Washington State:
Medicaid Quality Incentive Measure Guidelines

July 1, 2016

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. With the new ICD-10 coding, the impact to data results will be monitored and thresholds adjusted if needed.

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 Lucia Austin-Gil (LuciaA@wsha.org).

Infection Prevention:

- Catheter Associated-Urinary Tract Infections Per Device Days (HAI-2) (Hospital-Wide) (adult acute, rehabilitation, and pediatrics)
- Central Line Associated-Blood Stream Infection per Device Days (HAI-1) (Hospital-Wide) (adult acute and pediatric)
- Colon Surgical Site Infection per 100 procedures (NHSN) (adult acute)
- Staff Immunizations (NHSN) (hospital-wide adult acute, rehabilitation, pediatric, and behavioral health)

Safety:

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

Updated September 19, 2016
**Nursing Measures:**

- Catheter Associated-Urinary Tract Infections Per Device Days (HAI-2) (Hospital-Wide) (*adult acute, rehabilitation, and pediatrics*)
- Central Line Associated-Blood Stream Infection per Device Days (HAI-1) (Hospital-Wide) (*adult acute and pediatric*)
- Pressure Ulcer (AHRQ PSI 03) (Hospital-Wide) (*adult acute and rehabilitation*)
- Questions: (*acute, rehabilitation, and pediatric*)
  - Did the nurse staffing committee meet in 2016 and make recommendations to the executive team?
  - Did the executive team provide their response back to the nurse staffing committee?
  - Did the nurse staffing committee and executive team have access to the unit level data on the nursing measures?

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

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

**Safe Deliveries: (hospitals with obstetrical programs only):**

- Percent Non-Medically Indicated Inductions with Unfavorable Cervix in Nulliparous Women
- Percent of Patients with Elective Deliveries 37 to Less than 39 Weeks Gestational Age (PC-01)
- Cesarean Section Rate for Low Risk, First Born - NTSV (PC-02)

**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)
- Staff Immunizations (NHSN) (Hospital-Wide) (see above under infections)
Infection Prevention

Catheter Associated-Urinary Tract Infections Per 1000 Device Days (HAI-2) (Hospital-Wide) (adult acute, rehabilitation, and pediatric)

Clinical Rationale:

Greater than 560,000 CAUTI occur each year nationally with a 2.3 percent mortality rate and annual cost of $565 million1. Seventy-five percent of hospital acquired urinary tract infections are associated with catheters2 and in Washington some of the infections have been identified as being due to antibiotic resistant organisms. National literature shows that catheters are only placed for appropriate clinical indication 21 percent of the time and remain in use for unjustified reasons in as high as 40-60 percent of cases. Of the patients getting a urinary tract infection in the hospital, fifty percent will have a reoccurrence within sixty days3. The patients experience discomfort, prolonged hospital stays, increased cost, and are at a higher risk for other complications and even death.

Patients would benefit from interventions to prevent the significant complications of CAUTI. The measure will include all in-patients who spend the night in the hospital regardless of payor.

Recognizing that the infection rate between intensive care units (ICU) and medical/surgical units are different, the scores for ICU and medical/surgical units will be submitted separately and awarded points on their own unique point scale. The scores will added together and divided by two.

Selected References:

4. The National and State Healthcare-Associated Standardized Infection Report (SIR) released on February 7, 2013 by the Centers for Disease Control and Prevention (CDC)

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

Updated September 19, 2016
This measure is defined by the CDC in the NHSN Device Module. The complete definition can be found at [http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf](http://www.cdc.gov/nhsn/PDFs/pscManual/7pscCAUTIcurrent.pdf) with the most current definition for the time period to be used.

The primary strategies used to prevent CAUTI include:

- Placement only when medically necessary.
- Ensuring aseptic technique catheter insertion.
- Complying with hand hygiene recommendations.
- Ensuring appropriate urinary catheter maintenance.
- Removing unnecessary urinary catheters with nurse-directed protocols for removal.

Data will include information from applicable patients regardless of payor.

