This document provides the measurement 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. The 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.

Eligible 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-Thul (Judy.Zerzan@hca.wa.gov), or Washington State Hospital Association staff Cat Mazzawy (CatM@wsha.org).

Infection Prevention:

- Antimicrobial Stewardship (AMS)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Surgical Site Infection (SSI) Colon

Behavioral Health:

- Admission Screening for Violence Risk, Substance Use, Psychological Trauma, History, and Patient Strength Completed
- Distributing opioid overdose reversal medication in EDs and behavioral health settings
Workforce Safety:

- Workplace Violence Events

Diagnostic Excellence

- Diagnostic Error – Adoption of policy and practice to support the identification of Diagnostic Errors

ER is for Emergencies:

- ER is for Emergencies: Percent of Patients with Five or More Visits to the Emergency Room at the same facility with Care Guidelines

Fall Prevention:

- Fall Prevention and Harm Reduction

Safe Deliveries Roadmap:

- Emergency Department pregnant and postpartum triage
- Perinatal Substance Use Disorder (SUD)

Equity

- Bias Reporting and Response
- Social Determinants of Health (SDOH)

Climate Change

- Survey on Climate Change
Infection Prevention

Antimicrobial Stewardship (AMS)

Measure eligibility:
All acute care hospitals that participate in MQI are eligible to complete this metric.

Clinical Rationale:
AMS measure will be a new 2022 process measure focused on having a hospital policy specific to the pathogens of concern that will be reported to the proper state authority.

Hospitals will submit a policy associated with their pathogens of concern to the proper state authority. The hospitals will need to indicate that they have completed their submission of the policy by December 31, 2022.

Washington State’s law to prevent the spread of methicillin-resistant staphylococcus aureus (MRSA) in hospitals was updated in 2021 to increase patient and staff safety. The legislature originally passed the MRSA law in 2009 based on available information.

Today, infectious disease scientists’ understanding of MRSA is more comprehensive and the U.S. Centers for Disease Control and Prevention (CDC) has identified additional dangerous pathogens. Washington’s MRSA law overcommits hospital resources and attention to one pathogen, which consumes staff time and testing supplies, and limits hospital space without meaningfully increasing patient and staff safety.

Governor Inslee waived the law in March 2020 to provide hospitals more flexibility to respond to the COVID-19 pandemic. The waiver remains in effect and allows hospitals to prepare and respond to dangerous pathogens like COVID-19 without the MRSA law’s specific requirements. However, it has been replaced with House Bill 1739 during the 2021 legislative session and requires all hospitals to submit their new pathogens of concern policy to the Department of Health by the deadline, December 31, 2022.

Selected References:
• https://www.niaid.nih.gov/research/emerging-infectious-diseases-pathogens
• https://isid.org/guide/pathogens/

Definition:
House Bill 1739 on pathogens of epidemiological concern

https://www.cdc.gov/drugresistance/biggest-threats.html
Included Populations:
Populations included in the policy are pediatrics, admitted adult patients (i.e., ≥ 18 years of age), and specialty patients as appropriate to your hospital’s designation.

Fields to be reported
Submission of your hospital’s policy associated with pathogens of concern to the proper state authority by December 31, 2022.

Indicate the completion of this submission of policy to the Washington State Hospital Association Quality Benchmarking System QBS with the answer of Yes/No during the performance period or by January 31, 2022.

Data Collection period:
July 1, 2022- December 31, 2022

Reporting deadline:
30 days after the close of the performance period or by January 31, 2023

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

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

Data Scoring:
Hospitals obtain point awards based on the submission of policy to the proper state authority and an indication of completion in QBS to receive the full point awards for uploading their policy and answer of yes on the attestation.

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Answer of yes in QBS AND submission of policy to state authority.</th>
<th>Answer of no in QBS, OR no submission of policy to state authority.</th>
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<tbody>
<tr>
<td>Point Award 2022</td>
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<td>0 points</td>
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</table>
Infection Prevention

Catheter-Associated Urinary Tract Infections (CAUTI)

Measure eligibility:
All acute care hospitals that participate in MQI are eligible to complete this metric.

Clinical Rationale:
CAUTI (Catheter Urinary Tract Infection) measure will be built on the 2021 clinical process measure. The 2022 CAUTI measure will be focused on actionable policy content that is used to improve clinical processes that affect CAUTI outcomes.

There are three components as part of this measure.

- Hospitals will verify with an attestation in QBS that relevant clinical staff areas are educated on the CAUTI policy during their new employee orientation upon hire (during the first 60 days).
- Hospitals will verify with an attestation in QBS that CAUTI policy is reviewed annually with the relevant clinical staff of ≥1 year of employment.
- Hospitals will submit an algorithm associated with their CAUTI policy.

CAUTI is a common complication of indwelling catheters and is the most common healthcare- associated condition in the United States. There were 19,738 reported CAUTIs in 2020. Studies show a range of 1.4 to 15.8 CAUTIs per 1,000 catheter days. The Agency for Healthcare Research and Quality (AHRQ) cites studies that show that the additional cost for CAUTI is $13,793 (95% CI: $5,019 to $22,568) and excess mortality is 36 deaths for every 1,000 in-hospital CAUTI cases (95% CI: 0.004 to 0.079). The most important risk factor is the use of an indwelling catheter and most CAUTI prevention interventions focus on limiting the use and duration of urinary catheters. Despite this, 15% to 25% of all hospitalized patients receive a catheter and multi-drug resistant organisms (MDROs) in the setting of CAUTIs are likely to affect treatment as well as mortality, morbidity, and costs now and into the future.

Selected References:
Definition:
CDC Reference: https://www.cdc.gov/nhsn/cms/index.html provides some guidance to determine our definition for use of the term relevant. The relevant clinical staff is all licensed health care professionals who provide orders for, place, or manage indwelling catheters for patients in the following patient care locations:

- Intensive Care Units (ICUs) (excluding patients in neonatal ICUs [NICUs: Level II/III and Level III nurseries])
- Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations
- Other inpatient locations (excluding Level I and Level II nurseries).

NHSN identifies acute care general hospitals (including specialty hospitals), free-standing long-term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals as hospitals where CAUTIs can occur. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.

