Recommendations for 2017 SQRMS Hospital Measures Reporting April 1, 2016

Contact: Vicki Olson, Program Manager, Stratis Health
volson@stratishealth.org, 952-853-8554

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This material was prepared by Stratis Health under a contract with MN Community Measurement through funding from the Minnesota Department of Health.

Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

SQRMS (Statewide Quality Reporting and Measurement System) Hospital Measures: Recommendation Process and Recommendations

Stratis Health, under contract with Minnesota Community Measurement, convened the Hospital Quality Reporting Steering Committee (HQRSC) for one meeting, via conference call, on March 18, 2016 to consider and make recommendations for 2017 hospital SRQMS reporting. The committee charter was updated for the 2016-17 measurement cycle. Membership from 2014-2015 largely stayed the same, with the exception of two retirements, which has allowed for continuity from year-to-year.

In the prior year, the HQRSC recommended a shift in approach to hospital SQRMS reporting to align SQRMS measures with the measures contained in the CMS value-based purchasing program, readmission reduction program, hospital acquired condition program for PPS hospitals, and to report a composite measure for each of the three programs. For critical access hospitals (CAHs), last year the HQRSC recommended aligning SQRMS with the measures for the federal Medicare Beneficiary Quality Improvement Program (MBQIP). The Committee continued to endorse this approach for the 2017 hospital slate of measures, and no measure additions or removals were recommended. The Committee also considered Minnesota-specific measures currently in SQRMS, and recommended continuing those measures for 2017.

2016 Hospital Measures Recommendations for 2017 Reporting

PPS (Prospective Payment System) Hospitals

The Committee voted to recommend continued alignment of the SQRMS hospital measures with the three CMS composite measures. There were no measure changes to consider; however, the Committee voted to recommend revising SQRMS measure specifications to align with the CMS measures:

- Value-based purchasing program (VBP)
- Readmission reduction program (RRP)
- Hospital acquired condition (HAC) reduction program

These composite measures were recommended to be continued for SQRMS, with updated specification changes to reflect the Center for Medicare and Medicaid Services 2017 fiscal year.

CAHs (Critical Access Hospitals)

The Committee voted to recommend continued alignment of the SQRMS hospital measures with the measures in the Medicare Beneficiary Quality Improvement Program (MBQIP). No measures were added or removed. There were a number of changes made last year that are still in the implementation phase. It is anticipated that OP-4 and OP-18 will be added to the core measures set by HRSA, and since these are currently included in our slate of measures for critical access hospitals, Minnesota hospitals are well-situated for that change.

Minnesota-Specific Measures for All Hospitals

The steering committee voted to recommend continuing the current slate of Minnesota-specific measures that are part of SQRMS for all hospitals. One modification in specifications was recommended to align the populations covered by CMS' OP-23 measure and the MN Stoke Registry measure, Door to Imaging. Hemorrhagic stroke patients will be added to the MN Stroke Registry measure.

Development of a Patient Safety Composite

In keeping with a recommendation and plan developed last year, the HQRSC intends in 2016 and 2017 to focus resources on the development of a patient safety composite.

2016 Goal: To address criteria for measure inclusion in an index, measure selection, measure weighting, determining validity and reliability, and preliminary planning for data repository and reporting. (In 2017, the workgroup will focus on data analytics and testing of the index or composite, and consider how a composite could be flexible, to adapt as available measures change, and to incorporate newly developed measures.)

Proposed Workgroup Meeting Schedule: (Stratis Health and MNCM would provide as much support, information gathering, and materials preparation as resource allow.)

- A 30-minute kick-off and orientation call
- Two 2-hour in-person meetings focused on measure criteria and measure selection
- One 2-hour in-person meeting focused on the technical plan (measure weighting and composite calculation, validity and reliability, data repository and reporting)
- A 30-minute call to prepare to present to the full Hospital Quality Reporting Steering Committee
- Some review of materials or other "homework" between meetings

The proposed timeframe for this work was August through December 2016 but based on the Committee's feedback, the timeframe will be moved up to start in May/June.

