Washington State:
Medicaid Quality Incentive Measure Guidelines

July 1, 2023

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, contactthe Health Care Authority staff Dr. Judy Zerzan-Thul (Judy.Zerzan@hca.wa.gov), or Washington State Hospital Association staff Cat Mazzawy (CatM@wsha.org).

Hold Control + Click to Jump to the sections below.

Infection Prevention:

- Antimicrobial Stewardship (AMS) Training for prescribers and pharmacists
- **NEW**- Infection Prevention and Control – Training for Prescribers and pharmacists

Sepsis:

- **NEW**- Sepsis Protocols and Education

Equity:

- Bias Reporting System
- **NEW**- Health Disparities Action Plan
- SDOH Screening and Consultation

Diagnostic Excellence:

- Diagnostic Excellence: identify potential or actual diagnostic errors in current processes

Behavioral Health:

- Behavioral Health Fall Prevention and Harm Reduction
- Distributing opioid overdose reversal medication in emergency departments and behavioral health settings

Seclusion and Restraint:

- **NEW**- Seclusion and Restraint

Workforce Safety:

- Workplace Violence (WPV)

Safe Deliveries Roadmap:

- Screening for Pregnancy and Postpartum Status in Emergency Department Triage
- Medication for Opioid Use Disorder (MOUD) Protocol, Perinatal Substance Use Disorder (SUD)

Climate Change:

- Climate Change: Monitoring of Greenhouse Gas Emissions

Infection Prevention

Antimicrobial Stewardship (AMS) Training for Prescribers and pharmacists

Measure 1 **Contact Person**	**Sandra Assasnik, (206) 577-1805 or (503) 526-2016 (cell)**
Measure eligibility:	All acute care hospitals that participate in MQI are eligible to complete this metric
Why:	During 2021 and 2022 IPC Committee identification and prioritization of Infection Prevention and Control metrics and processes, members identified and prioritized AMS as one of the two top concerns. The IPC Committee helped to formulate and approve this metric over several months of meetings. They needed motivation to push forward AMS training for prescribers and pharmacists and felt that the MQI Program can play a major role in accomplishing this quality effort.
Clinical Rationale:	New CDC data states more than half of antibiotic prescribing for selected events in hospitals was not consistent with recommended prescribing practices. Antibiotic prescribing was not supported in: 79% of patients with community-acquired pneumonia, 77% of patients with urinary tract infections, 47% of patients prescribed fluroquinolone treatment, and 27% of patients prescribed intravenous vancomycin antibiotic. Hospital prescribers and pharmacists can improve antibiotic prescribing by optimizing antibiotic selection, re-assessing antibiotic treatment when the results of diagnostic testing are available, and using the shortest effective duration of therapy. Optimizing the use of antibiotics is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance. Antibiotic Stewardship Programs (ASPs) can help clinicians improve clinical outcomes and minimize harms by improving antibiotic prescribing. Hospital antibiotic stewardship programs can increase infection cure rates while reducing): • Treatment failures • *C. difficile* infections • Adverse effects • Antibiotic resistance • Hospital costs and lengths of stay The CDC has 7 core elements of hospital antibiotic stewardship, but there is no single template to optimize a program for antibiotic prescribing. The three fields identified by the IPC Committee for this MQI AMS measure contribute to establishing some standardized statewide elements that all hospitals can engage in to improve quality and safety. Standardized measures can help complex care show its value in improving outcomes and evaluating delivery and impact. This effort in improving AMS can be rewarded through MQI. • https://academic.oup.com/cid/article/44/2/159/328413

	• https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003543.pub4/pdf/full • https://journals.asm.org/doi/full/10.1128/AAC.00825-16 • https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(17)30325-0/fulltext • https://www.nationalcomplex.care/wp-content/uploads/2020/05/Quality-measures-report_final.pdf
Definition:	CDC definitions and how to improve hospital antibiotic use and help fight antibiotic resistance are located here: https://www.cdc.gov/antibiotic-use/core-elements/hospital/implementation.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fantibiotic-use%2Fcore-elements%2Fimplementation.htm Free CDC healthcare professional training with CEs is available here: https://www.train.org/cdctrain/training_plan/3697. Any course that fulfills Improvement Activities (IA) Patient Safety and Practice Assessment (PSPA)_23 and PSPA_24 under the Centers for Medicare & Medicaid Services (CMS) Merit-Based Incentive Programs, or MIPS may be used.
Included Populations: **Exclusions:**	All populations served by the hospital. No exclusions.
Fields to be reported:	a) Attestation that the antibiotic stewardship physician and/or pharmacist leaders have completed infectious diseases specialty training, a certificate program or other training on antibiotic stewardship and that personnel files document this (see definition). b) Percent of prescribers and pharmacists (direct employees, contracted employees, residents, interns, and full and part-time employees) who have received annual training on AMS c) Upload of hospital policy for AMS that includes a description of "a" and "b" above. There is no single template for a program to optimize antibiotic prescribing in hospitals. Implementation of antibiotic stewardship programs requires flexibility due to the complexity of medical decision-making surrounding antibiotic use and the variability in the size and types of care among U.S. hospitals. • https://www.cdc.gov/antibiotic-use/core-elements/hospital.html#:~:text=Antibiotic%20Stewardship%20Programs%20(ASPs)%20can,Treatment%20failures
	July 1, 2023 - December 31, 2023

Reporting deadline:	30 days after the close of the performance period or by January 31, 2024.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Once during the performance period from July 1, 2023, to December 31, 2023.
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	a) 3 points for attestation that the appointed leader(s) for AMS have completed infectious diseases specialty training, a certificate program or other training on antibiotic stewardship and that personnel files document this. b) 3 points are provided for providing the percent of current prescribers and pharmacists who have received training on AMS. c) 4 points for upload of hospital policy for AMS that includes a description of "a" and "b" above. Ten points are possible.

Thresholds	a) Attestation that the appointed leader(s) for AMS have completed infection diseases specialty training (see above)	b) Providing the percent of current prescribers and pharmacists who have received training on AMS (see above)	Upload of hospital policy for AMS that includes a description of (a) and (b).
Point Awards 2023	3 points	3 points	4 points

Infection Prevention

NEW- Infection Prevention and Control- Emerging pathogen (also called emerging infection diseases – "EIDs") preparedness & response.

Measure 2 Contact Person	**Sandra Assasnik, (206) 577- 1805 or (503) 526-2016 (cell)**
Measure eligibility:	All acute care hospitals that participate in MQI are eligible to complete this metric.
Why:	During 2021 and 2022 IPC Committee identification and prioritization of Infection Prevention and Control metrics and processes, members identified and prioritized preparation for EIDs as one of the two top concerns. The IPC Committee helped to formulate and approve this metric over several months of meetings. They needed motivation to push forward this metric especially after the COVID-19 pandemic and felt that the MQI Program can play a major role in accomplishing this quality effort.
Clinical Rationale:	The World Health Organization warned in its 2007 report that infectious diseases are emerging at a rate that has not been seen before. Since the 1970s, about 40 infectious diseases have been discovered, including SARS, MERS, Ebola, chikungunya, avian flu, swine flu, Zika and most recently COVID-19, caused by a new coronavirus, SARS-CoV-2. EIDs not only threaten public health, but also stress the surrounding health care infrastructure, including hospitals. Receiving EID cases requires hospitals to learn about the disease pathology and recommended protocols, and may require substantial staff training, additional equipment, and supplies. The Medicare Conditions of Participation (CoP) requires hospitals to have policies and procedures to prepare for potential emergencies, and to also operate programs to prevent, control, and investigate infectious and communicable diseases. According to the Office of Inspector General, state survey agencies only performed these surveys at about 13 percent of accredited hospitals and had not performed any in 13 States because of CMS's limited authority over accredited hospitals. As a result of these limitations, CMS could not ensure that accredited hospitals would continue to provide quality care and operate safely during the COVID 19 emergency, and cannot ensure quality and safety at accredited hospitals when a future emerging infectious disease threatens the United States.
Definition:	The term "emerging infectious diseases" refers to diseases of infectious origin whose incidence in humans has either increased within the past two decades or threatens to increase in the near future. https://pubmed.ncbi.nlm.nih.gov/25121245/
Included Populations:	EIDs must be considered for all populations served by the hospital.

