Minnesota Statewide Quality Reporting and Measurement System:

Appendices to Minnesota Administrative Rules, Chapter 4654

Minnesota Department of Health

December 2015

MDH
Minnesota Department of Health

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Introduction

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

Measures that will be used for public reporting are identified in Appendices A and B. The standardized set of measures are defined in the body of the rule and include the measures identified in Appendices A, B, and D. The hospital measures in Appendix B 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2016 (2015 Dates of Service) and Every Year Thereafter		
Diabetes		
Optimal Diabetes Care composite measure These measures are used to assess the percent of adult patients who have type I or type II diabetes with optimally managed modifiable risk factors: ▪ HbA1c control (less than 8 percent) ▪ Blood pressure control (less than 140/90 mmHg) ▪ Statin use unless allowed contraindications or exceptions are present ▪ Documented tobacco non-user ▪ For patients with a diagnosis of ischemic vascular disease (IVD), daily aspirin or anti-platelet use unless allowed contraindications or exceptions are present *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics submitting summary-level data must submit the following data for the Optimal Diabetes Care composite measure and for each of the five component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65-75), diabetes type (Type 1, Type 2), gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure	Optimal Diabetes Care Specifications, 2016 Report Year, 01/01/2015 to 12/31/2015 Dates of Service. MN Community Measurement, 2015 or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2016 (2015 Dates of Service) and Every Year Thereafter		
	▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Optimal Diabetes Care composite measure and for each of the five component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, diabetes type (Type 1, Type 2), gender, zip code, and patient identification methodology *Beginning in January 2018, physician clinics will be required to report race, ethnicity, preferred language, and country of origin data. Additional information about specific reporting requirements will be made available in a future update to Minnesota Administrative Rules, Chapter 4654.*	
Cardiovascular Conditions		
Optimal Vascular Care composite measure These measures are used to assess the percent of adult patients who have ischemic vascular disease (IVD) with optimally managed modifiable risk factors: ▪ Blood pressure control (less than 140/90 mmHg) ▪ Statin use unless allowed contraindications or exceptions are present	Physician clinics submitting summary-level data must submit the following data for the Optimal Vascular Care composite measure and for each of the four component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs,	Optimal Vascular Care Specifications, 2016 Report Year, 01/01/2015 to 12/31/2015 Dates of Service. MN Community Measurement, 2015 or as updated.

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2016 (2015 Dates of Service) and Every Year Thereafter		
▪ Documented tobacco non-user ▪ Daily aspirin or anti-platelet use unless allowed contraindications or exceptions are present *(Urgent Care Centers are not required to submit data on this measure.)*	self-pay, uninsured) age (18-44, 45-64, 65-75), gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Optimal Vascular Care composite measure and for each of the four component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, zip code, and patient identification methodology *Beginning in January 2018, physician clinics will be required to report race, ethnicity, preferred language, and country of origin data. Additional information about specific reporting requirements*	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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2016 (2015 Dates of Service) and Every Year Thereafter		
	will be made available in a future update to Minnesota Administrative Rules, Chapter 4654.	
Data Required for Reporting Beginning in February 2016 (2014 Dates of Index) and Every Year Thereafter		
Behavioral Health Conditions		
Depression Remission at Six Months This measure is used to assess the percent of adult patients who have major depression or dysthymia who reached remission six months (+/- 30 days) after an index visit with a PHQ-9 score of greater than 9. Remission is defined as a PHQ-9 score of less than 5. *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics submitting summary-level data must submit the following data for the Depression Remission at Six Months measure: ▪ Patient identification methodology ▪ Submit the following two data elements by three bands of initial PHQ-9 scores (10-14; 15-19; 20 and above), primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured) age (18-44, 45-64, 65 and over), gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients meeting the targets in the measure ▪ Number of patients meeting the exclusion criteria ▪ Number of patients for whom a follow-up six month (+/- 30 days) PHQ-9 assessment was not completed ▪ Calculated rate	Depression Remission at Six Months Specifications, 2016 Report Year, 01/01/2014 to 12/31/2014 Dates of Index. MN Community Measurement, 2015 or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2016 (2015 Dates of Service) and Every Year Thereafter		
	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), age, gender, zip code, exclusion reason, and patient identification methodology	

