Washington State:
Medicaid Quality Incentive Measure Guidelines

July 1, 2019

This document provides the measure guidelines for the Medicaid Quality Incentive. The measures, clinical rationale, data definitions, data reporting process, and time lines are included.

In selecting the measures, national guidelines and clinical experts were used to identify potential measures that are evidence-based and significant for Medicaid patients and, where possible, part of the Health Care Authority Performance Measures. Final selection of measures was done by the Health Care Authority. Where possible, the definitions from national organizations were used. For measures where data were available from prior years, the data were arrayed in quartiles based on prior performance to set performance thresholds for the upcoming year monitoring for safety and appropriateness.

Hospitals wishing to earn the quality incentive will report on measures for their inpatient units. The data reported by hospitals for the quality incentive will be available upon request from the state. For questions regarding definitions or data collection, contact the Health Care Authority staff Dr. Judy Zerzan (Judy.Zerzan@hca.wa.gov) or Washington State Hospital Association staff Cat Mazzawy (CatM@wsha.org).

Infection Prevention:

- Colon Surgical Site Infection per 100 procedures (NHSN) (*adult acute*)

Workforce Safety:

- Worker's Compensation Claims per 100 Full-Time Employee (FTE) (QBS)

General Care Measures:

- Pressure Ulcer (AHRQ PSI 03) (Hospital-Wide) (*adult acute and rehabilitation*)
- Falls with Injury Per Patient Day (NQF 0202) (*adult acute and rehabilitation*)
- Post-fall Huddle Protocol: Is there a protocol in place at your facility that requires a post fall huddle conducted after every fall? If yes, please include your protocol and an example of your post fall huddle document.

ER is for Emergencies (adult and pediatric hospitals with emergency rooms only):

- Percent of Patients with Five or More Visits to the Emergency Room *at the same facility* with a Care Guideline

Safe Deliveries: (hospitals with obstetrical programs only):

- Early Elective Delivery (PC-01)
- Hospital Enrollment and Participation in AIM (Alliance for Innovation on Maternal Health)
- Severe Maternal Morbidity: Cardiopulmonary Protocol

Opioid MAT (Medication-Assisted Therapy):

- Buprenorphine included in facility formulary
- MAT Protocol

Behavioral Health Safety: (behavioral health hospitals or units only):

- Transition Record with Specified Elements Received by Discharge (CMS)
- Behavioral Health Measure: Multiple Antipsychotic Medications at Discharge with Appropriate Justification - Overall Rate (HBIPS-5)

Infection Prevention

Colon Surgical Site Infections Per 100 Procedures (NHSN) (adult acute)

Clinical Rationale:

More than 15 million surgeries are performed in the United States annually. Between two and five percent of these patients will develop an SSI, equating to between 160,000 and 300,000 SSIs nationwide each year. This rate is substantially higher if the patient undergoes colorectal surgery, with reported rates of 5% to 30%. SSIs are now the most common and most expensive health care-associated infection in the U.S. Fortunately, through the adoption of evidence-based practices, 60 percent of SSIs are potentially preventable.

In a recent study, with more than 10,000 colorectal surgery patients, the 30-day readmission rate was 11.4%, the 90-day readmission rate was 23.3%, and the 30-day SSI rate was 18.8%. The mean readmission length of stay was 8 days, and the median cost for an SSI readmission was $12,835. These reports support the concept that interventions that reduce SSIs are likely to reduce length of stay and costs. Patients with an SSI have a 2–11-times higher risk of death compared with operative patients without an SSI. Seventy-seven percent of deaths in patients with SSI are directly attributable to SSI.

Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk.

Research indicates that have a care bundle that includes the following components can reduce the incident of surgical site infections and patient outcomes. Hospitals should ensure their bundle minimally includes:

- Clinician, patient and family education on SSI prevention.
- A surgical safety checklist.
- Peri-operative glucose control.
- Evidenced based pre-operative skin cleansing and antisepsis.
- Evidence based pre-operative oral and intra-operative IV antimicrobial prophylaxis.
- Normothermia in the operating room.

Selected References:

1. Keenan, J. E., Speicher, P. J., Thacker, J. K., Walter, M., Kuchibhatla, M., & Mantyh, C. R. (2014). Preventive surgical site infection bundle in colorectal surgery. JAMA Surgery JAMA Surg, 149(10), 1045. doi:10.1001/jamasurg.2014.346.
2. Kwon, S., Thompson, R., Dellinger, P., Rogers, T., & Flum, D. (2012). Importance of perioperative glycemic control in general surgery: A report from the surgical care and

outcomes assessment program. Journal of Surgical Research, 172(2), 274. doi:10.1016/j.jss.2011.11.457.
3. Preventing Surgical Site Infections. Healthcare Research and Educational Trust (HRET). February 2017. Retrieved from http://www.hret-hiin.org/Resources/ssi/17/HRETHIIN_SSI_ChangePackage-Final_508.pdf.
4. NHSN SSI Module-Centers for Disease Control and Prevention. Published January 2017. Retrieved from https://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf.
5. Wick EC, Galante DJ, Hobson DB, et al. Organizational culture changes result in improvement in patient-centered outcomes: implementation of an integrated recovery pathway for surgical patients. J Am Coll Surg. 2015;221:669-677. Available at http://www.sciencedirect.com/science/article/pii/S1072751515003701.
6. WSHA SSI Colon Prevention Toolkit. Published August 2016. Retrieved from http://www.wsha.org/wp-content/uploads/2016_FINAL-SSI_Colon_toolkit_2016.pdf.

Definition – Centers for Disease Control and Prevention (CDC) – National Healthcare Safety Network (NHSN)

This measure is defined by the CDC in the NHSN Procedure Module. The complete definition can be found at https://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf with the most current definition for the time period to be used.

Data will include information from applicable patients regardless of payor.

Numerator: Total colon SSI that meets NHSN criteria.

Denominator: Total colon procedures that meet NHSN criteria.

Included Populations:

- Includes only in-plan, inpatient COLO procedures in adult patients (i.e., ≥ 18 years of age).
- Includes only deep incisional primary SSIs and organ/space SSIs with an event date within 30 days of the procedure.

Data Source

Data are to be reported monthly.