 Included Populations:
Populations included in the policy are pediatrics, admitted adult patients (i.e., ≥ 18 years of age), and specialty patients as appropriate to your hospital’s designation.

Fields to be reported
- Hospitals will verify with an attestation in QBS that new relevant clinical staff are being educated on the CAUTI policy during their employee orientation upon hire (during the first 60 days). Submission of this attestation to QBS immediately after the performance period of by January 31, 2023.

- Hospitals will verify with an attestation in QBS that CAUTI policy is reviewed with the relevant clinical staff of ≥ 1 year of employment. Submission of this attestation to QBS immediately after the performance period or by January 31, 2023.

Data Collection period:
July 1, 2022- December 31, 2022

Reporting deadline:
30 days after the close of the performance period or by January 31, 2023
**Audits and validation:**
Data are subject to the audit by the state. WSHA will not audit but will complete a few basic validity checks.

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

**Data Scoring:**
Hospitals obtain point awards based on 4 points for education about the CAUTI policy on hire (within 60 days) with 95% or better of new relevant clinical staff during doing orientation (verified with attestation); or 2 points with an 80%-94% of new relevant clinical staff (verified with attestation).

4 points for annual review of CAUTI policy with 95% or greater of the current relevant clinical staff of 1 year or greater employment (verified with attestation); or 2 points with an 80%-94% of relevant current relevant clinical staff (verified with attestation)

2 points for submission of algorithm associated with the CAUTI policy
- Option of not applicable (N/A) for some hospitals that do not use urinary catheters and/or are not described under the use of the term relevant; hospitals in this category will not be penalized.

**CAUTI Attestation Submissions**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>≤ 84% of new relevant clinical staff receive education about CAUTI policy at new employee orientation</th>
<th>85-94% of new relevant clinical staff receive education about CAUTI policy at new employee orientation</th>
<th>&gt; 95% of new relevant clinical staff receive education about CAUTI policy at new employee orientation</th>
<th>≤ 84% of relevant clinical staff employed for ≥ 1 year about review CAUTI policy</th>
<th>85-94% of relevant clinical staff employed for ≥ 1 year about reviewing CAUTI policy</th>
<th>&gt; 95% of relevant clinical staff employed for ≥ 1 year about reviewing CAUTI policy</th>
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<td>2 points</td>
<td>4 points</td>
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**CAUTI Algorithm**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Answer of yes <strong>AND</strong> upload of CAUTI algorithm associated with CAUTI policy.</th>
<th>Answer of no <strong>OR</strong> does NOT upload the CAUTI algorithm.</th>
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</thead>
<tbody>
<tr>
<td>Point Award 2022</td>
<td>2 points</td>
<td>0 points</td>
</tr>
</tbody>
</table>
Infection Prevention

Surgical Site Infection (SSI) Colon

Measure eligibility:
All acute care hospitals that participate in MQI are eligible to complete this metric.

Clinical Rationale:
Surgical Site Infection (SSI) Colon measure will be built on the 2021 clinical process measure. The 2022 SSI Colon measure will be focused on actionable policy content that is used to improve clinical processes that affect SSI Colon outcomes.

There are three components as part of this measure.

1. Hospitals will verify with an attestation in QBS that new relevant clinical staff is educated on the SSI Colon policy during their new employee orientation upon hire (during the first 60 days).

2. Hospitals will verify with an attestation in QBS that SSI policy is reviewed annually with the relevant clinical staff of > 1-year employment.

3. Hospitals will submit an algorithm associated with their SSI Colon policy.

SSIs are a common complication in acute care facilities and occur in 2% to 5% of patients undergoing inpatient surgery. This results in approximately 160,000 to 300,000 SSIs each year in the United States. SSIs are the most common and costly of all healthcare-associated infections (HAIs). Colon surgery is associated with infection rates of 15% to 30%, one of the highest rates of surgical site infections. SSIs after colon surgery prolong hospital length of stay and increase the risk of death. Patients with SSI are at a 2 to 11 times higher risk of mortality compared with operative patients without an SSI.

Approximately 60% of SSIs are preventable by using evidence-based guidelines. This creates an opportunity to eliminate approximately 7 to 11 additional postoperative hospital days. Preventing SSI Colon requires a cohesive multidisciplinary approach, standardization, and reduction in operative variance with patient and family engagement to successfully address the complexity of multiple variables specific to patients and patient populations, processes, organizational factors, and surgical practice.

Selected References:
10.1016/j.jamcollsurg.2016.10.029;

- CDC (2010). Surgical Site Infection (SSI) [https://www.cdc.gov/hai/ssi/ssi.html]

**Definition:**
The NHSN provides some guidance to determine our definition for use of the term *relevant*. The *relevant clinical staff* is all licensed health care professionals who perform on a surgical team in an inpatient facility and/or hospital outpatient procedure department (HOPD) where the selected NHSN operative procedure is performed that can generate an SSI Colon. Typically, surgeons performing colon operations include general surgeons, colorectal surgeons, gynecological oncologists, and acute care surgeons. A *relevant* surgical care team typically consists of surgeons, anesthesiologists, peri-operative nurses, and floor nurses.

For the SSI Colon MQI measure, all those whose job requirement is performing or assisting in surgery or providing perioperative care where an SSI Colon can occur (as defined by NHSN), must review the policy during initial employment orientation or as a required annual SSI Colon policy review. [https://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf]

**Included Populations:**
Populations included in the policy are pediatrics, admitted adult patients (i.e., ≥ 18 years of age), and specialty patients as appropriate to your hospital’s designation.

**Fields to be reported**
- Hospitals will verify with an attestation in QBS that new relevant clinical staff is educated on the SSI Colon policy during their new employee orientation upon hire (during the first 60 days). Submission of this attestation to QBS immediately after the performance period or by January 31, 2023.

- Hospitals will verify with an attestation in QBS that SSI Colon policy is reviewed annually with the relevant clinical staff of ≥ 1-year of employment. Submission of this attestation to QBS immediately after the performance period or by January 31, 2023.