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in February 2016 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 HIT in their clinical practice.	Internet-based survey as updated in 2016	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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2016 (July 1, 2015 – June 30, 2016 Dates of Service) and Every Year Thereafter		
Respiratory Conditions		
Optimal Asthma Control composite measure These measures are used to assess the percent of pediatric and adult asthma patients who are well controlled. Optimal control is defined as: ▪ Asthma is well controlled as demonstrated by specified assessment tools ▪ Patient is not at increased risk of exacerbations *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics submitting summary-level data must submit the following data for the Optimal Asthma Control composite measure and for each of the two component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (5-11, 12-17, 18-34, 35-50), gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample (NOTE: One sample per pediatric population and adult population 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	Optimal Asthma Control Specifications, 2016 Report Year, 07/01/2015 to 06/30/2016 Dates of Service. MN Community Measurement, 2015 or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2016 (July 1, 2015 – June 30, 2016 Dates of Service) and Every Year Thereafter		
	▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Optimal Asthma Control composite measure and for each of the two component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, zip code, and patient identification methodology *Beginning in July 2017, physician clinics will be required to report race, ethnicity, preferred language, and country of origin data. Additional information about specific reporting requirements will be made available in a future update to Minnesota Administrative Rules, Chapter 4654.*	
Asthma Education and Self-management This measure is used to assess the percent of pediatric and adult asthma patients who have been educated about their asthma and self-management of their condition and also have a written asthma management plan present. *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics submitting summary-level data must submit the following data for the asthma education and self-management measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (5-11, 12-17, 18-34, 35-50), gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR**	Asthma Education & Self-Management Measure Specifications, 2016 Report Year, 07/01/2015 to 06/30/2016 Dates of Service. 2015 or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2016 (July 1, 2015 – June 30, 2016 Dates of Service) and Every Year Thereafter		
	Number of patients in data submission if submitting a sample (NOTE: One sample per pediatric population and adult population 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 Physician clinics submitting patient-level data must submit the following data for the asthma education and self-management measure: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, zip code, and patient identification methodology	
Preventive Care		
Colorectal Cancer Screening This measure is used to assess the percent of adult patients, aged 50 to 75 years, who are up to date with appropriate colorectal cancer screening. The screening methods include: ▪ Colonoscopy within ten years ▪ Sigmoidoscopy within five years ▪ Stool Blood Test within the measurement year	Physician clinics submitting summary level-data must submit the following data for the Colorectal Cancer Screening measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs,	Colorectal Cancer Screening Specifications, 2016 Report Year, 07/01/2015 to 06/30/2016 Dates of Service. MN Community Measurement, 2015 or as updated. Measure specifications can be found on the Minnesota

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2016 (July 1, 2015 – June 30, 2016 Dates of Service) and Every Year Thereafter		
(Urgent Care Centers are not required to submit data on this measure.)	self-pay, uninsured) age (50-64, 65-75), gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients with colorectal cancer screening ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Colorectal Cancer Screening measure: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, zip code, and patient identification methodology *Beginning in July 2017, physician clinics will be required to report race, ethnicity, preferred language, and country of origin data. Additional information about specific reporting requirements will be made available in a future update to Minnesota Administrative Rules, Chapter 4654.*	Department of Health website www.health.state.mn.us/healthreform

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in July 2016 (July 1, 2015 – June 30, 2016 Dates of Service) and Every Year Thereafter		
Maternity Care		
Cesarean Section Rate This measure is used to assess the percent of cesarean deliveries for first births.	Physician clinics submitting summary-level data must submit the following data for the maternity care Cesarean Section Rate measure: ▪ 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, 18-24, 25-34, 35 and over), gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients with Cesarean section ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the maternity care Cesarean Section Rate measure: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), date of birth, gender, zip code, and patient identification methodology	Maternity Care: Cesarean Section Rate Specifications, 2016 Report Year, 07/01/2015 to 06/30/2016 Dates of Delivery. MN Community Measurement, 2015 or as updated. 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 2016 and Every Other Year Thereafter		
Data Required for Reporting Beginning in 2017 (September 1, 2016 – November 30, 2016 Dates of Service) and Every Other Year Thereafter		
Patient Experience of Care		
Patient Experience of Care Survey 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) 6-Month Survey, Version 3.0. *[Primary care clinics may add the CG-CAHPS Patient-Centered Medical Home (PCMH) Items to the 6-month survey.]* *(Excluded specialties include Psychiatry.)*	Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) 6-Month Survey, Version 3.0	Patient Experience of Care Specifications, 2016 Report Year, 09/01/2016 to 11/30/2016 Dates of Service. MN Community Measurement, 2015 or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2016 (2014 Dates of Procedure) and Every Year Thereafter		
Orthopedic Procedures		
Total Knee Replacement: Functional Status and Quality of Life outcome measures These measures are used to assess the average change between pre-operative and post-operative functional status and quality of life at one year as measured by specified assessment tools for patients who had a primary or revision total knee replacement surgery. Outcome measures are stratified by primary versus revision procedures.	Physician clinics submitting summary-level data must submit the following data for the Total Knee Replacement Functional Status and Quality of Life outcome measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance,	Total Knee Replacement Outcome Measures Specifications, 2016 Report Year, 01/01/2014 to 12/31/2014 Dates of Procedure. MN Community Measurement, 2015 or as updated.

