Minnesota Statewide Quality Reporting and Measurement System:

Appendices to Minnesota Administrative Rules, Chapter 4654

Minnesota Department of Health

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MINNESOTA MDH DEPARTMENT OF HEALTH

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INTRODUCTION

Minnesota Statutes 62U.02 requires the Commissioner of Health to establish standards for measuring health outcomes and develop a standardized set of measures to assess the quality of health care services offered by health care providers. In addition, Minnesota Statutes 62U.02 requires the Commissioner of Health to issue annual public reports on provider quality using a subset of measures from the standardized set of measures. The Department of Health has contracted with Minnesota Community Measurement (MNCM) to lead a consortium of organizations, including Stratis Health, the Minnesota Medical Association (MMA), the Minnesota Hospital Association (MHA), and the University of Minnesota School of Public Health, to assist in the completion of these tasks.

Measures that will be used for public reporting are identified in Appendices A, B and C. The standardized set of measures are defined in the body of the rule and include the measures identified in Appendices A, B, C, and D. The hospital measures in Appendix B and the ambulatory surgical center measures in Appendix C are defined by the referenced national quality organizations and will likely change over time as modified by the national quality organizations.

APPENDIX A
REQUIRED PHYSICIAN CLINIC QUALITY MEASURE DATA

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2012 (2011 Dates of Service) and Every Year Thereafter		
Diabetes		
Optimal diabetes care (ODC) composite These measures are used to assess the percent of adult patients who have type I or type II diabetes with optimally managed modifiable risk factors: ▪ HbA1c control (less than 8 percent) ▪ Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) ▪ Blood pressure (BP) control (less than 140/90 mm Hg) ▪ Daily aspirin use if patient has diagnosis of ischemic vascular disease (IVD) or valid contraindication to aspirin ▪ Documented tobacco free *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics must submit the following data for the optimal diabetes care measure and for each of the five component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) and presence / absence of ischemic vascular disease (IVD) co-morbidity: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion	Optimal Diabetes Care Specifications, 2012 (2011 Dates of Service). MN Community Measurement. Revised 08/08/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2012 (2011 Dates of Service) and Every Year Thereafter		
	criteria ▪ Calculated rate	
Cardiovascular Conditions		
Optimal vascular care (OVC) composite These measures are used to assess the percent of adult patients who have ischemic vascular disease (IVD) with optimally managed modifiable risk factors: ▪ Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) ▪ Blood pressure (BP) control (less than 140/90 mm Hg) ▪ Daily aspirin use or contraindication to aspirin ▪ Documented tobacco free *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics must submit the following data for the optimal vascular care measure and for each of the four component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) and presence / absence of diabetes co-morbidity: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria	Optimal Vascular Care Specifications, 2012 (2011 Dates of Service). MN Community Measurement. Revised 08/08/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2012 (2011 Dates of Service) and Every Year Thereafter		
	▪ Calculated rate	

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in February 2012 (February 1, 2011– January 31, 2012 Dates of Service) and Every Year Thereafter		
Behavioral Health Conditions		

Depression remission at six months
 	
This measure is used to assess the percent of adult patients who have major depression or dysthymia who have reached remission at six months (+/- 30 days) after being identified as having an initial PHQ-9 score greater than 9. Remission is identified as a PHQ-9 score less than 5.
 	
(Urgent Care Centers are not required to submit data on this measure.)
	Physician clinics must submit the following data for the depression remission at six months measure:
	▪ Patient identification methodology
	▪ Submit the following two data elements by three bands of initial PHQ-9 scores (10-14; 15-19; 20 and above):
	  ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure
	  ▪ Numerator: Number of patients meeting the targets in the measure
	▪ Number of patients meeting the exclusion criteria
	▪ Number of patients for whom a follow up six month (+/- 30 days) PHQ-9 assessment was not completed.
	▪ Calculated rate
		Depression Remission at Six Months Specifications, 2012 (February 1, 2011 – January 31, 2012 Dates of Service). MN Community Measurement. Revised 08/12/2011.
		
		Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in February 2012 and Every Year Thereafter		
Health Information Technology (HIT)		
Health information technology (HIT) This survey is used to assess a physician clinic's adoption and use of Health Information Technology (HIT) in their clinical practice.	Internet-based survey as updated in 2012	MN Health Information Technology (HIT) Ambulatory Clinic Survey. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2012 (July 1, 2011 – June 30, 2012 Dates of Service) and Every Year Thereafter		
Respiratory Conditions		
Optimal asthma care composite These measures are used to assess the percent of pediatric and adult asthma patients who are receiving optimal care. Optimal care is defined as: ▪ Asthma is well controlled ▪ Patient is not at increased risk of exacerbations ▪ Patient has a current written asthma action/management plan *(Urgent Care Centers are not required to submit data on this*	Physician clinics must submit the following data for the optimal asthma care measure and for each of the three component measures: ▪ Patient identification methodology ▪ Within two separate age bands, ages 5-17 and 18-50, submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay):	Optimal Asthma Care Specifications, 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/12/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2012 (July 1, 2011 – June 30, 2012 Dates of Service) and Every Year Thereafter		
measure.)	▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample (NOTE: One sample per age band is required for this measure.) ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	healthreform
Preventive Care		
Colorectal cancer screening This measure is used to assess the percent of adult patients who are up to date with appropriate colorectal cancer screening. The screening methods include: ▪ Colonoscopy within ten years ▪ Sigmoidoscopy within five years ▪ Stool Blood Tests (gFOBT or FIT) within the measurement year	Physician clinics must submit the following data for the colorectal cancer screening measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay): ▪ Denominator:	Colorectal Cancer Screening Specifications, 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/12/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2012 (July 1, 2011 – June 30, 2012 Dates of Service) and Every Year Thereafter		
(Urgent Care Centers are not required to submit data on this measure.)	Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	healthreform
NEW: Maternity Care		
NEW: Primary c-section rate This measure is used to assess the percent of cesarean deliveries for first births. *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics must submit the following data for the maternity care primary c-section rate measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay): ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients meeting	Maternity Care Primary C-Section Rate Specifications, 2012 (July1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/12/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2012 (July 1, 2011 – June 30, 2012 Dates of Service) and Every Year Thereafter		
	the targets in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	

Data Required for Reporting Beginning in Calendar Year 2013 and Every Other Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in Spring of 2013 (September 1, 2012 – November 30, 2012 Survey Period) and Every Other Year Thereafter		
Patient Experience of Care		
Patient experience of care This survey will be used to assess adult patient experience of care. MDH will require use of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) visit specific questionnaire. *(Physician clinics with less than 715 unique eligible adult patients with face-to-face visits in the three month period from September 1, 2011 – November 30, 2011 are not required to submit data on this measure. Excluded specialties include Psychiatry and Adolescent/Pediatric Medicine.)*	Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) visit specific questionnaire	Patient Experience of Care Survey Specifications. MN Community Measurement. Revised 08/12/2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2013 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2013 (July 1, 2012 – June 30, 2013 Dates of Service) and Every Year Thereafter		
NEW: Maternity Care		
NEW: Early elective induction This measure is used to assess the percent of electively induced deliveries between 37 and 39 weeks gestational age. *(Urgent Care Centers are not required to submit data on this measure.)*	This measure will be required for reporting beginning in July 2013. Additional information about the measure, the measure specification and specific reporting requirements will be made available in a future update to Minnesota Administrative Rules, Chapter 4654. This measure is currently undergoing pilot testing.	