Fields to be reported: Hospitals shall attest that they are in compliance with CoP regarding EIDs.	For this MQI measure, hospitals shall attest that they have reviewed and validated that their emergency plans addresses potential EIDs and includes: compliance with all requirements regarding four core elements of emergency preparedness: (1) annually updating emergency plans using an "all hazards" approach that encompasses a range of potential emergencies (although not specifically EIDs); (2) developing and maintaining a communication plan for interacting with other entities involved in disaster response; (3) developing and maintaining policies and procedures that include both the emergency plan and the communication plan; and (4) developing and maintaining an emergency training program, testing the plan annually, and making revisions based on the results of exercises, which could include both "tabletop" exercises and full-scale drills. Examples of contents and elements include: 1. https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals 2. https://www.cdc.gov/mmwr/preview/mmwrhtml/00031393.htm
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Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Once during the performance period from July 1, 2023, to December 31, 2024.
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	Answer all 4 questions for 10 points Is your hospital? (1) annually updating emergency plans using an "all hazards" approach that encompasses a range of potential emergencies (although not specifically EIDs). Yes or No (2) developing and maintaining a communication plan for interacting with other entities involved in disaster response. Yes or No (3) developing and maintaining policies and procedures that include both the emergency plan and the communication plan. Yes or No

	(4) developing and maintaining an emergency training program, testing the plan annually, and making revisions based on the results of exercises, which could include both "tabletop" exercises and full-scale drills. Yes or No The hospital must answer all questions full points. Full 10 points will be obtained for answering either yes or no for all of the questions.

Thresholds	Answer all the questions regardless of (yes or no) answers
Points Awards 2023	10 points

Sepsis

NEW- Sepsis Protocols and Education

Measure 3 Contact Person	Rosemary Grant, (206) 216-2516
Measure eligibility:	All acute care hospitals including free-standing psychiatric facilities that participate in MQI are eligible to complete this metric
Why?	Prompt recognition and treatment of patients with sepsis is key to reducing mortality so educating clinical staff about sepsis is fundamental to improving patient outcomes. WSHA is asking hospitals what protocols/policies/procedures and educational cadence are currently in place regarding sepsis in their facilities. Future measures around sepsis may look at specific elements of the protocols/policies/procedures and/or about the percentage and/or cadence of staff trained in these protocols/policies/procedures.
Clinical Rationale:	Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have triggers a chain reaction throughout your body. Infections that lead to sepsis most often start in the lung, urinary tract, skin, or gastrointestinal tract. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death. Delaying recognition and treatment of sepsis has a significant impact on mortality. According to Kumar (2006) for every hour of delay in initiation of antibiotics, survival decreases by 7.6%. There is evidence that requiring sepsis protocols for timely recognition and treatment decreases mortality (Gigli, 2021).
Definition:	Answer the questions about sepsis protocols and education for full MQI point award. Full points will be awarded for both yes and no answers.
Included Populations: **Exclusions:**	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. No exclusions.
Fields to be reported:	Three questions to be answered by the hospital: 1. Does your hospital have a sepsis policy, protocol, or procedure? If yes, please submit. 2. Are all relevant clinical staff required to complete education on the signs and symptoms of sepsis and/or of the sepsis policy, protocol, pathway, or procedure during orientation/onboarding (within the first 60 days of employment)? If yes, answer next question. If no, no further questions. 3. Are all relevant clinical staff required to complete yearly refresher training on the signs and symptoms of sepsis and/or of the sepsis policy, protocol, pathway, or procedure?

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<tr><td>Data collection system:</td><td>Washington State Hospital Association Quality Benchmarking System, QBS.</td></tr>
<tr><td>Data Scoring:</td><td>10 points awarded regardless of the answer “yes” or “no” for answering all eligible questions.
<table>
<tr><td>Thresholds</td><td>Answer all the questions regardless of (yes or no) answers</td></tr>
<tr><td>Points Awards 2023</td><td>10 points</td></tr>
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Equity

Bias Reporting System

Measure 4 Contact Person	Abigail Berube, (206) 216 -2544
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric. Critical Access Hospitals (CAH) are not eligible to receive the incentive payment.
Why?	For the first time, in 2022, Bias Reporting was introduced as an MQI measure. This inaugural measure sought to incentivize the uptake of systems to allow for low-barrier reporting of bias in the healthcare setting. Upon review of the submitted data, we found basic criteria met by most hospitals in 2022 in the form of attesting to existing policies: Patient/Visitor reporting was primarily captured through Grievance Procedure and Non-Discrimination Policy; the purpose of data collection was on resolution with patient/family; and reports were primarily reviewed and investigated by Risk Management, Compliance, and Civil Rights Coordinator, Patient Experience Professional. Workforce reporting was primarily captured in Harassment and Code of Conduct Policies; clear protections regarding illegal sexual harassment or discrimination were noted, but not microaggressions; workforce reports were reviewed and investigated by HR. In reviewing 2022 data, it became clear that while these policies are foundational, a true Bias Reporting System would complement these systems and provide better insight into cultural “blind spots” needed to direct change. The measure was reviewed and modified by the WSHA Health Equity MQI Review Committee to stipulate components that ensure an effective system. The new measure, Bias Reporting Systems, for 2023 replaces the old measure and now requires documented attestation for each of the criteria, in addition to the use of training and specific policy language.
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 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. Bias Reporting Systems go beyond anti-harassment policies and regulatory non-discrimination requirements and provide a safe way for all employees, patients and visitors to share problematic behavior and discriminatory practices. They

	are complementary to established HR and risk-management practices but to not focus solely on reducing hospital liability and conducting individual investigations. Instead, bias reporting should collect data in a way that allows for organizational learning and to guide culture change as a system. This measure builds on the previous Bias Reporting and Response MQI measure to include specific aspects of bias reporting systems. Hospitals are encouraged to build on existing infrastructure to meet the components listed in the measure. To protect the anonymity of reporters, hospitals are encouraged to make the bias reporting system available to all departments instead of piloting with small teams or individual units. **Selected References:** 1. Paul-Emile, K et al. Addressing Patient Bias Toward Health Care Workers: Recommendations for Medical Centers. Annals of Internal Medicine, 2020 https://doi.org/10.7326/M20-0176; also see summary editorial 2. Warsame RM and Hayes SN. Mayo Clinic's 5-Step Policy for Responding to Bias Incidents. AMA Journal of Ethics, 2019. 3. UW Bias Reporting Tool, Initial Community Report Feb-May 2021
Definition:	The Bias Reporting System measure is comprised of three parts: 1.) Bias Defined: Is "bias" defined and explained in your workforce anti-harassment policy, patient non-discrimination policy and codes of conduct? 2.) Is education provided to all staff on what is "bias" and how it manifests in healthcare? For example, what is a microaggression, what is unconscious bias and how to report experiences using bias reporting systems. 3.) Bias System: Does your Bias Reporting System include the following (must attest to all 7 components to receive credit): • Allows for anonymous reporting • Assures anti-retaliation, closes the loop with the reporter and shares action or next steps • Available to patients, visitors and workforce • Reviewed by personnel trained in diversity, equity and inclusion principles or unconscious bias • Quantifies the categories of report types which is able to be summarize in a report to inform culture change • At least annually, informs key stakeholders including leaders, licensed practitioners, and staff • Includes described approach for addressing bias through culture change.

Included Populations: **Exclusions:**	The Bias Reporting System must be accessible to patients, visitors and workforce. No exclusions.
Fields to be reported:	1.) Bias Defined: If the hospital currently has "bias" defined and explained in its workforce anti-harassment policy, and patient non-discrimination policy and codes of conduct, then answer Yes to "Bias Defined". Can enter Yes anytime during the data collection period. In QBS, upload copy of policies with "bias" defined (suggest merging multiple policies into one doc) 2.) If education provided to all staff on what is "bias" and how it can show up (For example, what is a microaggression and how to report using bias reporting systems), then answer Yes to "Bias Education" Can enter Yes anytime during the data collection period. 3.) Bias System: If the hospital currently has a Bias Reporting System that meets the following 7 criteria: • Allows for anonymous reporting • Assures anti-retaliation, closes the loop with the reporter and shares action or next steps • Available to patients, visitors and workforce • Reviewed by personnel trained in diversity, equity and inclusion principles or unconscious bias • Quantifies the categories of report types and able to summarize in a report to inform culture change • At least annually, informs key stakeholders including leaders, licensed practitioners, and staff • Includes described approach for addressing bias through culture change then answer Yes to "Bias System". This reporting system must be accessible to patients, visitors and workforce. Can enter Yes anytime during the data collection period. In QBS, upload documentation describing how the Bias Reporting System meets all 7 criteria. Template available upon request. Note: Patient Grievance policies and Severe Event Incident Reporting are not appropriate for this measure, these policies and procedures should exist IN ADDITION to Bias Reporting Systems. Only an answer of Yes to all parts and upload of all required documents will allow eligible hospitals to receive full credit toward the incentive.

