DATE: **June 15, 2012**

RE: **2013 Final Recommendations**
Physician Clinics, Ambulatory Surgical Centers, and Hospitals
Statewide Quality Reporting and Measurement System

The attached table summarizes MN Community Measurement's (MNCM's) final recommendations to the Minnesota Department of Health (MDH) for physician clinic, ambulatory surgical center, and hospital measures for the 2013 Statewide Quality Reporting and Measurement System. These recommendations were reviewed and approved by MNCM's Measurement and Reporting Committee.

Key proposed changes for the 2013 Statewide Quality Reporting and Measurement System as compared with the 2012 Statewide Quality Reporting and Measurement System include the following:

- The removal of Ischemic Vascular Disease and Diabetes as factors of comorbidity for risk adjustment of the Optimal Diabetes Care (ODC) and Optimal Vascular Care (OVC) measures, respectively; and
- The addition of a new Spine Surgery measure.

All proposed changes are highlighted in yellow in the attached tables.

In its preliminary recommendations to the state, MNCM had included the addition of depression as a factor of comorbidity for risk adjustment of the ODC and OVC measures; however, in its final set of recommendations, MNCM withdrew that component.

MDH invites interested stakeholders to review and comment on MNCM's final recommendations for physician clinic, ambulatory surgical center, and hospital measures for the 2013 Statewide Quality Reporting and Measurement System. Please send your comments to health.reform@state.mn.us through June 29.

Additionally, MDH and MNCM will hold a **public forum in St. Paul on June 27**, to present MNCM's final quality measure recommendations in connection with the annual update of the Statewide Quality Reporting and Measurement System. MNCM will also present its measure concept recommendations for development of new measures related to Spine Surgery. The public forum will include an opportunity for interested stakeholders to comment on the recommendations and to ask questions.

MDH will consider all public comments during the development of the proposed rule for the 2013 Statewide Quality Reporting and Measurement System. The proposed rule will be published in August.

Public Forum Information:
June 27, 2012
10:00 – 12:00 a.m.
Snelling Office Park –
Mississippi Room
Minnesota Department of Health
1645 Energy Park Drive
St. Paul, MN 55108
Directions:
http://www.health.state.mn.us/about/sop.html

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Physician Clinics**
2013 Report Year

Existing measures

Measure	Eligible providers	Collection date / dates of service	Data elements	Risk adjustment
Optimal Diabetes Care (ODC) • HbA1c (less than 8 percent) • Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use if patient has diagnosis of IVD (or valid contraindication to aspirin) • Documented tobacco free	• Family medicine (includes General practice) • Internal medicine • Geriatric medicine • Endocrinology	Collecting January 1, 2013 on calendar 2012 dates of service	• Adults age 18 to 75 • Seen by an eligible provider in an eligible specialty face-to-face at least two times during the prior 2 years with visits coded with a diabetes ICD-9 code • Seen by an eligible provider in an eligible specialty face-to-face at least one time during the prior 12 months for any reason	Insurance product type: • Commercial • Medicare • MN Government Programs and Self-pay / Uninsured ~~Ischemic Vascular Disease co-morbidity~~
Optimal Vascular Care (OVC) • Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use or contraindication to aspirin • Documented tobacco free	• Family medicine (includes General practice) • Internal medicine • Geriatric medicine • Cardiology	Collecting January 1, 2013 on calendar 2012 dates of service	• Adults age 18 to 75 • Seen by an eligible provider in an eligible specialty face-to-face at least two times during the prior 2 years with visits coded with an ischemic vascular disease ICD-9 code • Seen by an eligible provider in an eligible specialty face-to-face at least one time during the prior 12 months for any reason	Insurance product type: • Commercial • Medicare • MN Government Programs and Self-pay / Uninsured ~~Diabetes co-morbidity~~
Depression Remission at 6 Months • Patients with major depression or dysthymia and an initial PHQ-9 score > 9 whose PHQ-9 score at 6 months (+/- 30 days) is less than 5	• Family Medicine (includes General practice) • Internal medicine • Geriatric medicine • Psychiatry • Licensed behavioral health (if physician on site)	Collecting January 1, 2013 on calendar 2012 dates of service	• Adults age 18 and older • Patient visits or contacts during the measurement period with Diagnosis of Major Depression or Dysthymia • Initial PHQ-9 score is > 9	Insurance product type: • Commercial • Medicare • MN Government Programs and Self-pay / Uninsured Initial PHQ-9 severity bands

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Physician Clinics**
2013 Report Year

