Washington State Hospital Association

Washington State Health Care Authority

Medicaid Quality Incentive Measure Guidelines

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 patient population applicable to each measure. The data reported by hospitals for the quality incentive will be available upon request from HCA and other state agencies for auditing purpose. 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 Jessica Symank (JessicaS@wsha.org).

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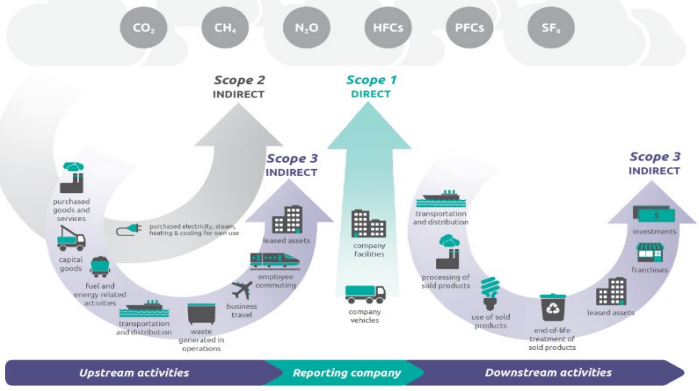
Washington State Hospital Association

Climate Change: Monitoring of Greenhouse Gas Emissions

Contact	Jessica Symank; JessicaS@wsha.org
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 2022/2023 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. **Overview of GHG Protocol scopes and emissions across the value chain** 
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: 1.	Enter "–1" for not applicable. Part A: Submission of survey response: 1. Does your hospital monitor greenhouse gas emissions? 2. If not, 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/
Data Collection period:	2023 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.
Submission Frequency:	For both Part A and Part B submit once during 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>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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Washington State Hospital Association

Opioid Harm Prevention: Naloxone Distribution

Proposed Measure	Brittany Weiner; BrittanyW@wsha.org
Measure eligibility:	All adult acute and pediatric hospitals with emergency departments or inpatient psychiatric units, and freestanding psychiatric hospitals
Clinical Rationale:	**For 2024, changes are being made to the structure of the denominator.** Naloxone distribution has been an MQI metric since 2SSB 5195 went into effect in 2022. WSHA continues to encourage all hospitals to develop their own process for adherence to the law. The intent of the law is to ensure all patients at risk of an opioid overdose, who enter the emergency department or an inpatient behavioral health setting, receive take-home naloxone at discharge. For this MQI measure, hospitals are asked to report a standardized denominator by using a specific list of diagnosis codes. 2024 Naloxone Distribution DX Reference.xlsx In determining the change to the structure of the denominator, the following considerations were made: 1. By standardizing the denominator, thresholds and year-to-year comparisons can be developed, allowing for the MQI data to support ongoing quality improvement initiatives statewide, which is the intent of MQI. 2. Using pre-defined diagnosis codes to create the denominator will allow for future automation of this measure utilizing available claims data, reducing or eliminating the need to report manually. 3. WSHA is providing a list of diagnoses to identify the denominator for this measure only. Hospitals are still encouraged to use their own internal processes for how at-risk patients are being identified but may want to consider adding the diagnoses to internal processes if not already captured. 4. Using diagnosis codes to create the denominator does limit the ability to identify exceptions, but the benefit of long-term standardization and automation outweighs the loss of those specific data points. Nationwide, opioid-related deaths have increased substantially in the last 15 years, and Washington has seen similar trends. According to data from the Department of Health, over 17,000 Washington residents died from a drug overdose between 2007 and 2021 and 68% of those deaths involved an opioid. Additionally, the presence of illicit fentanyl in other substances has led to a significant increase in polysubstance use and lives lost due to unexpected fentanyl in the drug supply. On January 1, 2022, 2SSB 5195 went into effect, mandating hospital emergency departments and any organization with a Behavioral

