Washington State:
Medicaid Quality Incentive Measure Guidelines

July 1, 2021

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

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

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

Hold Control + Click to Jump to the sections below.

Infection Prevention:

- Colon Surgical Site Infection (SSI)
- CAUTI (catheter associated urinary tract infection)

Workforce Safety:

- Workplace Violence

General Care Measures:

- Pressure Ulcer NPIAP - (adult acute and rehabilitation)
- Falls with Injury/1000 patient day and post fall huddle

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 Emergency Departments and obstetrical programs only):

- Safe Sleep Policy/Procedure
- Emergency Department Triage

Diagnostic Excellence (acute care hospitals, rehab hospitals)

- Diagnostic Excellence Measure

Inpatient Behavioral Health - (behavioral health hospitals or units only):

- Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed
- Transition Record with Four Specified Elements Received by Discharged Patients

SDOH Screening

- Social Determinants of Health (SDOH)

Infection Prevention

Colon Surgical Site Infections

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

Colon Surgical Site Infection (SSI) measure will be moving to a process measure for the 2021 MQI Performance period starting July 1, 2021- December 31, 2021. Non-comparable rates for infection measures may be inequitable based on patient populations, type of care provided and other factors. The modification to process measures will permit other hospitals to participate in the MQI program that may have been excluded previously.

Data will include submission of policy and tools from the AHRQ Safety Program for Surgery or other evidence-based tools that help perioperative and surgical units in hospitals identify opportunities to improve care, safety and best practices.

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

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

Selected References:

1. Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project—statistics on hospital stays. 2013. http://hcupnet.ahrq.gov. Retrieved 14May2021.

2. Anderson DJ, Pyatt DG, Weber DJ, Rutala WA. Statewide costs of health care–associated infections: estimates for acute care hospitals in North Carolina. Am J Infect Control 2013;41(9): 764–768.
3. Cruse P. Wound infection surveillance. Rev Infect Dis 1981; 3(4):734–737.
4. Engemann JJ, Carmeli Y, Cosgrove SE, et al. Adverse clinical and economic outcomes attributable to methicillin resistance among patients with Staphylococcus aureus surgical site infection. Clin Infect Dis 2003;36(5):592–598.
5. Graves EJ. National Hospital Discharge Survey: Annual Summary, 1987. Series 13, no. 99. Hyattsville, MD: National Center for Health Statistics, 1989.
6. Kirkland KB, Briggs JP, Trivette SL, Wilkinson WE, Sexton DJ. The impact of surgical-site infections in the 1990s: attributable mortality, excess length of hospitalization, and extra costs. Infect Control Hosp Epidemiol 1999;20(11):725–730.
7. Lewis SS, Moehring RW, Chen LF, Sexton DJ, Anderson DJ. Assessing the relative burden of hospital-acquired infections in a network of community hospitals. Infect Control Hosp Epidemiol 2013;34(11):1229–1230.
8. Scott RD. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. Atlanta: Centers for Disease Control and Prevention, 2009. http://www.cdc.gov/hai/pdfs/hai/scott_costpaper.pdf. Retrieved 14May2021.
9. Zywot, A., Lau, C.S., Stephen Fletcher, H. et al. Bundles Prevent Surgical Site Infections After Colorectal Surgery: Meta-analysis and Systematic Review. J Gastrointest Surg 21, 1915–1930 (2017). https://doi.org/10.1007/s11605-017-3465-3
10. AHRQ Toolkit to Promote Safe Surgery https://www.ahrq.gov/hai/tools/surgery/index.html
11. AHRQ PSNet Patient Safety Network. https://psnet.ahrq.gov/issue/national-surgical-quality-improvement-program
12. Centers for Disease Control and Prevention Guideline for the Prevention of Surgical Site Infection,2017. https://jamanetwork.com/journals/jamasurgery/fullarticle/2623725
13. AHRQ Advances in the Prevention and Control of HAIs https://www.ahrq.gov/hai/patient-safety-resources/advances-in-hai/hai-article17.html

Definition

From NHSN last updated January 2021 taken 14May2021 from: https://www.cdc.gov /nhsn/ pdfs/pscmanual/9pscssicurrent.pdf

Included Populations:

Peds, and admitted adult patients (i.e., ≥ 18 years of age) and specialty patients.

Data Source:
Upload the policy and tools in QBS one time during the performance period starting July 1, 2021 to December 31, 2021.

Fields to be reported:
Submission of policy that includes tools developed by the AHRQ Safety Program for Surgery or other evidence-based tools that help perioperative and surgical units in hospitals identify opportunities to improve care and safety practices and implement evidence-based interventions to prevent surgical site infections.

Examples of content elements include:

1. AHRQ Surgical Safety Team Roles and Responsibilities Tool
   Surgical safety team roles and responsibilities tool
2. AHRQ Perioperative Staff Safety Assessment
   Perioperative staff safety assessment tool
3. AHRQ Learn From Defects Tool-Perioperative Setting
   Learn from defects tool-perioperative setting
4. AHRQ Briefing and Debriefing Tool
   Briefing and debriefing tool
5. AHRQ Operating Room Briefing and Debriefing Audit Tool
   Operating room briefing and debriefing audit tool

Data collection period:
July 1, 2021 – December 31, 2021

Reporting deadline:
Upload policy and tool one time during the performance period 30 days after the close of the reporting period or by January 31, 2022.

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

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

Data Scoring:

Data and awards are scored on submission of policy and tools. Hospitals upload policy and tools to receive full credit toward the incentive. Hospitals obtain 10-point awards for uploading of their policy and tools.

Threshold	Submission of policy that includes tools developed by the AHRQ Safety Program for Surgery or other evidence-based tools
Point Award 2021	10

Infection Prevention

CAUTI (Catheter Associated Urinary Tract Infection)

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

CAUTI (Catheter Urinary Tract Infection) measure will be moving to a process measure for the 2021 MQI Performance period starting July 1, 2021 – December 31, 2021. Non-comparable rates for infection measures may be inequitable based on patient populations, type of care provided and other factors. The modification to process measures will permit other hospitals to participate in the MQI program that may have been excluded previously.