Measure	Eligible providers	Collection date / dates of service	Data elements	Risk adjustment
Optimal Asthma Care • Asthma is well controlled (asthma control tool/test results indicate control) • Patient is not at risk for future exacerbations (patient reports less than two total emergency department visits and hospitalizations during previous 12 months) • Patient has been educated about asthma and has a current written asthma management plan containing information on medication doses and effects, what to do during an exacerbation, and information on the patient's triggers (written/reviewed within the measurement period)	• Family medicine (includes General practice) • Internal medicine • Pediatrics • Allergy / Immunology • Pulmonology	Collecting July 1, 2013 on dates of service: July 1, 2012 – June 30, 2013	• Patient ages 5-17 • Patient ages 18-50 • Seen by an eligible provider in an eligible specialty face-to-face at least two times during the prior 2 years with visits coded with an asthma ICD-9 code • Seen by an eligible provider in an eligible specialty face-to-face at least one time during the prior 12 months for any reason	Insurance product type: • Commercial • Medicare • MN Government Programs and Self-pay / Uninsured
Colorectal Cancer Screening • Patient is current with colorectal cancer screening (allowable screens: colonoscopy within 10 years, sigmoidoscopy within 5 years, FOBT or FIT within the reporting period)	• Family medicine (includes General practice) • Internal medicine • Geriatric medicine • Obstetrics / Gynecology	Collecting July 1, 2013 on dates of service: July 1, 2012 – June 30, 2013	• Adults age 50-75 • Seen by an eligible provider in an eligible specialty face-to-face at least two times during the prior 2 years for any reason • Seen by an eligible provider in an eligible specialty face-to-face at least one time during the prior 12 months for any reason	Insurance product type: • Commercial • Medicare • MN Government Programs and Self-pay / Uninsured
Health Information Technology Survey • Survey topics cover adoption of HIT, use of HIT, exchange of information, and on-line services	All specialties	Collecting February 15 – March 15, 2013 on current HIT status	Clinic-level survey	Not applicable – data reported as descriptive statistics only

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Physician Clinics**
2013 Report Year

Measure	Eligible providers	Collection date / dates of service	Data elements	Risk adjustment
Patient Experience of Care • Survey topics cover getting care when needed/access to care, communication, helpfulness of office staff, and doctors with an exceptional rating	All specialties except Psychiatry and Pediatric / Adolescent medicine *Clinic sites with fewer than 715 unique patients visiting the clinic during 09/01/11 through 11/30/11 are not required to conduct the survey or submit survey results*	Collecting February – April 2013 on dates of service to survey: September 1 – November 30, 2012 Sample should achieve a minimum of 250 responses *Measure will be required every other year*	All patients ages 18 and older with a face-to-face visit at the clinic during the timeframe, are eligible for inclusion in the survey regardless of: • Physician specialty • Reason for visit • Duration of patient/physician relationship	Survey responses to: • Self-reported health status • Age • Education
Maternity Care: Primary C-Section Rate • Percentage of cesarean deliveries for first births	• Family medicine (includes General practice) • ~~Internal medicine~~ • Obstetrics / Gynecology • Perinatology	Collecting July 1, 2013 on dates of service: July 1, 2012 – June 30, 2013	All live, singleton deliveries to nulliparous women performed by a medical clinic site, including all cesarean and all vaginal deliveries	Insurance product type: • Commercial • Medicare • MN Government Programs and Self-pay / Uninsured
Total Knee Replacement • Average post-operative functional status improvement at 1 year post-operatively measured by the Oxford Knee Score tool • Average post-operative quality of life improvement at 1 year post-operatively measured using the EQ-5D tool	• Orthopedic surgery	Collecting April 1, 2014 on dates of service: January 1, 2012 through December 31, 2012 *The collection date allows for a 1 year (± 3 months) post-operative follow up period*	Adult patients age 18 and older with no upper age limit undergoing a primary total knee replacement or a revision total knee replacement during the required dates of service	• TBD *This measure is currently undergoing pilot testing; risk adjusters will be determined after the conclusion of the pilot in May 2013*

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Physician Clinics**
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NEW measure