Fields to be reported:

- Number of SSI
- Number of colon procedures based on NHSN definition

Data collection period: July 1, 2019 – December 31, 2019

Reporting deadline: Reported within 75 days after the end of the prior month.

Data collection system: National Healthcare Safety Network (NHSN)

***Audits and validation*:** Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

This measure is used in the quality incentive for acute care hospitals.

Workforce Safety

Clinical Rationale:

Healthcare is the fastest-growing sector of the U.S. economy, employing over 18 million workers. In 2011, U.S. hospitals recorded 253,700 work-related injuries and illnesses, a rate of 6.8 work-related injuries and illnesses for every 100 full-time employees. In terms of lost-time case rates, it is more hazardous to work in a hospital than in construction or manufacturing. Cases of nonfatal occupational injury and illness with healthcare workers are among the highest of any industry sector.

Hospitals have serious hazards, including: lifting, transferring, and repositioning patients; aggressive behavior and violence; and slips and falls. Hospital work takes place in an unpredictable environment with a unique culture. Caregivers feel an ethical duty to "do no harm" to patients, and some will even put their own safety and health at risk to help a patient.

Avoidable hospital injuries and illnesses come at a high cost. When an employee gets hurt on the job, hospitals pay in many ways. Workers' compensation must cover lost wages and medical costs. The average hospital experiences $0.78 in workers' compensation losses for every $100 of payroll. Nationally, this translates to a total annual expense of $2 billion. The impact on clinical care is also challenging. Temporary staffing, backfilling, and overtime may be needed when injured employees miss work. Turnover costs are incurred when an injured employee quits. It costs significantly to recruit, hire, and train their replacement. Productivity and morale decrease as employees become physically and emotionally fatigued which undeniably impacts quality, patient safety and clinical outcomes.

OSHA has created a suite of resources to help hospitals assess workplace safety needs, implement safety and health management systems, and enhance their safe patient handling programs. Preventing worker injuries not only helps workers—it also helps patients and will save resources for hospitals.

Selected References:

1. The National Institute for Occupational Safety and Health (NIOSH) Healthcare Workers. Retrieved from https://www.cdc.gov/niosh/topics/healthcare/default.html.
2. The Occupational Safety and Health Administration. Worker Safety in Hospitals: Caring for our Caregivers. Retrieved from https://www.osha.gov/dsg/hospitals/.
3. WSHA Preventing HealthCare Workplace Violence Toolkit. Published April 2017. Retrieved from http://www.wsha.org/wp-content/uploads/FINAL_2017_05_12_WS_Toolkit.pdf.

Definition – Worker's Compensation Claims

Number of workers' compensation claims per 100 full-time workers (OSHA) per the Washington Department of Labor and Industries.

The primary strategies used to prevent workforce injuries include:

- Leadership commitment to workplace safety as priority.
- Workplace hazard assessment for correction and control.
- Worker education on safety measures and compliance expectations.
- Implementation of robust reporting system and response to events.
- Protective equipment for workers.
- Prompt and appropriate follow-up with injured worker.

Numerator: Number of approved worker's compensation claims.

Denominator: Total number of hours worked by all employees.

Rate Calculation: $\left(\frac{Numerator}{Denominator}\right) \times$ Unit

(Per Unit: 200,000 is a constant value representing the hours worked of 100 full-time workers)

Data Categories

The rate is calculated for all approved workers' compensation claims to provide an overall incident rate. To focus on primary causes of injury, rates are also calculated for three specific types of workers' compensation claims which include:

- Patient Handling: Claims that occur in the course, of moving or assisting a patient with moving or ambulating in any capacity.
- Aggressive Behavior: Claims that occur as a result of, aggressive or assaultive behavior form a patient, visitor or co-worker.
- Slips and Falls: Claims that occur due to a slip, trip or fall in the workplace.

Data Source

Updated September 24, 2019

Worker's compensation claims data are to be reported monthly.

Data collection period: July 1, 2019 – December 31, 2019

Reporting deadline: Reported within 45 days after the end of the prior month.

Data collection system: Third Party Administrator and QBS.

Audits and validation: Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

This measure is used in the quality incentive for acute care and rehabilitation hospitals.

General Care Measures

Pressure Ulcer (AHRQ PSI 03) (adult acute and rehabilitation)

Clinical Rationale:

Pressure ulcers remain a major health problem affecting approximately 2.5 million adults. Pressure ulcers cost $9.1--$11.6 billion per year in the U.S. The cost of individual patient care ranges from $20,900 to $151,700 per pressure ulcer. Medicare estimated in 2007 that each pressure ulcer added $43,180 in costs to a hospital stay. Pressure ulcers may be associated with severe pain and about 60,000 patients die as a direct result of a pressure ulcer each year.

Pressure injuries are commonly seen in high-risk populations, such as the elderly and those who are very ill. Critical care patients are at high risk for development of pressure ulcers because of the increased use of devices, hemodynamic instability and the use of vasoactive drugs.

The development of pressure ulcers or injuries can interfere with the patient's functional recovery, may be complicated by infection and can contribute to longer hospital stays. The development of Stage 3 and 4 and unstageable pressure ulcers is currently considered by the Washington Department of Health as a Serious Reportable Event.

In 2008, the Centers for Medicare and Medicaid Services (CMS) announced it will not pay for additional costs incurred for hospital-acquired pressure ulcers. The development of pressure ulcers can be prevented by the use of evidence-based nursing practice.

Selected References:

1. The Joint Commission on Preventing Pressure Injuries. Published July 2016. Retrieved from https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_25_July_20161.PDF.
2. Preventing Pressure Ulcers in Hospitals. Content last reviewed October 2014. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html.

Definition – AHRQ PSI 03

This measure is defined by the AHRQ. The definition can be found at https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2019/TechSpecs/PSI_03_Pressure_Ulcer_Rate.pdf

with the most current definition for the time period to be used. ICD-10 codes are utilized.

The primary strategies used to prevent pressure ulcers include:

- Assessing for pressure ulcer risk and creating care plan.
- Using skin care products and appropriate pressure relief surfaces.
- Implementing repositioning program.
- Preventing skin tears and deep tissue injury.
- Monitoring nutritional and hydration status.
- Implementing a pressure ulcer prevention protocol.

