NATIONAL QUALITY FORUM

Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 2860
Corresponding Measures:
De.2. Measure Title: Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)
Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services
De.3. Brief Description of Measure: This facility-level measure estimates an all-cause, unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.

The performance period for the measure is 24 months.
1b.1. Developer Rationale: The objective of the IPF Readmission measure is to reduce 30-day readmission rates by promoting shared accountability and collaboration with patients, families, and providers in other settings of care. Including this measure in the suite of measures for IPFs will help create a comprehensive picture of the quality of care patients receive at those IPFs.
Literature has identified effective interventions that IPFs can employ to improve readmission rates by connecting patients with other settings of care and ensuring that appropriate care continues after discharge. Examples of these interventions include providing patients' medications to them prior to discharge (Akerele et al. 2017; Comer et al. 2017), interviews with care managers prior to discharge to identify and address barriers to continuing treatment (Taylor et al. 2016), and various discharge planning interventions to connect patients to services they will need after discharge (Mark et al. 2013; Steffen et al. 2009; Vigod et al. 2013).

The national unplanned readmission rate has decreased since the IPF Readmission measure was included in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program, although the decrease is not statistically significant. During the first performance period for which the IPF Readmission measure was in the program, July 1, 2015–June 30, 2017, the national unplanned readmission rate among IPFs that met the minimum case count was 20.1 percent. For the July 1, 2017, through June 20, 2019, performance period, this rate was 18.5 percent.
References
Akerele, E., C. Lim, T. Olupona, O. Ojo, N. Co, and J.J. Lim. "Reducing Readmission Rates in Inpatient Settings." International Journal of Mental Health, vol. 46, no. 3, 2017, pp. 168–176. https://doi: 10.1080/00207411.2017.1295782
Comer, D., J. Goldsack, J. Flaherty, K. Van Velzen, R. Caplan, K. Britt, H. Viohl et al. "Impact of a Discharge Prescription Program on Hospital Readmissions and Patient Satisfaction." Journal of the American Pharmacist Association, vol. 57, no. 4, 2017, pp. 498–502. https://doi:10.1016/j.japh.2017.04.007
Mark, T., K.S. Tomic, N. Kowlessar, B.C. Chu, R. Vandivort-Warren, and S. Smith. "Hospital Readmission Among Medicaid Patients with an Index Hospitalization for Mental and/or Substance Use Disorder." J. Behav. Health Serv. Res., vol. 40, no. 2, 2013, pp. 207–221.

Steffen, S., M. Kosters, T. Becker, and B. Puschner. "Discharge Planning in Mental Health Care: A Systematic Review of the Recent Literature." Acta Psychiatr. Scand, vol. 120, no. 1, 2009, pp. 1–9.

Taylor, C., B. Holsinger, J.V. Flanagan, A.M. Ayers, S.L. Hutchinson, and L. Terhorst. "Effectiveness of a Brief Care Management Intervention for Reducing Psychiatric Hospitalization Readmissions." Journal of Behavioral Health Services & Research, vol. 43, no. 2, 2014, pp. 262–271. https://doi.10.1007/s11414-014-9400-4
Vigod. S.N., P.A. Kurdyak, C.L. Dennis, T. Leszcz, V.H. Taylor, D. M. Blumberger, and D.P. Seitz. "Transitional Interventions to Reduce

Early Psychiatric Readmissions in Adults: Systematic Review." Br. J. Psychiatry, vol. 202, no. 3, 2013; pp. 187–194. https:// doi: 10.1192/bjp.bp.112.115030

S.4. Numerator Statement: The measure estimates the incidence of unplanned, all-cause readmissions to IPFs or short-stay acute care hospitals following discharge from an eligible IPF index admission. A readmission is defined as any admission that occurs within 3-30 days after the discharge date from an eligible index admission to an IPF, except those considered planned.

S.6. Denominator Statement: The target population for this measure is Medicare FFS beneficiaries discharged from an IPF with a principal diagnosis of a psychiatric disorder. A readmission within 30 days is eligible as an index admission, if it meets all other eligibility criteria.

S.8. Denominator Exclusions: The measure excludes admissions for patients:
- Discharged against medical advice (AMA)
- With unreliable demographic and vital status data defined as the following:
o Age greater than 115 years
o Missing gender
o Discharge status of "dead" but with subsequent admissions
o Death date prior to admission date
o Death date within the admission and discharge dates but the discharge status was not "dead"
- With readmissions on the day of discharge or day following discharge because those readmissions are likely transfers to another inpatient facility. The hospital that discharges the patient to home or a non-acute care setting is accountable for subsequent readmissions.
- With readmissions two days following discharge because readmissions to the same IPF within two days of discharge are combined into the same claim as the index admission and do not appear as readmissions due to the interrupted stay billing policy. Therefore, complete data on readmissions within two days of discharge are not available.