**Data Collection period:**
July 1, 2022 - December 31, 2022

**Reporting deadline:**
30 days after the close of the performance period or by January 31, 2023

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

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

**Data Scoring:**
Hospitals obtain point awards based on the submission of policy to the proper state authority and an indication of completion in QBS to receive the full point awards for uploading their policy and answer of yes.

Hospitals obtain point awards based on 4 points for review education about SSI Colon policy on hire (within 60 days) with 95% or better of new relevant clinical staff during orientation (verified with attestation); or 2 points with 80%-94% of relevant new clinical staff (verified with attestation).

4 points for annual review of SSI Colon policy with 95% or greater of the relevant current clinical staff of 1 year or greater employment (verified with attestation); or 2 points with an 80%-94% of relevant current clinical staff (verified with attestation).

2 points for submission of algorithm associated with the SSI Colon policy.

- Option of not applicable (N/A) for some hospitals that do not use urinary catheters and are not described under the use of the term relevant; hospitals in this category will not be penalized.

**SSI Colon Attestation Submissions**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Point Award 2022</th>
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<tr>
<td>≤ 84% of new relevant clinical staff receive education about SSI Colon policy at new employee orientation</td>
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</tr>
<tr>
<td>85-94% of new relevant clinical staff receive education about SSI Colon policy at new employee orientation</td>
<td>2 points</td>
</tr>
<tr>
<td>≥ 95% of new relevant clinical staff receive education about SSI Colon policy at new employee orientation</td>
<td>4 points</td>
</tr>
<tr>
<td>≤ 84% of relevant clinical staff employed for ≥ 1 year receive refresher about review SSI Colon policy</td>
<td>0 points</td>
</tr>
<tr>
<td>85-94% of relevant clinical staff employed for ≥ 1 year receive refresher about SSI Colon policy</td>
<td>2 points</td>
</tr>
<tr>
<td>≥ 95% of relevant clinical staff employed for ≥ 1 year receive education about SSI Colon policy</td>
<td>4 points</td>
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</table>
SSI Colon Algorithm

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Answer of yes <strong>AND</strong> upload of SSI Colon algorithm associated with SSI Colon policy.</th>
<th>Answer of no <strong>OR</strong> does not upload the SSI Colon algorithm.</th>
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</thead>
<tbody>
<tr>
<td><strong>Point Award 2022</strong></td>
<td>2 points</td>
<td>0 points</td>
</tr>
</tbody>
</table>
Behavioral Health Safety

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

Measure eligibility:
Inpatient behavioral health hospitals and units only.

Clinical Rationale:
Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as a 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 to develop an 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).

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

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

Fields to be reported

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

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

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

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

Sampling:
The hospital may use CMS Sampling Specifications for the quarterly sample size based on the on-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

Data Collection period:
July 1, 2022 - December 31, 2022

Reporting deadline:
45 days after the close of the performance period or by February 15, 2023
Audits and validation:
Data are subject to the audit by the state. WSHA will not audit but will complete a few basic validity checks.

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

Data Scoring:

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<td>3 points</td>
<td>5 points</td>
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</tbody>
</table>
Behavioral Health Safety

Distributing opioid overdose reversal medication in EDs and behavioral health settings

Measure eligibility:
All adult Acute and Pediatric Hospitals with Emergency rooms, and Psychiatric hospitals.

Clinical Rationale:
With over 1,700 reported overdose deaths in 2020, the Centers for Disease Control and Prevention estimates a 37 percent increase in Washington state from the year before. The CDC data also shows a national trend of increasing overdose deaths with an estimated yearly increase of nearly 30 percent.

On January 1, 2022, 2SSB 5195 went into effect. This law requires hospital emergency departments (EDs) and facilities licensed as Behavioral Health Agencies (BHAs), which includes inpatient psychiatric units and psychiatric hospitals, to dispense or distribute opioid overdose reversal medication to patients at risk of an opioid overdose for individual use after discharge. The purpose of the new law is to have individuals at risk of an opioid overdose leave the facility with opioid overdose reversal medication to prevent future overdoses. Prescriptions are not sufficient as they often remain unfilled. The law also requires hospitals to provide these patients with overdose prevention education, information about harm reduction strategies, and resources on medications for opioid use disorder.

Selected References:
- How do I bill for take-home naloxone? (govdelivery.com)
- Naloxone Distribution Plan (SFY 2022 FINAL) (wa.gov)
- Mental Health Services Billing Guide (wa.gov)
- Prescription Drug Program Billing Guide (wa.gov)
- Retroactive to date of service on and after January 1, 2022, hospitals, EDs, opioid treatment programs, and certified or licensed BHAs may be reimbursed for prepackaged opioid overdose reversal medication, naloxone, distributed to clients at risk of an opioid overdose. Naloxone distributed to Apple Health fee-for-service (FFS) clients may be billed as a separate line item with one of the following HCPCS codes and the National Drug Code (NDC) of the product distributed.
Definition:
Patients who were seen in the hospital emergency department or inpatient psychiatric hospital were screened and determined to be eligible for distribution of an opioid overdose reversal medication based on 2SSB 5195.

Included Populations:
Patients at an ED or a licensed BHA that present with:
- an opioid overdose or suspected overdose
- other adverse events related to opioid use
- opioid use disorder; or
- who reports recent use of opioids

Fields to be reported

Policy Submission:
Submission of policy that includes:
- Screening and identification of individuals who would benefit from opioid overdose reversal medication
- Process for providing identified individuals with (1) opioid overdose reversal medication, (2) education about overdose prevention, reversal, and harm reduction strategies, and information about resources on medications for opioid use disorder upon discharge
- Process for using professional discretion if not providing opioid overdose reversal medication

Metric Submission

Numerator:
Patients provided with opioid overdose reversal medication upon discharge from the ED or BHA.

Denominator:
Patients at an ED or a licensed BHA that present with:
- an opioid overdose
- other adverse events related to opioid use
- opioid use disorder; or
- who reports recent use of opioids

Exclusions:
- Patients that died.
- Patients who were transferred to another facility
- Patients who left before being screened
- Patients for whom there is professional discretion used in not distributing the medication
  - For hospital EDs, the treating practitioner must determine “in their clinical and professional judgment that dispensing or distributing opioid overdose reversal medication is not
appropriate or the practitioner has confirmed that the patient already has opioid overdose reversal medication.” RCW 18.64.011 defines a practitioner to mean a physician, nurse, or another person duly authorized by law or rule in the state of Washington to prescribe drugs.