**Numerator:** CAUTI that meets NHSN criteria will be reported for ICU and non-ICU separately.

Included Populations:

- Adult, pediatric, and neonatal inpatient units (excluding units classified in NHSN as behavioral health, ICU burn, ICU neuro, and ICU trauma)

**Denominator:** Device days for ICU and non-ICU will be used for the denominator reporting as CAUTI per 1000 device days. ICU and non-ICU will be reported separately.

Included Populations:

- Patients of any age on an eligible reporting unit are included in the device day total.

Excluded Populations:

- Burn, neuro, and trauma intensive care units and behavioral health units as designated in NHSN.

**Data Source**
Data are to be reported monthly.

**Fields to be reported:**
- Number of CAUTI ICU
- Number of device days ICU
- Number of CAUTI non-ICU
- Number of device days non-ICU

**Data collection period:** July 1, 2016 – December 31, 2016

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

Updated September 19, 2016
**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.

<table>
<thead>
<tr>
<th>CAUTI Per Device Day Award Table ICU:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Threshold</strong></td>
</tr>
<tr>
<td><strong>Point Award</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CAUTI Per Device Day Award Table non-ICU:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Threshold</strong></td>
</tr>
<tr>
<td><strong>Point Award</strong></td>
</tr>
</tbody>
</table>

This measure is used in the quality incentive for acute care, pediatric, and rehabilitation hospitals. Points are awarded based on adding together the scores from an ICU and non-ICU and dividing by two.
Infection Prevention

Central Line Associated-Blood Stream Infection per 1000 Device Days (HAI-1) (Hospital-Wide) (adult acute and pediatric)

Clinical Rationale:

An estimated 41,000 central line associated-bloodstream infections (CLABSI) occur in U.S. hospitals each year. Bloodstream infections (BSIs) are a major cause of healthcare-associated morbidity and up to 35% attributable mortality. BSI leads to prolonged hospital stays, fever, discomfort for the patient and increased cost.¹

Fortunately, CLABSI is preventable in the majority of cases.² A substantial number of CLABSIs occur in non-ICU settings, especially in outpatient hemodialysis centers and inpatient wards.³ CLABSIs can often be prevented through following proper precautions at the time the line is inserted (central line insertion practices), care of the line while it is in place (central line maintenance practices), and removal of the line as soon as it is no longer necessary.

All patients, regardless of payor, will be included in this measure and benefit from the key interventions to prevent CLABSI and the associated complications. Recognizing that the infection rate between intensive care units (ICU) and medical/surgical units are different, the scores for ICU and medical/surgical units will be submitted separately and awarded points on their own unique point scale. The points will then be added together and divided by two.

Selected References:

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 [http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf](http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf) with the most current definition for the time period to be used.4

The primary strategies used to prevent CLABSI include:

- Placement only when medically necessary.
- Choosing proper central line insertion sites.
- Complying with hand hygiene recommendations.
- Adequate skin antisepsis.
- Following proper insertion and maintenance practices.
- Performing adequate hub/access port disinfection.
- Providing education on central line maintenance and insertion.
- Removing as early as possible.

Data will include information from applicable patients regardless of payor.

**Numerator:** CLABSI that meets NHSN criteria will be reported for ICU and non-ICU separately.

Included Populations:

- Adult, pediatric, and neonatal inpatient units (excluding units classified in NHSN as behavioral health, ICU burn, and ICU trauma)

**Denominator:** Device days for ICU and non-ICU will be used for the denominator reporting. ICU and non-ICU will be reported separately.

Included Populations:

- Patients of any age on an eligible reporting unit are included in the device day total.

Excluded Populations:

- Units classified in NHSN as behavioral health, ICU burn, and ICU trauma.

**Data Source**

Data are to be reported monthly.

**Fields to be reported:**

- Number of CLABSI ICU
- Number of device days ICU

Updated September 19, 2016
• Number of CLABSI non-ICU
• Number of device days non-ICU

Data collection period: July 1, 2016 – December 31, 2016

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

Data collection system: National Healthcare Safety Network (NHSN) or Quality Benchmarking System (QBS)

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

CLABSI Per Device Day Award Table ICU:

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 1.04</th>
<th>1.04 - &gt; 0.52</th>
<th>0.52 - &gt; 0.00</th>
<th>0.00</th>
</tr>
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<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

CLABSI Per Device Day Award Table non-ICU:

