Washington State:
Medicaid Quality Incentive Measure Guidelines

July 1, 2017

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

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

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

Infection Prevention:

- Clostridium difficile Infections per 10,000 patient days (NHSN) (Hospital-Wide)
- Colon Surgical Site Infection per 100 procedures (NHSN) (*adult acute*)

Antimicrobial Stewardship:

- Achievement of WSHA Antimicrobial Stewardship Basic Tier Structural Components

Workforce Safety:

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

Nursing Measures:

- Pressure Ulcer (AHRQ PSI 03) (Hospital-Wide) (*adult acute and rehabilitation*)
- Falls with Injury Per Patient Day (NQF 0202) (*adult acute and rehabilitation*)

Updated March 19, 2018

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

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

Safe Deliveries: (hospitals with obstetrical programs only):

- Percent of Patients with Elective Deliveries 37 to Less than 39 Weeks Gestational Age (PC-01)—*Data Submission only*
- Percent Non-Medically Indicated Inductions with Unfavorable Cervix in Nulliparous Women
- Severe Maternal Morbidity: Hemorrhage and Severe Hypertension/Preeclampsia Policies and Procedures

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

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

Infection Prevention

Clostridium difficile Infections per 10,000 patient days (NHSN) (Hospital-Wide)

Clinical Rationale:

C. difficile is responsible for half a million infections and 29,000 U.S. deaths each year. While 50 percent of CDI occur in those younger than 65, infections in the elderly are particularly devastating with a mortality rate of 90 percent. It is estimated that costs associated with CDI increased by estimates of up to $4.8 billion annually.

Clostridium difficile is a spore forming bacteria spread by the fecal-oral route and resistant to heat and many standard cleaning agents. Transmission in health-care facilities usually occurs as a result of environmental surface contamination and hand carriage by staff members and infected patients of these spores. After colonizing the colon, *Clostridium difficile* releases two protein endotoxins, A and B, which result in illness, ranging from uncomplicated diarrhea, pseudomembranous colitis, and toxic megacolon, which can, in some instances, lead to sepsis and even death. A balanced and healthy intestinal flora normally bars colonization. This resistance is weakened by exposure to antibiotics.

Several factors may have contributed to the rise in CDI incidence in recent years. The most important primary risk factors include:

- Advanced age (greater than 65)
- Prolonged duration of hospital stay
- Antimicrobial therapy
- Gastric acid suppression--proton pump inhibitors (PPIs)
- Immunosuppressed or immunocompromised status
- Kidney disease

Patients would benefit from interventions to prevent the significant complications of CDI. The measure will include all in-patients regardless of payor.

Selected References:

1. Agency for Healthcare Research and Quality. (2012). *Evaluation and Research on Antimicrobial Stewardship's Effect on Clostridium difficile (ERASE C. difficile) Project Toolkit for Reduction of Clostridium difficile Through Antimicrobial Stewardship* (AHRQ Publication No. 12-0082-EF). Rockville, MD.
2. Dubberke, E. R., Carling, P., Carrico, R., Donskey, C. J., Loo, V. G., McDonald, L. C. …Gerding, D. (2014). Strategies to prevent clostridium difficile infections in acute care hospitals: 2014 update. *Infection Control & Hospital Epidemiology*, 35(06), 628-645.

3. Goudarzi, M., Seyedjavadi, S. S., Goudarzi, H., Aghdam, E. M., & Nazeri, S. (2014). Clostridium difficile Infection: Epidemiology, pathogenesis, risk factors, and therapeutic options. *Scientifica*, 2014, Article ID 916826, 1-9. doi:10.1155/2014/916826
4. Lessa, F., Mu, Y., Bamberg, W. M., Beldavs, Z.G., Dumyati, G. K., Dunn, J. R. … McDonald, L. C. (2015). Burden of clostridium difficile infection in the United States. *The New England Journal of Medicine*, 372, 825-834.
5. NHSN CDI Module-Centers for Disease Control and Prevention. Published January 2017. Retrieved from https://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf
6. WSHA CDI Prevention Toolkit. Published June 2016. Retrieved from http://www.wsha.org/wp-content/uploads/07_11_16_CDI_Toolkit_2016-FINAL.pdf.

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

This measure is defined by the CDC in the NHSN Device Module. The complete definition can be found at https://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf with the most current definition for the time period to be used.

The primary strategies used to prevent CDI include:

- Clinician, patient and family education on prevention of CDI transmission.
- Implementation of a robust Antimicrobial Stewardship program.
- Early rapid testing and diagnosis.
- Contact Enteric Precautions and Isolation.
- Compliance with recommended guidelines for Hand Hygiene.
- Strict cleaning and disinfection of equipment and environment.