Statewide Quality Reporting and Measurement System
Hospital Quality Reporting Steering Committee Meeting
Date: March 18, 2016, 11:00-12:00 Conference call (open to public)

Members present:
Peter Benner; Marie Dotseth; Kathy Geier; Vickie Haverkamp; Jennifer Lundblad (facilitator); Steve Meisel; Vicki Tang Olson (facilitator); Carolyn Pare; Hugh Renier; Britney Rosenau; Shaina Witt
Ex-officio members present:
David Hesse; Denise McCabe; Mark Sonneborn; Dina Wellbrock; Anne McGeary Snowden
Not present:
Judy Bernhardt; Demeka Campbell; Darrell Carter; Laurie Drill-Mellum; Larry Lee; John Kvasnicka; Mary Mayer; Tammy Suchy

Topic	Discussion/Decision	Follow-up: Who/What/When
Welcome and introductions	**Meeting Goals:** • Provide an overview of 2016-2017 committee charge • Review and take action on 2016 draft recommendations for SQRMS hospital measures for 2017 reporting • Identify next steps for advancing a patient safety composite measure Jennifer Lundblad reviewed the committee charge and completed the roll call	

Topic	Discussion/Decision	Follow-up: Who/What/When
	Supporting materials: • Hospital Quality Reporting Steering Committee - Committee Charge 2016-2017	
Review and endorse updated alignment of SQRMS measures to federal programs: Value-Based Purchasing (VBP) measures, Readmissions Reduction Program (RRP) measures, Hospital Acquired Conditions (HAC) measures, and Medicare Beneficiary Quality Improvement Project (MBQIP) measures	PPS (Prospective Payment System) Hospitals: Jennifer Lundblad reviewed the overview document of reporting and incentive programs, and the recommendation made last year by the HQRSC to focus SQRMS hospital reporting on the three CMS incentive programs and use of these results as composite measures for PPS hospitals. No changes in measures were recommended. The Committee voted unanimously to update SQRMS specifications to align with CMS FY2017 incentive programs. The comment was made that these measures reflect historical, not current performance and it would be helpful to be looking forward with those measures included in the composite. CAH (Critical Access Hospitals): For CAHs, the alignment sought is with HRSA's MBQIP (Medicare Beneficiary Quality Improvement Program). No measure changes were recommended, since new measures from last year are just beginning their implementation cycle so there is not experience with the measures or initial results to review. The Committee voted unanimously to continue the current slate of MBQIP measures which continues to align CAHs with HRSA's MBQIP. Supporting materials:	The VBP, RRP and HAC composite measure specification changes were recommended for PPS hospitals for 2017 SQRMS reporting. The suggestion of how to help hospitals look ahead and preview coming measures and our performance on those measures will be referred to Stratis Health's Quality Innovation Network VBP Advisory Committee in Minnesota. The MBQIP measures were recommended for 2017 reporting.

Topic	Discussion/Decision	Follow-up: Who/What/When
	• Quality Reporting and Value-Based Purchasing: National and Minnesota • 2017 Value-based Purchasing Specifications • 2017 Hospital Acquired Conditions Program Specifications • 2017 Readmission Reduction Program Specifications • MBQIP Quality Domains	
Update on final rule for Minnesota-specific SQRMS measures for 2016 reporting and discussion of 2017 recommendations	David Hesse from MDH reviewed the changes made in the hospital slate of measures after the HQRSC recommendation from last year. Changes included the PSI 4, PSI 90 and IQI 90 AHRQ indicators and the two MN stroke measures. Vicki Olson shared the recommendation from the MN Stroke Registry leadership to modify the specifications for population for the Door to Imaging measure to include hemorrhagic stroke patients, which will more closely align with the population used for CMS' OP-23 measure. The difference between the Minnesota and the remaining CMS measures does cause some additional data collection burden although the volume is not high. A question was asked about where SQRMS measures are publically reported, and comment made that it makes a difference to an hospital/health system if measures are available to the public. If not, it impacts the decisions around collecting additional measures. The ED Transfer Communication and the MN Stroke measures are two examples where the measures are not available on Hospital Compare and not currently reported by the state.	The Minnesota-specific measures were recommended for 2017 reporting. Al Tsai from MDH shared that there is a plan to share stroke measure performance on the MDH website.

