Medicaid Quality Incentive Measure Guidelines

July 1, 2026

The Medicaid Quality Incentive (MQI) is a program that provides opportunity for most Washington State Prospective Payment hospitals to earn up to a 1% incentive on inpatient Medicaid payments by meeting specific financial and quality reporting requirements. Critical Access Hospitals are not eligible for the financial incentive but can be formally recognized for their participation in the quality program.

This document provides the measurement guidelines for the MQI quality reporting. 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.

To receive the Medicaid Quality Incentive eligible hospitals must meet established thresholds in two areas:

1. Quality reporting submitted to the Washington State Hospital Association (WSHA), as outlined in this guide.
2. Timely financial reporting submitted to the Department of Health DOH, including CHARS, Year-End Reports, Employee Compensation, Provider based clinics, and quarterly reports.

DOH and WSHA provide financial and quality performance to the Washington State Health Care Authority (HCA). The HCA makes the final determination of which hospitals qualify and receive the incentive. Eligible hospitals wishing to receive the quality incentive will report on measures for their patient population applicable to each measure. For questions regarding definitions or data collection, contact the Washington State Hospital Association staff at MQIprogram@wsha.org.

General Specifications

Performance Period: July 1, 2026 – December 31, 2026

Data submission deadlines: No data will be accepted after January 31, 2027. Some individual measures and measure components have earlier deadlines. Late submissions will not be counted towards the MQI score but are still encouraged for data trending purposes. It is your responsibility to ensure that what you submit meets the measure requirements. Should you have any questions about requirements or encounter any difficulties with data submission, please reach out to WSHA **prior to any upcoming deadlines** for assistance. We recommend starting your work well in advance of the deadlines for this reason.

Audit 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: WSHA Performance Pulse will be the data collection platform for all measures. This replaces the WSHA QBS System. Login to Performance Pulse using your WSHA DASH credentials. You will see all your assigned measures, and you can filter for MQI measures.

Eligibility and scoring: Most Washington Prospective Payment Hospitals (PPS) are eligible to receive the financial incentive. Individual measures may have different eligibility criteria; measures for which a hospital is not eligible will not be counted against its score. Critical Access Hospitals are encouraged to participate but cannot receive the financial incentive. For hospitals that are reporting under one license (a shared CCN), the combined data will be submitted once for all eligible hospitals under that license.

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Measure Crosswalk

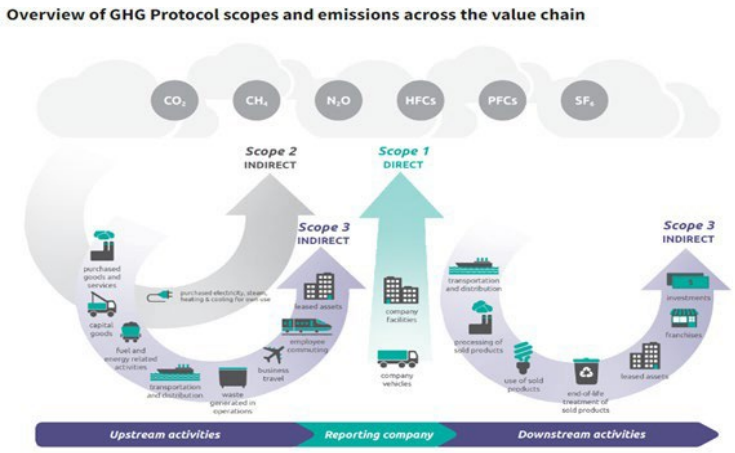
Measure	Description	Fields/Type	Points	Frequency	Deadline
Climate Change	Update on GHG Reduction Goals OR New GHG Reduction Goals	Document	10	Once	1/31/27
Health Equity Pt 1	Language Access Documentation in Medical Record	Document/screenshot	5	Once	1/31/27
Health Equity Pt 2	Language Access Monitoring	Document	5	Once	1/31/27
Opioid Harm Prevention Pt 1	Documentation of MOUD prescribing practices OR action plan to implement MOUD prescribing	Document	4	Once	1/31/27
Opioid Harm Prevention Pt 2	Documentation of inpatient naloxone discharge education.	Document	4	Once	1/31/27
Opioid Harm Prevention Pt 3	Naloxone distribution for patients at risk of overdose	Numerator/denominator	2	Monthly	Last day of the next month
Safe Deliveries Roadmap Pt 1	TeamBirth Monthly Huddle Submissions	Huddle observation form	6	Monthly	Last day of the next month
Safe Deliveries Roadmap Pt 2	TeamBirth Variety of Huddle Observers (at least 4)	Determined from Huddle observation form	2	From monthly data	1/31/27
Safe Deliveries Roadmap Pt 3	TeamBirth Category II Fetal Heart Rate Huddles	Determined from Huddle observation form	2	From monthly data	1/31/27
Sepsis Pt 1	Action Plan Update	Document	2	Once	1/31/27
Sepsis Pt 2	Sepsis Awareness Month Activities - Staff	Attestation	1	Once	10/31/26
Sepsis Pt 3	Sepsis Awareness Month Activities – Patient/Community	Attestation	1	Once	10/31/26
Sepsis Pt 4	Sepsis Readmissions Chart audits or patient interviews	Document	6	Once	1/31/27
Workplace Violence Pt 1	Monthly event reporting	Numerator/denominator	5	Monthly	Last day of the next month
Workplace Violence PT 2	Event investigation summary	Document	2	Once	1/31/27
Workplace Violence Pt 3	Recommendations for improvement action	Document	3	Once	1/31/27

