Public Comment Summary Report

Project Title:

Inpatient Psychiatric Facility (IPF) Outcome and Process Measure Development and Maintenance

Dates:

- The Call for Public Comment was open from November 25, 2015 to December 11, 2015.
- The Public Comment Summary was completed on December 23, 2015.

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Health Services Advisory Group, Inc. (HSAG), to develop, maintain, reevaluate, and support the implementation of quality outcome and process measures for the CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program under the Measure & Instrument Development and Support (MIDS) Contract (Contract #: HHSM-500-2013-13007I), and Task Order Inpatient Psychiatric Facility Outcome and Process Measure Development and Maintenance (Task Order #: HHSM-500-T0004).

Project Objectives:

The primary project objectives are as follows:

- Develop new measures that drive quality improvement, are patient centered, are aligned with other programs, and that fill critical gaps for future inclusion in the CMS IPFQR Program;
- Maintain and reevaluate existing IPF measures; and
- Support measure implementation in the IPFQR Program.

To provide an important indicator of the quality of care patients receive in the IPF setting, HSAG developed a measure that estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of psychiatric disorder. To obtain input from stakeholder organizations and interested parties, public comments were solicited for this proposed quality measure, *Thirty-day All-cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)*.

Information About the Comments Received:

- The announcement for the Call for Public Comment was posted on the CMS Public Comment webpage. The Measure Information Form, Data Dictionary, and the Measure Technical Report were available to the commenters to review.
- Public comments were solicited by notifying 27 organizations/groups about the opening of the public comment via e-mail. (Please see Appendix A for the list of stakeholder organizations.) In addition, HSAG notified 28 individuals (i.e., experts, technical expert

panel members, and measure workgroup members) regarding the Call for Public Comment announcement and requested sharing the announcement with interested colleagues.

- Twelve entries were completed and submitted in the comment tool, which represented the contributions of 17 participants because one entry consisted of a compilation of comments from a group of contributors. Of the 12 entries, six (50%) represented an individual perspective and six (50%) reflected an organizational perspective.

Stakeholder Comments—General and Measure-Specific

The participants were requested to provide feedback on four categories: Importance/Relevance, Scientific Acceptability, Feasibility, and General Comments for the proposed measure: *Thirty-day All-cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF).* The comments within the entries were summarized by HSAG and are presented in this section with the responses from CMS to the comments.

Importance/Relevance

a. Ten entries (83%) expressed support for this measure and emphasized the importance of measuring readmissions in this population. Several entries indicated that the information provided by this measure would improve care for psychiatric patients treated at these facilities.
   Response: We appreciate your comments and support of the measure.

Scientific Acceptability

a. Five entries (42%) expressed that the measure methodology appears to be scientifically acceptable.
   Response: We thank you for your comment.

b. One entry (8%) indicated that a readmission measure was not appropriate for the inpatient psychiatric facility setting.
   Response: We thank you for your comment. Readmission after hospital discharge for any condition is an adverse event from the patient perspective because it represents deterioration in mental and/or medical health status. CMS and HSAG recognize that there are factors external to the IPF that may influence readmission rates in the psychiatric population. Although not all readmissions are preventable, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to reduce readmission rates.[1-6] The goal of this measure is to reduce readmissions and the variation in performance across IPFs.

Feasibility

a. Four entries (33%) indicated that the measure appears to be feasible.
   Response: We thank you for your comment.

b. Six entries (50%) noted that the IPF is not the only entity with influence over readmission rates in the psychiatric patient population and that some readmissions are not preventable.

Response: We thank you for your comment. We recognize that there are factors external to the IPF that may influence readmission rates in the psychiatric population. Although not all readmissions are preventable, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to reduce readmission rates.[1-6] The goal of this measure is to reduce readmissions and the variation in performance across IPFs.

General

a. Two entries (17%) recommended that the measure evaluate only those readmissions that are related to the principal cause of the index admission. However, another responder differed and expressed that evaluation of all-cause readmissions at IPFs and acute care facilities was needed for a "holistic and integrative approach to mental health care".

Response: We appreciate your comments. This measure evaluates an all-cause, unplanned readmission rate in order to capture adverse events experienced by patients following discharge from an IPF. With the goal of reduction of adverse events, some aspects to consider related to readmissions of IPF patients are:

1) It is important to treat both the psychiatric and medical needs of patients.
2) It may be difficult to determine if a readmission is related to the index admission in this patient population because different principal diagnosis codes could be used to describe the same symptomology.
3) Readmission due to medical conditions may actually be related to the previous psychiatric index admission. For example, a patient discharged with bipolar disorder from the index admission may self-harm if his or her symptoms are not well managed and be readmitted because of a suicide attempt.

Similar to other types of readmission measures, hospital-acquired complications may manifest in a range of clinical diagnoses that can be unrelated to the principal or secondary diagnoses of the index admission. Two examples of complications include preventable adverse drug events or nosocomial infections. Finally, while IPFs cannot always address all medical conditions, much like some acute-care facilities, they do have a responsibility to ensure that patients with comorbid medical conditions are transferred or referred to appropriate medical care upon discharge.

b. Two entries (17%) recommended risk adjustment for sociodemographic factors.

Response: We thank you for your comment. Generally, the National Quality Forum (NQF) and CMS have advised against risk adjustment for sociodemographic status (SDS) in quality measures. However, the NQF is currently in the process of revising its recommendations for inclusion of SDS risk factors and is asking measure developers to include analyses on SDS risk adjustment in their endorsement or re-endorsement submissions. As such, we will include the results of the analyses of available SDS risk factors for this measure when the measure is submitted to NQF for endorsement. In addition, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is

conducting research on the issue of risk adjustment for socioeconomic status as directed by the IMPACT Act and will issue a report to Congress by October 2016. At the conclusion of that work, CMS will consider the recommendations from ASPE and determine the applicability to this measure.

c. Three entries (25%) offered strategies that can be effective at reducing readmission rates and increasing compliance with care plans in the psychiatric patient population. Some of these strategies include use of case managers in the inpatient setting to coordinate care transitions, improved communication between the physician and the patient, use of technology to track medication adherence, and limiting discharges on weekends when social services may not be available.

   Response: We thank you for your comments.

d. Two entries (17%) mentioned aligning the acute-care hospital readmission measures with this measure so that they fully capture admissions and readmissions for psychiatric diagnoses across the spectrum of care.

   Response: We thank you for your comments. This measure was developed to evaluate Inpatient Psychiatric Facilities for the Inpatient Psychiatric Facility Quality Reporting Program so admissions to acute care hospitals are not included in the measure cohort.

e. Five entries (42%) indicated that there is a shortage of mental health providers and community resources for people with mental health conditions. Several recommended providing additional financial resources or incentives to support patient's needs in the outpatient setting.

   Response: We thank you for your comments.

