

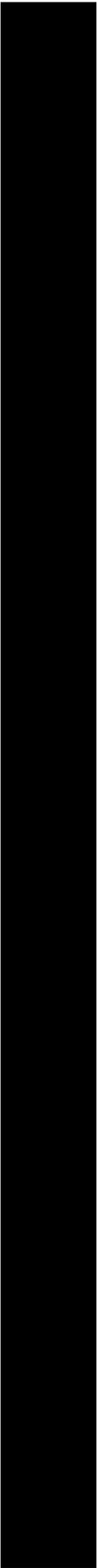
Minnesota Statewide Quality Reporting and Measurement System: *Appendices to Minnesota Administrative Rules, Chapter 4654*

Minnesota Department of Health

November 2013



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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 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Data Required for Reporting Beginning in January 2014 (2013 Dates of Service) and Every Year Thereafter		
Diabetes		
<p>Optimal diabetes care (ODC) composite</p> <p>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:</p> <ul style="list-style-type: none"> ▪ 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 <p><i>(Urgent Care Centers are not required to submit data on this measure.)</i></p>	<p>Physician clinics submitting summary-level data must submit the following data for the optimal diabetes care measure and for each of the five component measures:</p> <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-25, 26-50, 51-65, 66-75), diabetes type (Type 1, Type 2), gender, and zip code: <ul style="list-style-type: none"> ▪ Denominator: <p style="margin-left: 20px;">Number of patients meeting the criteria for inclusion in the measure if submitting on the full population</p> <p style="text-align: center;">OR</p> <p style="margin-left: 20px;">Number of patients in data submission if submitting a sample</p> ▪ 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 	<p>Optimal Diabetes Care Specifications, 2014 (01/01/2013 – 12/31/2013 Dates of Service). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform</p>

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 January 2014 (2013 Dates of Service) and Every Year Thereafter		
	<p>criteria</p> <ul style="list-style-type: none"> Calculated rate <p>Physician clinics submitting patient-level data must submit the following data for the optimal diabetes care measure and for each of the five component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, diabetes type (Type 1, Type 2), gender, zip code, exclusion reason, and patient identification methodology.</p>	
Cardiovascular Conditions		
<p>Optimal vascular care (OVC) composite</p> <p>These measures are used to assess the percent of adult patients who have ischemic vascular disease (IVD) with optimally managed modifiable risk factors:</p> <ul style="list-style-type: none"> 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 <p><i>(Urgent Care Centers are not required to submit data on this measure.)</i></p>	<p>Physician clinics submitting summary-level data must submit the following data for the optimal vascular care measure and for each of the four component measures:</p> <ul style="list-style-type: none"> Patient identification methodology Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured) age (18-25, 26-50, 51-65, 66-75), gender, and zip code: <ul style="list-style-type: none"> Denominator: <p>Number of patients meeting the criteria for inclusion in the measure if submitting on the full population</p> <p>OR</p> <p>Number of patients in data</p> 	<p>Optimal Vascular Care Specifications, 2014 (01/01/2013 – 12/31/2013 Dates of Service). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/healthreform</p>

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 January 2014 (2013 Dates of Service) and Every Year Thereafter		
	<p>submission if submitting a sample</p> <ul style="list-style-type: none"> ▪ 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 <p>Physician clinics submitting patient-level data must submit the following data for the optimal vascular care measure and for each of the four component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, exclusion reason, and patient identification methodology</p>	

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 February 2014 (Follow-up visits for July 1, 2012 – June, 30 2013 Index Contact Dates) and Every Year Thereafter		
Behavioral Health Conditions		
<p>Depression remission at six months</p> <p>This measure is used to assess the percent of adult patients who have</p>	<p>Physician clinics submitting summary-level data must submit the following data for the depression</p>	<p>Depression Remission at Six Months Specifications, 2014 (Follow-up Visits for</p>

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 February 2014 (Follow-up visits for July 1, 2012 – June, 30 2013 Index Contact Dates) and Every Year Thereafter		
<p>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.</p> <p><i>(Urgent Care Centers are not required to submit data on this measure.)</i></p>	<p>remission at six months measure:</p> <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements by three bands of initial PHQ-9 scores (10-14; 15-19; 20 and above), primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured) age (18-25, 26-50, 51-65, 66 and over), gender, and zip code: <ul style="list-style-type: none"> ▪ 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 <p>Physician clinics submitting patient-level data must submit the following data for the depression remission at six months measure: PHQ-9 score, primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, exclusion reason, and patient identification methodology</p>	<p>07/01/2012 – 06/30/2013 Index Contact Dates). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform</p>

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 February 2014 and Every Year Thereafter		
Health Information Technology (HIT)		
Health information technology (HIT) survey 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 2014	MN Health Information Technology (HIT) Ambulatory Clinic Survey. Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/healthreform

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 July 2014 (July 1, 2013 – June 30, 2014 Dates of Service) and Every Year Thereafter		
Respiratory Conditions		
Optimal asthma care (OAC) 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: <ul style="list-style-type: none"> ▪ Asthma is well controlled ▪ Patient is not at increased risk of exacerbations ▪ Patient has a current written asthma action/management plan 	Physician clinics submitting summary-level data must submit the following data for the optimal asthma care measure and for each of the three component measures: <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Within two separate age bands, ages 5-17 and 18-50, submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), gender, and 	Optimal Asthma Care Specifications, 2014 (07/01/2013 – 06/30/2014 Dates of Service). MN Community Measurement; September 2013 or as updated. Measure specifications can be found on the Minnesota Department of Health website