De.1. Measure Type: Outcome
S.17. Data Source: Claims
S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Dec 09, 2016 **Most Recent Endorsement Date:** Dec 09, 2016

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. *Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.*

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
IPFRead_2021_evid_attach_to_NQF.docx
1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?
Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.
Yes

1b. Performance Gap
Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:
- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. **Briefly explain the rationale for this measure** *(e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)*

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

The objective of the IPF Readmission measure is to reduce 30-day readmission rates by promoting shared accountability and collaboration with patients, families, and providers in other settings of care. Including this measure in the suite of measures for IPFs will help create a comprehensive picture of the quality of care patients receive at those IPFs.

Literature has identified effective interventions that IPFs can employ to improve readmission rates by connecting patients with other settings of care and ensuring that appropriate care continues after discharge. Examples of these interventions include providing patients' medications to them prior to discharge (Akerele et al. 2017; Comer et al. 2017), interviews with care managers prior to discharge to identify and address barriers to continuing treatment (Taylor et al. 2016), and various discharge planning interventions to connect patients to services they will need after discharge (Mark et al. 2013; Steffen et al. 2009; Vigod et al. 2013).

The national unplanned readmission rate has decreased since the IPF Readmission measure was included in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program, although the decrease is not statistically significant. During the first performance period for which the IPF Readmission measure was in the program, July 1, 2015–June 30, 2017, the national unplanned readmission rate among IPFs that met the minimum case count was 20.1 percent. For the July 1, 2017, through June 20, 2019, performance period, this rate was 18.5 percent.

References

Akerele, E., C. Lim, T. Olupona, O. Ojo, N. Co, and J.J. Lim. "Reducing Readmission Rates in Inpatient Settings." International Journal of Mental Health, vol. 46, no. 3, 2017, pp. 168–176. https://doi: 10.1080/00207411.2017.1295782

Comer, D., J. Goldsack, J. Flaherty, K. Van Velzen, R. Caplan, K. Britt, H. Viohl et al. "Impact of a Discharge Prescription Program on Hospital Readmissions and Patient Satisfaction." Journal of the American Pharmacist Association, vol. 57, no. 4, 2017, pp. 498–502. https://doi:10.1016/j.japh.2017.04.007

Mark, T., K.S. Tomic, N. Kowlessar, B.C. Chu, R. Vandivort-Warren, and S. Smith. "Hospital Readmission Among Medicaid Patients with an Index Hospitalization for Mental and/or Substance Use Disorder." J. Behav. Health Serv. Res., vol. 40, no. 2, 2013, pp. 207–221.

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Taylor, C., B. Holsinger, J.V. Flanagan, A.M. Ayers, S.L. Hutchinson, and L. Terhorst. "Effectiveness of a Brief Care Management Intervention for Reducing Psychiatric Hospitalization Readmissions." Journal of Behavioral Health Services & Research, vol. 43, no. 2, 2014, pp. 262–271. https://doi.10.1007/s11414-014-9400-4

Vigod. S.N., P.A. Kurdyak, C.L. Dennis, T. Leszcz, V.H. Taylor, D. M. Blumberger, and D.P. Seitz. "Transitional Interventions to Reduce Early Psychiatric Readmissions in Adults: Systematic Review." Br. J. Psychiatry, vol. 202, no. 3, 2013; pp. 187–194. https:// doi: 10.1192/bjp.bp.112.115030

1b.2. **Provide performance scores on the measure as specified (<u>current and over time</u>) at the specified level of analysis**. *(<u>This is required for maintenance of endorsement</u>. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Risk-Standardized readmission rate distribution across IPFs

July 1, 2017, through June 30, 2019 (n = 1,700 IPFs)

Mean 20.2%

Standard Deviation 2.8%

Min 11.5%

10th percentile 17.0%

20th percentile 18.0%

30th percentile 18.8%

40th percentile 19.4%

50th percentile 20.0%

60th percentile 20.6%

70th percentile 21.4%

80th percentile 22.3%
90th percentile 23.6%
Max 34.9%

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.
Not applicable. Please see Section 1b.2 for performance data on the measure.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (_This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use._
Data are from July 1, 2017, through June 30, 2019
1,064 IPFs (facilities with fewer than 25 eligible discharges during the performance period were excluded from the analysis)
With large sample sizes, small differences that are statistically significant might not always be practically or clinically meaningful. Therefore, we also computed Cohen's "d effect" size (the difference in mean scores divided by the pooled standard deviation). A d of 1 indicates the two groups differ by 1 standard deviation; a d of 2 indicates they differ by 2 standard deviations, and so on. Following Cohen's (1988) definitions, we defined effect size values for dichotomous variables as small (0.2), medium (0.5), or large (0.8).

