Medicaid Quality Incentive Measure Guidelines

July 1, 2024

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

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

There are two program requirements to receive the incentive as part of the MQI. Hospitals report quality reporting to the Washington State Hospital Association (WSHA). Hospitals report the financial reporting to the Department of Health (DOH). DOH and WSHA provide financial and quality performance to the HCA. The HCA makes the final determination of which hospitals qualify and receive the incentive payment. Eligible hospitals wishing to receive the quality incentive will report on measures for their patient population applicable to each measure. The data reported by hospitals for the quality incentive will be available upon request from HCA and other state agencies for auditing purpose. For questions regarding definitions or data collection, contact the Health Care Authority staff Dr. Judy Zerzan-Thul (Judy.Zerzan@hca.wa.gov), or Washington State Hospital Association staff Melina Ovchiyan (MelinaO@wsha.org).

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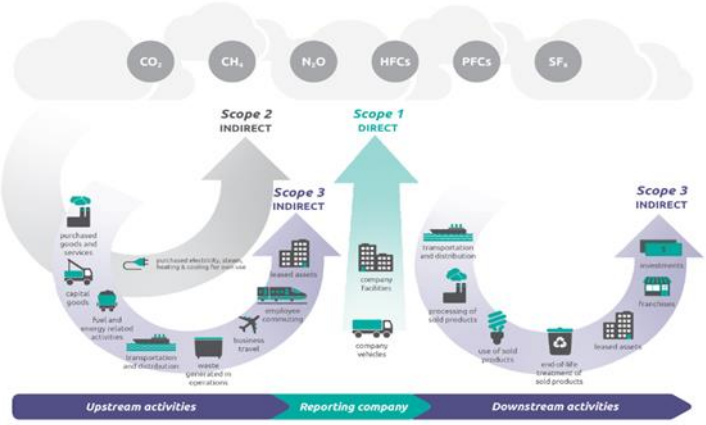
Washington State Hospital Association

Climate Change: Monitoring of Greenhouse Gas Emissions

Contact	Melina Ovchiyan; MelinaO@wsha.org
Measure eligibility:	All acute care hospitals that participate in MQI are eligible to complete this metric
Clinical Rationale:	The Climate Change initiative for 2024 builds upon the progress made in 2022 and 2023, which received significant attention from the Health Care Authority (HCA) and the Washington State Hospital Association (WSHA's) Board, Safety and Quality Committee for the MQI Program. For the 2024 MQI, the focus for hospitals will be on implementing a phased yearly approach for a more sustainable, long-term strategy to address the reduction in greenhouse gasses as part of the climate change measure. Hospitals will be asked to delve deeper into emission reduction measures and establish a dedicated team and work plans to address the issue of reducing greenhouse gas emissions (GHG). WSHA and the HCA recognize the unique needs of hospitals in WA State and provide flexibility in how they can achieve emission reductions (GHG). Through a phased approach and the integration of these recommendations, WSHA, in collaboration with HCA, aims to develop a climate change measure that is both considerate of the challenges hospitals face in terms of implementation, resource allocation, and policy development with climate change and aims to make the work plans meaningful for hospitals to address moving forward. The U.S. health sector is responsible for an estimated 8.5% of national carbon emissions. The climate crisis is a public health and equity crisis. Ameliorating the health care sector's environmental effects and reducing greenhouse-gas emissions could not only improve health for everyone, but also reduce costs of care. **Overview of GHG Protocol scopes and emissions across the value chain** 