Data will include submission of policy and tools from the AHRQ Toolkit for Reducing CAUTI or other evidence-based tools that are used to improve safety culture and transfer of best practices to reduce CAUTI infections.

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

CAUTI toolkits have been shown to improve outcomes in hospitalized patients through minimizing exposure to urinary catheters and decreasing catheter days as well as improving culturing practices. An example by PE Davies, et al., CAUTI rates were reduced over one third after implementation. These care bundles, or toolkits, can assist in enhancing compliance to evidence-based quality process measures to improve patient care. Care bundles include a set of evidence-based measures that when implemented together have greater outcomes than when isolated implementation of individual measures occurs. Bundles help create reliable and

consistent care in hospital systems and promote multi-disciplinary collaboration. Health care providers are advised to follow each bundle element for every patient, always—promoting positive habits and ultimately reliable care processes. These bundled interventions can help to improve the "culture" of patient safety by promoting teamwork, measuring compliance, and providing feedback and accountability to frontline teams and hospital leadership to improve care.

Selected References:

1. Ashtekar DR, Costa-Periera R, Shrinivasan T, Iyyer R, Vishvanathan N, Rittel W. Oxazolidinones, a new class of synthetic antituberculosis agent. In vitro and in vivo activities of DuP-721 against Mycobacterium tuberculosis. *Diagn Microbiol Infect Dis.* 1991;14(6):465-471.
2. Centers for Disease Control and Prevention. Catheter-associated Urinary Tract Infections (CAUTI). Health-care associated infections; 2015. Available from: https://www.cdc.gov/hai/ca_uti/uti.html. Taken 14 May 2021.
3. Davies PE, Daley MJ, Hecht J, Hobbs A, Burger C, Watkins L, Murray T, Shea K, Ali S, Brown LH, Coopwood TB, Brown CVR. Effectiveness of a bundled approach to reduce urinary catheters and infection rates in trauma patients. Am J Infect Control. 2018 Jul;46(7):758-763. doi: 10.1016/j.ajic.2017.11.032. Epub 2018 Feb 1. PMID: 29397230.
4. Estimating the Additional Hospital Inpatient Cost and Mortality Associated With Selected Hospital-Acquired Conditions. Content last reviewed November 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/hai/pfp/haccost2017-results.html
5. Jain M, Miller L, Belt D, King D, Berwick DM. Decline in ICU adverse events, nosocomial infections and cost through a quality improvement initiative focusing on teamwork and culture change. *Quality & safety in health care.* 2006;15(4):235-239.
6. Lo E, Nicolle LE, Coffin SE, Gould C, Maragakis LL, Meddings J, et al. Strategies to prevent catheter-associated urinary tract infections in acute care hospitals: 2014 update. Infect Control Hosp Epidemiol 2014;35:464-79.
7. Marwick C, Davey P. Care bundles: the holy grail of infectious risk management in hospital? *Current opinion in infectious diseases.* 2009;22(4):364-369.
8. Patel PK, Gupta A, Vaughn VM, et al. Review of Strategies to Reduce Central Line-Associated Bloodstream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI) in Adult ICUs. Journal of Hospital Medicine. 2018 Feb;13(2):105-116. DOI: 10.12788/jhm.2856.

9. Riley DK, Classen DC, Stevens LE, Burke JP. A large randomized clinical trial of a silver-impregnated urinary catheter: lack of efficacy and staphylococcal superinfection. Am J Med 1995;98:349-56.
10. Saint S, Chenoweth CE. Biofilms and catheter-associated urinary tract infections. Infect Dis Clin North Am 2003;17:411-32.
11. Stone PW. Economic burden of healthcare-associated infections: an American perspective. Expert Rev Pharmacoecon Outcomes Res 2009;9:417-22.
12. -Definition NHSN last updated January 2021 Taken 14May2021 from: https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf
13. Resar R, Griffin FA, Haraden C, Nolan TW. Using care bundles to improve health care quality. IHI innovation series white paper.: Institute for Healthcare Improvement;2012.
14. Richards GA, Brink AJ, Messina AP, Feldman C, Swart K, van den Bergh D. Stepwise introduction of the 'Best Care Always' central-line-associated bloodstream infection prevention bundle in a network of South African hospitals. The Journal of hospital infection. 2017;97(1):86-92.
15. AHRQ The Comprehensive Unit-based Program (CUSP) Method https://www.ahrq.gov/hai/cusp/index.html
16. CDC Centers for Disease Control and Prevention. TAP Catheter-Associated Urinary Tract Infection (CAUTI) Implementation Guide https://www.cdc.gov/hai/prevent/tap/cauti.html
17. Centers of Excellence. Bundle (ABCDE) Checklist for Prevention of CAUTIs bundle-abcde-checklist-for-prevention-of-cautis.html https://www.urotoday.com/library-resources/indwelling-catheters/115558
18. Hospital Quality Institute. Eliminating Catheter-Associated Urinary Tract Infection (CAUTI) https://www.hqinstitute.org/hqi-toolkit/eliminating-catheter-associated-uninary-tract-infection-cauti
19. International Society for Infectious Diseases. Guide to Infection Control in the Healthcare Setting https://isid.org/guide/infectionprevention/bundles/

Included Populations:

Peds, and admitted adult patients (i.e., ≥ 18 years of age) and specialty patients.

Data Source:

Upload the policy and tool in QBS one time during the performance period starting July 1, 2021-December 31, 2021.

