Inpatient Psychiatric Facility Quality Reporting Program

Support Contractor

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

Questions and Answers

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Question 1: **Is the definition of planned readmission available (i.e., algorithm followed, diagnosis codes, etc.)? I'm aware of the definition for acute care, but not for the inpatient psychiatric setting. Do you have the link for Version 3.0 of the Planned Readmission Algorithm?**

The IPF readmission measure uses Version 3.0 of the Planned Readmission Algorithm developed for the Hospital-Wide Readmission measure. The final measure specifications, including the planned readmission algorithm, are listed in the methodology report posted in the Inpatient Psychiatric Facility Readmission Measure file at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Question 2: **What is parsimonious?**

Parsimonious is a model that accomplishes a desired level of explanation with as few predictor variables as possible.

Question 3: **What is unreliable vital status data? What is the definition of unreliable vital status data as an exclusion for the readmission measure?**

Unreliable vital status is unreliable date of death. For example, a claim has a death date, but also a subsequent admission.

Question 4: **Are the specific factors utilized for Risk Adjustment available? Will the risk model items described in the webinar presentation be published anywhere for reference?**

The final measure specifications, including the risk model, are listed in the methodology report posted in the Inpatient Psychiatric Facility Readmission Measure file at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Question 5: **I understand the need for outcome metrics, such as readmission rate, but what metric would you recommend to measure process performance in which compliance can positively impact the outcome metric?**

Evidence-based processes that IPFs can implement to prevent readmissions are identified in the methodology report published on the CMS website, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Question 6: **If readmissions also qualify for another index admission, are standard errors corrected for lack of independence (same patient included in multiple observations)?**

A patient may have multiple index admissions included in the measure cohort during a single measurement period, if each admission meets all of the eligibility criteria. This means that a readmission can also be eligible as an index admission. To align with other readmission measures, we treat multiple admissions as statistically independent. The correction for lack of independence is too computationally intensive (i.e., admissions within patients and patients within IPFs) to perform on a national sample and would not likely result in any meaningful differences in the classifications of hospital performance.

Question 7: **Is each admission considered an index admission or can you only have one index admission in a 30 day period?**

A patient may have multiple index admissions included in the measure cohort during a 30-day period, if each admission meets all of the eligibility criteria.

Question 8: **What is the national benchmark readmission rate for psychiatric readmissions?**

The data presented in the webinar used a national unadjusted readmission rate of 20.9% for 2012 through 2013 IPF discharges.

Question 9: **When can we expect our preliminary report for this measure? When will each IPF be notified of their own (baseline) readmission data? How can we see our hospital's readmission data compared to the baseline reporting period 2012–2013?**

CMS anticipates sending IPFs a facility-specific report during the dry run, which is planned for 2017. The facility-specific report will not have baseline data but will have the risk-standardized readmission ratio (RSRR) for the 2014 through 2015 reporting period. Each facility's RSRR is calculated by multiplying the facility's standardized readmission ratio by the national readmission rate for that reporting period.

Question 10: **What do you mean by "high performing" and "low performing" hospitals?**

High performing hospitals were defined as the tenth percentile of IPFs nationally. The tenth percentile had an unadjusted readmission rate of 12% or lower based on 2012 through 2013 data.

Low performing hospitals were defined as the ninetieth percentile of IPFs nationally. The ninetieth percentile had an unadjusted readmission rate of 27% or higher based on 2012-2013 data.

Question 11: **More than 20%, does that refer to readmissions at the same site or at multiple sites?**

20.9% is the national unadjusted rate of readmissions across all eligible IPFs. A readmission may be to the same IPF, a different IPF, or to an acute care or critical access hospital.

Question 12: **Is it considered a readmission if the patient readmits to a non-IPF, such as an acute care hospital? What if a patient is readmitted for a non-psychiatric reason?**

Yes, the measure includes readmissions to both IPFs and acute-care hospitals. A readmission is defined as an admission for any cause between days three and thirty, post-discharge, so it can be for unplanned psychiatric or medical reasons.