Preliminary Recommendations

We appreciate the feedback from all of the participants. After review and evaluation of the public comments, we did not identify any specific modifications to the proposed measure, *Thirty-day All-cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF),* at this time.

The measure will be submitted to NQF for review and endorsement consideration in January 2016. The submission will include an assessment of the potential inclusion of SDS variables in the risk model.

Overall Analysis of the Comments and Recommendations

Numerous commenters expressed support for this measure and commented both on the importance of measuring readmissions in the IPF setting and recognized the measure methodology to be scientifically acceptable. The comments received provide useful input for further development of this readmission measure for the IPF setting.

Public Comment Verbatim Report

Verbatim comments from each entry are listed in the order in which they were received by date in Appendix B. Comments appear as they were received and have not been edited for spelling, punctuation, grammar, or any other reasons.

References

1. Dieterich M, Irving CB, Park B, Marshall M. Intensive case management for severe mental illness. *Cochrane Database Syst Rev.* 2010(10):CD007906.
2. Durbin J, Lin E, Layne C, Teed M. Is readmission a valid indicator of the quality of inpatient psychiatric care? *J Behav Health Serv Res.* 2007;34(2):137-150.
3. VA/DoD Clinical Practice Guideline for Management of Bipolar Disorder in Adults (BD). Department of Veterans Affairs; 2010. Available at: http://www.healthquality.va.gov/bipolar/bd_306_sum.pdf.
4. Mark TL, Mark T, Tomic KS, et al. Hospital readmission among medicaid patients with an index hospitalization for mental and/or substance use disorder. *J Behav Health Serv Res.* 2013;40(2):207-221.
5. Vigod SN, Kurdyak PA, Dennis CL, et al. Transitional interventions to reduce early psychiatric readmissions in adults: systematic review. *Br J Psychiatry.* 2013;202(3):187-194.
6. Steffen S, Kösters M, Becker T, Puschner B. Discharge planning in mental health care: a systematic review of the recent literature. *Acta Psychiatr Scand.* 2009;120(1):1-9.

Appendix A: Listing of Stakeholders Invited to Participate in Public Comment

Table A.1. Stakeholders Invited to Participate in Public Comment

	Stakeholder Organization Name
1.	American Pharmacists Association
2.	Agency for Healthcare Research and Quality (AHRQ)
3.	American Psychiatric Association
4.	American Psychiatric Nurses Association
5.	American Association of Clinical Endocrinologists (AACE)
6.	American Psychological Association
7.	American Association of Endocrine Surgeons (AAES)
8.	American Society of Health System Pharmacists
9.	Association of VA Psychologist Leaders
10.	Federation of American Hospitals
11.	Healthcare Leadership Council
12.	Institute for Healthcare Improvement
13.	Mental Health America
14.	American College of Surgeons (ACS) – National Surgical Quality Improvement Program (NSQIP)
15.	National Alliance for the Mentally Ill
16.	American Health Information Management Association (AHIMA)
17.	National Association of Psychiatric Health Systems
18.	America's Essential Hospitals
19.	National Association of Social Workers
20.	National Association of State Mental Health Program Directors
21.	American Pharmacists Association (APhA)
22.	National Council for Behavioral Health
23.	National Institute of Mental Health
24.	Agency for Healthcare Research & Quality
25.	Inpatient Psychiatric Facility Quality Reporting Program
26.	Office of the Assistant Secretary for Planning and Evaluation
27.	Substance Abuse and Mental Health Services Administration

Appendix B. Listing of Verbatim Comments from Responders

Table B.1. Verbatim Comments

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
1.	November 30, 2015	Geetha Jayaram, MD Associate Professor, Johns Hopkins University	Provider Organization (e.g., hospital, nursing home, home health agency, ambulatory care center)	Organization	Importance/Relevance: Unplanned readmissions within 30 days can occur in psychiatry for various reasons that have nothing to do with care provided during an inpatient stay. For example, homelessness is a major factor, prompting patients to say they are suicidal; substance abuse is another, with many liquor stores right at the corner of the hospital; violence in the community, failure of the public psychiatry system, leading to poor care as outpatients, or lapse of entitlements. Scientific Acceptability: The denominators need to be clearer about subgroups of patients, not just "Medicare beneficiaries" Feasibility: Too hard to track, because a patient can get readmitted because a family member called the police to bring them in. Or patients can get discharged and go right to the ED of another hospital.	Importance/Relevance: We appreciate your comment and recognize that there are factors external to the IPF that may influence readmission rates in the psychiatric population. Although not all readmissions are preventable, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can reduce readmission rates. No action taken at this time. Scientific Acceptability: We thank you for your comment. The denominator for the measure includes all admissions that meet all of the inclusion criteria and do not meet any of the exclusion criteria. Using subpopulations in the denominator did not improve the measure performance and would make the measure more difficult for users to interpret. Therefore, the denominator uses a single measure cohort. No action taken at this time. Feasibility: We thank you for your comment. The claims-based data provided to the IPF for this measure, should it be implemented, will give providers information about their patients even if they were readmitted to another institution. No action taken at this time.

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
					General: This measure works for patients who have undergone a medical procedure or surgery, but is not a good measure of anything in psychiatry.	General: We thank you for your comment. Readmission after hospital discharge for any condition is an adverse event from the patient perspective because it represents deterioration in mental and/or medical health status. No action taken at this time.
2.	December 1, 2015	Cheryl, BS	Education	Individual	Importance/Relevance: This is a waste of tax dollars. If they hadn't closed so many of the IPF's and long term care facilities they may not have this problem. Autonomy is all well and fine for many psychiatric patients, but many are extremely non-compliant and will continue to be for the rest of their lives, putting their own lives at risk. Scientific Acceptability: It is preferable to have the Medicare FFS beneficiaries with mobility, critical thinking and interpersonal skills (as is appropriated for their age) in tact before allowing them to exit Inpatient care. How does benefit the patient if they are released and they are not stable? Feasibility: 1) If their preventative care and follow-up is not good, then the feasibility of re-hospitalization is high. As is the case with so many psychiatric patients. 2) Case managers (Social worker or Nurse Practitioner) would be more feasible if they were non-compliant, to set up a goals and objectives management plan 3) These in office Case Managers could then follow-up with Psychologists, Psychiatrists or Physicians to go over the purposed plan and make sure that the Psychologist, Psychiatrist and Physician are on board with the patients requests	Importance/Relevance: We thank you for your comment. Scientific Acceptability: We thank you for your comment. We agree, patients whose condition has been stabilized prior to discharge from the index hospitalization and discharged to the appropriate setting should have a lower risk of readmission. No action taken at this time. Feasibility: We thank you for your comment. We agree, the goal of the readmission measure is to incentivize inpatient care that improves transitions to the outpatient setting. No action taken at this time.