	Selected References: 1. GHG Inventory Development Process and Guidance | US EPA. (2022, December 6). US EPA. https://www.epa.gov/climateleadership/scopes-1-2-and-3-emissions-inventorying-and-guidance 2. World Resources Institute | Making Big Ideas Happen. (n.d.). World Resources Institute. https://www.wri.org/
Definition:	Scope 1 emissions are direct greenhouse (GHG) emissions that occur from sources that are controlled or owned by an organization (e.g., emissions associated with fuel combustion in boilers, furnaces, vehicles). Scope 2 emissions are indirect GHG emissions associated with the purchase of electricity, steam, heat, or cooling. Although scope 2 emissions physically occur at the facility where they are generated, they are accounted for in an organization's GHG inventory because they are a result of the organization's energy use. Scope 3 emissions are the result of activities from assets not owned or controlled by the reporting organization, but that the organization indirectly affects in its value chain. Scope 3 emissions include all sources not within an organization's scope 1 and 2 boundary. The scope 3 emissions for one organization are the scope 1 and 2 emissions of another organization. Scope 3 emissions, also referred to as value chain emissions, often represent the majority of an organization's total greenhouse gas (GHG) emissions. Scope 1, 2, and 3 refer to different categories used to classify greenhouse gas emissions (GHG) according to their origin in a company's activities. In summary: Scope 1 - What your facility burns (direct emissions from owned or controlled sources). Scope 2 - Energy your facility buys (indirect emissions from purchased electricity, heat, etc.). Scope 3 - Everything beyond that (all other indirect emissions throughout the value chain).
Included Populations: **Exclusions:**	All locations associated with the hospital tax ID. No exclusions.

Fields to be reported:	The 2024 MQI Climate Change measure comprises four key components. A total of 10 points will be awarded for the measure broken out by the four components (see below). 1. Hospitals to complete a "greenhouse gas emission survey" in QBS, which includes the question of whether hospitals track GHG emissions. Part 1: Submission of survey response: **1. Does your hospital monitor greenhouse gas emissions?** Answer Yes/No in QBS. Only an answer of Yes will hospitals attain 2 points. No point awards will be received for a No response. **2. Hospitals will be asked to form a dedicated team** of two or more individuals at their facility to help address the reduction of GHG emissions. Answer Yes/No in QBS. **3. Hospitals will be asked to collaborate with the established team to set two or more goals** for reducing greenhouse gas emissions. Answer Yes/No in QBS. **4. Hospitals will be asked to identify and submit two or more barriers to tracking greenhouse emissions** in QBS as a free text field. List your barriers in order of priority.
Data Collection period:	2024 Calendar year data reported once during the performance period.
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	For all four components submit once during the performance period from July 1, 2024, to December 31, 2024.
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	Hospitals received the full 10 points on the submission of all four components.

Thresholds	Submission of GHG survey. *Yes/No, ONLY a response of Yes will receive point awards*	Form a team of 2+ to address GHG	Collaborate with team to establish 2+ goals to reduce GHG	Submit 2+ barriers on tracking GHG
Point Awards 2024	2 points = Yes response 0 points = No response	4 points	2 points	2 points

Washington State Hospital Association

Opioid Harm Prevention: Naloxone Distribution

Contact	Brittany Weiner; BrittanyW@wsha.org
Measure eligibility:	All adult acute and pediatric hospitals with emergency departments or inpatient psychiatric units, freestanding emergency departments, and freestanding psychiatric hospitals
Clinical Rationale:	For 2024, changes are being made to the naloxone distribution measure to better understand barriers faced in effective naloxone distribution as well as providing healthcare services for people who use drugs. Opioid-related death rates continue to climb nationally and in Washington state. According to data from the Department of Health, over 17,000 Washington residents died from a drug overdose between 2007 and 2021 and 68% of those deaths involved an opioid. Due to the evolving illicit drug landscape and presence of fentanyl in non-opioid drugs, understanding who is at-risk must also evolve. In 2021-2022, 26% of overdose deaths in Washington were poly-substance including both a stimulant and fentanyl. Offering naloxone only to those who present with identified opioid use is not sufficient to get naloxone in the hands of individuals at-risk of opioid-related harm. Any person who uses illicit drugs may be at-risk. **Part 1: Needs Assessment** Hospitals are frequently the first healthcare contact for a person who uses drugs and requires medical care. This creates an opportunity for hospitals to provide them with the care and resources needed to reduce the risk of harm from drug use and take steps toward recovery. Because of service variability across Washington hospitals, a needs assessment is being included in the 2024 naloxone distribution measure. The needs assessment is a tool to objectively evaluate each hospital's current state with implementation of naloxone distribution and support strategic aims in improving care for patients who use drugs. **Part 2: Naloxone Distribution** Naloxone distribution has been an MQI metric since 2SSB 5195 went into effect on January 1, 2022. The intent of the law is to ensure all patients at-risk of an opioid overdose, who enter the emergency department or an inpatient behavioral health setting, receive take-home naloxone at discharge. According to 2SSB 5195, individuals at-risk of opioid-related harm and eligible for naloxone distribution include:

	1. Opioid overdose 2. Opioid use disorder 3. Other adverse event related to opioid use Since the implementation of 2SSB 5195, hospitals developed workflows to ensure people at-risk are offered naloxone prior to discharge. Due to the prevalence of fentanyl in the drug supply, hospitals are strongly encouraged to work on including this list of diagnosis codes in their current workflows. 2024 Naloxone Distribution Reference In 2025, this list is expected to be used to establish the denominator for the naloxone measure moving forward. By utilizing a diagnosis list, the denominator can be extracted from available administrative claims data, thereby reducing the reporting burden for hospitals. While using diagnosis codes to establish the denominator has limitations, the advantages of long-term standardization and automation outweigh the loss of those specific data points. HCA Emergency Department Implementation Toolkit HCA Behavioral Health Agency Implementation Toolkit
Definition:	Patients who were seen in a hospital emergency department, freestanding emergency department, inpatient psychiatric unit, or freestanding psychiatric hospital and were determined to be eligible for distribution of naloxone, an opioid overdose reversal medication, based on 2SSB 5195. This includes patients who present with symptoms of the following: 1. Opioid overdose 2. Opioid use disorder 3. Other adverse event related to opioid use
Included Populations: **Exclusions:**	Any patient receiving care in a hospital emergency department, freestanding emergency department, or inpatient behavioral health setting who is identified as being at-risk of opioid-related harm. Exclusions: Patients who were not discharged from the care settings included in this measure (e.g., patient died, patient was admitted to a different inpatient unit, patient was transferred to another facility) or patients on hospice care.

Fields to be reported:	**Needs assessment:** Complete the needs assessment using the Qualtrics survey: SUD Needs Assessment Survey Link **Naloxone distribution:** **Emergency departments** (all adult and pediatric hospitals with emergency departments as well as freestanding emergency departments) Numerator: number of included population of patients who received naloxone at discharge Denominator: total number of discharged patients who were identified as being at-risk of opioid-related harm **Behavioral health settings** (freestanding psychiatric hospitals and acute hospitals with inpatient behavioral health units) Numerator: number of included population of patients who received naloxone at discharge Denominator: total number of discharged patients who were identified as being at-risk of opioid-related harm
Data Collection period:	July 1, 2024 - December 31, 2024
Reporting deadline:	1. Needs assessment: Complete survey by December 31, 2024 2. Naloxone distribution: 30 days after the close of the performance period or by January 31, 2025.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Needs assessment: One time submission completed by December 31, 2024. Naloxone distribution: Monthly (every month for the six months of the performance period from July 1, 2024, to December 31, 2024).
Data collection system:	Needs assessment: SUD Needs Assessment Survey Link: Qualtrics Survey Naloxone distribution: Washington State Hospital Association Quality Benchmarking System, QBS.

Data Scoring:	Hospitals receive 5 points for submission of the needs assessment in Qualtrics and 5 points for submission of the six months of naloxone distribution data.

Thresholds	Submission of the Needs Assessment in Qualtrics	Submission of all six months of data
Point Awards 2024	5 points	5 points

(New) Equity: Patient Demographics

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

<table>
<tr><td>Data Collection period:</td><td>The final calculation will be based on only date of service through November 2024 claims (one month snapshot). Improvements made, then lost before November will not impact the measure. Due to claims processing time between data submission to the final dataset, measure scores will be calculated and available to view in DASH by mid-February 2025.</td></tr>
<tr><td>Reporting deadline:</td><td>Jan 14, 2025 (see PNWPop data submission deadline schedule).</td></tr>
<tr><td>Audits and validation: Do not change</td><td>Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.</td></tr>
<tr><td>Submission Frequency:</td><td>Hospitals do not need to submit any additional data.</td></tr>
<tr><td>Data collection system:</td><td>Washington State Discharge dataset</td></tr>
<tr><td>Data Scoring:</td><td>November 2024 data will be scored for this measure as follows:

The target for percent “unknown” is 20% or less for each demographic. For each of the four demographics, 2.5 points will be awarded if the target is met.