Characteristic: Gender
Male // Female
Index admissions: 273,711 // 273,485
Observed readmission rate: 0.223 // 0.179
SD: 0.416 // 0.383
Effect size (Cohen's d) for differences in means between patient groups: 0.457

Characteristic: Alcohol or substance use disorder (SUD)
Alcohol/SUD // No alcohol/SUD
Index admissions: 33,272 // 513,924
Observed readmission rate: 0.200 // 0.201
SD: 0.400 // 0.401
Effect size (Cohen's d) for differences in means between patient groups: 0.012

Characteristic: Schizophrenia diagnosis
Schizophrenia diagnosis // No schizophrenia diagnosis
Index admissions: 188,884 // 358,312
Observed readmission rate: 0.228 // 0.187
SD: 0.419 // 0.390
Effect size (Cohen's d) for differences in means between patient groups: 0.424

Characteristic: Race (Black, White)
Black // White
Index admissions: 90,424 // 416,256
Observed readmission rate: 0.225 // 0.194
SD: 0.418 // 0.396
Effect size (Cohen's d) for differences in means between patient groups: 0.230

Characteristic: Race (White, Non-White)
White // Non-White

Index admissions: 416,256 // 130,940
Observed readmission rate: 0.194 // 0.223
SD: 0.396 // 0.416
Effect size (Cohen's d) for differences in means between patient groups: 0.239

Characteristic: Dual status
Dual Medicare-Medicaid // Medicare only
Index admissions: 263,104 // 284,092
Observed readmission rate: 0.221 // 0.182
SD: 0.415 // 0.386
Effect size (Cohen's d) for differences in means between patient groups: 0.372

Characteristic: Agency for Healthcare Research and Quality (AHRQ) Socioeconomic Status (SES) Index
1st quartile (<51.2 on a 0 to 100 scale) // 4th quartile (>53.9 on a 0 to 100 scale)
Index admissions: 135,680 // 135,672
Observed readmission rate: 0.208 // 0.195
SD: 0.406 // 0.396
Effect size (Cohen's d) for differences in means between patient groups: 0.140

Characteristic: Length of stay
1st quartile (<6 days) // 4th quartile (>16 days)
Index admissions: 119,267 // 136,278
Observed readmission rate: 0.211 // 0.185
SD: 0.408 // 0.388
Effect size (Cohen's d) for differences in means between patient groups: 0.263

Cohen J. (1988). Statistical Power Analysis for the Behavioral Sciences. New York, NY: Routledge Academic

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4
Not applicable. Please see Section 1b.4 for data on disparities.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area *(check all the areas that apply):*
Behavioral Health, Behavioral Health : Alcohol, Substance Use/Abuse, Behavioral Health : Depression, Behavioral Health : Other Serious Mental Illness, Behavioral Health : Post-Traumatic Stress Disorder (PTSD), Behavioral Health : Suicide, Neurology

De.6. Non-Condition Specific*(check all the areas that apply):*
Care Coordination, Care Coordination : Readmissions, Care Coordination : Transitions of Care, Person-and Family-Centered Care, Safety

De.7. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*
Populations at Risk

S.1. **Measure-specific Web Page** *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*
https://www.qualitynet.org/ipf/ipfqr/resources#tab2

S.2a. **If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)
This is not an eMeasure **Attachment:**

S.2b. **Data Dictionary, Code Table, or Value Sets** *(and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)*
Attachment **Attachment:** IPFRead_codebook_2021.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.
No, this is not an instrument-based measure **Attachment:**

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.
Not an instrument-based measure

S.3.1. **For maintenance of endorsement:** Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.
Yes