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 July 2014 (July 1, 2013 – June 30, 2014 Dates of Service) and Every Year Thereafter		
(Urgent Care Centers are not required to submit data on this measure.)	<p>zip code:</p> <ul style="list-style-type: none"> ▪ Denominator: <ul style="list-style-type: none"> 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 <p>Physician clinics submitting patient-level data must submit the following data for the optimal asthma care measure and for each of the three component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, exclusion reason, and patient identification methodology</p>	www.health.state.mn.us/health reform

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 July 2014 (July 1, 2013 – June 30, 2014 Dates of Service) and Every Year Thereafter		
Preventive Care		
<p>Colorectal cancer screening</p> <p>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:</p> <ul style="list-style-type: none"> ▪ Colonoscopy within ten years ▪ Sigmoidoscopy within five years ▪ Stool Blood Tests (gFOBT or iFOBT/FIT) within the measurement year <p><i>(Urgent Care Centers are not required to submit data on this measure.)</i></p>	<p>Physician clinics submitting summary level-data must submit the following data for the colorectal cancer screening measure:</p> <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured) age (51-65, 66-75), gender, and zip code: <ul style="list-style-type: none"> ▪ Denominator: <p>Number of patients meeting the criteria for inclusion in the measure if submitting on the full population</p> <p>OR</p> <p>Number of patients in data submission if submitting a sample</p> ▪ 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 <p>Physician clinics submitting patient-level data must submit the following data for the colorectal cancer screening measure: primary payer type (private</p>	<p>Colorectal Cancer Screening Specifications, 2014 (07/01/2013 – 06/30/2014 Dates of Service). MN Community Measurement; September 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform</p>

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 July 2014 (July 1, 2013 – June 30, 2014 Dates of Service) and Every Year Thereafter		
	insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, exclusion reason, and patient identification methodology	
Maternity Care		
<p>Primary c-section rate</p> <p>This measure is used to assess the percent of cesarean deliveries for first births.</p> <p><i>(Urgent Care Centers are not required to submit data on this measure.)</i></p>	<p>Physician clinics submitting summary-level data must submit the following data for the maternity care primary c-section rate measure:</p> <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured) age (17 and under, 18-20, 21-25, 26-30, 31-35, 36 and over), gender, and zip code: <ul style="list-style-type: none"> ▪ Denominator: Number of patients meeting the criteria for inclusion in the 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 <p>Physician clinics submitting patient-level data must submit the following data for the maternity care</p>	<p>Primary C-Section Rate Specifications, 2014 (07/01/2013 – 06/30/2014 Dates of Service). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform</p>

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 July 2014 (July 1, 2013 – June 30, 2014 Dates of Service) and Every Year Thereafter		
	primary c-section rate measure: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, exclusion reason, and patient identification methodology	

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		
Total Knee Replacement		
<p>Average post-operative functional status score at one year</p> <p>This measure is used to assess the average change between pre-operative and post-operative functional status at one year as measured by the Oxford Knee Score tool.</p> <p><i>(Urgent Care Centers are not required to submit data on this measure.)</i></p>	<p>Physician clinics submitting summary-level data must submit the following data for the total knee replacement average post-operative functional status score at one year measure:</p> <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-25, 26-50, 51-65, 66 and over), body mass index, tobacco status, gender, and zip code: <ul style="list-style-type: none"> ▪ Denominator: <p style="margin-left: 40px;">Number of patients meeting the criteria for inclusion in the measure</p> ▪ Numerator: Number of patients meeting 	<p>Total Knee Replacement Specifications, 2014 (01/01/2012 – 12/31/2012 Dates of Procedure). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/healthreform</p>

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		
	<p>the targets in the measure</p> <ul style="list-style-type: none"> ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate <p>Physician clinics submitting patient-level data must submit the following data for the total knee replacement average post-operative functional status score at one year measure: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, body mass index, tobacco status, gender, zip code, exclusion reason, and patient identification methodology</p>	
<p>Average post-operative quality of life score at one year</p> <p>This measure is used to assess the average change between pre-operative and post-operative quality of life score at one year as measured by the EQ-5D tool.</p> <p><i>(Urgent Care Centers are not required to submit data on this measure.)</i></p>	<p>Physician clinics submitting summary-level data must submit the following data for the total knee replacement average post-operative quality of life score at one year measure:</p> <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-25, 26-50, 51-65, 66 and over), body mass index, tobacco status, gender, and zip code: <ul style="list-style-type: none"> ▪ Denominator: <p style="margin-left: 40px;">Number of patients meeting the</p> 	<p>Total Knee Replacement Specifications, 2014 (01/01/2012 – 12/31/2012 Dates of Procedure). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform</p>

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		
	<p>criteria for inclusion in the measure</p> <ul style="list-style-type: none"> ▪ 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 <p>Physician clinics submitting patient-level data must submit the following data for the total knee replacement average post-operative quality of life score at one year measure: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, body mass index, tobacco status, gender, zip code, exclusion reason, and patient identification methodology</p>	

Data Required for Reporting Beginning in Calendar Year 2015 and Every Other Year Thereafter		
Data Required for Reporting Beginning in 2015 (September 1, 2014 – November 30, 2014 Survey Period) and Every Other Year Thereafter		
Patient Experience of Care		
<p>Patient experience of care survey</p> <p>This survey will be used to assess adult patient experience of care. MDH requires use of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) 12-</p>	<p>Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) 12-Month Survey.</p>	<p>Patient Experience of Care Survey Specifications. MN Community Measurement; August 2013 or as updated.</p>