<table>
<tr><th>Threshold for Demographic Reporting</th><th>Target met (“unknown”) ≤20%</th><th>Target not met (“unknown”) >20%</th></tr>
<tr><td>Sexual Orientation</td><td>2.5</td><td>0</td></tr>
<tr><td>Gender Identity</td><td>2.5</td><td>0</td></tr>
<tr><td>Disability Condition</td><td>2.5</td><td>0</td></tr>
<tr><td>Disability Daily Living</td><td>2.5</td><td>0</td></tr>
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Falls: Falls Prevention and Harm Reduction

Contact	Amy Anderson, AmyA@wsha.org
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric (includes all inpatient units, ED, behavioral health facilities, cancer care centers and children's hospitals).
Clinical Rationale:	Falls are consistently listed as one of The Joint Commission's "Top 10" Sentinel Events reported to the database, with patient falls being the single largest reported harm in 2022. In the first half of 2023, approximately 47% of sentinel events reported to The Joint Commission were fall related events (Becker's Clinical Leadership). While extensive clinical research and adult evidence-based strategies in fall prevention exist, reducing injurious falls in the hospital environment remains a significant safety and quality challenge. Falls result in more than 3 million injuries treated in emergency departments annually, including over 800,000 hospitalizations (CDC). These falls result in approximately 250,000 injuries per year. Along with injuries, these falls often result in rehospitalization, decrease in function and independence, and an increased risk of morbidity and mortality, especially in the elderly. Also, falls place a heavy burden on patients and organizations with medical costs for fall-related injuries. The cost of treating injuries caused by falls is projected to increase to over $101 billion by 2030 (American Journal of Lifestyle Medicine). This cost is likely to increase with patient age. Among adults 65 years or older within Washington, falls are the leading cause of injury-related death for persons both in and out of the hospital per 100,000 people. For older adults in the U.S., fall death rates went up by 41% from 2012-2021(CDC). According to the WA Department of Health data, there has been a recent 0.48% decrease in fatal falls in men over the past 4 years, whereas we have seen an increase of 3.95% of our female counterparts in the same timespan(WA DOH Tracking Network) **Selected References:** 1. Carr H., et.al. A system-wide approach to prevention of in-hospital newborn falls. American Journal of Maternal/Child Nursing. 2019; 44: 100-107 4. 2. Centers for Disease Control and Prevention. (2023, May 12). Facts about falls. Centers for Disease Control and Prevention. https://www.cdc.gov/falls/data-research/index.html 3. Houry, D., Florence, C., Baldwin, G., Stevens, J., & McClure, R. (2015, July). The CDC Injury Center's Response to the Growing Public Health Problem of Falls Among Older Adults. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4681302/pdf/10.1177 1559827615600137.pdf 4. Miner J. Implementation of a comprehensive safety bundle to support newborn fall/drop event prevention and response. Nursing for Women's Health. 2019; 23:327-339

	https://www.sciencedirect.com/science/article/abs/pii/S1751485119301291 5. NDNQI. (2020, January). Guidelines for Data Collection and Submission On Patient Falls Indicator. 6. Quigley, P. (2019, June). Building Clinical Capacity and Competency: Fall and Fall Injury Prevention. Medbridge. Building Clinical Capacity and Competency: Fall and Fall Injury Prevention - MedBridge (medbridgeeducation.com) https://www.medbridge.com/enterprise/resources/building-clinical-capacity-and-competency-fall-and-fall-injury-prevention/ 7. Twenter, P. (2023). Most common Sentinel events in first half of 2023: Joint Commission. Becker's Hospital Review. https://www.beckershospitalreview.com/patient-safety-outcomes/most-common-sentinel-events-in-first-half-of-2023-joint-commission.html 8. Washington Tracking Network (WTN). (n.d.). https://fortress.wa.gov/doh/wtn/WTNPortal/#!q0=296
Definition:	NDNQI. (2020, January). Guidelines for Data Collection and Submission On Patient Falls Indicator.
Included Populations: **Exclusions:**	All acute care inpatients, observation patients, emergency room, neonates, pediatrics, maternal ward, behavioral health, rehabilitation units. No exclusions.
Fields to be reported:	The 2024 MQI Falls measure will comprise the three data elements that are required for all hospitals reporting to attain the quality improvement incentive including: 1. **All Falls** – total number of all facility falls, with or without injury (whether assisted by a staff member or not) 2. **Post Fall Huddle Completion** 3. **Age of patient** **Optional Full Data Reporting:** Hospitals might have existing Electronic Health Records (EHRs) systems set up to report **on all seven** data elements and may continue to submit on the elements utilizing QBS or QBS-Falls-Form-2023 v11_16. Please note that providing the monthly full data submission for falls is voluntary. **Below are the seven fall data elements.** Total number of each of the 7 identified categories in any licensed care area within the facility during the calendar month, including: • All Falls – total number of all facility falls, with or without injury (whether assisted by a staff member or not) • Post Fall Huddle Completion