Data will include information from applicable inpatients regardless of payor.

***Clostridium difficile (C. difficile)* LabID Event Reporting** From CDC NHSN measure, the measure is the overall facility-wide inpatient LabID events, that is, the number of hospital-onset CDI Laboratory-identified events collected >3 days after admission to the facility per 10,000 patient days. C. difficile testing in the laboratory is performed only on unformed (i.e., conforming to the shape of the container) stool samples.

Numerator: CDI LabID Events from all inpatient locations.

Denominator: Total number of patient days for the facility x 10,000, minus NICU, SCN, babies in LDRP, well-baby nurseries and well-baby clinics

Included Populations:

- C. difficile LabID Event reporting in any inpatient location.

Excluded Populations:

- NICU, SCN, babies in LDRP, well-baby nurseries and well-baby clinics.

Data Source
Data are to be reported monthly.

Fields to be reported:
- Number of CDI LabID Event for all inpatient locations.
- Total number of patient days for inpatient locations.

Data collection period: July 1, 2017 – December 31, 2017

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

Data collection system: National Healthcare Safety Network (NHSN)

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

CDI Event Award Table:

Threshold	> 8.00	> 3.67 to 8.00	> 0 to 3.67	0
Point Award	0	3	5	10

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

Infection Prevention

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

Clinical Rationale:

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

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

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

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

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

Selected References:

1. Keenan, J. E., Speicher, P. J., Thacker, J. K., Walter, M., Kuchibhatla, M., & Mantyh, C. R. (2014). Preventive surgical site infection bundle in colorectal surgery. JAMA Surgery JAMA Surg, 149(10), 1045. doi:10.1001/jamasurg.2014.346.
2. Kwon, S., Thompson, R., Dellinger, P., Rogers, T., & Flum, D. (2012). Importance of perioperative glycemic control in general surgery: A report from the surgical care and outcomes assessment program. Journal of Surgical Research, 172(2), 274. doi:10.1016/j.jss.2011.11.457.

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

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

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

Data will include information from applicable patients regardless of payor.

Numerator: Total colon SSI that meets NHSN criteria.

Denominator: Total colon procedures that meet NHSN criteria.

Included Populations:

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

Data Source

Data are to be reported monthly.

Fields to be reported:

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

Data collection period: July 1, 2017 – December 31, 2017

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

Data collection system: National Healthcare Safety Network (NHSN)

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

Colon Surgical Site Infections Award Table:

Threshold	> 4	> 2 to 4	> 0 to 2	0
Point Award	0	3	5	10

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

Antimicrobial Stewardship (AMS)- Achievement of WSHA AMS Basic Tier

Clinical Rationale:

The discovery of antibiotics in the early 20th century fundamentally transformed medicine. Antibiotics save millions of lives each year in the United States and around the world. However, 20-50% of all antibiotics prescribed in U.S. acute care hospitals are either unnecessary or inappropriate.

Patients which are unnecessarily exposed to antibiotics are placed at risk for serious adverse events with no clinical benefit. The misuse of antibiotics has also contributed to the growing problem of antibiotic resistance, which has become one of the most serious and growing threats to public health. Unlike other medications, the potential for spread of resistant organisms means that the misuse of antibiotics can adversely impact the health of patients who are not even exposed to them. The Centers for Disease Control and Prevention (CDC) estimates more than two million people are infected with antibiotic-resistant organisms, resulting in approximately 23,000 deaths annually.

Improving the use of antibiotics is an important patient safety and public health issue as well as a national priority. Hospital based programs dedicated to improving antibiotic use have demonstrated the optimal treatment of infections, reduction of adverse events associated with antibiotic use such as CDI and cost savings. Detecting, preventing, and controlling antibiotic resistance requires a strategic, coordinated, and sustained effort. Pharmacists, physicians and nurses play a key role. In recognition of the urgent need to improve antibiotic use in hospitals and the benefits of stewardship, in 2014, the CDC recommended that all acute care hospitals implement AMS Programs.

The WSHA AMS Tier Map summarizes core elements of successful hospital AMS programs and is in alignment with The Joint Commission, Centers for Medicare and Medicaid Services Conditions of Participation and the Centers for Disease Control elements.

