Quality ID #XXX: 30-day Risk Standardized All-Cause Mortality following Inpatient Psychiatric Facility Discharge
– National Quality Strategy Domain: Effective Clinical Care
– Meaningful Measures Area: Risk Adjusted Mortality

2022 COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Percentage of adult patients who died, from any cause, within 30 days of discharge from an inpatient psychiatric facility (IPF).

INSTRUCTIONS:
This measure is to be submitted each time a patient is discharged from the IPF.

Measure Submission Type:
Measure data may be submitted by IPFs participating in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. The listed denominator criteria are used to identify the intended patient population. All measure- specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option. The numerator quality-data code will be determined by CMS using data from the Master Beneficiary File.

DENOMINATOR:
Adult Medicare beneficiaries discharged alive from an IPF during the measurement period.

Denominator Criteria (Eligible Cases):
- Patients aged ≥ 18 years, at the time of IPF admission, discharged alive from an IPF
- AND
- Primary diagnosis of psychiatric, behavioral, or substance or drug use disorder: 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 670 (AHRQ Clinical Classifications Software (CCS) Psychiatric Principal Discharge Diagnosis categories)

NUMERATOR:
Patients that died, from any cause, within 30-days of IPF discharge.

Numerator Instructions: Death is determined by CMS review of data contained within the Master Beneficiary File, occurring within 30 days of discharge, excluding the day of discharge.

Numerator Quality-Data Coding Options:

Denominator Exclusion: GXXXX: Patients discharged against medical advice

OR

Denominator Exclusion: GXXXX: Patient receiving hospice or palliative care during the IPF stay or in the 30-day period following IPF discharge

OR

Denominator Exclusion: GXXXX: Patients discharged to another facility (acute care, residential care, hospice, correctional facility)
OR
Patients that died from any cause
Performance Met: GXXXX: Patients that died, from any cause, within 30-days of IPF discharge

OR
Patients alive 30 days after IPF discharge
Performance Not Met: GXXXX: Patients alive 30 days after IPF discharge

RISK ADJUSTMENT:
To make meaningful comparisons about the survival rates post-discharge at the IPF level the all-cause mortality outcome will be risk-adjusted to account for differences in patient case mix across facilities. Hierarchical (two-level) logistic regression will be used to model the log-odds of survival following a discharge from an IPF. The two-level specification of the risk-adjustment allows reliable estimates for small-volume hospitals while accepting a certain amount of shrinkage toward the mean. Potential risk adjustment variables include age, sex, gender, primary discharge diagnosis, and history of suicidal attempt, ideation, or intentional self-harm. We will examine the appropriateness of these risk adjustment variables, as well as others that are identified, during measure development and testing.

STRATIFICATION:
The risk standardized all-cause mortality measure may be stratified by the IPF primary diagnostic group at discharge – substance use disorders only, mental health condition only, and dual-diagnosis. The latter will be determined by the presence of a mental health CCS as the primary diagnosis and a substance use disorder CCS as a secondary diagnosis, or vice-versa. The need for stratification will be explored during the measure development and testing process.

RATIONALE:
Individuals with psychiatric disorders have a higher risk of mortality compared to the general population. Druss et al. (2012), using National Health Interview Survey linked with National Death Index data, found that individuals with mental health disorders lived eight fewer years than their counterparts without mental health disorders. Risk factors for mortality included age; tobacco use; diabetes; cardiovascular disease, particularly hypertension; and lower cognitive functioning (Dickerson et al., 2021). Some risk factors are modifiable and could begin to be addressed in the IPF setting, including tobacco cessation counseling—currently a quality action for which a measure already exists—as well as blood pressure control and glycemic control, quality actions with existing measure in other CMS reporting programs. Substance use disorders also contribute to premature death and are amenable to interventions aimed at behavior change (Watkins et al., 2016).

Deaths occurring within 30-days of discharge could be from suicide or natural causes. The U.S. Department of Veterans Affairs (VA) health system examined post-discharge mortality among patients treated in its inpatient mental health units during 2013 and 2014. Among the 106,430 patients, 0.39 percent died within 30 days of discharge (n = 413) and 1 percent died within 90 days of discharge (n = 1,070). Of the 413 individuals who died within 30 days, 18 percent were due to suicide (n = 74) and nearly two-thirds (n = 262) were due to natural causes. Similar results were seen at 90 days. Of the 1,070 individuals who died within 90 days of discharge, 14 percent were due to suicide (n = 152) and 70 percent were due to natural causes (n = 756) (Katz et al., 2019). This study concludes that VA patients with mental illness are at a high risk of post-discharge mortality. In their discussion, the authors suggest that focusing on post-discharge interventions could contribute to a reduction in post-discharge mortality.

Individuals with serious mental illness who are diagnosed with medical conditions often have less awareness of concomitant physical disorders than those without a mental illness (Kilbourne et al., 2006). Also, the primary care treatment received by patients with serious mental illness is frequently of lower quality than that received by the general population (Goldberg et al., 2007; Kisely et al., 2008; Mitchell et al., 2009).


CLINICAL RECOMMENDATION STATEMENTS:
Patients with mental illness have increased risk for mortality and shorter life expectancy. Given the finality of the outcome, the proposed measure will serve as an important quality metric and will help facilitate patient-centric, holistic, multidisciplinary care that spans the continuum from the hospital setting to the community.

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