Climate Change: Monitoring and Reduction of Green House Gas Emissions

Clinical Rationale: The U.S. health sector is responsible for approximately 8.5% of U.S. carbon emissions. These emissions are made up of three scopes:

- **Scope 1**: Operations of healthcare facilities; direct emissions occur from sources owned or controlled by the organization.
- **Scope 2**: Purchased sources of energy, heating, and cooling, indirect emissions.
- **Scope 3**: Supply chain purchases for services and goods, and value chain and investments in the healthcare sector

The healthcare sector's emissions stem from various resources, including hospital operations, energy consumption, supply chains, and transportation. Reducing these emissions is essential for mitigating the health impacts of climate change and promoting environmental sustainability. See the visual below.



Selected Reference Links:

- Key Actions to Reduce Greenhouse Gas Emissions by U.S. Hospitals and Health Systems - NAM
- Climate-friendly healthcare: reducing the impacts of the healthcare sector on the world's climate | Sustainability Science | Springer Nature Link
- Sustainable healthcare practices: Pathways to a carbon-neutral future for the medical industry - ScienceDirect
- 3 health care sustainability trends to follow in 2025 | Health Care Without Harm - US & Canada
- Greenhouse Gases at EPA | US EPA

Eligibility: All hospitals

Climate Change: Monitoring and Reduction of Green House Gas Emissions
The focus for hospitals this year will be to demonstrate progress on the goals submitted in the 2025 program or to establish new goals if none were submitted previously. This approach supports a sustainable, long-term strategy for reducing greenhouse gas (GHG) emissions as part of the climate

change measure. It reinforces hospitals' commitment to setting clear targets, monitoring their performance, and transparently sharing progress toward meaningful GHG reductions.	
Population	All hospitals
Exclusions:	None
Fields	For the 2026 MQI Program**,** hospitals will do one of two things: 1. If a hospital submitted GHG reduction goals in 2025: → It will provide an update on its progress toward those goals. 2. If a hospital did ***not*** submit goals in 2025**:** → It will submit new GHG reduction goals for the 2026 program. This ensures every hospital either continues the work it has already started or sets new goals to reduce greenhouse gas emissions.
Deadline:	January 31, 2027.
Frequency:	Once
Scoring:	• If a hospital did *not* submit climate goals for the 2025 MQI Program**:** It will earn 10 points for submitting new GHG emission reduction goals. • If a hospital *did* submit climate goals for the 2025 MQI Program: It will earn 10 points for submitting an update on its 2025 goals.