Selected References:

1. CDC Core Elements of Hospital Antibiotic Stewardship Programs. Retrieved from https://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html
2. CDC Checklist for Core Elements of Hospital Antibiotic Stewardship Programs. Retrieved from https://www.cdc.gov/getsmart/healthcare/implementation/checklist.html
3. The Joint Commission Antibiotic Stewardship Standards. Published June 22, 2016. Retrieved from https://www.jointcommission.org/assets/1/6/HAP-CAH_Antimicrobial_Prepub.pdf
4. EQUIP Jump Start Stewardship Workbook for Critical Access Hospitals. Published March 2016. Retrieved from http://www.doh.wa.gov/Portals/1/Documents/5600/JumpstartStewardshipWorkbook.pdf.
5. Executive Order—Combating Antibiotic-Resistant Bacteria. September 18, 2014. Retrieved from https://obamawhitehouse.archives.gov/the-press-office/2014/09/18/executive-order-combating-antibiotic-resistant-bacteria.
6. National Quality Partners Playbook: Antibiotic Stewardship in Acute Care. Published May 2016. Retrieved from http://www.qualityforum.org/Publications/2016/05/National_Quality_Partners_Playbook__Antibiotic_Stewardship_in_Acute_Care.aspx.

Definition of Antimicrobial Stewardship Basic Tier--WSHA

The goal is to identify areas of opportunity to optimize antimicrobial utilization and decrease antimicrobial resistance patterns, development of secondary infections and adverse medication effects.

The WSHA AMS Basic Tier asks 8 questions related to leadership and multidisciplinary team commitment which is fundamental to creating the infrastructure to advance this work, moving towards implementation of the Intermediate and Advanced Tiers.

Data Source:

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

Fields to be Reported:

Answer "Yes" or "No" to the following 8 questions:

WSHA AMS Basic Tier's 8 Questions

1. Does your hospital have leadership commitment and accountability, establishing AMS as a priority, including policies and procedures? (Yes/No)
2. Does your hospital have collaboration with Infection Control and hospital QAPI leadership? (Yes/No)

3. Does your hospital have a dedicated multidisciplinary team to advance AMS, inclusive of pharmacy and clinical expertise? (Yes/No)
4. Is your hospital reporting Antimicrobial Utilization (AU) and improving upon AU (such as DOT of select antibiotics per 1000 patient days)? (Yes/No)
5. Does your hospital require annual competency based training of staff and licensed practitioners on AMS? (Yes/No)
6. Does your hospital provide patient and family education regarding appropriate use of antimicrobials? (Yes/No)
7. Has your hospital implemented organizational protocols, for example de-escalation processes, guidelines or 48-72 hour time-outs? (Yes/No)
8. Does your hospital have drug expertise, including an appointed pharmacist leader responsible for improving AMS? (Yes/No)

Inclusion Criteria:

- Patients of all ages, who are admitted to hospital bed regardless of status (e.g. include observation, rehab and swing bed patients)
- All routes (oral, IV, IM)

Exclusion Criteria:

- Well newborns not admitted to a pediatric unit or NICU
- Doses given to patients in the Emergency Department or Ambulatory Surgery

Data collection period: July 1, 2017 – December 31, 2017

Reporting deadline: Reported within 45 days after the end of the performance period.

Data collection system: Quality Benchmarking System (QBS)

Antimicrobial Stewardship Basic Tier Award Table:

Threshold	Answer "No" to all 8 questions	Answer "No" to some questions and "Yes" to some questions	Answer "Yes" to all 8 questions
Point Award	0	0	10

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

Workforce Safety

Clinical Rationale:

Healthcare is the fastest-growing sector of the U.S. economy, employing over 18 million workers. In 2011, U.S. hospitals recorded 253,700 work-related injuries and illnesses, a rate of

6.8 work-related injuries and illnesses for every 100 full-time employees. In terms of lost-time case rates, it is more hazardous to work in a hospital than in construction or manufacturing. Cases of nonfatal occupational injury and illness with healthcare workers are among the highest of any industry sector.

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

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

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

Selected References:

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

Definition – Worker's Compensation Claims

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

The primary strategies used to prevent workforce injuries include:

- Leadership commitment to workplace safety as priority.
- Workplace hazard assessment for correction and control.

- Worker education on safety measures and compliance expectations.
- Implementation of robust reporting system and response to events.
- Protective equipment for workers.
- Prompt and appropriate follow-up with injured worker.

Numerator: Number of approved worker's compensation claims.

Denominator: Total number of hours worked by all employees.

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

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

Data Categories

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

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

Data Source

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

Data collection period: July 1, 2017 – December 31, 2017

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

Data collection system: Third Party Administrator and QBS.

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

Workforce Safety Award Table:

Threshold	>= 8.5	6.28 to < 8.5	4.5 to < 6.28	0 to < 4.5
Point Award	0	3	5	10

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

Nursing Measures

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

Clinical Rationale:

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

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

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

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

Selected References:

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

Definition – AHRQ PSI 03

This measure is defined by the AHRQ. The definition can be found at https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD10/TechSpecs/PSI_03_Pressure_Ulcer_Rate.pdf with the most current definition for the time period to be used. ICD-10 codes are utilized.