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
					General: 1) Better initial intake at time of initial contact with Psychologist/Psychiatrist or Physician Providing an individual with 2) Better outside resources that will help patients get additional help, if they are starting to have problems with compliance 3) More IPF's as there are far to many individuals with Psychiatric disorders that need help and are not getting it on a daily basis from their outside provider	General: We thank you for your comment. We agree, the goal of the readmission measure is to incentivize inpatient care that improves transitions to the outpatient setting. We thank you for your comment. No action taken at this time.
3.	December 3, 2015	Geoffrey C. Ammerman, MS Ed LP, Vice President Acute Care Services, Meridian Behavioral Health	Provider Organization (e.g., hospital, nursing home, home health agency, ambulatory care center)	Individual	Importance/Relevance: This is an important measure to bring to light the needs of individuals evidencing a mental illness and what makes their care more effective. It is essential to apply research informed, evidence based protocols to the field of behavioral health and this measure is an excellent first step. Scientific Acceptability: The measure appears to evidence validity and reliability. I mention in my general comments where I believe there could be further consideration given as to risk factors. Feasibility: As with all proposed measures, it's all in the roll out. I believe that partnering with all organizations to improve care, using these data to identify needs and then fill those needs with this information would be of infinite value and would likely bring very willing participants to the table. General: In the assessment tool and supporting documentation, case management appears to have a significant impact upon recidivism. I would think that the quality and availability of case management services would have a more significant impact upon recidivism to an IPF. Additionally, the number, quality and availability of appropriate services, residential and outpatient would have an equally significant impact upon recidivism. If for	Importance/Relevance: We agree and we thank you for your comment. Scientific Acceptability: We thank you for your comment. Feasibility: We thank you for your comment. General: We thank you for your comment. We recognize that there are factors external to the IPF that may influence readmission rates in the psychiatric population. However, there is evidence that improvements to the quality of care for patients in the IPF setting, including the

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
					example a case manager indicates that a given patient requires community residential placement, but there are either no beds available or services are limited, the likelihood of that patient returning to the IPF is significantly greater. IPF's that are in areas where these support and case management services are limited would likely have a higher recidivism rate due to the lack of these supportive services. It is my recommendation that the number, quality and availability of all levels of support services outside of the IPF should be included in this measure so as not to unduly apply financial consequences to an IPF which may be one of the few facilities that offer services to the mentally ill in any given community. Money would be well spent to focus on preventative and support services, residential and outpatient, which would be over time, far less costly that repeated readmissions to IPF's. Additionally, an inclusion of high tech interventions by the IPF such as the Genesight® or Cytochrome P-450 testing to determine medication efficacy would also serve to reduce recidivism, given that the patients would receive more effective pharmacological treatment from the beginning of their care and thus will provide increased behavioral stability.	discharge process, can reduce readmission rates. We thank you for your comment. Performance on this measure is not tied to reimbursement. We thank you for your comment. No action taken at this time.
4.	December 4, 2015	Jessica Hatcher, LPC Therapist	Industry/Supplier	Individual	Importance/Relevance: while decreased readmissions are certainly the goal for any provider, this measure does not adequately capture the measurement of treatment success given the chronicity of psychiatric and substance abuse conditions, nor the complaince issues surrounding these diagnoses.	Importance/Relevance: We recognize that there are factors external to the IPF that may influence readmission rates in the psychiatric population. Although not all readmissions are preventable, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can reduce readmission rates. Additionally, risk adjustment for comorbidities, history of illness, and discharges against medical advice in the year preceding the index admissions should account for chronicity and perhaps differences in compliance with care plans.

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
					Scientific Acceptability: readmissions cannot control for patient compliance, failure to follow aftercare follow-up, relapse of symptoms nor limited resources leading to readmissions of the psychiatric population (medications not on formulary, medication cost, no housing, etc.) Feasibility: No response. General: The patient populations served in psychiatric settings are more complex, more chronic and more prone to noncompliance than most any other hospitalized patient population. Lack of resources to continue medications, attend follow-up appointments, pay co-pays, and have basic needs met all contribute to readmissions and cannot adequately be controlled scientifically to reduce readmissions without additional resources to support those with psychiatric and substance abuse issues in the community.	No action taken at this time. Scientific Acceptability: We thank you for your comment. Please see response above. No action taken at this time. Feasibility: No response. General: We thank you for your comment.
5.	December 6, 2015	Andrew Kokesh, RN	Other-None	Individual	Importance/Relevance: I believe that measures like this are critical to tracking the patterns of readmission to IPFs. Chronic readmissions to IPFs are a consistent problem and decreasing the number of "frequent flyers" at these facilities will help to control costs, reduce strain on public services, and result in better quality of life for the patients who receive services at these facilities. Scientific Acceptability: I appreciate that the measure is standardized based on risk for each facility, because acuity levels can vary dramatically from one facility to the other based on the locations, specialties, and patient populations they serve. Without this sort of standardization facilities would draw valid comparisons to one another.	Importance/Relevance: We agree and thank you for the comment. No action taken at this time. Scientific Acceptability: We agree and thank you for the comment.

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
					Also, I question why those patients who are discharged and readmitted within 3 days should be excluded. This sort of extremely rapid readmission should be captured in the measure. While it may not be as reflective of rapid readmissions those patients discharging AMA and readmitted should also be counted in the measure. <u>Feasibility</u>: Based on the steps laid out in the calculation algorithm/measure logic I believe the measure is feasible, but does have some challenges. All of the data for steps 1, 2, 3, 4, and 6 should be easily obtainable from charts at these facilities, but I believe that step 5 (risk factors) may be more challenging because data regarding risk factors may not be collected in the same way at each facility. <u>General</u>: I question whether the criteria of a 30 day readmission is really appropriate for this population. Of course rapid readmission is a significant concern, I believe readmissions within 60 or even 90 days should also play a part in this measure.	We agree with your suggestion to capture rapid readmissions. However, we do not include days 0-2 because admissions on these days are not reliably identifiable as readmissions in the claims data used to calculate the measure. We thank you for your comment. As part of routine measure maintenance, the measure developer will continue to explore improvements to the measure specifications as feasible. No action taken at this time. <u>Feasibility</u>: We thank you for your comment. This measure will be calculated using Medicare claims data that hospitals and providers submit to CMS for billing purposes. This allows CMS to capture historical claims for risk adjustment and readmissions to other facilities. Hospitals will not be required to submit any additional information to calculate this measure. For details on the methodology used to calculate the measure please see measure technical report: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html No action taken at this time. <u>General</u>: We thank you for your comment. While we considered whether a 60- or 90-day readmission rate would be appropriate for this measure, we ultimately decided that 30-days best reflects the quality of care provided at the IPF and is less influenced by factors in the outpatient setting.