Health Equity: Language Access Use

Clinical Rationale: To be compliant with Title VI of the Civil Rights Act, hospitals must take reasonable steps to ensure that patients speaking languages other than English are afforded access to qualified medical interpreters.

Additionally, Section 1557 of the Affordable Care Act of 2010 prohibits discrimination on the grounds of "national origin," for example not providing services in the patient's language of care. Ensuring effective communication is a tenant of providing high-quality patient-centered care. It is also strongly linked to improved patient experience, reduced medical diagnostic and treatment errors.

Results from the 2025 WSHA Language Access Assessment showed low rates of hospitals reporting consistent documentation of patient access to qualified language interpreters. Without information on patient access to qualified interpreters, hospitals are unable to assess the scale of access issues or develop appropriate improvement efforts.

This year WSHA will focus on supporting hospitals to design, deploy or enhance approaches for consistently documenting when an interpreter is needed and monitoring language access programs. This builds on last year's structural measure and will support future MQI measures to collect process and outcome data.

This measure incentivizes work to integrate documentation workflows keeping in mind that future measures may require consistent reporting of language access with possible targets.

1. National Health Law: What is required under Title VI and Section 1557 to ensure Language Access for Individuals with Limited English Proficiency?
2. Joint Commission standards for language access - Propio

Eligibility: All hospitals

<table>
<tr><th colspan="2">Part 1: Language Access Documentation in Medical Record</th></tr>
<tr><td colspan="2">Hospitals will report fields or provide a de-identified screenshot of how language service needs are documented in the medical record.

1. At minimum required fields must include patient language of care (or "preferred" language) and whether an interpreter is needed.
2. Consider integrating documentation for whether an interpreter was provided and the modality (in-person, video, telephone, etc).
3. Explain how "good faith" efforts to procure an interpreter are documented and can be provided upon request</td></tr>
<tr><td>Populations:</td><td>Documentation refers to all patients with a language of care other than English (including sign languages) with at least one inpatient stay in 2026 in need of language interpreter services.

Hospitals may include documentation for ED and outpatient settings, but inpatient documentation must also be reported.</td></tr>
</table>

Exclusions:	It is assumed that all services are already provided in English. Therefore, language access documentation and reporting is not needed for English proficient patients
Fields:	Upload a document that contains de-identified screenshot(s) of medical record fields. May include multiple screenshots combined into one document if fields are stored/displayed in several places. The document must at minimum display how language of care and interpreter need are charted in the medical record and explain how "good faith" efforts are documented and provided upon request. No points will be awarded if these elements are not included.
Deadline:	January 31, 2027
Frequency:	Once
Scoring:	5 points

Part 2: Language Access Monitoring	
In order to ensure that patients who need language services are consistently receiving them, a hospital is expected to have structures in place to evaluate the effectiveness of its language access program. Describe your process for monitoring language access rates for patients with language of care other than English or those with a documented need for a medical interpreter. (See fields for more specific requirements) This must be explained for inpatient hospital stays. Hospitals may choose to expand narrative to include ED and outpatient language access monitoring.	
Populations:	All patients with a language of care other than English (including sign languages) with at least one inpatient stay in 2026 in need of language interpreter services should be included in the monitoring narrative. Hospitals may include narrative on monitoring language access for ED and outpatient settings, but inpatient monitoring must also be included.
Exclusions:	It is assumed that all services are already provided in English. Therefore, language access monitoring is not needed for English proficient patients who do not need an interpreter.
Fields:	Upload a written narrative of your process for monitoring language access rates for patients with language of care other than English or those with a documented need for a medical interpreter. **The hospital's language access monitoring program must include all seven listed elements to receive points for this measure.** In your narrative, please include an explanation of how you are accomplishing each element. 1. Individual or committee responsible for monitoring language access 2. Frequency of monitoring 3. How requests for interpreters are tracked 4. How interpreter fill rates are monitored