The primary strategies used to prevent pressure ulcers include:

- Assessing for pressure ulcer risk and creating care plan.
- Using skin care products and appropriate pressure relief surfaces.

- Implementing repositioning program.
- Preventing skin tears and deep tissue injury.
- Monitoring nutritional and hydration status.
- Implementing a pressure ulcer prevention protocol.

Data will include information from applicable patients regardless of payor.

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

Denominator: All medical and surgical discharges age 18 years and older as defined.

Excluded Populations:

- Length of stay of less than 3 days
- A principal ICD-10-CM diagnosis code for pressure ulcer
- Any secondary ICD-10-CM diagnosis codes for pressure ulcer stage III or IV (or unstageable) present on admission
- Any-listed ICD-10-CM diagnosis codes for hemiplegia, paraplegia, or quadriplegia
- Any-listed ICD-10-CM diagnosis codes for spina bifida or anoxic brain damage
- Any-listed ICD-10-PCS procedure codes for debridement or pedicle graft before or on the same day as the major operating room procedure (surgical cases only)
- Any-listed ICD-10-PCS procedure codes for debridement or pedicle graft as the only major operating room procedure (surgical cases only)
- Transfer from a hospital (different acute care facility)
- Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- A principal or any secondary ICD-10-CM diagnosis codes present on admission for major skin disorders
- MDC 14 (pregnancy, childbirth, and puerperium)
- Missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

Data Source

Data are to be reported monthly

Fields to be reported:

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

Data collection period: July 1, 2017 – December 31, 2017

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

Data collection system: CHARS

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

Pressure Ulcer Award Table:

Threshold	> 0.8	> 0.55 to 0.8	> 0 to 0.55	0
Point Award	0	3	5	10

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

Nursing Measures

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

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

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

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

Successful strategies to prevent falls include the use of a standardized assessment tool to identify fall and injury risk factors, assessing an individual patient's risks that may not have been captured through the tool, and interventions tailored to an individual patient's identified risks.

In addition, systematic reporting and analysis of falls incidents are important components of a falls prevention program

Selected References:

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

Definition – National Quality Forum

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

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

The primary strategies used to prevent falls with injuries include:

- Screening for fall and injury risk and creating care plan.
- Conducting on-going risk assessments, including medication review.
- Implementing scheduled rounding protocols.
- Performing routine environmental safety rounds.
- Ensuring assistive devices are within reach.
- Educating staff and patients on fall prevention.

Definition:

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

Included Populations:

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

Injury Levels:

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

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

Included Populations:

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

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

<u>Data Source:</u>
Data are to be submitted to WSHA by the Quality Benchmarking System (QBS) or Collaborative Alliance of Nursing Outcomes (CALNOC). National Database of Nursing Quality Indicators (NDNQI) not available at this time due to request for payment if they share the information.

Fields to be reported:

- Aggregate number of patients with falls minor through death

- Aggregate number of patient days from all eligible units

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

Data collection period: July 1, 2017 – December 31, 2017

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

Data collection system: WSHA Quality Benchmarking System or CALNOC. NDNQI currently not available.

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

Falls with Injury Per Patient Day Award Table:

Threshold	> 1	> 0.68 to 1.00	> 0.38 to 0.68	0 to 0.38
Point Award	0	3	5	10

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

ER is for Emergencies

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

Clinical Rationale:

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

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

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

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

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

Data Source:

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

Fields to be reported:

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

Data collection period: July 1, 2017 – December 31, 2017

Updated March 19, 2018

Data collection system: EDIE

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

ER is for Emergencies Award Table:

Threshold	0%	>10% to 20%	>20% to 31%	>31%
Point Award	0	3	5	10

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

Safe Deliveries

Percent Non-Medically Indicated Inductions with Unfavorable Cervix in Nulliparous Women

Clinical Rationale:

Due to the rising costs and complications of pregnancy in the United States over the last several years, the quality and cost effectiveness of perinatal care have received increased attention from clinicians, consumers, and payors[1, 2, 3].

A known contributor to the current state is the utilization of treatments that are not necessary. In the seminal report entitled *Evidenced-based Maternity Care: What it is and What it Can Achieve (2008),* induction of labor without a medical indication was listed as an intervention that is commonly overused [4.]

As part of the Choosing Wisely Campaign, a partnership initiative between American Board of Internal Medicine (ABIM) and medical specialty societies to help physicians, patients and other health care stakeholders talk about the overuse of health care resources in the United States, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP) are recommending not to schedule non-medically indicated inductions of labor between 39 and 41 weeks gestation unless the cervix is favorable[5].