	Health Agency designation to distribute naloxone at discharge to patients identified as at-risk of opioid-related harm. • HCA Emergency Department Implementation Toolkit • HCA Behavioral Health Agency Implementation Toolkit
Definition:	Patients who were seen in a hospital emergency department or inpatient psychiatric hospital and were determined to be eligible for distribution of naloxone, an opioid overdose reversal medication, based on 2SSB 5195. This includes patients who present with symptoms of the following: 1. Opioid overdose 2. Opioid use disorder 3. Other adverse event related to opioid use
Included Populations: **Exclusions:**	For the purpose of this measure, included populations will be any patient who is assigned one of the diagnoses on this list who received care in the emergency department or behavioral health unit. Patients should be included if they have the diagnosis present on the encounter, even if it is not the primary diagnosis. Exclusions: The only patients who should be excluded are those who were not discharged from the care settings included in this measure (e.g., patient died, patient was admitted to a different inpatient unit) or patients on hospice care.
Fields to be reported:	**Emergency departments** *Numerator*: number of included population of patients who received naloxone at discharge each month *Denominator*: total number of discharged patients who were assigned one of the diagnoses on this list each month **Behavioral health settings** (freestanding psychiatric hospitals and acute hospitals with inpatient behavioral health units) *Numerator*: number of included population of patients who received naloxone at discharge each month *Denominator*: total number of discharged patients who were assigned one of the diagnoses on this list each month
Data Collection period:	July 1, 2024 - December 31, 2024
Reporting deadline:	30 days after the close of the performance period or by January 31, 2025.
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, 2024, to December 31, 2024).

<table>
<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>Threshold</td><td>Submission of all six months</td></tr>
<tr><td>Point Award 2024</td><td>10 points
No partial points will be awarded</td></tr>
</table>
</td></tr>
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Washington State Hospital Association

(New) Equity: Patient Demographics

Proposed Measure	Abigail Berube, AbigailB@wsha.org
Measure Name: Demographic Data Reporting	Percent of patient demographics (sexual orientation, gender identity, disability condition, disability daily living) for inpatient and observation claims coded as "unknown" in the Washington State Discharge dataset; target set as 20% or less for each demographic.
Measure eligibility:	All hospitals that participate in MQI are eligible to complete this metric
Clinical Rationale:	Documenting patient self-reported demographics is foundational for building datasets used in population health analysis. Stratifying clinical measures by socio-demographics allows for detection of healthcare disparities. Ensuring complete data, with few missing or "unknown" data enables data utility for health equity planning. This year, the new MQI Demographic Data Reporting measure will focus on collection of four new demographics: sexual orientation, gender identity (SOGI), disability condition and disability daily living. These demographic categories are stipulated by Washington law (WAC-246-455-025) but new to most inpatient settings. WA is a frontier state learning how to improve both the collection process and documentation of patient responses. Incentivizing rapid improvement of demographic data will positively impact statewide datasets (CHARS) and improve internal use of the data for health equity work. Additionally, collection of patient demographics to monitor health equity has long been promoted as a best practice by the American Hospital Association, Joint Commission and the Institute for Healthcare Improvement.
Definition:	Percent of inpatient and observation claims coded as "unknown" for each of the four priority demographics: sexual orientation, gender identity, disability condition, disability daily living. Each claim is counted as a record, not each unique patient. One patient may be counted several times if they are admitted more than once; all claim records must have demographics reported.
Included Populations: **Exclusions:**	All inpatient (including swing bed) and observation claims for patients age 13 and older are included. Exclude patients under age 13.
Fields to be reported:	Hospitals do not need to submit any additional data. The measure will be calculated using Washington State Discharge dataset files for November 2024 date of service claims. This data is already submitted to WSHA by hospitals. Hospitals will be able to track progress towards the target by accessing the member-facing Inpatient & Observation Demographic Dashboard on DASH or by requesting progress reports directly from the WSHA team.

Data Collection period:	The final calculation will be based on only date of service through November 2024 claims (one month snapshot). Improvements made, then lost before November will not impact the measure. Due to claims processing time between data submission to the final dataset, measure scores will be calculated and available to view in DASH by mid-February 2025.
Reporting deadline:	Jan 14, 2025 (see PNWPop data submission deadline schedule)
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:	Hospitals do not need to submit any additional data.
Data collection system:	Washington State Discharge dataset
Data Scoring:	November 2024 data will be scored for this measure as follows: The target for percent "unknown" is 20% or less for each demographic. For each of the four demographics, 2.5 points will be awarded if the target is met.