Fields to be reported:

Submission of policy with policy statements and tools from the AHRQ Toolkit for Reducing Catheter-Associated Urinary Tract Infections (CAUTI) in Hospital Units: Implementation Guide or other evidence-based tools that are used to improve safety culture at the unit level following clinical best practices to reduce CAUTI.

Examples of content elements include:

- Checklists for assessing executive and physician champion potential
- Urinary catheterization-sample policy
- Sample bladder scan policy
- Urinary catheter decision-making algorithm
- Example of a nurse-driven protocol for catheter removal
- Skin care in the incontinent patient
- CAUTI event report template
- Interpreting CAUTI data trends tool

Data collection period:
July 1, 2021 – December 31, 2021

Reporting deadline:
Upload policy and tool one time during the performance period. 30 days after the close of the reporting period or by January 31, 2022

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

Data collection system:
Washington State Hospital Association Quality Benchmarking System (QBS)

Data Scoring:
Data and awards are scored on submission of policy and tools. Hospitals upload policy and tools to receive full credit toward the incentive. Hospitals obtain 10-point awards for uploading of their policy and tools.

Threshold	Submission of policy with policy statements and tools from the AHRQ Toolkit for Reducing Catheter-Associated Urinary Tract Infection (CAUTI) in Hospital Units: Implementation Guide or other evidence-based tools
Point Award 2021	10

Workplace Violence Events

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

Clinical Rational

A data driven approach is needed for action-oriented interventions. Gaps exist in the current data collection related to the role of race, ethnicity and language (REaL) as contributing factors and trends in WPV events. By better understanding if a relationship exists between WPV events and REaL data, hospitals can prioritize staff training and explore where hospital culture may be contributing to incidents of WPV. Furthermore, evidence-based root cause analysis is required to truly understand the contributing factors to WPV events for prevention to occur.

This data directly correlates with the WPV programming that WSHA is launching in 2021. The three aims are:

1. Data collection that includes root cause analysis and ReaL data to better understand contributing factors and disparities in WPV.
2. Support of the WPV event responder through self-awareness, crisis management and trauma-informed care.
3. Support of patients and families to safely transition back into the healthcare setting.

Definition

Number (count) of workplace violence events in which a physical assault or threat of physical assault occurs toward hospital staff or providers within the hospital setting.

Selected References:

1. American Hospital Association. Cost of community violence to hospitals and health systems, July 26, 2017. Accessed September 27, 2018.
2. Occupation Violence, Fast Facts https://www.cdc.gov/niosh/topics/violence/fastfacts.html
3. Violence Occupational Hazards in Hospitals https://www.cdc.gov/niosh/docs/2002-101/default.html

Data Source:

Washington State Hospital Association Quality Benchmarking System.

Fields to be reported:
Count of events that occur anywhere within the hospital setting should be reported on a monthly cadence.

Data collection period:
July 1, 2021 – December 31, 2021

Reporting deadline:
Attestations can be reported at the end of the performance period or before 30 days after the close of reporting period or by January 31, 2022.

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

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

Data Scoring:
Hospitals obtain points based on submission of supporting data into the QBS data portal (6 points). Count of events that occur anywhere within the hospital setting should be reported on a monthly cadence.
Attestation to be reported at the end of the MQI cycle in December 2021:(4 points)

1. Does your hospital perform root cause analysis on event submissions?
   Answer Yes or No (Yes =1 point).
   Yes = 1
   No= 0
   If yes please upload policy or process related to WPV events. (1 point)

2. Does your hospital collect race, ethnicity and language (REaL) data on the patient or other persons inciting and receiving violence?
   Answer: Yes, No, In Progress. Any answer = 1 point.
   Yes=1
   No=0
   In Progress = 2
   If yes, please upload policy or process = 1 point.

Thresholds	Count of events that occur anywhere within the hospital	1. Do you perform root cause analysis on event submissions. Answer Yes or No (Yes =1 point)	2. If yes, please upload policy or process related to WPV events = 1 point	3. Do you collect REaL data on the patient or other persons inciting and receiving violence. Answer Yes, No, In progress. (Any answer =1 point)	4. If yes, please upload policy or process = 1 point
Point Award 2021	6 points	1 point	1 point	1 point	1 point

Attestations can be reported at the completion of the MQI period to attain the 4 points.

General Care Measures

Pressure Ulcer (NPIAP) (adult acute and rehabilitation)

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

Clinical Rationale:
Pressure ulcers continue to be a top health care focus, affecting approximately 2.5 million adults within acute care facilities each year. Many patients who suffer from pressure injuries are those who are elderly, malnourished, or who have been in the hospital for longer periods of time. Patients who have multiple devices in use, hemodynamic instability and/or are under the use of vasoactive medications are also at risk of pressure ulcer development. Following the development of a pressure ulcer, patients may suffer from severe pain, chronic wound management and even the risk of death.

Pressure ulcers may be associated with severe pain and about 60,000 patients die as a direct result of a pressure ulcers each year. The development of pressure ulcers and/or injuries can interfere with the patient's functional recovery which than can contribute to longer hospital stays, with an average of an additional 2 days attributed to the length of stay secondary to the pressure ulcer/injury.

Pressure ulcers cost $3.3-$11.6 billion per year in the U.S[1,2]. Additionally, CMS reported that the cost of the care for chronic pressure injury care was noted to be $22 billion[3]. It is estimated that the average cost of a pressure ulcer costs approximately $10,708-$21,767 per patient, with the additional cost to the hospital being anywhere from $500 to more than $70,000.[4,5,6]

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. As of 2008, the Centers for Medicare and Medicaid Services (CMS) announced it will not pay for additional costs incurred for hospital-acquired pressure ulcers. One key recommendation to assist in the prevention of pressure injury is a comprehensive skin inspection. According to (Haesler, E., 2019) "a skin inspection should be a high priority and performed as soon as possible following admission to a healthcare service"[9]. The guidelines then continue to state that organizations should ensure that complete skin assessments are a part of the risk assessment policies within the service lines (Haesler, E., 2019)[9].