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2016 (2014 Dates of Procedure) and Every Year Thereafter		
	Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Average change between pre-operative and post-operative functional status or quality of life ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Total Knee Replacement Functional Status and Quality of Life outcome measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, zip code, and patient identification methodology	Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/healthreform
Spinal Surgery: Lumbar Fusion Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures These measures are used to assess the average change between pre-operative and post-operative functional status, quality of life, back pain, and leg pain at one year as measured by specified assessment tools.	Physician clinics submitting summary-level data must submit the following data for the Lumbar Fusion Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance,	Spinal Surgery: Lumbar Fusion Outcome Measure Specifications, 2016 Report Year, 01/01/2014 to 12/31/2014 Dates of Procedure. MN Community Measurement, 2015 or as updated.

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2016 (2014 Dates of Procedure) and Every Year Thereafter		
	Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Average change between pre-operative and post-operative functional status, quality of life, back pain, or leg pain ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Lumbar Fusion Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, zip code, and patient identification methodology	Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/healthreform
Spinal Surgery: Lumbar Discectomy Laminotomy Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures These measures are used to assess the average change between pre-operative and post-operative functional status, quality of life, back pain, and leg pain at three months as measured by specified assessment tools.	Physician clinics submitting summary-level data must submit the following data for the Lumbar Discectomy Laminotomy Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures: ▪ Patient identification methodology	Spinal Surgery: Lumbar Discectomy Laminotomy Outcome Measures Specifications, 2016 Report Year, 01/01/2014 to 12/31/2014 Dates of Procedure. MN Community

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2016 (2014 Dates of Procedure) and Every Year Thereafter		

	▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and zip code:
	  ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure
	  ▪ Numerator: Average change between pre-operative and post-operative functional status, quality of life, back pain, or leg pain
	▪ Denominator: Number of patients meeting the criteria for inclusion in the measure
	▪ Number of patients meeting the exclusion criteria
	▪ Calculated rate
	Physician clinics submitting patient-level data must submit the following data for the Lumbar Discectomy Laminotomy Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, zip code, and patient identification methodology
		Measurement, 2015 or as updated.
		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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2016 (2015 Dates of Service) and Every Year Thereafter		
Pediatric Preventive Care		
Adolescent Mental Health and/or Depression Screening This measure is used to assess the percent of adolescent patients who receive mental health and/or depression screening as measured by specified assessment tools and have the screening tool result documented in the medical record. *(Clinics that provide well-child visit services are required to submit data on this measure.)* *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics submitting summary-level data must submit the following data for the Adolescent Mental Health and/or Depression Screening measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (12-17), gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients with mental health and/or depression screening and screening tool results documented. ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Adolescent Mental Health and/or Depression Screening: primary payer type (private insurance, Medicare, Minnesota Health	Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening Specifications, 2016 Report Year, 01/01/2015 to 12/31/2015 Dates of Service. MN Community Measurement, 2015 or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2016 (2015 Dates of Service) and Every Year Thereafter		
	Care Programs, self-pay, uninsured), age, gender, zip code, and patient identification methodology	
Overweight Counseling This measure is used to assess the percent of pediatric patients that have an overweight/obesity assessment, and for those with a BMI percentile greater than or equal to 85, that they have documentation of counseling for both physical activity and nutrition. *(Clinics that provide well-child visit services are required to submit data on this measure.)* *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics submitting summary-level data must submit the following data for the Overweight Counseling measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (3-4, 5-11, 12-17), body mass index, tobacco status, gender, and zip code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of overweight children with both nutrition and physical activity counseling documented ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Overweight Counseling measure: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass	Pediatric Preventive Care: Overweight Counseling Specifications, 2016 Report Year, 01/01/2015 to 12/31/2015 Dates of Service. MN Community Measurement, 2015 or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2016 (2015 Dates of Service) and Every Year Thereafter		
	index, tobacco status, gender, zip code, and patient identification methodology	