Threshold for Demographic Reporting	**Target met ("unknown") ≤20%**	**Target not met ("unknown") >20%**
Sexual Orientation	2.5	0
Gender Identity	2.5	0
Disability Condition	2.5	0
Disability Daily Living	2.5	0

Falls: Falls Prevention and Harm Reduction

Proposed Measure	Amy Anderson, AmyA@wsha.org
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric (includes all inpatient units, ED, behavioral health facilities, cancer care centers and children's hospitals).
Clinical Rationale:	**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 2022**. In the first half of 2023, approximately 47% of sentinel events reported to The Joint Commission were fall related events (Becker's Clinical Leadership). While extensive clinical research and adult evidence-based strategies in fall prevention exist, reducing injurious falls in the hospital environment remains a significant safety and quality challenge. Falls result in more than 3 million injuries treated in emergency departments annually, including over 800,000 hospitalizations (CDC). These falls result in approximately 250,000 injuries per year. Along with injuries, these falls often result in rehospitalization, decrease in function and independence, and an increased risk of morbidity and mortality, especially in the elderly. Also, falls place a heavy burden on patients and organizations with medical costs for fall-related injuries. The cost of treating injuries caused by falls is projected to increase to over $101 billion by 2030 (American Journal of Lifestyle Medicine). This cost is likely to increase with patient age. Among adults 65 years or older within Washington, falls are the leading cause of injury-related death for persons both in and out of the hospital per 100,000 people. For older adults in the U.S., fall death rates went up by 30% from 2007-2016, and researchers predict there will be 7 deadly falls every hour by 2030 (CDC). According to the WA Department of Health data, there has been a recent 0.48% decrease in fatal falls in men over the past 4 years, whereas we have seen an increase of 3.95% of our female counterparts in the same timespan(WA DOH Tracking Network).
Definition:	NDNQI. (2020, January). Guidelines for Data Collection and Submission On Patient Falls Indicator. Guidelines - PatientFalls.pdf (nursingquality.org)
Included Populations: **Exclusions:**	All acute care inpatients, observation patients, emergency room, neonates, pediatrics, maternal ward, behavioral health, rehabilitation units. NA
Fields to be reported:	1. All Falls – total number of all facility falls, with or without injury (whether assisted by a staff member or not) 2. Age of patient 3. Post Fall Huddle Completion

Data Collection period:	July 1, 2024 - December 31, 2024
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, 2024, to December 31, 2024). Beginning in 2025, submission will be every month for the entire calendar year.
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	Include thresholds on submission of measures. All 6 months of data are required for points award at completion of performance period.

Threshold	**All Falls, Post Fall Huddle Completion & Age**
Points Award 2024	10

References:

1. Carr H., et.al. A system-wide approach to prevention of in-hospital newborn falls. American Journal of Maternal/Child Nursing. 2019; 44: 100-107 4.
2. Centers for Disease Control and Prevention. (2023, May 12). *Facts about falls*. Centers for Disease Control and Prevention. https://www.cdc.gov/falls/facts.html
3. Houry, D., Florence, C., Baldwin, G., Stevens, J., & McClure, R. (2015, July). The CDC Injury Center's Response to the Growing Public Health Problem of Falls Among Older Adults. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4681302/pdf/10.1177_1559827615600137.pdf
4. Miner J. Implementation of a comprehensive safety bundle to support newborn fall/drop event prevention and response. Nursing for Women's Health. 2019; 23: 327- 339 https://doi.org/10.1016/j.nwh.2019.06.0026.
5. NDNQI. (2020, January). Guidelines for Data Collection and Submission On Patient Falls Indicator. https://members.nursingquality.org/NDNQIPortal/Documents/General/Guidel ines%20-%20PatientFalls.pdf?linkid=s0_f776_m73_m230_a0_m236_a0_m242_a0.
6. 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)
7. Twenter, P. (2023). *Most common Sentinel events in first half of 2023: Joint Commission*. Becker's Hospital Review. https://www.beckershospitalreview.com/patient-safety-outcomes/most-common-sentinel-events-in-first-half-of-2023-joint-commission.html
8. Washington Tracking Network (WTN). (n.d.). https://fortress.wa.gov/doh/wtn/WTNPortal/#!q0=296