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
						Furthermore, the 30-day timeframe is harmonized with readmission measures in other settings. No action taken at this time.
6.	December 8, 2015	Sherrie Margiotta, MSN, RN PMHNP Graduate Student, The University of Texas at Austin	Other- University	Individual	Importance/Relevance: The topic for the proposed measure for readmission to an IPF within 30 days is not only relevant to measure in this population, but necessary to inform providers, both inpatient and outpatient providers, with accurate data about the frequency of readmissions, why they might be occurring, and what interventions could be taken with these patients to prevent their return to an IPF. Scientific Acceptability: The proposed measure appears to include standardized measures and data analysis instruments/algorithms to accurately assess the problem of the individual IPFs readmission rates compared to national readmission rates. Feasibility: The feasibility of the proposed measure seems appropriate for assessing the readmission rates at an individual IPFs due to Medicare records being easily accessed at the facility level. General: This measure for reflecting the quality of care that patients receive at an IPF is of great importance when looking at readmission rates of this patient population. If we are to improve the care we provide either directly or by referring to social/community sources to assist these patients after discharge back into the community, then we need data from quality improvement projects such as these to inform providers where exactly improvements may be needed.	Importance/Relevance: We thank you for your comment. Scientific Acceptability: We thank you for your comment. Feasibility: We thank you for your comment. General: We thank you for your comment.

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
7.	December 8, 2015	Jef Bayless, RN San Marcos Treatment Center	Provider Organization (e.g., hospital, nursing home, home health agency, ambulatory care center)	Individual	Importance/Relevance: I feel that estimating RSRR is an important aspect of providing quality care and striving to decrease the number of readmissions seen in IPFs. Considering the numerous factors that play into readmissions a scientifically developed statistical measure to assist in evaluating risk is extremely valuable Scientific Acceptability: Admittedly, much of the scientific acceptability of the proposed measure was over my head. That being said, I think that a comprehensive approach was utilized to come up with a statistical significant measurement in evaluating IPFs readmissions and that it can undoubtedly assist providers and institutions in improved individualized care. Feasibility: I saw no constraints in terms of feasibility or application of the proposed measure. General: As mentioned, connecting patients with severe mental illness to intensive case management (ICM) can help reduce the average number of days in hospital by 0.86 days per month, but some research has found that shorter duration of stays in IPFs results in higher readmission rates at numerous time intervals. Is CMS also reporting that in effect shorter hospitalizations is a goal for IPFs looking to impact their readmission rates? Considering the rates of readmission for patients ranging in age from 18-64 does CMS believe age to be a protective factor in readmission for psychiatric purposes? Or is it possibly due to a higher level of complex medical comorbidities that we see such a significant decrease in readmissions in those patients 65 and older?	Importance/Relevance: We agree and appreciate the comment. Scientific Acceptability: We thank you for your comment. Feasibility: We thank you for your comment. General: We thank you for your comment. No, CMS is not reporting that shorter hospitalizations are a goal for IPFs. The goal of this measure is to incentivize interventions to improve care transitions to the outpatient setting and reduce variation in readmission rates across IPFs. We thank you for your comment. There are differences in Medicare eligibility in the under= and over-65 age groups. Patients who are aged 65 or over qualify for Medicare regardless of health status. However, patients under age 65 qualify for Medicare only if they have a long-term disability.

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
					Can CMS account or provide possible reasons for the disparity in terms of race when evaluating the readmission rates for minorities such as African Americans and Hispanics?	We thank you for your comment. Sociodemographic factors, like race and ethnicity, are complex and we have not identified any underlying causes for disparities to date. CMS does not currently risk adjust for race/ethnicity on the readmission measure but does routinely monitor disparities during measure maintenance. No action taken at this time.
8.	December 8, 2015	Samantha Shugarman, Deputy Director of Quality, American Psychiatric Association	Health Professional Organization	Organization	Importance/Relevance: No response. Scientific Acceptability: No response. Feasibility: In the review of the measure we were unable to view validity testing or other data that justifies this measure. General: In general the APA supports this measure. It appears to improve upon general/cross-cutting readmission measures by taking into account risk adjustment. We do have some questions related to measure testing (noted in another comment area), but do identify the measure/care gap this aims to address. Additionally, it is unclear whether the hospital	Importance/Relevance: No response. Scientific Acceptability: No response. Feasibility: We thank you for your comment. Information on the justification for the measure and validity are provided in the measure technical report: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallforPublicComment.html No action taken at this time. General: We thank you for your comment. We recognize that there are factors external to the IPF that may influence readmission rates in the psychiatric population. Although not all

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
					will be held accountable for something which they have no control (i.e. if the patient doesn't receive community services and are readmitted, that would ding the hospital). Given the concern over follow-up services, it is our suggestion that this measure be utilized as a quality indicator for the "community," rather than something that could come back to negatively reflect on the hospital.	readmissions are preventable, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can reduce readmission rates. No action taken at this time.
9.	December 11, 2015	Frank A. Ghinassi, PhD Vice President/Associate Professor, Quality, Safety, Regulatory and Health Information Management Western Psychiatric Institute and Clinic of UPMC Presbyterian/Shadyside	Provider Organization (e.g., hospital, nursing home, home health agency, ambulatory care center)	Organization	Importance/Relevance: Focuses attention on the multiple patient and system factors which influence re-hospitalizations, which should include patient acuity factors, housing stability, natural supports or lack of same, inpatient provider efforts and the companion regional ambulatory provider access, efforts and efficacy Will encourage increased communication and collaboration among all the involved stakeholders (patients, families, providers, payors, legislators, county/state systems, etc) needed to reduce preventable re-hospitalizations Incentives, including aligned financial incentives across provider systems, for quality improvement could lead to a reduction in the national rates and a reduction in the variation in rates across facilities Scientific Acceptability: One concern regarding this measure is the focus on the accountability of only one link, in this case acute inpatient facilities, in the much broader provider system of inpatient and ambulatory services that must combine efforts to insure sustained community tenure for individuals who on occasion require acute inpatient services. Any meaningful solutions must require the alignment, financial and otherwise, of acute inpatient facilities and the full array of ambulatory treatment and broader human services agencies and programs.	Importance/Relevance: We thank you for your comment. We thank you for your comment. We thank you for your comment. Scientific Acceptability: We appreciate your comment and recognize that there are factors external to the IPF that may influence readmission rates in the psychiatric population. Although not all readmissions are preventable, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can reduce readmission rates. No action taken at this time.

