**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** 2860

**Measure Title**: Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 4/2/2021

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| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Outcome: Readmission

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Click here to name what is being measured

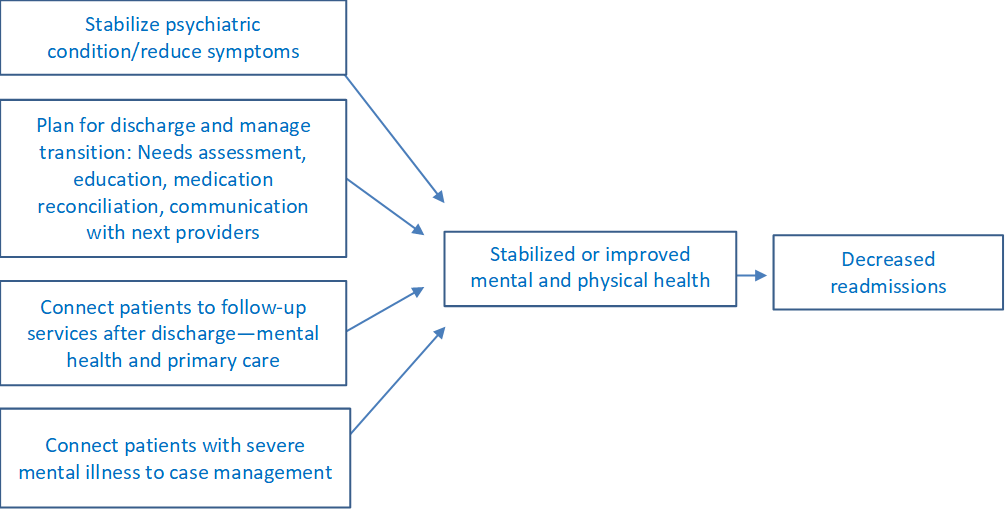
Appropriate use measure: Click here to name what is being measured

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.2** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

Readmissions can be influenced by the care received during both the index admission and the discharge process.



**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

n/a

**\*\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

2021 submission content:

Building on the initial endorsement submission, we identified three recent studies that provide additional evidence of interventions that can help to reduce readmission rates. Similar to the evidence below that was provided for initial endorsement, the following studies support the relationship between IPF processes of care and readmission rates.

Akerele et al. (2017) found that the 30-day readmission rate was reduced by 27 percent (*p* = 0.004) among inpatient psychiatric patients who participated in an intervention program. The program delivered patients’ medications from the pharmacy to the psychiatric unit on the day of discharge, provided a follow-up phone call within 72 hours of discharge, and provided the option for additional patient navigator services, such as weekly check-in phone calls.

Similarly, Comer et al. (2017) found that the 30-day readmission rate was reduced by 16 percent (*p* < 0.05) among inpatient psychiatric patients who participated in an intervention program that allowed patients to pick up their medications prior to discharge. They also received a phone call from a hospital pharmacist with 72 hours of discharge.

Taylor et al. (2016) studied an intervention for psychiatric patients that consisted of an interview with a care manager prior to discharge to identify and address barriers to continuing treatment. Patients who did not receive the interventions were significantly more likely to be readmitted within 30 days of discharge than those who received the intervention (OR= 2.44, *p* = 0.02).

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

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

2016 submission content:

Focused primarily on systematic reviews of the evidence for interventions to prevent readmission, the following information supports the relationship between IPF processes of care and the outcome of readmission. Studies have demonstrated that improvements in the following areas can reduce readmissions:

* Connecting patients with severe mental illness to intensive case management (ICM) may help prevent readmissions. A systematic review of ICM for those with severe mental illness found that compared to standard care, ICM reduced the average number of days in the hospital by 0.86 days per month.1
* “Attending to stability of condition” at discharge was found to modestly prevent early readmission by a systematic review of literature on 30-90 day readmissions.2 Administering effective, evidence-based treatments for psychiatric conditions (e.g., the Veterans Affairs/Department of Defense guideline for management of bipolar disorder)3 is a pre-requisite to stabilizing patients experiencing an acute episode of a psychiatric disorder and preventing readmissions after discharge.
* Connecting patients to services they will need post-discharge can help prevent readmission. In a study of 30-day behavioral health readmissions using a multistate Medicaid database, a 1% increase in the percent of patients receiving follow-up within seven days of discharge was associated with a 5% reduction in the probability of being readmitted.4
* Transitional interventions such as pre- and post-discharge patient education, structured needs assessments, medication reconciliation/education, transition managers, and inpatient/outpatient provider communication have been effective to reduce early psychiatric readmissions. A systematic review of such interventions observed reductions of 13.6% to 37.0%.5 The time period for counting readmissions varied across studies from 3-24 months post-discharge.
* Similarly, discharge planning in mental health was effective at reducing readmissions. In a systematic review, a meta-analysis of pooled data for 11 studies with a mean follow-up of 3.83 months demonstrated a 34% reduction in risk of readmission.6

1. Dieterich M, Irving CB, Park B, Marshall M. Intensive case management for severe mental illness. *The Cochrane database of systematic reviews.* 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. Department of Veterans Affairs/Department of Defense. *Clinical Practice Guideline for Management of Bipolar Disorder in Adults.* Washington, DC: Department of Veterans Affairs, Department of Defense; May 2010.
4. Mark T, Tomic KS, Kowlessar N, Chu BC, Vandivort-Warren R, Smith S. 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, Kosters 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.

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)**

☐ Clinical Practice Guideline recommendation (with evidence review)

☐ US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** |  |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. |  |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade |  |
| Provide all other grades and definitions from the evidence grading system |  |
| Grade assigned to the **recommendation** with definition of the grade |  |
| Provide all other grades and definitions from the recommendation grading system |  |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? |  |
| Estimates of benefit and consistency across studies |  |
| What harms were identified? |  |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? |  |

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**1a.4 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.** A list of references without a summary is not acceptable.

**1a.4.2 What process was used to identify the evidence?**

**1a.4.3.** **Provide the citation(s) for the evidence.**