Data Required for Reporting Beginning in Calendar Year 2015 and Every Other Year Thereafter		
Data Required for Reporting Beginning in 2015 (September 1, 2014 – November 30, 2014 Survey Period) and Every Other Year Thereafter		
<p>Month Survey.</p> <p><i>[Primary care clinics may add the CG-CAHPS Patient-Centered Medical Home (PCMH) Items to the 12-month survey.]</i></p> <p><i>(Excluded specialties include Psychiatry.)</i></p>		<p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform</p>

Data Required for Reporting Beginning in Calendar Year 2015 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Data Required for Reporting Beginning in April 2015 (2013 Dates of Service) and Every Year Thereafter		
Spine surgery		
<p>Lumbar discectomy/laminotomy</p> <p>This measure is used to assess the average change between pre-operative and post-operative functional status at three months as measured by the following functional status tools: Oswestry Disability Index (ODI), Visual analog pain scale (VAS), EQ5D self-reported health status, and/or EQ5D health status index.</p> <p><i>(Urgent Care Centers are not required to submit data on this measure.)</i></p>		<p>This measure will be required for reporting beginning in April 2015. 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.</p>
<p>Lumbar spinal fusion</p> <p>This measure is used to assess the average change between pre-operative and post-operative functional status at one year as measured by the following functional status tools: Oswestry Disability Index (ODI), Visual analog pain scale (VAS), EQ5D self-reported health status, and/or EQ5D health status index.</p> <p><i>(Urgent Care Centers are not required to submit data on this</i></p>		<p>This measure will be required for reporting beginning in April 2015. 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.</p>

Data Required for Reporting Beginning in Calendar Year 2015 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Data Required for Reporting Beginning in April 2015 (2013 Dates of Service) and Every Year Thereafter		
<i>measure.)</i>		

Data Required for Reporting Beginning in Calendar Year 2015 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Data Required for Reporting Beginning in Spring 2015 (2014 Dates of Service) and Every Year Thereafter		
NEW: Pediatric Preventive Care		
<p>New: Adolescent Mental Health and/or Depression Screening</p> <p>This measure is used to assess the percent of adolescent patients who receive mental health and/or depression screening.</p> <p><i>(Clinics that provide well-child visit services are required to submit data on this measure.)</i></p>		<p>This measure will be required for reporting beginning in Spring 2015. 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.</p>
<p>New: Obesity/BMI and Counseling</p> <p>These measures are used to assess the percent of pediatric patients that have a documented BMI assessment, and for those with a BMI greater than the 85th percentile that they have documentation of both physical activity and nutrition discussion, counseling, or referral.</p> <p><i>(Clinics that provide well-child visit services are required to submit data on this measure.)</i></p>		<p>This measure will be required for reporting beginning in Spring 2015. 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.</p>

**APPENDIX B
REQUIRED HOSPITAL QUALITY MEASURE DATA**

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Quality Measures		
<p>Acute myocardial infarction (AMI) – Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates</p> <p>The hospital process of care measures include the following measures related to heart attack care:</p> <ul style="list-style-type: none"> ▪ 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. ▪ Statin prescribed at discharge (AMI-10) – This measure is used to assess the percent of acute myocardial infarction 	<p>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:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.3, Discharges 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2014 or as updated.</p> <p>Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
(AMI) patients who are prescribed a statin at hospital discharge.		
<p>Heart failure (HF) – Heart failure (HF) process of care measures for applicable hospital discharge dates</p> <p>The hospital process of care measures include the following measures related to heart failure care:</p> <ul style="list-style-type: none"> ▪ 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. 	<p>All hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.3, Discharges 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2014 or as updated.</p> <p>Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<p>Pneumonia (PN) – Pneumonia (PN) process of care measures for applicable hospital discharge dates</p> <p>The hospital process of care measures include the following measures related to pneumonia care:</p> <ul style="list-style-type: none"> ▪ 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. 	<p>All hospitals must submit data for each of the hospital compare pneumonia process of care quality measures. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.3, Discharges 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2014 or as updated.</p> <p>Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org</p>
<p>Surgical care improvement project (SCIP) – Surgical care improvement project (SCIP) process of care measures for applicable hospital discharge dates</p> <p>The hospital process of care measures include the following measures related to surgical care improvement project:</p> <ul style="list-style-type: none"> ▪ Prophylactic antibiotic received within one hour prior to surgical incision (SCIP-Inf-1) – 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 	<p>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:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.3, Discharges 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2014 or as updated.</p> <p>Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<p>infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.</p> <ul style="list-style-type: none"> ▪ Prophylactic antibiotic selection for surgical patients (SCIP-Inf-2) – 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 (SCIP-Inf-3) – This measure is used to assess the percent of surgical patients whose prophylactic antibiotics were discontinued within 24 hours after <i>Anesthesia End Time</i>. 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 postoperative blood glucose (SCIP-Inf-4) – This measure is used to assess the percent of cardiac surgery patients with controlled postoperative blood glucose (less than or equal to 180 mg/dL) in the timeframe of 18 to 24 hours after <i>Anesthesia End Time</i>. ▪ 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. 		<p>website www.qualitynet.org</p>

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Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<ul style="list-style-type: none"> ▪ 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 96.8° Fahrenheit/36°Celsius recorded within the 30 minutes immediately prior to or the 15 minutes immediately after <i>Anesthesia End Time</i>. ▪ 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 administering the medication were documented. If the postoperative length of stay is < 2 days, the measure will evaluate the administration of the beta-blocker on the day prior to or the day of surgery only, unless reasons for not administering the medication were documented. ▪ 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 received appropriate Venous Thromboembolism (VTE) prophylaxis within 24 hours prior to <i>Anesthesia Start Time</i> to 		