- For BHAs, the behavioral health provider must determine “using clinical and professional judgment that opioid overdose reversal medication is not appropriate.” RCW 71.24.025 defines behavioral health provider to mean osteopaths, physicians, physician assistants, osteopaths and osteopath physician assistants, psychologists, substance use disorder professionals, mental health counselors, marriage and family therapists, social workers, and registered nurses and advanced registered nurse practitioners.

Data Collection period:
July 1, 2022- December 31, 2022

Reporting deadline:
45 days after the close of the performance period or by February 15, 2023

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

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

Data Scoring:

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<th>Threshold</th>
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<tr>
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</table>
Workplace Safety

Workplace Violence Events

Measure eligibility:
All hospitals who wish to participate in MQI are eligible to complete this metric.

Clinical Rationale:
A data-driven and patient-centered approach is needed for action-oriented interventions. Gaps exist in the current data collection related to the role of race, ethnicity, and language (REaL) as contributing factors and trends in WPV events. By better understanding if a relationship exists between WPV events and REaL data, hospitals can prioritize staff training and explore where hospital culture may be contributing to incidents of WPV.

Additionally, research shows debriefing after a workplace violence incident does not happen consistently across facilities. Debriefing after an event can allow for real-time problem solving, assess for the necessary support of all individuals involved in the event, and contribute to the development of a culture of safety.

This data directly correlates with the WPV programming that WSHA is conducting in 2022.

Selected References:
- Debrief and post-incident support: views of staff, patients, and careers | Nursing Times
- Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup
- Addressing Emergency Department Nurses’ Experiences of Workplace Violence through the Development of a Peer-based, Post Code Gray Support Tool 2021
- Debriefing for Patient Safety

Definition:
Number (count) of workplace violence events in which a physical assault or threat of physical assault within the hospital setting.

Included Populations:
Any workplace violent events that are reported in the hospital settings.
**Fields to be reported**

- Number (count) of workplace violence events in which a physical assault or threat of physical assault occurred within the hospital setting (2 points).
- Do you have a policy on debriefing with affected individuals including patients after a workplace violence event? Answer yes, no, or in progress. (Any answer = 1 point). If yes, please submit your policy (3 points).
- Please share your policy on collecting REaL data on the patient or other persons inciting and receiving violence (4 points).

**Data Collection period:**
July 1, 2022 - December 31, 2022

**Reporting deadline:**
30 days after the close of the performance period or by January 31, 2023

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

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

**Data Scoring:**

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</tr>
<tr>
<td>Do you have a policy on debriefing affected individuals after a workplace violence event? Answer yes, no, or in progress. (Any answer = 1 point)</td>
<td>1 point</td>
</tr>
<tr>
<td>If yes, please upload your policy or process.</td>
<td>3 points</td>
</tr>
<tr>
<td>Please share your policy on collecting REaL data on the patient or other persons inciting and receiving violence.</td>
<td>4 points</td>
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Diagnostic Excellence

Diagnostic Error- Adopting policy and practices to support the identification of Diagnostic Errors

Measure eligibility:
All acute, rehab, and children’s hospitals that participate in MQI are eligible to complete this metric.

Clinical Rationale:
The effects of diagnostic errors are currently estimated to affect upwards of 12 million Americans each year. Diagnostic errors cause more harm to patients than all other hospital errors combined. Analysis reveals that accurate and timely diagnosis depends nearly as much on the health care system as it does on the diagnosticians (providers) themselves.

Diagnostic errors also have a marked impact on health care providers, and the emotional effects of diagnostic errors can be long-lasting and harmful. Patients identify the ramifications of diagnostic errors as emotional distress, prolonged illness and medical complications, impairment in activities of daily living, and decreased confidence in the health care system.

Given the prevalence and impacts of diagnostic errors, health care leaders must address them as part of their quality improvement and patient safety programs.

While there is no single cause of the diagnostic error and therefore no single solution to the problem, this complex issue must be solved through systems improvement. Inpatient safety literature, several causes of diagnostic error were identified, including:

A. Errors in clinical assessment and subsequent decision making
B. Lack of time with the clinician
C. Communication between clinicians and patients
D. Communication between clinicians
E. System failure

Selected References:
• AHRQ, Diagnostic Safety Measurement for Learning and Improvement 1. A Resource to Identify, Analyze, and Learn from Diagnostic Safety Events found at https://www.ahrq.gov/patient-safety/reports/issue-briefs/state-of-
Definition: Diagnostic Error Defined

The National Academies of Sciences, Engineering, and Medicine defines a diagnostic error as the failure to (a) establish an accurate and timely explanation of the patient’s health problem(s) or (b) communicate that explanation to the patient. Further subsets include:

- **A delayed diagnosis** refers to a case where the diagnosis should have been made earlier. Delayed diagnosis of cancer is by far the leading entity in this category. A major problem in this regard is that there are very few good guidelines on making a timely diagnosis, and many illnesses aren’t suspected until symptoms persist, or worsen.
- **A wrong diagnosis** occurs, for example, if a patient truly having a heart attack is told their pain is from acid indigestion. The original diagnosis is found to be incorrect because the true cause is discovered later.
- **A missed diagnosis** refers to a patient whose medical complaints are never explained. Many patients with chronic fatigue or chronic pain fall into this category, as well as patients with more specific complaints that are never accurately diagnosed. (1)

Other definitions for reference include:

**WHO**
A diagnostic error emerges when a diagnosis is missed, inappropriately delayed, or is wrong. Diagnoses can be completely missed (cancer missed despite symptoms), wrong (patients told they have one diagnosis when there is evidence of another,) or delayed (abnormal test results suggestive of cancer, but no one has told the patient). There may be overlaps in these classifications. Diagnoses often occur over time, rather than at one point in time, including initial assessment, performing, and interpreting diagnostic tests, follow-up and tracking of the introduction of diagnostic information, referral-related communication, and coordination, and patient behaviors, adherence, and engagement. Diagnostic errors can occur at each of these points. Diagnostic errors are a failure to provide an accurate and timely explanation of the patient’s health problems or communicate that explanation to the patient. They are considered missed opportunities to make a correct or timely diagnosis based on available evidence. The missed opportunity may result from cognitive or system factors or both. To reduce hindsight bias, there should be evidence of omission (failure to do the right thing) or commission (doing something wrong) at the point in time at which the error occurred.
The Joint Commission has renewed the national patient safety goal (NPSG.02.03.01) on the reporting of critical results of tests and diagnostic procedures on a timely basis. The rationale for this work is that “critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.”