Measure	Eligible providers	Collection date / dates of service	Data elements	Risk adjustment
Spine Surgery Lumbar discectomy/ laminotomy: • Average change in post-operative functional status improvement at 3 months post operatively for patients undergoing discectomy/ laminotomy with a diagnosis of disc herniation as measured by the following functional status tools: Oswestry Disability Index (ODI), Visual analog pain scale (VAS), EQ5D self-reported health status, and/or EQ5D health status index Lumbar spinal fusion: • Average change in post-operative functional status improvement at 1 year post operatively for patients undergoing any level of lumbar spinal fusion as measured by the following functional status tools: ODI, VAS, EQ5D self-reported health status, and/or EQ5D health status index	• Orthopedic surgery • Neurosurgery	Collecting April 1, 2015 on dates of service: January 1, 2013 through December 31, 2013	Lumbar discectomy/laminotomy: • Adult patients age 18 and older with no upper age limit undergoing a lumbar discectomy/laminotomy procedure for a diagnosis of disc herniation with the date of procedure occurring within a fixed measurement period Lumbar spinal fusion: • Adult patients age 18 and older with no upper age limit undergoing any level of lumbar spinal fusion with a date of procedure occurring with a fixed measurement period	• TBD *This measure is currently undergoing pilot testing; risk adjusters will be determined after the conclusion of the pilot in February 2014*

Existing measures

Measure	Eligible providers	Collection date / dates of service	Data elements	Risk adjustment
Prophylactic Intravenous (IV) Antibiotic Timing	Freestanding ambulatory surgical centers (ASC)	Collecting July 1, 2013 on dates of service: July 1, 2012 – June 30, 2013	Numerator • Number of ASC admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection, who received the prophylactic antibiotic on time (within 1 hour prior to the time of the initial surgical incision or the beginning of the procedure or 2 hours prior if vancomycin or fluoroquinolones are administered). Denominator • All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection	N/A
Hospital Transfer/Admission	Freestanding ambulatory surgical centers (ASC)	Collecting July 1, 2013 on dates of service: July 1, 2012 – June 30, 2013	Numerator • ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC Denominator • All ASC admissions	American Society of Anesthesiologists (ASA) Physical Status classification categories • Physical status -1 • Physical status -2 • Physical status -3
Appropriate Surgical Site Hair Removal	Freestanding ambulatory surgical centers (ASC)	Collecting July 1, 2013 on dates of service: July 1, 2012 – June 30, 2013	Numerator • ASC admissions with surgical site hair removal with clippers or depilatory cream Denominator • All ASC admissions with surgical site hair removal	N/A

Existing measures

CMS measures	Collection date / Dates of service	Data elements
Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates • Aspirin prescribed at discharge (AMI-2) • Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a) • Primary PCI received within 90 minutes of hospital arrival (AMI-8a) • Appropriate Care Measure (percent of patients that met ALL heart attack process of care measures, if eligible)	(CMS schedule) / DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All heart failure (HF) process of care measures for applicable hospital discharge dates • Discharge instructions (HF-1) • Evaluation of LVS function (HF-2) • ACEI or ARB for LVSD (HF-3) • Appropriate Care Measure (percent of patients that met ALL heart failure process of care measures, if eligible)	(CMS schedule) / DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

CMS measures	Collection date / Dates of service	Data elements
Pneumonia (PN) process of care measures for applicable hospital discharge dates • Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN-3b) • Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (PN-6) • Appropriate Care Measure (percent of patients that met ALL pneumonia process of care measures, if eligible)	(CMS schedule) / DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the hospital compare pneumonia process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All surgical care improvement project (SCIP) process of care measures for applicable hospital discharge dates • Prophylactic antibiotic received within one hour prior to surgical incision * (SCIP-Inf-1) • Prophylactic antibiotic selection for surgical patients (SCIPInf-2) • Prophylactic antibiotics discontinued within 24 hours after surgery end time * (SCIP-Inf-3) • Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (SCIP-Inf-4) • Urinary catheter removed on postoperative day 1 or postoperative day 2 with day surgery being day zero (SCIP-Inf-9) • Surgery patients with perioperative temperature management (SCIP-Inf-10) • Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period (SCIP-Card-2) • Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1) • Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2)	(CMS schedule) / DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the hospital compare surgical care improvement project (SCIP) process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

CMS measures	**Collection date / Dates of service**	**Data elements**
Outpatient acute myocardial infarction (AMI) and chest pain Measures. The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: • Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2) • Median time to transfer to another facility for acute coronary intervention (OP-3) • Aspirin at arrival (OP-4) • Median time to ECG (OP-5) • Troponin results for Emergency Department AMI patients or chest pain patients received within 60 minutes of arrival (OP-16)	(CMS schedule) / DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Outpatient surgery department measures The hospital outpatient process of care measures include the following measures related to hospital outpatient surgery care: • Timing of antibiotic prophylaxis (OP-6) • Prophylactic antibiotic selection for surgical patients (OP-7)	(CMS schedule) / DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the outpatient surgery department quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All ED throughput process of care measures for applicable hospital discharge dates • Median time from ED arrival to ED departure for admitted ED patients (ED-1) • Median time from admit decision time to ED departure time for admitted patients (ED-2)	(CMS Schedule)/DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the emergency room throughput quality measures. This data includes the following information: • Number of minutes for defined steps in patient flow.