Appendix B

Required Hospital Quality Measure Data

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Prospective Payment System (PPS) Hospital Measures		
Centers for Medicare & Medicaid Services' (CMS) Value-Based Purchasing Programs Quality Measures		
Hospital Value-Based Purchasing Total Performance Score This score is used to assess a hospital's performance providing high-quality care. The score includes measures within the following domains related to quality of care: ▪ Clinical Outcome ▪ Patient Experience of Care ▪ Efficiency ▪ Clinical Process of Care	The Centers for Medicare & Medicaid Services (CMS) calculates this measure and results are published on Hospital Compare. Hospitals do not need to submit additional data elements for this measure. Each hospital will have satisfied its data submission requirements for this quality measure 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.	Hospital Value-Based Purchasing Total Performance Score Specifications, 2016. Stratis Health; August 2015, or as updated. Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/healthreform
Hospital Readmissions Reduction Program composite measure This composite is used to assess a hospital's readmission performance compared to the national average for the hospital's set of patients with the applicable condition. The composite includes the following excess readmission ratio measures: ▪ Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization ▪ Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization	The Minnesota Hospital Association (MHA) calculates this composite measure based on the Centers for Medicare & Medicaid Services (CMS) excess readmission ratio measures published on Hospital Compare. Hospitals do not need to submit additional data elements for this measure. Each hospital will have satisfied its data submission requirements for this quality measure by meeting the requirement to publically report their data on Hospital Compare as part of their participation in the inpatient program and receiving their annual payment from CMS.	Hospital Readmissions Reduction Program Excess Readmission, 2016. Stratis Health; August 2015 or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Prospective Payment System (PPS) Hospital Measures		
▪ Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following pneumonia (PN) hospitalization ▪ Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) hospitalization ▪ Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)		
Total Hospital Acquired Condition (HAC) Score This score is used to assess a hospital's performance in reducing hospital acquired conditions. The ratio includes the following measures related to hospital acquired conditions: ▪ Patient Safety for Selected Indicators composite (PSI 90) ▪ Central Line-associated Bloodstream Infection ▪ Catheter-associated Urinary Tract Infection ▪ Harmonized Procedure Specific Surgical Site Infection – Colon Surgery ▪ Harmonized Procedure Specific Surgical Site Infection – Abdominal Hysterectomy	The Centers for Medicare & Medicaid Services (CMS) calculates this measure and results are published on Hospital Compare. Hospitals do not need to submit additional data elements for this measure. Each hospital will have satisfied its data submission requirements for this quality measure 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.	Hospital Acquired Conditions Specifications, 2015. Stratis Health; August 2015, or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Critical Access Hospital (CAH) Measures		
Centers for Medicare & Medicaid Services (CMS) Medicare Beneficiary Quality Improvement Project Quality Measures		
Inpatient Critical Access Hospital (CAH) measures		
Emergency department (ED) measures – Emergency department (ED) process of care measures for applicable hospital discharge dates The hospital emergency department (ED) process of care measures include the following measures related to hospital ED care: ▪ Median time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate (ED-1a) – This measure is used to assess the median time from emergency department arrival to 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 – Overall Rate (ED-2a) – This measure is used to assess the median time from admit decision time to time of departure from the emergency department for admitted patients.	Critical Access Hospitals (CAH) must submit data for each of the emergency department (ED) quality measures. This data includes the following information: Number of minutes for defined steps in patient flow.	Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.0a, Discharges 10/01/15 (4Q15) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; May 2015 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org
Readmission measures – Readmission measures for applicable hospital discharge dates The hospital measures include the following measures related to readmissions: ▪ READM-30 Heart Failure (HF) 30-Day Readmission Rate – This measure estimates a hospital-level 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of heart failure (HF).	Critical Access Hospitals (CAH) must submit data for each of these readmission quality measures. The Centers for Medicare & Medicaid Services (CMS) calculates these measures and results are published on Hospital Compare. Hospitals do not need to submit additional data elements for these measures. Each hospital will have satisfied its 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.	Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.0a, Discharges 10/01/15 (3Q15) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2014 or as updated.

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Critical Access Hospital (CAH) Measures		
▪ READM-30 Pneumonia (PN) 30-Day Readmission Rate – This measure estimates a hospital-level 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of pneumonia. ▪ READM-30 Chronic Obstructive Pulmonary Disease (COPD) – This measure estimates a hospital-level risk-standardized readmission rate (RSRR) for patients discharged from the hospital with either a principal diagnosis of COPD or a principal diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD.	Department of Health & Human Services Hospital Compare website for all cases for each applicable quality measure.	Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org
Immunization (IMM) measure – Immunization (IMM) process of care measure for applicable hospital discharge dates ▪ Influenza Immunization (IMM-2) – This measure is used to assess healthcare facility 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.	Critical Access Hospitals (CAH) must submit data for each of the prevention immunization process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients meeting the targets in the measure ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.0a, Discharges 10/01/15 (3Q15) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; May 2015 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org
Perinatal care (PC) – Perinatal care (PC) process of care measure for applicable hospital discharge dates	Critical Access Hospitals (CAH) must submit data for the perinatal process of care quality measure. This data includes the following information:	Specifications Manual for Joint Commission National Quality Measures, Version 2014 A1,

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Critical Access Hospital (CAH) Measures		
▪ 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.	▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients with elective deliveries ▪ Calculated rate	Discharges 01/01/15 (1Q15) through 12/31/15 (4Q15). The Joint Commission; 2015 or as updated. Measure specifications can be found on The Joint Commission website manual.jointcommission.org
Healthcare Personnel Influenza Immunization This measure is used to assess percentage of healthcare personnel who receive the influenza vaccination	Critical Access Hospitals (CAH) must submit data for the healthcare personnel influenza immunization quality measure. This data includes the following information: ▪ Denominator: Number of healthcare personnel meeting the criteria for inclusion in the quality measure. ▪ Numerator: Number of healthcare worker meeting the targets in the quality measure. ▪ Calculated rate	Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.0a, Discharges 10/01/15 (4Q15) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; May 2015 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org
Outpatient Critical Access Hospital (CAH) Measures		
Outpatient acute myocardial infarction (AMI) and chest pain measures	Critical Access Hospitals (CAH) must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain emergency department (ED)	Hospital Outpatient Quality Reporting Specifications Manual, Version 9.0, Encounter

