Washington State:
Medicaid Quality Incentive Measure Guidelines

July 1, 2020

This document provides the measure guidelines for the Medicaid Quality Incentive. The measures, clinical rationale, data definitions, data reporting process, and timelines 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) and Tina Seery (TinaS@wsha.org).

Infection Prevention:

- Colon Surgical Site Infection per 100 procedures (NHSN) (adult acute)
- CAUTI (catheter associated urinary tract infection)

Workforce Safety:

- Workplace Safety Events

General Care Measures:

- Pressure Ulcer (AHRQ PSI 03) (Hospital-Wide) (adult acute and rehabilitation)
- Falls with Injury (all in-hospital units, EDs)

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):

- Alliance for Innovation in Maternal Health (AIM) Program Data Submission

Medications for Opioid Use Disorder (MOUD):

- Buprenorphine Included in Facility Formulary and at least Five Data 2000 Prescribers
- MOUD Protocol for ED and/or Inpatient Settings

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

- Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed
- Transition Record with Four Specified Elements Received by Discharged Patients

SDOH Screening

- Social Determinants of Health (SDOH)

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 a Surgical Site Infection(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 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.
- Evidence based pre-operative skin cleansing and antisepsis.
- Evidence based pre-operative oral and intra-operative IV antimicrobial prophylaxis.
- Normothermia in the operating room.
- Implementation of a Quality Improvement Program (e.g., the AHRQ Comprehensive-based Safety Program, (CUSP), etc.)

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/pcsmanual_current.pdf

Data will include information from applicable patients regardless of payor.

Colon SSI Rates

Numerator: Number of observed colon SSI

Denominator: Number of colon SSI procedures

(multiply result by 100)

Included Populations:

- Includes only in-plan, inpatient Colon 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 operative procedures as defined by NHSN

Data collection period: July 1, 2020 – December 31, 2020

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.

CAUTI (Catheter Associated Urinary Tract Infection)

Clinical Rationale:

Urinary tract infections (UTIs) are the most common type of health-care associate infection reported to the National Safety Health Network (NHSN) and rates continue to increase, leading to longer hospital stays, greater medical costs, morbidity and even mortality.

Among UTIs acquired in the hospital, approximately 75% are associated with a urinary catheter. Between 15-25% of hospitalized patients receive urinary catheters during their hospital stay. One study identified the annual cost of CAUTIs for the U.S. is between $340 million to $1.7 billion. Another report estimated that each CAUTI averages $13,793 with a range from $5,019 to $22,568 (95%CI). This same report estimated that for every 1,000 in-hospital CAUTI cases, there are 36 excess deaths. CAUTIs can be prevented.

The Center for Disease Control (CDC) estimates that 17% to 69% of CAUTIs can be prevented with recommended infection control measures. The most important risk factor for a CAUTI is prolonged use. Urinary catheters should only be used for patients who have clear indications and should be removed as soon as they are not required. Another issue associated with CAUTI has been unnecessary antimicrobial use and urinary drainage systems are often reservoirs for multidrug resistant bacteria and a source of transmission to other patients.

Hospitals should ensure their CAUTI Prevention Bundle minimally includes:

- Appropriate urinary catheter use (i.e., including the consideration of alternatives to indwelling catheters)
- Proper techniques for urinary catheter insertion, (i.e., hand hygiene, by trained personnel, in a sterile environment with sterile equipment, etc.)

Selected References:

1. Hollenbeak, Christopher S. and Schilling, Amber L (2018). The attributable cost of catheter-associated urinary tract infections in the United States: A systematic review. American Journal of Infection Control, 46(7), July 2018: 751-757.

2. AHRQ (2017). Estimating the Additional Cost and Mortality Associated with Selected Hospital-Acquired Conditions. Taken 05/22/2020 from: https://www.ahrq.gov/hai/pfp/haccost2017-results.html
3. CDC (2015). Catheter-associated urinary tract infections. Healthcare-associate Infections. Taken 05/22/2020 from: https://www.cdc.gov/HAI/ca_uti/uti.html
4. CDC (2015). Guideline for prevention of catheter-associated urinary tract infections (2009). Infection Control. Taken 05/20/2020 from: https://www.cdc.gov/HAI/ca_uti/uti.html
5. CDC (2015) Catheter-Associated Urinary Tract Infections. Infection Control. Taken 05/21/2020 from: https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html.