CMS measures	Collection date / Dates of service	Data elements
All prevention global immunization process of care measures for applicable hospital discharge dates • Pneumococcal immunization-overall rate (Prev-Imm-1a) • Influenza immunization-overall rate (Prev-Imm-2a)	(CMS Schedule)/DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the inpatient prevention global immunization quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates • Statin prescribed at discharge (AMI-10)	(CMS Schedule)/DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
PPS only: All mortality outcome of care measures for applicable hospital discharge dates • Acute myocardial infarction (AMI) 30-day mortality rate (MORT-30-AMI) • Heart failure (HF) 30-day mortality rate (MORT-30-HF) • Mortality pneumonia (PN) 30-day mortality rate(MORT-30-PN)	(CMS Schedule)/DOS July 1, 2009 to June 30, 2012 reported in April 2013	CMS calculates using claims data. 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

Existing measures

AHRQ measures	Collection date / Dates of service	Data elements
Abdominal aortic aneurysm (AAA) repair volume (IQI 4) – This measure is used to assess the raw volume of provider-level abdominal aortic aneurysm (AAA) repair (surgical procedure).	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the abdominal aortic aneurysm (AAA) repair volume (IQI 4) quality measure. This data includes the following information: • Volume
Abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) – This measure is used to assess the number of deaths per 100 discharges with procedure code of abdominal aortic aneurysm (AAA) repair.	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Coronary artery bypass graft (CABG) volume (IQI 5) – This measure is used to assess the raw volume of provider-level coronary artery bypass graft (CABG) (surgical procedure).	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the coronary artery bypass graft (CABG) volume (IQI 5) quality measure. This data includes the following information: • Volume
Coronary artery bypass graft (CABG) mortality rate (IQI 12) – This measure is used to assess the number of deaths per 100 discharges with a procedure code of coronary artery bypass graft (CABG).	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the coronary artery bypass graft (CABG) mortality rate (IQI 12) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

AHRQ measures	**Collection date / Dates of service**	**Data elements**
Percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) – This measure is used to assess the raw volume of provider level percutaneous transluminal coronary angioplasty (PTCA) (surgical procedure).	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) quality measure. This data includes the following information: • Volume
Percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) – This measure is used to assess the number of deaths per 100 percutaneous transluminal coronary angioplasties (PTCAs).	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Hip fracture mortality rate (IQI 19) – This measure is used to assess the number of deaths per 100 discharges with principal diagnosis code of hip fracture.	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the hip fracture mortality rate (IQI 19) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

AHRQ measures	**Collection date / Dates of service**	**Data elements**
Pressure ulcer (PSI 3) – This measure is used to assess the number of cases of decubitus ulcer per 1,000 discharges with a length of stay greater than 4 days.	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the pressure ulcer (PSI 3) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Death among surgical inpatients with serious treatable complications (PSI 4) – This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization.	DOS 4th Quarter 2011 through 3rd quarter 2012	Hospitals must submit data for the death among surgical inpatients with serious treatable complications (PSI 4) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in each of the quality measure • Calculated rate
Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) – This measure is used to assess the number of cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 1,000 surgical discharges with an operating room procedure.	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

AHRQ measures	**Collection date / Dates of service**	**Data elements**
Obstetric trauma – vaginal delivery with instrument (PSI 18) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries.	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Obstetric trauma – vaginal delivery without instrument (PSI 19) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 without instrument assistance.	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

AHRQ measures	**Collection date / Dates of service**	**Data elements**
Mortality for selected conditions composite measure. This composite measure includes the 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 (CHF) mortality rate (IQI 16) • Acute stroke mortality rate (IQI 17) • GI Hemorrhage mortality rate (IQI 18) • Hip fracture mortality rate (IQI 19) • Pneumonia mortality rate (IQI 20)	DOS 4th Quarter 2011 through 3rd quarter 2013	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
Patient safety for selected indicators composite measure. This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Pressure ulcer (PSI 3) • Iatrogenic pneumothorax (PSI 6) • Selected infections due to medical care (PSI 7) • Postoperative hip fracture (PSI 8) • Postoperative hemorrhage or hematoma (PSI 9) • Postoperative physiological and metabolic derangements (PSI 10) • Postoperative respiratory failure (PSI 11) • Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) • Postoperative sepsis (PSI 13) • Postoperative wound dehiscence (PSI 14) • Accidental puncture or laceration (PSI 15)	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the patient safety for selected indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