Data will include information from applicable patients regardless of payor.

Numerator: Discharges, among cases meeting the inclusion and exclusion rules for the denominator, with any secondary ICD-10-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable).

Denominator: All medical and surgical discharges age 18 years and older. Medical (Appendix C: MEDIC2R) and surgical (Appendix E: SURGI2R) and discharges are defined by specific MS-DRG

Appendix C - Medical Discharge MS-DRGs
https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2018/TechSpecs/PSI_Appendix_C.pdf

Appendix E - Surgical Discharge MS-DRGs
https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2018/TechSpecs/PSI_Appendix_E.pdf

Excluded Populations:

- with length of stay of less than 3 days
- with a principal ICD-10-CM diagnosis code for pressure ulcer stage III or IV (or unstageable)
- With all secondary ICD-10-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable) present on admission. If more than one diagnosis of pressure ulcer is present, all diagnoses must be present on admission for the discharge to be excluded.
- with any ICD-10-CM diagnosis code for severe burns (≥20% body surface area)
- with any ICD-10-CM diagnosis code for exfoliative disorders of the skin (≥20% body surface area)
- with a MDC code of 14 (pregnancy, childbirth, and puerperium)

with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

Data Source

Data are to be reported monthly

Fields to be reported:

- Number of discharges among cases meeting the inclusion and exclusion rules for the denominator with any secondary diagnosis field code of pressure ulcer stage III or IV (or unstageable) in any secondary diagnosis field.
- All medical and surgical and rehabilitation discharges age 18 years and older as defined.

Data collection period: July 1, 2019 – December 31, 2019

Reporting deadline: Reported within 45 days after the end of the prior month.

Data collection system: CHARS

Audits and validation: Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

This measure is used in the quality incentive for acute care and rehabilitation hospitals.

Reducing Harm: Falls with Injury (NQF 0202) (acute care and rehabilitation)

Clinical Rationale:

Falls with serious injury are consistently listed as one of the Top 10 Sentinel events reported to the Joint Commission Sentinel Event database. While extensive clinical research and evidence-based strategies in fall prevention exist, reducing injurious falls in the hospital environment remains difficult. Falls are a serious patient safety problem, accounting for nearly 84% of all inpatient incidents. Among adults 65 years or older, falls are the leading cause of injury-related death. Literature review shows that close to one-third of falls can be prevented. A comprehensive fall prevention program includes managing a patient's underlying fall risk factors and optimizing the hospital's physical design and environment. Several factors contribute to falls such as variation in assessment tools to identify fall risk factors, ineffective communication and handoffs, inadequately individualizing a patient's plan of care and physical environment. A high-reliable and sustainable fall prevention program includes: organizational leadership support, an interdisciplinary and diverse team that meets routinely and systematically to analyze fall data and identify trends and opportunities for continuous improvement; a standard comprehensive fall risk assessment tool, communication plan and educational training for all staff, patient and family engagement and a standard post fall management process, including the Post-Fall Huddle.

Hospital falls resulting in injury remain a prevalent patient safety problem and affects somewhere between 700,000 and 1,000,000 people in the United States each year. Patient falls occur in approximately 1.9 to 3 percent of all acute care hospitalizations with an estimated 30 percent of them resulting in serious injury.

The sequelae from falls are costly. Fall-related injuries account for up to 15 percent of re-hospitalizations in the first month after discharge from hospital. Based on data from 2000, total annual estimated costs were between $16 billion and $19 billion for nonfatal, fall-related injuries and approximately $170 million dollars for fall-related deaths across care settings in the community.

In 2008, the Centers for Medicare & Medicaid Services (CMS) does not reimburse hospitals for certain types of traumatic injuries that occur while a patient is in the hospital. For hospitals, an accidental fall resulting in a serious injury (fracture, subdural hematoma, injury requiring surgical intervention, and death) adds an additional $13,300 in operating costs and increased length of stay by 6.27 days. A patient death or serious injury associated with a fall while being cared for in a healthcare setting is currently considered by the Washington Department of Health as a Serious Reportable Event.

Successful strategies to prevent falls include the use of a standardized assessment tool to identify fall and injury risk factors, assessing an individual patient's risks that may not have been captured through the tool, and interventions tailored to an individual patient's identified risks. In addition, systematic reporting and analysis of falls incidents are important components of a falls prevention program

Selected References:

1. Cameron ID, Murray GR, Gillespie LD, et al. (2010). Interventions for preventing falls in older people in nursing care facilities and hospitals. *Cochrane Database of Systematic Reviews* 2010, Issue 1. Art. No.: CD005465.
2. Currie L. (2008). Fall and Injury Prevention In: Hughes RG. Ed. *Patient Safety and Quality*: An Evidenced-Based Handbook for Nurse. (AHRQ Publication No. 08-0043). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.ahrq.gov/professionals/clinicians-providers/resources/nursing/nurseshdbk/CurrieL_FIP.pdf.
3. Halfon P, et al. (2001). "Risk of Falls for Hospitalized Patients: A Predictive Model Based on Routinely Available Data." *J. Clin Epidemiol.* 54(12) 1258-66. Retrieved from: http://hepatop.biopredictive.com/publication/11750195/risk-of-falls-for-hospitalized-patients-a-predictive-model-based-on-routinely-available-data/
4. The Joint Commission Sentinel Event Alert on preventing falls and fall-related injuries in health care facilities. Published September 28, 2015. Retrieved from http://www.jointcommission.org/assets/1/18/SEA_55.pdf.
5. Wong, C. A., et al. (2011). "The cost of serious fall-related injuries at three Midwestern hospitals.' The Joint Commission Journal on Quality and Patient Safety; 37(2):81-87.

Definition – National Quality Forum

This measure is defined by the American Nurses Association and is endorsed by the National Quality Forum (NQF). The complete definition can be found at The National Quality Forum, #0202. This is the definition used for the National Database of Nursing Quality Indicators (NDNQI) and Collaborative Alliance or Nursing Outcomes (CALNOC) benchmarking databases. All documented patient falls with an injury level of minor or greater on eligible unit types during the calendar month for all patients regardless of payer type. The measure is reported as a rate, falls with injury per 1,000 Patient Days.