	5. Performance targets or goals 6. How quality of interpreter services is assessed 7. How language access reports are shared with leadership If any of these elements are not currently in place, a hospital has until the reporting deadline to put these processes in place and submit a narrative.
Deadline:	January 31, 2027
Frequency:	Once
Scoring:	5 points (must include all 7 criteria or no points will be awarded for this component)

Opioid Harm Prevention

Clinical Rationale: Washington's persistently elevated rate of nonfatal opioid overdoses presents a critical point of care opportunity for hospitals to reduce mortality, prevent future overdose and strengthen patient recovery trajectories. Evidence based practices such as naloxone distribution, structured harm reduction education, and initiation of medications for opioid use disorder (MOUD) are proven to increase survival, reduce readmissions, and stabilize individuals with OUD during high-risk transitions of care. Prescribing MOUD is especially impactful, not only as a potential tool for recovery, but also as an overdose prevention measure if the person returns to use within 48 hours of discharge from the hospital. Embedding these interventions into routine clinical workflows improves patient outcomes, enhances staff confidence, and reduces risk exposure for healthcare organizations.

The 2026 MQI Opioid Harm Prevention measure focuses on consistent delivery of these life-saving practices and will prepare hospitals for more robust performance reporting in future years.

Eligibility: All hospitals other than rehabilitation hospitals

Part 1: Prescribing Practices	
Hospitals are expected to undertake structural quality improvement efforts to ensure MOUD, particularly buprenorphine, is reliably available as a treatment option, including for pregnant patients. To receive points for this section, hospitals can document those steps by either: 1. Submitting documentation (e.g., policies, procedures, order sets, other supporting documentation) that reflects the current best practice for MOUD initiation and maintenance including responsive dosing strategies to respond to fentanyl potency, OR 2. Submitting an action plan to demonstrate the hospital is taking steps to implement MOUD prescribing based on their current level of readiness. a. Demonstrating progress may look different across hospitals. Examples of activities could include: enrollment in ScalaNW and providing estimated go-live date, adding buprenorphine to formulary if not currently available, integrating MOUD access into routine clinical workflows, board/executive engagement with opioid harm prevention, and training staff on effective MOUD prescribing.	
Populations:	Hospitals should choose at least one service area for this process, but location is not specified due to multiple hospital types being eligible for the measure. Hospitals with EDs should consider starting there due to the high opportunity for intervention but may choose inpatient settings if ED MOUD prescribing is already robust.
Exclusions:	None.
Fields:	Upload supporting documentation to demonstrate current MOUD prescribing practices, or upload action plan outlining needed steps and anticipated timeline for implementation.
Deadline:	January 31, 2027
Frequency:	Once
Scoring:	4 points

Part 2: Inpatient Naloxone Discharge Education	
Hospitals should establish and document a reliable process for providing standardized naloxone education at inpatient discharge for patients with diagnosed OUD and patients admitted for opioid overdose. At minimum, education must include why carrying naloxone is essential and how and where to access naloxone in the community. To receive points for this section, hospitals can document those steps by: 1. Submitting documentation that shows this information is provided (e.g., workflows for naloxone education, standard discharge template language, patient flyers or other materials). a. If your hospital does not have these materials in place for inpatient discharge education, consider these examples of appropriate resources	
Population:	Patients who are admitted to an inpatient unit with OUD or symptoms of an opioid overdose.
Exclusions:	Patients who died, are on hospice, or those who are transferred to another care setting (e.g., admitted for inpatient care, discharged to a skilled nursing facility).
Fields:	Upload supporting documentation to demonstrate appropriate naloxone education for patients with OUD or those who were admitted following an opioid overdose.
Deadline:	January 31, 2027
Frequency:	Once
Scoring:	4 points

Part 3: Naloxone Distribution	
Naloxone should be distributed to patients who were seen in a hospital emergency department, freestanding emergency department, inpatient psychiatric unit, or freestanding psychiatric hospital who presented with symptoms of: 1. Opioid overdose 2. Opioid use disorder 3. Other adverse event related to opioid use a. Due to the prevalence of fentanyl in the drug supply, hospitals should ensure patients who may be unintentionally exposed to opioids through use of other illicit substances are included in the at-risk population. You may incorporate this list of diagnosis codes into their existing distribution workflows or use other internal processes. The numerator and denominator remain the same from 2025 and remain a consistent way to support compliance with state law.	
Population:	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 died, are on hospice, or those who are transferred to another setting (e.g., admitted for inpatient care, discharged to a skilled nursing facility, transferred to jail).