Question 13: **If a patient is discharged from a psych facility and is then admitted to a hospital after a car accident two weeks later, is it considered a readmission?**

A readmission is defined as an admission for any cause to an IPF or short-stay acute care hospital or critical access hospital on or between days three and thirty, post-discharge, except those considered planned. This scenario would be considered a readmission because it is unplanned. As mentioned on the webinar, not all readmissions are preventable.

Question 14: **What is an example of a planned readmission?**

An admission for electroconvulsive therapy (ECT) is an example of a readmission that could be considered planned.

Question 15: **To summarize, this is a measure that is being proposed to the IPFQR program that is claims-based and risk adjusted, so there is nothing to abstract from the record, correct?**

Correct. CMS will calculate the rates for this claims-based measure; therefore, IPFs will not be required to abstract data for this measure.

Question 16: **Would an admission from a psychiatric department to a medical floor for a medical reason fall under "interrupted stay?" These are discharges and admissions in our hospital.**

A patient discharged from an IPF unit and admitted to a medical floor on the same day, day one, or day two after discharge would be considered a transfer or interrupted stay and the IPF admission would be excluded from the measure.

Question 17: **Would an interrupted stay not qualify as an index case at all?**

The interrupted stay billing procedure requires one claim if a patient is readmitted to the same IPF within three days (day zero, one, or two, post-discharge), whereas two claims would be submitted, if the patient is readmitted to a different IPF or an acute care facility during this time frame.

An interrupted stay to the same IPF may be an index admission, if it meets all other eligibility criteria, as there would be only one claim.

In the case of an interrupted stay to a different IPF, the first IPF admission is excluded from the measure. The readmission may be an index admission if it meets eligibility criteria.

Question 18: **Could a hospital medical floor admission with primary psychiatric diagnosis also fall into this measure? Or would only claims from psychiatric units be included?**

Eligible index admissions include those for which the patients are admitted to an IPF. Admissions to a medical floor or acute care hospital with a primary psychiatric diagnosis are not included in this measure.

Question 19: **Could a short stay acute care readmission be due to a non-psychiatric reason?**

Yes, readmission for non-psychiatric diagnoses are included in the outcome definition because a readmission is defined as an admission for any cause between days three and thirty, post-discharge.

Question 20: **Did I understand correctly that if the patient is readmitted within two days to either IPF or acute care that they are excluded?**

Correct. Patients discharged from an IPF and readmitted to an IPF or acute care hospital on the same day of discharge, day one or day two, post-discharge, are excluded from the measure.

Question 21: **Do IPPS and IRF claims count as readmissions?**

Unplanned admissions within thirty days of discharge to an acute care hospital or critical access hospital that submits claims under the Inpatient Prospective Payment System (IPPS) may be counted as a readmission. Admissions to an Inpatient Rehabilitation Facility (IRF) do not count as a readmission.

Question 22: **How are we dealing with planned readmissions from a medical service?**

The IPF readmission measure uses Version 3.0 of the Planned Readmission Algorithm developed for the Hospital-Wide Readmission measure. Version 3.0 of the algorithm includes both medical and psychiatric procedure categories that are classified as either always or potentially planned, depending on the accompanying principal discharge diagnosis.

The planned readmission algorithm is listed in the final measure specifications posted in the Inpatient Psychiatric Facility Readmission Measure file at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Question 23: **How is aggression measured? Is an assessment tool available?**

Aggression is identified in the administrative claims by the presence of ICD-9-CM 301.7, 312.x, or 313.81 in: secondary diagnosis on the index admission; principal or secondary diagnosis on an admission within 12 months prior to index admission; or, on at least two emergency department (ED) or outpatient evaluation and management (E&M) claims in the previous 12 months.

Question 24: **What would a patient characteristic be, as mentioned on slide 25?**

Patient characteristics that were used in the phase one model are shown on slide 26. Patient characteristics include:

- *Demographics (age, gender)*
- *Principal discharge diagnoses of index admission*
- *Comorbidities*
- *Other psychiatric-specific risk factors identified in the literature*

Question 25: **How will it work if they are admitted to the acute care side and transferred to the IPF in the same hospital and then transferred back to the acute care side before discharge?**

Eligible index admissions include those for which the patients are admitted to an IPF. Admissions to a medical floor or acute care hospital with a primary psychiatric diagnosis are not included in this measure.