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- Type of fall
- New For BH is the intentional falls types for the 2023-2024 year.
- Age of patient
- Repeat Fall
- Gender of patient
- Location of fall

Beginning in 2025, submissions will be every month for the entire calendar year.
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<tr><td>Data Collection period:</td><td>July 1, 2024 - December 31, 2024</td></tr>
<tr><td>Reporting deadline:</td><td>30 days after the close of the performance period or by January 31, 2024.</td></tr>
<tr><td>Audits and validation: Do not change</td><td>Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.</td></tr>
<tr><td>Submission Frequency:</td><td>Monthly (every month for the six months of the performance period from July 1, 2024, to December 31, 2024). Beginning in 2025, submission will be every month for the entire calendar year.</td></tr>
<tr><td>Data collection system:</td><td>Washington State Hospital Association Quality Benchmarking System, QBS.</td></tr>
<tr><td>Data Scoring:</td><td>
<table>
<tr><th>Thresholds</th><th>All Falls</th><th>Post Fall Huddle Completion documented with each fall</th><th>Age of the Patient</th></tr>
<tr><td>Point Awards 2024</td><td>2 points</td><td>60-79% = 4 pts
≥ 80% = 5 pts</td><td>60-79% = 2 pts
≥ 80% = 3pts</td></tr>
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Washington State Hospital Association

(New) Safe Deliveries Roadmap: Perinatal Mental Health

Contact	Jenica Sandall, JenicaS@wsha.org
Measure eligibility:	All hospitals* that participate in MQI and have a labor and birth department are eligible to complete this metric.
Clinical Rationale:	According to the CDC, 1 in 5 birthing people suffer from a mental health or substance use disorder 1. Behavioral health conditions, including suicide, accounted for 32% of all pregnancy-related deaths in Washington State 2 and are the leading cause of maternal mortality in the United States. Eighty percent of all pregnancy-related deaths are preventable and significant disparities in incidence and outcomes exist, especially for Black and Indigenous patients. It is estimated that up to 75% of people with perinatal mental health (PMH) conditions never get treatment3. A priority recommendation from the WA Maternal Mortality Review Panel was to address mental health and substance use disorders by increasing screening, prevention, and treatment for pregnant and parenting people. Statewide implementation of the AIM Perinatal Mental Health Bundle4 aims to address this recommendation. Implementing systems to improve screening, treatment, referral, and continuity of care from antepartum to intrapartum and from postpartum to the community takes time. Perinatal mental health will continue as a measure in 2025 and hospitals are encouraged to continue AIM Perinatal Mental Health Bundle implementation activities between measurement periods. **Selected References:** 1. Centers for Disease Control and Prevention. (2022, September). Four in 5 pregnancy-related deaths in the U.S. are preventable. Centers for Disease Control and Prevention. https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html 2. Stein, B.-S., Sedano, C., Gardner, D., Silverman, E., Mentzer, K., Tibbs Christensen, T., & Shah, U.A. (2023, February). Washington State Maternal Mortality Review Panel: Maternal Deaths 2017–2020. Washington State Department of Health. https://doh.wa.gov/sites/default/files/2023-02/141-070-MaternalMortalityReviewPanelReport-2023.pdf 3. Clarke DE, De Faria L, Alpert JE, The Perinatal Mental Health Advisory Panel, The Perinatal Mental Health Research Team. (2023). Perinatal Mental and Substance Use Disorder: White Paper. American Psychiatric Association. https://www.psychiatry.org/maternal 4. American College of Obstetricians and Gynecologists. (2022). Perinatal Mental Health Conditions. AIM. https://saferbirth.org/psbs/perinatal-mental-health-conditions/