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2014 (2012 Dates of Service) and Every Year Thereafter		
NEW: Total Knee Replacement		
NEW: Average post-operative functional status improvement This measure is used to assess the average post-operative functional status improvement at one year post-operatively measured by the Oxford Knee Score tool. *(Urgent Care Centers are not required to submit data on this measure.)*	This measure will be required for reporting beginning in April 2014. Additional information about the measure, the measure specification and specific reporting requirements will be made available in a future update to Minnesota Administrative Rules, Chapter 4654. This measure is currently undergoing pilot testing.	
NEW: Average post-operative quality of life improvement This measure is used to assess the average post-operative quality of life improvement at one year post-operatively measured using the	This measure will be required for reporting beginning in April 2014. Additional information about the measure, the measure specification and specific reporting requirements will be made available in a future update to Minnesota Administrative	

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2014 (2012 Dates of Service) and Every Year Thereafter		
EQ-5D tool. *(Urgent Care Centers are not required to submit data on this measure.)*	Rules, Chapter 4654. This measure is currently undergoing pilot testing.	

APPENDIX B
REQUIRED HOSPITAL QUALITY MEASURE DATA

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Quality Measures		
Acute myocardial infarction (AMI) – Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to heart attack care: ▪ Aspirin prescribed at discharge (AMI-2) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge. ▪ Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less. ▪ Primary PCI received within 90 minutes of hospital arrival (AMI-8a) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary percutaneous coronary intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less. ▪ **NEW:** Statin prescribed at discharge (AMI-10) – This measure is used to assess the percent of acute myocardial	All hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
infarction (AMI) patients who are prescribed a statin at hospital discharge.		
Heart failure (HF) – Heart failure (HF) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to heart failure care: ▪ Discharge instructions (HF-1) – This measure is used to assess the percent of heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge or during hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen. ▪ Evaluation of LVS function (HF-2) – This measure is used to assess the percent of heart failure patients with documentation in the hospital record that left ventricular systolic (LVS) function was evaluated before arrival, during hospitalization, or is planned for after discharge. ▪ ACEI or ARB for LVSD (HF-3) – This measure is used to assess the percent of heart failure patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.	All hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
Pneumonia (PN) – Pneumonia (PN) process of care measures for	All hospitals must submit data for each of the	Specifications Manual for

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
applicable hospital discharge dates The hospital process of care measures include the following measures related to pneumonia care: ▪ Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN-3b) – This measure is used to assess the percent of pneumonia patients whose initial emergency room blood culture specimen was collected prior to first hospital dose of antibiotics. This measure focuses on the treatment provided to Emergency Department patients prior to admission orders. ▪ Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (PN-6) – This measure is used to assess the percent of immunocompetent patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines.	hospital compare pneumonia process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
Surgical care improvement project (SCIP) – Surgical care improvement project (SCIP) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to surgical care improvement project: ▪ Prophylactic antibiotic received within one hour prior to surgical incision – overall rate (SCIP-Inf-1a) – This measure is used to assess the percent of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for	All hospitals must submit data for each of the hospital compare surgical care improvement project (SCIP) process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time. ▪ Prophylactic antibiotic selection for surgical patients – overall rate (SCIP-Inf-2a) – This measure is used to assess the percent of surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure). ▪ Prophylactic antibiotics discontinued within 24 hours after surgery end time – overall rate (SCIP-Inf-3a) – This measure is used to assess the percent of surgical patients whose prophylactic antibiotics were discontinued within 24 hours after *Anesthesia End Time*. The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery. ▪ Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (SCIP-Inf-4) – This measure is used to assess the percent of cardiac surgery patients with controlled 6 A.M. blood glucose (less than or equal to 200 mg/dL) on postoperative day one (POD 1) and postoperative day two (POD 2) with *Anesthesia End Date* being postoperative day zero (POD 0). ▪ **NEW:** Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero (SCIP-Inf-9) – This measure is used to assess the percent of surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with Surgery being day zero.		http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
▪ **NEW:** Surgery patients with perioperative temperature management (SCIP-Inf-10) – This measure is used to assess the percent of surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at least one body temperature equal to or greater than 96.8º Fahrenheit/36ºCelsius recorded within the 30 minutes immediately prior to or the 15 minutes immediately after *Anesthesia End Time*. ▪ Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period (SCIP-Card-2) – This measure is used to assess the percent of surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period. The perioperative period for the SCIP Cardiac measures is defined as the day prior to surgery through postoperative day two (POD 2) with day of surgery being day zero. If the postoperative length of stay is ≥ 2 days, the measure evaluates the administration of more than one dose of a beta-blocker: the day prior to or the day of surgery **and** on postoperative day one (POD 1) or postoperative day two (POD 2) unless reasons for not administer ▪ Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1) – This measure is used to assess the percent of surgery patients with recommended Venous Thromboembolism (VTE) prophylaxis ordered anytime from hospital arrival to 24 hours after *Anesthesia End Time*. ▪ Surgery patients who received appropriate venous thromboembolism (VTE) prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2) – This measure is used to assess the percent of surgery patients who		