**Included Populations:**
All inpatient and ED populations

**Fields to be reported**
- Adopt a definition of diagnostic error within hospital practice, policy, and/or procedure utilizing one of the examples above. (2 points)
- Adopt a method to identify diagnostic errors with current systems. (4 points)
- Upload close the loop data as specified below. (4 points)

**Data Collection period:**
July 1, 2022 - December 31, 2022

**Reporting deadline:**
30 days after the close of the performance period or by January 31, 2023

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

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

**Data Scoring:**
Upload a policy, procedure, or documentation (meeting minutes) that reflects the incorporation of a diagnostic error definition that will be utilized to identify diagnostic errors. (2 points)

Adopt one or more methods to identify diagnostic errors (up to 4 points)

- **Method 1a.** Use quality and safety data already being collected by your organization, such as your event reporting system, root cause analysis, and peer review. Provide a total number of diagnostic errors identified by this method for the six-months.

- **Method 1b.** Solicit reports from clinicians and staff, voluntary submission of “diagnostic learning opportunities”. Provide the total number of diagnostic errors identified by this method during the six-months.
• **Method 1c.** Leverage patient-reported data from feedback and complaints. Provide a total number of diagnostic errors identified by this method for the six-month period.

• **Method 1d.** Electronic health record-enhanced chart review, such as database queries and electronic triggers. Provide a total number of diagnostic errors identified for the six-month period.

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Adopt one of the above methods of identifying diagnostic errors and provide a count of Diagnostic errors identified by this method</td>
<td>1 point</td>
</tr>
<tr>
<td>2.</td>
<td>Adopt two of the above methods of identifying Diagnostic errors and provide a count of Diagnostic errors identified by method</td>
<td>2 points</td>
</tr>
<tr>
<td>3.</td>
<td>Adopt three or more of the above methods of identifying Diagnostic errors and provide a count of Diagnostic errors identified by method</td>
<td>4 points</td>
</tr>
</tbody>
</table>

Close the loop communication data
The process to manage critical results, established time frames and the definition of who is a responsible licensed caregiver is defined by the hospital’s policy.

**Labs results**
1. Numerator one - a count of lab tests that are critical and have been communicated to a responsible licensed caregiver within acceptable timeframe for one month during the performance period July 1, 2022, to December 31, 2022 for inpatient and ED units.
2. Numerator two - a count of the total number of lab results identified as critical from any one month during the performance period July 1, 2022, to December 31, 2022, for inpatient and ED units.
3. Denominator – total number of lab tests performed in one month of the performance period between July 1, 2022, to December 31, 2022, for inpatient and ED units.

**Diagnostic Imaging**
1. a) Numerator one - a count of radiology tests that are critical and have been communicated to responsible licensed caregiver within acceptable timeframe for any one month during July 1, 2022, to December 31, 2022, for inpatient and ED units.
2. Numerator two - a count of the total number of radiology results identified as critical from any one month during July 1, 2022, to December 31, 2022, for inpatient and ED units.
3. Denominator – total number of radiology tests performed in the performance period from one month between July 1, 2022, to December 31, 2022, for inpatient and ED units.
Data Scoring:

**Policy upload 2 points**

Methods adopt **one or more methods to identify diagnostic errors (up to 4 points)**

<table>
<thead>
<tr>
<th>Adopt one of the above methods of identifying diagnostic errors and provide a count of Diagnostic errors identified by this method</th>
<th>1 point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopt two of the above methods of identifying Diagnostic errors and provide a count of Diagnostic errors identified by method</td>
<td>2 points</td>
</tr>
<tr>
<td>Adopt three or more of the above methods of identifying Diagnostic errors and provide a count of Diagnostic errors identified by method</td>
<td>4 points</td>
</tr>
</tbody>
</table>

**Close the Loop Communication on critical lab and imaging results**

<table>
<thead>
<tr>
<th>Thresholds</th>
<th>Points Award 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 81% for overall close the loop timely communication on lab and imaging data critical results</td>
<td>1 point</td>
</tr>
<tr>
<td>81-97% for overall close the loop timely communication on lab and imaging data critical results</td>
<td>2 points</td>
</tr>
<tr>
<td>&gt; 97% for overall close the loop timely communication on lab and imaging data critical results</td>
<td>4 points</td>
</tr>
</tbody>
</table>
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)

Measure eligibility:
Adult and Pediatric hospitals with emergency room only; including “Stand-alone/Free-standing EDs.”

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. The WA State Third Engrossed Substitute House Bill 2127 set forth seven best practices aimed at reducing unnecessary emergency department use by Medicaid clients.

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 the payor that visits the emergency department in the state of Washington.

Selected References:
- MEASURE SPECIFICATION: potentially avoidable Emergency Room (ER) visits
  (wahealthalliance.org)

Definition:
Percent of Patients with five or more visits to the Emergency Room to the same facility with a Care Guideline.

Included Populations:
Adult and Pediatric hospitals with emergency rooms only; including “Stand-alone/Free-standing EDs.”

Fields to be reported

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.
Data Collection period:
July 1, 2022 - December 31, 2022

Reporting deadline:
30 days after the close of the performance period or by January 31, 2023

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

Data collection system:
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. NOTE: all stand-alone ER facilities that may be affiliated within a health system quality for this metric. Measure guidelines, numerator/denominator apply.

Data Scoring:
Data is based on the 2021 WSHA Hospital Performance Reports and divided into quartiles. Hospitals can obtain the full 10-point awards toward their incentive for completing 90% of their care guidelines in the calendar month by the facility for patients with five or more visits.