	5. Maternal Mental Health Leadership Alliance. (December 2022). Perinatal mental health education and screening project. https://static1.squarespace.com/static/637b72cb2e3c555fa412eaf0/t/63ff6c10a47afd07e822073f/1677683735082/MMHLA+Final+Report+2-27-2023.pdf
Definition:	**Part A. Gap & Needs Assessment** • Complete and submit the Perinatal Mental Health gap and needs assessment with input from a multidisciplinary team with representation from relevant team members specific to your hospital/department workflow (i.e. nurse, social worker, obstetric clinician, pediatric clinician, case management, mental health clinician, etc.) **Part B. Process, Resource, & Policy Documents** • Upload documents: a. A document that describes the current process related to mental health screening, assessment, and education for obstetric patients in the hospital (~500 words or less). b. Documents or referral resources and communication pathways your hospital utilizes to address patient needs, including social drivers of mental and physical health c. Resources and education provided to patients identified as having a mental health condition before discharge (may be multiple files) d. Any hospital/OB department policy/protocol/guideline(s), etc. relevant to perinatal mental health, if available.
Included Populations: **Exclusions:**	Each hospital with a labor and birth department. Hospitals that **do not** have a labor and birth department
Fields to be reported:	**Part A**. Submit the completed gap and needs assessment via the Qualtrics: Part A – Perinatal Gap and Needs Assessment: Qualtrics Survey NOTE: Part A questions can be found here: link **Part B**. Submit the completed narrative and upload via SharePoint. For access permissions email Dataanalytics@wsha.org
Data Collection period:	Part A and Part B: July 1 – August 31, 2024
Reporting deadline:	**Part A and B submissions due by: August 31, 2024**

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<tr><td>Audits and validation: Do not change</td><td>Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.</td></tr>
<tr><td>Submission Frequency:</td><td>Part A and B. Once between July 1st and August 31st, 2024.</td></tr>
<tr><td>Data collection system:</td><td>Qualtrics for Part A and WSHA SharePoint for Part B</td></tr>
<tr><td>Data Scoring:</td><td>This measure is all or nothing scoring. Each hospital with a labor and birth unit must complete part A and part B to be eligible for scoring.

Hospitals that do not complete part A and B will receive 0 points. Hospitals that complete and submit part A and part B will receive 10 points.

*For hospitals that are reporting under one licensure (share a CCN): Data must be submitted from each hospital to be considered for this measure. Scores from each hospital will be averaged.

<table>
<tr><th>Thresholds</th><th>No Submissions for Part A AND Part B</th><th>Submit Part A (Needs Assessment) and Part B (Upload of Process, Resource & Policy Documents)</th></tr>
<tr><td>Point Awards 2024</td><td>0 points</td><td>10 points</td></tr>
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(New) Sepsis: Sepsis and Diagnostic Excellence