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
received appropriate Venous Thromboembolism (VTE) prophylaxis within 24 hours prior to *Anesthesia Start Time* to 24 hours after *Anesthesia End Time*.		
Home management plan of care given to patient/caregiver (CAC-3) – This measure is used to assess the number of pediatric asthma inpatients with documentation in the medical record that a Home Management Plan of Care (HMPC) document was given to the pediatric asthma patient/caregiver. The HMPC document addresses all of the following: ▪ Arrangements for follow-up care ▪ Environmental control and control of other triggers ▪ Method and timing of rescue actions ▪ Use of controllers ▪ Use of relievers	All hospitals must submit data for the home management plan of care given to patient/caregiver for pediatric asthma (CAC-3) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q11) through 06-30-11 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
NEW: Prevention immunization (PREV-IMM) – Prevention immunization (PREV-IMM) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to prevention immunization (PREV-IMM): ▪ Pneumococcal immunization (PPV23) – overall rate (PREV-IMM-1a) – This measure is used to assess acute care hospitalized inpatients 65 years of age and older AND inpatients aged between 6 and 64 years who are considered high risk and were screened for receipt of 23-valent pneumococcal polysaccharide vaccine (PPV23) and were vaccinated prior to discharge if indicated. The number	All hospitals must submit data for each of the hospital compare prevention immunization process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
captures two activities; screening and intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to PPV23, patients who were offered and declined PPV23 and patients who received PPV23 anytime in the past are captured as numerator events. ▪ Influenza immunization (PREV-IMM-2) – This measure is used to assess acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine and patients who received the vaccine during the current year's influenza season but prior to the current hospitalization are captured as numerator events. Influenza (flu) is an acute, contagious, viral infection of the nose, throat and lungs (respiratory illness) caused by influenza viruses. Outbreaks of seasonal influenza occur annually during late autumn and winter months although the timing and severity of outbreaks can vary substantially from year to year and community to community. Influenza activity most often peaks in February, but can peak rarely as early as November and as late as April. In order to protect as many people as possible before influenza activity increases, most flu-vaccine is administered in September through November, but vaccine is recommended to be administered throughout the influenza season as well. Because the flu vaccine usually first becomes available in September, health systems can usually meet public and patient needs for vaccination in advance of widespread influenza circulation.		http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
NEW: Mortality measures – Mortality measures for applicable hospital discharge dates The hospital measures include the following measures related to mortality: ▪ Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization (MORT-30-AMI) – This measure is used to assess a hospital-level risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal diagnosis of AMI. ▪ Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization (MORT-30-HF) – This measure is used to assess a hospital-level risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal diagnosis of HF. ▪ Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization (MORT-30-PN) – This measure is used to assess a hospital-level risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal diagnosis of pneumonia.	Centers for Medicare & Medicaid Services (CMS) calculates these measures using claims data and results are published on Hospital Compare. Hospitals do not need to submit additional data elements for these measures. Each hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also signs an authorization form allowing the data to be published on the U.S. Department of Health & Human Services Hospital Compare website for ***all*** cases for each applicable quality measure. This requirement applies to prospective payment system (PPS) hospitals and critical access hospitals (CAH).	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
NEW: Emergency department (ED) measures – Emergency department (ED) process of care measures for applicable hospital discharge dates The hospital emergency department (ED) process of care measures include the following measures related to hospital ED care: ▪ Median time from ED arrival to ED departure for admitted ED patients – overall rate (ED-1a) – This measure is used to assess the median time from emergency department arrival to	All hospitals must submit data for each of the emergency department (ED) quality measures. This data includes the following information: ▪ Median number of minutes	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
time of departure from the emergency room for patients admitted to the facility from the emergency department. This measure is used to assess the length of stay in the emergency room for admitted patients. ▪ Admit decision time to ED departure time for admitted patients – overall rate (ED-2a) – This measure is used to assess the median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. This measure is a subset of measure ED-1a and is used to assess the admission cycle time.		or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org
Outpatient acute myocardial infarction (AMI) and chest pain measures The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: ▪ Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2) – This measure is used to assess the percent of emergency department (ED) acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less. ▪ Median time to transfer to another facility for acute coronary intervention – overall rate (OP-3a) – This measure is used to assess the median time from emergency department (ED) arrival to time of transfer to another facility for acute coronary intervention for ED acute myocardial infarction (AMI) patients.	All hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: ▪ Median number of minutes **OR** ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for Hospital Outpatient Department Quality Measures, Version 5.0, encounter dates 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS); July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
▪ Aspirin at arrival (OP-4) – This measure is used to assess the percent of emergency department (ED) acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) who received aspirin within 24 hours before ED arrival or prior to transfer. ▪ Median time to ECG (OP-5) – This measure is used to assess the median time from emergency department (ED) arrival to electrocardiogram (ECG) (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or chest pain patients (with Probable Cardiac Chest Pain). ▪ **NEW:** Troponin results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probably Cardiac Chest Pain*) received within 60 minutes of arrival (OP-16) – This measure is used to assess the percent of emergency department (ED) acute myocardial infarction (AMI) patients or chest pain patients (with *Probably Cardiac Chest Pain*) with an order for troponin during the stay and having a time from ED arrival to completion of Troponin results within 60 minutes of arrival.		
Outpatient surgery department measures The hospital outpatient process of care measures include the following measures related to hospital outpatient surgery care: ▪ Timing of antibiotic prophylaxis (OP-6) – This measure is used to assess the percent of surgical patients with prophylactic antibiotics initiated within one hour* prior to surgical incision. *Patients who received vancomycin or a fluoroquinolone for prophylaxis should have the antibiotic initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics	All hospitals must submit data for each of the outpatient surgery department quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications Manual for Hospital Outpatient Department Quality Measures, Version 5.0, encounter dates 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS); July 2011 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
within two hours prior to incision time. ▪ Prophylactic antibiotic selection for surgical patients (OP-7) – This measure is used to assess the percent of surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).		(CMS), QualityNet website http://qualitynet.org
Appropriate Care Measures (ACM)		
Acute myocardial infarction appropriate care measure (AMI-ACM) The ACM is a pass/fail measure at the individual patient level that assesses whether eligible patients have received all of the appropriate care for acute myocardial infarction (AMI). The following individual measures are included in the AMI-ACM: ▪ AMI-2: Aspirin prescribed at discharge ▪ AMI-7a: Thrombolytic within 30 minutes of hospital arrival ▪ AMI-8a: PCI within 90 minutes of hospital arrival ▪ AMI-10: Statin prescribed at discharge (AMI-10)	All hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI)/heart attack process measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications for Acute Myocardial Infarction Appropriate Care: Stratis Health. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Heart failure appropriate care measure (HF-ACM) The ACM is a pass/fail measure at the individual patient level that assesses whether eligible patients have received all of the appropriate care for heart failure (HF). The following individual measures are included in the HF-ACM: ▪ HF-1: Discharge instructions ▪ HF-2: LVF assessment	All hospitals must submit data for each of the hospital compare heart failure (HF) process measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the	Specifications for Heart Failure Appropriate Care: Stratis Health. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
▪ HF-3: ACEI or ARB for LVSD	targets in each of the quality measures ▪ Calculated rate	
Pneumonia appropriate care measure (PN-ACM) The ACM is a pass/fail measure at the individual patient level that assesses whether eligible patients have received all of the appropriate care for pneumonia (PN). The following individual measures are included in the PN-ACM: ▪ PN-3b: Blood cultures before antibiotic ▪ PN-6: Initial antibiotic selection for CAP in immunocompetent patient	All hospitals must submit data for each of the hospital compare pneumonia (PN) process measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications for Pneumonia Appropriate Care: Stratis Health. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI)		
Abdominal aortic aneurysm (AAA) repair volume (IQI 4) – This measure is used to assess the raw volume of provider-level abdominal aortic aneurysm (AAA) repair (surgical procedure).	All hospitals must submit data for the abdominal aortic aneurysm (AAA) repair volume (IQI 4) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) – This measure is used to assess the number of deaths per 100 discharges with procedure code of abdominal aortic aneurysm (AAA) repair.	All hospitals must submit data for the abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Coronary artery bypass graft (CABG) volume (IQI 5) – This measure is used to assess the raw volume of provider-level coronary artery bypass graft (CABG) (surgical procedure).	All hospitals must submit data for the coronary artery bypass graft (CABG) volume (IQI 5) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Coronary artery bypass graft (CABG) mortality rate (IQI 12) – This measure is used to assess the number of deaths per 100 discharges with a procedure code of coronary artery bypass graft (CABG).	All hospitals must submit data for the coronary artery bypass graft (CABG) mortality rate (IQI 12) quality measure. This data includes the following	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
	information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) – This measure is used to assess the raw volume of provider-level percutaneous transluminal coronary angioplasty (PTCA) (surgical procedure).	All hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) – This measure is used to assess the number of deaths per 100 percutaneous transluminal coronary angioplasties (PTCAs).	All hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated.

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
	measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Hip fracture mortality rate (IQI 19) – This measure is used to assess the number of deaths per 100 discharges with principal diagnosis code of hip fracture.	All hospitals must submit data for the hip fracture mortality rate (IQI 19) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Inpatient Quality Indicators (IQI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Mortality for selected conditions composite (IQI 91) This composite is a weighted average of the mortality indicators for patients admitted for selected conditions and is used to assess the number of deaths for acute myocardial infarction (AMI), congestive heart failure (CHF), acute stroke, GI hemorrhage, hip fracture, and pneumonia. This composite includes the following Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) related to hospital inpatient mortality for specific conditions:	All hospitals must submit data for the mortality for selected conditions composite measure and for each of the mortality for selected conditions composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the	AHRQ Quality Indicators: Composite Measures User Guide for the Inpatient Quality Indicators (IQI), Department of Health and Human Services, Agency for Healthcare Research and Quality, Version 4.2 (September, 2010), Rev. May, 2011. http://qualityindicators.ahrq.go

