

**The Readmissions Quality Collaborative
Kick-Off Conference
June 21, 2012**

**Quality Collaborative
Activities**

Kate M. Sherman, LCSW
New York State Psychiatric Institute
New York State Office of Mental Health



The Collaborative and Quality Improvement Projects

Sponsor Organizations

- Greater New York Hospital Association (GNYHA)
- Healthcare Association of New York State (HANYS)
- New York State Office of Mental Health (OMH) Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) Team

The Learning Collaborative Model

- Hospitals work together toward a common goal
 - Conduct continuous quality improvement project
 - Identify and share successful strategies
 - Promotes rapid adoption of best practices
- Background
 - Institute for Healthcare Improvement (IHI) model
 - GNYHA has used in medical/surgical areas
 - First behavioral health collaborative last year

The Readmissions Quality Collaborative

- Steering Committee of peer institutions decides
 - Focus on readmissions
 - Strategies and activities
 - Reporting requirements
- 38 Participation Applications Received to Date
 - Additional hospitals here to learn
- 18 months: now through December, 2013
 - Select strategies
 - Identify best practice
 - See results

Hospital Activities: Form Quality Improvement Team

- Leadership / medical “champion” is key
- Project leads from relevant programs
- Interdisciplinary
- Data manager – crucial for monitoring / reporting

Hospital Activities: Continuous Quality Improvement (CQI)

- Select program(s) to participate
 - Flexible, but inpatient participation recommended
 - Inpatient, outpatient, emergency
 - Psychiatry, detoxification, substance abuse rehabilitation
- Select one or more strategies
 - Maximum flexibility
 - May be different for different programs, but coordinated effort is more manageable
 - Should support key indicator: inpatient readmissions

CQI Project: Select Goals and Strategies

Goal 1: Improve medication practices.	Emergency	In-patient	Out-patient
Increase use of depot medications		√	√
Increase use of clozapine		√	√
Medication-assisted alcohol treatment		√	√
Medication fill upon discharge	√	√	√
Clinical interventions to improve adherence	√	√	√
Goal 2: Improve engagement in outpatient care.			
Case Management, Assertive Community Treatment, Assisted Outpatient Treatment, Health Home	√	√	√
Peer services		√	√
Clinical interventions to improve adherence	√	√	√
Goal 3: Improve delivery of integrated treatment for psychiatric and substance use disorders.			
“Focus on Integrated Treatment”	√	√	√

CQI Project: Implement Core Activities

- Identifying clients at high risk of readmission
 - Screening tool in development, will incorporate
 - PSYCKES data
 - Clinical assessment
 - For outpatient programs, tracking “at risk” population
- Screening for/ addressing readmission risk factors
- Improving transitions in care
 - Inpatient/Emergency Department (ED): optimizing discharge planning process
 - Checklist in development
 - For outpatient: referrals, coordination of care

FOCUS-Plan-Do-Check-Act

F: Find an opportunity to improve

O: Organize a team

C: Clarify current knowledge of the process

- PSYCKES data
- Internal data
- Analysis of hospital's Medicaid data being prepared

U: Understand process variation and capacity

S: Select strategies for improvement

PDCA: Plan-Do-Check-Act (or other CQI approach)

Keeping CQI “Continuous:” Data-Driven Decision-Making

- Key to all CQI Models
- Build data collection into processes
- Use PSYCKES data
- Review data regularly to assess effectiveness of strategies and guide interventions
- Complete the cycle: adjust action plan as needed

**Support Provided by
GNYHA, HANYS and
PSYCKES**

Conferences, Calls and Site Visits

- Conferences
 - Kick-Off
 - Mid-point, share successful strategies
 - Conclusion
- Monthly Learning Collaborative Calls
 - Interactive, report on progress
- Strategies calls: Training on specific strategies
- Site Visits (selected hospitals)
 - Technical assistance
 - Identify best practices

PSYCKES Training and Technical Assistance

- Webinars for the Collaborative
 - Using PSYCKES to Support Quality Improvement
 - Monthly Data Submission
- Other PSYCKES webinars
 - PSYCKES Access and Implementation
 - Using PSYCKES for Clinicians
- Email PSYCKES-Help
- Visit the PSYCKES website: www.psyckes.org

PSYCKES Website: Hospital Collaborative Page

Click on “Hospital Collaborative” on navigation bar at left

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Hospital Quality Collaborative

Participants Learning Collaborative Project Tools Clinical Resources Project Impact Using PSYCKES

Hospital Quality Collaborative Reducing Behavioral Health Inpatient Readmissions

Overview of Project

Office of Mental Health (OMH) has partnered with the Greater New York Hospital Association (GNYHA) to bring Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) into hospital-inpatient and outpatient settings to support a quality collaborative focusing on reducing behavioral health inpatient admissions.

News

- [PSYCKES Medicaid Release Notes, Version 4.7.1](#)
A new release of the PSYCKES Medicaid application was made available on May 22, 2012.
- The GNYHA-PSYCKES Quality Collaborative has concluded. Planning for the next GNYHA-PSYCKES behavioral health quality collaborative is currently underway.

Calendar

Date	Time	Title
Tuesday, June 12, 2012	11 a.m. to 12 noon	Using Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) to Support Quality Improvement, June 12 ↗
Monday, July 16, 2012	1 p.m. to 2 p.m.	Using PSYCKES for Clinicians, July 16 ↗
Wednesday, July 18, 2012	1 p.m. to 2 p.m.	Using PSYCKES to Support Quality Improvement, July 18 ↗

Clinical Tools

- Currently in development (Seeking existing models)
 - Screening instrument
 - Clients at high risk of readmission
 - Modifiable risk factors (target of treatment)
 - Case review form
 - Discharge planning checklist
- Identification of other relevant tools
 - e.g. screening for co-occurring disorders

Project Data

Outcome Indicators in PSYCKES: Readmission Rates

- Key project indicator:
Inpatient behavioral health readmissions
Focus on discharges from your hospital that were followed by readmission
 - To same service type
 - At any institution
 - Within 15 and 30 days of discharge
- Additional indicator for participating outpatient programs: Behavioral health readmissions among clients on outpatient census – discharge and readmission both at any institution

Project Reporting

Hospitals Report Monthly to the Collaborative (draft)

- All hospitals report on inpatient admissions:
 - Number of inpatient admissions
 - Number of these known to be a readmission
- Outpatient Programs:
 - Number of clients on census at high risk of readmission
- Emergency Departments: To be determined
- All Hospitals report on milestones:
 - Programs participating
 - Strategies selected
 - Core activities implemented (screening, etc.)

Monthly Reporting Process

- Brief on-line survey
- Each participating program reports separately
- Submit data by the 10th of each month for quality improvement (QI) activities in the previous month
- First data submission: report July QI activities on August 10, 2012
 - Milestones

Collaborative Reports to Hospitals (draft)

- Monthly: Aggregate of self-report data
 - Hospital and program data versus aggregate data
 - Hospitals and programs relative to each other
- Quarterly: From the Medicaid Data
 - Key outcome: inpatient readmissions
 - Collaborative versus non-participating hospitals
 - Other data elements to be determined by steering committee

Additional Reporting

- Surveys
 - Completed by participating hospitals
 - Start and end of project
 - To identify and disseminate successful strategies
 - To identify training and resource needs
- Ad hoc analyses based on needs and interests of the collaborative and participants

Question and Answer