	Note: Patients who eloped, self-discharged (left AMA), or left before being seen are still included in the denominator.
Fields	**Emergency departments** (all adult and pediatric hospitals with emergency departments as well as freestanding emergency departments) and **Behavioral health settings** (freestanding psychiatric hospitals and acute hospitals with inpatient behavioral health units) report: • 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
Deadline:	Monthly, by the last day of the subsequent month
Frequency:	Monthly (every month for the six months of the performance period from July 1, 2026, to December 31, 2026).
Scoring:	2 Points (must submit all six months of data on time)

Safe Deliveries Roadmap

TeamBirth Huddles - Building a Culture of Communication and Patient Partnership

Clinical Rationale: The most recent Washington State Mortality Review Report shows racial disparities persist in outcomes and that poor communication is one of the most common issues impacting pregnancy-related deaths in WA.

Washington adopted TeamBirth as a foundational practice to help improve disparities and communication in perinatal care. TeamBirth is a structured communication framework that focuses on eliciting a birthing person's preferences, symptoms, and experiences and integrates this with clinical data to inform patient care plans and promote safe, respectful childbirth care. The WSHA Board declared TeamBirth a best practice recommendation for Washington State. More information about TeamBirth.

Huddle observations help keep a focus on TeamBirth as the foundational practice relevant to all care; they encourage huddles to happen and provide an opportunity for huddle participants to feel more confident through supportive reflection and just-in-time training. The 2026 Safe Deliveries Roadmap measure will continue to focus on health equity and the role of TeamBirth in improving a culture of communication and patient partnership. In addition, WSHA is supporting hospitals to lower primary cesarean birth rates, so this year's measure will incorporate focus on huddles for indeterminate fetal heart rate (Category II) as a tool for cesarean reduction.

Eligibility: All hospitals that have a labor and birth department

Submission: All parts of this measure are calculated from inputs using the Huddle observation form. An electronic version of this form is available through WSHA TeamBirth Huddle Observation Dashboard, which is where the data will be submitted.

Part 1: Monthly huddle submissions

Monthly huddle observation scoring will be calculated based on whether the minimum number of submissions is met each month. The minimum number of monthly submissions is approximately 3% of monthly volume and is represented as fixed thresholds in the table below.

Hospitals should utilize the TeamBirth Huddle Observation dashboard on DASH to monitor submissions.

2025 Birth Volume	Minimum # Monthly Observations
≥ 4000	10
≥ 2500 - < 4000	6
≥ 2000 - < 2500	5
≥ 1500 - < 2000	4
≥ 1000 - < 1500	3
< 1000	2

Population	Any patient in an obstetric department is eligible for inclusion
Exclusions:	Hospitals that do not have a dedicated obstetric department

Fields	See WSHA Huddle Observation Form
Deadline:	Monthly, by the last day of the subsequent month
Frequency:	Monthly
Scoring:	6 Points (no points will be awarded if minimum submissions not met or submissions are not submitted on time every month)

Part 2: Variety of observers

Variety of observers award scoring will be calculated cumulatively at the end of the measurement period and based on the stated role of the huddle observers. Throughout the entirety of the measurement period, at least 4 different observer roles must be represented. The categories of roles are staff nurse, provider, patient, support person, doula, other hospital staff and nurse leader.