S.3.2. **For maintenance of endorsement,** please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.
1.   Updated Table B3. Potentially planned procedure categories:
o   Added Procedure CCS 2 – Insertion; replacement; or removal of extracranial ventricular shunt
o   Added Procedure CCS 42 – Other OR Rx procedures on respiratory system and mediastinum
o   Added Procedure CCS 94 – Other OR upper GI therapeutic procedures
o   Added Procedure CCS 123 – Other operations on fallopian tubes
o   Added Procedure CCS 125 – Other excision of cervix and uterus
o   Added Procedure CCS 147 – Fracture treatment including reposition with or without fixation; lower extremity fracture or dislocation (other than hip or femur)
o   Added Procedure CCS 148 – Fracture treatment including reposition with or without fixation of other fracture or dislocation
o   Added Procedure CCS 160 – Other therapeutic procedures on muscles and tendons
o   Added Procedure CCS 161 – Other OR therapeutic procedures on bone
o   Added Procedure CCS 164 – Other OR therapeutic procedures on musculoskeletal system
o   Added Procedure CCS 202 – Electrocardiogram
o   Added Procedure CCS 211 – Radiation therapy
o   Added Procedure CCS 224 – Cancer chemotherapy
o   Removed Procedure CCS 49 – Other Or heart procedures
o   Removed Procedure CCS 170 – Excision of skin lesion
o   Removed ICD-10-PCS codes from 0B5N0ZZ, 0B5N3ZZ, 0B5N4ZZ, 0B5P0ZZ, 0B5P3ZZ, 0B5P4ZZ, 0BW10FZ, 0BW13FZ, 0BW14FZ Laryngectomy, revision of tracheostomy, scarification of pleura
o   Added new procedures categories and ICD-10-PCS codes for
i.   Excision; lysis peritoneal adhesions
ii.   Fracture treatment including reposition with or without fixation; hip or femur fracture or dislocation
iii.   Other OR therapeutic procedures; male genital
iv.   Other non-OR therapeutic procedures on musculoskeletal system
v.   Other non-OR therapeutic procedures on skin subcutaneous tissue fascia and breast
vi.   Other OR heart procedures

vii.	Other non-OR therapeutic cardiovascular procedures
viii.	Other non-OR lower GI therapeutic procedures
ix.	Other OR lower GI therapeutic procedures
x.	Other non-OR gastrointestinal therapeutic procedures
o	Rationale: These codes were updated to align with the HWR Measure's Planned Readmission Algorithm.
2.	Updated Table B4. Acute principal discharge diagnosis categories:
o	Added Diagnosis CCS 210 – Systemic lupus erythematosus and connective tissue disorders
o	Removed Diagnosis CCS 100 – Acute myocardial infarction
o	Removed Diagnosis CCS 225 – Joint disorders and dislocations; trauma-related
o	Removed Diagnosis CCS 226 – Fracture of neck of femur (hip)
o	Removed Diagnosis CCS 227 – Spinal cord injury
o	Removed Diagnosis CCS 288 – Skull and face fractures
o	Removed Diagnosis CCS 229 – Fracture of upper limb
o	Removed Diagnosis CCS 230 – Fracture of lower limb
o	Removed Diagnosis CCS 232 – Sprains and strains
o	Removed Diagnosis CCS 233 – Intracranial injury
o	Removed Diagnosis CCS 234 – Crushing injury or internal injury
o	Removed Diagnosis CCS 235 – Open wounds of head; neck; and trunk
o	Removed Diagnosis CCS 237 – Complication of device; implant or graft
o	Removed Diagnosis CCS 238 – Complications of surgical procedures or medical care
o	Removed Diagnosis CCS 239 – Superficial injury; contusion
o	Removed Diagnosis CCS 240 – Burns
o	Removed Diagnosis CCS 241 – Poisoning by psychotropic agents
o	Removed Diagnosis CCS 242 – Poisoning by other medications and drugs
o	Removed Diagnosis CCS 243 – Poisoning by nonmedicinal substances
o	Removed Diagnosis CCS 244 – Other injuries and conditions due to external causes
o	Removed Diagnosis CCS 253 – Allergic reactions
o	Removed Diagnosis CCS 661 – Substance-related disorders
o	Removed Diagnosis CCS 662 – Suicide and intentional self-inflicted injury
o	Removed ICD-10-CM codes I50.23, I50.33, I50.43 from Congestive heart failure; nonhypertensive
o	Added ICD-10-CM codes I21.9, I21.A1, I21.A9 to Acute myocardial infarction (without subsequent MI)
o	Added ICD-10-CM codes I50.810, I50.811, I50.814, I50.82, I50.83, I50.84, I50.89 to Congestive heart failure; nonhypertensive
o	Added ICD-10-CM codes K85.00, K85.01, K85.02, K85.10, K85.11, K85.12, K85.20, K85.21, K85.22, K85.30, K85.31, K85.32, K85.80, K85.81, K85.82, K85.90, K85.91, K85.92, K86.81, K86.89 to Pancreatic disorders
o	Added new diagnostic categories and ICD-10-CM codes for
i.	Aortic; peripheral; and visceral artery aneurysms
ii.	Other gastrointestinal disorders
iii.	Nonmalignant breast conditions
iv.	Complication of device; implant or graft
v.	Peripheral and visceral atherosclerosis
vi.	Other lower respiratory disease
vii.	Other male genital disorders
viii.	Other female genital disorders
ix.	Joint disorders and dislocations; trauma-related
x.	Fracture of neck of femur (hip)
xi.	Spinal cord injury
xii.	Skull and face fractures
xiii.	Fracture of upper limb
xiv.	Fracture of lower limb
xv.	Sprains and strains
xvi.	Intracranial injury
xvii.	Crushing injury or internal injury
xviii.	Open wounds of head; neck; and trunk