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<tr><td>Data collection system:</td><td>Washington State Hospital Association Quality Benchmarking System, QBS.</td></tr>
<tr><td>Data Scoring:</td><td>To receive all 10 points:

Define “bias” in policies (y/n) and upload policy: 2 points
Attest to providing bias edu (y/n): 2 points
Attest to bias system with 7 components (y/n) and upload documentation describing how all components are met: 6 points

<table>
<tr><th>Thresholds</th><th>Define “bias” in policies (y/n) AND upload policy</th><th>Attest to providing bias education (y/n)</th><th>Attest to bias system with 7 components (y/n) AND upload documentation describing how all components are met</th></tr>
<tr><td>Point Awards 2023</td><td>2 points</td><td>2 points</td><td>6 points</td></tr>
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Equity

NEW- Health Disparities Action Plan

Measure 5 **Contact Person**	**Abigail Berube, (206) 216- 2519**
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric. Critical Access Hospitals (CAH) are not eligible to receive the incentive payment.
Why?	This new measure aligns with The Joint Commission Requirements to Reduce Health Care Disparities Elements of Performance #3 and #4. (TJC R3) as well as CMS IQR Hospital Commitment to Health Equity measure (Domain 1). As hospitals progress in consistently collecting patient demographics (race, ethnicity, language, sexual orientation, gender identity and disabilities) and screening for health-related social needs (housing, food, transportation, utilities, violence), there is a need to transform data into action. This measure incentivizes all MQI eligible hospitals to take a closer look at one health disparity and develop a meaningful action plan. This measure provides additional guidance not currently part of the Joint Commission or CMS measures, to ensure that health disparities action plans are developed with the community and communicated transparently. It is our hope that this measure brings together collaborative sharing between hospitals to accelerate this important work.
Clinical Rationale:	Healthcare disparities are experienced by racial/ethnic minorities, people who prefer to speak a language other than English, gender minorities, older patients, people with disabilities, and other historically marginalized groups.[1] Therefore, it is essential for organizations to conduct analyses to understand the specific disparities that may exist at their institution. This process begins with stratifying existing measures hospital clinical measures.[2-4] Addressing health care disparities often involves the coordination of efforts across multiple departments and programs (including quality and safety) and should include the co-design and partnership of patients directly impacted by the disparity. Action planning to close the disparity gap may include staff training, new workflows, and improvements to the organization's ability to screen and address patients' health-related social needs. This is a new MQI Equity Measure and aligns with The Joint Commission Requirements to Reduce Health Care Disparities Elements of Performance #3 and #4. (TJC R3) **Selected References:** 1. Smedley, B., Stith, A., & Nelson, A. (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington, D.C.: National Academy Press.

	2. Centers for Medicare & Medicaid Services. (2021). Building an organizational response to health disparities. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf 3. O'Kane, M., Agrawal S., Binder, L., Dzau, V., Gandhi, T., Harrington, R., Mate, K., McGann, P., Meyers, D., Rosen, P., Schreiber, M., & Schummers, D. (2021). An equity agenda for the field of health care quality improvement. NAM Perspectives. National Academy of Medicine. Washington, DC. doi: 10.31478/202109b 4. Health Research & Educational Trust. (2014). A framework for stratifying race, ethnicity and language data. www.hpoe.org
Definition:	The Health Disparities Action Plan measure has one part: 4.) Complete a Health Disparities Action Plan including the following (must include all 5 components to receive credit): • A specific hospital clinical quality or process measure that has been stratified by patient socio-demographics to identify a health disparity (For example, measures may be stratified by identity such as race, ethnicity, language, disability, sexual orientation, gender or an indicator of socioeconomic status such as payer or zip code, health related social needs such as housing instability, food insecurity or transportation access) • Root cause analysis of the underlying contributors to the identified disparity • Patient/community engagement by those most impacted by the health disparity • An implementation plan specifically addressing the disparity, not broadly applicable to development of community health and wellbeing • A plan to report to a governing body or committee with oversight (ie. quality committee or board) Note: The Health Disparities Action Plan needs to only detail one disparity with an accompanying in-depth action plan and does not need to reflect the breadth of health equity activities undertaken at the participating hospital. The identified health disparity does NOT need to be a social driver of health (SDOH). Hospitals are encouraged to review available patient demographic data, including payer and geography, to identify disparities within their patient populations.
Included Populations: **Exclusions:**	The Health Disparities Action Plan must center on a historically marginalized population served by the hospital. No exclusions.

Fields to be reported:	1.) If the hospital currently has a Health Disparities Action Plan that includes all of the following 5 components: • A specific hospital clinical quality or process measure that has been stratified by patient socio-demographics to identify a health disparity • Root cause analysis of the underlying contributors to the identified disparity • Patient/community engagement by those most impacted by the health disparity • An implementation plan specifically addressing the disparity, not broadly applicable to development of community health and wellbeing • A plan to report to governing body or committee with oversight (ie. quality committee or board) then answer Yes to "Health Disparities Action Plan". Can enter Yes anytime during the data collection period. In QBS, upload your Health Disparities Action Plan that meets all 5 components. Template available upon request. Note: A hospital's Community Health Needs Assessment (CHNA) and Implementation Plan may not meet this criteria. The Health Disparities Action Plan must provide data on a specific disparity using hospital data and is not synonymous with community benefit or community health improvement services. Only an answer of Yes and upload of all required documents will allow eligible hospitals to receive full credit toward the incentive. Recommend submitting early, WSHA will be able to provide review and feedback prior to Nov.
Data Collection period:	July 1, 2023 - December 31, 2023
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Once during the performance period from July 1, 2023 to December 31, 2023.
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.

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<tr><td>Data Scoring:</td><td>To receive 10 points (all or nothing):
• Attest to action plan with all 5 components (y/n)
• Upload Disparities Action Plan

<table><tr><td>Thresholds</td><td>Attest to action plan with all 5 components (y/n)

Upload Disparities Action Plan</td></tr><tr><td>Point Awards 2023</td><td>10 points</td></tr></table></td></tr>
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Equity

SDOH Screening and Consultation

Measure 6 Contact Person	Abigail Berube, (206) 216-2544
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric. Critical Access Hospitals (CAH) are not eligible to receive the incentive payment.
Why?	2023 is the fourth year that MQI has included a measure pertaining to SDOH screening. Overall, uptake by hospitals of screening for at least 3 core health related social needs has been high and major EHR vendors have released enhancements that make documenting social needs much faster and easier. Previous SDOH measures have been primarily structural, uploading policies and screening questions. Beginning in 2023, this measure will now focus on the process, hospitals will enter the number of patients screened. Future measures may set targets for screening rates, with the goal of working towards universal screening. Last year (2022), hospitals were incentivized to share policies for the "action" or referral outlined in a policy or procedure. Similar to screening, this component has shifted from a structural measure (attestation) to a process measure (count of patients screened positive who received consultation). Additional points will be awarded to hospitals who are able to respond to at least 80% of patients who screen positive. The purpose of this point attribution is to incentivize the thoughtful rollout of screening, to ensure that patients who are screened can also be appropriately supported with staff and resources. While universal screening is the long-term goal, we recognize it takes time and creativity to design and implement effective workflows and community partnerships for addressing patient health related social needs.
Clinical Rationale:	Screening patients is the first step in addressing social needs, a key driver of health. Social drivers 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. The goal should be for hospitals to universally screen all patients including patients of all races, ethnicities and patients speaking languages other than English for SDOH needs. As many hospitals are still in the process of scaling up screening efforts, the 2023 measure scoring is not dependent on the percent screened this year. Points are awarded for reporting the proportion of patients screened stratified by race, ethnicity and language; there is no threshold or target this year. In addition, this measure requires that appropriate action be taken when patients screen positive for a health-related social need, such as consultation with case

	management or social work. The highest number of points will be awarded to hospitals who are able to respond to at least 80% of patients who screen positive. Again, we urge hospitals to thoughtfully scale up screening efforts to be able to respond in a timely meaningful way to needs that are identified. This measure builds on the SDOH MQI measures from previous years by moving away from structural measures requiring attestation and policy evidence to process measures on screening and action. **Selected References:** 1. AHA Screening for Social Needs: Guiding Care Teams to Engage Patients 2. Health Leads Screening Toolkit 3. Core Determinants of Health Screening Tool, aka the "Core 5" 4. CMS Accountable Health Communities Health-Related Social Needs Screening Tool 5. Collaborative Screening: a person-centered approach to gathering information and following up with referrals in health and social service settings 6. Bree Collaborative: Social Determinants of Health and Health Equity Recommendations, 2021 7. CMS Inpatient Quality Reporting (IQR) program, SDOH measure rationale and specifications, 2023
Definition:	SDOH Screening and Consultation measure is comprised of two parts: 5.) Report the number of inpatients screened upon admission or prior to discharge for all of the following core SDOH needs (housing instability, food insecurity, transportation, utilities and interpersonal violence), stratified by race, ethnicity and language. Do not include ED patients who are not admitted. Note: This measure is specific to screening for SDOH in an inpatient setting. For hospitals who are screening in ambulatory settings, if your clinical team is able to review recent SDOH screening results with a patient, the screening may instead be a review and confirmation of current data. 6.) For patients who "screen positive" for a SDOH, report number of patients with documentation showing that action was taken to address the need(s). This may consist of a consultation with case management, social work or a navigator for example. A referral without documentation of whether the referral took place will not be accepted. Hospitals do not need evidence of closed loop communication because access to community information exchanges (CIEs) are not yet widely available.