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Critical Access Hospital (CAH) Measures		
The hospital outpatient process of care measures include the following measures related to AMI and chest pain emergency department (ED) care: ▪ Median Time to Fibrinolysis (OP-1) – This measure is used to assess the time (in minutes) from ED arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation on the electrocardiogram (ECG) performed closest to ED arrival and prior to transfer. ▪ Fibrinolytic Therapy Received Within 30 Minutes (OP-2) – This measure is used to assess the percent of ED AMI patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less. ▪ Median Time to Transfer to Another Facility for Acute Coronary Intervention – Overall Rate (OP-3a) – This measure is used to assess the median time from ED arrival to time of transfer to another facility for acute coronary intervention. ▪ Aspirin at Arrival (OP-4) – This measure is used to assess the percent of ED 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 ED arrival to ECG (performed in the ED prior to transfer) for AMI or Chest Pain patients (with Probable Cardiac Chest Pain).	care quality measures. This data includes the following information: ▪ Median number of minutes **OR** ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Dates 01/01/16 (1Q16) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS); July 2015 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org
Emergency Department (ED) – Throughput measures	Critical Access Hospitals (CAH) must submit data for each of the ED Throughput quality measures. This data includes the following information:	Hospital Outpatient Quality Reporting Specifications Manual, Version 9.0, Encounter

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Critical Access Hospital (CAH) Measures		
The hospital outpatient process of care measures include the following measures related to hospital ED care: ▪ Median Time from ED Arrival to ED Departure for Discharged ED Patients (OP-18) – This measure is used to assess the time (in minutes) from ED arrival to time of departure from the emergency room for patients discharged from the ED. ▪ Door to Diagnostic Evaluation by a Qualified Medical Professional (OP-20) – This measure is used to assess the time (in minutes) from ED arrival to provider contact for ED patients. ▪ ED-patient Left without Being Seen (OP-22) – This measure is used to assess the percent of patients who leave the ED without being evaluated by a physician/advance practice nurse/physician's assistant.	▪ Median number of minutes **OR** ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Dates 01/01/16 (1Q16) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS); July 2015 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org
Pain Management measure The hospital outpatient process of care measures include the following measure related to pain management care: ▪ ED-Median Time to Pain Management for Long Bone Fracture (LBF) (OP-21) – This measure is used to assess the time (in minutes) from ED arrival to time of initial oral, intranasal, or parenteral pain medication administration for ED patients with a principal diagnosis of LBF.	Critical Access Hospitals (CAH) must submit data for the pain management quality measure. This data includes the following information: ▪ Median number of minutes	Hospital Outpatient Quality Reporting Specifications Manual, Version 9.0, Encounter Dates 01/01/16 (1Q16) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS); July 2015 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Critical Access Hospital (CAH) Measures		
Stroke measure The hospital outpatient process of care measures include the following measure related to stroke care: ▪ Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival (OP-23) – This measure is used to assess the percent of Emergency Department (ED) Acute Ischemic Stroke or Hemorrhagic Stroke patients who arrive at the ED within 2 hours of the onset of symptoms who have a head CT or MRI scan performed during the stay and having a time from ED arrival to interpretation of the Head CT or MRI scan within 45 minutes of arrival.	Critical Access Hospitals (CAH) must submit data for each of the outpatient stroke quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients meeting the targets in the measure ▪ Calculated rate	Hospital Outpatient Quality Reporting Specifications Manual, Version 9.0, Encounter Dates 01/01/16 (1Q16) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS); July 2015 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website www.qualitynet.org
Other outpatient measures The hospital outpatient process of care measures include the following: ▪ Safe Surgery Checklist Use (OP-25) – This measure assesses the use of a Safe Surgery Checklist for surgical procedures that includes safe surgery practices during each of the three critical perioperative periods: the period prior to the administration of anesthesia, the period prior to skin incision, and the period of closure of incision and prior to the patient leaving the operating room. ▪ Influenza Vaccination Coverage among Healthcare Personnel (OP-27) – This measure assesses the percent of healthcare personnel who receive the influenza vaccination.	Critical Access Hospitals (CAH) must submit data for each of the outpatient quality measures. This data includes the following information: OP-25 ▪ Does/did your facility use a safety checklist based on accepted standards of practice? (Y/N) OP-27 ▪ Denominator: Number of healthcare personnel meeting the inclusion criteria ▪ Numerator: Number of healthcare personnel meeting the target ▪ Calculated rate	Hospital Outpatient Quality Reporting Specifications Manual, Version 9.0, Encounter Dates 01/01/16 (1Q16) through 06/30/16 (2Q16). Centers for Medicare & Medicaid Services (CMS); July 2015 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Critical Access Hospital (CAH) Measures		
Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures		
Catheter Associated Urinary Tract Infection (CAUTI) This measure assesses the number of patients with observed healthcare-associated CAUTI in bedded inpatient care locations.	Critical Access Hospitals (CAH) must submit data for the CAUTI measure. This data includes the following information: ▪ Denominator: Number of patients meeting the inclusion criteria in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate per patient day	Guidance and reporting requirements for National Healthcare Safety Network (NHSN) Quality Measures can be found on the NHSN website; April 2015 or as updated. NHSN website www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf
Care Coordination		
Emergency Department Transfer Communication composite This measure is used to assess the percent of patients transferred to another healthcare facility whose medical record documentation indicated that required information was communicated to the receiving facility prior to departure (sub 1) or within 60 minutes of transfer (sub 2-7): ▪ Administrative communication (EDTC-Sub 1) ▪ Patient information (EDTC-Sub 2) ▪ Vital signs (EDTC-Sub 3) ▪ Medication information (EDTC-Sub 4) ▪ Physician or practitioner generated information (EDTC-Sub 5)	Critical Access Hospitals (CAH) submitting summary-level data must submit the following data for the Emergency Department Transfer Communication measure and for each of the seven component measures: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR**	Emergency Department Transfer Communication Specifications, 2016 (10/01/2015 – 09/30/2016 Discharge Dates). Stratis Health; July 2015, or as updated. 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 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Critical Access Hospital (CAH) Measures		
▪ Nurse generated information (EDTC-Sub 6) ▪ Procedures and tests (EDTC-Sub 7)	Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Calculated rate	