In 2012, experts from the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the American College of Obstetricians and Gynecologists, and the Society for Maternal-Fetal Medicine convened to review and synthesize the literature on labor management. Key points were identified to assist with reduction in cesarean rates including that labor induction should be performed primarily for medical indication; if done for non-medical indications, the gestational age should be at least 39 weeks or more and the cervix should be favorable, especially in the nulliparous patient[6].

In a more recent publication (February 2014), the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) released a consensus statement on the overuse of cesarean. The statement confirms that the procedure is too often used in ways that do not improve maternal and child health outcomes and among their recommendations they suggest that labor induction before the 41st week of pregnancy should generally be done for medical reasons only[7].

From a local perspective, in August of 2012 the Bree Collaborative released a significant paper supporting this work and recommending that hospitals follow specific guidelines for scheduling elective inductions between 39 and 41 weeks to prevent overuse[8]. The Perinatal Collaborative and WSHA have taken the medical evidence and translated it into evidence based care through the use of checklists.

Data shows wide variation among care providers in their criteria for offering a non-medically indicated induction. A few hospitals don't offer them at all, some hospitals offer them but only if the cervix is favorable, and many offer them even if the cervix is not favorable. This measure will require care providers to identify whether the cervix is favorable for a non-medical induction in nulliparous women.

Selected References:

1. Martin JA, Hamiton BE, Ventura SJ, et al. Births: Final data for 2009. National statistics reports. Vol 60, no 1. Hyattsville, MD: National Center for Health Statistics; 2011.
2. Kozhimannil, K. B., Law, M. R., & Viring, B. A. (2013). Cesarean delivery rates vary tenfold among US hospitals; Reducing variation may address quality and cost issues. vol. 32 no. 3 527-535. doi: 10.1377/hlthaff.2012.1030
3. Consumer Report (2014) - What hospitals don't want you to know about C-sections: expecting: Retrieved from http://www.consumerreports.org/cro/2014/05/what-hospitals-do-not-want-you-to-know-about-c-sections/index.htm
4. Sakala, C. & Corry, M.P. (2008). Evidence-based maternity care: What it is and what it can achieve. New York, NY: Milbank Memorial Fund. ISBN 978-1-887748-70-4.
5. Choosing wisely, AIBM Foundation (2013). The American College of Obstetricians and Gynecologists, Five Things Physicians and Patients Should Question. Retrieved from: http://www.choosingwisely.org/doctor-patient-lists/american-college-of-obstetricians-and-gynecologists/
6. Spong CY, Berghella V, Wenstrom KD, Mercer BM, Saade GR. Preventing the first cesarean delivery: summary of a joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop. Obstet Gynecol 2012;120:1181–93.
7. American College of Obstetricians and Gynecologists, & Society for Maternal-Fetal Medicine. (2014). *Safe prevention of the primary cesarean delivery*. Washington, DC: American College of Obstetricians and Gynecologists. Retrieved

from:http://www.acog.org/Resources_And_Publications/Obstetric_Care_Consensus_Series/Safe_Prevention_of_the_Primary_Cesarean_Delivery

8. Bree Collaborative (2012). Obstetrics care topic report and recommendations. Retrieved from: http://www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf

Measure Definition:

Description: Percent non-medically indicated inductions with unfavorable cervix in nulliparous women.

Numerator: Number of non-medically indicated inductions with Bishop's score < 9, prior to cervical ripening**,** in nulliparous women.

Denominator: Total number of deliveries.

Non-medically indicated induction:

Definition: Labor induction without clear medical benefits to mother or fetus at that point in time compared with continuation of pregnancy.

Guide for indications that make the induction non-medically indicated:

- History of fast labor.
- Distance from hospital.
- Suspected macrosomia (without history of shoulder dystocia).
- Psychosocial (e.g. partner's deployment date, family or significant relation availability, adoption, etc.).
- Maternal discomfort (e.g. hemorrhoids, reflux, sciatic nerve pain, fatigue, etc.).
- Advanced cervical dilation, GBS negative.

Source: WSHA Safe Deliveries Roadmap (adapted from NNEQUIN http://www.nnepqin.org/Guidelines.asp)

Data Source:

Data are to be submitted to WSHA by the Quality Benchmarking System or the Washington State Hospital Association Maternal Data Center. Data will be collected monthly.

Fields to be reported:

- Number of non-medically indicated inductions with Bishop's score <9, prior to cervical ripening, in nulliparous women. (*numerator*)
- Total number of deliveries. (*denominator*)

Data collection period: July 1, 2017 - December 31, 2017

Report deliveries starting July to determine which award table will be used.

Reporting deadline: 75 days following the end of the Month.