xix.   Complication of device; implant or graft
xx.   Complications of surgical procedures or medical care
xxi.   Superficial injury; contusion
xxii.   Burns Poisoning by psychotropic agents
xxiii. Poisoning by other medications and drugs
xxiv.   Other injuries and conditions due to external causes
xxv.   Allergic reactions
xxvi.   Diabetes mellitus with complications
xxvii. Substance-related disorders
xxviii. Suicide and intentional self-inflicted injury
o   Rationale: These codes were updated to align with the 2019 HWR Measure's Planned Readmission Algorithm.
3.   Removed all ICD-9 procedure and diagnosis codes.
o   Rationale: ICD-9 codes are no longer applicable—the FY 2021 calculation of IPF Readmission will use data from July 1, 2016, through June 30, 2019.

S.4. Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.*
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).
The measure estimates the incidence of unplanned, all-cause readmissions to IPFs or short-stay acute care hospitals following discharge from an eligible IPF index admission. A readmission is defined as any admission that occurs within 3-30 days after the discharge date from an eligible index admission to an IPF, except those considered planned.

S.5. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).
The risk-adjusted outcome measure does not have a traditional numerator and denominator. This section describes the outcome being measured. A readmission is defined as any admission, for any reason, to an IPF or a short-stay acute care hospital (including critical access hospitals) that occurs within 3-30 days after the discharge date from an eligible index admission to an IPF, except those considered planned.

Subsequent admissions on Days 0, 1, and 2 are not counted as readmissions due to transfers/interrupted stay policy. See denominator exclusions for details.

PLANNED READMISSION ALGORITHM (PRA)
The measure uses the CMS 30-day Hospital-Wide All-Cause Unplanned Readmission (HWR) Measure, PRA version 4.0.
Full information is in the "2020 All-Cause Hospital-Wide Measure Updates and Specifications Report: Hospital-Wide Readmission (05/01/20)" and the "2020 HWR Readmission Measure Updates and Specifications Report: Supplemental ICD-10 Code List (05/01/20)" available for download at https://www.qualitynet.org/inpatient/measures/readmission/methodology.

The planned readmission algorithm follows two principles to identify planned readmissions:
• Select procedures and diagnoses such as transplant surgery, maintenance chemotherapy/radiotherapy/immunotherapy, rehabilitation, and forceps delivery are considered always planned (summarized in the Data Dictionary, Tables PR1 and PR2).
• Some procedures such as colorectal resection or aortic resection, are considered either planned or unplanned depending on the accompanying principal discharge diagnosis (Data Dictionary, Table PR3). Specifically, a procedure is considered planned if it does not coincide with a principal discharge diagnosis of an acute illness or complication (Data Dictionary, Table PR4).

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*
The target population for this measure is Medicare FFS beneficiaries discharged from an IPF with a principal diagnosis of a psychiatric disorder. A readmission within 30 days is eligible as an index admission, if it meets all other eligibility criteria.

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*
IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The risk-adjusted outcome measure does not have a traditional numerator and denominator. This section describes the target population for measurement. The target population for this measure is adult Medicare FFS beneficiaries discharged from an IPF. The measure is based on all eligible index admissions from the target population.

An eligible index admission is defined as any IPF admission that meets the following criteria:
-        Age 18 or older at admission
-        Discharged alive
-        Enrolled in Medicare FFS Parts A and B during the 12 months before the admission date, month of admission, and at least one month after the month of discharge from the index admission
-        Discharged with a principal diagnosis that indicates psychiatric disorder (Data Dictionary, Table PsychCCS)

The measure uses the Clinical Classifications Software (CCS) developed by the Agency for Healthcare Research and Quality (AHRQ), available at https://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp, to group ICD-10-CM codes into clinically coherent groups.

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*
The measure excludes admissions for patients:
-        Discharged against medical advice (AMA)
-        With unreliable demographic and vital status data defined as the following:
o   Age greater than 115 years
o   Missing gender
o   Discharge status of "dead" but with subsequent admissions
o   Death date prior to admission date
o   Death date within the admission and discharge dates but the discharge status was not "dead"
-        With readmissions on the day of discharge or day following discharge because those readmissions are likely transfers to another inpatient facility. The hospital that discharges the patient to home or a non-acute care setting is accountable for subsequent readmissions.
-        With readmissions two days following discharge because readmissions to the same IPF within two days of discharge are combined into the same claim as the index admission and do not appear as readmissions due to the interrupted stay billing policy. Therefore, complete data on readmissions within two days of discharge are not available.