Target population is adult inpatient acute care and inpatient rehabilitation patients.

The primary strategies used to prevent falls with injuries include:

- Screening for fall and injury risk and creating care plan.
- Conducting on-going risk assessments, including medication review.
- Implementing scheduled rounding protocols.
- Performing routine environmental safety rounds.

- Ensuring assistive devices are within reach.
- Educating staff and patients on fall prevention.

Numerator: Total number of patient falls with an injury level of minor or greater (whether or not assisted by a staff member) on an eligible hospital unit during the calendar month.

Included Populations:

- Falls with a fall injury level of "minor" or "greater" which includes assisted and repeat falls with an injury level of "minor" or "greater."
- Hospital aggregate of patient injury falls occurring while on an eligible unit. Eligible unit types include adult critical care, step-down, medical, surgical, medical surgical combined, critical access, and adult inpatient rehabilitation.

Injury Levels:

1=**None** - No injury as a result of fall.
2=**Mild/Minor** - Resulted in bruise or abrasion, and/or required application of a dressing, ice, cleaning of a wound, limb elevation, or topical medication.
3=**Moderate** - Resulted in muscle or joint strain, and/or required suturing, application of steri-strips/skin/glue, or splinting.
4=**Major -** Resulted in surgery, casting, traction, fracture, or required consultation for neurological or internal injury
5=**Death** - Fall determined to be cause of death.

Denominator: Aggregate hospital patient days from all eligible units during the calendar month.

Included Populations:

- Inpatients, short stay patients, observation patients, and same day surgery patients who receive care on eligible inpatient units for all or part of a day.
- Adult critical care, step-down, medical, surgical, medical-surgical combined critical access and adult inpatient rehabilitation units.
- Patients of any age on an eligible reporting unit are included in the patient day totals.

Exclusions: Other unit types (e.g., pediatric, psychiatric, and obstetrical). Falls by visitors, staff, students, and if the patient is off their unit.

Data Source:

Data are to be submitted to WSHA by the Quality Benchmarking System (QBS).

Fields to be reported:

- Aggregate number of patients with falls minor through death
- Aggregate number of patient days from all eligible units

It is important that the patient days match what will be submitted to the state from your finance department.

Data collection period: July 1, 2019 – December 31, 2019

Reporting deadline: 45 days following the end of a month.

Data collection system: WSHA Quality Benchmarking System.

Audits and validation: Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

This measure is used in the quality incentive for inpatient acute care hospitals and rehabilitation units.

All Falls: Post-Fall Huddle Protocol

Clinical Rationale:

Successful strategies to prevent falls include the use of a standardized assessment tool to identify fall and injury risk factors, assessing an individual patient's risks that may not have been captured through the tool, and interventions tailored to an individual patient's identified risks. In addition, systematic reporting and analysis of falls incidents are important components of a falls prevention program

Definition: A post-fall huddle is a brief meeting immediately after a fall that includes staff caring for the patient and (ideally) the patient and family, to identify the source of injury, relative to the fall.

Data Source:

https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3o.html

Data are to be submitted to WSHA Quality Benchmarking System (QBS) once during the reporting period.

Data to be Reported:
Answer "Yes" or "No" to the following question and upload post-fall huddle protocol and tool to QBS.

- Post-fall Huddle protocol: Is there a protocol in place at your facility that requires a post fall huddle conducted after every fall?
- Post-Fall Huddle Protocol: Submit the post-fall huddle protocol.
- Post-Fall Huddle Tool: Provide an example of your facility Post-Fall Huddle Tool.

Data collection period: July 1, 2019 – December 31, 2019.

Reporting deadline: Data submitted by December 31, 2019.

Data collection system: Data submitted to QBS.

Audits and validation*:* Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

ER is for Emergencies

Percent of Patients with Five or More visits to the Emergency Room *to the same facility* with a Care Guideline (adult acute and pediatric hospitals with emergency rooms only)

Clinical Rationale:

In Washington State, as in other states, patients may visit the hospital emergency department (ED) for conditions that could be effectively treated in an alternative, less costly setting. Third Engrossed Substitute House Bill 2127 set forth seven best practices aimed at reducing unnecessary emergency department use by Medicaid clients. All Washington hospitals with emergency departments worked to implement these practices.

Best practices include adoption of a system to exchange patient information electronically among emergency departments. In order to reduce unnecessary use of the emergency room, hospitals need to be able to identify frequent users and share information regarding their care. The care guidelines are focused on all patients with five or more visits regardless of payor.

Numerator: Number of care guidelines completed in the calendar month by the facility for patients with five or more visits to the same facility in the last year without a care guideline.

Denominator: Number of patients without a care guideline with five or more visits to the same facility in the last year seen by the facility in the month and *are not admitted*.

Care guidelines are expected to be unique for the patient to provide valuable information for the next care provider.

Data Source:
Data are to be submitted to WSHA by the Emergency Department Information Exchange (EDIE). Data will be collected and distributed to the hospitals as part of the "ER is for Emergency" reports.

Fields to be reported:
- Number of care guidelines completed in the calendar month by the facility for patients with five or more visits in the last year without a care guideline.
- Number of patients without care guidelines with five or more visits in the last year seen by the facility in the month and were not admitted.

Data collection period: July 1, 2019 – December 31, 2019

Data collection system: EDIE

Audits and validation: Data are subject to audit by the state. WSHA will not audit but will complete a few basic checks

This measure is used in the quality incentive for acute care and pediatric hospitals with emergency room.