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/pcsmanual_current.pdf.

Data will include information from applicable patients regardless of payor. All CAUTI measures will utilize NHSN criteria.

CAUTI Rates

Numerator: Number of CAUTI per location

Denominator: Number of Urinary Catheter Days per location

(multiply result by 1,000)

Included Populations:

- Includes only admitted adult patients (i.e., ≥ 18 years of age).

Data Source:
Data are to be reported monthly.

Fields to be reported:

- Number of CAUTI
- Number of Urinary Catheter Days per location as defined by NHSN

Data collection period: July 1, 2020 – December 31, 2020

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.

Workplace Safety Events

Clinical Rationale:

Workplace violence (WPV) is an unfortunate and well recognized hazard in the health care industry. According to the Occupational Health and Safety Administration, WPV is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site.

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. Healthcare providers have a responsibility to ensure the safest care environment for patients and families as well as for themselves and colleagues.

To prevent workplace violence and advance improvement strategies, hospitals need a standardized way to track all events, understanding of the number of events and where they occur, actions taken by staff to respond or reduce WPV and conduct a root cause analysis on events. This measure will focus on a process for tracking WPV events where security or additional staff are called to provide support or initiate de-escalation interventions.

This measure supports hospitals as they work to implement Washington's new workplace violence prevention law (RCW 40.19) or (HB 1931). Data on events and their location will help inform decisions by the hospital's safety committee, the hospital WPV plan and appropriate training for healthcare providers.

Selected References:

1. April 2017. Retrieved from https://www.aha.org/workplace-violence.
2. April 2017. Retrieved from OSHA - https://www.osha.gov/SLTC/workplaceviolence/
3. April 2017. Retrieved from (OR Toolkit)–https://www.oahhs.org/safety

Definition – Worker Place Violence Events

Number (count) of workplace violence events where security or additional staff are called to respond to an event or where security is later informed of an event. The count will be stratified by area of the hospital to include (see areas of hospital stratification below).

Include Criteria:

- Workplace Violence events to include: "Workplace violence," "violence," or "violent act" which means any “physical assault or verbal threat of physical assault against an employee or provider of a health care setting on the property of the health care setting. This "includes any physical assault or verbal threat of physical assault involving the use of a weapon, including a firearm or a common object used as a weapon, regardless of whether the use of a weapon resulted in an injury” (RCW 40.19).

- When staff call a Code Grey or related alert-Combative or abusive behavior by patients, families, visitors, staff or physicians.

- When staff call a Code Silver – At risk or confronted by person with a weapon or a hostage situation.https://www.wsha.org/wpcontent/uploads/Standardization_PosterEmergencyCodeCallsAA.pdf

Measure: Number (count) of workplace violence events where security or additional staff are called to mitigate, respond to or are later informed of a violent event toward hospital staff or providers. The count will be stratified by area of the hospital.

Numerator: No numerator

Denominator: No denominator

Data Categories:
Areas of the hospital for stratification:

- ICU
- ED
- Acute Care Units OB
- Peds/NICU
- Psych
- Surgical Services
- Outpatient setting
- General Hospital settings (e.g., lobby, cafeteria, waiting areas, parking lots, breezeways or grounds)

Data Source:
Quality Benchmarking System

Data collection period: July 1, 2020 – December 31, 2020

Reporting deadline: Reported within 45 days after the end of the prior month. Data is to be reported monthly.

Data collection 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.

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 using 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.
3. WA State Adverse Events Adverse Events: Quarterly Report Serious Reportable Events TableQ12020 https://www.doh.wa.gov/Portals/1/Documents/2900/689010.pdf

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) (DECUBVD*).

Denominator: Surgical or medical discharges, for patients ages 18 years and older. Surgical (Appendix E: SURGI2R) and medical (Appendix C: MEDIC2R) discharges are defined by specific MS-DRG
AHRQ QI™ ICD-10-CM/PCS Specification v2019 PSI 03 Pressure Ulcer Rate
www.qualityindicators.ahrq.gov

* See below for code list
Exclude cases:

- 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) (DECUBVD*)
- With all secondary ICD-10-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable) present on admission (DECUBVD*). 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) (BURNDX*)
- with any ICD-10-CM diagnosis code for exfoliative disorders of the skin (≥20% body surface area) (EXFOLIATXD *)
- with an 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)All medical and surgical discharges age 18 years and older.