Selected References:

1. Van Den Bos J, Rustagi K, Gray T, et al. The $17.1 billion problem: the annual cost of measurable medical errors. Health Aff (Millwood). 2011;30(4):596-603.12.
2. Brem H, Maggi J, Nierman D, et al. High cost of stage IV pressure ulcers. Am J Surg. 2010;200(4):473-477
3. Padula WV, Delarmente BA. The national cost of hospital-acquired pressure injuries in the United States. Int Wound J. 2019 Jun;16(3):634-640. doi: 10.1111/iwj.13071. Epub 2019 Jan 28. PMID: 30693644. https://onlinelibrary.wiley.com/doi/epdf/10.1111/iwj.13071
4. Nussbaum SR, Carter MJ, Fife CE, et al. An economic evaluation of the impact, cost, and medicare policy implications of chronic non-healing wounds. Value Health. 2018;21(1):27-32
5. Haesler E. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Cambridge, UK: Cambridge Media; 2014.
6. 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.
7. Wassel CL, Delhougne G, Gayle JA, Dreyfus J, Larson B. Risk of readmissions, mortality, and hospital-acquired conditions across hospital-acquired pressure injury (HAPI) stages in a US National Hospital Discharge database. Int Wound J. 2020 Dec;17(6):1924-1934. doi: 10.1111/iwj.13482. Epub 2020 Aug 23. PMID: 32830460.
8. WA State Adverse Events Adverse Events: Quarterly Report Serious Reportable Events TableQ12020 https://www.doh.wa.gov/Portals/1/Documents/2900/689010.pdf
9. Haesler, E. (Ed.). (2019). *Prevention and treatment of pressure ulcers / Injuries: Clinical practice guideline*. Cambridge Media. Guideline Organizations: EPUAP, NPIAP, PPPIA

Definition

National Pressure Injury Advisory Panel (NPIAP)
Two-step process measure for this performance period. Please see the fields to be reported.

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.

Reporting Frequency:
Upload the facility policy and attestation once during the performance period by January 31, 2022.

Fields to be reported:
Two step reporting process for points.
Step 1 includes uploading of facility policy validating content as outlined below.
Step 2 will include attestation of number of staff who have completed required HAPI education as provided to facility by WSHA.

- Step 1: Submit policy showing of skin assessment to be completed by 2 RN's within 4 hours following admission, transfer, or if patient is away from the unit for >4 hours.
- Step 2: Submit attestation of >80% clinical staff completion of HAPI education.
- Standardized, evidenced-based clinical education content to be provided to participating hospitals by WSHA.

Definition of clinical staff is as follows:

- Includes staff who are permanent staff who care for patients in inpatient units within the hospital setting AND are responsible for assessing the patient's skin upon admission, transfer, or long length of stay away from unit.
- Does not include those who are out on approved FMLA or LOA
- Does not include those who are identified as temporary/agency hires

Data collection period:
July 1, 2021– December 31, 2021

Reporting deadline:
30 days after the close of the reporting period or by January 31, 2022.

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

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

Data Scoring:
Data and awards are scored on submission of policy and tools. Submit policy showing requirement of skin assessment to be completed by 2 RN's within 4 hours following admission,

transfer, or if patient is away from the unit for > 4 hours to obtain 5-point awards.
Submit attestation of > 80% clinical staff completion of HAPI education to obtain 5-point awards.

Threshold	Submit policy showing requirement of skin assessment to be completed by 2 RN's within 4 hours following admission, transfer, or if patient has away from the unit for > 4 hours	Submit attestation of ≥80% clinical staff completion of HAPI education*
Point Award 2021	5	5

Falls with Injury Prevention:

Falls with Injury/1,000 patient days and post fall huddle

Measure eligibility: All hospitals who wish to participate in MQI are eligible to complete this metric (includes all inpatient units, ED, behavioral health facilities, cancer care centers and children's hospitals).

Clinical Rationale:

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

Falls are consistently listed as one of The Joint Commission "Top 10" Sentinel Events reported to the database. While extensive clinical research and adult evidence-based strategies in fall prevention exist, reducing injurious falls in the hospital environment remains difficult. Falls are a serious patient safety problem, accounting for nearly 84% of all inpatient incidents. Among adults 65 years or older, falls are the leading cause of injury-related death. Worldwide, "falls are responsible for over 38 million DALYs (disability-adjusted life years) lost each year, and result in more years lived with disability than transport injury, drowning, burns and poisoning combined"1. Additionally, CMS considers "serious fall-related injury" to be one of the 14 hospital acquired conditions that are preventable and non-reimbursable.

When falls occur, they can result in an additional 6.3 inpatient days with a cost of approximately ~$14,056/patient. This accounts for up to 15% of re-hospitalizations within the first month. In 2005, accidental falls in patients >65 years old, resulted in total cost of $637 million, with the total cost of non-fatal falls equaling $31.3 billion in healthcare costs. Patient falls occur in approximately 1.9 to 3 percent of all acute care hospitalizations with an estimated 10 percent of them resulting in serious injury.