Population:	Any patient in an obstetric department is eligible for inclusion.
Exclusions:	Hospitals that do not have a dedicated obstetric department
Fields:	At least 4 different observer roles must be represented throughout the measurement period to score for this component. The categories of roles are staff nurse, provider, patient, support person, doula, support staff and nurse leader to be marked within the WSHA Huddle Observation Form
Deadline:	January 31, 2027.
Frequency:	N/A. There is no separate data submission for this component. There will be a one-time look back at all huddle data submitted (Part 1) at the end of the performance period (1/31/27) to determine points.
Data Scoring:	

4+ observer roles	2 points
2-3 observer roles	1 point
1 observer role	0 points

Part 3: Category II Fetal Heart Rate (FHR) Huddles

Within the huddle submissions, additional points are available for huddles related to indeterminate fetal heart rate (FHR) (Category II FHR). Category II FHR huddle award scoring will be calculated cumulatively at the end of the measurement period and based on the reason that prompted the huddle.

Category II FHR targets are based on 33% and 25% of the minimum required monthly huddle observations (Part 1) and are translated into fixed counts by birth volume (see Data Scoring below).

To avoid discouraging submission above minimum monthly requirements, these targets are fixed based on the minimum required observations. Submitting more than the minimum number of huddles does not increase the number of required Category II FHR submissions.

<table>
<tr><td>Population:</td><td>Any patient in an obstetric department is eligible for inclusion.</td></tr>
<tr><td>Exclusions:</td><td>Hospitals that do not have a dedicated obstetric department</td></tr>
<tr><td>Fields:</td><td>Huddles marked as “Category II FHR” within the WSHA Huddle Observation Form will count towards this component</td></tr>
<tr><td>Deadline:</td><td>January 31, 2027.</td></tr>
<tr><td>Frequency:</td><td>N/A. There is no separate data submission for this component. There will be a one-time look back at all huddle data submitted (Part 1) at the end of the performance period (1/31/27) to determine points.</td></tr>
<tr><td>Data Scoring:</td><td>Scoring will be calculated cumulatively as a look back at the end of the measurement period and based on the reason that prompted the huddle.

Point thresholds are based on the number of huddles marked as Category II FHR compared to fixed targets derived from six months of minimum required monthly observations (Part 1) and do not change based on total submissions above the minimum.

<table>
<tr><th>2025 Birth Volume</th><th>2 Points (≥ 33%)</th><th>1 point (≥25 to <33%)</th><th>0 points (<25%)</th></tr>
<tr><td>≥ 4000</td><td>≥20</td><td>15–19</td><td>≤14</td></tr>
<tr><td>≥ 2500 - < 4000</td><td>≥12</td><td>9–11</td><td>≤8</td></tr>
<tr><td>≥ 2000 - < 2500</td><td>≥10</td><td>8–9</td><td>≤7</td></tr>
<tr><td>≥ 1500 - < 2000</td><td>≥8</td><td>6–7</td><td>≤5</td></tr>
<tr><td>≥ 1000 - < 1500</td><td>≥6</td><td>5</td><td>≤4</td></tr>
<tr><td>< 1000</td><td>≥4</td><td>3</td><td>≤2</td></tr>
</table>
</td></tr>
</table>

Sepsis/Sepsis Readmissions

Clinical Rationale: Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Delaying recognition and treatment of sepsis has a significant impact on mortality[1]. Because the key to better sepsis outcomes is timely identification and treatment, it's important that hospital staff as well as patients, families and the community are aware of the signs and symptoms of sepsis. The Sepsis Alliance found that only 69% of U.S. adults are aware of the term sepsis and that even those aware of what sepsis is have misconceptions or misinformation about how to prevent sepsis and how to treat it.

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. Past MQI Sepsis measures have asked hospitals to complete the CDC's Core Elements Needs Assessment to identify opportunities for improvement and to complete a Sepsis Action Plans to help implement improvement ideas. This year's measure will build on these action plans.

Additionally, Sepsis is the #1 index diagnosis leading to 30-day readmission in Washington State[2]. The AHRQ has published a comprehensive guide to reducing readmissions, particularly in the Medicaid population. Part of the guide involves recommending patient interviews for patients who are readmitted to the hospital to identify key drivers of the readmission. Interviewing or performing a chart audit for patients who were readmitted to the hospital can help hospitals to design a data-informed portfolio of strategies to reduce readmissions at their facilities.