(New) Safe Deliveries Roadmap: Perinatal Mental Health

Proposed Measure	Jenica Sandall, JenicaS@wsha.org
Measure eligibility:	All hospitals* that participate in MQI and have a labor and birth department are eligible to complete this metric.
Clinical Rationale:	According to the CDC, 1 in 5 birthing people suffer from a mental health or substance use disorder[1]. Behavioral health conditions, including suicide, accounted for 32% of all pregnancy-related deaths in Washington State[2] and are the leading cause of maternal mortality in the United States. Eighty percent of all pregnancy-related deaths are preventable and significant disparities in incidence and outcomes exist, especially for Black and Indigenous patients. It is estimated that up to 75% of people with perinatal mental health (PMH) conditions never get treatment[3]. A priority recommendation from the WA Maternal Mortality Review Panel was to address mental health and substance use disorders by *increasing screening, prevention, and treatment for pregnant and parenting people*. Statewide implementation of the AIM Perinatal Mental Health Bundle[4] aims to address this recommendation. Implementing systems to improve screening, treatment, referral, and continuity of care from antepartum to intrapartum and from postpartum to the community takes time. Perinatal mental health will continue as a measure in 2025 and hospitals are encouraged to continue AIM Perinatal Mental Health Bundle implementation activities between measurement periods. Centers for Disease Control and Prevention. (2022, September). *Four in 5 pregnancy-related deaths in the U.S. are preventable*. Centers for Disease Control and Prevention. https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html Stein, B.-S., Sedano, C., Gardner, D., Silverman, E., Mentzer, K., Tibbs Christensen, T., & Shah, U.A. (2023, February). *Washington State Maternal Mortality Review Panel: Maternal Deaths 2017–2020*. Washington State Department of Health. https://doh.wa.gov/sites/default/files/2023-02/141-070-MaternalMortalityReviewPanelReport-2023.pdf?uid=6407ac5b5ea17 Clarke DE, De Faria L, Alpert JE, The Perinatal Mental Health Advisory Panel, The Perinatal Mental Health Research Team. (2023). *Perinatal Mental and Substance Use Disorder: White Paper*. American Psychiatric Association. https://www.psychiatry.org/maternal. American College of Obstetricians and Gynecologists. (2022). *Perinatal Mental Health Conditions*. AIM. https://saferbirth.org/psbs/perinatal-mental-health-conditions/ Maternal Mental Health Leadership Alliance. (December 2022). *Perinatal mental health education and screening project.* https://www.mmhla.org/s/MMHLA-Final-Report-2-27-2023.pdf
Definition:	**Part A. Gap & Needs Assessment** • Complete and submit the Perinatal Mental Health gap and needs assessment with input from a multidisciplinary team with representation from relevant team members specific to your hospital/department workflow (i.e. nurse, social worker,

	obstetric clinician, pediatric clinician, case management, mental health clinician, etc.) **Part B. Process, Resource, & Policy Documents** 1. Upload documents: a. A document that describes the current process related to mental health screening, assessment, and education for obstetric patients in the hospital (~500 words or less). b. Documents or referral resources and communication pathways your hospital utilizes to address patient needs, including social drivers of mental and physical health c. Resources and education provided to patients identified as having a mental health condition before discharge (may be multiple files) d. Any hospital/OB department policy/protocol/guideline(s), etc. relevant to perinatal mental health, if available.
Included Populations: **Exclusions:**	Each hospital with a labor and birth department. Hospitals that do not have a labor and birth department
Fields to be reported:	**Part A**. Submit the completed gap and needs assessment via the Smartsheet form: NOTE: Template for Part A questions can be found here: http://www.wsha.org/wp-content/uploads/2024-MQI-SDR-PART-A-PMH-Gap-and-Needs-Assessment.pdf **Part B**. Submit the completed narrative and uploads via the Smartsheet form: https://app.smartsheet.com/b/form/66c9e735dedf492482cde4db83f781d8
Data Collection period:	**Part A and Part B:** July 1 – July 31, 2024
Reporting deadline:	**Part A and B submissions due by:** July 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:	**Part A and B.** Once between July 1st and 31st, 2024.
Data collection system:	Smartsheet or Qualtrics Survey tool