Moreover, it has been estimated that 600 to 1,600 newborns in the United States experience an in-hospital fall/drop every year2. Several factors contribute to falls such as variation in assessment tools to identify fall risk factors, ineffective communication and handoffs, inadequately individualizing a patient's plan of care and physical environment. The most prevalent maternal risk factors associated with newborn falls and drops include: Cesarean birth, use of pain medication, breast feeding and second or third postpartum night, specifically around midnight to early morning hours. As a result of this increased risk, experts advise considering all newborns a high risk for newborn fall risk/drop in the absence of a validated assessment tool. Additionally, they recommend including a variety of strategies in a safety

bundle, including education, visual cues, checklists, intentional rounding, and processes focused on mitigating known risks[3,4]

Selected References:

1. World Health Organization. (2021). Falls. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/falls.
2. Ainsworth R., Summerlin-Long S., Mog C. A comprehensive initiative to prevent falls among newborns. Nursing for Women's Health. 2016; 20: 247-257 https://doi.org/10.1016/j.nwh.2016.04.025
3. Carr H., et.al. A system-wide approach to prevention of in-hospital newborn falls. American Journal of Maternal/Child Nursing. 2019; 44: 100-107
4. https://doi.org/10.1097/NMC.0000000000000516
5. Miner J. Implementation of a comprehensive safety bundle to support newborn fall/drop event prevention and response. Nursing for Women's Health. 2019; 23: 327-339 https://doi.org/10.1016/j.nwh.2019.06.002
6. NDNQI. (2020, January). *Guidelines for Data Collection and Submission On Patient Falls Indicator*.https://members.nursingquality.org/NDNQIPortal/Documents/General/Guidelines%20-%20PatientFalls.pdf?linkid=s0_f776_m73_m230_a0_m236_a0_m242_a0.

Included Populations:

Includes all inpatient units (adult, pediatric and OB) , ED, behavioral health facilities, cancer care centers and children's hospitals).

Fields to be reported:

Falls per 1,000 patient days

- Post Fall Huddle (PFH) completed for every fall completed? Answer Yes/No
- Attestation piece for the Post Fall Huddle at the end of the 6-month period

Reporting Frequency:

Monthly for Falls per 1,000 patient days measure

Post Fall huddle attestation completed at the end of the 6-month MQI period

Data collection period:

July 1, 2021 – December 31, 2021

Reporting deadline:
30 days after the close of the reporting period or by January 31, 2022.

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

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

Data Scoring:
Hospitals obtain data for entering the total falls and post fall huddles. All facilities can each earn 5 points by documenting 6 complete months of falls/1,000 patient days data. Additionally, facilities can submit an attestation at the completion of the MQI period for an additional 5 points if they have completed a post-fall huddle with each of their documented falls within their facility during the 6-month -performance - period.

Threshold	Total Falls	Post Fall Huddle
Point Award 2021	5	5
Point Award 2021 BH (9 independent facilities)	5	5

ER is for Emergencies

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

Measure eligibility: Adult 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. The 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 that visit emergency departments in the state of Washington, including "stand-alone ED's".

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

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, 2021– December 31, 2021

Reporting deadline:

Monthly. Data will be submitted directly to WSHA by EDIE (calculated automatically).

Audits and validation:

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

Data collection system:

EDIE

Data Scoring:

Data based on the 2020 WSHA Hospital Performance Reports and divided into quartiles. Hospitals can obtain the full 10-point awards toward their incentive for completing 90% of their care guidelines in the calendar month by the facility for patients with five or move visits.

Threshold	<=50	51% -75%	86%-89%	>90%
Point Award 2021	0	3	5	10

Safe Deliveries Roadmap

Safe Sleep Policy/Procedure

Measure eligibility: All birthing hospitals

Clinical Rationale:
Each year there are thousands of babies who experience a sleep related death. Although improvements have been accomplished over that last 30 years there is still work to do. In 2017, Ann Kellams et al. paper found that safe sleep practices and baby sleep location remained sub optimal. Ongoing sleep related deaths reflect an urgent need to help families understand safe sleep practices, but nearly half of caregivers don't receive correct advice about safe sleep from their healthcare providers.

Beyond back to sleep there are other recommended safe sleep practices today that include eliminating hazards, such as keeping blankets, pillows, bumper pads, and soft toys out of the sleep area. Recommendations also include room sharing. Practices can help lower the risk of sleep-related infant deaths, including sudden infant death syndrome (SIDS), accidental suffocation. Not all healthcare staff promote published recommendations. Healthcare providers can counsel caregivers on safe sleep practices prenatally, at delivery and at well newborn visits to increase the likelihood that infant caregivers and families receive consistent, instruction about safe sleep. Nursing education and role modeling can increase adherence to safe sleep practices.

Selected References:

1. CDC Safe Sleep for Babies, Eliminating hazards https://www.cdc.gov/vitalsigns/safesleep/infographic.html#graphichttps://www.cdc.gov/vitalsigns/safesleep/infographic.html#graphic https://www.cdc.gov/vitalsigns/safesleep/infographic.html#graphic
2. The American Academy of Pediatrics for safe sleep. http://bit.ly/2mwoaGV
3. CDC https://www.cdc.gov/vitalsigns/safesleep/infographic.html#graphic
4. Pediatrics November 2017, 140 (5) e20171816; DOI: https://doi.org/10.1542/peds.2017-1816
5. Lori Feldman-Winter, Jay P. Goldsmith, COMMITTEE ON FETUS AND NEWBORN and TASK FORCE ON SUDDEN INFANT DEATH SYNDROME, Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns

1. Pediatrics September 2016, 138 (3) e20161889; DOI: https://doi.org/10.1542/peds.2016-1889
2. National Action Partnership to Promote Safe Sleep (NAPPSS-IIN) Successful Strategies Hospitals Can Use to Support Safe Sleep
3. https://www.nichq.org/sites/default/files/inline-files/Change%20Ideas%20PDF.pdf

Definition:

The MQI - measure is comprised of two parts:

Part A:

- Does your hospital have a policy/procedure containing American Academy of Pediatrics Safe Sleep recommendations and outlines education requirements for staff and patients about Safe Sleep best practices? Answer Yes/No
  If yes, upload policy/procedure to QBS

Part B:

- Upload any written discharge instructions for Safe Sleep education provided to parents and/or caregivers.

  Please answer Yes/ No to the following formatting questions where
  Yes = 1
  No = 0

- Prenatal Education class Yes/ No?
- In-hospital video education Yes/ No?
- In-hospital individualized instruction Yes/ No?
- Patient facing App Yes/ No?
- Printed instruction Yes/ No?