	Note: This measure is specific to screening for SDOH in an inpatient setting. For hospitals who are screening in ambulatory settings, if your clinical team is able to review recent SDOH care plan with a patient, the "action" may instead be a review and confirmation of current care plan or making adjustments or updates taking into consideration any new complications.
Included Populations: **Exclusions:**	Pediatrics, adult patients and specialty patients. Exclude patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay. This exclusion pertains to patients who pass away prior to discharge or are transferred out of the hospital.
Fields to be reported:	1.) Report the number of patients screened for <u>all</u> of the following core SDOH needs (housing instability, food insecurity, transportation, utilities and interpersonal violence) prior to discharge over the 6-month reporting period; admitted July 1st to Dec 31st 2023. **Numerator:** The numerator consists of the number of patients admitted to an inpatient hospital and are screened for <u>all</u> of the following five SDOH: Housing instability, food insecurity, transportation needs, utility difficulties, and interpersonal violence during their hospital inpatient stay. **Denominator**: The denominator consists of the number of patients who are admitted to a hospital inpatient stay between July 1st to Dec 31st 2023. **Exclusion**: The following patients will be excluded from the denominator: (1) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay, (2) patients who pass away prior to discharge or are transferred out of the hospital. **Report** the number of patients who "opted-out" of screening and include this data in stratification by race, ethnicity and language (REaL stratification). **Stratification**: Stratify counts by race, ethnicity and language. In QBS, manually enter in the numerator and denominator and count of screening "Opt-outs." Upload an Excel file with the screening rate and opt-outs stratified by race, ethnicity and language. 2.) For patients who "screen positive" for a SDOH, report on number of patients with documentation showing that action was taken to address the need(s). This may consist of a consultation with case management, social work or a navigator for example. Note, an order or referral is <u>not</u> sufficient to count as "action taken." Note, if hospital stay is very brief, the action can take place immediately post-discharge.

	Option 1: Run report for patients who screen positive for SDOH and look for referral triggered. Validate through query of the notes if the consult took place or if follow-up happened with a community service provider. **Option 2:** Audit a random sample of 60 charts for patients who screened positive between July 1, 2023 and December 31, 2023 and review to note who received consults or warm handoffs to community service providers. In QBS, manually enter the **numerator** of patients who screened positive and received a consult or warm handoff and **denominator** of patients who screened positive for SDOH. Include **upload** of excel file with stratification by race, ethnicity and language.
Data Collection period:	July 1, 2023 - December 31, 2023
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Once during the performance period from July 1, 2023 to December 31, 2023. Submit between January 1st 2024 and January 31, 2024. *May lock the ability for early submissions prior to Jan 1 *Potentially give until Feb 15th to submit (signoff needed from WSHA)
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.

<table>
<tr><td>Data Scoring:</td><td>
To receive all 10 points:

Count of patients screened (numerator), count of inpatients (denominator), count of opt-outs and upload of stratification by REaL: 4 points
Note: There is no screening threshold. Points this year are awarded for submitting this data, not for the percent screened.
Count of patients screened positive with action (numerator), count of patients screened positive (denominator) and upload of stratification by REaL: 4 points
If at least 80% of patients screened positive have received action: 2 points

<table>
<tr><td>Thresholds</td><td>Count of patients screened (numerator), count of inpatients (denominator), count of opt-outs and Upload of stratification by REaL:</td><td>Count of patients screened positive with action (numerator), count of patients screened positive (denominator) and Upload of stratification by REaL</td><td>If at least 80% of patients screened positive have received action</td></tr>
<tr><td>Point Awards 2023</td><td>4 points</td><td>4 points</td><td>2 points</td></tr>
</table>
</td></tr>
</table>

Diagnostic Excellence

Diagnostic Excellence: identify potential or actual diagnostic errors in current processes

Measure 7 **Contact Person**	**Trish Anderson, (206) 216-2524**
Measure eligibility:	All acute, psychiatric/BH, rehab and children's hospitals that participate in MQI are eligible to complete this metric.
Why?	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 healthcare system as it does on the diagnosticians (providers) themselves. Diagnostic errors are common, harmful, and costly. Seventy – nine percent of diagnostic errors are related to the patient-clinician encounter. One in twenty patients reported a diagnostic error in the past five years. A recent study showed upwards of 58% of errors are occurring in the hospital setting. Patients and families go on to report that there have been (63%) serious health consequences from the diagnostic error. The most common types of diagnostic errors are mistakes made on tests, surgery or treatment(60%), followed by misdiagnosis(55%), wrong test, surgery or treatment(43%), incorrect medication(37%) followed by wrong or unclear instructions about follow up care (31%). Focusing on Diagnostic errors now is vital as errors and delays are low-value care. Last year WSHA learned that looking for diagnostic errors in WA state is in its infancy. Most WA facilities had a marked improvement in the close the loop process for important imaging and lab results. Finding diagnostic learning opportunities will help find system challenges for providers and patients as well as drive improvement in this area.
Clinical rationale:	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 diagnostic error and therefore no single solution to the problem, this complex issue must be solved through systems improvement. In patient safety literature, several causes of diagnostic error were identified, including: • Errors in clinical assessment and subsequent decision making • Lack of time with the clinician • Communication between clinicians and patients • Communication between clinicians • System failures **Selected References:** 1. National Academies of Sciences, Engineering, and Medicine. (2015). Improving diagnosis in health care. Washington, DC: The National Academies Press.

	2. The Safer DX Checklist: 10 High – Priority Organizational Practices for Diagnostic Excellence. (March 2022). Baylor College of Medicine. 3. Measure Dx: A Resource to Identify, Analyze, and Learn from Diagnostic Safety Events (2022). Agency for Healthcare Research and Quality.
Definition:	**Diagnostic Error Defined** The National Academies of Sciences, Engineering, and Medicine defined 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. The diagnosis may be delayed, missed or wrong.
Included Populations: **Exclusions:**	Any inpatient and ED patients. No exclusions.
Fields to be reported:	Enter "–1" for not applicable/ not able to retrieve the data Enter "0" if no potential cases discovered in numerator. Enter denominator data even if a zero in numerator. Use quality and safety data already collected by the organization to report diagnostic errors, as defined above and complete gap analysis about current processes. Methods of identification are listed below. **1. Event Reporting System** Review cases in the **event reporting system** the potential for diagnostic error. Report the number of cases in this category that had a potential diagnostic error (numerator) over the total number of cases in the event reporting system reported (denominator) monthly for 6 months. (1 point) **2. Root Cause Analysis (RCA)** Review **RCA** cases for the potential for diagnostic errors. Report the number of cases where a diagnostic error was found (numerator) over the total number of RCA cases (denominator) reported monthly for 6 months. (1 point) **3. Provider Peer review** Review **Provider Peer review** cases for the potential for diagnostic error. Report the number of cases identified with a potential diagnostic error (numerator) over the total number of peer review cases (denominator) monthly for 6 months. (1 point) **4. Patient-family reported complaints** Report the number of **patient-family reported complaints** that may have the potential for diagnostic error. Report the number of concerns/ complaints that mention diagnosis (numerator) over the total number of complaints reported (denominator) monthly for 6 months. (1 point)

<table>
<tr><td></td><td>
5. <u>Electronic health record-enhanced chart review</u>
From the EHR database queries and electronic triggers of the electronic health record report the number of potential diagnostic errors found. Report the total COUNT of potential diagnostic error cases using this method. Total for 6 months. (1 point)

6. Submit <u>Safer Diagnosis Gap Analysis</u>
CMO or CQO to complete the Safer DX survey one time by August 31, 2023. (5 points)

Diagnostic Excellence Survey (smartsheet.com)
</td></tr>
<tr><td>Data Collection period:</td><td>July 1, 2023 - December 31, 2023</td></tr>
<tr><td>Reporting deadline:</td><td>31 days after the close of the performance period or by January 31, 2024.</td></tr>
<tr><td>Audits and validation: Do not change</td><td>Data are subject to the audit by the state. WSHA will not audit but will complete a few basic validity checks.</td></tr>
<tr><td>Data collection system:</td><td>Washington State Hospital Association Quality Benchmarking System, QBS.
Smartsheet survey</td></tr>
<tr><td>Data Scoring:</td><td>
Measures to look for a diagnostic error in the systems already in place. (5 points) One point each for numerator and denominator where requested.