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, 2020– December 31, 2020

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.

MQI Measure Reducing Harm:

Reducing Harm: Falls with Injury (all in-hospital units, ED)

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. 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. Moreover, a patient death or serious injury associated with a fall while being cared for in a healthcare setting is currently considered by the Washington State Department of Health as a Serious Reportable Event.

Patient falls occur in approximately 1.9 to 3 percent of all acute care hospitalizations with an estimated 10 percent of them resulting in serious injury.

Additionally, it has been estimated that 600 to 1,600 newborns in the United States experience an in-hospital fall/drop every year. 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. The most prevalent maternal risk factors associated with newborn falls and drops include: Cesarean birth, use of pain medication, breast feeding and second or third postpartum night, specifically around midnight to early morning hours.

Falls with Injury: Measure Definitions Across the Continuum

The Agency for Healthcare Research and Quality (AHRQ) defines a fall as: "An unplanned descent to the floor with or without injury to the patient". Falls with Injury, as defined by the American Nurses Association and endorsed by the National Quality Forum (NQF), NQF 0202, is: "all documented patient falls with an injury level of minor or greater on eligible unit types during the calendar month".

The National Database for Nursing Quality Indicators (NDNQI) defines both newborn falls and newborn drops. A newborn fall is "a sudden, unintentional descent, with or without injury to the patient that results in the patient coming to rest on the floor, on or against another surface, on another person or object." A newborn drop is defined as "a fall in which a baby being held or carried by a health care professional, parent, family member, or visitor falls or slips from that person's hands, arms, lap, etc. This can occur when a child is being

transferred from one person to another. The fall is counted regardless of the surface on which the child lands and regardless of whether or not the fall resulted in injury." Current literature supports that this patient safety concern, defined as a newborn fall or a newborn drop, are synonymous; organizations should follow the same patient safety analysis process for both a fall and a drop.

Preventable Harm & Cost Containment

The sequelae from falls are costly. In 2008, the Centers for Medicare and Medicaid Services (CMS) categorized serious fall-related injuries as a preventable Hospital Acquired Condition (HAC). Fall-related injuries are one of 14 HAC's that are considered non-reimbursable according to CMS. Injuries related to falls can result in an additional 6.3 hospital days with an average cost of $14,056 per patient and account for up to 15 percent of re-hospitalizations in the first month following discharge from the hospital. Based on data from 2015, accidental falls in patients >65 years old resulted in a total cost of $637 million, with the total cost for non-fatal falls equaling $31.3 billion.

Strategies and Interventions

Successful strategies to prevent falls in adult and inpatient rehabilitation units include a multi-pronged approach with implementing standard tactics such as: 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, interventions tailored to an individual patient's identified risks and optimizing the hospital's physical design and environment. A high-reliable and sustainable fall prevention program includes organizational leadership support, an interdisciplinary and diverse team that meets routinely and a systematically way to analyze fall data and identify trends and opportunities for continuous improvement and the implementation of Post Fall Management. This includes an effective and transparent communication plan with the clinical team, educational training for all staff, engagement of patients and families, conducting a post fall huddle after every fall and a systematic reporting and analysis of falls incidents.

To reduce newborn falls/drops, the Joint Commission encourages hospitals to develop a tool for assessing newborn fall risk and educate parents based on the assessment; ensure hourly rounding by staff to help drowsy mothers or other caregivers place their newborn in a bassinet; promote maternal rest; develop signage for the patient room or crib card to reinforce infant fall risks; develop a standardized reporting and debriefing tool for infant falls; and provide emotional support to the family or caregiver in the event of a fall.

