NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
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SUBMITTED VIA www.regulations.gov

August 15, 2016

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445–G
Washington, DC 20201

RE: **CMS–3295–P: Proposed Rule** – "Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care" (RIN 0938-AS21)

Dear Mr. Slavitt,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the proposed rule (CMS-3295-P) titled "Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care" as published in the June 16, 2016, *Federal Register*.

We are commenting on the proposed changes to hospital Conditions of Participation.

COMMENTS

§482.13(e)(5) and §482.13(e) (8)(ii) Licensed Practitioners and ordering of Restraint and Seclusion

We support the deletion of the modifying term "independent" from the Conditions of Participation (CoP) relative to the ordering of restraint or seclusion. We think physician assistants should be allowed to order restraint and seclusion. This is consistent with other responsibilities that physician assistants carry out and facilitates the safe and timely care of patients during this emergency procedure.

§482.21 Quality Assessment and Performance Improvement (QAPI)

We note the addition of the requirement that hospital QAPI programs "incorporate data including patient care data submitted to or received from quality reporting and quality performance programs, including but not limited to data related to hospital readmissions and hospital-acquired conditions." We note that while psychiatric hospital services reimbursed through the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) collect facility-specific data relative to readmissions and hospital-acquired conditions, there is currently no data available to establish national benchmarks for readmissions. A readmission measure has recently been developed for IPF PPS facilities by CMS and will be worked into its quality reporting system, but that measure is not currently required.

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§482.23 Nursing Services

We support the clarification in the Nursing Services Condition of Participation that would allow a hospital to establish a policy that would specify which, if any, outpatient departments would not be required to have an RN physically present as well as develop the alternative staffing plans that would be established under such a policy.

We appreciate the clarification that the nursing care plan can be part of an interdisciplinary care plan. We acknowledge the distinction made between the content of a nursing care plan for a patient with more complex needs anticipating a longer length of stay and that for a patient with less complex needs.

We note the lengthy list of elements to be included in the nursing care plan. Based on experience with meeting the requirements of the Special Conditions of Participation: Special Provisions Applying to Psychiatric Hospital, we caution against the use of a list of elements as highly prescriptive as the one proposed. Surveying for every element becomes an end in itself and does not give the organization the freedom to design a treatment plan that is most appropriate for the patient and that evolves over time. Highly prescriptive elements can complicate and impede electronic health record design and implementation in ways that are not helpful to patients or clinicians.

We appreciate the clarification that the director of nursing services must provide for the adequate supervision and evaluation of the clinical activities of *all* nursing personnel.

§482.24 Medical Record Services

We acknowledge that the stated purpose of this proposed rule is to conform the Medicare requirements to current standards of practice and to support improvements in quality of care, reduce barriers to care, and reduce some issues that may exacerbate workforce shortage concerns. As the title of the proposed rule states, CMS envisions the changes as ways to "promote innovation, flexibility, and improvement in patient care." However, we raise concerns about the prescriptiveness of the proposed provisions and the potential for records to be seem as "checklists" of required elements rather than a compilation of relevant clinical data and conclusions that can take many different forms. We question the link between the prescriptiveness of the regulations and the stated goals of quality. Codifying elements as specific as these in regulation makes them difficult to change as the clinical delivery system and the areas of focus and attention change. The CoPs are not updated frequently. They become the basis for survey findings that may or may not be reflective of quality over time and should not be overly prescriptive.

§482.42 Infection Prevention and Control and Antibiotic Stewardship Programs

We support the CMS goal of building in a degree of latitude in the requirements "to allow for innovations in medical practice that improve the quality of care and move toward the reduction of medical errors and patient harm." We support the proposed clarification that CMS would expect hospitals to develop and manage an infection prevention and control program that "reflects the scope and complexity of the hospital services provided." Psychiatric hospitals take infection prevention and control very seriously and employ professionals to assist with this under the direction of the Board, CEO, and nursing leadership. However, the scope of the program should be appropriate to a psychiatric hospital that does not do invasive procedures nor care for patients with serious infections. When a patient's medical condition makes it impossible for him or her to participate in active psychiatric treatment, the patient would normally be transferred to the appropriate setting for medical stabilization (including infection control). We strongly recommend that hospitals be required to develop policies and procedures that are appropriate to the infection prevention and control issues with which they deal.

We recommend that the antibiotic stewardship program also be assessed according to the "scope and complexity" criteria as noted above. Psychiatric hospitals routinely use minimal antibiotics. Issues of antimicrobial resistance would be extremely rare in psychiatric hospitals. Such hospitals should not be required to have the complex systems in place that are described in §482.42(b)(2)(i), (ii), (iii) and

(b)(3)(4). If appropriate application of the proposed standards based on the "scope and complexity of the hospital services provided" is not made, psychiatric hospitals are at high risk being out of compliance with multiple standards that should not reasonably apply to them.

SUMMARY

CMS has clearly stated in the title of the proposed rule its aim for CoP changes "to promote innovation, flexibility, and improvement in patient care." We share those goals.

However, we strongly caution against changes that are overly prescriptive. As we noted in our comments above, the CoPs are not updated frequently. CoPs should stay as a framework that supports quality over time, particularly in an era when change is rapid. New delivery systems (ACOs, value-based purchasing, etc.), new technologies (e.g., telepsychiatry, etc.) that require new job skills and responsibilities, and quality measurement systems are evolving very quickly – often with new sets of requirements and expectations. It is important that CoPs not be overly prescriptive if innovation is to continue at a rapid pace.

Thank you for the opportunity to provide feedback.

If you have any questions, please contact me or NAPHS Director of Quality and Regulatory Affairs Kathleen McCann, R.N., Ph.D., at 202/393-6700, ext. 102.

Sincerely,

/s/

Mark Covall
President/CEO