Contact	**Rosemary Grant**, RosemaryG@wsha.org
Measure eligibility:	All hospitals that participate in MQI are eligible to complete this metric except free-standing psychiatric and rehabilitation hospitals
Clinical Rationale:	Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have triggers a chain reaction throughout your body. Infections that lead to sepsis most often start in the lung, urinary tract, skin, or gastrointestinal tract. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death. Delaying recognition and treatment of sepsis has a significant impact on mortality. Incorrect or delayed diagnoses are common, expensive, and harmful in healthcare. According to the National Academies of Sciences, Engineering, and Medicine (2015), diagnostic errors account for 6-17% of hospital adverse events. In addition, Newman-Toker, et. Al (2020) found that of patients who experience sepsis, the estimated number with missed or delayed diagnosis is between 8.2-20.8%. Missed or delayed diagnosis in sepsis has a huge impact on mortality. According to Kumar (2006) for every hour of delay in initiation of antibiotics, survival decreases by 7.6%. In 2023, the CDC published Hospital Sepsis Program Core Elements. This comprehensive guide provides hospitals with a roadmap to build or optimize multi-disciplinary hospital sepsis programs and includes a needs assessment for hospitals to determine their current state. Part of the recommendations in this toolkit are to track and monitor sepsis-specific metrics and to review sepsis cases for improvement opportunities.
Definition:	There are three parts of the sepsis/diagnostic excellence measure: 1. Needs Assessment- Completion of CDC Core Elements Sepsis Program Needs Assessment in Qualtrics by each hospital 2. Dashboard Engagement- WSHA will monitor hospital access of the sepsis dashboard on the DASH platform. The expectation is at least one view of the dashboard monthly by each hospital 3. Sepsis case reviews- To receive full points for this measure, hospitals will review 30 random cases for improvement opportunities in sepsis care including missed or delayed diagnosis. WSHA will provide guidance including suggested template for these case reviews. Hospitals should review 30 random cases from the following populations (baseline period for cases July 1, 2023-June 30 2024 discharges): a. Sepsis mortality (patients whose discharge disposition was expired, and had a sepsis diagnosis during their hospitalization). See methodology below.

	b. SEP-1 "fallout" case reviews (patients who were eligible for the SEP-1 bundle and did not meet the bundle requirements). See methodology below. General Definitions • Sepsis Definition – A diagnosis code of the following ('A40%', 'A41%', 'A021', 'A227', 'A267', 'A327', 'A5486', 'B377', 'T8144XA', 'P36%', 'O0337', 'O0387', 'O0487', 'O0737', 'O0882', 'O85', 'O8604') and not Severe Sepsis or Septic Shock • Severe Sepsis Definition – A diagnosis code of 'R6250' and not Septic Shock • Septic Shock Definition – A diagnosis code of the following ('R6521', 'T8112XA') 1. Methodology for Sepsis mortality: Patient has any code of Sepsis on the claim and the patient has an Expired discharge status 2. Methodology for SEP-1 fallout- any abstracted case for the SEP-1 measure that was a "fallout" where the bundle elements were not met for the particular case Hospitals should compile a list of the patients who meet the criteria above and randomly select 30 cases for review from this list. If there are not 30 total cases for a given hospital, all cases should be reviewed.
Included Populations: **Exclusions:**	See criteria above in 3 (a,b,c) No exclusions.
Fields to be reported:	1. **Needs Assessment**-Completion of CDC Core Elements Sepsis Program Needs Assessment in Qualtrics here 2. **Dashboard Engagement**- Tracking Sepsis Dashboard Engagement, Data captured through Dash Server (Site Status: Traffic to Views - Tableau Server (wsha.org) 3. **Sepsis case reviews**- After case reviews are completed, enter into QBS number of cases where: a. There was an opportunity for improvement in sepsis care b. There was a missed, delayed, or incorrect diagnosis
Data Collection period:	Baseline period for cases: July 1, 2023 - June 30, 2024, discharges Reporting period for cases: July 1, 2024 - December 31, 2024
Reporting deadline:	1. Needs Assessment: completed survey in Qualtrics by September 1, 2024. 2. Case review - 30 days after the close of the performance period or by December 31, 2024.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.

<table>
<tr><td>Submission Frequency:</td><td>Needs assessment - submitted once in Qualtrics by September 1, 2024.

Hospital Sepsis Program Core Elements: Assessment Tool: Qualtrics Survey

Dashboard engagement- dashboard to be accessed at least once per month from July 1, 2024, to December 31, 2024 (no submission required, this will be monitored and calculated by WSHA)

Sepsis case reviews- submitted at least once during the performance period from July 1, 2024-December 31, 2024

Sepsis MQI Measure ppt</td></tr>
<tr><td>Data collection system:</td><td>Qualtrics and Washington State Hospital Association Quality Benchmarking System, QBS.</td></tr>
<tr><td>Data Scoring:</td><td>Needs Assessment (1 point) Full survey must be completed by September 1, 2024 for 1 point. If not completed by this date or partially completed, no points will be awarded.

