zone Tool

- Patients and caregivers use the tool to monitor symptoms of depression.

Zone Tool
Self-Management for Depression

GREEN ZONE

GREEN ZONES: *ALL CLEAR*
Your Goals:
- Stable mood
- Sleeping well
- Healthy appetite
- Feeling hopeful
- Able to concentrate

GREEN ZONE ACTION STEPS:
- Having some fun
- Engage in activities you enjoy
- Your symptoms are under control
  - ✓ Continue taking your medications as ordered
  - ✓ Keep all physician appointments

YELLOW ZONE

YELLOW ZONE: *CAUTION means your symptoms are starting to Change*
The following symptoms maybe early warning signs that your depression is worsening
- Sad mood most of the time
- Not eating/eating too much
- Trouble concentrating
- Not sleeping well/sleeping too much
- Not finding pleasure in normal activities
- Increase in feelings of irritability/anger
- Loss of energy to do chores/activities
- Not taking medications as prescribed
- Missing physician appointments

YELLOW ZONE ACTION STEPS:
- Call your physician if you are going into the YELLOW zone.

Your symptoms may indicate that you need an adjustment of your medications.
Begin to use identified coping skills such as talking to a trusted friend or family member, gardening, needlework, watch a funny movie, etc...

Physician Name: _____

Phone Number: _____

RED ZONE

RED ZONES: *MEDICAL ALERT*
- Overwhelmed by feelings of sadness/despair
- Feeling hopeless and/or helpless
- Thoughts or feelings of killing or harming yourself
- Unable to leave the bed
- Not eating
- Not sleeping
- Stopped taking medications
- Missing physician appointment

RED ZONE MEANS:
This indicates that you need to be evaluated by a physician right away.

Get help immediately if you are in the RED ZONE. Call your physician, go to the nearest emergency room or call the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK)

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Quality Improvement Organizations
Lake Superior Quality Innovation Network

Conducting Stakeholder Sharing Calls

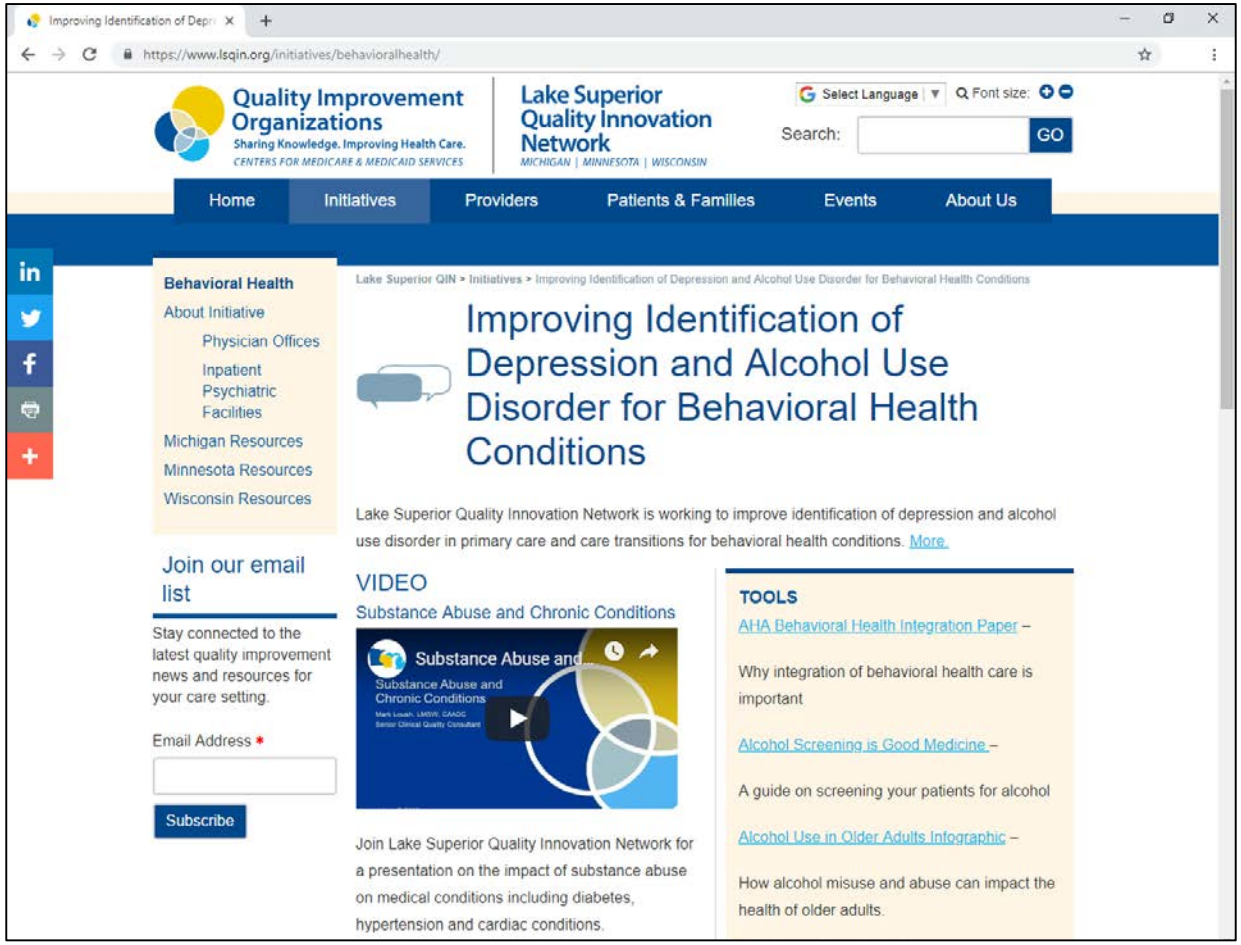
The Lake Superior QIN-QIO hosts stakeholder sharing calls to discuss best practices and address topics such as:

- READMIT Tool overview
- High utilization interdisciplinary team structure and success
- Step-down program integration into IPFs
- Care Transitions Models adapted to IPFs

Sharing Community Resources: Strategies for Readmission Reduction

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

Including IPFs in Care Coordination Community Coalitions



https://www.lsqin.org/initiatives/behavioralhealth/

How can I find my QIN-QIO?

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

Quality Innovation Network (QIN)-QIOs

Quality Innovation Network (QIN)-QIOs are responsible for working with health care providers and the community on data-driven projects to improve patient safety, reduce harm and improve clinical care at the local level. If you are a health care provider, stakeholder or partner interested in learning more about these projects, use the dropdown below to find the QIN-QIO for your area.

Select your state

Acronyms

ADE	adverse drug event
APM	Alternative Payment Model
APU	annual payment update
CAH	critical access hospital
CE	continuing education
CMS	Centers for Medicare & Medicaid Services
ED	emergency department
IPF	inpatient psychiatric facility
IPFQR	Inpatient Psychiatric Facility Quality Reporting
MIPS	Merit-Based Incentive Payment System
PPS	prospective payment system
QIN	Quality Innovation Network
QIO	Quality Improvement Organization
RARE	Reducing Avoidable Readmissions Effectively
RED	Re-engineered Discharge
VIQR	Value, Incentives, and Quality Reporting

Helpful Resources

Future Webinar Topics

FY 2020 IPF PPS Final Rule and APU Determination

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

FY 2020 IPFQR Program Data Review

- Review national-level data submitted during the summer 2019 data submission period

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

Helpful Resources

Helpful Resources

Stay up to date….

…and get answers to your questions.

Thank You

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