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
▪ Acute myocardial infarction (AMI) mortality rate (IQI 15) ▪ Congestive heart failure (CHF) mortality rate (IQI 16) ▪ Acute stroke mortality rate (IQI 17) ▪ GI Hemorrhage mortality rate (IQI 18) ▪ Hip fracture mortality rate (IQI 19) ▪ Pneumonia mortality rate (IQI 20)	targets in each of the quality measures ▪ Calculated rate	v/Downloads/Software/SAS/V42/Composite_User_Technical_Specification_IQI_REV%205-19-11.pdf See specific mortality for selected conditions composite measure component indicators for more information. Inpatient Quality Indicators Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/Modules/IQI_TechSpec.aspx
Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI)		
Pressure ulcer (PSI 3) – This measure is used to assess the number of cases of decubitus ulcer per 1,000 discharges with a length of stay greater than 4 days. *(Behavioral health only hospitals are not required to submit data on this measure.)*	All hospitals must submit data for the pressure ulcer (PSI 3) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
	▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx
Death among surgical inpatients with serious treatable complications (PSI 4) – This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization.	All hospitals must submit data for the death among surgical inpatients with serious treatable complications (PSI 4) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in each of the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx
Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) – This measure is used to assess the number of cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 1,000 surgical discharges with an operating room procedure.	All hospitals must submit data for the postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
	▪ Calculated rate	Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx
Obstetric trauma – vaginal delivery with instrument (PSI 18) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries.	All hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx
Obstetric trauma – vaginal delivery without instrument (PSI 19) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 vaginal deliveries without instrument assistance.	All hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Patient safety for selected indicators composite (PSI 90) This composite is a weighted average of most of the patient safety indicators and is used to assess the number of potentially preventable adverse events for pressure ulcer, iatrogenic pneumothorax, central venous catheter-related bloodstream infections, postoperative hip fracture, postoperative hemorrhage or hematoma, postoperative physiologic and metabolic derangments, postoperative respiratory failure, postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT), postoperative sepsis, postoperative wound dehiscence, and accidental puncture or laceration. This composite includes the following Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators: ▪ Pressure ulcer (PSI 3) ▪ Iatrogenic pneumothorax (PSI 6) ▪ Central venous catheter-related bloodstream infections (PSI 7) ▪ Postoperative hip fracture (PSI 8) ▪ Postoperative hemorrhage or hematoma (PSI 9) ▪ Postoperative physiologic and metabolic derangments (PSI 10) ▪ Postoperative respiratory failure (PSI 11) ▪ Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) ▪ Postoperative sepsis (PSI 13) ▪ Postoperative wound dehiscence (PSI 14) ▪ Accidental puncture or laceration (PSI 15)	All hospitals must submit data for the patient safety for selected indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	AHRQ Quality Indicators: Composite Measures User Guide for the Patient Safety Indicators (PSI), Department of Health and Human Services, Agency for Healthcare Research and Quality, Version 4.2 (September, 2010). http://qualityindicators.ahrq.gov/Downloads/Software/SAS/V42/Composite_User_Technical_Specification_PSI.pdf See specific patient safety for selected indicators composite measure component indicators for more information. Patient Safety Indicators (PSI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Agency for Healthcare Research and Quality (AHRQ) Pediatric Patient Safety Indicators (PDI)		
Pediatric heart surgery mortality (PDI 6) – This measure is used to assess the number of in-hospital deaths in pediatric patients undergoing congenital heart disease repair *or* undergoing a non-specific heart surgery with a diagnosis of congenital heart disease present.	All hospitals must submit data for the pediatric patients undergoing surgery for congenital heart disease repair mortality (PDI 6) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Pediatric Quality Indicators (PDI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx
Pediatric heart surgery volume (PDI 7) – This measure is used to assess the raw volume of provider-level congenital heart disease repair *or* non-specific heart surgery with a diagnosis of congenital heart disease present in pediatric patients	All hospitals must submit data for the pediatric patients undergoing surgery for congenital heart disease volume (PDI 7) quality measure. This data includes the following information: ▪ Volume	Pediatric Quality Indicators (PDI) Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx
Pediatric patient safety for selected indicators composite (PDI 19)	All hospitals must submit data for the pediatric	AHRQ Quality Indicators:

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
This composite is a weighted average of most of the pediatric quality indicators and is used to assess the number of potentially preventable adverse events for accidental puncture or laceration, pressure ulcer, iatrogenic pneumothorax, postoperative hemorrhage or hematoma, postoperative respiratory failure, postoperative sepsis, postoperative wound dehiscence, and central venous catheter-related bloodstream infections. This composite includes the following Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators: ▪ Accidental puncture or laceration (PDI 1) ▪ Pressure ulcer (PDI 2) ▪ Iatrogenic pneumothorax (PDI 5) ▪ Postoperative hemorrhage or hematoma (PDI 8) ▪ Postoperative respiratory failure (PDI 9) ▪ Postoperative sepsis (PDI 10) ▪ Postoperative wound dehiscence (PDI 11) ▪ Central venous catheter-related bloodstream infections (PDI 12)	patient safety for selected indicators composite measure and for each of the pediatric patient safety for selected indicators composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Composite Measures User Guide for the Pediatric Quality Indicators (PDI), Department of Health and Human Services, Agency for Healthcare Research and Quality, Version 4.2 (September, 2010). http://qualityindicators.ahrq.gov/Downloads/Software/SAS/V42/Composite_User_Technical_Specification_PDI.pdf See specific pediatric patient safety for selected indicators composite measure component indicators for more information. Pediatric Quality Indicators Technical Specifications, Version 4.2. Agency for Healthcare Research and Quality (AHRQ); September 2010 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
Patient Experience of Care		
Patient experience of care This measure is used to assess adult patients' perception of their hospital care using a national survey called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). *(This measure is not required for hospitals with less than 500 admissions in the previous calendar year.)*	Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey	Consumer Assessment of Healthcare Providers and Systems Hospital Survey (HCAHPS), Version 6.0. Centers for Medicare & Medicaid Services (CMS); March 2011 or as updated. Measure specifications for the HCAHPS patient experience of care survey are contained in the current HCAHPS Quality Assurance Guidelines manual, which is available at the HCAHPS On-Line Web site, http://www.hcahpsonline.org. CMS maintains the HCAHPS technical specifications by updating the HCAHPS Quality Assurance Guidelines manual annually, and CMS includes detailed instructions on survey implementation, data collection, data submission and other relevant topics. As necessary, HCAHPS Bulletins are issued to provide notice of changes and updates to technical specifications in HCAHPS data collection systems.

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
NEW: Minnesota Stroke Registry Indicators		
NEW: Emergency department (ED) stroke registry indicators for applicable hospital discharge dates The emergency department (ED) stroke registry indicators include the following: ▪ NIH stroke scale (NIHSS) performed in initial evaluation ▪ Door-to-imaging performed within 25 minutes or less	All hospitals must submit data for patients discharged from the emergency department or inpatient with diagnosis of ischemic stroke, subarachnoid hemorrhage, intracerebral hemorrhage, ill defined stroke. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Emergency Department Stroke Registry Process of Care Indicator Specifications. Minnesota Stroke Registry; August 2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
NEW: University of Minnesota Rural Health Research Center		
NEW: Critical Access Hospitals (CAHs) ONLY: Emergency department (ED) transfer communication measures – Emergency department (ED) transfer communication process of care measures for applicable hospital discharge dates *Only Critical Access Hospitals (CAHs) must submit data on these measures.* The hospital emergency department (ED) transfer communication process of care measures include the following seven subscales: ▪ Administrative communication – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that pre-transfer information was communicated to the	Critical Access Hospitals (CAHs) must submit data for each of the emergency department (ED) transfer communication quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Transfer Communication Measurement Specifications. University of Minnesota Rural Health Research Center; June 2011. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
receiving hospital within 60 minutes of departure. Pre-transfer information includes: nurse communication with receiving hospital and physician or practitioner communication with receiving physician or practitioner ▪ Patient information – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that patient identification was communicated to the receiving hospital within 60 minutes of departure. Patient identification includes: name, address, age, gender, significant others contact information, and insurance. ▪ Vital signs – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that vital signs were communicated to the receiving hospital within 60 minutes of departure. Vital signs include: pulse, respiratory rate, blood pressure, oxygen saturation, temperature, and glascow score (trauma, cognitively altered, or neuro patients only). ▪ Medication information – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that medication-related information was communicated to the receiving hospital within 60 minutes of departure. Medication information includes: medications given, allergies, and medications from home. ▪ Physician information – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that physician or practitioner generated information was communicated to the receiving hospital within 60 minutes of departure. Physician information includes: history and physical (physical exam, history of current event, chronic		