Entry No.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
					Feasibility: The measure appears to be technically feasible, but will require an ongoing stream of re-admissions data from CMS to hospitals regarding re-admissions to inpatient facilities that are not a part of the same organization as the discharging hospital. The other issue is timely reporting of this readmission data (e.g., monthly rolling reports), at the patient ID level must be available. Without timely reporting, and patient level detail, meaningful quality improvement efforts by participating hospitals will be compromised, uninformed and less effective. General: This measure will require much in the way of ongoing technical specification maintenance, and must address clearly such events as transfers from hospital to hospital, what precisely constitutes an AMA discharge, how interrupted stays are operationalized, and the clear and reliable reporting of other generally complex data elements	Feasibility: We thank you for your comment. Real-time reporting of IPF readmission rates by CMS is not feasible at this time because this measure is calculated using two years of Medicare administrative claims data to obtain adequate sample size for facility-level comparisons to a national readmission rate. No action taken at this time. General: We thank you for your comment. As part of routine measure maintenance, the measure developer will continue to explore improvements to the measure specifications as feasible. No action taken at this time.
10.	December 11, 2015	Kathleen McCann, R.N., Ph.D., Health care professional, National Association of Psychiatric Health Systems	Other (please specify) Provider trade association	Organization	Importance/Relevance: We see the value of a readmission measure as part of a set of measures that assess quality from different perspectives. The natural course of the severe and persistent diseases treated in IPFs may include crisis-level exacerbations that cannot be safely managed at any other level of care, thus necessitating readmission. Scientific Acceptability: HSAG worked very hard on the risk adjustment of this measure. We support that it be risk adjusted. We recommend that the adjustment factors be closely monitored in an ongoing way to be sure they are appropriate and that they be modified when necessary. Since the measure is claims-based, the limits of claims data (with special concern for psychiatric services), is a	Importance/Relevance: We thank you for your comment. We thank you for your comment. We recognize that not all readmissions are preventable. The goal of this measure is to reduce readmissions and the variation in performance across IPFs. No action taken at this time. Scientific Acceptability: We thank you for your comment. Generally, the National Quality Forum (NQF) and CMS have advised against risk adjustment for sociodemographic status (SDS) in quality measures. However, the NQF is currently in the process of revising its recommendations for

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					significant factor in understanding important aspects of readmissions such as psychosocial variables. Access to outpatient services is also a factor that affects readmission. The discussion within the development workgroup seemed to conclude there are no workable proxy measures for psychosocial variables and for access. This is a limitation in the ability to fully risk adjust the measure.	inclusion of SDS risk factors and is asking measure developers to include analyses on SDS risk adjustment in their endorsement or re-endorsement submissions. As such, we will present the results of the analyses of available SDS risk factors when the measure is submitted to NQF for endorsement in January of 2016. In addition, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research on the issue of risk adjustment for socioeconomic status as directed by the IMPACT Act and will issue a report to Congress by October 2016. At the conclusion of that work, CMS will consider ASPE's recommendations and the applicability to this measure. No action taken at this time.
					Feasibility: The measure requires CMS to query its own administrative claims database. The measure developers successfully used this methodology in the measure development process so it is probably feasible.	Feasibility: We thank you for your comment.
					General: We are concerned about how this measure will interface with readmission measures for other payment systems. We ask that this measure be carefully aligned with readmission measures used in other payment systems to be sure inpatient psychiatric facilities are not disadvantaged. A particular question that arose is the treatment of admissions to psychiatric facilities when the index admission is the acute care hospital. Are admissions to psychiatric hospitals or distinct part units in psychiatric hospitals included in the readmission rates for acute care hospitals?	General: We thank you for your comment. This measure methodology has been aligned to the extent possible with the NQF-endorsed Hospital-Wide All-Cause Unplanned Readmission (HWR) Measure for acute care hospitals. The HWR measure for acute-care hospitals only includes readmissions to acute-care facilities in the outcome.

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					If not, does an admission to a psychiatric distinct part unit or freestanding hospital within 30 days of discharge from an acute care hospital, become the index admission? We also ask that any influence on readmission rates caused by the relatively low number of IPF discharges (as compared with the number of discharges from acute care hospitals) be accounted for.	All admissions to an IPF that meet the IPF readmission measure inclusion and exclusion criteria are included in the measure cohort regardless of prior admissions to either acute care hospitals or IPFs. Similar to many existing publicly reported readmission measures, the IPF readmission measure uses more than one year of data to increase the sample size at each facility during the measurement period. A comparison of the IPF readmission measure to the HWR measure for acute care hospitals shows that the proportion of small volume facilities, defined as less than 25 index admissions per measurement period, is similar (4.2% and 3.8%, respectively). No action taken at this time.
11.	December 11, 2015	Donna Rolin, PhD, APRN, PMHCNS-BC Psychiatric Mental Health NP University of Texas at Austin School of Nursing Compiled Comments from University of Texas at Austin Psychiatric Mental Health Nurse Practitioner Graduate Program. Donna Rolin, PhD, APRN, PMHCNS-BC, Program Director. Jef Bayless, RN, PMHNP-Student (Individual response Number 7)	Other- Nursing Graduate Program	Organization	Importance/Relevance: • I feel that estimating RSRR is an important aspect of providing quality care and striving to decrease the number of readmissions seen in IPFs. Considering the numerous factors that play into readmissions a scientifically developed statistical measure to assist in evaluating risk is extremely valuable • This is very relevant as reimbursement methodologies have experienced a paradigm shift • This is very relevant as the aging population continues to grow in the United States presumably due to advancement of medical technology • I believe that measures like this are critical to tracking the patterns of readmission to IPFs. Chronic readmissions to	Importance/Relevance: Addressed under Importance/Relevance in response Number 7, submitted by Jef Bayless, RN. We thank you for your comment. We thank you for your comment. Addressed under Importance/Relevance in response Number 5, submitted by Andrew Kokesh, RN.

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		Nicholas Gaultney, RN, PMHNP-Student David Goen, RN, PMHNP-Student Andrew Kokesh, RN, PMHNP-Student (Individual response Number 5.) Sherrie Margiotta, RN, MSN, PMHNP-Student (Individual response Number 6) J. Logan Meza, RN, PMHNP-Student Katrina Rodies, WHNP, PMHNP-Student Zhan Yang, FNP, PMHNP-Student			IPFs are a consistent problem and decreasing the number of "frequent flyers" at these facilities will help to control costs, reduce strain on public services, and result in better quality of life for the patients who receive services at these facilities. • The topic for the proposed measure for readmission to an IPF within 30 days is not only relevant to measure in this population, but necessary to inform providers, both inpatient and outpatient providers, with accurate data about the frequency of readmissions, why they might be occurring, and what interventions could be taken with these patients to prevent their return to an IPF. Scientific Acceptability: • Admittedly, much of the scientific acceptability of the proposed measure was over my head. That being said, I think that a comprehensive approach was utilized to come up with a statistical significant measurement in evaluating IPFs readmissions and that it can undoubtedly assist providers and institutions in improved individualized care. • I appreciate that the measure is standardized based on risk for each facility, because acuity levels can vary dramatically from one facility to the other based on the locations, specialties, and patient populations they serve. Without this sort of standardization facilities would draw valid comparisons to one another. • Based on the steps laid out in the calculation algorithm/measure logic I believe the measure is feasible, but does have some challenges. All of the data for steps 1, 2, 3, 4, and 6 should be easily obtainable from charts at these facilities, but I believe that step 5 (risk factors) may be more challenging because data	Addressed under Importance/Relevance in response Number 6, submitted by Sherrie Margiotta, RN, MSN. Scientific Acceptability: Addressed under Scientific Acceptability in response Number 7, submitted by Jef Bayless, RN. Addressed under Scientific Acceptability in response Number 5, submitted by Andrew Kokesh, RN. Addressed under Scientific Acceptability in response Number 5, submitted by Andrew Kokesh, RN.