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Prospective Payment System (PPS) Hospital and Critical Access Hospital (CAH) Measures		
Patient Experience of Care		
Patient experience of care This measure is used to assess adult patients' perception of their hospital care using a national survey called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). *(This measure is not required for hospitals with less than 500 admissions in the previous calendar year.)*	Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey	Consumer Assessment of Healthcare Providers and Systems Hospital Survey (HCAHPS), Version 10.0. Centers for Medicare & Medicaid Services (CMS); March 2015 or as updated. Measure specifications for the HCAHPS patient experience of care survey are contained in the current HCAHPS Quality Assurance Guidelines manual,

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Prospective Payment System (PPS) Hospital and Critical Access Hospital (CAH) Measures		
		which is available at the HCAHPS On-Line Web site, www.hcahpsonline.org. CMS maintains the HCAHPS technical specifications by updating the HCAHPS Quality Assurance Guidelines manual annually, and CMS includes detailed instructions on survey implementation, data collection, data submission and other relevant topics. As necessary, HCAHPS Bulletins are issued to provide notice of changes and updates to technical specifications in HCAHPS data collection systems.
Minnesota Stroke Registry Indicators		
Emergency department stroke registry indicators for applicable hospital discharge dates The emergency department stroke registry indicators include the following: ▪ Door-to-Imaging Initiated Time ▪ Time to Intravenous Thrombolytic Therapy	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 information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure	Emergency Department Stroke Registry Indicator Specifications, 2016 (07/01/2015 – 06/30/2016 Discharge Dates). Minnesota Stroke Registry; Door-to-Imaging Initiated Time; July 2015, or as updated. Minnesota Stroke Registry; Time to Intravenous Thrombolytic Therapy; July 2015, or as updated.

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Prospective Payment System (PPS) Hospital and Critical Access Hospital (CAH) Measures		
	▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Measure specifications can be found on the Minnesota Department of Health website www.health.state.mn.us/healthreform
Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI)		
Mortality for Selected Conditions composite (IQI 91) This composite is a weighted average of the mortality indicators for patients admitted for selected conditions and is used to assess the number of deaths for acute myocardial infarction, 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: ▪ 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)	All hospitals must submit data for the Mortality for Selected Conditions composite measure and for each of the mortality for selected conditions composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	AHRQ QI™ Research Version 5.0, Inpatient Quality Indicators #91, Technical Specifications, Mortality for Selected Conditions; March 2015 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/IQI_TechSpec.aspx
Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI)		