Data Scoring:	Each hospital with a labor and birth unit *must complete part A and part B* to be eligible for scoring. Hospitals that complete and submit part A and part B will earn 10 points. *For hospitals that are reporting under one licensure (share a CCN): Data must be submitted from each hospital to be considered for this measure. Scores from each hospital will be averaged.

Washington State Hospital Association

(New) Sepsis: Sepsis and Diagnostic Excellence

Proposed Measure	**Rosemary Grant**, RosemaryG@wsha.org
Measure eligibility:	All hospitals that participate in MQI are eligible to complete this metric except free-standing psychiatric and rehabilitation hospitals
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. Incorrect or delayed diagnoses are common, expensive, and harmful in healthcare. According to the National Academies of Sciences, Engineering, and Medicine (2015), diagnostic errors account for 6-17% of hospital adverse events. In addition, Newman-Toker, et. Al (2020) found that of patients who experience sepsis, the estimated number with missed or delayed diagnosis is between 8.2-20.8%. Missed or delayed diagnosis in sepsis has a huge impact on mortality. According to Kumar (2006) for every hour of delay in initiation of antibiotics, survival decreases by 7.6%. In 2023, the CDC published Hospital Sepsis Program Core Elements. This comprehensive guide provides hospitals with a roadmap to build or optimize multi-disciplinary hospital sepsis programs and includes a needs assessment for hospitals to determine their current state. Part of the recommendations in this toolkit are to track and monitor sepsis-specific metrics and to review sepsis cases for improvement opportunities.
Definition:	There are three parts of the sepsis/diagnostic excellence measure: 1. **Needs Assessment**- Completion of CDC Core Elements Sepsis Program Needs Assessment in Qualtrics by each hospital 2. **Dashboard Engagement**- WSHA will monitor hospital access of the sepsis dashboard on the DASH platform. The expectation is at least one view of the dashboard monthly by each hospital 3. **Sepsis case reviews**- To earn full points for this measure, hospitals will review 30 random cases for improvement opportunities in sepsis care including missed or delayed diagnosis. WSHA will provide guidance including suggested template for these case reviews. Hospitals should review 30

	random cases from the following populations (baseline period for cases July 1, 2023-June 30 2024 discharges): a. Sepsis not present on arrival mortality (patients whose admission diagnosis did not include sepsis, discharge disposition was expired, and had a sepsis diagnosis during their hospitalization). See methodology below. b. SEP-1 "fallout" case reviews (patients who were eligible for the SEP-1 bundle and did not meet the bundle requirements). See methodology below. c. Patients with an ED visit 3 days prior to admission for sepsis (patients who were not admitted for the first ED encounter but were subsequently admitted within 3 days for sepsis. See methodology below. General Definitions • Sepsis Definition – A diagnosis code of the following ('A40%', 'A41%', 'A021', 'A227', 'A267', 'A327', 'A5486', 'B377', 'T8144XA', 'P36%', 'O0337', 'O0387', 'O0487', 'O0737', 'O0882', 'O85', 'O8604') and not Severe Sepsis or Septic Shock • Severe Sepsis Definition – A diagnosis code of 'R6250' and not Septic Shock • Septic Shock Definition – A diagnosis code of the following ('R6521', 'T8112XA') 1. Methodology for Sepsis not present on arrival mortality: Patient has any code of Sepsis on the claim, but Sepsis is not Present on the Admission, and the patient has an Expired discharge status 2. Methodology for SEP-1 fallout- any abstracted case for the SEP-1 measure that was a "fallout" where the bundle elements were not met for the particular case 3. Methodology for ED visit within 3 days prior to admission: Patient has any code of Sepsis present on the claim and visited an Emergency Department within 3 days prior to admission that did not result in hospital admission Hospitals should compile a list of the patients who meet the criteria above and randomly select 30 cases for review from this list. If there are not 30 total cases for a given hospital, all cases should be reviewed.
Included Populations: **Exclusions:**	See criteria above in 3 (a,b,c) No exclusions