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					regarding risk factors may not be collected in the same way at each facility.	
					• The proposed measure appears to include standardized measures and data analysis instruments/algorithms to accurately assess the problem of the individual IPFs readmission rates compared to national readmission rates	Addressed under Scientific Acceptability in response Number 6, submitted by Sherrie Margiotta, RN, MSN
					• The graphical outlay and depth of statistical analysis explanation is fantastic, but the report should include a succinct discussion of the results. This would allow for more efficient utilization and understandability of the information presented in this report as well as making the report more accessible and easier to cite for future research.	We thank you for your comment. We will take your recommendation into consideration.
					Feasibility: • I saw no constraints in terms of feasibility or application of the proposed measure.	Feasibility: Addressed under Feasibility in response Number 7, submitted by Jef Bayless, RN.
					• I question whether the criteria of a 30 day readmission is really appropriate for this population. Of course rapid readmission is a significant concern, I believe readmissions within 60 or even 90 days should also play a part in this measure	Addressed under Feasibility in response Number 5, submitted by Andrew Kokesh, RN.
					• The feasibility of the proposed measure seems appropriate for assessing the readmission rates at an individual IPFs due to Medicare records being easily accessed at the facility level	Addressed under Feasibility in response Number 6, submitted by Sherrie Margiotta, RN, MSN.
					• The summary is succinct and informative. While it is reasonable to use ICD-9 codes considering the data was gathered during the period in which ICD-9 was still in effect, the data would potentially be more relevant moving forward if it were categorized according to ICD-10.	We thank you for your comment. An ICD-10 crosswalk of the measure will be provided in future documentation of this measure.
					• One considerable oversight I noticed is that there is no discussion of the cost, availability, or feasibility of the	We thank you for your comment. This measure is meant to provide information on areas for

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					recommended strategies for reducing 30-day readmissions. This information is vital if one is to consider these strategies beyond anything but a theoretical discussion	performance improvement. When available, we will provide cost and feasibility estimates of interventions listed.
					• While defining the "comorbid risk variable", it is said that only "secondary diagnosis" from "index admissions" are counted if they are within 12 month prior to admission. Many chronic diseases or conditions could easily fall out of this category if measured this way, but they may play a significant role in terms of readmission.	We thank you for your comment. The measure considers four different types of risk factors. The first are demographic factors (age and gender). Next, the measure accounts for the principal discharge diagnosis of the index admission. Then, the measure accounts for comorbidities that are identified either as secondary diagnoses of the index admission or as primary and secondary diagnoses of inpatient and outpatient encounters in the 12-months prior to the admission. Finally, the measure accounts for history of discharges against medical advice, suicide attempts or ideation, and aggression.
					• Limited mental health diagnosis are included as "principal discharge diagnoses". Only 13 of the diagnosis are selected. They represent a very small fraction of patients treated impatiently in the mental health facilities.	We thank you for your comment. The psychiatric diagnoses included in the measure cohort account for 98.9% of IPF admissions.
					Also, one of these 13 variables is defined as "CCS 670/663 other mental disorder", I would assuming this variable end up accounts for large proportion of the subjects enrolled in the study. If so, the study would cause a great confusion because of lack of universality of "other mental disorder" definition and understanding	We thank you for your comment. No, the most common CCS categories for index admissions in this measure are for schizophrenia, mood disorders, and dementia.
					• Author decide to use "30 days" time frame to measure the variable. I am not sure how this very short of period to be the "quality indicator" for hospital readmission. Author cite SAMHSA and CMHS as validating authorities to identify this time frame to be most appropriate for this study. They also argue 90 days' measurement would not be more sensitive. But what about 45 days or 60 days, then?	We thank you for your comment. While we considered whether a 60- or 90-day readmission rate would be appropriate for this measure, we ultimately decided that 30-days best reflects the quality of care provided at the IPF and is less influenced by factors in the outpatient setting. Additionally, the 30-day timeframe is harmonized with readmission measures in other settings.

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						No action taken at this time.
					General: • As mentioned, connecting patients with severe mental illness to intensive case management (ICM) can help reduce the average number of days in hospital by 0.86 days per month, but some research has found that shorter duration of stays in IPFs results in higher readmission rates at numerous time intervals. Is CMS also reporting that in effect shorter hospitalizations is a goal for IPFs looking to impact their readmission rates?	General: Addressed under General in response Number 7, submitted by Jef Bayless, RN.
					• Considering the rates of readmission for patients ranging in age from 18-64 does CMS believe age to be a protective factor in readmission for psychiatric purposes? Or is it possibly due to a higher level of complex medical comorbidities that we see such a significant decrease in readmissions in those patients 65 and older?	Addressed under General in response Number 7, submitted by Jef Bayless, RN.
					• Can CMS account or provide possible reasons for the disparity in terms of race when evaluating the readmission rates for minorities such as African Americans and Hispanics	Addressed under General in response Number 7, submitted by Jef Bayless, RN.
					• As I understand it, the focus of this study was to create a measure by which quality of care provided by inpatient psychiatric facilities (IPFs) may be judged based on readmission rates. Perhaps I am overlooking something here, but what I found strange was the "all-cause" readmission approach. The authors state that initial admissions "with principal psychiatric disorders…to short-stay acute care hospitals without IPF units" accounted for about one-third of admissions and that these admissions were not included in the study. Yet, non-psychiatric causes for readmission to accounted for about 25% of readmissions and were included in this measure. I understand that any hospital admission is costly and "undesirable" and I also understand that IPFs may be in a position to bridge the gap between psychiatric patients and non-psychiatric health care. However, it seems to me that more logical approaches would	We thank you for your comment. This measure was developed to evaluate Inpatient Psychiatric Facilities for the Inpatient Psychiatric Facility Quality Reporting Program, so admissions to acute care hospitals are not included in the measure cohort. However, this measure's methodology has been aligned to the extent possible with the Hospital-Wide All-Cause Unplanned Readmission (HWR) Measure for acute care hospitals. Based on 2015 specifications, that measure includes some psychiatric diagnoses as index admissions (e.g., delirium, dementia, and alcohol related disorders) while other psychiatric admissions (e.g., schizophrenia, depression) are excluded.