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
24 hours after <i>Anesthesia End Time</i> .		
<p>Prevention immunization (PREV-IMM) – Prevention immunization (PREV-IMM) process of care measures for applicable hospital discharge dates</p> <p>The hospital process of care measures include the following measures related to prevention immunization (IMM):</p> <ul style="list-style-type: none"> ▪ Influenza immunization (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. 	<p>All hospitals must submit data for each of the hospital compare prevention immunization process of care quality measures. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.3, Discharges 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2014 or as updated.</p> <p>Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org</p>
<p>Mortality measures – Mortality measures for applicable hospital discharge dates</p> <p>The hospital measures include the following measures related to mortality:</p> <ul style="list-style-type: none"> ▪ 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. 	<p>The 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</p>	<p>Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.3, Discharges 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2014 or as updated.</p> <p>Measure specifications can be found on the Centers for</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<ul style="list-style-type: none"> ▪ 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. 	<p>requirement applies to Prospective Payment System (PPS) hospitals and Critical Access Hospitals (CAH).</p>	<p>Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org</p>
<p>Emergency department (ED) measures – Emergency department (ED) process of care measures for applicable hospital discharge dates</p> <p>The hospital emergency department (ED) process of care measures include the following measures related to hospital ED care:</p> <ul style="list-style-type: none"> ▪ Median time from ED arrival to ED departure for admitted ED patients (ED-1) – This measure is used to assess the median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. ▪ Admit decision time to ED departure time for admitted patients (ED-2) – This measure is used to assess the median time from admit decision time to time of departure from the emergency department for admitted patients. <p><i>[Critical Access Hospitals' (CAH) submission of data for these measures is voluntary.]</i></p>	<p>Prospective Payment System (PPS) hospitals must submit data for each of the emergency department (ED) quality measures. This data includes the following information:</p> <p>Number of minutes for defined steps in patient flow.</p>	<p>Specifications Manual for National Hospital Inpatient Quality Measures, Version 4.3, Discharges 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2014 or as updated.</p> <p>Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<p>NEW: Perinatal care (PC) – Perinatal care (PC) process of care measures for applicable hospital discharge dates</p> <p>The hospital process of care measures include the following measures related to perinatal care:</p> <ul style="list-style-type: none"> ▪ Elective delivery (PC-01) – This measure is used to assess the percent of patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed. <p><i>[Prospective Payment System (PPS) hospitals must report on this measure beginning with third quarter 2013 discharge dates. Critical Access Hospitals (CAH) must report on this measure beginning with first quarter 2014 discharge dates.]</i></p>	<p>Hospitals must submit data for the elective delivery process of care quality measure. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients with elective deliveries ▪ Calculated rate 	<p>Specifications Manual for Joint Commission National Quality Core Measures, Version 2013B, Discharges 07/01/13 (3Q13) through 12/31/13 (4Q13). The Joint Commission; 2013 or as updated.</p> <p>Measure specifications can be found on The Joint Commission website manual.jointcommission.org</p>
<p>Outpatient acute myocardial infarction (AMI) and chest pain measures</p> <p>The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care:</p> <ul style="list-style-type: none"> ▪ 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 (OP-3) – This measure is used to assess the median time from emergency department (ED) arrival to time of transfer to another facility for acute coronary 	<p>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:</p> <ul style="list-style-type: none"> ▪ Median number of minutes <p>OR</p> <ul style="list-style-type: none"> ▪ 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 	<p>Specifications Manual for Hospital Outpatient Quality Measures, Version 7.0, encounter dates 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS); June 2013 or as updated.</p> <p>Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<p>intervention.</p> <ul style="list-style-type: none"> ▪ 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). 		
<p>Outpatient surgery department measures</p> <p>The hospital outpatient process of care measures include the following measures related to hospital outpatient surgery care:</p> <ul style="list-style-type: none"> ▪ 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 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). 	<p>All hospitals must submit data for each of the outpatient surgery department quality measures. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Specifications Manual for Hospital Outpatient Quality Measures, Version 7.0, encounter dates 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS); June 2013 or as updated.</p> <p>Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI)		
<p>Mortality for selected conditions composite (IQI 91)</p> <p>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), heart failure, acute stroke, gastrointestinal 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:</p> <ul style="list-style-type: none"> ▪ Acute myocardial infarction (AMI) mortality rate (IQI 15) ▪ Congestive heart failure mortality rate (IQI 16) ▪ Acute stroke mortality rate (IQI 17) ▪ Gastrointestinal hemorrhage mortality rate (IQI 18) ▪ Hip fracture mortality rate (IQI 19) ▪ Pneumonia mortality rate (IQI 20) 	<p>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:</p> <ul style="list-style-type: none"> ▪ 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 	<p>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 4.5 (May, 2013 www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V45/TechSpecs/IQI%2091%20Mortality%20for%20Selected%20Conditions.pdf).</p> <p>See specific mortality for selected conditions composite measure component indicators for more information.</p> <p>Inpatient Quality Indicators Technical Specifications, Version 4.5. Agency for Healthcare Research and Quality (AHRQ); May 2013 or as updated.</p> <p>Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website www.qualityindicators.ahrq.gov</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
		v/Modules/IQI_TechSpec.aspx
Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI)		
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.	<p>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:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Patient Safety Indicators (PSI) Technical Specifications, Version 4.5. Agency for Healthcare Research and Quality (AHRQ); May 2013 or as updated.</p> <p>Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website www.qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx</p>
Obstetric trauma – vaginal delivery with instrument (PSI 18) – This measure is used to assess the number of cases of obstetric trauma (3 rd and 4 th degree lacerations) per 1,000 instrument-assisted vaginal deliveries.	<p>All hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Patient Safety Indicators (PSI) Technical Specifications, Version 4.5. Agency for Healthcare Research and Quality (AHRQ); May 2013 or as updated.</p> <p>Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website www.qualityindicators.ahrq.gov</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
		v/modules/PSI_TechSpec.aspx
<p>Obstetric trauma – vaginal delivery without instrument (PSI 19) – This measure is used to assess the number of cases of obstetric trauma (3rd and 4th degree lacerations) per 1,000 vaginal deliveries without instrument assistance.</p>	<p>All hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Patient Safety Indicators (PSI) Technical Specifications, Version 4.5. Agency for Healthcare Research and Quality (AHRQ); May 2013 or as updated.</p> <p>Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website www.qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx</p>
<p>Patient safety for selected indicators composite (PSI 90)</p> <p>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 derangements, 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:</p> <ul style="list-style-type: none"> ▪ Pressure ulcer (PSI 3) ▪ Iatrogenic pneumothorax (PSI 6) 	<p>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:</p> <ul style="list-style-type: none"> ▪ 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 	<p>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 4.5 (May 2013).</p> <p>www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V45/TechSpecs/PSI%2090%20Patient%20Safety%20for%20Selected%20Indicators.pdf</p> <p>See specific patient safety for</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<ul style="list-style-type: none"> ▪ 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) 		<p>selected indicators composite measure component indicators for more information.</p> <p>Patient Safety Indicators (PSI) Technical Specifications, Version 4.5. Agency for Healthcare Research and Quality (AHRQ); May 2013 or as updated.</p> <p>Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website www.qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx</p>
Agency for Healthcare Research and Quality (AHRQ) Pediatric Patient Safety Indicators (PDI)		
<p>Pediatric heart surgery mortality (PDI 6) – This measure is used to assess the number of in-hospital deaths in pediatric patients with congenital heart disease undergoing surgery</p>	<p>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:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Pediatric Quality Indicators (PDI) Technical Specifications, Version 4.5. Agency for Healthcare Research and Quality (AHRQ); May 2013 or as updated.</p> <p>Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
		www.qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx
Pediatric heart surgery volume (PDI 7) – This measure is used to assess the volume of provider-level discharges of pediatric patients with congenital heart disease undergoing a heart surgery procedure.	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: <ul style="list-style-type: none"> Volume 	Pediatric Quality Indicators (PDI) Technical Specifications, Version 4.5. Agency for Healthcare Research and Quality (AHRQ); May 2013 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website www.qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx
Pediatric patient safety for selected indicators composite (PDI 19) 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:	All hospitals must submit data for the pediatric 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: <ul style="list-style-type: none"> 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 Pediatric Quality Indicators (PDI) Composite Measures, Department of Health and Human Services, Agency for Healthcare Research and Quality, Version 4.5 (May 2013). www.qualityindicators.ahrq.gov/Downloads/Modules/PDI/V45/TechSpecs/PDI%2019%20