Topic	Discussion/Decision	Follow-up: Who/What/When
	Supporting materials: • Statewide Quality Reporting Measurement System 2016 Summary of Changes • 2017 SQRMS Minnesota-Specific Measures	
Determine action steps on Patient Safety composite	The draft workplan for 2016 to start developing a patient safety index or composite was reviewed. • A call for members (including previous members), including a special request for CAH and hospital reporting expertise. • A suggestion was made to start the work sooner than the draft plan specifies. Discussion and comments focused on the daunting task of identifying measures and developing a weighted composite, the need for consumer input and connecting with organizations (e.g., Leapfrog) that have experience in this area, and healthy skepticism balanced with a strong sense of how important this work is. Supporting materials: • Patient Safety Composite or Index (2015 Hospital Quality Reporting Steering Committee Recommendation)	Marie Dotseth, Steve Meisel, Carolyn Pare and Mark Sonneborn shared their commitment to continuing to be on this subgroup. Vickie Haverkamp and Britney Rosenau volunteered to join the group. A follow-up invitation for new members will be sent via email, for those not in attendance today.
Wrap up	Closing comments were shared from MDH, MNCM, MHA and Stratis Health.	Next meeting in planned for late 2016/early 2017.

Hospital Quality Reporting Steering Committee

March 18, 2016
11 a.m. - noon
Via public conference call: 866-939-8416, Participant Code: 3516271#

Meeting Goals:

- Provide an overview of 2016-2017 committee charge
- Review and take action on 2016 draft recommendations for SQRMS hospital measures for 2017 reporting
- Identify next steps for advancing a patient safety composite measure

Agenda:

1. *Welcome and introductions*
   Supporting materials:
   - Hospital Quality Reporting Steering Committee - Committee Charge 2016-2017v2

2. *Review and endorse updated alignment of SQRMS measures to federal programs: Value-Based Purchasing (VBP) measures, Readmissions Reduction Program (RRP) measures, Hospital Acquired Conditions (HAC) measures, and Medicare Beneficiary Quality Improvement Project (MBQIP) measures*

   Note: There are no new or removed measures at the federal level; however, there have been changes to measure specifications. A SQRMS goal is to be aligned with federal measures to reduce reporting burden for hospitals.

   Recommendation: Include VBP, RRP, HAC composites for PPS hospitals using updated FY2017 specifications in the 2017 slate of hospital measures. Include current MBQIP core and additional MBQIP measures for CAH hospitals (OP-4 and OP-18 will likely be included in core measures by HRSA next September) in the 2017 slate of measures.

   Supporting materials:
   - Quality Reporting and Value-Based Purchasing: National and Minnesota
   - 2017 Value-based Purchasing Specifications
   - 2017 Hospital Acquired Conditions Program Specifications
   - 2017 Readmission Reduction Program Specifications v2
   - MBQIP Quality Domains

3. *Update on final rule for Minnesota-specific SQRMS measures for 2016 reporting and discussion of 2017 recommendations*
   Recommendation: Include current slate of measures with one measure specification modification in the 2017 slate of hospital measures. The population included in the MN Stroke Registry

measure door to imaging would be modified to include hemorrhagic stroke patients and then will align with the population used for OP-23. This will simplify the case identification process.
Supporting materials:

- Statewide Quality Reporting Measurement System 2016 Summary of Changes
- 2017 SQRMS Minnesota-Specific Measures

4. *Determine action steps on Patient Safety composite measure*
   Supporting materials:
   - Patient Safety Composite or Index (2015 Hospital Quality Reporting Steering Committee Recommendation)

5. *Wrap up*

Funding provided by the Minnesota Department of Health through a contract with Minnesota Community Measurement.