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 1.01</th>
<th>1.01 - &gt; 0.59</th>
<th>0.59 - &gt; 0.00</th>
<th>0.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

This measure is used in the quality incentive for acute care, pediatric, and rehabilitation hospitals. Points are awarded based on adding together the scores from an ICU and non-ICU and dividing by two.
**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 each year and is a major contributor to healthcare associated infections (HAI). As of March 2014, the CDC reported that surgical site infections (SSI) account for 22% of all HAI per each year.\(^1\) Associated cost of SSI are between 3.5 and 10 billion annually and result in increased readmissions, ICU admissions, long-term surgical complications and death. SSI rates are disproportionately higher among patients following colorectal surgeries.\(^2\)

While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death. SSI is associated with a mortality rate of 3%, and 75% of SSI-associated deaths are directly attributable to the SSI.\(^1\)

Surveillance of SSI with feedback of appropriate data to surgeons has been shown to be an important component of strategies to reduce SSI risk \(^6-^9\).

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: \(^2\)

- Adopt a surgical safety checklist.
- Evidenced based antimicrobial prophylaxis.
- Evidenced based pre-operative skin cleansing and peri-operative skin antisepsis.
- Normothermia in the operating room.
- Peri-operative glucose control.

**Selected References:**


Updated September 19, 2016

**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 http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSIcurrent.pdf?agree=yes&next=Accept 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, 2016 – December 31, 2016

**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.

**Surgical Site Infections Award Table:**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 4.36</th>
<th>4.36 - &gt; 0.95</th>
<th>0.95 - &gt; 0.00</th>
<th>0.00</th>
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Updated September 19, 2016
<table>
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<tr>
<th>Point Award</th>
<th>0</th>
<th>3</th>
<th>5</th>
<th>10</th>
</tr>
</thead>
</table>

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

**Influenza Vaccination Coverage among Healthcare Personnel (NHSN) (hospital-wide acute, rehabilitation, pediatric, and behavioral health)**

**Clinical Rationale:**

The Advisory Committee on Immunization Practices (ACIP) recommends that all healthcare personnel (HCP) and persons in training for healthcare professions should be vaccinated annually against influenza.\(^1\) Persons who are infected with influenza virus, including those with subclinical infection, can transmit influenza virus to persons at higher risk for complications from influenza. Vaccination of HCP has been associated with reduced work absenteeism and with fewer deaths among nursing home patients and elderly hospitalized patients. Although annual vaccination is recommended for all HCP and is a high priority for reducing morbidity associated with influenza in healthcare settings, national survey data have demonstrated that vaccination coverage levels are only approximately 70%\(^2\). This is well below the Healthy People 2020 goal of 90% for HCP influenza vaccination\(^3\).

**Clinical References:**


3. Healthy People 2020. Immunization and Infectious Diseases

**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 [http://www.cdc.gov/nhsn/acute-care-hospital/hcp-vaccination/](http://www.cdc.gov/nhsn/acute-care-hospital/hcp-vaccination/) with the most current definition for the time period to be used.

Acute care hospitals must submit data for the entire influenza vaccination season (October 1 through March 31) to NHSN.

Updated September 19, 2016
**Numerator:** Number of HCP who received an influenza vaccination during the time from when the vaccine became available (e.g. August or September) through March 31 of the following year.
- Received an influenza vaccination.
- Have a medical condition of allergic reaction or history of Guillain-Barre Syndrome within six weeks after a previous flu vaccination.
- Declined influenza vaccination.
- Are persons with unknown vaccination status or who do not otherwise meet any of the definitions above.

**Denominator:** Number of HCP who are working in the healthcare facility for at least one working day between October 1 and March 31, regardless of clinical responsibility or patient contact. Denominators are to be calculated separately for employees, licensed independent practitioners, students, trainees, and volunteers.

**Data Source**
Data are to be reported in March.

**Fields to be reported:**
- Number of immunizations
- Number healthcare personnel

**Data collection period:** July 1, 2016 – March 31, 2017

**Reporting deadline:** Reported on March 31.

**Data collection system:** National Healthcare Safety Network (NHSN) or 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.