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2012 and Every Year Thereafter		
conditions) and physician or practitioner orders and plan. ▪ Nurse information – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that nurse generated information was communicated to the receiving hospital within 60 minutes of departure. Nurse information includes: assessment/interventions/response, impairments, catheters, immobilizations, respiratory support, and oral limitations. ▪ Procedures and tests – This measure is used to assess the percent of patients transferred to another acute care hospital whose medical record documentation indicated that procedures and tests were communicated to the receiving hospital within 60 minutes of departure. Procedures and tests includes: procedures and tests done and procedures and tests results sent.		

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measure Required for Reporting in June 2012 and Every Year Thereafter (2011 Dates of Service)		
Vermont Oxford Network (VON)		
Late sepsis or meningitis in very low birth weight (VLBW) neonates This measure is used to assess the infection rate for inborn and outborn infants meeting certain age and weight requirements for	Hospitals with a level 3 neonatal intensive care unit (NICU) must submit data for the late sepsis or meningitis in very low birth weight (VLBW) neonates. This data includes the following	Late Sepsis or Meningitis in Very Low Birth Weight Neonates Specifications: Vermont Oxford Network.

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measure Required for Reporting in June 2012 and Every Year Thereafter (2011 Dates of Service)		
hospitals with a level 3 neonatal intensive care unit (NICU).	information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Measure specifications can be found on the Vermont Oxford Network website http://www.vtoxford.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in February 2012 and Every Year Thereafter (July 2011 – June 2012 Event Dates)		
Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures		
Central line-associated bloodstream infection (CLABSI) event This measure is used to assess the infection rate of patients with a central line-associated bloodstream infection (CLABSI) event by inpatient hospital unit for hospitals with a neonatal intensive care unit (NICU) and/or pediatric intensive care unit (PICU).	Hospitals with a neonatal intensive care unit (NICU) and/or a pediatric intensive care unit (PICU) must submit data for the central line-associated bloodstream infection (CLABSI) event by neonatal and pediatric intensive care units. This data includes the following information for each intensive care unit: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of patients meeting the	Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.0, Discharges 01-01-12 (1Q12) through 06-30-12 (2Q12). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2011 or as updated. Measure specifications can be found on the Centers for

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in February 2012 and Every Year Thereafter (July 2011 – June 2012 Event Dates)		
	targets in the quality measure ▪ Calculated rate	Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Health Information Technology (HIT)		
Health information technology (HIT) This survey is used to assess a hospital's adoption and use of Health Information Technology (HIT) in its clinical practice.	The information technology supplement of the American Hospital Association (AHA) annual survey and any additional Minnesota specific questions as updated in 2012	2011 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C with MN-Specific Additional Questions.

Retired Measures		
Measure Name and Description	**Data Elements**	**Specification Information**
Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Quality Measures		
Acute myocardial infarction (AMI)		
▪ Aspirin at arrival (AMI-1) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who received aspirin within 24 hours before or after hospital arrival.	Hospitals are no longer required to submit data for this measure.	This measure was suspended effective with January 1, 2012 (1Q12) discharges.
▪ ACEI or ARB for LVSD (AMI-3) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.	Hospitals are no longer required to submit data for this measure.	This measure was suspended effective with January 1, 2012 (1Q12) discharges.
▪ Adult smoking cessation advice/counseling (AMI-4) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
▪ Beta-blocker prescribed at discharge (AMI-5) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who are prescribed a beta-blocker at hospital discharge.	Hospitals are no longer required to submit data for this measure.	This measure was suspended effective with January 1, 2012 (1Q12) discharges.

Retired Measures		
Heart failure (HF) ▪ Adult smoking cessation advice/counseling (HF-4) – This measure is used to assess the percent of heart failure patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
Pneumonia (PN) ▪ Pneumococcal vaccination (PN-2) – This measure is used to assess the percent of pneumonia patients, age 65 and older, who were screened for pneumococcal vaccine status and were administered the vaccine prior to discharge, if indicated.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
▪ Adult smoking cessation advice/counseling (PN-4) – This measure is used to assess the percent of pneumonia patients with a history of smoking cigarettes who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
▪ Initial antibiotic received within 6 hours of hospital arrival (PN-5c) – This measure is used to assess the percent of pneumonia patients who receive their first dose of antibiotics within 6 hours after arrival at the hospital.	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.
▪ Influenza vaccination (PN-7) – This measure is used to assess the percent of pneumonia patients age 50 years and older, hospitalized during October, November, December, January, February, or March who were screened for influenza vaccine	Hospitals are no longer required to submit data for this measure.	This measure was retired effective with January 1, 2012 (1Q12) discharges.

Retired Measures		
status and were vaccinated prior to discharge, if indicated.		
Surgical care improvement project (SCIP) ▪ Surgery patients with appropriate hair removal (SCIP-Inf-6) – This measure is used to assess the percent of surgery patients with appropriate surgical site hair removal. No hair removal, or hair removal with clippers or depilatory is considered appropriate. Shaving is considered inappropriate.	Hospitals are no longer required to submit data for this measure.	This measure was suspended effective with January 1, 2012 (1Q12) discharges.

APPENDIX C
REQUIRED AMBULATORY SURGICAL CENTER MEASURE DATA

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in July 2012 (Dates of Service July 1, 2011 – June 30, 2012) and Every Year Thereafter		
Prophylactic intravenous (IV) antibiotic timing – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who were administered antibiotics for prevention of surgical site infection on time	Ambulatory surgical centers must submit data for the prophylactic intravenous (IV) antibiotic timing quality measure. This data includes the following information: ▪ Patient identification methodology ▪ Submit the following three data elements: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	Ambulatory Surgical Center Measure Specifications. 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/08/11. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Hospital transfer/admission – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who are transferred or admitted to a hospital upon discharge from the ASC.	Ambulatory surgical centers must submit data for the hospital transfer/admission quality measure. This data includes the following information: ▪ Patient identification methodology	Ambulatory Surgical Center Measure Specifications. 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement.