<table>
<thead>
<tr>
<th>Threshold</th>
<th>≤ =50</th>
<th>51% -75%</th>
<th>76% -89%</th>
<th>&gt;90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award 2022</td>
<td>0 points</td>
<td>3 points</td>
<td>5 points</td>
<td>10 points</td>
</tr>
</tbody>
</table>
Fall Prevention

Fall Prevention and Harm Reduction

Measure eligibility:
All hospitals that wish to participate in MQI are eligible to complete this metric.

Clinical Rationale:
The NDNQI defines a patient fall as an unplanned descent to the floor that may or may not result in injury.

Falls are consistently listed as one of The Joint Commission’s “Top 10” Sentinel Events reported to the database, with patient falls being the single largest reported harm in 2021\(^1\). While extensive clinical research and adult 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. Additionally, CMS considers “serious fall-related injury” to be one of the 14 acquired hospital-acquired conditions that are preventable and non-reimbursable. When falls occur, they can result in an additional 6.3 inpatient days with a cost of approximately ~$14k per patient. This accounts for up to 15% of re-hospitalizations within the first month. In 2015, medical costs for fall-related injuries were over $50 billion, which places a large financial burden on patients and healthcare organizations alike. 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.

Moreover, it has been estimated that 600 to 1,600 newborns in the United States experience an in-hospital fall/drop every year\(^2\) 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, breastfeeding, and second or third postpartum night, specifically around midnight to early morning hours. As a result of this increased risk, experts advise considering all newborns a high risk for newborn fall risk/drop in the absence of a validated assessment tool. Additionally, they recommend including a variety of strategies in a safety bundle including education, visual cues, checklists, intentional rounding, and processes focused on mitigating known risks\(^3,4\)

Selected References:
**Definition:**
https://members.nursingquality.org/NDNQIPortal/Documents/General/Guidelines%20-PatientFalls.pdf?linkid=s0_f776_m73_m230_a0_m236_a0_m242_a0.%20

**Included Populations:**
Inpatients, short-stay patients, emergency room, neonates, pediatrics, maternal ward, behavioral health, rehabilitation units, clinic patients listed under hospital license.

**Fields to be reported**
Total number of each the 7 identified categories in any licensed care area within the facility during the calendar month. Of note: if post fall huddle not completed following a fall, categories 3-7 may not be reported consistently each month.

1. All falls- a total number of all facility falls, with or without injury (whether assisted by a staff member or not).
2. Post Fall Huddle Completion
3. Type of fall
4. Age of patient
5. Repeat Fall
6. Gender of patient
7. Location of fall

**Data Collection period:**
July 1, 2022- December 31, 2022

**Reporting deadline:**
30 days after the close of the performance period or by January 31, 2023

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

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

**Data Scoring:**

All Falls

<table>
<thead>
<tr>
<th>Threshold</th>
<th>All Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award 2022</td>
<td>2 points</td>
</tr>
</tbody>
</table>

Post Fall Huddle Completion

<table>
<thead>
<tr>
<th>Threshold</th>
<th>60% - 79%</th>
<th>&gt;80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award 2022</td>
<td>1 point</td>
<td>2 points</td>
</tr>
</tbody>
</table>

Outcome Measures
A Fields 3 through 5

<table>
<thead>
<tr>
<th>Threshold</th>
<th>60% - 79%</th>
<th>&gt;80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award 2022</td>
<td>1 point</td>
<td>3 points</td>
</tr>
</tbody>
</table>

B Fields 6 through 7

<table>
<thead>
<tr>
<th>Threshold</th>
<th>60% - 79%</th>
<th>&gt;80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award 2022</td>
<td>1 point</td>
<td>3 points</td>
</tr>
</tbody>
</table>
Safe Deliveries Roadmap (SDR)

Emergency Department pregnant and postpartum triage

Measure eligibility:
All hospitals with an Emergency Department.

Clinical Rationale:
This metric is designed to improve the quality and safety of care provided to women during all stages of pregnancy and postpartum. Studies have shown that delays in the diagnosis and treatment of severe hypertension/preeclampsia and receipt of suboptimal treatment of severe hypertension/preeclampsia are linked with adverse maternal outcomes. Having clear procedures in place and educating staff around these procedures should decrease failures to recognize and treat severe hypertension/preeclampsia.

“Postpartum emergencies may include a variety of clinical presentations, ranging from minor concerns to life-threatening emergencies. Problems of pregnancy comprise 1.3% of emergency department (ED) visits annually. 1 About 25% of postpartum patients with pregnancy complications seek ED care within the six months following delivery. 2 Among postpartum patients, about 1% will require readmission. 3 The most common ED complaints include obstetric wound complication complications, fever, abdominal pain, breast complications, and hypertension. Common postpartum emergencies include pain, fever, hemorrhage, hypertension, preeclampsia, eclampsia, infection, and depression. ED management should include a thorough history, including the date and route of delivery, procedural complications, pregnancy history, and current symptoms.

The physical exam should include vital signs, and lung, cardiac, and abdominal examinations. Diagnostic studies should be ordered to address the specific emergency and may include focused assessment with sonography in trauma (FAST) examination or pelvic ultrasound. Management should include initial stabilization, followed by disease-specific treatment. Among ED visits for postpartum complications, approximately 22% will require readmission.” say authors Catherine Marco, Kelli Thomas & Walter Rzecznik in their monograph titled “Postpartum Emergencies” access at https://www.reliasmedia.com/articles/145171-postpartum-emergencies

Selected References:

Definition:
The MQI measure is comprised as outlined below.

Included Populations:
Women aged 12-50 were evaluated in the emergency room.

Fields to be reported

Numerator:
A random sample of 30 charts of women between 12 and 50 years of age who were seen in the emergency room between July 2022 and December 2022 and were screened for pregnancy or postpartum within the last year.

Denominator:
A random sample of 30 charts of all women between ages 12 and 50 was seen in the ER between July 2022 and December 2022.

Data Collection period:
July 1, 2022 - December 31, 2022

Reporting deadline:
30 days after the close of the performance period or by January 31, 2023

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

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

Data Scoring:
Data weighted by a percentage based on hospitals achieving screening of women aged 12-50 screened for pregnancy and postpartum within the last year.