Safe Deliveries:

- **Early Elective Deliveries (PC-01)**
- **Hospital Enrollment and Participation in AIM (Alliance for Innovation on Maternal Health)**
- **Severe Maternal Morbidity: Cardiopulmonary Protocol**

Early Elective Deliveries: Percent of Patients with Elective Deliveries 37 to less Than 39 Weeks Gestational Age

Clinical Rationale:

For almost three decades, the American College of Obstetricians and Gynecologists[2] and the American Academy of Pediatrics[1] have had in place a standard requiring 39 completed weeks gestation prior to elective delivery, either vaginal or operative[2]. Recently ACOG and SMFM reiterated their recommendations against nonmedically indicated delivery prior to 39 weeks[3]:

- Nonmedically indicated delivery, including cesarean delivery, inductions of labor, and cervical ripening should not occur before 39 0/7 weeks of gestation.
- Implementation of a policy to decrease the rate of nonmedically indicated deliveries before 39 0/7 weeks of gestation has been found to decrease the number of these deliveries and, as a result, improve overall neonatal outcomes.
- Avoidance of a nonmedically indicated delivery before 39 0/7 weeks of gestation is distinct from, and should not result in, an increase in expectant management of patients with medical indications for delivery before 39 0/7 weeks of gestation.
- Indications for delivery before 39 0/7 weeks of gestation should be documented clearly and discussed with the patient.
- Because nonrespiratory morbidities also are increased in early-term deliveries, documentation of fetal pulmonary maturity does not justify an early nonmedically indicated delivery. Amniocentesis for the determination of fetal lung maturity should not be used to guide the timing of delivery, even in suboptimally dated pregnancies.

The focus on elective deliveries prior to 39 weeks was the first step in an effort to reduce the rate of C-sections in Washington State. In 2010, the rate of elective delivery prior to 39 weeks in Washington was 15.5%. The Washington rate is now around 2%.

Selected References:

1. American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved May 29, 2013: http://www.aafp.org/afp/2000/0215/p1173.html.

2. American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
3. Avoidance of nonmedically indicated early-term deliveries and associated neonatal morbidities. ACOG Committee Opinion No. 765. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e156–63. Retrieved June 14, 2019: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Avoidance-of-Nonmedically-Indicated-Early-Term-Deliveries-and-Associated-Neonatal-Morbidities?IsMobileSet=false

Definition: The Joint Commission Definition using Total Population (not sampling)
This measure is defined by The Joint Commission under PC-01. The current complete definition can be found at https://manual.jointcommission.org/releases/TJC2019A/MIF0166.html
The most up to date definition from The Joint Commission for the data collection period will be used. Data will include information from applicable patients regardless of payor.

Sampling will not be used. The current minimum data sampling by The Joint Commission and also followed by CMS is problematic for quality improvement as it results in extremely small denominator sizes. This process results in unstable rates with wide variations in high and low rates. In order to make the data more precise and meaningful for the Medicaid Quality Incentive hospitals will utilize the patient population who deliver at 37-<39 weeks instead of all delivering patients.

Numerator: Patients with elective deliveries >=37 and < 39 weeks gestation
Included Populations: ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following:

1. Medical induction of labor as defined in Appendix A, Table 11.05 while not in Labor prior to the procedure
2. Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:
    - not in Labor
    - no history of a Prior Uterine Surgery per Joint Commission acceptable list:
        - Prior classical cesarean birth which is defined as a vertical incision into the upper uterine segment
        - Prior myomectomy
        - Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury
        - History of a uterine window or thinning or defect of the uterine wall noted during prior uterine surgery or during a past or current ultrasound
        - History of uterine rupture requiring surgical repair
        - History of a cornual ectopic pregnancy
        - History of transabdominal cerclage
        - History of metroplasty and/or prior removal of vestigial horn with entry into the uterine cavity

Denominator: Patients delivering newborns between >=37 and < 39 weeks of gestation.

Included Populations:

- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1

Excluded Populations:

- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
- History of prior stillbirth
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay > 120 days
- Gestational Age < 37 or >= 39 weeks or UTD

Sampling*:* Sampling is not accepted because The Joint Commission method results in an extremely small denominator size.

Data Source:

Data are to be submitted to the Quality Benchmarking System or the WSHA-Maternal Data Center.

Fields to be reported:

- Patients with elective deliveries >= 37 and < 39 weeks of gestation
- Patients delivering newborns with >= 37 and < 39 weeks of gestation after exclusions removed (see denominator definition above)

Data collection period: July 1, 2019 – December 31, 2019

Reporting deadline: Monthly data submitted by 75 days following the end of a month.

Data collection system: Data submitted to the Washington State Hospital Association Quality Benchmarking System or the Washington State Hospital Association Maternal Data Center.

Audits and validation*:* Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

For 2019 we are reinstating the HCA case review and appeal process:

Review Process for Safety

Updated September 24, 2019

It is understood that The Joint Commission definition does not exclude from the denominator all patients needing an elective delivery. As an example, if an expectant mother finds out that she has cancer and needs chemotherapy as soon as possible, the patient and medical staff may elect to deliver early. With the current definition, this patient would be counted against the hospital.

To ensure that the Medicaid Quality Incentive does not encourage poor care, in cases where the hospital and medical staff determine through a multidisciplinary review that the elective delivery was medically necessary they may submit the case for review by the Chief Medical Officer of the Health Care Authority who will work in collaboration with a small group of obstetricians as HIPAA allows. HCA will have the final authority.

Request for External Review of Early Elective Delivery

Any cases that the hospital wishes to be reviewed must be submitted to the Health Care Authority Chief Medical Officer in writing by February 15, 2020. For November and December deliveries the deadline is March 15, 2020. The review form is available on the quality incentive page of the WSHA website: http://www.wsha.org/quality-safety/projects/medicaid-quality-incentive/

Points are solely awarded on complete monthly data submission for the time period.

This measure is used in the quality incentive for acute care hospitals with maternity units.

Safe Deliveries:

Hospital Enrollment and Participation in AIM (Alliance for Innovation on Maternal Health)

Clinical Rationale: The United States has the highest maternal mortality rate of any high resource country—and it is the only country outside of Afghanistan and Sudan where the rate is rising. The Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement initiative based on proven implementation approaches to improving maternal safety and outcomes in the U.S. The program end goal is to eliminate preventable maternal mortality and severe morbidity across the United States.

AIM works through state teams and health systems to align national, state, and hospital level quality improvement efforts to improve overall maternal health outcomes.

Any U.S. hospital in a participating AIM state or hospital system can join the growing and engaged AIM community of multidisciplinary healthcare providers, public health professionals, and cross-sector stakeholders who are committed to improving maternal outcomes in the U.S.