Hospital Quality Reporting Steering Committee
Committee Charge
2016-2017

The Minnesota State Legislature passed significant Health Care Reform legislation into law in 2007 and 2008. As part of this legislation, the MN Statewide Quality Reporting and Measurement System (SQRMS) was established for hospitals and clinics. The measures are reviewed annually and additions or deletions are made. The goal is to create a uniform approach to quality measurement in Minnesota to enhance market transparency and improve health care quality.

Minnesota Community Measurement is leading a consortium of organizations to make recommendations to the state regarding the design and implementation of the public reporting and incentive payment system. As part of this consortium, Stratis Health, in collaboration with the Minnesota Hospital Association, will convene and facilitate the Hospital Quality Reporting Steering Committee to make recommendations to MN Community Measurement regarding measures to be used for hospitals as part of the MN Statewide Quality Reporting and Measurement System.

The focus for additional measures in 2010 was on pediatric measures. In 2011, The Minnesota Department of Health was focused in looking at rural sensitive measures and clinically enhanced AHRQ indicators. The focus in 2012 was evaluating existing measures and processes, but not adding any new measures. In 2013, the Committee recommended a perinatal and stroke measure be added and several measures were removed. In 2014 and 15, the committee tapped more broadly into existing expert groups and coalitions to guide measure selection; and the Committee identified six areas of focus for hospital quality measurement – 1.) Care Transitions and Readmissions, 2.) Safer Care and Avoiding Harm, 3. Cost/Spending, 4. End of Life, 5. Behavioral Health, and 6. End of Life Care, and put forward a preliminary plan for a safety index (in support of #2).

2016 Committee Charge for 2017 Reporting
The committee is charged to recommend any modifications to and/or removal of the existing slate of required measures for 2017 Hospital Measures for the MN Statewide Quality Reporting and Measurement System. The hospitals affected include PPS, CAH and Children's hospitals. Recommendations regarding deletions or updated specifications to the current measures are within the scope. Clinic measures and Ambulatory Surgery measures are out of scope. The steering committee will recommend changes in the measures in an advisory capacity to MN Community Measurement; final decision-making rests with the MN Department of Health. The committee will:

1. Continue to seek alignment of Minnesota hospital SQRMS measures with federal quality measure initiatives:
    - Align federal composite measures (VBP, RRP, HAC) with FY2017 or FY2018 program components
    - Align MBQIP measures with HRSA changes and Minnesota critical access hospital recommendations
2. In 2016, establish a Patient Safety Expert Workgroup that would focus on:
    - criteria for measure inclusion in an index,
    - measure selection,

- measure weighting, determining validity and reliability, and
- preliminary planning for data repository and reporting

In 2017, the workgroup would focus on:

- Data analytics and testing of the index or composite, and consider how a composite could be flexible, to adapt as available measures change, and to incorporate newly developed measures

MDH has defined the recommendation criteria and process described here:

Recommendations for publicly reported quality measures in SQRMS must be developed in consideration of what information will aid consumers, employers, and other health care purchasers in their comparison of physician clinics and hospitals, and decision making. At a minimum, quality measure recommendations for public reporting and quality improvement will adhere to, and include discussion of conclusions related to, each of the criteria outlined below. It is understood that different measures may relate more to some criteria than others, and that the Hospital Quality Reporting Steering Committee may choose to consider additional criteria. In recommending measures, the Contractor must consider MDH's strong preference for outcome, patient-reported outcome (or functional status), and electronic measures. In recommending measure modifications and removals, the Hospital Quality Reporting Steering Committee should consider clinical research findings and evidence, and the results of previously collected quality measure data.