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Prospective Payment System (PPS) Hospital and Critical Access Hospital (CAH) Measures		
Death Rate among Surgical Inpatients with Serious Treatable Complications (PSI 04) – This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization.	All hospitals must submit data for the Death Rate among Surgical Inpatients with Serious Treatable Complications (PSI 04) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in each of the quality measure ▪ Calculated rate	AHRQ QI™ Research Version 5.0, Patient Safety Indicators 04, Technical Specifications, Death Rate among Surgical Inpatients with Serious Treatable Complications; March 2015 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/PSI_TechSpec.aspx
Patient Safety for Selected Indicators composite (PSI 90) This composite is a weighted average of most of the patient safety indicators and is used to assess the number of potentially preventable adverse events for pressure ulcer, iatrogenic pneumothorax, central venous catheter-related bloodstream infections, postoperative hip fracture, postoperative hemorrhage or hematoma, postoperative physiologic and metabolic derangements, postoperative respiratory failure, postoperative pulmonary embolism or deep vein thrombosis, postoperative sepsis, postoperative wound dehiscence, and accidental puncture or laceration. This composite includes the following Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators: ▪ Pressure Ulcer Rate (PSI 03) ▪ Iatrogenic Pneumothorax Rate (PSI 06)	All hospitals submit data for the Patient Safety for Selected Indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	AHRQ QI™ Research Version 5.0, Patient Safety Indicators 90, Technical Specifications, Patient Safety for Selected Indicators; March 2015 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/PSI_TechSpec.aspx

Data Required for Reporting Beginning in Calendar Year 2016 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2016 and Every Year Thereafter		
Prospective Payment System (PPS) Hospital and Critical Access Hospital (CAH) Measures		
▪ Central Venous Catheter-Related Blood Stream Infections Rate (PSI 07) ▪ Postoperative Hip Fracture Rate (PSI 08) ▪ Postoperative Hemorrhage or Hematoma Rate (PSI 09) ▪ Postoperative Physiologic and Metabolic Derangement Rate (PSI 10) ▪ Postoperative Respiratory Failure Rate (PSI 11) ▪ Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12) ▪ Postoperative Sepsis Rate (PSI 13) ▪ Postoperative Wound Dehiscence Rate (PSI 14) ▪ Accidental Puncture or Laceration Rate (PSI 15)		
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 2015	2015 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**
Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival (AMI-7a)	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction Hospitalization (MORT-30-AMI)	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure Hospitalization (MORT-30-HF)	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization (MORT-30-PN)	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges
Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (SCIP-Inf-4)	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges
Pediatric Heart Surgery Mortality (PDI 6)	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges
Pediatric Heart Surgery Volume (PDI 7)	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges
Pediatric Patient Safety for Selected Indicators (PDI 19)	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges

Removed Measures		
Measure Name and Description	**Data Elements**	**Specification Information**
Obstetric Trauma – Vaginal Delivery with Instrument (PSI 18)	Hospitals are no longer required to submit data for this measure	This measure will be removed effective with July 1, 2015 (3Q15) discharges
Obstetric Trauma – Vaginal Delivery without Instrument (PSI 19)	Hospitals are no longer required to submit data for this measure	This measure will be removed effective with July 1, 2015 (3Q15) discharges
Late Sepsis or Meningitis in Very Low Birth Weight neonates	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges
Central line-associated bloodstream infection for neonates	Hospitals are no longer required to submit data for this measure	This measure will be removed effectively with July 1, 2015 (3Q15) discharges

Appendix C

Required Ambulatory Surgical Center Quality Measure Data

Retired

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 2015, 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) 2015 Volume 2: Technical Specifications. National Committee for Quality Assurance (NCQA); 2014 or as updated
National Quality Forum (NQF) endorsed measures	All NQF-endorsed measures as of September 1, 2015, 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

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, 2016 and no later than February 10, 2016 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 2016. (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 composite measure. 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 (18-44, 45-64, 65-75), 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), age, diabetes type (Type 1, Type 2), gender, zip code. 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, 2016 and no later than February 15, 2016, 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, 2014 are required to submit data on their full patient population for this measure.)

Optimal Vascular Care composite measure. 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 (18-44, 45-64, 65-75), 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), age, gender, zip code. 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, 2016 and no later than February 15, 2016, 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, 2014 are required to submit data on their full patient population for this measure.)

Optimal Asthma Control composite measure. 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 (5-11, 12-17, 18-34, 35-50), gender, and zip code. Specifically, this includes: patient identification methodology; separation of the data by pediatric population and adult population; 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), age, gender, and zip code. 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, 2016 and no later than August 15, 2015, 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, 2014 are required to submit data on their full patient population for this measure.)

Asthma Education and Self-management. 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 (5-11, 12-17, 18-34, 35-50), gender, and zip code. Specifically, this includes: patient identification methodology; separation of the data by pediatric population and adult population; 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), age, gender, and zip code. 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, 2016 and no later than August 15, 2016, 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, 2014 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 (50-64, 65-75), 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), age, gender, and zip code. 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, 2016 and no later than August 15, 2016, 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, 2014 are required to submit data on their full patient population for this measure.)