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*
DISCHARGE AGAINST MEDICAL ADVICE
Index admissions where there is an indicator in the claims data that patients left against medical advice (AMA) are excluded because the facility may have limited opportunity to complete treatment and prepare for discharge.

UNRELIABLE DATA
Index admissions with unreliable demographic and death information are excluded from the denominator. Unreliable demographic information is defined as age greater than 115 years or missing gender. Unreliable death information is defined as:
• An admission with a discharge status of "dead" but the person has subsequent admissions;
• The death date is prior to the admission date; or
• The death date is within the admission and discharge dates for an admission but the discharge status is not "dead".

TRANSFERS/INTERRUPTED STAYS
Index admissions that result in a transfer or interrupted stay are excluded because transfers and interrupted stays cannot always be distinguished from true readmissions in the claims data. This exclusion is defined as an index admission with a readmission on Days 0, 1, or 2 post-discharge.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*
The measure is not stratified.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)
Statistical risk model
If other:

S.12. Type of score:
Rate/proportion
If other:

S.13. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*
Better quality = Lower score

S.14. Calculation Algorithm/Measure Logic (*Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)*
Key Algorithm Steps:
1. Identify all IPF admissions in the performance period.
2. Apply inclusion/exclusion criteria to identify index admissions.
3. Identify readmissions to IPF or short stay acute care hospitals within 30 days of discharge from each index admission.
4. Apply the planned readmission algorithm to identify unplanned readmissions and remove them from the outcome.
5. Identify risk factors in the 12 months prior to index admission and during the index admission.
6. Run hierarchical logistic regression to compute the risk-stratified readmission rate (RSRR) for each IPF.

Hierarchical logistic regression is used to model the log-odds of readmission. The two-level specification allows reliable estimates for small-volume hospitals while accepting a certain amount of shrinkage toward the mean. The model includes risk factors as fixed effects and a hospital-specific intercept as random effect. The estimate of hospital-specific intercept reflects the quality of care received at an IPF after adjusting for case mix.

A standardized risk ratio (SRR), which is the "predicted" number of readmissions over the "expected" number of readmissions, is calculated for each IPF. The "predicted" number of readmissions is the number of readmissions, given the IPF's performance and its observed case mix, which is calculated by taking the mean of the estimated probabilities of readmission for the index admissions at the IPF, based on the IPF-specific intercept and all other risk factors. The "expected" number of readmissions is the number of readmissions given the national performance and its observed case mix, which is calculated by taking the mean of the estimated probabilities of readmission for the index admissions contributing to the IPF, based on the average intercept and all other risk factors. The confidence interval of the SRR is calculated by bootstrapping to take into account uncertainty of the estimate. An SRR greater than 1 indicates worse quality of care compared to the national average. An SRR less than 1 indicates better quality of care. The risk-standardized readmission rate (RSRR) is be calculated by multiplying SRR with the overall national readmission rate for better interpretation.

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*
IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
Not applicable

S.16. Survey/Patient-reported data *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*
Specify calculation of response rates to be reported with performance measure results.
Not applicable

S.17. Data Source *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in S.18.
Claims

S.18. Data Source or Collection Instrument *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*
IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.
For measure calculation, the following Medicare files are required:

•   Medicare beneficiary and coverage files – Provides information on patient demographic, enrollment, and vital status information to identify the measure population and certain risk factors.
•   Medicare fee-for-service (FFS) Part A records – Contains final action claims submitted by acute care and critical access hospitals, inpatient psychiatric facilities, home health agencies, and skilled nursing facilities to identify the measure population, readmissions, and certain risk factors.
•   Medicare FFS Part B records – Contains final action claims submitted by physicians, physician assistants, clinical social workers, nurse practitioners, and other outpatient providers to identify certain risk factors. For this measure, claims for services such as laboratory tests, medical supplies, or other ambulatory services were not used. This ensures that diagnoses result from an encounter with a provider trained to establish diagnoses and not a claim for a diagnostic test.

Index admissions and readmissions are identified in the Medicare Part A data. Comorbid conditions for risk adjustment are identified in the Medicare Part A and Part B data in the 12 months prior to and including the index admission. Demographic and fee-for-service (FFS) enrollment information are identified in the Medicare beneficiary and coverage files.