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

QBS file name:

MQI_Elective_Induction_With_Unfavorable_Cervix_in_Nullips_per_Total_Deliveries_(*Hospital_Name*).xls

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

Obstetrical Inductions Award Tables:

For hospitals with ≤100 deliveries/6 months (July-December 2017)

Threshold	> 3 cases	3 cases	2 cases	≤ 1 case
Point Award	0	3	5	10

For hospitals with >100 deliveries/6 months (July-December 2017)

Threshold	> 3%	3% – > 2%	2% – 0.6%	< 0.6 %
Point Award	0	3	5	10

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

Safe Deliveries:

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

Clinical Rationale:

For almost three decades, the American College of Obstetricians and Gynecologists[2] and the American Academy of Pediatrics[1] have had in place a standard requiring 39 completed weeks gestation prior to elective delivery, either vaginal or operative[2]. A 2007 ACOG and March of Dimes survey of almost 20,000 births conducted in Hospital Corporation of America hospitals found that almost one-third of all term babies 37 weeks gestational age or greater were electively delivered with 5 percent delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) [3].

According to Glantz, compared to spontaneous labor, elective inductions result in more cesarean deliveries and longer maternal length of stay[4]. The American Academy of Family Physicians also notes that elective induction doubles the cesarean delivery rate[1]. Repeat elective cesarean sections before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns[5].

The focus on elective deliveries prior to 39 weeks was the first step in an effort to reduce the rate of C-sections in Washington State. In 2010, the rate of elective delivery prior to 39 weeks in Washington was 15.5%. Washington is now at about 1%. Since 2010, other strategies have been implemented such as best practices for induction of labor between 39 and 41 weeks, and first and second stage labor management.

Selected References:

1. American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved May 29, 2013: http://www.aafp.org/afp/2000/0215/p1173.html.
2. American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
3. Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. Am J Obstet Gynecol. 200:156.e1-156.e4.
4. Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. J Reprod Med. 50(4):235-40.
5. Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. NEJM. 360:2, 111-120.

Definition – The Joint Commission Definition using Total Population (not sampling)

This measure is defined by The Joint Commission under PC-01. The current complete definition can be found at https://manual.jointcommission.org/releases/TJC2016B1/MIF0166.html
The most up to date definition from The Joint Commission for the data collection period will be used. Data will include information from applicable patients regardless of payor.

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

Definition:

Numerator: Patients with elective deliveries >=37 and < 39 weeks gestation

Included Populations: ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following:

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

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

Included Populations:

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

Excluded Populations:

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

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

Data Source:

Updated March 19, 2018

Data are to be submitted to Quality Benchmarking System or the Washington State Hospital Association Maternal Data Center.

Fields to be reported:

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

Data collection period: July 1, 2017 – December 31, 2017

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

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

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

Review Process for Safety

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

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

Request for External Review of Early Elective Delivery

Any cases that the hospital wishes to be reviewed must be submitted to the Health Care Authority Chief Medical Officer in writing by February 15, 2018. November and December deliveries only have a deadline of March 15, 2018. The review form is available on the quality incentive page of the WSHA website: http://www.wsha.org/quality-safety/projects/medicaid-quality-incentive/

Elective Delivery Between 37 and 39 Weeks Award Table:

Threshold	Incomplete data	Complete Data
Point Award	0	5

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

Safe Deliveries:

Severe Maternal Morbidity: Hemorrhage and Severe Hypertension /Preeclampsia Policies and Protocols

Clinical Rationale:

The 2016 American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal–Fetal Medicine's (SMFM) Obstetric Care Consensus publication on severe maternal morbidity states: "Severe maternal morbidity is associated with a high rate of preventability, similar to that of maternal mortality. It also can be considered a near miss for maternal mortality because without identification and treatment, in some cases, these conditions would lead to maternal death. Identifying severe morbidity is, therefore, important for preventing such injuries that lead to mortality and for highlighting opportunities to avoid repeat injuries."[1] Unfortunately, the incidence of severe maternal morbidity is increasing in the United States, with a 200% increase in incidence between 1993 (47.6 per 10,000 deliveries) and 2014 (141.6 per 10,000 deliveries).[2] The two most common preventable causes of severe maternal morbidity are obstetric hemorrhage and severe hypertension/preeclampsia in pregnancy.[3]

The National Partnership for Maternal Safety (NPMS), part of the Council on Patient Safety in Women's Healthcare, has developed and published Patient Safety Bundles focusing on many topics contributing to severe maternal morbidity, including Obstetric Hemorrhage and Severe Hypertension in Pregnancy.[4] The California Maternal Quality Care Collaborative (CMQCC) has also developed and published toolkits on obstetric hemorrhage and preeclampsia.[5] Both the NPMS and CMQCC bundles for obstetric hemorrhage and severe hypertension/preeclampsia include a focus on readiness, recognition and response in an effort for timely identification of women at risk to mitigate the severity of the outcome. Specifically, with regards to hemorrhage the CMQCC Obstetric Hemorrhage Toolkit states:

> "Rapid recognition and treatment are necessary to prevent progression of hemorrhage as women can lose large volumes of blood very quickly due to the physiologic changes of pregnancy. However, obstetric hemorrhage is also a low-volume, high-risk event for any given birth facility: without advance planning the probability of mounting a rapid, coordinated response is low. Indeed, maternal mortality reviews have consistently revealed problems with recognition, communication, and effective application of interventions as contributory factors in deaths from maternal hemorrhage."[6]

With the passing of the Maternal Mortality Review Panel bill in 2016, there has been an increased focus and systematic evaluation of maternal deaths in Washington to identify the causes and create recommendations for "system changes to improve health care services for women in this state."[7]

Ensuring that all hospitals have a policy/protocol to address readiness, recognition and response to maternal hemorrhage and severe hypertension/preeclampsia is a first step to reducing the incidence of severe maternal morbidity and mortality in Washington State.

Selected References:

1. https://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Severe-Maternal-Morbidity-Screening-and-Review
2. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html#anchor_References
3. D'Alton ME1, Main EK, Menard MK, Levy BS. The National Partnership for Maternal Safety. Obstet Gynecol. 2014 May;123(5):973-7
4. http://safehealthcareforeverywoman.org/patient-safety-bundles/
5. https://www.cmqcc.org/resources-tool-kits/toolkits
6. https://www.cmqcc.org/resource/ob-hem-executive-summary
7. http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/MaternalMortalityReviewPanel

Definition:

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

Data Source:

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

Fields to be Reported:

Answer "Yes" or "No" to the following 2 questions and upload each policy/protocol to QBS:

1. Do you have a Hemorrhage policy/protocol in place for assessing, recognizing and responding to maternal hemorrhage? (Yes/No)
2. Do you have a Severe Hypertension/Preeclampsia policy/protocol in place for assessing, recognizing and responding maternal severe hypertension/preeclampsia? (Yes/No)

Data collection period: July 1, 2017 – December 31, 2017. Monthly data submission not required. Submit only one response for both question #1 and question #2, along with your policies/protocols, for the MQI time period.

Reporting deadline: Data submitted by December 31, 2017.

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

Updated March 19, 2018

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

Severe Maternal Morbidity Measure Award Table:

Threshold	Answer "No" to both question #1 and #2; no policies/protocols submitted	Answer "No" to one question and "Yes" to one question; one policy/protocol submitted	Answer "Yes" to both question #1 and #2; both policies/protocols submitted
Point Award	0	0	10

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

Behavioral Health Safety Measures-Adult and Pediatrics

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

Clinical Rationale:

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

The Transition Record with Specified Elements Received by Discharged Patients measure assesses the percentage of patients, regardless of age, discharged from an In-Patient Psychiatric Facility (IPF) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, two (of 11 recommended by CMS) specified elements.

Definition:

Definition of the CMS measure is at:

http://www.wsha.org/wp-content/uploads/IPF_CY16_IPFQRPrgmMnl_012616-8.pdf

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

Sampling: *The hospital may use CY 2017 CMS Sampling Specifications for the quarterly sample size based on the non-stratified initial patient population for the measure set. However, if the hospital has 0-77 cases per quarter, then 100% of the initial patient population would be required. The CMS methodology (page 11) is available at:*

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

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

Contact Information/Plan for Follow-up Care
- Plan for follow-up care, AND
- Primary physician, other health care professional, or site designated for follow-up care.

These are 2 of the 11 elements which CMS required effective January 1, 2017.

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

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

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

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

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

Data collection period*:* July 1, 2017 – December 31, 2017

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

Updated March 19, 2018

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

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

Behavioral Health Transition Record with Two Specified Elements Received by Discharged Patients Overall Rate Award Table:

Threshold	< 70%	70% - 80%	>80% – 90%	> 90%
Point Award	0	3	5	10

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

Behavioral Health Safety Measures-Adult and Pediatrics

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

Clinical Rationale:

Research studies have found that 4-35% of outpatients and 30-50% of inpatients treated with an antipsychotic medication concurrently received 2 or more antipsychotics (Covell, Jackson, Evans, & Essock, 2002; Ganguly, Kotzan, Miller, Kennedy, & Martin, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; Kreyenbuhl, Valenstein, McCarthy, Ganocyz, & Blow, 2006; Stahl & Grady, 2004). One study reported 4.6% of patients concurrently received 3 or more antipsychotics (Jaffe & Levine, 2003). These findings are seen across diverse sectors: state mental health authorities, the Veterans Health System and Medicaid-financed care. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes (Ananth, Parameswaran, & Gunatilake, 2004; Stahl & Grady, 2004). As a result, a range of stakeholders have called for efforts to reduce unnecessary use of multiple antipsychotics (Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Gilmer, Dolder, Folsom, Mastin, & Jeste, 2007; National Association of State Mental Health Program Directors, 2001; University Applications/LocalApps.HealthSystem Consortium, 2006). Practice guidelines recommend the use of a second antipsychotic only after multiple trials of a single antipsychotic have proven inadequate (American Psychiatric Association [APA] Practice Guidelines, 2004). Randomized controlled trials (RCTs) provide some evidence to support augmentation with a second antipsychotic in treatment resistant patients. Most of these studies were limited to augmentation of clozapine with another second-generation antipsychotic (Tranulis, Skalli, Lalonde, & Nicole, 2008). Among patients without a documented history of previous treatment failures of antipsychotic monotherapy, multiple RCTs and other

controlled trials failed to show a benefit of antipsychotic polypharmacy over monotherapy (Ananth, Parameswaran, & Gunatilake, 2004; Centorrino, Gören, Hennen, Salvatore, Kelleher, & Baldessarini, 2004; Potkin, Thyrum, Alva, Bera, Yeh, & Arvanitis, 2002; Shim et al., 2007; Stahl,& Grady, 2004). Clinical circumstances, such as shorter inpatient stays, may require hospitals to discharge a patient on multiple antipsychotics with an aftercare plan to transition to monotherapy. In such cases, effective communication between the inpatient and aftercare clinician is an essential element of care.

Selected references:

1. American Psychiatric Association (APA). (2004). Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry*. 161(2 Suppl):1-56
2. Ananth, J., Parameswaran, S., & Gunatilake, S. (2004). Antipsychotic polypharmacy comparing monotherapy with polypharmacy and augmentation. *Curr Med Chem*. 11(3):313-327 *Curr Pharm Des*. 10(18):2231-2238.
3. Centorrino, F., Gören, J.L., Hennen, J., Salvatore, P., Kelleher, J.P., & Baldessarini, R.J. (2004) Multiple versus single antipsychotic agents for hospitalized psychiatric patients: a case control study of risk versus benefit. *Am J Psychiatry*. 161 (4):700-706.
4. Covell, N.H., Jackson, C.T., Evans, A.C., & Essock, S.M. (2002). Antipsychotic prescribing practices in Connecticut's public mental health system: rates of changing medication prescribing styles. *Schiz Bull*. 28(1):17-29,
5. Ganguly, R., Kotzan, J.A., Miller, L.S., Kennedy, K., & Martin, B.C. (2004). Prevalence, trends, and factors associated with antipsychotic polypharmacy among Medicaid-eligible schizophrenia patients, 1998-2000. *J Clin Psychiatry*. 65(10):1377-88.
6. Gilmer, T.P., Dolder, C.R., Folsom, D.P., Mastin, W., & Jeste, D.V. (2007), Antipsychotic polypharmacy trends among Medicaid beneficiaries with schizophrenia in San Diego County, 1999 - 2004. *Psychiatric Serv*. 59(7):1007-1010.
7. Jaffe, A.B. & Levine, J. (2003). Antipsychotic medication co-prescribing in a large state hospital system. *Pharmacoepidemiol Drug Saf*.12:41-48.
8. Kreyenbuhl, J., Valenstein, M., McCarthy, J.F., Ganocyz, D., & Blow, F.C. (2006). Long-term combination antipsychotic treatment in VA patients with schizophrenia.*Schiz Res*.84:90-99.
9. National Association of State Mental Health Program Directors (NASMHPD). (2001).Technical report on psychiatric polypharmacy. Alexandria, VA.
10. Potkin, S.G., Thyrum, P.T., Alva, G., Bera, R., Yeh, C., & Arvanitis, L.A. (2002). The safety and pharmacokinetics of quetiapine when coadministered with haloperidol, risperidone or thioridazine. *J Clin Psychopharmacol*. 22:121-130.
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Definition:

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

Data will include information from applicable patients regardless of payor.

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

Included Populations:

- All ages

Denominator:
Psychiatric inpatient discharges.

Included:

- Patients with *ICD-10-CM Principal or Other Diagnosis Codes* for Mental Disorders as defined in Appendix A, Table 10.01 discharged on two or more routinely scheduled antipsychotic medications (refer to Appendix C, Table 10.0- Antipsychotic Medications).

Exclusions:

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

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

Fields to be reported:

- Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.
- Psychiatric inpatient discharges.

Data collection period*:* July 1, 2017 – December 31, 2017

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

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

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

Behavioral Health Patients Discharges on Multiple Antipsychotic with Justification Award Table:

Threshold	0% to < 50%	50% to < 70	70% to < 80%	>= 80%
Point Award	0	3	5	10

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