Washington state joined the national AIM program this past fall, choosing the AIM hemorrhage bundle as the first project. The WA AIM program is co-led by WSHA and the Department of Health, with the goal of 100% of hospitals participating. AIM is free for all participants and encourages readiness, recognition, response and reporting of severe maternal events. The enrollment form is available on the quality incentive page of the WSHA website: http://www.wsha.org/quality-safety/projects/medicaid-quality-incentive/

Selected References:
https://safehealthcareforeverywoman.org/aim-program/

Description:

The MQI AIM measure is comprised of two parts:

Part A - Hospital has submitted an AIM Enrollment form.

Part B - Hospital has submitted at a minimum one quarter of AIM data, including AIM process and/or structure measures. Hospitals may choose to submit only process measures or only structure measures, but whichever they choose data for each measure within that category must be submitted.

Data Source:

Part A - Enrollment forms are available on the MQI and Safe Deliveries Roadmap website.

Part B - The AIM measures consist of outcome, process and structure measures. The measure overview document and measure definitions may be found on the Safe Deliveries Roadmap website. AIM data are to be submitted to the Quality Benchmarking System or the WSHA-Maternal Data Center.

Fields to be Reported:

Part A - Answer "yes" or "no" to the following question: "My hospital has submitted an AIM enrollment form (yes/no)". If yes, upload the AIM enrollment form to QBS.

Part B – Refer to the AIM measure overview document for process/structure measures and measure definitions for fields to be reported.

Data collection period: July 1, 2019 – December 31, 2019.

Reporting deadline:

Part A - Enrollment form: submitted by December 31, 2019. Monthly data submission not required. Submit only one response for the question, along with your enrollment form, for the MQI time period.

Part B – AIM data submitted 45 days after the end of the month.

Updated September 24, 2019

Data collection system:
Part A – Enrollment form: submit to QBS
Part B – AIM data: submit to QBS or MDC

Audits and validation: Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

This measure is used in the quality incentive for acute care hospitals with maternity units.

Safe Deliveries:

Severe Maternal Morbidity: Cardiopulmonary Protocol

Clinical Rationale:

The 2016 American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal–Fetal Medicine's (SMFM) Obstetric Care Consensus publication on severe maternal morbidity states: "Severe maternal morbidity is associated with a high rate of preventability, similar to that of maternal mortality. It also can be considered a near miss for maternal mortality because without identification and treatment, in some cases, these conditions would lead to maternal death. Identifying severe morbidity is, therefore, important for preventing such injuries that lead to mortality and for highlighting opportunities to avoid repeat injuries."[1] Unfortunately, the incidence of severe maternal morbidity is increasing in the United States, with a 200% increase in incidence between 1993 (47.6 per 10,000 deliveries) and 2014 (141.6 per 10,000 deliveries).[2]

With the passing of the Maternal Mortality Review Panel bill in 2016, there has been an increased focus and systematic evaluation of maternal deaths in Washington to identify the causes and create recommendations for "system changes to improve health care services for women in this state."[3]

In late 2017, WSHA's Safe Deliveries Roadmap initiated a new program for all delivering hospitals called, "Maternity Watch".[4] Its primary objective is to reduce maternal morbidity and mortality by improving early intervention. This is accomplished using an early warning screen tool developed by Dr. Larry Shields, from Dignity Health.[5,7] The program also incorporates the use of an algorithm with four clinical pathways: Sepsis, cardiopulmonary, hypertension and hemorrhage.[6,7] Research demonstrated that the use of this tool and algorithm significantly reduced severe maternal morbidity compared with nonpilot sites.[7] The Maternity Watch program laid the foundation for Washington state's enrollment in 2018 as an Alliance for Innovation on Maternal Health (AIM) state.

Ensuring that all hospitals have policies/protocols and systems in place to address readiness, recognition and response to obstetric emergencies is a first step to reducing the incidence of severe maternal morbidity and mortality in Washington State. In 2017, the focus for MQI was postpartum hemorrhage and hypertension policies and protocols. In 2018, the focus was on response to maternal hemorrhage and readiness for sepsis. The cardiopulmonary protocol is the final protocol in the series of 4 pathways of the maternal early warning trigger program. The cardiopulmonary protocol measure is a process measure which includes assessment of whether a hospital has a policy/protocol for assessing, recognizing and responding to cardiopulmonary events in the maternal population (i.e. cardiomyopathy/CHF, myocardial infarction, pulmonary edema, pulmonary HTN, pulmonary embolus/DVT).

Selected References:

1. https://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Severe-Maternal-Morbidity-Screening-and-Review
2. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html#anchor_References
3. http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/MaternalMortalityReviewPanel
4. http://www.wsha.org/quality-safety/projects/safe-deliveries/maternity-watch-maternal-early-warning-trigger/
5. http://www.wsha.org/wp-content/uploads/Maternal-Triggers-Screening-Tool-v11-PILOT.pdf
6. http://www.wsha.org/wp-content/uploads/MEWT-updated-algorithm-9-2017.pdf
7. http://www.wsha.org/wp-content/uploads/Shields-article.pdf
8. D'Alton ME1, Main EK, Menard MK, Levy BS. The National Partnership for Maternal Safety. Obstet Gynecol. 2014 May;123(5):973-7
9. http://safehealthcareforeverywoman.org/patient-safety-bundles/
10. https://www.cmqcc.org/resources-tool-kits/toolkits
11. https://www.cmqcc.org/resource/ob-hem-executive-summary

Definition:

The Severe Maternal Morbidity measure is a process measure which includes assessment of whether a hospital has policies/protocols for assessing, recognizing and responding to maternal cardiopulmonary events.

Data Source:

Data are to be reported to the Quality Benchmarking System (QBS).

Fields to be Reported:

Answer "Yes" or "No" to the following question and upload the policy/protocol to QBS**:**

- Do you have a protocol in place for assessing, recognizing and responding to cardiopulmonary events in the maternal population? (Yes/No)

Data collection period: July 1, 2019 – December 31, 2019. Monthly data submission not required. Submit only one response for the question, along with your policies/protocols, for the MQI time period.

Reporting deadline: Data submitted by December 31, 2019.

Data collection system: Data submitted to the Quality Benchmarking System (QBS).

Audits and validation: Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

This measure is used in the quality incentive for acute care hospitals with maternity units.