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in July 2012 (Dates of Service July 1, 2011 – June 30, 2012) and Every Year Thereafter		
	▪ Submit the following two data elements by the American Society of Anesthesiologists (ASA) Physical Status classification system categories (i.e., ASA Physical Status 1 – ASA Physical Status 3): ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	Revised 08/08/11. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Appropriate surgical site hair removal – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who have appropriate surgical site hair removal.	Ambulatory surgical centers must submit data for the appropriate surgical site hair removal quality measure. This data includes the following information: ▪ Patient identification methodology ▪ Submit the following three data elements: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting	Ambulatory Surgical Center Measure Specifications. 2012 (July 1, 2011 – June 30, 2012 Dates of Service). MN Community Measurement. Revised 08/08/11. Measure specifications can be found on the Minnesota Department of Health website

Data Required for Reporting Beginning in Calendar Year 2012 and Every Year Thereafter		
Measure Name and Description	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in July 2012 (Dates of Service July 1, 2011 – June 30, 2012) and Every Year Thereafter		
	on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	http://www.health.state.mn.us/healthreform

APPENDIX D
OTHER STANDARDIZED QUALITY MEASURES

Measure Name	Measure Elements	Specification Information
Unlimited Availability		
Healthcare Effectiveness Data and Information Set (HEDIS)	All Healthcare Effectiveness Data and Information Set (HEDIS) measures as of HEDIS 2011, or as updated, that are applicable to physician clinics, are included in the standardized set of quality measures.	Healthcare Effectiveness Data and Information Set (HEDIS) 2011 Volume 2: Technical Specifications. National Committee for Quality Assurance (NCQA); 2010 or as updated.
National Quality Forum (NQF) endorsed measures	All NQF-endorsed measures as of August 1, 2011, or as updated, that are applicable to physician clinics and hospitals, are included in the standardized set of quality measures, excluding those requiring use of proprietary databases or registries.	More information about these measures can be found on the National Quality Forum (NQF), website http://qualityforum.org

Measure Name	Measure Elements	Specification Information
Time-Limited Availability: These Measures are Available for Use for Two Years (2011 Dates of Service Through 2012 Dates of Service)		
Pediatric asthma	For patients, ages 5 to 19 years: ▪ At the last asthma visit, is the asthma severity level (intermittent or persistent) documented? ▪ If it is documented that the patient has persistent asthma, is the patient on an anti-inflammatory medication? ▪ If the patient is a smoker or exposed to second hand smoke, is advice regarding smoking cessation documented in the last year?	Clinical Review: Measure Specifications for Pediatric Asthma. Medica; Pediatric Asthma; July 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

	▪ If the patient is a smoker, or exposed to second hand smoke, is advice regarding smoking cessation documented at the last visit? ▪ Is the child's environment tobacco smoke free? ▪ Is there evidence in the medical records that the patient received a written Asthma Action Plan? ▪ Unless contraindicated, is there evidence in the medical record that the patient has received an influenza vaccine within the past year?	

Measure Name	Measure Elements	Specification Information
Time-Limited Availability: These Measures are Available for Use for One Year (2011 Dates of Service)		
Adult depression	For adults, ages 19 years and older: ▪ At the time of initial diagnosis in the past year, was there documentation of at least 5 of the symptoms of depression, or that the patient met the criteria for depression using a standardized depression diagnosing tool? ▪ At the time of the initial diagnosis in the past year, is there documentation that the patient was assessed for alcohol consumption? ▪ If the patient was at the clinic for a primary care visit more than 6 weeks after the initial diagnosis, is there documentation of ongoing assessment of their depression status? ▪ Was the patient's depression status reassessed using the PHQ-9 tool at a follow up visit within 6 months after diagnosis? ▪ Was the PHQ-9 depression diagnostic tool used for the initial depression diagnosis?	Clinical Review: Measure Specifications for Adult Depression. Medica; July 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

APPENDIX E
SUBMISSION SPECIFICATIONS

I. Submission Requirements for Physician Clinics

1. **Registration.** Each physician clinic, regardless of the number of full-time equivalent (FTE) clinical staff or shared ownership with another clinic, must register electronically and obtain a login user ID and password from the commissioner or commissioner's designee beginning January 1, 2012 and no later than February 10, 2012 and no later than February 10 of each subsequent year, and must supply data elements, including the following:

    a. **Physician clinic information:** Name, street address, unique clinic national provider identifier (NPI) regardless of the physician clinic's number of full-time equivalent (FTE) clinical staff or shared ownership with another clinic (i.e. satellite clinics);

    b. **Contact information for individual(s) responsible for submitting data:** Company, name, title, mailing address, telephone number, fax number, e-mail address;

    c. **Contact information for physician clinic general contact:** Name, title, mailing address, telephone number, fax number, e-mail address;

    d. **Clinical staff information for the previous calendar year:** Name, unique national provider identifier (NPI), full-time equivalent (FTE) status, license number, board certifications for each clinical staff that have provided health care services at the physician clinic during the previous calendar year;

    e. **Description of health care services provided by the physician clinic.**

    f. **Medical group affiliation.**

    NOTE: If multiple physician clinic locations meet the criteria in MN Rules 4654.0200 subp. 13 and choose to submit data as a single entity, each individual physician clinic location must still register and indicate under which entity their data will be submitted.

2. **Data Submission.**

    a. **Measures for which physician clinics may submit on their full patient population or a random sample in 2012. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place for the prior full measurement period are required to submit data on their full patient population.)**

    Optimal diabetes care (ODC) composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) and by presence / absence of ischemic vascular disease (IVD) co-morbidity to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type and IVD co-morbidity, number of patients meeting the exclusion

criteria, and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type or by IVD co-morbidity. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2012 and no later than February 15, 2012 and beginning January 1 and no later than February 15 of each subsequent year. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place since January 1, 2010 are required to submit data on their full patient population for this measure.)

Optimal vascular care (OVC) composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) and by presence / absence of diabetes co-morbidity to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type and by diabetes co-morbidity, number of patients meeting the exclusion criteria, and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type or by diabetes co-morbidity. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2012 and no later than February 15, 2012 and beginning January 1 and no later than February 15 of each subsequent year. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place since January 1, 2010 are required to submit data on their full patient population for this measure.)

Optimal asthma care composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee. For this measure, this includes identifying the patients in two separate age bands, ages 5-17 and ages 18-50. If the physician clinic submits a sample, there must be one sample per age band. Within these two age bands, data on the number of patients receiving the applicable health care services must be allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay). Specifically, this includes patient identification methodology, separation of the data by age bands, numerator and denominator by primary payer type, number of patients meeting the exclusion criteria, and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2012 and no later than August 15, 2012 and beginning July 1 and no later than August 15 of each subsequent year. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place since July 1, 2010 are required to submit data on their full patient population for this measure.)

Colorectal cancer screening. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type, number of patients meeting the exclusion criteria, and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2012 and no later than August 15, 2012 and beginning July 1 and no later than August 15 of each subsequent year. (NOTE: Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place since July 1, 2010 are required to submit data on their full patient population for this measure.)

i. **Data submission requirements.** A physician clinic may satisfy the data submission requirement for these quality measures by completing the following steps:

   1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. Develop a list of the eligible patients for each measure using a practice management, billing system, or electronic medical record.

   2. **Data collection: total population versus sample.** Identification of the population of patients eligible for the denominator for each measure is accomplished via a query of a practice management system or an electronic medical record. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. Physician clinics may choose one of the following options:

      a. Full patient population. Physician clinics with electronic medical records in place for the prior full measurement period are required to submit data on their full patient population for each measure. Physician clinics without electronic medical records in place for the prior full measurement period are encouraged to submit data using their full patient population for each measure, but may use a random sampling methodology, as described below.

      b. Random sampling methodology. Physician clinics may submit data on a random sample of relevant patients in 2012. At a minimum, physician clinics must select 60 patients for

the random sample population and must oversample by at least 20 patients. If a physician clinic's total population for a particular measure is less than 60, the physician clinic must submit data using their full patient population for that measure. Beginning with 2012 data submission deadlines, physician clinics with electronic medical records in place for the prior full measurement period will be expected to submit data on a full population basis. (NOTE: For the optimal asthma measure, there must be one sample per age band, one for ages 5-17 and one for ages 18-50.)