Five points for completion of gap analysis.
A zero numerator could be a valid entry for no cases found over the 6-month time period. When submitting data monthly, all 6 months of data must be present for each category for total points.

<table>
<tr><th></th><th>Numerator</th><th>Denominator</th><th>Total potential points</th><th>Frequency</th></tr>
<tr><td>Measure 1</td><td>Yes</td><td>Yes</td><td>1</td><td>Monthly</td></tr>
<tr><td>Measure 2</td><td>Yes</td><td>Yes</td><td>1</td><td>Monthly</td></tr>
<tr><td>Measure 3</td><td>Yes</td><td>Yes</td><td>1</td><td>Monthly</td></tr>
<tr><td>Measure 4</td><td>Yes</td><td>Yes</td><td>1</td><td>Monthly</td></tr>
<tr><td>Measure 5</td><td>None</td><td>Total count only</td><td>1</td><td>6 month total</td></tr>
<tr><td>Safer Dx Checklist Gap Analysis</td><td>NA</td><td>NA</td><td>5</td><td>Complete Once</td></tr>
</table>
</td></tr>
</table>

Behavioral Health

Fall Prevention and Harm Reduction

Measure 8 Contact Person	Ryan Robertson
Measure eligibility:	Psychiatric hospitals and hospitals with an inpatient behavioral health unit
Why?	Many psychiatric organizations have yet to implement NDNQI-endorsed definitions for falls, so this measure provides the opportunity to support this transition. For 2023, medical facilities will not be submitting falls data for MQI purposes but are encouraged to continue to report the data for long-term benchmarking.
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 20211. For 2023, this MQI measure is going to focus specifically on behavioral health settings as those areas are still working to implement NDNQI recommendations. Addition of Intentional Falls-An intentional fall event occurs when patient age 5 or older falls on purpose or falsely claims to have fallen. Patients may fall intentionally or falsely claim to have fallen for various reasons, including seeking attention or obtaining pain medication. It is important to add this type of fall as it is recommended by the NDNQI endorsed by the National Quality Forum. **Selected References:** 1. The Joint Commission (2022, March). Sentinel Event data released for 2021. *Joint Commission Online.* Sentinel Event data released for 2021 | The Joint Commission 2. NDNQI. (2020, January). Guidelines for Data Collection and Submission On Patient Falls Indicator. Patient Falls Indicator (nursingquality.org) 3. Quigley, P. (2019, June). Building Clinical Capacity and Competency: Fall and Fall Injury Prevention. Medbridge. Building Clinical Capacity and Competency: Fall and Fall Injury Prevention - MedBridge (medbridgeeducation.com) 4. WSHA Fall prevention support for member hospitals. (September 3, 2021)
Definition:	Definitions for falls can be found here: Patient Falls Indicator (nursingquality.org)
Included Populations: **Exclusions:**	All patients admitted to inpatient behavioral health units and patients at freestanding psychiatric facilities. No exclusions.

<table>
<tr><td>Fields to be reported:</td><td>Total number of each of the 7 identified categories in any licensed care area within the facility during the calendar month.
All Falls – total number of all facility falls, with or without injury (whether assisted by a staff member or not)
Post Fall Huddle Completion
Type of fall
New For BH is the intentional falls types for the 2023-2024 year.
Age of patient
Repeat Fall
Gender of patient
Location of fall</td></tr>
<tr><td>Data Collection period:</td><td>July 1, 2023 - December 31, 2023</td></tr>
<tr><td>Reporting deadline:</td><td>30 days after the close of the performance period or by January 31, 2024.</td></tr>
<tr><td>Audits and validation: Do not change</td><td>Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.</td></tr>
<tr><td>Submission Frequency:</td><td>Monthly (every month for the six months of the performance period from July 1, 2023, to December 31, 2023).</td></tr>
<tr><td>Data collection system:</td><td>Washington State Hospital Association Quality Benchmarking System, QBS.</td></tr>
<tr><td>Data Scoring:</td><td><table><tr><td>Thresholds</td><td>All Falls</td><td>Post Fall Huddle Completion documented with each fall</td><td>Fields 3 through 5 are to be reported with each fall (see above)</td><td>Fields 6 and 7 are to be reported with each fall (see above)</td></tr><tr><td>Point Awards 2023</td><td>2 points</td><td>60-79% = 1pt
≥ 80% = 2pts</td><td>60-79% = 1pt
≥ 80% = 3pts</td><td>60-79% = 1pt
≥ 80% = 3pts</td></tr></table></td></tr>
</table>

Behavioral Health

Distributing opioid overdose reversal medication in emergency departments and behavioral health settings

Measure 9 Contact Person	Ryan Robertson
Measure eligibility:	All adult acute and pediatric hospitals with emergency rooms or inpatient psychiatric units, and psychiatric hospitals
Why?	Naloxone distribution is an effective strategy for reducing deaths caused by opioid poisoning and is required by law to be distributed by emergency departments and BHAs to individuals at risk of an opioid overdose. Initial implementation of this law was challenging for many WSHA members and continuing to collect data will inform any needed technical assistance. Based on feedback received from members, additional context has been provided this year and hospitals with both an emergency department and an inpatient psychiatric unit will be asked to report those totals separately.
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:** 1. Distributing opioid overdose reversal medications (2SSB 5195) | Washington State Health Care Authority 2. https://lawfilesext.leg.wa.gov/biennium/2021-22/Htm/Bills/Session Laws/Senate/5195-S2.SL.htm?q=20210601152428
Definition:	Patients who were seen in a 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.

<table>
<tr><td>Included Populations:</td><td>All patients who present to an emergency department or a licensed behavioral health agency setting with symptoms of the following must be provided with naloxone in hand:
Opioid overdose,
Opioid use disorder,
Other adverse event related to opioid use
Each hospital may develop their own strategy for identifying individuals who meet these criteria. Some examples include utilizing a universal screening practice and implementing a flag within the electronic record system, using specific F codes to identify patients effectively (e.g., F11.xx), or using valid procedure codes the CMS ICD-10-PCS master code table and SUB 3 populations for opiates identified by your organization as an individual who are at risk for opiate overdose. (PCS Long and Abbreviated Titles):
https://www.cms.gov/Medicare/Coding/ICD10/index.html</td></tr>
<tr><td>Exclusions:</td><td>The exceptions to naloxone distribution are as follows:
Patients who expired
Patient declines medication
Provider judgement that it is not appropriate
Patient already has naloxone
Patient is transferred to another unit prior to discharge.</td></tr>
</table>

<table>
<tr><td>Fields to be reported:</td><td>Based on member feedback, reporting will be separated this year for emergency departments and behavioral health settings.

Emergency departments
Numerator: number of included population of patients who received opioid overdose reversal medication
Denominator: total number of included population of patients who qualify for distribution of opioid overdose reversal medication

Behavioral health settings (inpatient behavioral health units and freestanding psychiatric hospitals)
Numerator: number of included population of patients who received opioid overdose reversal medication
Denominator: total number of included population of patients who qualify for distribution of opioid overdose reversal medication

Sampling of Data
Sampling is not required, but hospitals who meet certain thresholds of monthly inpatient population totals may choose to utilize sampling of data. Hospitals who have a monthly inpatient population lower than the minimum number of cases may not use sampling.