If you answered yes to any of the format questions, please enter Yes and upload your instructions.

Data Source:

Answers to Part A and Part B are due to be reported one time during the time period of measurement.

Fields to be Reported:

Part A policy / procedure upload of newborn, NICU and pediatric safe sleep practices

Part B format of education: classroom, digital, handouts, prenatal teach, app and upload hospital discharge instructions regarding safe sleep.

Data collection period:
July 1, 2021 – December 31, 2021.

Reporting deadline:
30 days after the close of the reporting period or by January 31, 2022.

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

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

Data Scoring:
These data are based on data submission scoring. Hospitals obtain point awards based on submission of data into the QBS data portal. Only an answer of Yes and upload of hospital's discharge instructions in QBS will allow eligible hospitals to receive 5-point awards - toward the incentive.

Safe Sleep Policy/Procedure – Part A

Threshold	Answer of yes AND uploads policy/procedure.	Answer of no, OR answer of yes and does not upload policy/procedure
Point Award 2021	5	0

Safe Sleep Policy/Procedure – Part B

Threshold	Upload any written discharge instructions	No response - OR response provided, and discharge instructions not uploaded to QBS.
Point Award 2021	5	0

Safe Deliveries Roadmap

Emergency Department pregnant and postpartum triage

Measure eligibility: All hospitals with an Emergency Department

Clinical Rationale:
This metric designed to improve the quality and safety of care provided to women during all stages of pregnancy and postpartum. Studies have shown that delays in the diagnosis and treatment of severe hypertension/preeclampsia and receipt of suboptimal treatment of severe hypertension/preeclampsia are linked with adverse maternal outcomes. Having clear procedures in place and educating staff around these procedures should decrease failures to recognize and treat severe hypertension/preeclampsia. "Postpartum emergencies may include a variety of clinical presentations, ranging from minor concerns to life-threatening emergencies. Problems of pregnancy comprise 1.3% of emergency department (ED) visits annually.1 About 25% of postpartum patients with pregnancy complications seek ED care within the six months following delivery.2 Among postpartum patients, about 1% will require readmission.3 The most common ED complaints include obstetric wound complication, fever, abdominal pain, breast complications, and hypertension. Common postpartum emergencies include pain, fever, hemorrhage, hypertension, preeclampsia, eclampsia, infection, and depression. ED management should include a thorough history, including date and route of delivery, procedural complications, pregnancy history, and current symptoms.

The physical exam should include vital signs, lung, cardiac, and abdominal examinations. Diagnostic studies should be ordered to address the specific emergency and may include focused assessment with sonography in trauma (FAST) examination or pelvic ultrasound. Management should include initial stabilization, followed by disease-specific treatment. Among ED visits for postpartum complications, approximately 22% will require readmission." say authors Catherine Marco, Kelli Thomas & Walter Rzecznik in their mnongraph titled "Postpartum Emergencies" access at https://www.reliasmedia.com/articles/145171-postpartum-emergencies Issue date: October 15, 2019and accessed 5/11/20212

Selected References:

1. R 3 Provision of Care, Treatment, and Services standards for maternal safety found here: https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_24_maternal_safety_hap_9_6_19_final1.pdf

2. American College of Obstetricians and Gynecologists. “Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period. ACOG Committee Opinion No. 767.” Obstetrics & Gynecology. 2019;133:e174-180.
3. American College of Obstetricians and Gynecologists. “Task Force on Hypertension in Pregnancy. Hypertension in Pregnancy Task Force Report.” DOI: 10.1097/01.AOG.0000437382.03963.88 Troiano NH and Witcher PM.
4. “Maternal Morbidity in the United States: Classification on Causes, Preventability and Critical Care Obstetric Implications.” Journal of Perinatalogy & Neonatal Nursing. 2018;32(3):222-231.
5. Druzin JL, et al. Preeclampsia Toolkit — “Improving Health Care Response to Preeclampsia: A California Toolkit to Transform Maternity Care (2014).” Developed under contract #11- 10006 with the California Department of Public Health; Maternal, Child and Adolescent Health Division. Published by the California Maternal Quality Care Collaborative. 2013.

Definition:

The MQI - measure is comprised of Part A

Part A:

Does your hospital ED consistently ask the following question during triage to all females between the ages of 8 – 64 (The Joint Commission age specification): “Are you currently pregnant or have you been pregnant within the past year?” Answer Yes/No

If yes, upload policy/procedure to QBS

Data collection period:

July 1, 2021 – December 31, 2021.

Reporting deadline:

Enter one time during the time period of measurement. 30 days after the close of the reporting period or by January 31, 2022.

Audits and validation:

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

Data collection system:

Washington State Hospital Association Quality Benchmarking System (QBS).

Data Scoring:

These data are based on data submission scoring. Hospitals obtain point awards based on submission of data into the QBS data portal. Only an answer of Yes in QBS will allow eligible hospitals to receive 5-point awards toward the incentive.

Threshold	Answer of yes, upload policy/procedure to QBS	Answer of no
Point Award 2021	5	0

Diagnostic Excellence

Measure eligibility: Acute care hospitals, ED and inpatient units are eligible to participate in MQI are eligible to complete this metric.

Clinical Rational:
The National Academies of Sciences, Engineering, and Medicine defined "diagnostic error as the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient."2 Three subtypes of diagnostic error emerge: **delayed diagnosis, wrong diagnosis** or a **missed diagnosis**.

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

Patients identify the ramifications of diagnostic errors as emotional distress, prolonged illness and medical complications, impaired activities of daily living, and decreased confidence in the health care system. In addition to lost time to intervention or further testing for patients, the outcome can be untimely death or disability.

