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

**Measure Number** (*if previously endorsed*)**:** Click here to enter NQF number

**Measure Title**: 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries

**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**: 2/5/2014

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| **Instructions**  *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.*   * Respond to all questions as instructed with answers immediately following the question. 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. * Maximum of 10 pages (*incudes questions/instructions*; minimum font size 11 pt; do not change margins). ***Contact NQF staff if more pages are needed.*** * 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 Steering 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:   * Health outcome: [**3**](#Note3) a rationale supports the relationship of the health outcome to processes or structures of care. Applies to patient-reported outcomes (PRO), including health-related quality of life/functional status, symptom/symptom burden, experience with care, health-related behavior. * 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.   **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 U.S. Preventive Services Task Force (USPSTF) [grading definitions](http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm) and [methods](http://www.uspreventiveservicestaskforce.org/methods.htm), or Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org/publications/index.htm).  **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

☒ Health outcome: Click here to name the health outcome

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

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors*

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

☐ Process: Click here to name the process

☐ Structure: Click here to name the structure

☐ Other: Click here to name what is being measured

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**HEALTH OUTCOME/PRO PERFORMANCE MEASURE**  *If not a health outcome or PRO, skip to* [*1a.3*](#Section1a3)

**1a.2.** **Briefly state or diagram the path between the health outcome (or PRO) and the healthcare structures, processes, interventions, or services that influence it.**

30-day rehospitalizations (readmissions) of Medicare fee-for-service (FFS) beneficiaries, the health outcomes that this measure addresses, are related to the health care services that individuals receive (or do not receive) in their communities.1,2 People with chronic health conditions and/or their caregivers need to be actively engaged in helping to keep these conditions under control rather than solely being dependent on physicians and other health care providers as passive recipients of treatment.3 Medicare beneficiaries often suffer from multiple chronic conditions since they are elderly (over age 65) or disabled. Furthermore, in most cases the disease processes that underlie chronic conditions are going to worsen over time and the patient is going to suffer more from their manifestations.4

If the services provided by health care providers, as well as social support services, in a community do not address the ongoing care needs of Medicare beneficiaries, they are more likely to suffer from short-term and long-term complications of their chronic conditions and more likely to be readmitted to the hospital.5 For example, appropriate medication may be prescribed for a patient with congestive heart failure, but if that patient (and/or his/her caregiver) cannot afford to purchase the medication, or does not have a way to get to the pharmacy to pick up the medication, or has not been effectively educated about warning signs of worsening disease to look out for, that patient may end up being hospitalized for a problem that was preventable.

Medicare FFS patient with chronic condition(s)

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Patient not effectively educated about nor engaged in managing his/her condition(s); lack of systems in the health care system in community to help patients manage their conditions, including through coordination of care from different providers

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Patient suffers from complications from his/her condition(s) leading to an acute exacerbation

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Patient requires rehospitalization to a hospital

It has been shown that many rehospitalizations are preventable if patients/caregivers are well-informed about their conditions and what they need to do to manage them as well as are receiving support from health care and social service providers.6 Some rehospitalizations may be caused by events that occurred while the patient was hospitalized during the index admission, such as care that does not meet standards, or inadequate education of patients and/or their caregivers about managing their conditions, or other inadequate preparation for discharge. However, many other rehospitalizations are caused by events that occur after the patient has been discharged, such as poor communication between the providers in different health care settings (e.g. between the hospital and a nursing home), lack of standard processes for assuring that patients receive good follow-up care (e.g. lack of a process for medication reconciliation to assure that patients and other healthcare providers have been accurately informed about the medications that they should be taking once that have been discharged), and poor patient education or “activation” (e.g. the patient and/or caregivers understand what they need to do to for the patient to remain as healthy as possible and are motivated to be involved in managing his/her condition).7 In order to reduce these avoidable rehospitalizations, many providers and other stakeholders in the community need to be involved in efforts to provide good transitions of care.8 Therefore it is appropriate to measure rates of rehospitalization for a geographic area, such as a state or a community, rather than at the hospital level.