Sampling guidelines:
If the average monthly inpatient population is:
< 51 – no sampling; 100% of population must be included
51-254 – use 51 as a minimum sample size
255-509 – use 20% of patient population size
≥ 510 – use 102 as a minimum sample size</td></tr>
<tr><td>Data Collection period:</td><td>July 1, 2023 - December 31, 2023</td></tr>
<tr><td>Reporting deadline:</td><td>30 days after the close of the performance period or by January 31, 2024.</td></tr>
<tr><td>Audits and validation: Do not change</td><td>Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.</td></tr>
<tr><td>Submission Frequency:</td><td>Monthly (every month for the six months of the performance period from July 1, 2023, to December 31, 2023).</td></tr>
<tr><td>Data collection system:</td><td>Washington State Hospital Association Quality Benchmarking System, QBS.</td></tr>
<tr><td>Data Scoring:</td><td><table><tr><td>Thresholds</td><td>All 6 months of metrics given</td></tr><tr><td>Point Award 2023</td><td>10 points</td></tr></table></td></tr>
</table>

Seclusion and Restraints

NEW- Seclusion and Restraints

Measure 10 Contact Person	Ryan Robertson, (206) 216-2536
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric.
Why?	Seclusion and Restraint are a quality and patient safety indicator required by CMS and other accreditation entities. Many WSHA members continue to ask for data in event form that help benchmark in Washington state. The reporting by event and type will help create data that helps make informed decision at the facility level.
Clinical Rationale:	All healthcare providers that value and respect an individual's autonomy, independence, and safety, seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. This is a new metric for 2023 and will likely become more robust in future years. **Selected references:** 1. An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital - PubMed (nih.gov) (Donat, 2003) 2. CMS Conditions of participation-Patient Rights, CFR-2010-title42-vol5-sec482-13.pdf (govinfo.gov) 3. Special Section on Seclusion and Restraint: Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program (psychiatryonline.org) 4. CFR-2010-title42-vol5-sec482-13.pdf (govinfo.gov)
Definition:	Number (count) of: • Seclusion events – the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. • Restraint events – any manual method, restraint device, material, or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely.

Included Populations: **Exclusions:**	Patients for whom at least one seclusion or physical/mechanical restraint event is reported during the month **Exclusions**: Restraint events where chemical restraints were utilized. This data will not be collected during the 2023 MQI reporting period.
Fields to be reported:	Number (count) of: • Seclusion events • Restraint events, separating out:
Data Collection period:	July 1, 2023 - December 31, 2023
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Monthly (every month for the six months of the performance period from July 1, 2023, to December 31, 2023).
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	<table><tr><td>**Thresholds**</td><td>All Events</td></tr><tr><td>**Point Award 2023**</td><td>10 points</td></tr></table>

Workplace Safety

Workplace Violence (WPV)

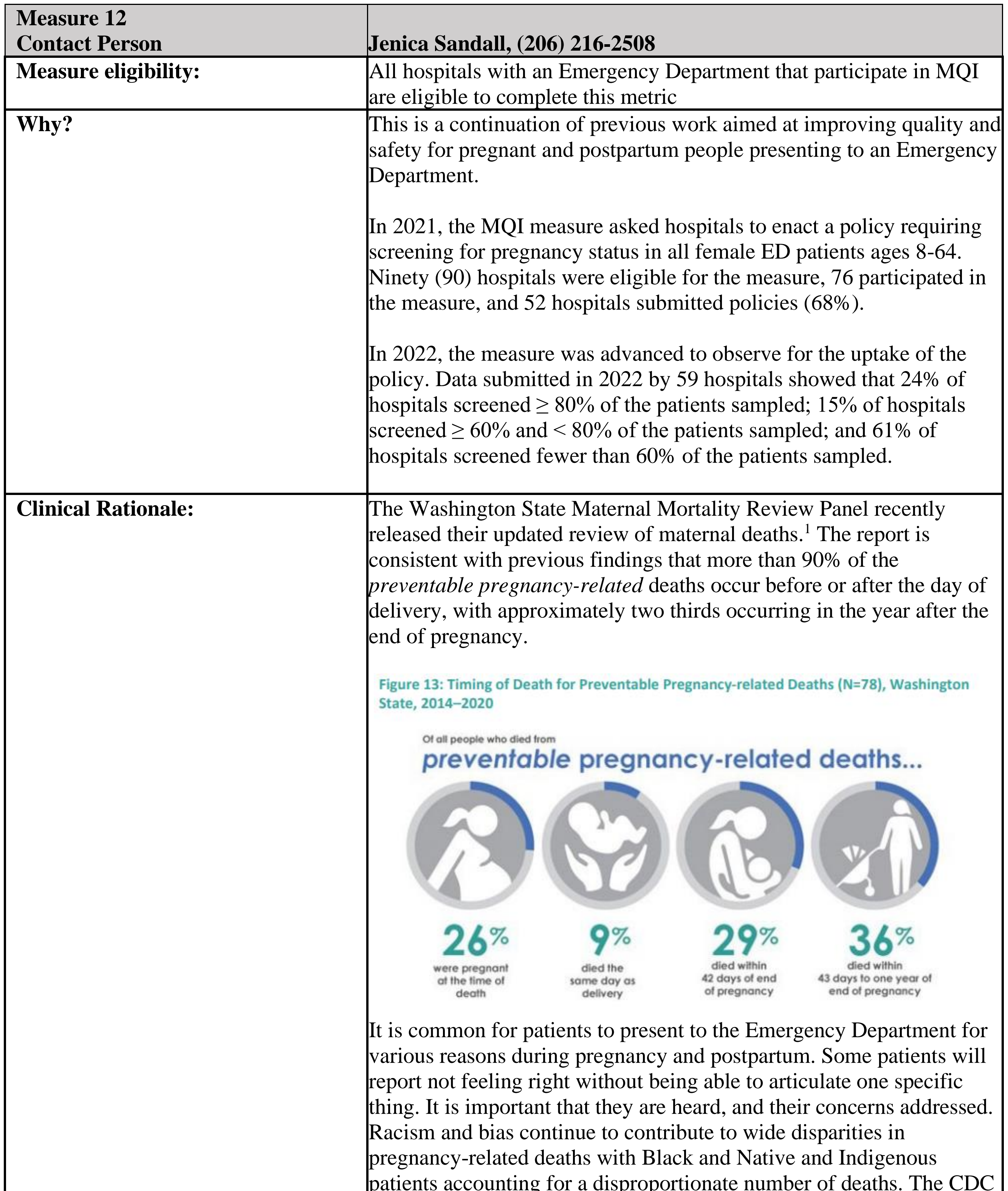
Measure 11 **Contact Person**	**Ryan Robertson, (206)216-2536**
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric.
Why?	Workplace violence is a pervasive challenge facing all hospitals. Members have asked for WSHA's support in identifying strategies for reducing WPV using data to identify and mitigate events in a meaningful way.
Clinical Rationale:	Workplace violence that occurs between hospital care providers and patients impacts more than 5 million workers across hospitals of all types in the United States. Staff are exposed to many safety and health hazards, including violence. In 2017 the Bureau of Labor Statistics found that 18,400 workers experienced trauma from nonfatal workplace violence and required days away from work. Diving further into the data they also found: • 70% were female • 67% were aged 25 to 54 • 71% worked in the healthcare and social assistance industry • 18% required 31 or more days away from work to recover, and 25% involved 3 to 5 days away from work. According to the CDC, WPV events are reported most frequently in psychiatric units, emergency rooms, waiting rooms and geriatric units. The risk factors for violence vary from hospital to hospital depending on location, size, and type of care. Common risk factors for hospital violence include the following: • Working directly with patients who are cognitively impaired e.g., are under the influence of drugs or alcohol, have brain injuries, have acute or chronic paranoia or have a recent or substantial history of violence. • Patients with histories of emotional or physical trauma as a child or adult • Transitions in patients' daily schedules: e.g., mealtimes, visiting hours and shift changes • Patients having to wait a long time for service • Patients having to be in overcrowded, uncomfortable waiting rooms • Staff working alone • Lack of staff training and policies to care for patients who are at risk of violent behavior.

	• Environmental design: poorly lit corridors, rooms, parking lots, and other areas2 Due to historical trauma and individual experiences, seeking healthcare can be a challenging experience for some individuals. This can contribute to feeling unsafe and it is imperative that patients be treated with care, compassion, and understanding. Language barriers can make feeling safe challenging, and patients should be given access to translators when seeking care in an environment where their primary language is not spoken. This data directly correlates with the WPV programming that WSHA is conducting in 2023. Selected References: • Addressing Emergency Department Nurses' Experiences of Workplace Violence through the Development of a Peer-based, Post Code Gray Support Tool 2021
Definition:	Number (count) of workplace violence events in which a physical assault or threat of physical assault within the hospital setting.
Included Populations: **Exclusions:**	Pediatrics, admitted adult patients (i.e., ≥ 18 years of age), and specialty patients. No exclusions.
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 • Age • Location • # of English speakers vs non-English speakers • # of times non-English speakers were offered a translator
Data Collection period:	July 1, 2023 - December 31, 2023
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Monthly (every month for the six months of the performance period from July 1, 2023, to December 31, 2023).
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.