Hospitals obtain point awards based on the percentage of 30 charts randomly reviewed that reveal documentation of recommended screening of women between ages 12-50 screened for pregnancy and postpartum within the last year.
<table>
<thead>
<tr>
<th>Threshold</th>
<th>40%-59%</th>
<th>60% - 79%</th>
<th>&gt;80%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Point Award 2022</strong></td>
<td>1 point</td>
<td>3 points</td>
<td>5 points</td>
</tr>
</tbody>
</table>
Safe Deliveries Roadmap (SDR)

Perinatal Substance Use Disorder (SUD)

Measure eligibility:
All acute care birthing hospitals that participate in MQI are eligible to complete this metric.

Clinical Rationale:
Pregnancy is a unique time to address the complex and challenging health needs of people with a substance use disorder. It’s an opportunity to provide interventions that can improve maternal and child health well beyond the perinatal period. Hospitals play a critical role in providing evidence-informed services and linkages to treatment.

In their most recent legislative report, the WA State Maternal Mortality Review Panel found that one of the leading underlying causes of pregnancy-related deaths were behavioral health conditions including suicide and overdose; and opioids were involved in most of the pregnancy-associated accidental overdose.

Selected References:

Definition:
National Institute of Mental Health (NIH) [https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health](https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health)

Included Populations:
All pregnant or postpartum patients being evaluated within the obstetrical unit.

Fields to be reported
Has your hospital implemented a universal screening of obstetrical patients using a validated substance use disorder screening tool? Answer Yes/No
If yes, upload policy/procedure/algorithm to QBS
If no, skip to Part A

- **Part A** – Has your hospital selected a validated screening tool and developed an implementation plan for the incorporation of the verbal screening tool?
  - Response options: Answer Yes/No
  - If yes, upload the implementation plan which includes the name of the tool If no, skip to Part B

- **Part B** -Has your hospital selected a validated verbal screening tool for substance use disorder?
  - Response options: Answer Yes/No
  - If yes, upload the tool
Data Collection period:
July 1, 2022 - December 31, 2022

Reporting deadline:
30 days after the close of the performance period or by January 31, 2023

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

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

Data Scoring:
Data and awards are scored on the submission of policy and tools. Hospitals upload policies and tools to receive full credit toward the incentive. Hospitals obtain 5-point awards for uploading their policy and tools.

If yes then upload the tool, timeline/plan to implement the screening tool, and screening tool selected.

If the answer is “no” to both parts, point value = 0

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Verbal screening tool selected</th>
<th>Verbal screening tool selected, and an implementation plan has been developed</th>
<th>Verbal screening fully implemented (implies that screening tool has been selected and plan implemented)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award 2022</td>
<td>1 point</td>
<td>3 points</td>
<td>5 points</td>
</tr>
</tbody>
</table>
Equity

Bias Reporting and Response

Measure eligibility:
All hospitals that wish to participate in MQI are eligible to complete this metric.

Clinical Rationale:
Unfortunately, despite codes of conduct, individuals may consciously or unconsciously engage in microaggressions, demonstrate negative biases, and express racist, sexist, xenophobic, homophobic, transphobic, or other discriminating beliefs and behaviors. These incidents of bias may be generated by or directed towards patients, visitors, or the healthcare workforce and adversely impact the experiences and wellbeing of others. The first step to reducing bias and encouraging safe and inclusive interactions in the healthcare setting is to establish a reporting system. Once incidents are easily and safely reported, timely review and appropriate response can begin to shift cultural norms and create accountability.

Selected References:
- Paul-Emile, K et al. Addressing Patient Bias Toward health Care Workers: Recommendations for Medical Centers. Annals of Internal Medicine, 2020 https://www.acpjournals.org/doi/10.7326/M20-0176; also see summary editorial
- UW Bias Reporting Tool, Initial Community Report February - May 2021

Definition:
The MQI Equity measure is comprised of two parts:

- **Part One** – Does your hospital have a bias reporting system or procedure?
  - Response options: Answer Yes/No

- **Part Two** – Does your hospital review and respond to reported incidents of bias?
  - Response options: Answer Yes/No

Included Populations:
This may apply to incidents experienced by patients, visitors, or the workforce.
Fields to be reported
If the hospital currently has a system or procedure to allow and encourage reporting of incidents of bias, then answer Yes to “Bias Reporting”. This may apply to incidents experienced by patients, visitors, or the workforce. Can enter Yes anytime during the data collection period.

If the hospital currently has a committee or policy guiding timely review and response to reported incidents of bias, then answer Yes to “Bias Response”. This may apply to incidents experienced by patients, visitors, or the workforce. Can enter Yes anytime during the data collection period.

In QBS, upload documentation illustrative of the bias reporting system describing how incidents are received and the committee or policy in place to review and respond to reported incidents of bias. This may include, for example, a committee charter or bias reporting tool and response team description.

Only an answer of Yes to both parts (report and respond) and upload of all required documents will allow eligible hospitals to receive full credit toward the incentive.

Data Collection period:
July 1, 2022 - December 31, 2022

Reporting deadline:
30 days after the close of the performance period or by January 31, 2023

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

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

Data Scoring:
Hospitals obtain point awards based on the submission of supporting data and documentation into the QBS data portal. Only an answer of Yes to both parts (reporting and response) and upload of required documentation in QBS will allow eligible hospitals to receive 10-point awards toward the incentive.
Bias Reporting (part one)

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Point Award 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer of yes AND upload of a description of the reporting system.</td>
<td>8 points</td>
</tr>
<tr>
<td>Answer of no, OR answer of yes and does NOT upload a description of the reporting system.</td>
<td>0 points</td>
</tr>
</tbody>
</table>

Bias Response (part two)

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Point Award 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer of yes AND upload of description of how reported incidents of bias are reviewed and responded to.</td>
<td>2 points</td>
</tr>
<tr>
<td>Answer of no, OR answer of yes and does NOT upload a description of how reported incidents of bias are reviewed and responded to.</td>
<td>0 points</td>
</tr>
</tbody>
</table>
Equity

Social Determinants of Health (SDOH) Screening and Referral

Measure eligibility:
All hospitals that wish to participate in MQI are eligible to complete this metric.