Recommendation criteria:

- Degree of impact. The magnitude of the individual and societal burden imposed by a clinical condition being measured by the quality measure, including disability, mortality, and economic costs.
- Degree of improvability. The extent of the gap between current practices and evidence-based practices for the clinical condition being measured by the quality measure, and the likelihood that the gap can be closed and conditions improved through changes in the clinical processes.
- Degree of inclusiveness. The relevance of a measure to a broad range of individuals with regard to: age, gender, socioeconomic status, and race/ethnicity; the generalizability of quality improvement strategies across the spectrum of health care conditions; and the capacity for change across a range of health care settings and providers.
- National consensus. The measure has either been developed or accepted/approved through a national consensus effort (e.g., the National Quality Forum).
- Degree of performance variation. The measure performance rates show a wide degree of variation across the health care system.
- Degree of validity and reliability. The extent to which the measure is valid and reliable.
- Degree of alignment. The measure is aligned with other state and national quality measurement, improvement, and reporting initiatives, and does not duplicate existing efforts.
- Degree of reporting burden. The reporting burden is reasonable in balance with the previous criteria.

Written preliminary and final quality measure recommendations for SQRMS must, at a minimum:

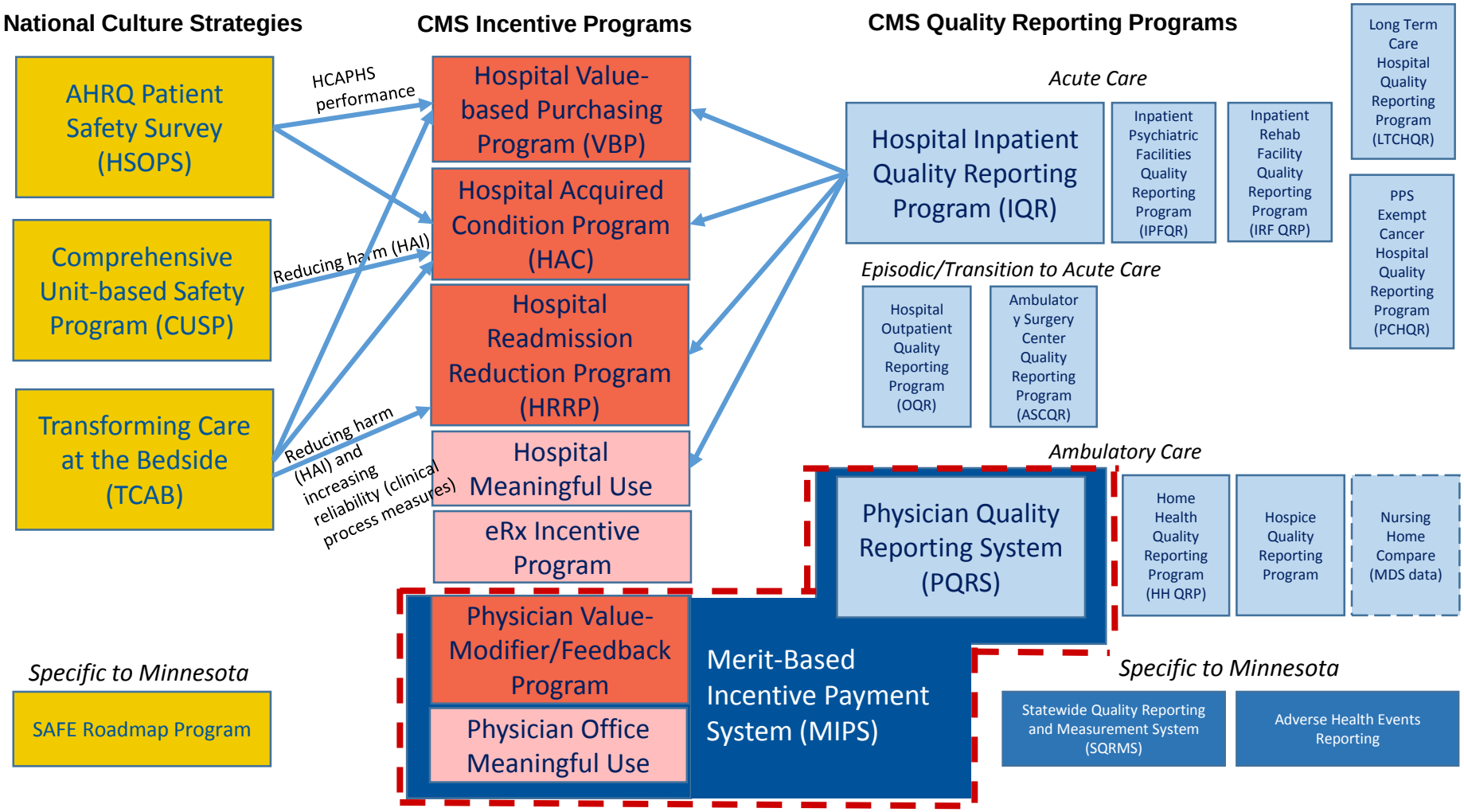
- Clearly convey in writing (1) the extent to which each measure meets the applicable aforementioned recommendation criteria, (2) how the concordance with measurement criteria addition, modification, or removal of each quality measure, and (3) what process was used to determine concordance with each criterion.
- Include quality measures that were considered but ultimately not recommended for addition, modification, or removal, and the supporting justifications.