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.
6. WA State Adverse Events Adverse Events: Quarterly Report Serious Reportable Events TableQ12020 https://www.doh.wa.gov/Portals/1/Documents/2900/689010.pdf

Falls: Detailed Measures

All Falls by Type and Post Fall Huddle

- **Total number of post-fall huddles** (enter the number of post fall huddles that were conducted during this month; a post-huddle should be conducted after every non-injurious/injurious fall to determine cause of why the body went down and/or to identify source that caused the injury.)
- **Types of Falls** (enter the number of falls, per category that occurred during this month; in the absence of completing the post-fall huddle and without identifying fall by type, select "Unsure")

  Select type of fall by category description:
  - **Accidental/Environmental**: fall that is related to environmental circumstance (trip over cord or wire, liquid on a floor, uneven floor, unlocked chair or bed wheels).
  - **Anticipated Physiological**: fall that is intrinsic to the patients known risk factors such as poor vision, polypharmacy, history of falls, unsteady or impaired gait.
  - **Unanticipated Physiological**: physical condition that cannot predict risk of falling such as seizure, collapse from sudden cardiac arrest
  - **Unsure**: inability to categorize type of fall; post fall huddle not conducted or incomplete

Reporting Frequency – Monthly

Collected - Facility-wide

Data source:

- **Post Fall Huddles**: Total number of post-fall huddles (enter the number of post fall huddles that were conducted during this month)

- **Types of Falls:**
- **Accidental:** Total number of accidental falls due to environment
- **Anticipated Physiological**: Total number of anticipated physiological falls due to known risk factors
- **Unanticipated Physiological**: Total number of unanticipated physiological falls due to known risk factors
- **Unsure**: Total number of falls with unknown causes (enter the number of falls that cannot be categorized as accidental, anticipated physiological, unanticipated physiological)

Included Populations:
Inpatients, short stay patients, observation patients, emergency room, neonates, pediatrics, maternal ward, behavioral health, rehabilitation units.

All Falls-Age-based Populations

Reporting Frequency – Monthly

Collected - Facility-wide

Data source: All falls stratified by age-based populations, with or without injury (whether assisted by a staff member) in any in-hospital unit during the calendar month.

- < than 1 year old
- Age 1-17 year old
- Age 18-44 year old
- Age 45-64 year old
- Age 65-74 year old
- Age 75-84 year old
- Over age 85

Included Populations:
Inpatients, short stay patients, observation patients, emergency room, neonates, pediatrics, maternal ward, behavioral health, rehabilitation units.

All Falls-Repeat Falls

- All repeat falls, with or without injury (whether assisted by a staff member) In any in-hospital unit during the calendar month. (if a patient has more >1 repeat fall, include number of repeat falls during patient's admission encounter.

Reporting Frequency: Monthly

Collected: Facility-wide

Data collection period: July 1, 2020 – December 31, 2020

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.

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, 2020– December 31, 2020

Data collection system: EDIE

New: Commencing January 1, 2021, this measure will remain in effect to support and address patient care visits in excess of 5 visits/calendar year. Hospitals will continue to leverage opportunities to address potentially avoidable visits and link patient-centric and individualized clinical care.

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:

Alliance for Innovation on Maternal Health (AIM) Program Data Submission

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.

The WA AIM program is co-led by WSHA and the Department of Health. AIM is free for all participants and encourages readiness, recognition, response and reporting of severe maternal events. Washington state joined the national AIM program in 2019, choosing the AIM hemorrhage bundle as the first project. The 2019 MQI AIM measure included 2 parts: hospital enrollment in AIM and submission of data. For the 2020 AIM measure hospitals will build upon the work being done by submitting two quarters of AIM hemorrhage bundle process measures and providing authorization for WSHA to submit their AIM data to the National AIM data portal.

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

Description:

The MQI AIM measure is comprised of two parts:
Part A - Hospital submission of **2 quarters of all 5 AIM hemorrhage bundle process measures.**
Part B - Hospital authorization for WSHA to transfer AIM data to the National AIM data portal.

This requires:
Submitting to WSHA the name and email address of the data contact for each hospital, who will be responsible for authorizing data transfer from WSHA to the AIM data portal.

The data contact will receive log in information for the AIM data portal and must log in to the data portal and click the "authorization" pop up window.

NOTE: hospitals who have previously submitted the data contact name AND authorized data transfer within the AIM data portal will automatically receive credit for Part B and do not need to complete it.

Data Source:
Part A: WSHA Maternal Data Center (MDC) or WSHA QBS.

Part B: WSHA will internally track hospital completion of Part B criteria.

Fields to be Reported:
Part A - Refer to the AIM Data Collection Plan document on https://safehealthcareforeverywoman.org/aim-data/ for hemorrhage process measures and measure definitions for fields to be reported.