AHRQ measures	**Collection date / Dates of service**	**Data elements**
Pediatric patient safety for selected indicators composite measure. This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Accidental puncture or laceration (PDI 1) • Pressure ulcer (PDI 2) • Iatrogenic pneumothorax (PDI 5) • Postoperative hemorrhage or hematoma (PDI 8) • Postoperative respiratory failure (PDI 9) • Postoperative sepsis (PDI 10) • Postoperative wound dehiscence (PDI 11) • Selected infections due to medical care (PDI 12)	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the pediatric patient safety for selected indicators composite measure and for each of the pediatric patient safety for selected indicators composite measure component indicators. This data includes the following information: • 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
Pediatric Heart Surgery Volume measure. (PDI 7) This measures the number of in-hospital congenital heart surgeries for pediatric patients.	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the pediatric patient for selected indicators: Volume: Pediatric patients undergoing surgery for congenital heart disease
Pediatric Heart Surgery Mortality Rate measure (PDI 6) This measures the number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: Pediatric patients undergoing surgery for congenital heart disease • Numerator: Number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease • Calculated rate

AHRQ measures	**Collection date / Dates of service**	**Data elements**
Central Venous Catheter-related Bloodstream Infections (PDI 12) This measures the number of patients with specific infection codes per 1,000 eligible admissions (population at risk).	DOS 4th Quarter 2011 through 3rd quarter 2013	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: All medical and surgical patients (defined by DRG), age 0-17 years • Numerator: Other infection (Infection, sepsis or septicemia following infusion, injection, transfusion, or vaccination) and Infection and inflammatory reaction due to other vascular device, implant, and graft • Calculated rate

Existing measures

Other measures	Collection date / Dates of service	Data elements
Home Management Plan of Care Given to Patient/Caregiver for Pediatric Asthma (Joint Commission CAC-3) Measures the number of pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care (HMPC) document *Specification information:* Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.0. Centers for Medicare and Medicaid Services (CMS), The Joint Commission	DOS ending 3rd Quarter 2013	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: Pediatric asthma inpatients (ages 2-17) discharged home • Numerator: Pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care (HMPC) document that addresses **all** of the following: 1. Arrangements for follow-up care 2. Environmental control and control of other triggers 3. Method and timing of rescue actions 4. Use of controllers 5. Use of relievers • Calculated rate
Late Sepsis or Meningitis in Neonates (Vermont Oxford Network) Measures the infection rate for inborn and outborn infants meeting certain age and weight requirements. *Specification information:* Late Sepsis or Meningitis in Very Low Birth Weight Neonates Specifications: Vermont Oxford Network	September 2013	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: inborn and outborn infants meeting criteria (see full specifications) • Numerator: Infection criteria (see full specifications) • Calculated rate

Other measures	**Collection date / Dates of service**	**Data elements**
Central line-associated bloodstream infection (CLABSI) event This measure is used to assess the infection rate of patients with a central line-associated bloodstream infection (CLABSI) event by inpatient hospital unit. *Specification information:* Central Line-Associated Bloodstream Infection (CLABSI) Event Specifications: Center for Disease Control and Prevention	2013	Hospitals with neonatal intensive care unit (NICU) and/or a pediatric intensive care unit (PICU) must submit data for the central line-associated bloodstream infection (CLABSI) event by neonatal and pediatric intensive care units. This data includes the following information for each intensive care unit: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure. • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate.
Patient experience – This measure is used to assess 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)*	2013	Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey
Health Information Technology (HIT) This survey is used to assess ***a hospital's*** adoption and use of Health Information Technology (HIT) in ***its*** clinical practice. *Specification information:* 2012 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C. with MN-Specific Additional Questions	May 2013	Survey