- As part of articulating the process used, explain the stakeholder input employed and include a summary of any concerns or objections that stakeholders raised during the recommendation process.
- Include a description of each quality measure: name, data elements (i.e., denominator, numerator), specification information, measurement time period, data submission dates, the entity to which the data is reported (e.g., Contractor, Minnesota Hospital Association, Centers for Medicare & Medicaid Services, etc.), National Quality Forum (NQF) number (if applicable), and technical description.

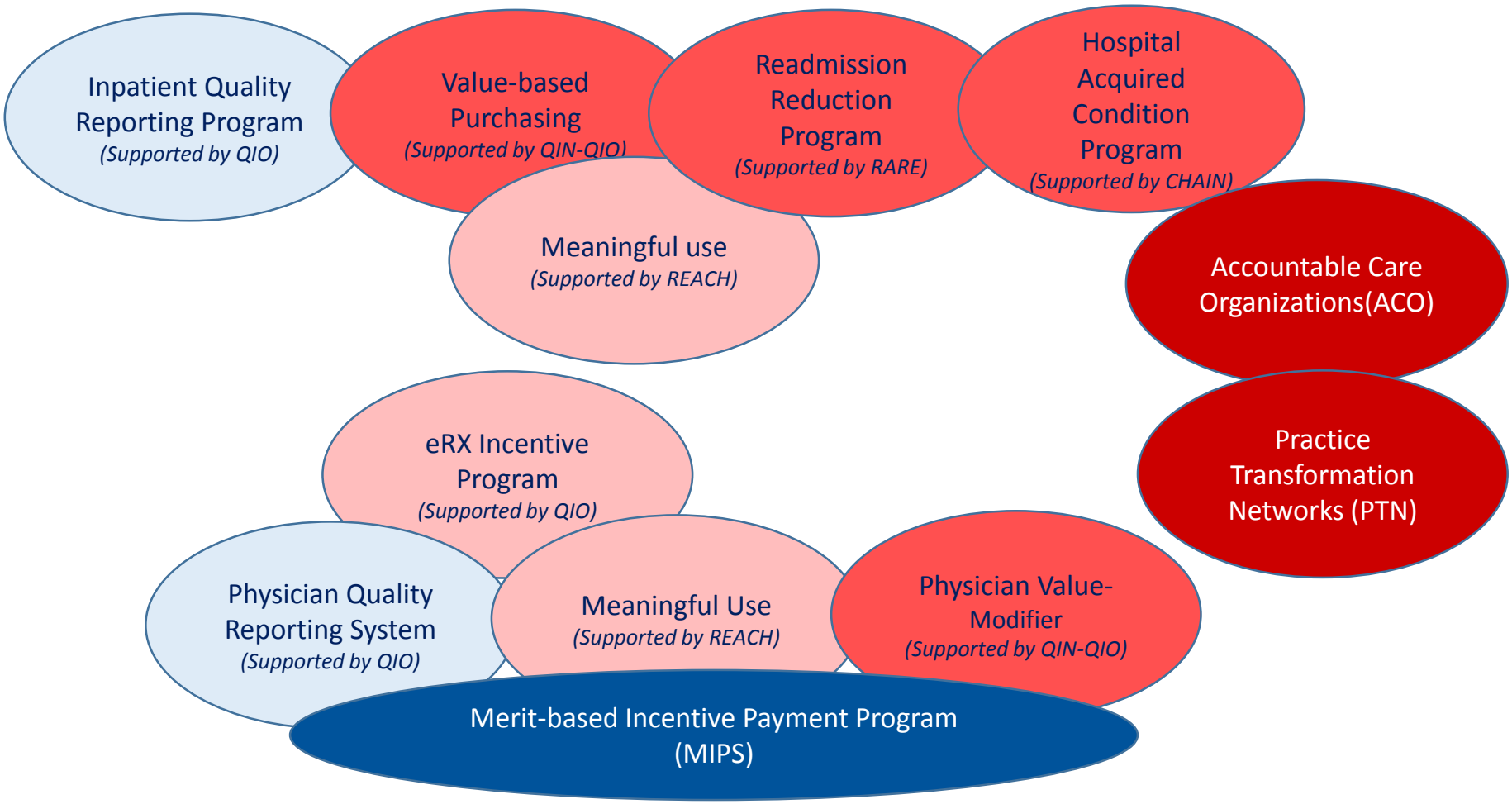
Members

Name	*Organization*	*Representation*
Shaina Witt, MA	American Heart Association (AHA)	Disease advocacy/ consumer organization
Peter Benner	Former AFSCME Council 6 Executive Director	Consumer/Labor
Carolyn Pare	Minnesota Health Action Group	Purchaser leadership
Larry Lee, MD	Blue Cross Blue Shield	Health plan physician leadership
Laurie Drill-Mellum, MD, MPH	MMIC	Physician risk insurer
Marie Dotseth, MHA	Minnesota Alliance for Patient Safety (MAPS)	Patient safety leadership
Hugh Renier, MD	Essentia Health System	PPS/CAH health system medical leadership
John Kvasnicka, MD	HealthEast Health System	PPS health system medical leadership
Steve Meisel, PharmD	Fairview Health System	Health system, patient safety leadership and pharmacy
Demeka Campbell, MD	Regions Hospital	Hospitalist
Britney Rosenau	Allina Health	PPS hospital regulatory
Kathy Geier, RN, BS, CPHIMS	HealthEast Health System	PPS hospital regulatory
Judy Bernhardt, RN, MSN	St. Luke's Hospital Duluth	PPS hospital quality
Darrell Carter, MD	Community Medical Centers PA, Granite Falls	CAH medical leadership, CALS
Mary Mayer, RN	Perham Memorial Hospital and Home	CAH hospital operations
Tammy Suchy	TriCounty Hospital	CAH quality leadership
Vickie Haverkamp, RN	Meeker Memorial Hospital	CAH pt safety/informatics leadership