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					have been to either look at the system as a whole and expand the scope of this measure to include admission of psychiatric patients for non-psychiatric causes to non-psychiatric facilities or limit readmissions to those that can be more directly linked to the performance of IPFs.	We appreciate your comment. This measure evaluates an all-cause, unplanned readmission rate to capture adverse events experienced by patients following discharge from an IPF. This approach encourages treatment of the patient as a whole. Additionally, there are several factors that make it difficult to parse out which readmissions are related to the index admission in this patient population. Determination of the relationship between the principal discharge diagnosis of the index admission and the principal discharge diagnosis of the readmission is complex because even similar clinical presentations might be captured with slightly different principal diagnosis codes. Similarly, psychiatric patients may self-harm if their symptoms are not well managed and can be readmitted for medical conditions that are, in fact, related to the index admission. For example, a patient discharged with bipolar disorder from the index admission may be readmitted because of a suicide attempt. Similar to other types of readmission measures, hospital-acquired complications may manifest in a range of clinical diagnoses that can be unrelated to the principal or secondary diagnoses of the index admission. Two examples of complications include preventable adverse drug events or nosocomial infections. Finally, while IPFs cannot always address all medical conditions, much like some acute-care facilities, they do have a responsibility to ensure that patients with comorbid medical conditions

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						are transferred or referred to appropriate medical care upon discharge.
					• This measure for reflecting the quality of care that patients receive at an IPF is of great importance when looking at readmission rates of this patient population. If we are to improve the care we provide either directly or by referring to social/community sources to assist these patients after discharge back into the community, then we need data from quality improvement projects such as these to inform providers where exactly improvements may be needed.	Addressed under General in response Number 6, submitted by Sherrie Margiotta, RN, MSN.
					Suggestions for effective interventions and medications, such as long-acting injectable medications, with supported data would hopefully improve care for these patients.	We appreciate your comment.
					• Limiting search criteria to only Medicare and Medicaid databases may limit generalizability of results and may exclude valuable information outside of the scope of these databases. Strategies that have value in reducing readmission rates amongst non-Medicare and non-Medicaid patients may also be valuable within the Medicare and Medicaid population.	We thank you for your comment. This measure is calculated using data from Medicare administrative claims data only. At this time, it is not feasible to calculate the measure for other payers. However, CMS anticipates that interventions designed to reduce the readmission rate will be implemented by facilities for all patients regardless of payer.
					• The comparison between medical and psychiatric readmission was interesting information and points to the need for a holistic and integrative approach to mental health care.	We thank you for your comment.
					• The inclusion of gender was appropriate, but a discussion of transgendered individuals and gender identities beyond of the bounds of simple male/female must be included for accurate examination of the data. Sexuality also goes unaddressed in this report, which is an unfortunate oversight as it plays a major role in the mental health of many people.	We thank you for your comment. Transgendered individuals will appear in the data with the gender that they selected upon enrollment in Medicare. At the time of measure development, data on patients' sexuality is not collected by Medicare but the measure developer did examine sexual orientation as a risk factor to the extent it is described in ICD-9 diagnosis codes. These diagnoses are included in the measure

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						under the "Other Psych Disorders" ICD-9-CM grouping.
					• Another 12 psychiatric related disorders are selected to be part of comorbidity variables. Most of these 12 diagnosis are replicated in the "principal discharge diagnoses" as well. Therefore, technically they can be measured as either a principle discharge diagnosis, or a "comorbidity". I am assuming many of subjects have more than one primary diagnosis while admitting to inpatient psychiatric facility. This would be even more confused for audience to validate the study. It would great affect the result with manipulating and reclassifying the subjects between their multiple diagnoses. A "bipolar disorder" diagnosis can fit into both principle and comorbid diagnose, and if patient also carries the diagnoses of personality disorder and alcohol disorder (both on authors' lists), then this subject could be the chess placed everywhere.	We thank you for your comment. The principal discharge diagnosis is the diagnosis that a provider indicates as the primary cause for the admission. IPFs are required to submit claims providing a principal diagnosis. Providers have an incentive to provide valid information for billing purposes because claims are regularly audited and the claims determine the amount they will get paid for treating each patient. The measure uses the principal discharge diagnosis selected by the provider on the claim to identify whether an admission is eligible as an index admission in the measure cohort and in the risk model because some psychiatric diagnoses carry higher risks of readmission than others. Comorbidities are considered if they are present during the index admission in any of the secondary diagnosis fields of the claim and are not a complication of care or if they occurred in the 12 months prior to the index admission.
					• Planned readmission is excluded. I am concerning that disorders carry the feature of worsening course and progression would not be reflected in the study. For example, a patient with severe dementia discharged from IPF with planned readmission in acute hospital for orthopedic work up/surgery, appears to be non-compliant with medication for his/her dementia or other comorbid medical condition since discharge. He or she may present on readmission with worsening and preventable psychiatric or medical symptoms. This case would clearly demonstrate the relevant factors/variables affecting the readmission outcomes. But according to the exclusion criteria of this study, it would be easily put into "planned readmission" group. Many psychiatric disorders may demonstrate similar features as the example of dementia patient I described above. It	We thank you for your comment. Readmissions for planned procedures that are accompanied by acute diagnoses such as dementia, alcohol- or substance-abuse disorders, or suicidality are considered unplanned and are included in the measure outcome. Procedures that are not accompanied by an acute diagnosis do not appear to reflect a worsening of a patient's condition and are considered planned.

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					would be too easy for these patients to fall off the measurable subject's list. This would affect the validity of the entire study because we cannot generalize the conclusion to the entire subjects' population anymore. Author state only 2.7% readmission patients are excluded in this study, but this small population may demonstrate important clinical features to help us not only understand their specific risk factors, but also generalize to other patients. Overall, 2.7% isn't that small of a percentage considering the numbers of measurable variables. Some of the variables may count even less of percentage.	
					• As an admissions nurse in an acute care psychiatric hospital, I agree with the stated premise that readmission to acute care facilities is an undesirable outcome. On an individual level, it requires a patient's condition to have decompensated from a baseline of stability (required for discharge) to a level necessary for inpatient care.	We thank you for your comment.
					In practical terms, patients seeking readmission may be in spell of illness or have exhausted their Medicare days entirely. These factors make subsequent admissions—or readmissions—difficult, especially when considering placement in private facilities. In Travis County, such patients may apply for Health Department (HD) funding to cover their stay. But this funding is given out on a "first serve" basis each morning—meaning that many patients may find that no funding opportunities exist by midday. The goal to provide more intensive discharge planning is certainly worthwhile; however, in my experience, the services to meet these needs are simply not there. Austin Travis County Integral Care (ATCIC) does a noble job of providing medication and case management services to the mentally ill, but they are functioning under the same budgetary constraints as other social welfare agencies. The reality is that often, our most acutely mentally ill patients are also the ones who have the least access to stable housing and healthcare. Group homes, where many of our chronically mentally ill are discharged, are notorious for lack of monitoring and even illegal actions. Here in Austin, post-discharge facilities such as The Arch and The Inn are quite	We thank you for your comment and recognize that there are factors external to the IPF that may influence readmission rates in the psychiatric population. Although not all readmissions are preventable, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can reduce readmission rates.