A patient discharged from an IPF unit and admitted to a medical floor on the same day, day one, or day two, post-discharge, would be considered a transfer or interrupted stay and the IPF admission would be excluded from the measure

In this scenario, the episode of care is not eligible as an index admission in this measure.

Question 26: **If a patient comes back for ECT within 30 days, is that considered a planned readmission? If patients return for ECT outpatient treatments, does that impact the measure?**

If a patient is admitted within 30 days of an index admission, has an ECT procedure, and does not have an acute diagnosis or complication of care, then the readmission is planned. Services received in the outpatient setting after the index admission are not considered in the measure calculation.

Question 27: **If a patient is discharged from an inpatient psychiatric facility and re-admitted to a hospital for a medical reasons within 30 days, is this patient excluded or included?**

A readmission is defined as an admission for any cause (except those considered planned) to an IPF or short-stay acute care hospital, including

critical access hospitals, on or between days three and 30, post discharge. Therefore, readmissions can be for psychiatric or medical reasons.

Question 28: **Can you please explain how neighborhoods were determined for the IPF readmission measure?**

Neighborhoods were defined using the US Census tracts based on the zip code where the beneficiary resided.

Question 29: **Is it considered a readmission if a patient admitted to an IPF is discharged due to an acute medical illness and is admitted to a medical facility?**

A patient discharged from an IPF and admitted to an acute care hospital or critical access hospital on the same day, day one or day two, post-discharge, would be considered a transfer or interrupted stay and the IPF admission would be excluded from the measure.

Question 30: **Are there any information on length of stay (LOS) and its impact on the readmission rate?**

We did not evaluate the length of stay of the index admission and its impact on the readmission rate in the risk model development since increased length of stay may correlate with hospital performance.

Question 31: **Our IPF is connected with our hospital. If a patient is transferred from our IPF to the hospital for a medical reason and then back to our IPF, am I correct that that would be considered a readmission?**

A patient discharged from an IPF unit and admitted to a medical floor on the same day, day one or day two, post-discharge, would be considered a transfer or interrupted stay. Therefore, the IPF admission would be excluded from the measure.

Question 32: **Would this be a claims-based measure versus chart abstracted?**

This measure will be claims-based.

Question 33: **Is this measure part of the new proposed rule that will be released later this month?**

Yes. The proposed rule was published on the Federal Register on April 27, 2016. To view the display version of the Proposed Rule, CMS-1655-P, go to http://federalregister.gov/a/2016-09120 and click on "Download PDF."

Question 34: **If I understand this measure correctly, this is still in the proposed stage and until NQF endorsed is not a finalized measure. Is this correct? When do you anticipate this becoming an approved measure? If endorsed by NQF, is it plausible that this measure will start with 1/1/2017 discharges?**

No, Version 1.0 of the measure has been finalized and is included in the proposed rule for FY 2019 Payment Determination based on discharges starting 1/1/2016. However, the measure has been submitted to the National Quality Forum (NQF) for review. Any recommendations from the NQF, or feedback from other stakeholders, may be incorporated into Version 2.0 of the measure for FY 2019 Payment Determination.

Question 35: **When will this measure start being collected?**

The measure is proposed for reporting in FY 2019 Payment Determination based on discharges starting 1/1/2016.

Question 36: **When will penalties to the annual payment update (APU) occur for IPFs with high readmission rates?**

As proposed, there is no financial implication for facilities based on an IPF's performance on the readmission measure.

Question 37: **IPFQR is a Pay For Reporting Program. Since this new All Cause Readmission Measure is part of the IPFQR Program, can you confirm that there is no financial implication, if an IPF's performance for this measure is below expected?**

As proposed, there is no financial implication for facilities based on an IPF's performance on the readmission measure.

Question 38: **If a facility is a court ordered facility how is that cost adjusted?**

The readmission measure does not adjust for cost.

To maximize the usefulness of the questions and answers transcript we have consolidated questions received through the Chat feature during the event and focused on the most important and frequently asked questions. To obtain answers to questions that are not specific to the content of this webinar, we recommend that you refer to the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Manual, the QualityNet Q&A tool, or call the Hospital Inpatient VIQR Support Contractor at 866.800.8765 or 844.472.4477.