Fields to be reported:	1. Needs Assessment-Completion of CDC Core Elements Sepsis Program Needs Assessment in Qualtrics here 2. Dashboard Engagement- Tracking Sepsis Dashboard Engagement, Data captured through Dash Server (Site Status: Traffic to Views - Tableau Server (wsha.org) 3. Sepsis case reviews- After case reviews are completed, enter into QBS number of cases where: a. There was an opportunity for improvement in sepsis care b. There was a missed, delayed, or incorrect diagnosis
Data Collection period:	Baseline period for cases: July 1, 2023 - June 30, 2024, discharges Reporting period for cases: July 1, 2024 - December 31, 2024
Reporting deadline:	1. Needs Assessment participation will be captured in Qualtrics. No additional entry is needed. 2. Case review -30 days after the close of the performance period or by December 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:	Needs assessment- submitted once in Qualtrics by September 1, 2024. Dashboard engagement- dashboard to be accessed at least once per month from July 1, 2024, to December 31, 2024 (no submission required, this will be monitored and calculated by WSHA) Sepsis case reviews- submitted at least once during the performance period from July 1, 2024-December 31, 2024
Data collection system:	Qualtrics and Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	Needs Assessment (1 point)- full survey must be completed by September 1, 2024 for 1 point. If not completed by this date or partially completed, no points will be awarded. Dashboard Engagement (2 points)- Must access dashboard each month for 2 points. If dashboard is accessed 4 or 5 of the 6 months, hospital receives 1 point. If accessed 3 or fewer months during submission period, no points will be awarded. Sepsis Case Reviews (7 points)- Hospitals must submit data on case reviews of 30 random cases from the populations specified above. If a hospital has less than 30 cases total for these 3 populations for a 1 year period, they should complete case reviews and submit data on 100% of cases. Hospitals must submit data on 30 cases (or 100% of

	cases if less than 30 are part of the population) to receive the 7 points.

Workforce Safety: Workplace Violence (WPV)

Proposed Measure	Ryan Robertson, RyanR@wsha.org
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric.
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

<table>
<tr><td></td><td>given access to translators when seeking care in an environment where their primary language is not spoken.

Language has been included to ensure that hospitals are reviewing language as a consideration of investigation into workplace violent events, and is included in proper documentation for review of WPV events.
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</td></tr>
<tr><td>Definition:</td><td>Number (count) of workplace violence events by a patient in which a workplace violent event has occurred within the hospital setting.</td></tr>
<tr><td>Included Populations:

Exclusions:</td><td>Pediatrics and admitted adult patients (i.e., ≥ 18 years of age), and specialty patients.

No exclusions.</td></tr>
<tr><td>Fields to be reported:</td><td>• Number (count) of workplace violence events in which a physical assault or threat of physical assault occurred within the hospital setting
• Age
• Location
• # of non-English speakers
• # of times non-English speakers were offered a translator</td></tr>
<tr><td>Data Collection period:</td><td>July 1, 2024 - December 31, 2024</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, 2024, to December 31, 2024).</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>Submission of all WPV events for all 6 months with no "N/A".
<table>
<tr><td>Thresholds</td><td>All Patient WPV Events
• Age |Location
• # non-English speakers
• # of times non-English speakers were offered a translator</td></tr>
<tr><td>Point Awards 2024</td><td>10 points</td></tr>
</table></td></tr>
</table>