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					frankly, dangerous (as last week's shooting attests) and are "last ditch options" for the mentally ill without family or other avenues of support. Unfortunately, no amount of discharge planning is going to change that. Complicating the picture is that private hospitals also have a financial incentive to discharge patients who have termed out on their insurance benefits before they are truly clinically stable. I can say from experience in a private facility that this does not represent a small portion of patients. I agree that presenting a clear picture of the factors that lead to readmission and encouraging more intense case management has the potential to improve the length of time between admissions.	
					As an admissions nurse who works with a Medicare majority population, I would also offer the following practical suggestions: Where possible, limit the amount of discharges that occur over the weekends. Many of the shelters and social services available to the mentally ill/economically underserved keep short operating hours during the week. By discharging on weekends or holidays, we set patients up for failure if they don't have their own housing resources or ability to independently secure them	We thank you for your comment.
					• Increase/earmark funding support for the programs such as ATCIC to provide comprehensive services to recently discharged patients. (This could be be similar to the successful "Head Start" model of programming in underserved school districts)	We thank you for your comment.
					• Establish a public funding initiative that offers financial incentives to institutions who have successful discharge rates (defined as no readmissions to acute care facilities within 30 days)	We thank you for your comment.
					Encourage institutional utilization of outpatient programming, which can provide some of the therapeutic structure and medication management necessary for patients to stay stable. (Again, offering a financial incentive for facilities who successfully demonstrate continuity of care would also improve this outcome).	We thank you for your comment. No action taken at this time.

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12.	December 11, 2015	Evelyn Knolle, MPH, JD Senior Associate Director, Policy American Hospital Association	Other	Organization	Importance/Relevance: Scientific Acceptability: Feasibility: General: The American Hospital Association (AHA) appreciates the opportunity to comment on the measure for thirty-day, all-cause, unplanned readmission following psychiatric hospitalization in an Inpatient Psychiatric Facility (IPF). The AHA believes that identifying and reducing avoidable readmissions—including those related to psychiatric care—has the potential to improve patient safety, improve coordination of care across settings, and reduce healthcare spending. The experience of the field to date suggests that readmissions reduction requires participation from, and collaboration among, all providers—inpatient facilities, post-acute providers, and physicians—as well as the patients and communities they serve. Well-designed measures of readmission performance hold the potential to facilitate readmission reduction. We urge HSAG and CMS to address the following features of the measure: 1. We urge you to adjust the measure for sociodemographic factors. As demonstrated in a growing body of research, sociodemographic factors – such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services – significantly influence performance on outcome measures like readmissions, mortality and resource use. For the inpatient psychiatric facility readmission measure, we believe adjusting for sociodemographic factors is significantly important. In many instances, the readmission risk for psychiatric and behavioral health patients will hinge on whether they have access to outpatient mental health services after discharge from an inpatient psychiatric facility.	Importance/Relevance: Scientific Acceptability: Feasibility: General: We appreciate your comment. We thank you for your comment. Generally, the National Quality Forum (NQF) and CMS have advised against risk adjustment for sociodemographic status (SDS) in quality measures. However, the NQF is currently in the process of revising its recommendations for inclusion of SDS risk factors and is asking measure developers to include analyses on SDS risk adjustment in their endorsement or re-endorsement submissions. As such, we will present the results of the analyses of available SDS risk factors for this measure when the measure is submitted to NQF for endorsement.

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						In addition, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research on the issue of risk adjustment for socioeconomic status as directed by the IMPACT Act and will issue a report to Congress by October 2016. At the conclusion of that work, CMS will consider ASPE's recommendations and the applicability to this measure.
					However, the U.S. currently has a shortage of mental health professionals and services. For example, currently the Health Resources and Services Administration has identified 4,000 mental health professional shortage areas.	We thank you for your comment.
					Measures that fail to adjust for sociodemographic factors, when there is a relationship between those factors and the measure outcome, lack credibility, unfairly portray the performance of providers caring for more complex populations, and may serve to exacerbate health care disparities.	We thank you for your comment.
					2. We urge you to ensure the measures are adjusted so that readmissions that are unrelated to the IPF admission do not count against it. We agree that IPFs should evaluate and treat patients in a holistic way and address their mental as well as physical health needs during the IPF stay. In addition, we believe that IPFs should have robust discharge planning procedures that help ensure a patient's mental and physical health needs are met after the inpatient stay. We are concerned that there may be instances, for example, where the IPF readmissions measure would penalize an IPF because of an unrelated readmission, even if the IPF did everything within its control to ensure a good outcome for the patient. For example, a patient may be discharged from an IPF after an admission for severe depression, and within 30 days be readmitted to an acute care hospital for appendicitis or another condition, illness, or injury that is not related to the patient's depression. While the planned readmissions algorithm addresses some of our concerns about	We thank you for your comment. This measure evaluates an all-cause, unplanned readmission rate to capture adverse events experienced by patients following discharge from an IPF. This approach encourages treatment of the patient as a whole. Additionally, there are several factors that make it difficult to parse out which readmissions are related to the index admission in this patient population. Determination of the relationship between the principal discharge diagnosis of the index admission and the principal discharge diagnosis of the readmission is complex because even similar clinical presentations might be captured with slightly different principal diagnosis codes. Similarly, psychiatric patients may self-harm if their symptoms are not well managed and can be

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					unplanned readmissions, it does not address all of our concerns about unrelated readmissions.	readmitted for medical conditions that are, in fact, related to the index admission. For example, a patient discharged with bipolar disorder from the index admission may be readmitted because of a suicide attempt. Similar to other types of readmission measures, hospital-acquired complications may manifest in a range of clinical diagnoses that can be unrelated to the principal or secondary diagnoses of the index admission. Two examples of complications include preventable adverse drug events or nosocomial infections. Finally, while IPFs cannot always address all medical conditions, much like some acute-care facilities, they do have a responsibility to ensure that patients with comorbid medical conditions are transferred or referred to appropriate medical care upon discharge. Readmissions for completely unrelated diagnoses are rare. For example, readmission rates for appendicitis are 0.03% of all readmissions in this population. The low rates of readmissions for these types of conditions are unlikely to influence a hospital's performance on the measure. No action taken at this time.

*Comments appear verbatim and have not been edited for spelling, punctuation, grammar, or any other reasons.