**HCP Influenza Vaccination Rates Table:**

<table>
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<tr>
<th>Threshold</th>
<th>&lt; 80%</th>
<th>80% - &lt; 84%</th>
<th>84% - 93%</th>
<th>&gt; 93%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

This measure is used in the quality incentive for acute care, rehabilitation, pediatric, and behavioral health hospitals. The score is counted hospital-wide and applied to all areas.

Updated September 19, 2016
Safety

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

Clinical Rationale:

Pressure ulcers remain a major health problem affecting approximately 3 million adults.¹ In 1993, pressure ulcers were noted in 280,000 hospital stays, and 11 years later the number of ulcers was 455,000.² The Healthcare Cost and Utilization Project (HCUP) report found from 1993 to 2003, a 63 percent increase in pressure ulcers, but the total number of hospitalizations during this time period increased by only 11 percent. Pressure ulcers are costly, with an average charge per stay of $37,800.² In the fourth annual HealthGrades Patient Safety in American Hospitals Study, which reviewed records from about 5,000 hospitals from 2003 to 2005, pressure ulcers had one of the highest occurrence rates, along with failure to rescue and postoperative respiratory failure.³ [http://www.ncbi.nlm.nih.gov/books/NBK2650/]

Selected References:


Definition – AHRQ PSI 03

This measure is defined by the NQF. The definition can be found at http://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V44/TechSpecs/PSI%2003%20Pressure%20Ulcer%20Rate.pdf with the most current definition for the time period to be used. Will be modified for ICD-10.

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.

Updated September 19, 2016
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 diagnosis field code of pressure ulcer stage III or IV (or unstageable) in any secondary diagnosis field.

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

Excluded Populations:
- Length of stay of less than 5 days
- Principal diagnosis of pressure ulcer or a secondary diagnosis of pressure ulcer present on admission* and a secondary diagnosis of pressure ulcer stage III or IV present on admission
- MDC 9 (Skin, Subcutaneous Tissue, and Breast)
- MDC 14 (pregnancy, childbirth, and puerperium)
- Diagnosis of hemiplegia, paraplegia, or quadriplegia
- Diagnosis of spina bifida or anoxic brain damage AHRQ QI, Patient Safety Indicators #3, Technical Specifications, Pressure Ulcer Rate www.qualityindicators.ahrq.gov.
- Procedure code for debridement or pedicle graft before or on the same day as the major operating room procedure (surgical cases only)
- Transfer from a hospital (different facility)
- Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- Missing gender (SEX=missing), age (AGE=missing), month (DQTR=missing), year (YEAR=missing) or principal diagnosis (DX1=missing) * Only for cases that otherwise qualify for the numerator

**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, 2016 – December 31, 2016

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

**Data collection system:** CHARS

Updated September 19, 2016
**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 Per Device Day Award Table:** (Table will be updated based on initial data based on ICD-10 coding. Will update table late summer.)

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; .80</th>
<th>0.80 - &gt; 0.55</th>
<th>0.55 - &gt; 0.00</th>
<th>0</th>
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<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
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</table>

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

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

Clinical Rationale:
Hospital falls are a serious patient safety problem and affects somewhere between 700,000 and 1,000,000 people in the United States each year\(^1\). 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\(^1\,\,^2\). Researchers have determined that many falls can be prevented\(^3\).

As of 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\(^4\). 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\(^5\).

Selected References:

4. As of October 2012, CMS’ list of codes for falls and trauma includes fractures, dislocations, intracranial injuries, crushing injuries, burns, and other injuries (such as hypothermia). CMS updates for these codes can be found at www.cms.gov

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 https://www.bing.com/search?q=falls+nqf+0202&form=EDGHPC&qs=PF&cvid=eb52b39a322a486aad025b052111ca7e&pq=falls%20nqf%200202 This is the definition used for the National

Updated September 19, 2016
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:**

Updated September 19, 2016
• 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.