**1a.2.1.** **State the rationale supporting the relationship between the health outcome (or PRO) to at least one healthcare structure, process, intervention, or service (*i.e., influence on outcome/PRO*).**

*Note: For health outcome/PRO performance measures, no further information is required; however, you may provide evidence for any of the structures, processes, interventions, or service identified above.*

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By determining the incidence of rehospitalizations per 1,000 Medicare FFS beneficiaries in a defined geographic area over time, these measures can help communities track the effectiveness of interventions that are implemented and readjust their efforts if they are not effective in reducing rehospitalizations and hospitalizations.

Many different interventions have been shown to be effective in reducing rates of rehospitalization for Medicare FFS patients. These may include effectively educating patients and their caregivers about the importance of managing their chronic conditions and how to do so, arranging for timely and appropriate follow-up of patients after they are discharged, transmitting key information about the patient to receiving providers, and when applicable, educating patients or their caregivers about options for end-of-life care.9

For example, it has been shown that providing “care transitions coaches” to help patients with chronic diseases such as congestive heart failure during the time period after they have been discharged from the hospital can reduce rehospitalizations within 30 days after discharge by over 30%.10 These coaches visit patients in their homes (or in nursing facilities) shortly after discharge from the hospital to help patients become more involved in their own care through understanding their medications, knowing warning signs of worsening of their chronic conditions, making a follow-up appointment with their primary care provider, and creating their own personal health record. The coaches then make follow-up telephone calls to their patients to provide additional support in the next few weeks after discharge.

1 Brock, J, Mitchell, J, Irby K, Stevens B, Archibald T, Goroski, A, Lynn J. Association between quality improvement for care transitions in communities and rehospitalizations among Medicare beneficiaries. JAMA, Jan 23;309(4):381-91. Available from: <http://jama.jamanetwork.com/article.aspx?articleid=1558278>

2 Jackson, CT, Trygstad, TK, DeWalt, DA, DuBard, CA. Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions. Health Aff, Aug 32:1407-1415. Available from <http://content.healthaffairs.org/content/32/8/1407.abstract>

3 Von Korff, M, Gruman, J, Schaefer J, Curry, SJ, Wagner, EH. Collaborative management of chronic illness. Ann Intern Med. Dec 15;127(12):1097-102. Available from: <http://annals.org/article.aspx?articleid=711027>

4 Lunney, JR, Lynn, J, Foley, DJ, Lipson, S, Guralnik, JM. Patterns of functional decline at the end of life. JAMA, May 14;289(18):2387-92. Available from: <http://jama.jamanetwork.com/article.aspx?articleid=196538>

5 The Remington Report (September/October 2013). A Community-Based Approach to Improving Care Transitions and Reducing Hospital Readmissions: Updating the Evidence. The Remington Report. Available from: <http://www.cfmc.org/integratingcare/files/Remington%20Report%20Sept%202013%20QIO%20Care%20Transitions.pdf>

6 Mitchell, SE, Gardiner, PM, Sadikova, E, Martin JM, Jack, BW, Hibbard, JH, Paasche-Orlow, MK. Patient education/activation can prevent readmissions. J Gen Intern Med October 2013, DOI: 1525-1497,10.1007/s11606-013-2647-2. Available from: <http://link.springer.com/article/10.1007%2Fs11606-013-2647-2>

7 Integrating Care for Populations & Communities National Coordinating Center, CFMC. <http://www.cfmc.org/integratingcare/toolkit_rca.htm>

8 The Remington Report (September/October 2013). A Community-Based Approach to Improving Care Transitions and Reducing Hospital Readmissions: Updating the Evidence. The Remington Report. Available from: <http://www.cfmc.org/integratingcare/files/Remington%20Report%20Sept%202013%20QIO%20Care%20Transitions.pdf>

9 The Remington Report (September/October 2013). A Community-Based Approach to Improving Care Transitions and Reducing Hospital Readmissions: Updating the Evidence. The Remington Report. Available from: <http://www.cfmc.org/integratingcare/files/Remington%20Report%20Sept%202013%20QIO%20Care%20Transitions.pdf>

10 Voss R, Gardner R, Baier R, Butterfield K, Lehrman S, Gravenstein S. The care transitions intervention: translating from efficacy to effectiveness. Archives of Internal Medicine [Internet]. 2011 Jul 25 [cited 2013 Dec 12]; 171(14):1232-1237. Available from: <http://archinte.jamanetwork.com/article.aspx?articleid=1105851>

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**intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measure**

**1a.3.****Briefly state or diagram the path between structure, process, intermediate outcome, and health outcomes**. Include all the steps between the measure focus and the health outcome.