Dashboard Engagement (2 points) Must access dashboard each month for 2 points. If dashboard is accessed 4 or 5 of the 6 months, hospital receives 1 point. If accessed 3 or fewer months during submission period, no points will be awarded.

Sepsis Case Reviews (7 points) Hospitals must submit data on case reviews of 30 random cases from the populations specified above (except for smaller hospitals that may not have 30 cases). If a hospital has less than 30 cases total for these 2 populations for a 1 year period, they should complete case reviews and submit data on 100% of cases. Hospitals must submit data on 30 cases (or 100% of cases if less than 30 are part of the population) to receive the 7 points.

<table>
<tr><th>Thresholds</th><th>Needs Assessment completed</th><th>Dashboard Engagement and Access</th><th>Sepsis Case Reviews completed</th></tr>
<tr><td>Point Awards 2024</td><td>1 point</td><td>1 point = ≤ 4 or 5 months

2 points = ≥ 6 months</td><td>7 points = 30 cases or 100% of cases if less than 30 of pt. population</td></tr>
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Workforce Safety: Workplace Violence (WPV)

Contact	Ryan Robertson, RyanR@wsha.org
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric.
Clinical Rationale:	Workplace violence that occurs between hospital care providers and patients impacts more than 5 million workers across hospitals of all types in the United States. Staff are exposed to many safety and health hazards, including violence. In 2017 the Bureau of Labor Statistics found that 18,400 workers experienced trauma from nonfatal workplace violence and required days away from work. Diving further into the data they also found: • 70% were female • 67% were aged 25 to 54 • 71% worked in the healthcare and social assistance industry • 18% required 31 or more days away from work to recover, and 25% involved 3 to 5 days away from work. According to the CDC, WPV events are reported most frequently in psychiatric units, emergency rooms, waiting rooms and geriatric units. The risk factors for violence vary from hospital to hospital depending on location, size, and type of care. Common risk factors for hospital violence include the following: • Working directly with patients who are cognitively impaired e.g., are under the influence of drugs or alcohol, have brain injuries, have acute or chronic paranoia, or have a recent or substantial history of violence. • Patients with histories of emotional or physical trauma as a child or adult • Transitions in patients' daily schedules: e.g., mealtimes, visiting hours and shift changes • Patients having to wait a long time for service • Patients having to be in overcrowded, uncomfortable waiting rooms • Staff working alone • Lack of staff training and policies to care for patients who are at risk of violent behavior. • Environmental design: poorly lit corridors, rooms, parking lots, and other areas2 Due to historical trauma and individual experiences, seeking healthcare can be a challenging experience for some individuals. This can contribute to feeling unsafe and it is imperative that patients be treated with care, compassion, and understanding. Language barriers can make feeling safe challenging, and patients should be given access to translators when

	seeking care in an environment where their primary language is not spoken. Language has been included to ensure that hospitals are reviewing language as a consideration of investigation into workplace violent events, and is included in proper documentation for review of WPV events. This data directly correlates with the WPV programming that WSHA is conducting in 2023. **Selected References:** • Addressing Emergency Department Nurses' Experiences of Workplace Violence through the Development of a Peer-based, Post Code Gray Support Tool 2021
Definition:	Number (count) of workplace violence events by a patient in which a workplace violent event has occurred within the hospital setting.
Included Populations: **Exclusions:**	Pediatrics and admitted adult patients (i.e., ≥ 18 years of age), and specialty patients. No exclusions.
Fields to be reported:	• **Number (count) of workplace violence events** in which a physical assault or threat of physical assault occurred within the hospital setting • **Age** • **Location** • **# of non-English speakers** • **# of times non-English speakers were offered a translator**
Data Collection period:	July 1, 2024 - December 31, 2024
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024.
Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Monthly (every month for the six months of the performance period from July 1, 2024, to December 31, 2024).
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	Submission of all WPV events for all 6 months with no "N/A "entries.. Hospitals that submit N/A or -1 for responses will receive 0 points. Hospitals must submit data except for N/A or -1 to receive the full 10 points.

Thresholds	All Patient WPV Events • N/A or -1 submissions	All Patient WPV Events • Age |Location • # non-English speakers • # of times non-English speakers were offered a translator
Point Awards 2024	0 points	10 points