Eligibility: All hospitals except free-standing psychiatric and rehabilitation hospitals

Part 1: Sepsis Action Plan Update	
Complete a Sepsis Action Plan Update for the QI project at your facility aimed at improving sepsis care and outcomes that you began in 2025. See Fields to Be Reported Section for more details. See Fields to Be Reported Section for more details. Hospitals that did not submit a Sepsis Action Plan in 2025 should not submit an "update" for 2026. Instead, please complete a new Sepsis Action Plan. Hospitals that feel their 2025 project is "complete" as of December 31, 2025 may submit a new Sepsis Action Plan to meet this part of the requirement. In either case, please contact rosemaryg@wsha.org for approval.	
Population:	Any area of the hospital
Exclusions:	None

[1] Kumar A, Roberts D, Wood KE, Light B, Parrillo JE, Sharma S, Suppes R, Feinstein D, Zanotti S, Taiberg L, Gurka D, Kumar A, Cheang M. Duration of hypotension before initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock. Crit Care Med. 2006 Jun;34(6):1589-96. doi:

[2] Data from https://analytics.wsha.org/

Fields:	Submit action plan updates using the template provided. Share progress and plan for sustainability. If submitting a new plan instead of an update use this template.
Deadline:	December 31, 2026
Frequency:	Once
Data Scoring:	2 points

Part 2: Staff-facing Sepsis Awareness Month Activity	
Complete a staff-facing Sepsis Awareness Month activity in September 2026 and attest that this was completed. See here for ideas.	
Population:	Any area of the hospital
Exclusions:	None
Fields:	Attestation and Description of Activities
Deadline:	October 31, 2026
Frequency:	Once
Data Scoring:	1 point

Part 3: Patient, family, and/or community Sepsis Awareness Month Activity	
Complete a patient/family/community facing Sepsis Awareness Month activity in September 2026 and attest that this was completed. See here for ideas.	
Population:	Any area of the hospital and/or community.
Exclusions:	None
Fields:	Attestation and Description of Activities
Deadline:	October 31, 2026
Frequency:	Once
Data Scoring:	1 point

Part 4: Sepsis Readmissions Interviews or Chart Reviews
• Complete sepsis readmission interviews or chart reviews. Interviews and chart reviews are intended to help identify key drivers of readmission and should go beyond a medical diagnosis that is connected to the readmission. Interviews can follow the interview guide in the ASPIRE toolkit, a "5 why's" exercise, or other interview questions hospitals choose. • Chart reviews can be completed by using the chart abstraction template or other readmission review templates of your choosing to identify key drivers. You will not be submitting the chart review tool in its entirety, just the key drivers and whether you identified an opportunity for improvement in patient care, discharge planning, transitions of care, or other care

opportunities that might have helped to avoid a readmission. The readmission window is 30 days.

- 4a. For hospitals with 30 or more sepsis readmissions during 2025: Either prospectively interview 15 readmitted patients whose index hospitalization was for sepsis (preferred) in 2026 OR retrospectively perform a chart audit on 30 patients who were readmitted with an index hospitalization for sepsis in 2025.
- 4b. For hospitals with less than 30 but more than 4 sepsis readmissions during 2025: retrospectively perform a chart audit on all patients who were readmitted with an index hospitalization for sepsis in 2025.
- 4c. For hospitals with less than 5 sepsis readmissions during 2025: retrospectively perform a chart audit on all patients who were readmitted with an index hospitalization for sepsis in 2025 AND as many additional patients who were readmitted with ANY index hospitalization diagnosis to total 5 case reviews (preferred index diagnoses for infection if possible).

Hospitals may do a combination of chart reviews and interviews if so desired. Each interview "counts" for 2 chart reviews. If you choose to do a combination of interviews and chart reviews, please advise Rosemary Grant (rosemaryg@wsha.org).

Hospitals should determine the number of readmissions for 2025 based on internal data, not based on DASH data. DASH data includes readmissions to hospitals other than the index hospitalization facility so those numbers will be higher than your internal data. See fields to be reported section for more details.