Other Measures	**Collection Date / Dates of Service**	**Data Elements**
All ED throughput process of care measures for applicable hospital discharge dates ED Measure: Transfer Communication • Administrative communication (NQF 0291) • Vital signs (NQF 0292) • Medication information(NQF 0293) • Patient information(NQF 0294) • Physician information(NQF 0295) • Nursing information(NQF 0296) • Procedures and tests(NQF 0297) *Specification information:* Transfer Communication Measure Specifications, University of Minnesota Rural Health Research Center	DOS ending 3rd Quarter 2013	Hospitals must submit data for each of the transfer communication quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All ED/inpatient stroke registry process of care measures for applicable hospital discharge dates • Documentation that NIH stroke scale performed in initial evaluation *Specification information:* Emergency Department Stroke Registry Process of Care Indicator Specifications, Minnesota Stroke Registry	DOS ending 3rd Quarter 2013	Hospitals must submit data for patients discharge from the emergency department or inpatient with diagnosis of ischemic stroke, subarachnoid hemorrhage, intracerebral hemorrhage, ill defined stroke (MN Stroke Registry specifications). 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

Other Measures	**Collection Date / Dates of Service**	**Data Elements**
All ED/ inpatient stroke registry process of care measures for applicable hospital discharge dates • Door-to-imaging performed time *Specification information:* Emergency Department Stroke Registry Process of Care Indicator Specifications, Minnesota Stroke Registry	DOS ending 3rd Quarter 2013	Hospitals must submit data for patients discharge from the emergency department or inpatient with diagnosis of ischemic stroke, subarachnoid hemorrhage, intracerebral hemorrhage, ill defined stroke (MN Stroke Registry specifications). This data includes the following information: • Number of minutes for defined steps in patient flow.

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Hospitals**
2013 Report Year

Submission Deadlines for Hospitals

Data Submission for Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Measures

Inpatient Quality Measures
Discharge Dates; Data Submission Deadline
Third Quarter, 2012: July 1 – September 30; February 15, 2013
Fourth Quarter, 2012: October 1 – December 31; May 15, 2013
First Quarter, 2013: January 1 – March 31; August 15, 2013
Second Quarter, 2013: April 1 – June 30; November 15, 2013

Outpatient Quality Measures
Discharge Dates Data Submission Deadline
Third Quarter, 2012: July 1 – September 30; February 1, 2013
Fourth Quarter, 2012: October 1 – December 31; May 1, 2013
First Quarter, 2013: January 1 – March 31; August 1, 2013
Second Quarter, 2013: April 1 – June 30; November 1, 2013

Appropriate Care Measures (ACM)
Discharge Dates Data Submission Deadline
Third Quarter, 2012: July 1 – September 30; February 15, 2013
Fourth Quarter, 2012: October 1 – December 31; May 15, 2013
First Quarter, 2013: January 1 – March 31; August 15, 2013
Second Quarter, 2013: April 1 – June 30; November 15, 2013

Data Submission for Inpatient Quality Indicators (IQI), Patient Safety Indicators (PSI), and Pediatric Patient Safety Indicators (PDI), Agency for Healthcare Research and Quality

Discharge Dates; Data Submission Deadline
Third Quarter, 2012: July 1 – September 30; January 28, 2013
Fourth Quarter, 2012: October 1 – December 31; April 29, 2013
First Quarter, 2013: January 1 – March 31; July 23, 2013
Second Quarter, 2013: April 1 – June 30; October 22, 2013

Data Submission for Vermont Oxford Network (VON)

Discharge Dates: Data Submission Deadline
All 2012 Dates of Service June 30, 2013

Data Submission for the Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures

Event Dates; Data Submission Deadline
Third Quarter, 2012: July 1 – September 30; February 15, 2013
Fourth Quarter, 2012: October 1 – December 31; May 15, 2013
First Quarter, 2013: January 1 – March 31; August 15, 2013
Second Quarter, 2013: April 1 – June 30; November 15, 2013

Data Submission for Minnesota Stroke Registry Indicators

Discharge Dates Data; Submission Deadline
Third Quarter, 2012: July 1 – September 30; February 15, 2013
Fourth Quarter, 2012: October 1 – December 31; May 15, 2013
First Quarter, 2013: January 1 – March 31; August 15, 2013
Second Quarter, 2013: April 1 – June 30; November 15, 2013

Data Submission for Emergency Department (ED) Transfer Communication Measures

Discharge Dates Data; Submission Deadline
Third Quarter, 2012: July 1 – September 30; February 15, 2013
Fourth Quarter, 2012: October 1 – December 31; May 15, 2013
First Quarter, 2013: January 1 – March 31; August 15, 2013
Second Quarter, 2013: April 1 – June 30; November 15, 2013