<table>
<tr><td>Data Scoring:</td><td>All WPV Events
<table><tr><td>Thresholds</td><td>All Events</td></tr><tr><td>Point Award 2023</td><td>10 points</td></tr></table></td></tr>
</table>

Safe Deliveries Roadmap

Screening for Pregnancy and Postpartum Status in Emergency Department Triage



Measure 12 Contact Person	Jenica Sandall, (206) 216-2508
Measure eligibility:	All hospitals with an Emergency Department that participate in MQI are eligible to complete this metric
Why?	This is a continuation of previous work aimed at improving quality and safety for pregnant and postpartum people presenting to an Emergency Department. In 2021, the MQI measure asked hospitals to enact a policy requiring screening for pregnancy status in all female ED patients ages 8-64. Ninety (90) hospitals were eligible for the measure, 76 participated in the measure, and 52 hospitals submitted policies (68%). In 2022, the measure was advanced to observe for the uptake of the policy. Data submitted in 2022 by 59 hospitals showed that 24% of hospitals screened ≥ 80% of the patients sampled; 15% of hospitals screened ≥ 60% and < 80% of the patients sampled; and 61% of hospitals screened fewer than 60% of the patients sampled.
Clinical Rationale:	The Washington State Maternal Mortality Review Panel recently released their updated review of maternal deaths.[1] The report is consistent with previous findings that more than 90% of the *preventable pregnancy-related* deaths occur before or after the day of delivery, with approximately two thirds occurring in the year after the end of pregnancy. Figure 13: Timing of Death for Preventable Pregnancy-related Deaths (N=78), Washington State, 2014–2020 Of all people who died from *preventable* pregnancy-related deaths... 26% were pregnant at the time of death 9% died the same day as delivery 29% died within 42 days of end of pregnancy 36% died within 43 days to one year of end of pregnancy It is common for patients to present to the Emergency Department for various reasons during pregnancy and postpartum. Some patients will report not feeling right without being able to articulate one specific thing. It is important that they are heard, and their concerns addressed. Racism and bias continue to contribute to wide disparities in pregnancy-related deaths with Black and Native and Indigenous patients accounting for a disproportionate number of deaths. The CDC

	(Centers for Disease Control) considers this so important that they created the HEAR HER Campaign with excellent education materials for patients, their families and health care providers. "…Risk assessment, evaluation for early warning signs of maternal and fetal compromise, followed by timely communication and coordination with obstetric clinicals are essential."[3] Having clear policies and procedures in place and educating staff around these procedures is imperative to help improve equity and safety for *all* pregnant and postpartum patients. 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 complications, fever, abdominal pain, breast complications, and hypertension. Common postpartum emergencies include pain, fever, hemorrhage, hypertension, preeclampsia, eclampsia, infection, and depression. Among ED visits for postpartum complications, approximately 22% will require readmission.[4] **Selected References:** 1. Washington State Department of Health. (2023). *Washington State Maternal Mortality Review Panel: Maternal Deaths 2017-2020*. https://doh.wa.gov/sites/default/files/2023-02/141-070-MaternalMortalityReviewPanelReport-2023.pdf?uid=63fe81ba7cb9b 2. Centers for Disease Control and Prevention. (2022, November 17). *Hear her campaign*. Centers for Disease Control and Prevention. Retrieved March 10, 2023, from https://www.cdc.gov/hearher/index.html 3. McMurtry Baird, S., Braun, B., & Wolf, L. (2020). *Emergency care for patients during pregnancy and the postpartum period: Emergency Nurses Association and Association of Women's Health, Obstetric and Neonatal Nurses Consensus Statement*. AWHONN Position Statements. Retrieved February 27, 2023, from https://i7g4f9j6.stackpathcdn.com/wp-content/uploads/2020/11/20141939/ENA-AWHONN-Consensus-Statement-Final-11.18.2020.pdf 4. Marco, C. A., Thomas, K., & Rzecznik, W. (2019, October 15). *Postpartum emergencies*. Relias Media | Online Continuing Medical Education | Relias Media - Continuing Medical Education Publishing. Retrieved February 27, 2023, from https://www.reliasmedia.com/articles/145171-postpartum-emergencies
Definition:	The percent of female patients seen in an Emergency Department who were screened for pregnancy/postpartum status in triage.

<table>
<tr><td>Included Populations:

Exclusions:</td><td>Female patients between the ages of ≥12 and <50 years who were seen in the Emergency Department.

No exclusions.</td></tr>
<tr><td>Fields to be reported:</td><td>Numerator: The number of female patients between ≥12 and <50 years who were seen in the Emergency Department and have documentation of pregnancy or postpartum status during triage in the EMR.

Denominator: The number of female patients between ≥12 and <50 years who were seen in the Emergency Department.

Instructions:
Hospitals may choose the number of patients to submit as the denominator each month with the following parameters:
The sample must be randomized unless the hospital chooses to submit the entire population
Hospitals with ≥10 eligible patients in that month will submit at least 10
Hospitals with <10 eligible patients in that month will submit all eligible patients</td></tr>
<tr><td>Data Collection period:</td><td>July 1, 2023 - December 31, 2023</td></tr>
<tr><td>Reporting deadline:</td><td>30 days after the close of the performance period or by January 31, 2024.</td></tr>
<tr><td>Audits and validation: Do not change</td><td>Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.</td></tr>
<tr><td>Submission Frequency:</td><td>Monthly (every month for six months during the performance period from July 1, 2023, to December 31, 2023).</td></tr>
<tr><td>Data collection system:</td><td>Washington State Hospital Association Quality Benchmarking System, QBS.</td></tr>
<tr><td>Data Scoring:</td><td>This measure is worth 10 points. Hospitals must submit all six months to be considered.

<table>
<tr><td>Thresholds</td><td>≥ 50% to < 70%</td><td>≥ 70% to <90%</td><td>≥ 90%</td></tr>
<tr><td>Point Awards 2023</td><td>3 points</td><td>7 points</td><td>10 points</td></tr>
</table></td></tr>
</table>

Safe Deliveries Roadmap

Medication for Opioid Use Disorder (MOUD) Protocol, Perinatal Substance Use Disorder (SUD)

Measure 13 **Contact Person**	**Jenica Sandall, (206) 216-2508**
Measure eligibility:	All acute care hospitals that participate in MQI are eligible to complete this metric
Why?	Washington Maternal Mortality Review Panel Reports have shown that SUD was a key factor in a majority of pregnancy-associated deaths in Washington State. In response, WSHA, in partnership with the WA DOH, began a perinatal SUD learning collaborative in 2022. The 2022 MQI measure encouraged hospitals to adopt the recommendation to implement universal SUD screening using a validated tool. Of 45 reporting hospitals, 60% implemented universal screening and 33% created plans to implement universal screening in 2022. The 2023 MQI measure is a continuation of work aimed at improving quality and safety across the state for all pregnant and postpartum people who are affected by substance use disorder.
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, again, that the leading underlying cause of pregnancy-related deaths was behavioral health conditions, including suicide and overdose, and opioids were involved in most of the pregnancy-associated deaths involving accidental overdose.[1] According to WSHA's inpatient/outpatient discharge data, patients with SUD are 178% more likely to leave the hospital Against Medical Advice. Readiness to provide coordinated clinical pathways for pregnant and postpartum people with SUD is necessary for all hospitals.[2] Please visit http://www.wsha.org/wp-content/uploads/Medication-for-Opioid-Use-Disorder-MOUD-toolkit.pdf for resources, including provider remote consultation options. **Selected References:** 1. Washington State Department of Health. (2023). *Washington State Maternal Mortality Review Panel: Maternal Deaths 2017-2020*. https://doh.wa.gov/sites/default/files/2023-02/141-070-MaternalMortalityReviewPanelReport-2023.pdf?uid=63fe81ba7cb9b 2. Alliance for Innovation on Maternal Health. (2021). *Care for Pregnant and Postpartum People with Substance Use*