Opioid Medication-Assisted Therapy (MAT)

Buprenorphine included in facility formulary

Medication-Assisted Therapy Protocol in Place

Clinical Rationale:

Dependence on prescription opioids and heroin is a major public health problem that is increasing in the United States. Opioid-dependent patients often use the emergency department (ED) for medical care. Among opioid-dependent patients, ED-initiated buprenorphine treatment was found to significantly increased engagement in addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services.

Opioid agonist treatment, such as buprenorphine, is an effective treatment. Patients with opioid use disorder or dependence are at risk of adverse health events and often only seek medical care in emergency departments for such conditions as substance use disorder, comorbid medical and psychiatric conditions, or acute illnesses and trauma.

Buprenorphine provides ED physicians a treatment for opioid use disorder that decreases withdrawal, craving, and opioid use and that can be administered in the ED setting without a DEA X license.

What forms of buprenorphine should Hospitals have on the formulary? At minimum, sublingual tablet formulations of buprenorphine should be available to be administered and/or prescribed from the ED. The most common formulations are sublingual (alone or in combination with

naloxone: Suboxone), transdermal (10mcg/hr = about 0.5mg/day), and intravenous (Buprenex). See ED-BRIDGE Guide to Emergency Buprenorphine Treatment.

ED-BRIDGE is a program through the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis Grant to the California Department of Health Care Services (DHCS).

Selected References:

Gail D'Onofrio, MD, MS, Patrick G. O'Connor, MD, MPH, Michael V. Pantalon, PhD, Marek C. Chawarski, PhD, Susan H. Busch, PhD, Patricia H. Owens, MS, Steven L. Bernstein, MD, and David A. Fiellin, MD (2015). Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence, *JAMA.* 2015;313(16):1636-1644.

D'Onofrio, G., Chawarski, M.C., O'Connor, P.G. et al. J GEN INTERN MED (2017) 32: 660. https://doi.org/10.1007/s11606-017-3993-2

Definition: Buprenorphine included in Facility Formulary as an orderable.

Data Source:
Data are to be reported to the Quality Benchmarking System (QBS) at anytime during the measurement period.

Fields to be reported:

Add Buprenorphine to hospital formulary: Y/N If already on formulary, then Yes. Can enter yes at anytime during the time period of measurement

Approved protocol for MAT initiation in ED (ED bridge or other). If already have protocol in place, then should enter "Yes".

Data Collection period: July 1, 2019 – December 31, 2019

Reporting deadline: 60 days following the end of the prior month.

***Data collection system*:** Quality Benchmarking System (QBS).

Audits and validation: Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

Updated September 24, 2019

Behavioral Health Safety Measures-Adult and Pediatrics

Behavioral Health Measure: Transition Record with Four Specified Elements Received by Discharged Patients

Clinical Rationale:

Providing detailed discharge information enhances the preparation of patients to self-manage post-discharge care and comply with treatment plans. Randomized trials have shown that many hospital readmissions can be prevented by patient education, pre-discharge assessment, and domiciliary aftercare. One recent study found that patients participating in a hospital program providing detailed, personalized instructions at discharge, including assistance with arranging follow-up appointments, had 30% fewer subsequent emergency visits and hospital readmissions than patients who received usual care at discharge.

Transition record – A core, standardized set of data elements consolidated into a single document related to patient's demographics, diagnosis, treatment, and care plan that is discussed with and provided to the patient and/or caregiver in a printed or electronic format at each transition of care and transmitted to the facility/physician/other health care professional providing follow-up care. The transition record may only be provided in electronic format if acceptable to the patient and only after all components have been discussed with the patient. If a patient is transferred to another inpatient facility and the discharging clinician documents in the patient record that the patient is clinically unstable, or the patient and/or caregiver is unable to comprehend the information at discharge, then the discharging facility is not required to discuss and provide the transition record to the patient and/or caregiver; however, all four of the following elements must be discussed with the receiving facility to be included in the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure:

- 24-hour/7-day contact information, including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care, AND
- Primary physician, other health care professional, or site designated for follow-up care.

Definition:

Transition record – A core, standardized set of data elements consolidated into a single document related to patient's demographics, diagnosis, treatment, and care plan that is discussed with and provided to the patient and/or caregiver in a printed or electronic format at each transition of care and transmitted to the facility/physician/other health care professional providing follow-up care. The transition record may only be provided in electronic format if acceptable to the patient and only after all components have been discussed with the patient. If a patient is transferred to another inpatient facility and the discharging clinician documents in

the patient record that the patient is clinically unstable, or the patient and/or caregiver is unable to comprehend the information at discharge, then the discharging facility is not required to discuss and provide the transition record to the patient and/or caregiver; however, all four of the following elements must be discussed with the receiving facility to be included in the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure:

• 24-hour/7-day contact information, including physician for emergencies related to inpatient stay, AND
• Contact information for obtaining results of studies pending at discharge, AND
• Plan for follow-up care, AND
• Primary physician, other health care professional, or site designated for follow-up care. Found in Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Four elements have been selected for measurement. Data will include information from applicable patients regardless of payor.

Sampling: *The hospital may use CMS Sampling Specifications for the quarterly sample size based on the non-stratified initial patient population for the measure set. However, if the hospital has 0-77 cases per quarter, then 100% of the initial patient population would be required. The CMS methodology is available at:*

http://www.wsha.org/wp-content/uploads/CMS_Sampling-Specs_2016.pdf

Numerator: Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including the following four elements:

Contact Information/ Plan for Follow-up Care

• 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND
• Contact information for obtaining results of studies pending at discharge, AND
• Plan for follow-up care, AND
• Primary physician, other health care professional, or site designated for follow-up care

All applicable elements must be captured to satisfy the measure numerator. Please refer to the data element definitions for additional guidance pertaining to the required elements for this measure.

Denominator:
All patients, regardless of age, discharged from the inpatient facility to home/self-care or any other site of care.

Exclusions:
Patients who died or left against medical advice (AMA) or discontinued care.

Data Source:
Data are to be submitted to Quality Benchmarking System by the hospital. Data will be collected monthly.

Fields to be reported:
- Psychiatric inpatients with all of defined elements met.
- Psychiatric inpatient discharges.

Data collection period*:* July 1, 2019 – December 31, 2019

Reporting deadline: 60 days following the end of the prior month.

Data collection system: Washington State Hospital Association Quality Benchmarking System.