3. **Data submission template**. Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either extracted from an electronic medical record system or abstracted through medical record review.
4. **Data file upload.** Submit data electronically to the commissioner or the commissioner's designee.
5. **Data validation.** Physician clinics must maintain documentation for the data described in Appendix A, including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

b. Measures for which physician clinics may only submit data on their full patient population in 2012.

Depression remission at six months. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee. For this measure, the data elements must be submitted by three bands of initial PHQ9 scores (10-14; 15-19; 20 and above). The number of patients for whom a follow up six month (+/- 30 days) PHQ9 assessment was not completed is a required data element as well. Specifically the required data includes, patient identification methodology, numerator and denominator separated by three bands of initial PHQ9 scores, number of patients who did not get a second PHQ9 assessment, number of patients meeting the exclusion criteria, and calculated rate. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning February 7, 2012 and no later than February 25, 2012.

Primary c-section rate. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type, number of patients meeting the exclusion criteria, and calculated rate. A physician clinic may work with a single subcontractor to submit the required data on their

behalf. Data may be submitted beginning July 1, 2012 and no later than August 15, 2012 and beginning July 1 and no later than August 15 of each subsequent year.

i. **Data submission requirements.** A physician clinic may satisfy the data submission requirement for these quality measures by completing the following steps:

1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. Develop a list of the eligible patients for each measure using a practice management, billing system, or electronic medical record.

2. **Data collection: Total population.** Identification of the population of patients eligible for the denominator for each measure is accomplished via a query of a practice management system or an electronic medical record. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. For this measure physician clinics must submit data using their full patient population.

3. **Data submission template**. Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either extracted from an electronic medical record system or abstracted through medical record review.

4. **Data file upload.** Submit data electronically to the commissioner or the commissioner's designee.

5. **Data validation.** Physician clinics must maintain documentation for the data described in Appendix A, including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

3. **Health information technology (HIT) survey.** Each physician clinic must complete the internet-based survey available annually from the commissioner or commissioner's designee beginning February 15, 2012 and no later than March 15, 2012 and beginning February 15 and no later than March 15 of each subsequent year.

4. **Patient experience of care survey.** Each physician clinic must use a vendor certified by CMS.[1] Each physician clinic must either select a CMS-certified vendor of its choice or use the services of a centralized vendor coordinated by the commissioner or the commissioner's designee. Survey period will include patients seen September 1, 2012 – November 30, 2012.

[1] CMS does not certify vendors to administer CG-CAHPS for physician clinics. For purposes of fulfilling state requirements under Chapter 4654, physician clinics must use a vendor certified by CMS to administer HCAHPS or MA and PDP CAHPS.

II. Submission Requirements for Hospitals

1. **Data Submission for Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Measures.** Each hospital must submit the data described in Appendix B required to calculate the applicable quality measures. There are two ways hospitals may satisfy this requirement:

    a. **Submission to the Centers for Medicare & Medicaid Services (CMS).** If a hospital normally submits data for all cases for these quality measures to the Centers for Medicare & Medicaid Services (CMS), using the Centers for Medicare & Medicaid Services' (CMS) existing schedule, specifications, and processes, and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also signs an authorization form allowing the data to be published on the U.S. Department of Health & Human Services Hospital Compare website for ***all*** cases for each applicable quality measure; or

    b. **Submission directly to commissioner or commissioner's designee.** If a hospital does not submit data for these quality measures to the Centers for Medicare & Medicaid Services (CMS), the hospital must submit data to the commissioner or the commissioner's designee according to the following schedule:

Inpatient Quality Measures

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

Outpatient Quality Measures

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 1, 2012
Fourth Quarter, 2011: October 1 – December 31	May 1, 2012
First Quarter, 2012: January 1 – March 31	August 1, 2012
Second Quarter, 2012: April 1 – June 30	November 1, 2012

i. Data collection and analysis.

1. Hospitals must use the CMS Abstraction & Reporting Tool (CART), available from the Centers for Medicare & Medicaid Services (CMS), for the collection and analysis of the data required to calculate each measure.

2. Use the measurement specifications referenced in Appendix B to determine whether each patient is eligible for inclusion in the measurement calculation.

ii. Data validation. At their own expense, hospitals must have their data validated by a third-party vendor using protocols and standards consistent with those of the Centers for Medicare & Medicaid Services (CMS) to verify that the data is consistent and reproducible.

iii. Data submission. Submit data electronically to the commissioner or the commissioner's designee on a form provided by the commissioner or the commissioner's designee.

2. Data Submission for Appropriate Care Measures (ACM). Each hospital must submit the data described in Appendix B required to calculate the applicable quality measures according to the following schedule:

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

There are two ways hospitals may satisfy this requirement.

a. Each hospital may authorize a single organization to complete the following steps and submit the data on their behalf:

i. Signs an authorization form allowing Stratis Health to release summary level ACM data, calculated from data in the CMS national data repository, to MHA for publication on the MHA website, Minnesota Hospital Quality Report.

b. Each hospital may perform the following steps itself:

i. Data collection and analysis. Identify the patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix B to determine eligibility for each patient, only including patients that meet denominator criteria. The ACM is a pass/fail measure at the individual patient level that asks whether eligible patients have received ALL of the appropriate care for the condition they are being treated for. A patient is included if the patient meets denominator criteria for at least one of the measures in a topic. These topics include heart failure, acute myocardial infarction, and pneumonia. Within each topic, a patient must meet numerator criteria for each measure in which the patient meets denominator criteria to be considered as having appropriate care (Pass).

ii. Data submission. Submit data electronically to the commissioner or the commissioner's designee.

3. **Data Submission for Inpatient Quality Indicators (IQI), Patient Safety Indicators (PSI), and Pediatric Patient Safety Indicators (PDI), Agency for Healthcare Research and Quality.** Each hospital must submit the data described in Appendix B required to calculate the applicable quality measures according to the following schedule:

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	January 28, 2012
Fourth Quarter, 2011: October 1 – December 31	April 29, 2012
First Quarter, 2012: January 1 – March 31	July 23, 2012
Second Quarter, 2012: April 1 – June 30	October 22, 2012

There are two ways hospitals may satisfy this requirement.

a. Each hospital may authorize a single organization to complete the following steps and submit the data on their behalf:

i. Apply Version 4.3, or the most recent version of the Quality Indicator software, available from the Agency for Healthcare Research and Quality's (AHRQ), to the hospital's discharge data. A hospital must participate in verifying the results of the analysis as needed.

ii. Validate the data.

1. In the event data validation procedures show that data is inaccurate, hospitals must correct the inaccurate information and resubmit corrected data. Resubmitted data must be verified for accuracy.

2. The results of the analysis using the Quality Indicator software for each hospital must be verified for accuracy by each hospital prior to submission.

iii. Submit the data to the commissioner or the commissioner's designee.

b. Each hospital may perform the following steps itself:

i. Apply Version 4.3, or the most recent version of the Quality Indicator software, available from the Agency for Healthcare Research and Quality's (AHRQ), to its discharge data.

ii. Validate the data submission through a third-party vendor.

iii. Submit data electronically to the commissioner or the commissioner's designee on a form provided by the commissioner or the commissioner's designee.

4. **Data Submission for Vermont Oxford Network (VON).** Each hospital with a level 3 neonatal intensive care unit (NICU) must submit the data required to calculate the applicable quality measure, as described in Appendix B, to VON.

a. Each hospital with a level 3 NICU must submit applicable data on the specified patients to VON, for measure calculation and inclusion in VON's annual report to the hospital, according to the following VON data submission schedule:

Discharge Dates	Data Submission Deadline
All 2011 Dates of Service	June 30, 2012

b. Each hospital with a level 3 NICU must submit summary level results electronically for the previous calendar year to the commissioner or the commissioner's designee by October 31, 2012 and every year thereafter.