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<ul style="list-style-type: none"> ▪ 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) 	<p>targets in each of the quality measures</p> <ul style="list-style-type: none"> ▪ Calculated rate 	<p>Pediatric%20Safety%20for%20Selected%20Indicators.pdf</p> <p>See specific pediatric patient safety for selected indicators composite measure component indicators for more information.</p> <p>Pediatric Quality Indicators Technical Specifications, Version 4.5. Agency for Healthcare Research and Quality (AHRQ); May 2013 or as updated.</p> <p>Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website www.qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx</p>
Patient Experience of Care		
<p>Patient experience of care</p> <p>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).</p> <p><i>(This measure is not required for hospitals with less than 500</i></p>	<p>Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey</p>	<p>Consumer Assessment of Healthcare Providers and Systems Hospital Survey (HCAHPS), Version 8.0. Centers for Medicare & Medicaid Services (CMS);</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<i>admissions in the previous calendar year.)</i>		<p>March 2013 or as updated.</p> <p>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, www.hcahponline.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.</p>
Minnesota Stroke Registry Indicators		
<p>Emergency department (ED) stroke registry indicators for applicable hospital discharge dates</p> <p>The emergency department (ED) stroke registry indicators include the following:</p>	<p>All hospitals must submit data for patients discharged from the emergency department or inpatient with diagnosis of ischemic stroke or ill-defined stroke. This data includes the following</p>	<p>Emergency Department Stroke Registry Indicator Specifications, 2014 (07/01/2013 – 06/30/2014 Discharge Dates). Minnesota</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<ul style="list-style-type: none"> ▪ Door-to-imaging performed time ▪ NEW: Time to intravenous thrombolytic therapy 	information: <ul style="list-style-type: none"> ▪ 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 	Stroke Registry; August 2013 or as updated. Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform
University of Minnesota Rural Health Research Center		
Emergency department (ED) transfer communication measures. <i>[This measure is required for Critical Access Hospitals (CAH) ONLY.]</i> The hospital emergency department (ED) transfer communication process of care measures include the following seven subscales: <ul style="list-style-type: none"> ▪ Administrative communication – This measure is used to assess the percent of patients transferred to another health care facility whose medical record documentation indicated that pre-transfer information was communicated to the receiving hospital prior to discharge. ▪ Patient information – This measure is used to assess the percent of patients transferred to another health care facility whose medical record documentation indicated that patient identification was communicated to the receiving hospital within 60 minutes of discharge. ▪ Vital signs – This measure is used to assess the percent of patients transferred to another health care facility whose medical record documentation indicated that vital signs were 	Critical Access Hospitals (CAH) must submit data for each of the emergency department (ED) transfer communication quality measures. This data includes the following information: <ul style="list-style-type: none"> ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting all of the applicable targets in each of the quality measures ▪ Calculated rate 	Emergency Department Transfer Communication Specifications, 2014 (07/01/2013 – 06/30/2014 Discharge Dates). Stratis Health; September 2013 or as updated. Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
<p>communicated to the receiving hospital within 60 minutes of discharge.</p> <ul style="list-style-type: none"> ▪ Medication information – This measure is used to assess the percent of patients transferred to another health care facility whose medical record documentation indicated that medication-related information was communicated to the receiving hospital within 60 minutes of discharge. ▪ Physician information – This measure is used to assess the percent of patients transferred to another health care facility whose medical record documentation indicated that physician or practitioner generated information was communicated to the receiving hospital within 60 minutes of discharge. ▪ Nurse information – This measure is used to assess the percent of patients transferred to another health care facility whose medical record documentation indicated that nurse generated information was communicated to the receiving hospital within 60 minutes of discharge. ▪ Procedures and tests – This measure is used to assess the percent of patients transferred to another health care facility whose medical record documentation indicated that procedures and tests were communicated to the receiving hospital within 60 minutes of discharge. 		