Part B - Send hospital data contact name and email with the subject line "AIM Data Contact" to: AshleighB@wsha.org. Afterwards, an email with an invitation and link to log into the AIM data portal will come from support@maternalsafety.org.

Data collection period: July 1, 2020 – December 31, 2020.

Reporting deadline:
Part A - Hospital must report AIM hemorrhage bundle process measures for the entire reporting period: July 1, 2020- December 31, 2020 (2 quarters).

Part B – Hospitals must send data contact name and email to WSHA by November 1, 2020. Data contacts must log in to the AIM data portal and authorize data transfer by December 31, 2020.

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.

Medications for Opioid Use Disorder (MOUD)

Buprenorphine included in facility formulary and at least five Data 2000 waivered prescribers

MOUD Protocol in Place for ED and/or Inpatient

Clinical Rationale:

Opioid misuse is a major public health problem in the United States. Patients with opioid use disorders (OUDs) are at increased risk for adverse health consequences, and often use the emergency department (ED) to treat these problems. ED and inpatient hospital settings offer an opportunity to screen for OUDs, provide intervention, and facilitate referrals for ongoing treatment. Recognizing and treating OUDs in hospitals is an important clinical quality issue.

Opioid agonist treatment, such as buprenorphine, is an effective best practice treatment for OUDs. Buprenorphine is a schedule III opioid medication. The most common formulations are sublingual as monoproduct (Subutex) or in combination with naloxone (Suboxone). It can also be transdermal for pain (Butrans), intravenous for pain (Buprenex), transmucosal (Subsys) or subcutaneous for OUDs (Sublocade).

Buprenorphine provides a treatment for OUDs that decreases withdrawals, cravings, and opioid use and can be administered in ED and inpatient settings (under certain circumstances) without a DATA 2000 waiver. The best practice for hospitals, however, is to ensure that a sufficient number of prescribers are waivered to prescribe buprenorphine for OUDs as this allows for better treatment options and valuable educational opportunities for prescribers to deliver safe and effective care for patients with OUDs.

What forms of buprenorphine should hospitals have on the formulary? At a 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).

Multiple resources, including clinical guidelines and algorithms for hospitals can be found at CA Bridge.

Selected References:

1. California Bridge Treatment Starts Here. Available from https://www.bridgetotreatment.org/
2. D'onofrio, G., O'connor, P., Pantalon, M., Chawarski, M., Busch, S., Owens, P., . . . Fiellin, D. (2015). Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA*, 313(16), 1636-1644.

3. D'Onofrio, G., Chawarski, M., O'Connor, C., Pantalon, P., Busch, G., Owens, M., . . . Fiellin, H. (2017). Emergency department-initiated buprenorphine for opioid dependence with continuation in primary care: Outcomes during and after intervention. *Journal of General Internal Medicine*, 32(6), 660-666.
4. Duber, H., Barata, Cioè-Peña, Liang, Ketcham, Macias-Konstantopoulos, . . . Whiteside. (2018). Identification, management, and transition of care for patients with opioid use disorder in the emergency department. *Annals of Emergency Medicine*, 72(4), 420-431.
5. Substance Abuse and Mental Health Services Administration (2020). *Treatment Improvement Protocol TIP 63: Medications for Opioid Use Disorder*. Available from https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

Definitions: Buprenorphine included in Facility Formulary as an orderable.

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

Fields to be reported:
- Buprenorphine on hospital formulary: Y/N If already on formulary, then Yes. Can enter yes at any time during the time period of measurement
- # of DATA-2000 waivered prescribers at facility
- Protocol for MOUD in ED (CA-Bridge or other). If already have protocol in place, enter "Yes".
- Protocol for MOUD in inpatient (CA-Bridge or other). If already have protocol in place, enter "Yes".

Data Collection period: July 1, 2020 – December 31, 2020

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

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

Behavioral Health Safety Measures – Adult and Pediatrics

Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Clinical Rationale:

Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint.

Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

For more information, see the Hospital Based Inpatient Psychiatric Services (HBIPS-1)

Selected References:

1. American Psychiatric Association (2016). *Practice guidelines for the psychiatric evaluation of adults*. Third edition. Arlington (VA): American Psychiatric Association.
2. Lyons JS, Uziel-Miller ND, Reyes F, Sokol PT (2000). Strengths of children and adolescents in residential settings: Prevalence and associations with psychopathology and discharge placement. Journal of the American Academy of Child & Adolescent Psychiatry, Vol 39(2): 176-181.
3. NASMHPD (2005). *Position statement on services and supports to trauma survivors*. Alexandria, VA: NASMHPD.
4. Rapp CA (1998). The strengths model: Case management with people suffering from severe and persistent mental illness. London: Oxford University Press.
5. Ruiz P (2004). Addressing culture, race, & ethnicity in psychiatric practice. *Psychiatric Annals*, Vol 34(7): 527-532.
6. Ziedonis DM (2004). Integrated treatment of co-occurring mental illness and addiction: Clinical intervention, program, and system perspectives. *CNS Spectrums*, 9(12): 892,894-904,925

Definition:
Patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all the following: risk of violence to self and others, substance use, psychological trauma history, and patient strengths.

Numerator: Patients with admission screening within the first three days of admission for all the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths.

Denominator:
All patients admitted to inpatient psychiatric facility/unit.

Exclusions:
- Patients that died.
- Patients with length of stay < 3 days.
- Patients for whom there is an inability to complete admission screening

Data Elements:
- Patient Strengths
- Psychological Trauma History
- Substance Use
- Violence Risk to Others
- Violence Risk to Self

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

Data collection period: July 1, 2020 – December 31, 2020

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 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.

Definition:

Transition record – A core, standardized set of data elements consolidated into a single document related to a 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 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: Inpatient psychiatric 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:

• 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 (QBS) by the hospital. Data will be collected monthly.

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

Data collection period: July 1, 2020 – December 31, 2020

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

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.

Social Determinants of Health

Inpatient Screening for Social Determinants of Health (SDOH)

Clinical Rationale:

Screening patients is the first step in addressing social needs, a key determinant of health. SDOH account for at least 80% of health outcomes. This first SDOH metric will promote screening and identification of patient SDOH needs. Future metrics will focus on referral and linkage to resources and program to address SDOH needs.

Selected references:

1. Health Policy Brief: "The Relative Contribution of Multiple Determinants to Health Outcomes," Health Affairs, August 2014. (https://www.healthaffairs.org/do/10.1377/hpb20140821.404487/full/)
2. "Screening for Social Needs: Guiding Care Teams to Engage Patients," American Hospital Association, June 2019. (https://www.aha.org/system/files/media/file/2019/09/screening-for-social-needs-tool-value-initiative-rev-9-26-2019.pdf)
3. SIREN SDOH Screening Tool Comparison (https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison); Gravity Project (HL7 standards) (https://www.hl7.org/gravity/);
4. Gravity Project (HL7 standards) (https://www.hl7.org/gravity/);
5. Children's Hospital Association SDOH Screening (https://www.childrenshospitals.org/Issues-and-Advocacy/Population-Health/Reports/Screening-for-Social-Determinants-of-Health);
6. CMS Core SDOH Domains (https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf);
7. EHR implementation guides for PRAPARE with configuration templates for Cerner, Epic, eClinicalWorks, GE Centricity, and NextGen EHRs.

Definition:

Screening for Social Determinants of Health (housing instability, food insecurity, and transportation needs) in the inpatient setting.

Data Source:

Data (attestation and upload of supporting documents) are to be reported to the Quality Benchmarking System (QBS) anytime during the measurement period.

Fields to be reported:

- Screening for housing stability, food insecurity, and transportation needs SDOH: Yes or No. If SDOH screening is already in place, then enter Yes. Can enter Yes anytime during the time period of measurement. Upload a copy of screening tool or screening questions in use. Only an answer of Yes will allow eligible hospitals to receive credit toward the incentive.
- Code SDOH screening results in EHR. Yes or No. If SDOH screening results are coded in EHR system (for the purposes of tracking, treatment planning ad-hoc data analysis), then enter Yes. Can enter Yes anytime during the time period of measurement. Upload of codes used to document SDOH in EHR or check code list (LOINC, SNOMED, Z-Codes, Other) in QBS. Only an answer of Yes will allow eligible hospitals to receive credit toward the incentive.

Data collection period*:* July 1, 2020 – December 31, 2020

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.