S.19. Data Source or Collection Instrument *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*
No data collection instrument provided

S.20. Level of Analysis *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*
Facility

S.21. Care Setting *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
Inpatient/Hospital
If other:

S.22. COMPOSITE Performance Measure - Additional Specifications *(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)*
Not applicable

2. Validity – See attached Measure Testing Submission Form
Spring_2021_IPF_Read_testing_attachment_to_NQF.docx

2.1 For maintenance of endorsement
Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.
Yes

2.2 For maintenance of endorsement
Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.
Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.
Yes - Updated information is included

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes
    For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.
Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)
If other:

3b. Electronic Sources
    The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*) Update this field for **maintenance of endorsement**.
ALL data elements are in defined fields in electronic claims

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.
Attachment:

3c. Data Collection Strategy
    Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.
IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.
There have been no issues regarding feasibility. This measure uses CMS administrative claims data that are readily available, accessible, and timely.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (*e.g., value/code set, risk model, programming code, algorithm*).
The administrative data (collected by CMS primarily for billing purposes) are used as the data source for this measure. Therefore, the

cost of data collection is negligible.

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4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency
Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current _and_ Planned Use
NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting IPFQR program public reporting data https://data.cms.gov/provider-data/search?keyword=IPFQR Payment Program Inpatient Psychiatric Facility Quality Reporting (IPFQR) program https://qualitynet.cms.gov/ipf

4a1.1 For each CURRENT use, checked above (update for _maintenance of endorsement_), provide:
- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

The measure is included in CMS's IPFQR program, which incorporates all IPFs nationwide that are paid under the Inpatient Psychiatric Facilities Prospective Payment System. The IPFQR pay-for-reporting program is intended to provide consumers with quality of care information to make more informed decisions about health care options. It is also meant to encourage hospitals and clinicians to improve the quality of inpatient care provided to beneficiaries by ensuring that providers are aware of and reporting on best practices for their respective facilities and type of care.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (*e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?*)
n/a

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)
n/a

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.
How many and which types of measured entities and/or others were included? If only a sample of measured entities were

included, describe the full population and how the sample was selected.

IPFs nationwide receive their measure scores, as well as mean state and national scores, via CMS's IPFQR program preview period each fall. Results of the measure scores are provided to IPFs in a preview report that is publicly reported a few months later. CMS monitors stakeholder feedback.

4a2.1.2. **Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

CMS supplies IPFs with their measure scores every fall via a Microsoft Excel workbook that provides detailed information on all discharges included in the measure score. CMS releases a publicly available user guide on QualityNet for the IPF report that explains these data and also holds an annual on-demand webinar detailing this data.

4a2.2.1. **Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**
Describe how feedback was obtained.

Measured entities submit questions on the IPF-specific reports at qnetsupport@hcqis.org during the confidential review period. All questions on the measure specifications or general questions related to the IPFQR program can be submitted to the Quality Question and Answer Tool (https://cmsqualitysupport.servicenowservices.com/qnet_qa) at any time. CMS monitors stakeholder feedback. Thus far, feedback has been only in the form of clarifying questions on the measure.

4a2.2.2. Summarize the feedback obtained from those being measured.

IPFs have asked an average of two or three questions per year for the past three years, all of which have been clarifying questions on the measure specifications.

4a2.2.3. Summarize the feedback obtained from other users

No feedback has been obtained from other users.

4a2.3. **Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

We did not modify the measure based on feedback from IPFs because they have not provided any feedback indicating that modifications were required.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. **Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**
If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

As noted in Section 1b.1, mean national readmission rate has decreased from 20.1 percent to 18.5 percent in the three years that the measure has been in the IPFQR program, although this decrease is not statistically significant. We will continue to monitor any change in the national unplanned readmission rate as additional periods of data become available.

By calculating the facility-level measure scores in Medicare FFS claims data and providing results to facilities, CMS aims to encourage quality improvement, specifically relating to decreasing readmission rates after discharge from an IPF.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. **Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended**

impacts on patients.
We have not identified any unintended negative consequences.

4b2.2. Please explain any unexpected benefits from implementation of this measure.
n/a

5. Comparison to Related or Competing Measures

If a measure meets the above criteria <u>and</u> there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures
Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)
1768 : Plan All-Cause Readmissions (PCR)
1789 : Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)
2502 : All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)
2504 : 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
2510 : Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.
Hospital, 30-day all-cause risk-standardized readmission rate (RSRR) following acute ischemic stroke hospitalization (Steward: CMS/Yale)

5a. Harmonization of Related Measures
   The measure specifications are harmonized with related measures;
   OR
   The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):
Are the measure specifications harmonized to the extent possible?
Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.
The IPF Readmission measure uses the planned readmission algorithm (PRA) from the NQF-endorsed HWR measure (1789) to identify and exclude planned follow-up visits from the measure. We did not identify harmonization opportunities with the other measures, which focus on other facility types. Because the IPF Readmission measure is calculated by CMS using Medicare claims data, there is no data collection burden.