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Description	Data Elements	Specification Information
Measure Required for Reporting in June 2014 and Every Year Thereafter (2013 Dates of Service)		
Vermont Oxford Network (VON)		
<p>Late sepsis or meningitis in very low birth weight (VLBW) neonates</p> <p>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).</p>	<p>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 information:</p> <ul style="list-style-type: none"> ▪ 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 	<p>Late Sepsis or Meningitis in Very Low Birth Weight Neonates Specifications: Vermont Oxford Network.</p> <p>Measure specifications can be found on the Vermont Oxford Network website www.vtoxford.org</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures		
<p>Central line-associated bloodstream infection (CLABSI) event</p> <p>This measure is used to assess the infection rate of patients with a</p>	<p>Hospitals with a neonatal intensive care unit (NICU) and/or a pediatric intensive care unit (PICU) must</p>	<p>Specifications Manual for National Hospital Inpatient</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2014 and Every Year Thereafter		
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).	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: <ul style="list-style-type: none"> ▪ 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 	Quality Measures, Version 4.3, Discharges 01/01/14 (1Q14) through 09/30/14 (3Q14). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; June 2013 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Description	Data Elements	Specification Information
Health Information Technology (HIT)		
Health information technology (HIT) survey 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 2013	2013 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C with MN-Specific Additional Questions.

Removed Measures		
Measure Name and Description	Data Elements	Specification Information
Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Quality Measures		
Aspirin prescribed at discharge (AMI-2)	Hospitals will no longer be required to submit data for this measure	This measure will be removed effective with January 1, 2014 (1Q14) discharges.
Statin prescribed at discharge (AMI-10)	Hospitals will no longer be required to submit data for this measure	This measure will be removed effective with January 1, 2014 (1Q14) discharges.
Discharge instructions (HF-1)	Hospitals will no longer be required to submit data for this measure	This measure will be removed effective with January 1, 2013 (1Q14) discharges.
ACEI or ARB for LVSD (HF-3)	Hospitals will no longer be required to submit data for this measure	This measure will be removed effective with January 1, 2014 (1Q14) discharges.
Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN-3b)	Hospitals will no longer be required to submit data for this measure	This measure will be removed effective with January 1, 2014 (1Q14) discharges.
New surgery patients with perioperative temperature management (SCIP-Inf-10)	Hospitals will no longer be required to submit data for this measure	This measure will be removed effective with January 1, 2014 (1Q14) discharges.
Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2012 (3Q12) discharges.

Removed Measures		
Home management plan of care given to patient/caregiver (CAC-3)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Pneumococcal immunization (IMM-1)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Troponin results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with <i>Probably Cardiac Chest Pain</i>) received within 60 minutes of arrival (OP-16)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2012 (3Q12) discharges.
Appropriate Care Measures (ACM)		
Acute myocardial infarction appropriate care measure (AMI-ACM)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Heart failure appropriate care measure (HF-ACM)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Pneumonia appropriate care measure (PN-ACM)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI)		
Abdominal aortic aneurysm (AAA) repair volume (IQI 4)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013

Removed Measures		
		(3Q13) discharges.
Coronary artery bypass graft (CABG) volume (IQI 5)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Coronary artery bypass graft (CABG) mortality rate (IQI 12)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Hip fracture mortality rate (IQI 19)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI)		
Pressure ulcer (PSI 3)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.
Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12)	Hospitals are no longer required to submit data for this measure	This measure was removed effective with July 1, 2013 (3Q13) discharges.