Adolescent Mental Health and/or Depression 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 (12-17), 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), age, gender, and zip code. 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, 2016 and no later than May 15, 2016, and beginning April 1 and no later than May 15 of each subsequent

year. (NOTE: Physician clinics with electronic medical records in place since April 1, 2014 are required to submit data on their full patient population for this measure.)

Overweight Counseling. 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 (3-4, 5-11, 12-17), 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), age, gender, and zip code. 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, 2016 and no later than May 15, 2016, and beginning April 1 and no later than May 15 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since April 1, 2014 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 2016. 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.

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 2016.

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 (18-44, 45-64, 65 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), age, 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, 2016 and no later than February 28, 2016.

Cesarean 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, 18-24, 25-34, 35 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), age, gender, and zip code. 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, 2016 and no later than August 15, 2016, and beginning July 1 and no later than August 15 of each subsequent year.

Total Knee Replacement: Functional Status and Quality of Life outcome measures. 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 (18-44, 45-64, 65 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), age, body mass index, tobacco status, gender, and zip code. 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, 2016 and no later than

May 15, 2016, and beginning April 1 and no later than May 15 of each subsequent year.

Spinal Surgery: Lumbar Fusion Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures. 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 (18-44, 45-64, 65 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), age, body mass index, tobacco status, gender, and zip code. 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, 2016 and no later than May 15, 2016, and beginning April 1 and no later than May 15 of each subsequent year.

Spinal Surgery: Lumbar Discectomy Laminotomy Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures. 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 (18-44, 45-64, 65 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), age, body mass index, tobacco status, gender, and zip code. 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, 2016 and no later than

May 15, 2016, 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, 2016 and no later than March 15, 2016, 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 select a CMS-certified vendor of its choice. The survey period includes patients seen September 1, 2016 through November 30, 2016.

II. Submission Requirements for Hospitals

1. **Data Submission for Centers for Medicare & Medicaid Services' (CMS) Value-Based Purchasing programs.** Each Prospective Payment System (PPS) hospital must submit the data described in Appendix B required to calculate the applicable quality measures. There are two ways PPS hospitals may satisfy this requirement:

    a. **Submission to the Centers for Medicare & Medicaid Services (CMS).** If a PPS 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 its 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 PPS hospital does not submit data for these quality measures to CMS, the hospital must submit data to the commissioner or the commissioner's designee by January 31, 2016.

        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.

[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.

2. **Data Submission for Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Medicare Beneficiary Quality Improvement Project Quality Measures.** Each Critical Access Hospital (CAH) must submit the data described in Appendix B required to calculate the applicable quality measures. There are two ways CAHs may satisfy this requirement:

   a. **Submission to the Centers for Medicare & Medicaid Services (CMS).** If a CAH 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 its 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 CAH 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, 2015: July 1 – September 30	February 15, 2016
Fourth Quarter, 2015: October 1 – December 31	May 15, 2016
First Quarter, 2016: January 1 – March 31	August 15, 2016
Second Quarter, 2016: April 1 – June 30	November 15, 2016

Outpatient Quality Measures

Discharge Dates	Data Submission Deadline
Third Quarter, 2015: July 1 – September 30	February 1, 2016
Fourth Quarter, 2015: October 1 – December 31	May 1, 2016
First Quarter, 2016: January 1 – March 31	August 1, 2016
Second Quarter, 2016: April 1 – June 30	November 1, 2016

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.

3. **Data Submission for the Centers for Disease Control and Prevention (CDC) /National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures.** Each Critical Access Hospital (CAH) 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 its 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, 2015: July 1 – September 30	February 15, 2016
Fourth Quarter, 2015: October 1 – December 31	May 15, 2016
First Quarter, 2016: January 1 – March 31	August 15, 2016
Second Quarter, 2016: April 1 – June 30	November 15, 2016

i. **Data collection and analysis.**

1. Hospitals must submit data to the CDC through the NHSN according to NHSN definitions 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.

4. **Data Submission for Emergency 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
Fourth Quarter, 2015: October 1 – December 31	January 31, 2016
First Quarter, 2016: January 1 – March 31	April 30, 2016
Second Quarter, 2016: April 1 – June 30	July 31, 2016
Third Quarter, 2016: July 1 – September 30	October 31, 2016

   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.

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

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

Discharge Dates	Data Submission Deadline
Third Quarter, 2015: July 1 – September 30	February 15, 2016
Fourth Quarter, 2015: October 1 – December 31	May 15, 2016
First Quarter, 2016: January 1 – March 31	August 15, 2016
Second Quarter, 2016: April 1 – June 30	November 15, 2016

   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 its 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 its 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).

7. Data Submission for Inpatient Quality Indicators (IQI) and Patient Safety Indicators (PSI), 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
All 2015 Dates of Service	April 30, 2016

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 5.0, 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 5.0, 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.

8. Health information technology (HIT) survey. Each hospital must complete the survey available annually from the commissioner or commissioner's designee in calendar year 2016 and each subsequent year.

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