5b. Competing Measures
   The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);
   OR
   Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):
Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)
The related measures that we identified are not competing measures because the IPF Readmission measure is specific to IPFs.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.
No appendix **Attachment:**

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Centers for Medicare & Medicaid Services
Co.2 Point of Contact: Yuling, Li, Yuling.Li@cms.hhs.gov, 410-786-8421-
Co.3 Measure Developer if different from Measure Steward: Mathematica
Co.4 Point of Contact: Jason, Smoot, JSMOOT@MATHEMATICA-MPR.COM, 734-205-3109-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development
Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
MEASURE DEVELOPMENT WORKGROUP
Susannah Bernheim, MD, MHS: Yale New Haven Health Services Corporation Center for Outcomes Research & Evaluation
Alisa Busch, MD, MS – McLean Hospital
Marina Cecchini, MBA – UF Health Shands Psychiatric and UF Health Shands Rehab Hospitals
Betsy Dodd, PharmD, BCPP – University of Florida
Frank Ghinassi, PhD, ABPP – Western Pyschiatric Institute and Clinic Steve Pittman, PhD – Meridian Behavioral Healthcare, Inc.
Andrea Goldenson, PharmD, MS, PhD – Malcom Randall Veterans Affairs Medical Center
Tracy Lenzini, BS – Grand Traverse Health Advocates
Kathleen McCann, RN, PhD – National Association of Psychiatric Health Systems
Gayle Olano-Hurt, MPH, CPHQ, PMC – Sheppard Pratt Health System
Irene Ortiz, MD, MSW – Molina Healthcare of New Mexico
Thomas Penders, MS, MD, DLFAPA – North Carolina Psychiatric Association
Lucille Schacht, PhD – National Association of State Mental Health Program Directors Research Institute, Inc.
Lisa Shea, MD – Butler Hospital
Jeffrey Scott Harman, MS, PhD – University of Florida, Health Service Research
Ben Staley, PharmD – UF Health Pharmacy Services
Rajiv Tandon, MS, MD – University of Florida, Department of Psychiatry; Malcam Randall Veterans Affairs Medical Center
Thomedi Ventura, MS, MSPH – Telligen

The measure workgroup established clinical definitions of the outcome being measured and operationalized the measure specifications. Workgroup members reviewed results from testing and were involved in the iterative process of measure specification revisions.

TECHNICAL EXPERT PANEL (TEP)
Alisa Busch, MD, MS – McLean Hospital
Kathleen Delaney, PhD, PMH-NPRN – Rush College of Nursing
Jonathan Delman, PhD, JD, MPH – Systems and Psychosocial Advanced Research Center, University of Massachusetts Medical School
Frank Ghinassi, PhD, ABPP – Western Psychiatric Institute and Clinic
Eric Goplerud, PhD – NORC at the University of Chicago
Geetha Jayaram, MD – Schools of Medicine, Health Policy and Management and the Armstrong Institute for Patient Safety, Johns Hopkins University
Charlotte Kauffman, MA, LCPC – State of Illinois-Division of Mental Health
Tracy Lenzini, BS – Grand Traverse Health Advocates
Kathleen McCann, RN, PhD – National Association of Psychiatric Health Systems

Gayle Olano-Hurt, MPH, CPHQ, PMC – Sheppard Pratt Health System
Mark Olfson, MD, MPH – New York State Psychiatric Institute
Irene Ortiz, MD, MSW – Molina Healthcare of New Mexico
Thomas Penders, MS, MD, DLFAPA – North Carolina Psychiatric Association
Lucille Schacht, PhD – National Association of State Mental Health Program Directors Research Institute, Inc.
Lisa Shea, MD – Butler Hospital
Thomedi Ventura, MS, MSPH – Telligen
Elvira Ryan, MBA, BSN, RN – The Joint Commission

The TEP evaluated the proposed measure and discussed the strengths and weaknesses of the proposed measure and made recommendations regarding measure specifications, inclusion and exclusion criteria, and appropriate risk adjustment.

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.2 Year the measure was first released: 2016
Ad.3 Month and Year of most recent revision: 07, 2020
Ad.4 What is your frequency for review/update of this measure? Annually
Ad.5 When is the next scheduled review/update for this measure? 07, 2021

Ad.6 Copyright statement: Not applicable
Ad.7 Disclaimers: Not applicable

Ad.8 Additional Information/Comments: None