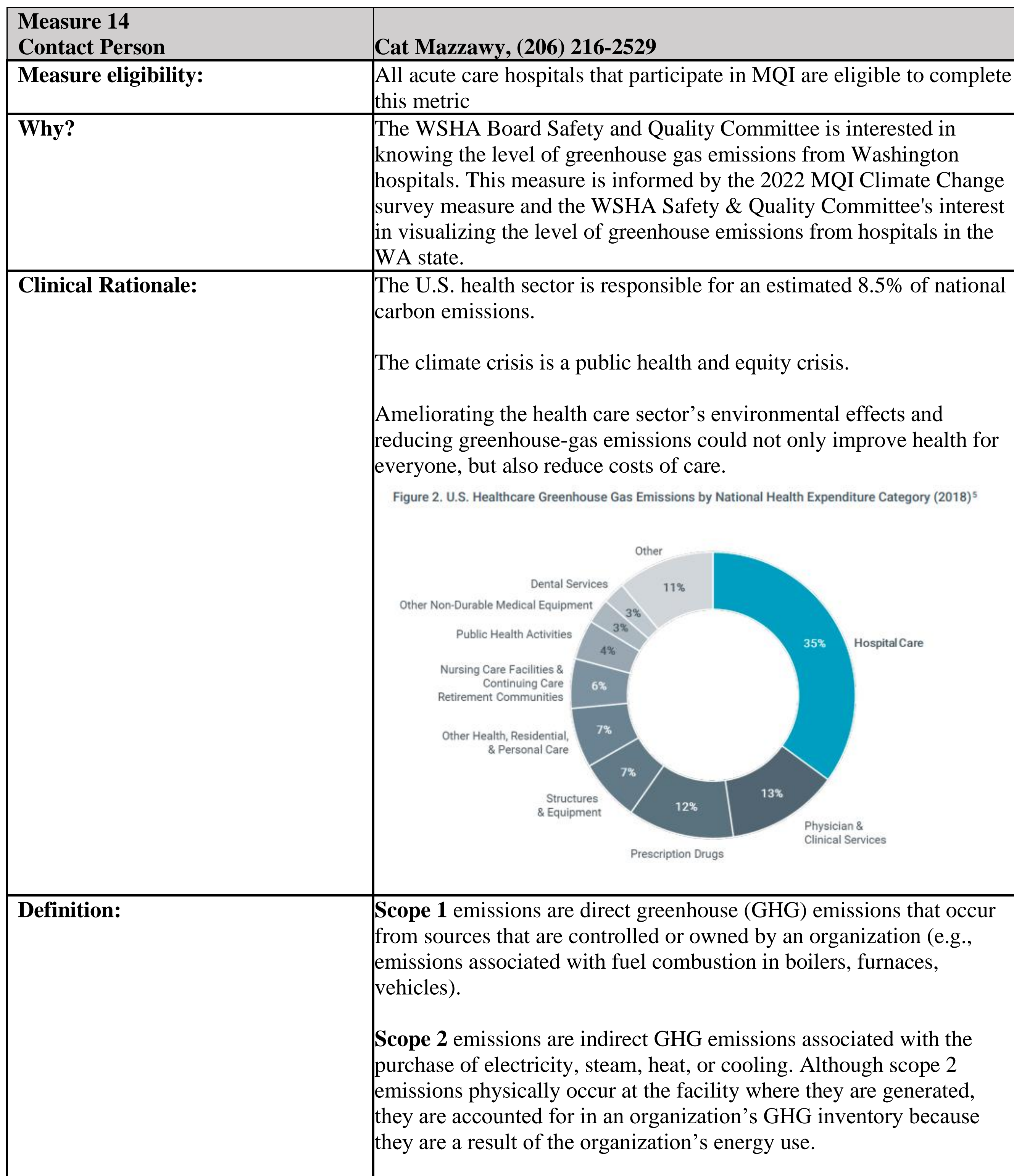
	Disorder. https://saferbirth.org/psbs/care-for-pregnant-and-postpartum-people-with-substance-use-disorder/ 3. *Perinatal substance use disorder learning collaborative*. Washington State Hospital Association. (2023, February 8). Retrieved March 6, 2023, from https://www.wsha.org/perinatal-substance-use-disorder-learning-collaborative/
Definition:	Hospitals with birthing services will utilize a multidisciplinary team to create a facility-specific Medication for Opioid Use Disorder (MOUD) protocol. The protocol shall include: **PART 1** A. A written process to consult a provider on-site or on-call that has the skills and scope to begin maintenance medications that treat opioid use disorder and/or adjust (titrate) maintenance medications that treat opioid use disorder during pregnancy, labor and delivery, and postpartum. **OR** B. If the hospital does not have an on-site/on-call provider that has the skills and scope to manage medications, there is a written procedure in place to consult with a provider to initiate or adjust maintenance medications during pregnancy, labor and delivery, and postpartum. AND **PART 2** C. *At minimum*, a treatment algorithm (or guideline, etc.) for inpatient MOUD initiation for both buprenorphine and methadone and which includes adjunctive therapies to optimize MOUD induction (see the resource under Treatment in the WSHA Perinatal SUD Toolkit).[3]
Included Populations: **Exclusions:**	All pregnant or postpartum patients being evaluated within the hospital obstetrical departments (including antepartum, intrapartum, or postpartum units) Excluded populations: Pregnant or postpartum patients treated exclusively outside of a non-obstetrical unit.
Fields to be reported:	Hospitals will submit the relevant written protocol

Data Collection period:	July 1, 2023 - December 31, 2023
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Once during the performance period from July 1, 2023, to December 31, 2023.
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	This measure is worth 10 points

Thresholds	Does not meet criteria	Meets only Part 1	Meets only Part 2	Meets Part 1 AND Part 2
Point Awards 2023	0 points	3 points	7 points	10 points

Climate Change

Monitoring of Greenhouse Gas Emissions

Measure 14 **Contact Person**	**Cat Mazzawy, (206) 216-2529**
Measure eligibility:	All acute care hospitals that participate in MQI are eligible to complete this metric
Why?	The WSHA Board Safety and Quality Committee is interested in knowing the level of greenhouse gas emissions from Washington hospitals. This measure is informed by the 2022 MQI Climate Change survey measure and the WSHA Safety & Quality Committee's interest in visualizing the level of greenhouse emissions from hospitals in the WA state.
Clinical Rationale:	The U.S. health sector is responsible for an estimated 8.5% of national carbon emissions. The climate crisis is a public health and equity crisis. Ameliorating the health care sector's environmental effects and reducing greenhouse-gas emissions could not only improve health for everyone, but also reduce costs of care. 
Definition:	**Scope 1** emissions are direct greenhouse (GHG) emissions that occur from sources that are controlled or owned by an organization (e.g., emissions associated with fuel combustion in boilers, furnaces, vehicles). **Scope 2** emissions are indirect GHG emissions associated with the purchase of electricity, steam, heat, or cooling. Although scope 2 emissions physically occur at the facility where they are generated, they are accounted for in an organization's GHG inventory because they are a result of the organization's energy use.

	Scope 3 emissions are the result of activities from assets not owned or controlled by the reporting organization, but that the organization indirectly affects in its value chain. Scope 3 emissions include all sources not within an organization's scope 1 and 2 boundary. The scope 3 emissions for one organization are the scope 1 and 2 emissions of another organization. Scope 3 emissions, also referred to as value chain emissions, often represent the majority of an organization's total greenhouse gas (GHG) emissions.
Included Populations: **Exclusions:**	All locations associated with the hospital tax ID. No exclusions.
Fields to be reported:	Enter "–1" for not applicable Part A: Submission of survey response: 1. Does your hospital monitor greenhouse gas emissions? 2. If no, do you plan to start monitoring greenhouse gas emissions and when? 3. If yes, complete Part B. Part B: Submission of greenhouse gas emissions data. Enter the number of greenhouse gas emissions accumulated for the calendar year of 2022. • Scope 1 • Scope 2 • Scope 3 **Selected References:** 1. GHG Inventory Development Process and Guidance | US EPA. (2022, December 6). US EPA. https://www.epa.gov/climateleadership/ghg-inventory-development-process-and-guidance 2. World Resources Institute | Making Big Ideas Happen. (n.d.). World Resources Institute. https://www.wri.org/ 3. Reducing Healthcare Carbon Emissions. AHRQ. (n.d.). https://www.ahrq.gov/healthsystemsresearch/decarbonization/inde.html
Data Collection period:	2022 Calendar year data reported once during the performance period.
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

<table>
<tr><td>Submission Frequency:</td><td>For both Part A and Part B submit once during the performance period from July 1, 2023, to December 31, 2023.</td></tr>
<tr><td>Data collection system:</td><td>Washington State Hospital Association Quality Benchmarking System, QBS.</td></tr>
<tr><td>Data Scoring:</td><td>Data and awards are scored on the submission of survey and data. Hospitals obtain 5-point award for submission of survey and an additional 5-point award for submission of data.
<table>
<tr><td>Threshold</td><td>Submission of greenhouse gas emissions survey</td><td>Submission of greenhouse gas emissions data</td></tr>
<tr><td>Point Award 2023</td><td>5 points</td><td>5 points</td></tr>
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