APPENDIX C
REQUIRED AMBULATORY SURGICAL CENTER QUALITY MEASURE DATA

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter		
Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in July 2014 (Dates of Service July 1, 2013 – June 30, 2014) and Every Year Thereafter		
Prophylactic intravenous (IV) antibiotic timing – This measure is used to assess the percent of ambulatory surgical center (ASC) patients who were administered antibiotics for prevention of surgical site infection on time	<p>Ambulatory surgical centers must submit data for the prophylactic intravenous (IV) antibiotic timing quality measure. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements: <ul style="list-style-type: none"> ▪ Denominator: <p style="margin-left: 20px;">Number of patients meeting the criteria for inclusion in the measure if submitting on the full population</p> <p style="text-align: center;">OR</p> <p style="margin-left: 20px;">Number of patients in data submission if submitting a sample</p> ▪ 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 	<p>Ambulatory Surgical Center Measure Specifications, 2014 (07/01/2013 – 06/30/2014 Dates of Service). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/healthreform</p>
Hospital transfer/admission – This measure is used to assess the percent of ambulatory surgical center (ASC) patients who are transferred or admitted to a hospital upon discharge from the ASC.	<p>Ambulatory surgical centers must submit data for the hospital transfer/admission quality measure. This data includes the following information:</p>	<p>Ambulatory Surgical Center Measure Specifications, 2014 (07/01/2013 – 06/30/2014</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in July 2014 (Dates of Service July 1, 2013 – June 30, 2014) and Every Year Thereafter		
	<ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements by the American Society of Anesthesiologists (ASA) Physical Status classification system categories: <ul style="list-style-type: none"> ▪ Denominator: <ul style="list-style-type: none"> 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 	<p>Dates of Service). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/health/reform</p>
<p>Appropriate surgical site hair removal – This measure is used to assess the percent of ambulatory surgical center (ASC) patients who have appropriate surgical site hair removal.</p>	<p>Ambulatory surgical centers must submit data for the appropriate surgical site hair removal quality measure. This data includes the following information:</p> <ul style="list-style-type: none"> ▪ Patient identification methodology ▪ Submit the following two data elements: <ul style="list-style-type: none"> ▪ Denominator: <ul style="list-style-type: none"> Number of patients meeting the criteria 	<p>Ambulatory Surgical Center Measure Specifications, 2014 (07/01/2013 – 06/30/2014 Dates of Service). MN Community Measurement; August 2013 or as updated.</p> <p>Measure specifications can be found on the Minnesota</p>

Data Required for Reporting Beginning in Calendar Year 2014 and Every Year Thereafter

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in July 2014 (Dates of Service July 1, 2013 – June 30, 2014) and Every Year Thereafter		
	<p>for inclusion in the measure if submitting on the full population</p> <p>OR</p> <p>Number of patients in data submission if submitting a sample</p> <ul style="list-style-type: none"> ▪ 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 	<p>Department of Health website www.health.state.mn.us/health/reform</p>

**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 2013, 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) 2013 Volume 2: Technical Specifications. National Committee for Quality Assurance (NCQA); 2012 or as updated.
National Quality Forum (NQF) endorsed measures	All NQF-endorsed measures as of August 1, 2013, 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 www.qualityforum.org

Removed Measures		
Measure Name and Description	Measure Elements	Specification Information
Time-Limited Availability		
Pediatric asthma	Physician clinics are no longer required to submit data for this measure	This measure was removed effective with 2013 dates of service.

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, 2014 and no later than February 10, 2014 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; and**
 - 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 2014. (NOTE: 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 to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-25, 26-50, 51-65, 66-75), diabetes type (Type 1, Type 2), gender, and zip code. Specifically, this includes: patient identification methodology; numerator and denominator by

primary payer type, age, diabetes type, gender, and zip code; 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, age, diabetes type, gender, and zip code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, diabetes type (Type 1, Type 2), gender, zip code, and exclusion reason. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2014 and no later than February 15, 2014, and beginning January 1 and no later than February 15 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since January 1, 2012 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 to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured) age (18-25, 26-50, 51-65, 66-75), gender, and zip code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type age, gender, and zip code; 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, age, gender, and zip code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, and exclusion reason. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2014 and no later than February 15, 2014, and beginning January 1 and no later than February 15 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since January 1, 2012 are required to submit data on their full patient population for this measure.)

Optimal asthma care (OAC) 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 physician clinics submitting summary-level data, identify 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, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), gender, and zip code. Specifically, this includes: patient identification methodology; separation of the data by age bands; numerator and denominator by primary payer type, gender, and zip code; 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, gender, and zip code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, and exclusion reason. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2014 and no later than August 15, 2014, and beginning July 1 and no later than August 15 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since July 1, 2012 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 to the commissioner or the commissioner's designee.

For physician clinics submitting summary level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (51-65, 66-75), gender, and zip code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, gender, and zip code; 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 and age.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, and exclusion reason. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2014 and no later than August 15, 2014, and beginning July 1 and no later than August 15 of each

subsequent year. (NOTE: Physician clinics with electronic medical records in place since July 1, 2012 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 2014. 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. Physician clinics with electronic medical records in place for the prior full measurement period are 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 2014.

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 physician clinics submitting summary-level data, data elements must be submitted by three bands of initial PHQ-9 scores (10-14; 15-19; 20 and above), primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-25, 26-50, 51-65, 66 and over), gender, and zip code. Specifically, this includes: patient identification methodology; numerator and denominator separated by three bands of initial PHQ-9 scores, primary payer type, age, gender, and zip code; number of patients meeting the exclusion criteria; and calculated rate.

For physician clinics submitting patient-level data, additional data elements include: PHQ-9 score, primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, and exclusion reason. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning February 1, 2014 and no later than February 28, 2014.

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 to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (17 and under, 18-20, 21-25, 26-30, 31-35, 36 and over), gender, and zip code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, gender, and zip code; number of patients meeting the exclusion criteria; and calculated rate.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health

Care Programs, self-pay, uninsured), date of birth, gender, zip code, and exclusion reason. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning July 1, 2014 and no later than August 15, 2014, and beginning July 1 and no later than August 15 of each subsequent year.