There are several causes of diagnostic error identified throughout the healthcare settings, including clinical assessment and subsequent decision making, lack of time with the clinician, communication between clinicians and patients, communication between clinicians as well as system opportunities. The Joint Commission identified the timely reporting of results of critical tests and diagnostic procedures as a National Patient Safety Goal in 2005 (NPSG.02.03.01) Unfortunately, the implementation of this safety goal has been slow and difficult, especially with communicating test results that are "sub-critical", which don't necessarily require a verbal communication channel.

This measure will focus on results that should require closed-loop communication to the clinical decision maker to be able to follow up on values outside the normal range. These results are tests results that may constitute an immediate health risk to the patient and may require multiple parties within the health care system working together to hand off tests, interpret the results, and communicate them in language the patient can understand. Timely and accurate lab and radiology information, results or results to an actionable provider is key to improving the diagnosis for a patient.

Selected References:

1. Hospital: 2021 National Patient Safety Goals found at: https://www.jointcommission.org/standards/national-patient-safety-goals/hospital-national-patient-safety-goals/
2. The National Academies of Sciences, Engineering & Medicine, Diagnostic Error in Health Care: found at: https://www.nationalacademies.org/our-work/diagnostic-error-in-health-care
3. Singh H & Vij MS. Eight recommendations for policies for communicating abnormal test results. *The Joint Commission Journal on Quality and Patient Safety*, 2010;36(5):226-32.
4. Kwan JL & Singh H. Assigning responsibility to close the loop on radiology test results. *Diagnosis*, 2017;4(3)173-177. doi:10.1515/dx-2017-0019.

Part A:

Upload policy, procedure and/or workflow of notifying ordering or provider who can take action on an abnormal lab test and/or radiology test finding showing closed loop communications. (4 points) by December 31, 2021.

Part B:

1. Data LAB upload - (3 points) One monthly data upload to QBS
   - **Count**: Total number of **lab** tests that are critical and have been communicated to an actionable provider from July 1, 2021 to December 31, 2021 for inpatient and ED units. One monthly data upload to QBS
   - **Count**: Total number of **lab** results identified as critical from July 1, 2021 to December 31, 2021 for inpatient and ED units. One monthly data upload to QBS
   - **Count**: Total number of **lab** test performed in performance period from July 1, 2021 to December 31, 2021 for inpatient and ED units. One monthly data upload to QBS AND

2. Data RADIOLOGY upload - (3 points)
   - **Count:** Total number of **radiology** findings that are critical in nature that have communicate with an actionable provider from July 1, 2021 to December 31, 2021 for inpatient and ED units. One monthly data upload to QBS
   - **Count:** Total number of **radiology** findings that are critical in nature from July 1, 2021 to December 31, 2021 for inpatient and ED units. One monthly data upload to QBS

- **Count:** Total **radiology** tests ordered and completed in any month for the ED patients and inpatients from July 1, 2021 to December 31, 2021 for inpatient and ED units. One monthly data upload to QBS

Inclusion:
All ordered tests through the hospital lab or radiology department.

Exclusion:
Outpatient lab and radiology tests and results follow up.

Data Collection period:
July 1, 2021 – December 31, 2021

Reporting deadline:
30 days after the close of the reporting period or by January 31, 2022.

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

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

Data Scoring:
Hospitals obtain point awards based on submission of above components into the QBS portal. Upload policy, procedure and/or workflow of notifying ordering or provider who can take action on an abnormal lab test and/or radiology test finding showing closed loop communications will receive 4 points. Submit at least one month of count data for the 6 components as outlined above for the reporting period in Part B to received full 6 points for part B.

Threshold	Part A: Upload policy, procedure and/or workflow on communicating critical labs and	Part B: **Data Lab upload** - only upload one month of data during the performance period **Count:** Total # of lab tests that are critical and have	**Data Radiology upload** - only upload one month of data during the performance period **Count:** Total # of radiology result findings that are

	critical radiology findings showing closed loop communications by December 31, 2021.	been communicated to an actionable provider from July 1, 2021 to December 31, 2021 for inpatient and ED units. **Count:** Total # of lab results identified as critical from July 1, 2021 to December 31, 2021 for inpatient and ED units. **Count:** Total # of lab test performed in performance period from July 1, 2021 to December 31, 2021 for inpatient and ED units. "Critical results" and "actionable" are defined by the hospital policy.	critical in nature that have communicated to an actionable provider from July 1, 2021 to December 31, 2021 for inpatient and ED units. **Count:** Total # of radiology results findings that are critical in nature from July 1, 2021 to December 31, 2021 for inpatient and ED units. **Count:** Total radiology tests ordered and completed in any month for the ED patients and in patients from July 1, 2021 to December 31, 2021 for inpatient and ED units.
Point Award 2021	4	3	3

Inpatient Behavioral Health Safety

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

Measure Eligibility**:** Inpatient behavioral health hospitals and units only

Clinical Rationale:
Substantial evidence exists that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under-identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004; NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients' strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals' community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

For more information, see the Hospital Based Inpatient Psychiatric Services (HBIPS-1).

Selected References:

1. American Psychiatric Association (2016). Practice Guidelines for the Psychiatric Evaluation of Adults. Third edition. Arlington (VA): American Psychiatric Association.
2. Lyons JS, Uziel-Miller ND, Reyes F, Sokol PT (2000). Strengths of children and adolescents in residential settings: Prevalence and associations with psychopathology and discharge placement. Journal of the American Academy of Child & Adolescent Psychiatry, Vol 39(2): 176-181.
3. NASMHPD. (2005) Position Statement on Services and Supports to Trauma Survivors. Alexandria, VA: NASMHPD.
4. Rapp CA (1998). The strengths model: Case management with people suffering from severe and persistent mental illness. London: Oxford University Press.
5. Ruiz P (2004). Addressing Culture, Race, & Ethnicity in Psychiatric Practice. Psychiatric Annals, Vol 34(7): 527-532.