**1a.3.1.** **What is the source of the systematic review of the body of evidence that supports the performance measure?**

☐ Clinical Practice Guideline recommendation – ***complete sections*** [***1a.4***](#Section1a4)***, and*** [***1a.7***](#Section1a7)

☐ US Preventive Services Task Force Recommendation – ***complete sections*** [***1a.5***](#Section1a5) ***and*** [***1a.7***](#Section1a7)

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)

☐ Other – ***complete section*** [***1a.8***](#Section1a8)

*Please complete the sections indicated above for the source of evidence. You may skip the sections that do not apply.*

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**1a.4. CLINICAL PRACTICE GUIDELINE RECOMMENDATION**

**1a.4.1.** **Guideline citation** (*including date*) and **URL for guideline** (*if available online*):

**1a.4.2.** **Identify guideline recommendation number and/or page number** and **quote verbatim, the specific guideline recommendation**.

**1a.4.3.** **Grade assigned to the quoted recommendation with definition of the grade:**

**1a.4.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: If separate grades for the strength of the evidence, report them in section 1a.7.*)

**1a.4.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.4.1*)**:**

**1a.4.6. If guideline is evidence-based (rather than expert opinion), are the details of the quantity, quality, and consistency of the body of evidence available (e.g., evidence tables)?**

☐Yes **→ *complete section*** [***1a.7***](#Section1a7)

☐No **→ *report on another systematic review of the evidence in sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)***; if another review does not exist, provide what is known from the guideline review of evidence in*** [***1a.7***](#Section1a7)

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**1a.5.** **UNITED STATES PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

**1a.5.1.** **Recommendation citation** (*including date*) and **URL for recommendation** (*if available online*):

**1a.5.2.** **Identify recommendation number and/or page number** and **quote verbatim, the specific recommendation**.

**1a.5.3.** **Grade assigned to the quoted recommendation with definition of the grade**:

**1a.5.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: the* *grading system for the evidence should be reported in section 1a.7.*)

**1a.5.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.5.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.6. OTHER SYSTEMATIC REVIEW OF THE BODY OF EVIDENCE**

**1a.6.1.** **Citation** (*including date*) and **URL** (*if available online*):

**1a.6.2.** **Citation and** **URL for methodology for evidence review and grading** (*if different from 1a.6.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.7. FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE supporting the measure**

*If more than one systematic review of the evidence is identified above, you may choose to summarize the one (or more) for which the best information is available to provide a summary of the quantity, quality, and consistency of the body of evidence. Be sure to identify which review is the basis of the responses in this section and if more than one, provide a separate response for each review.*

**1a.7.1.** **What was the specific structure, treatment, intervention, service, or intermediate outcome addressed in the evidence review?**

**1a.7.2.** **Grade assigned for the quality of the quoted evidence with definition of the grade**:

**1a.7.3. Provide all other grades and associated definitions for strength of the evidence in the grading system.**

**1a.7.4.** **What is the time period covered by the body of evidence? (*provide the date range, e.g., 1990-2010*). Date range**: Click here to enter date range

**QUANTITY AND QUALITY OF BODY OF EVIDENCE**

**1a.7.5.****How many and what type of study designs are included in the body of evidence**? (*e.g., 3 randomized controlled trials and 1 observational study*)

**1a.7.6.** **What is the overall quality of evidence across studies in the body of evidence**? (*discuss the certainty or confidence in the estimates of effect particularly in relation to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population*)

**ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE**

**1a.7.7.** **What are the estimates of benefit—magnitude and direction of effect on outcome(s) across studies in the body of evidence**? (*e.g., ranges of percentages or odds ratios for improvement/ decline across studies, results of meta-analysis, and statistical significance*)

**1a.7.8.** **What harms were studied and how do they affect the net benefit (benefits over harms)?**

**UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE**

**1a.7.9.** **If new studies have been conducted since the systematic review of the body of evidence, provide for each new study: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review**.

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**1a.8 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.8.1** **What process was used to identify the evidence?**

**1a.8.2.** **Provide the citation and summary for each piece of evidence.**