Total knee replacement. 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 physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay uninsured), age (18-25, 26-50, 51-65, 66 and over), body mass index, tobacco status, gender, and zip code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, body mass index, tobacco status, gender, and zip code; number of patients meeting the exclusion criteria; and calculated rate.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, body mass index, tobacco status, gender, zip code, and exclusion reason. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning April 1, 2014 and no later than May 15, 2014, and beginning April 1 and no later than May 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, 2014 and no later than March 15, 2014, 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. The survey period includes patients seen September 1, 2014 through November 30, 2014.

¹ For purposes of fulfilling state requirements under Chapter 4654, physician clinics must use a vendor certified by CMS to administer HCAHPS, MA and PDP CAHPS, or CG-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 CMS, using CMS's 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 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, 2013: July 1 – September 30	February 15, 2014
Fourth Quarter, 2013: October 1 – December 31	May 15, 2014
First Quarter, 2014: January 1 – March 31	August 15, 2014
Second Quarter, 2014: April 1 – June 30	November 15, 2014

*For the following measures, hospitals must report on third and fourth quarters 2013 discharge dates only: Aspirin prescribed at discharge (AMI-2), Statin prescribed at discharge (AMI-10), Discharge instructions (HF-1), ACE or ARB for LVSD (HF-3), Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN-3b), and Surgery patients with perioperative temperature management (SCIP-Inf-10). For Elective delivery (PC-01), Prospective Payment System (PPS) hospitals must report on this measure beginning with third quarter 2013 discharge dates. Critical Access Hospitals (CAH) must report on this measure beginning with first quarter 2014 discharge dates.

Outpatient Quality Measures

Discharge Dates	Data Submission Deadline
Third Quarter, 2013: July 1 – September 30	February 1, 2014
Fourth Quarter, 2013: October 1 – December 31	May 1, 2014
First Quarter, 2014: January 1 – March 31	August 1, 2014
Second Quarter, 2014: April 1 – June 30	November 1, 2014

i. Data collection and analysis.

1. Hospitals must use the CMS Abstraction & Reporting Tool (CART), available from 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 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 Inpatient Quality Indicators (IQI), Patient Safety Indicators (PSI), and Pediatric Patient Safety Indicators (PDI), Agency for Healthcare Research and Quality (AHRQ). 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, 2013: July 1 – September 30	January 27, 2014
Fourth Quarter, 2013: October 1 – December 31	April 28, 2014
First Quarter, 2014: January 1 – March 31	July 28, 2014
Second Quarter, 2014: April 1 – June 30	October 27, 2014

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. **Data collection and analysis.** Apply Version 4.5, or the most recent version of the Quality Indicator software, available from the AHRQ, to the hospital's discharge data. A hospital must participate in verifying the results of the analysis as needed.

ii. **Data validation.**

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

b. Each hospital may perform the following steps itself:

- i. **Data collection and analysis.** Apply Version 4.5, or the most recent version of the Quality Indicator software, available from the AHRQ, to its discharge data.
- ii. **Data validation.** Validate the data submission through a third-party vendor.
 - 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. **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.

3. 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. **Data collection and analysis.** Applicable data on the specified patients must be submitted 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 2013 Dates of Service	June 30, 2014

- b. **Data submission.** Summary level results must be submitted electronically for the previous calendar year to the commissioner or the commissioner's designee by October 31, 2014 and every year thereafter.

4. 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 CMS, using CMS's 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 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, 2013: July 1 – September 30	February 15, 2014
Fourth Quarter, 2013: October 1 – December 31	May 15, 2014
First Quarter, 2014: January 1 – March 31	August 15, 2014
Second Quarter, 2014: April 1 – June 30	November 15, 2014

i. **Data collection and analysis.**

1. Hospitals must submit data to the CDC through the 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 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.

5. 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, 2013: July 1 – September 30	February 15, 2014
Fourth Quarter, 2013: October 1 – December 31	May 15, 2014
First Quarter, 2014: January 1 – March 31	August 15, 2014
Second Quarter, 2014: April 1 – June 30	November 15, 2014

There are three ways hospitals may satisfy this requirement.

- a. **Participation in the Minnesota Stroke Registry (MSR).** If a hospital normally participates in the MSR and submits data for all cases to the 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 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. **Data collection and analysis.** 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. **Data submission.** Submit data electronically to the commissioner or the commissioner’s designee using the Minnesota Stroke Registry Tool (MSRT).

6. Data Submission for Emergency Department (ED) Transfer Communication Measures. Each Critical Access Hospital (CAH) 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, 2013: July 1 – September 30	February 15, 2014
Fourth Quarter, 2013: October 1 – December 31	May 15, 2014
First Quarter, 2014: January 1 – March 31	August 15, 2014
Second Quarter, 2014: April 1 – June 30	November 15, 2014

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.

7. Health information technology (HIT) survey. Each hospital must complete the survey available annually from the commissioner or commissioner’s designee in calendar year 2014 and each subsequent year.

8. 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, 2014 and no later than April 1, 2014, 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, 2014 and no later than August 15, 2014, and beginning July 1 and no later than August 15 of each subsequent year. Data submission deadlines require each ambulatory surgical center to allocate data required to calculate 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 2014, based on current measures, this applies 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.** Ambulatory surgical centers with an electronic medical record in place since July 1, 2012 are required to submit data on their full population for these measures. 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 2014. 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 to the commissioner or commissioner's designee. Specifically, data elements include 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.** Ambulatory surgical centers with an electronic medical record in place since July 1, 2012 are required to submit data on their full population for this measure. 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 2014. 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.

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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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