6. Ziedonis DM (2004). Integrated treatment of co-occurring mental illness and addiction: Clinical intervention, program, and system perspectives. CNS Spectrums 9(12): 892,894-904,925.

Definition:

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

Numerator:

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

Denominator:

All patients admitted to inpatient psychiatric facility/unit.

Exclusions:

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

Data Elements:

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

Data Source:

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

Data collection period:

July 1, 2021 – December 31, 2021

Reporting deadline:

30 days after the close of the reporting period or by January 31, 2022.

Audits and validation:

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

Data collection system:

Washington State Hospital Association Quality Benchmarking System.

Data Scoring:

Data weighted by percentage based on hospitals achieving admission screening. Hospitals obtain 10-point awards based 99% of documentation of Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed.

Threshold	< 80%	80% - 94%	95% – 98%	≥ 99%
Point Award 2021	0	3	5	10

Inpatient Behavioral Health Safety

Behavioral Health: Transition Record with Four Specified Elements

Received by Discharged Patients

Measure Eligibility: Inpatient behavioral health hospitals and units only

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.

Definition:
Transition record – A core, standardized set of data elements consolidated into a single document related to a patient's demographics, diagnosis, treatment, and care plan that is discussed with and provided to the patient and/or caregiver in a printed or electronic format at each transition of care and transmitted to the facility/physician/other health care professional providing follow-up care. The transition record may only be provided in electronic format if acceptable to the patient and only after all components have been discussed with the patient. If a patient is transferred to another inpatient facility and the discharging clinician documents in the patient record that the patient is clinically unstable, or the patient and/or caregiver is unable to comprehend the information at discharge, then the discharging facility is not required to discuss and provide the transition record to the patient and/or caregiver; however all four of the following elements must be discussed with the receiving facility to be included in the numerator for the Transition Record with Specified Elements Received Discharged Patients measure:

- 24-hour/7-day contact information, including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care, AND
- Primary physician, other health care professional, or site designated for follow-up care.

Found in Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Sampling:
The hospital may use 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 is available at: http://www.wsha.org/wp-content/uploads/CMS_Sampling-Specs_2016.pdf

Numerator:
Inpatient psychiatric 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 four elements:

- 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care, AND
- Primary physician, other health care professional, or site designated for follow-up care.

All applicable elements must be captured to satisfy the measure numerator.

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.

Fields to be reported:
- Psychiatric inpatients with all defined elements met.
- Psychiatric inpatient discharges.

Data collection period:
July 1, 2021 – December 31, 2021

Reporting deadline:
30 days after the close of the reporting period or by January 31, 2022.

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

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

Data Scoring:
Data weighted by percentage based on hospitals review and documentation of the transition Record with Four Specified Elements Received by Discharge Patients. Hospitals obtain 10-point awards based on completion of 99% of documentation of Transition Record with Four Specified Elements Received by Discharge Patients.

Threshold	< 80%	80% - 94%	95% – 98%	≥ 99%
Point Award 2021	0	3	5	10

Social Determinants of Health

Inpatient Screening for Social Determinants of Health (SDOH)

Measure eligibility: All hospitals who wish to participate in MQI are eligible to complete this metric. Critical Access Hospitals (CAH) are not eligible to receive the incentive payment.

Clinical Rationale:
Screening patients is the first step in addressing social needs, a key determinant of health. SDOH account for at least 80% of health outcomes. This SDOH metric promotes screening and identification of three core patient social needs: housing instability, food insecurity, transportation. Future MQI metrics may focus on linkage to community-based resources and achieving universal screening.

Selected References:

1. Health Policy Brief: "The Relative Contribution of Multiple Determinants to Health Outcomes," Health Affairs, August 2014. https://www.healthaffairs.org/do/10.1377/hpb20140821.404487/full/
2. Health Leads Screening Toolkit: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/
3. AHA Screening for Social Needs: Guiding Care Teams to Engage Patients: https://www.aha.org/system/files/media/file/2019/09/screening-for-social-needs-tool-value-initiative-rev-9-26-2019.pdf
4. PRAPARE Implementation and Action Toolkit: https://www.nachc.org/research-and-data/prapare/toolkit/
5. Core Determinants of Health Screening Tool, aka the "Core 5": https://cdn.ymaws.com/www.ohioleaguefornursing.org/resource/resmgr/ohio_action_coalition/ph_nurse_leader_project/Attachment_B_CDH_Screening_T.pdf
6. CMS Accountable Health Communities Health-Related Social Needs Screening Tool: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
7. SIREN: https://sirenetwork.ucsf.edu/SocialNeedsScreeningToolComparisonTable

Metric:

- Does your hospital conduct inpatient screening for housing stability, food insecurity, and transportation needs in at least one unit or defined patient group?
- Response options: Answer Yes/No.

Fields to be reported:
If screening for all three core SDOH (housing, food, transportation) is in place for at least one unit or a defined patient population, then enter Yes. Can enter Yes anytime during the time period of measurement.

In QBS, upload a copy of the SDOH screening protocol inclusive of the workflow and screening questions.

Only an answer of Yes *and* upload of all required documents will allow eligible hospitals to receive credit toward the incentive.

(Note: the 2021 SDOH screening metric does not require reporting use of standard coding in medical records, however this is recommended to support data analytics and allows for better understanding of population health needs)

Data collection period:
July 1, 2021 – December 31, 2021

Reporting deadline:
Can enter Yes anytime during the time period of measurement. 30 days after the close of the reporting period or by January 31, 2022.

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

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

Data Scoring:
Hospitals obtain point awards based on submission of supporting data and documentation into the QBS data portal. Only an answer of Yes and upload of all required documents in QBS (screening questions, protocol, and workflow) will allow eligible hospitals to receive 10-point awards - toward the incentive.

Threshold	Answer "No" to Screening	Only an answer of Yes and upload of required documents in QBS will allow eligible hospitals to receive credit toward the incentive:
Point Award 2021	0	10