Clinical Rationale:
Screening patients is the first step in addressing social needs, a key determinant of health. Social determinants of health (SDOH) account for at least 80% of health outcomes. This SDOH metric promotes screening and identification of five core health-related social needs: housing instability, food insecurity, transportation, utilities, and interpersonal violence. In addition, it requires that appropriate action be taken when patients screen positive for a health-related social need, such as linkage to community-based resources.

Selected References:
- AHA Screening for Social Needs: Guiding Care Teams to Engage Patients
- Health Leads Screening Toolkit
- Core Determinants of Health Screening Tool, aka the “Core 5”
- CMS Accountable Health Communities Health-Related Social Needs Screening Tool
- Collaborative Screening: a person-centered approach to gathering information and following up with referrals in health and social service settings
- Bree Collaborative: Social Determinants of Health and Health Equity Recommendations, 2021

Definition:
The MQI Equity measure is comprised of two parts:

- **Part One** – Does your hospital conduct inpatient screening for housing instability, food insecurity, transportation, utilities, and interpersonal violence?
  - Response options: **Answer Yes/No**

- **Part Two** – Does your hospital have a policy or procedure to take action to address the identified health-related social needs, such as a warm handoff?
  - Response options: **Answer Yes/No**
**Included Populations:**
This measure is applicable to any patient and does not need to reflect universal screening.

**Fields to be reported**
If screening for all five health-related social needs (housing, food, transportation, utilities, interpersonal violence) is conducted for at least one unit or a defined patient population, then enter Yes. Can enter Yes anytime during the data collection period.

If the hospital has a policy or procedure in place to adapt care plans and/or direct patients to services to address the identified health-related social needs, then enter Yes. This may include referrals to social work, warm handoff procedures with community-based resources, or other program referrals. Can enter Yes anytime during the data collection period.

In QBS, upload a copy of the SDOH screening questions or data fields for all five social needs and describe how the data is used to address individual social needs or generate referrals. Only an answer of Yes to both parts (screening and referral) and upload of all required documents will allow eligible hospitals to receive full credit toward the incentive.

**Data Collection period:**
July 1, 2022 - December 31, 2022

**Reporting deadline:**
30 days after the close of the performance period or by January 31, 2023

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

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

**Data Scoring:**
Hospitals obtain point awards based on the submission of supporting data and documentation into the QBS data portal. Only an answer of Yes to both parts (screening and referral) and upload of required documentation in QBS will allow eligible hospitals to receive 10-point awards toward the incentive.
**SDOH Screening (part one)**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Answer of yes <strong>AND</strong> upload of 5 SDOH screening questions or data fields</th>
<th>Answer of no, OR answer of yes and does <strong>NOT</strong> upload 5 SDOH screening questions or data fields</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Point Award 2022</strong></td>
<td>2 points</td>
<td>0 points</td>
</tr>
</tbody>
</table>

**SDOH Referral (part two)**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Answer of yes <strong>AND</strong> upload of description of how identified SDOH needs are addressed</th>
<th>Answer of no, OR answer of yes and does <strong>NOT</strong> upload a description of how identified SHOD needs are addressed</th>
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</thead>
<tbody>
<tr>
<td><strong>Point Award 2022</strong></td>
<td>8 points</td>
<td>0 points</td>
</tr>
</tbody>
</table>
Climate Change

Survey on Climate Change and Health

Measure eligibility:
All hospitals that wish to participate in MQI are eligible to complete this metric.

Clinical Rationale:
Extreme weather events and climate events are increasingly impacting population health. The increased frequency of heatwaves, wildfires, flooding, and water- and vector-borne illnesses all pose a risk to the health of the population of WA state.

These risks are unevenly distributed and have the potential to exacerbate preexisting inequities. Individuals who suffer from chronic disease, immunocompromised status, or who have lower socioeconomic status are more vulnerable to climate-associated health risks.

Additionally, these events may also cause disruptions in the delivery of healthcare and constrain hospitals’ and health systems’ ability to provide high-quality care. As extreme weather events intensify, they may ultimately lead to increased hospital crowding, the intermittent need for hospital evacuations, transportation disruption, and supply-chain disruptions.

The health sector is also a significant contributor to the greenhouse gas emissions that may result in damaging impacts as noted above. National estimates suggest that the US health care sector is responsible for between 8-10 percent of GHGs in the US.

Selected References:

Definition:
Complete the survey about climate change measure in your hospital for additional MQI point awards.

Included Populations:
The general population served by the hospital
**Fields to be reported**
Submission of your hospital’s climate survey by September 30, 2022, to obtain the full point awards.

Answer the following questions:

- What environment/climate conditions has your organization had to take action to respond to?
- What projects, programs, practices or policies do you have regarding how you are addressing population health in the context of these environmental/climate conditions?
- OPTIONAL: Are you creating a plan for prevention or emergency preparedness? Does your organization currently measure and/or share performance and gaps associated with your response to climate-related events? For example: do you measure harm to vulnerable populations as a result of such events, or extend service disruption?
- To what degree does your organization have projects, programs, practices, or policies that address environmental sustainability practices?
  - Please rate the below on a scale of 1-5, according to the following reference:
    - 1 haven’t started yet
    - 2 just starting or new to this work
    - 3 we have some things in place and are tracking
    - 4 we continue to refine our initial plans and continue to add new ways to impact our goals
    - 5 we’ve taught other organizations about how to manage and measure progress on this topic
  - Environmental Sustainability practices:
    - Waste reduction (including total waste and food waste)
    - Energy efficiency
    - Water conservation
    - Chemical use reduction
    - Transportation emission reduction
    - Improving sustainable purchasing of supplies/equipment
    - Other (blank paragraph, not on a scale)
  - How do you measure progress in any of the above topics?
  - Do you measure greenhouse gas emissions? If so, how? If not, do you have plans to?

**Data Collection period:**
July 1, 2022 - September 30, 2022

**Reporting deadline:**
Hospitals have until September 30, 2022, to respond to the survey on climate change to inform decisions about future measures.

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

**Data Scoring:**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Complete the survey about climate change measure to attain point awards</th>
<th>Does NOT complete the survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award 2022</td>
<td>10 points</td>
<td>0 points</td>
</tr>
</tbody>
</table>