Data Source: 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, 2016 – December 31, 2016

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:

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 1.18</th>
<th>1.18 – &gt; 0.72</th>
<th>0.72 – &gt; 0.45</th>
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<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

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

Updated September 19, 2016
Nursing Measures

The following are the three nursing measures as defined earlier in this document. They will be counted a second time under nursing measures:
- Catheter Associated-Urinary Tract Infections Per Device Days (HAI-2) (Hospital-Wide) (<i>adult acute, rehabilitation, and pediatrics</i>)
- Central Line Associated-Blood Stream Infection per Device Days (HAI-1) (Hospital-Wide) (<i>adult acute and pediatric</i>)
- Pressure Ulcer (AHRQ PSI 03) (Hospital-Wide) (<i>adult acute and rehabilitation</i>)

The point(s) will then be added with the points of the other nursing measures and divided by the number of applicable measures. If a hospital does not have an ICU, their medical/surgical score will be used.

Additional scoring adjustments will be made as follows:
- If zero is earned on any of the three measures, the hospital earns zero points.
- If the hospital earns ten, five, and five points on the measures, the hospital earns 10 points.
- If the hospital earns ten points on two of the measures and does not get a zero on the third, the hospital earns 10 points.

Nursing Questions

1. Did the nurse staffing committee meet in 2016 and make recommendations to the executive team? (Yes/No)
2. Did the executive team provide their response back to the nurse staffing committee? (Yes/No)
3. Did the nurse staffing committee and executive team have access to the unit level data on the nursing measures? (Yes/No)

Data collection period: January 1, 2016 – December 31, 2016

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

Data collection system: Quality Benchmarking System (QBS)

Bonus Points: 2 bonus points can be earned for answering all three nursing questions.

Updated September 19, 2016
**ER is for Emergencies**

**Percent of Patients with Five or More visits to the Emergency Room 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 in the last year without a care guideline.

**Denominator:** Number of patients without a care guideline with five or more visits 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, 2016 – December 31, 2016

**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:**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&lt; 2%</th>
<th>2% – &lt; 10.9%</th>
<th>10.9% – &lt; 16.9%</th>
<th>≥ 16.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

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. 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:


Updated September 19, 2016
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. Data will be collected monthly.

Fields to be reported:

Updated September 19, 2016
• 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, 2016 - December 31, 2016

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

**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 2016)**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 3 cases</th>
<th>3 cases</th>
<th>2 cases</th>
<th>≤ 1 case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

**For hospitals with >100 deliveries/6 months (July-December 2016)**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 3%</th>
<th>3% – &gt; 2%</th>
<th>2% – 0.6%</th>
<th>&lt; 0.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

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

Updated September 19, 2016
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:


Updated September 19, 2016
**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/TJC2016A/MIF0166.html](https://manual.jointcommission.org/releases/TJC2016A/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:
- Medical induction of labor as defined in Appendix A, Table 11.05 while not in Labor prior to the procedure
- Cesarean section 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 section 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 of the uterine wall noted during prior uterine surgery or during past or current ultrasound
    - History of uterine rupture requiring surgical repair
    - History of corneal ectopic pregnancy
    - History of transabdominal cerclage

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

Included Populations:

Updated September 19, 2016
- **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

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

**Data Source:**
Data are to be submitted to Quality Benchmarking System.

**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, 2016 – December 31, 2016

**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.

**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.

Updated September 19, 2016
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 HIPPA allows. HCA will have the final authority. This was a consideration in the design of the point awards and payment thresholds.

**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 1, 2017. The review form is available on the quality incentive page of the WSHA website: [http://www.wsha.org/quality-safety/projects/medicaid-quality-incentive/](http://www.wsha.org/quality-safety/projects/medicaid-quality-incentive/)

**Elective Delivery Between 37 and 39 Weeks Award Table:**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&gt; 1.7%</th>
<th>1.7% – &gt; 0.6%</th>
<th>0.6% – 0.1%</th>
<th>&lt; 0.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

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

Cesarean Rate for Low Risk, First Born - NTSV (PC-02)

Clinical Rationale:
The growing support for the claim that provider-dependent indications are contributing to the overall increase among cesareans can be seen from the results of two recent studies examining the drivers for the increase in cesarean deliveries. Barber et al. (2011) at Yale analyzed primary and repeat cesareans from 2003 to 2009. Among primary cesarean deliveries, more subjective indications (non-reassuring fetal status and arrest of dilation) contributed larger proportions than more objective indications (malpresentation, maternal-fetal, and obstetric conditions). Similarly, Getahun et al. (2009) examined the causes for the rise in cesarean deliveries among different racial and ethnic groups in Kaiser Permanente Southern California over the last 17 years. Their findings were similar to those from Yale. In a retrospective cohort study conducted by Ehrenthal et al. (2010), labor induction was associated with a twofold increase in the odds of a cesarean delivery after adjustment for confounders. This was more pronounced among a low-risk group of women without major complications.