Population:	Interviews and/or chart reviews can include patients in any area of the hospital. For hospitals with low sepsis readmission volumes (less than 5 per year), readmission chart reviews may be done for any diagnosis but sepsis and infection should be prioritized.
Exclusions:	None
Fields:	After interviews or chart reviews are completed, enter the key drivers of readmission and opportunities for improvement for each case interviewed or chart reviewed.
Deadline:	January 31, 2027
Frequency:	Once
Data Scoring:	6 points (no partial credit)

Workplace Violence Prevention and Response

Clinical Rationale: WPV is a significant occupational hazard and a widespread global problem. It reduces healthcare workers' job satisfaction, commitment, and efficiency ultimately harming their quality of life. For patients, WPV can disrupt current care, influence future decisions about seeking healthcare, and increase the risk of future violence.

Understanding statewide trends and better practices promotes opportunities to prevent WPV events and improve response when events occur. Strengthening these efforts enhances care providers' ability to deliver safe high-quality care to all patients.

Washington State regulations require hospitals to collect specific WPV data and to develop, monitor, and revise WPV plans based on that data. Recent revisions to the regulations require hospitals to investigate all WPV events directed toward hospital employees that are threats of physical harm and acts of physical violence. Hospitals must submit investigation summaries to their WPV committee either quarterly or twice yearly, depending on hospital type. These summaries are expected to guide improvement action aimed at reducing WPV events.

Eligibility: All Hospitals

Part 1: WPV Event Reporting	
Monthly reporting of the total number of WPV events against an employee, including location, and type of event. • "Workplace violence event" is defined as any physical assault or threat of physical assault against an employee of a health care setting on the property of the healthcare setting. • "Location" is defined as the physical location within the property of the healthcare setting that is covered by the hospital license, including inpatient areas, inpatient psychiatric areas, emergency departments, non-patient care areas and hospital- based outpatient areas.	
Population:	All hospital employees who have been threatened with physical assault or have been physically assaulted
Exclusions:	• WPV events against others who are not hospital employees (e.g., patients or visitors) • WPV events that do not include the threat of physical assault or physical assault of an employee
Fields:	Total number of WPV events against an employee, including location, and type of event. Hospitals report WPV events monthly, year round, through MS Forms, with data displayed on the WSHA DASH WPV Dashboard. This same monthly reporting will be counted for the MQI during the data collection period. Duplicate submissions are not required
Deadline:	Monthly, by the last day of the subsequent month
Frequency:	Monthly

Data Scoring:	• 5 points for submitting all 6 months • 0 points for data submission <6 months Submissions must be on time to be counted

Part 2: WPV Event Summary	
Submit one WPV Event Investigation Summary that was submitted to the WPV committee in the format used by the hospital. WPV event investigation summary includes the following data with any personal information de-identified: • Summary of violent acts record data (as described in RCW 49.19.040) • Analysis of any systemic and common causes of WPV incidents	
Population:	All hospital employees who have been threatened with physical assault or have been physically assaulted
Exclusions:	• WPV events against others who are not hospital employees (e.g., patients or visitors) • WPV events that do not include the threat of physical assault or physical assault of an employee
Fields:	Submit one WPV Event Investigation Summary that was submitted to the WPV committee in the format used by the hospital
Deadline:	January 31, 2027.
Frequency:	Once
Data Scoring:	2 points

Part 3: WPV Improvement Action	
Submit one improvement action implemented or planned for implementation by the hospital based on recommendations from a WPV event investigation summary. This could be recommendations for WPV plan modification or other improvement action to prevent future incidents of WPV.	
Population:	All hospital employees who have been threatened with physical assault or have been physically assaulted
Exclusions:	• WPV events against others who are not hospital employees (e.g., patients or visitors) • WPV events that do not include the threat of physical assault or physical assault of an employee

Fields:	Submit one improvement action implemented or planned for implementation by the hospital based on recommendations from a WPV event investigation summary using the Workplace Violence Action Plan form. An electronic version of this form is available in WSHA Performance Pulse, which is how where this measure will be submitted.
Deadline:	January 31, 2027.
Frequency:	Once
Data Scoring:	3 points