Audits and validation: Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

This measure is used in the quality incentive for acute care hospitals with behavioral health units and behavioral health hospitals.

Behavioral Health Safety Measures-Adult and Pediatrics

Behavioral Health Measure: Multiple Antipsychotic Medications at Discharge with Appropriate Justification - Overall Rate (HBIPS-5)

Clinical Rationale:

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University Applications/LocalApps.HealthSystem Consortium, 2006). Practice

guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in treatment resistant patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients without a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

Selected references:

1. American Psychiatric Association (APA). (2004). Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry*. 161(2 Suppl):1-56
2. Ananth, J., Parameswaran, S., & Gunatilake, S. (2004). Antipsychotic polypharmacy comparing monotherapy with polypharmacy and augmentation. *Curr Med Chem*. 11(3):313-327 *Curr Pharm Des*. 10(18):2231-2238.
3. Centorrino, F., Gören, J.L., Hennen, J., Salvatore, P., Kelleher, J.P., & Baldessarini, R.J. (2004) Multiple versus single antipsychotic agents for hospitalized psychiatric patients: a case control study of risk versus benefit. *Am J Psychiatry*. 161 (4):700-706.
4. Covell, N.H., Jackson, C.T., Evans, A.C., & Essock, S.M. (2002). Antipsychotic prescribing practices in Connecticut's public mental health system: rates of changing medication prescribing styles. *Schiz Bull*. 28(1):17-29,
5. Ganguly, R., Kotzan, J.A., Miller, L.S., Kennedy, K., & Martin, B.C. (2004). Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998-2000. *J Clin Psychiatry*. 65(10):1377-88.
6. Gilmer, T.P., Dolder, C.R., Folsom, D.P., Mastin, W., & Jeste, D.V. (2007), Antipsychotic polypharmacy trends among Medicaid beneficiaries with schizophrenia in San Diego County, 1999 - 2004. *Psychiatric Serv*. 59(7):1007-1010.
7. Jaffe, A.B. & Levine, J. (2003). Antipsychotic medication co-prescribing in a large state hospital system. *Pharmacoepidemiol Drug Saf*.12:41-48.
8. Kreyenbuhl, J., Valenstein, M., McCarthy, J.F., Ganocyz, D., & Blow, F.C. (2006). Long-term combination antipsychotic treatment in VA patients with schizophrenia.*Schiz Res*.84:90-99.
9. National Association of State Mental Health Program Directors (NASMHPD). (2001).Technical report on psychiatric polypharmacy. Alexandria, VA.

10. Potkin, S.G., Thyrum, P.T., Alva, G., Bera, R., Yeh, C., & Arvanitis, L.A. (2002). The safety and pharmacokinetics of quetiapine when coadministered with haloperidol, risperidone or thioridazine. *J Clin Psychopharmacol*. 22:121-130.
11. Shim, J.C., Shin, J.G., Kelly, D.L., Jung, D.U., Seo, Y.S., Liu, K.H., et al. (2007). Adjunctive treatment with a dopamine partial agonist aripiprazole, for treatment of antipsychotic-induced hyperprolactinemia: A placebo controlled trial. *Am J Psych.164*:1404-1410.
12. Stahl, S.M. & Grady, M.M. (2004). A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy augmentation. *Curr Med Chem.11*:313-327.
13. Tranulis, C., Skalli, L., Lalonde, P., & Nicole, L. (2008). Benefits and risks of antipsychotic polypharmacy. An evidence based review of the literature. *Drug Saf*.31(1):7-20
14. University Applications/LocalApps.HealthSystem Consortium. (2006). Mental health performance measures field brief. Oakbrook, IL.
15. Baumeister SE, Schumann A, Meyer C, et al. Effects of smoking cessation on health care use: is elevated risk of hospitalization among former smokers attributable to smoking-related morbidity? *Drug Alcohol Depend*. 2007 May 11;88(2-3):197-203. Epub 2006 Nov 21.
16. Lightwood JM. The economics of smoking and cardiovascular disease. Prog Cardiovasc Dis. 2003 Jul-Aug;46(1):39-78.
17. Lightwood JM, Glantz SA. Short-term economic and health benefits of smoking cessation: myocardial infarction and stroke. *Circulation*. 1997 Aug 19;96(4):1089-96.
18. Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2007. Atlanta, GA, Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2007.
19. Fiore MC et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
20. Critchley J, Capewell S. Smoking cessation for the secondary prevention of coronary heart disease. Cochrane Database Syst Rev. 2004;(1):CD003041.
21. Ford ES, Ajani UA, Croft JB, et al. Explaining the decrease in U.S. deaths from coronary disease, 1980-2000. *N Engl J Med*. 2007 Jun 7;356(23):2388-98.
22. Hurley SF. Short-term impact of smoking cessation on myocardial infarction and stroke hospitalizations and costs in Australia. *Med J Aust*. 2005 Jul 4;183(1):13-7.
23. McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA* 1993 Nov 10;270(18):2207-12

Definition:

Overall score for patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. The most up to date definition from Specifications Manual for National Hospital Inpatient Quality Measures for the data collection period will be used which is located at https://manual.jointcommission.org/releases/TJC2016A/MIF0120.html

Data will include information from applicable patients regardless of payor.

Numerator:
Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

- *Appropriate Justification for Multiple Antipsychotic Medications*

Included Populations:
- All ages

Denominator:
Psychiatric inpatient discharges.

Included:
- Patients with *ICD-10-CM Principal or Other Diagnosis Codes* for Mental Disorders as defined in discharged on two or more routinely scheduled antipsychotic medications

Exclusions:
- Patients who expired.
- Patients with an unplanned departure resulting in discharge due to elopement.
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patients with a length of stay ≤ 3 days.

Data Source:
Data are to be submitted to Quality Benchmarking System by the hospital. Data will be collected monthly.

Fields to be reported:
- Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.
- Psychiatric inpatient discharges.

Data collection period: July 1, 2019 – December 31, 2019

Reporting deadline: 60 days following the end of the prior month.

Data collection system: Washington State Hospital Association Quality Benchmarking System.

Audits and validation: data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

This measure is used in the quality incentive for acute care hospitals with behavioral health units and behavioral health hospitals.
Updated September 24, 2019