Beyond the medical burden to mothers and babies, the financial burden on payers is large: facility charges for cesarean are nearly twice that for vaginal delivery ($24,700 vs. $14,500). In California alone, the additional health care costs to the system are conservatively estimated to be over $300 million annually (Main et al., 2011).

The most frequent causes of severe maternal morbidity are obstetric hemorrhage (bleeding) and uterine infection. These are significantly more common with cesarean surgery and also represent the two leading causes of hospital readmission in the first 30 days post delivery. A recent CDC analysis showed that the rate of severe obstetric hemorrhage has significantly increased (by 50%) over the last 15 years in the U.S. There has also been a 270% increase in blood transfusions, with both hemorrhage and transfusions correlated to the rise in cesarean deliveries. Infection is the most common serious complication of cesarean delivery with typical rates of 3 to 9% (Kuklina et al., 2009).

The American College of Obstetrics and Gynecology (ACOG) report, “Evaluation of Cesarean Delivery,” recognizes the importance of the Nulliparous, Term Singleton Vertex (NTSV) population as the optimal focus for measurement and quality improvement action. Furthermore, the report identified a target of 15.5% for NTSV births, one recommended by the National Center for Health Statistics. Although the ACOG target rate was directed at the NTSV cesarean delivery rate, the recommendation has been widely misread as recommending a 15.5% total cesarean delivery rate (ACOG, 2000).

In its 2000 report, ACOG formally recommended that NTSV Cesarean Delivery Rate be used to benchmark all U.S. hospitals and practitioners. This measure and target was then endorsed by the United States Healthy People 2010 objectives: 16-9 (DHHS, 2000). This same measure has
been reaffirmed in Healthy People 2020 (MICH-7.1) but with a more modest target of a 23.9% NTSV rate (DHHS, 2010).

Selected References:


**Definition:**

This measure is based on The Joint Commission measure under PC-02. The current Joint Commission definition can be found at https://manual.jointcommission.org/releases/TJC2016A/MIF0167.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.

**Description:** Nulliparous women with a term (>=37 weeks gestational age), singleton baby in the vertex position, delivered by cesarean section.

**Numerator:** From among the denominator, patients with a cesarean delivery.

**Denominator:** Nulliparous patients delivering a live term singleton newborn in vertex presentation.

Updated September 19, 2016
• **Exclusions:** *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for multiple gestations and other presentations as defined in Appendix A, Table 11.09
  - Less than 8 years of age
  - Greater than or equal to 65 years of age
  - Length of Stay >120 days
  - *Gestational Age* < 37 weeks

**Data Source:**

Data are to be submitted to Quality Benchmarking System.

**Fields to be reported:**

- Patients with cesarean section from among the denominator
- Nulliparous patients delivering a live term singleton newborn in vertex presentation after exclusions removed (see denominator definition above)

**Data collection period:** *July* through December 2016, submitted monthly, 75 days following the end of a month.

**Cesarean Rate for Low Risk, First Born Award Table:**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Incomplete data</th>
<th>N/A</th>
<th>Complete Data</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

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:


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 2016 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:


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

Updated September 19, 2016
• Primary physician, other health care professional, or site designated for follow-up care.

These are 2 of the 11 elements which CMS will require 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:** September 1, 2016 – December 31, 2016

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

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&lt; 41%</th>
<th>41% - 54%</th>
<th>&gt;54% – 64%</th>
<th>&gt; 64%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

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

Updated September 19, 2016
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, Ganoczy, & 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:


Updated September 19, 2016


**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.

Updated September 19, 2016
**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, 2016 – December 31, 2016

**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:**

<table>
<thead>
<tr>
<th>Threshold</th>
<th>&lt; 25%</th>
<th>25% - &lt; 50%</th>
<th>50% - &lt; 75%</th>
<th>≥ 75%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Award</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

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

Updated September 19, 2016