ID#	Council/ Public	Commenter	Comment	Response	Topic
1188	Provider	Ms. Patty Atkins, RN, MS; Sharp Healthcare	I recommend to change the exclusion criteria from 'Readmission to another acute care facility within a day of discharge' to 'Readmission to another acute care facility on the same date of discharge'. This wording will exclude transfers but not readmissions that occur >24 hours of discharge. Also - a point of clarification: every case should become an index case. In other words, a readmission should become an index case that could have a subsequent readmission associated with it - assuming it fell within the time period. Lastly, the DRGs 370-375 are no longer used and need to be updated	1) The intent was to remove only same day transfers and not readmissions occurring on the following day. New language clarifying this distinction was added during the recent maintenance period. 2) All cases, including readmissions, are intended to be index cases. 3) For the current endorsed measure we would recommend mapping DRGs 370 - 375 to current DRGs for vaginal and cesarean section deliveries. During the recent maintenance period, we proposed to change the approach to use AHRQ-derived diagnosis and procedure classifications as opposed to DRGs to risk-adjust the population.	0329: Risk-Adjusted 30-Day All-Cause Readmission Rate

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1180	Public	Dr. Shannon Sims, MD, PhD; Rush University Medical Center	There should be more exclusion: For planned readmissions. We see this frequently for planned cardiac or vascular procedures and patients undergoing chemotherapy. Risk adjustment:To ignore the impact of economic and social factors on readmission doesn't make sense for those of us who see a large patient base of disadvantaged patients. A substantial portion of readmissions, in our experience, is due to factors like inadequate transportation, lack of funds to pay for medications, or dire social situations where they PREFER to be in the hospital rather than home. Regarding the overall intent of this measure: The evidence that readmissions are a modifiable outcome is often based on specific conditions (Naylor) or specific scenarios like high risk geriatric patients. I realize that Coleman's work and other projects have more generalizable findings. Many of us struggle to successful replicate these interventions' success with our existing resources and expertise. There also remains a lack of clear, conclusive approach to identify patients at risk for readmissions with modifiable risk factors. We may be measuring an outcome without completely understanding the underlying processes. So, I do wonder if a generic, one-size fits all measure like this has adequate discriminatory power to distinguish institutions and their providers.	1) The intent of this measure is to provide an expected readmission rate for all readmission, planned or otherwise. Readmission rates for hospitals with larger volume of planned readmissions are adjusted to reflect their true performance on readmission management. 2) We understand that socioeconomic status sometimes plays a role in the risk of readmission, however, data that are readily available to predict readmission rates often do not include any contributing economic and social factors. 3) The intent of the measure is to provide a relative yardstick with which past and current readmission rates can be assessed. The expected rate is generated using patients' underlying DRGs to predict the expected readmission rate. During the recent maintenance period, we proposed to change the approach to direct standardization of patients' relative risk using AHRQ-derived diagnosis and procedure classifications. Expected readmit rates are derived from the facility-specific casemix. Statistical testing has demonstrated that the measure does distinguish between institutions.	0329: Risk-Adjusted 30-Day All-Cause Readmission Rate