5. Data Submission for the Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures. Each hospital with a neonatal and/or pediatric intensive care unit must submit the data described in Appendix B required to calculate the applicable quality measure. There are two ways hospitals with a neonatal and/or pediatric intensive care unit may satisfy this requirement:

a. Submission to the Centers for Medicare & Medicaid Services (CMS). If a hospital normally submits data for all cases for these quality measures to the Centers for Medicare & Medicaid Services (CMS), using the Centers for Medicare & Medicaid Services' (CMS) existing schedule, specifications, and processes, and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also signs an authorization form allowing the data to be published on the U.S. Department of Health & Human Services Hospital Compare website for ***all*** cases for each applicable quality measure; or

b. Submission directly to commissioner or commissioner's designee. If a hospital does not submit data for these quality measures to the Centers for Medicare & Medicaid Services (CMS), the hospital must submit data to the commissioner or the commissioner's designee according to the following schedule:

Event Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

i. Data collection and analysis.

1. Hospitals must submit data to the Centers for Disease Control and prevention (CDC) through the National Healthcare Safety Network (NHSN) according to NHSN definitions for each intensive care unit for the collection and analysis of the data required to calculate each measure.

2. Use the measurement specifications referenced in Appendix B to determine whether each patient is eligible for inclusion in the measurement calculation.

ii. Data validation. At their own expense, hospitals must have their data validated by a third-party vendor using protocols and standards

consistent with those of the Centers for Medicare & Medicaid Services (CMS) to verify that the data is consistent and reproducible.

iii. Data submission. Submit data electronically to the commissioner or the commissioner's designee on a form provided by the commissioner or the commissioner's designee.

6. **Data Submission for Minnesota Stroke Registry Indicators.** Each hospital must submit the data described in Appendix B required to calculate the applicable quality indicators according to the following schedule:

Discharge Dates	Data Submission Deadline
Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

There are three ways hospitals may satisfy this requirement.

a. **Participation in the Minnesota Stroke Registry (MSR).** If a hospital normally participates in the Minnesota Stroke Registry (MSR) and submits data for all cases to the Minnesota Stroke Registry (MSR), using the Minnesota Stroke Registry Tool (MSRT), existing schedule, specifications, and processes, and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also authorizes the data to be calculated and submitted to the commissioner or the commissioner's designee.

b. **Data submission to a third-party vendor.** If a hospital normally submits data used to calculate these quality measures to a third-party vendor and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also authorizes the data to be shared with the Minnesota Stroke Registry (MSR) and authorizes the Minnesota Stroke Registry Tool (MSRT) to calculate and submit the data to the commissioner or the commissioner's designee.

c. **Each hospital may perform the following steps itself:**

i. Identify the patients meeting the criteria for inclusion in the indicator. Use the measurement specifications referenced in Appendix B to determine eligibility for each patient, only including patients that meet denominator criteria.

ii. Submit data electronically to the commissioner or the commissioner's designee using the Minnesota Stroke Registry Tool (MSRT).

7. **Data Submission for Emergency Department (ED) Transfer Communication Measures.** Each critical access hospital must submit the data described in Appendix B required to calculate the applicable quality measures according to the following schedule:

Discharge Dates	Data Submission Deadline

Third Quarter, 2011: July 1 – September 30	February 15, 2012
Fourth Quarter, 2011: October 1 – December 31	May 15, 2012
First Quarter, 2012: January 1 – March 31	August 15, 2012
Second Quarter, 2012: April 1 – June 30	November 15, 2012

a. Data collection and analysis. Identify the patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix B to determine eligibility for each patient, only including patients that meet denominator criteria.

b. Data submission. Submit summary level data electronically to the commissioner or the commissioner's designee.

8. **Health information technology (HIT) survey.** Each hospital must complete the survey available annually from the commissioner or commissioner's designee in calendar year 2012 and each subsequent year.

9. **Patient experience of care survey.** Each hospital must complete the HCAHPS survey using a CMS-certified vendor.

III. Submission Requirements for Ambulatory Surgical Centers

1. **Registration.** Each ambulatory surgical center must register electronically and obtain a login user ID and password from the commissioner or commissioner's designee beginning March 1, 2012 and no later than April 1, 2012 and no later than April 1 of each subsequent year; and must supply data elements, including the following:
    a. **Ambulatory Surgical Center information:** Name, street address, ambulatory surgical center national provider identifier (NPI);
    b. **Contact information for individual(s) responsible for submitting data:** Company, name, title, mailing address, telephone number, fax number, e-mail address;
    c. **Contact information for ambulatory surgical center general contact:** Name, title, mailing address, telephone number, fax number, e-mail address;
    d. **Clinical staff information for the previous calendar year:** Name, national provider identifier (NPI), board certifications for all clinical staff that have provided health care services at the ambulatory surgical center during the previous calendar year;
    f. **Medical group affiliation if applicable.**
2. **Data Submission.** Each ambulatory surgical center must submit the data required to calculate the applicable quality measures, as described in Appendix C, to the commissioner or the commissioner's designee. An ambulatory surgical center may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2012 and no later than August 15, 2012 and beginning July 1 and no later than August 15 of each subsequent year. Beginning with 2012 data submission deadlines, each ASC must allocate the data required to calculate the applicable quality measures by the American Society of Anesthesiologists (ASA) Physical Status classification when the commissioner or the commissioner's designee determines the results must be risk adjusted. In 2012, based on current measures, this would apply to the hospital transfer/admission measure.
    a. **Prophylactic intravenous (IV) antibiotic timing and Appropriate surgical site hair removal.**
        i. **Data submission requirements.** Each ambulatory surgical center may satisfy the data submission requirements for these quality measures by completing the following steps:
            1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix C to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list.
            2. **Data collection: total population versus sample.** Beginning in 2012, ambulatory surgical centers with an electronic medical record in place for the prior full measurement period will be expected to submit data on a full population basis. Ambulatory surgical centers without an electronic medical record in place for the prior full

measurement period may submit data on a random sample of relevant patients in 2012. Ambulatory surgical centers with fewer than 60 relevant patients for each measure must submit data on all relevant patients.

3. **Data submission template.** Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either extracted from an electronic medical record system or abstracted through medical record review.

4. **Data file upload. Submit data electronically to the commissioner or the commissioner's designee.**

5. **Data validation.** Ambulatory surgical centers must maintain documentation for the data described in Appendix C including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template for purposes of data validation.

b. Hospital transfer/admission.

For this measure, the data elements must be submitted by the American Society of Anesthesiologists (ASA) Physical Status classification categories (i.e., ASA Physical Status 1 – ASA Physical Status 3) to the commissioner or commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by ASA Physical Status, number of patients meeting the exclusion criteria, and calculated rate.

i. Data submission requirements. Each ambulatory surgical center may satisfy the data submission requirements for these quality measures by completing the following:

1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix C to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list.

2. **Data collection: total population versus sample.** Beginning in 2012, ambulatory surgical centers with an electronic medical record in place for the prior full measurement period will be expected to submit data on a full population basis. Ambulatory surgical centers without an electronic medical record in place for the prior full measurement period may submit data on a random sample of relevant patients in 2012. Ambulatory surgical centers with fewer than 60 relevant patients for each measure must submit data on all relevant patients.

3. **Data submission template.** Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either

extracted from an electronic medical record system or abstracted through medical record review.

4. **Data file upload. Submit data electronically to the commissioner or the commissioner's designee.**
5. **Data validation.** Ambulatory surgical centers must maintain documentation for the data described in Appendix C including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template for purposes of data validation.

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