Quality Reporting and Value-Based Purchasing: National and Minnesota



Evolution of Hospital Pay for Reporting and Pay for Performance Programs



Hospital Value-based Purchasing Specifications
2017
Updated March 2016

Description	CMS incentive program for PPS hospitals. The purpose is to achieve value by tying payment to process, outcome, patient experience and efficiency measures. Measure scores are either determined by improvement as compared to the hospitals baseline performance or achievement as compared to the achievement and benchmark targets; whichever is greater. These are rolled up into domain scores, which are weighted to determine the total performance score
Methodology	Specifications of individual measures are on QualityNet. The details of the Value-based Performance program are contained in the CMS IPPS final rule.
Measurement Period	Data will be submitted on an annual basis on the following schedule. Final results are reported by CMS at the beginning of the fiscal year in the 2017 final rule tables. For FY2017 the fiscal year begins with October 1, 2016 discharges and ends with September 30, 2017 discharges. Results are published on Hospital Compare in December 2016. This will be the data source Performance periods for individual measures are listed below.
Allowable Exclusions	• Hospitals with less than 2 domain scores • Hospitals subject to payment reduction for the IQR program • Hospitals that have been cited for deficiencies that pose immediate jeopardy the health or safety of patients

Total Performance Score	Measure scores are either determined by improvement as compared to the hospitals baseline performance or achievement as compared to the achievement and benchmark targets; whichever is greater. The domain score is determined by summing the measure scores and dividing by the potential points. Each domain score is weighted as determined by the IPPS rule. For FY2017, it is as follows
	• 30% - Clinical Care - Process
	  ○ 5% Clinical Care - Process
	  ○ 25% Clinical Care – Outcomes
	• 25% - Patient experience of care
	• 20% - Safety
	• 25% - Efficiency
	TPS = (Clinical Care Domain)(30%) + (Patient Experience Domain)(25%) +(Safety Domain)(20%) + (Efficiency Domain)(25%)

Individual measures	Listed below by domain:

Hospital Value-based Purchasing Specifications
2017
Updated March 2016

CLINICAL CARE - PROCESS		
Baseline Period	**Performance Period**	
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015	
Measures	**Threshold (%)**	**Benchmark (%)**
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival	95.4545	100
IMM-2 Influenza Immunization	95.1607	99.7739
PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation	3.1250	0.00

CLINICAL CARE -OUTCOME		
Mortality		
Baseline Period	**Performance Period**	
October 1, 2010 – June 30, 2012	October 1, 2013 – June 30, 2015	
Measure (Displayed as survival rate)	**Threshold (%)**	***Benchmark (%)***
30-day mortality, AMI	85.1458	87.1669
30-day mortality, heart failure	88.1794	90.3985
30-day mortality, pneumonia	88.2986	90.8124

Hospital Value-based Purchasing Specifications
2017
Updated March 2016

PATIENT EXPERIENCE OF CARE			
Baseline Period	**Performance Period**		
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015		
HCAHPS Survey Dimensions	**HCAHPS Performance Standard**		
	Floor (%)	**Threshold (%)**	**Benchmark (%)**
Communication with nurses	58.14	78.19	86.61
Communication with doctors	63.58	80.51	88.80
Responsiveness of hospital staff	37.29	65.05	80.01
Pain management	49.53	70.28	78.33
Communication about medications	41.42	62.88	73.36
Cleanliness and quietness	44.32	65.30	79.39
Discharge information	64.09	85.91	91.23
Overall rating of hospital	35.99	70.02	84.60

Hospital Value-based Purchasing Specifications
2017
Updated March 2016

SAFETY		
Complication/Patient Safety for Selected Indicators		
Baseline Period	**Performance Period**	
October 1, 2010 – June 30, 2012	October 1, 2013 – June 30, 2015	
Measure	**Threshold (%)**	**Benchmark (%)**
AHRQ PSI 90 composite	.777936	.547889
Healthcare-Associated Infections		
Baseline Period	**Performance Period**	
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015	
Measure	**Threshold (†)**	**Benchmark (†)**
CLABSI	0.457	0.000
CAUTI	0.845	0.000
SSI Colon‡	0.751	0.000
Abdominal Hysterectomy‡	0.698	0.000
C. difficile	0.750	0.000
MRSA	0.799	0.000

†Standardized infection ratio.
‡There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

Hospital Value-based Purchasing Specifications
2017
Updated March 2016

EFFICIENCY		
Baseline Period	**Performance Period**	
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015	
Measure	**Threshold (%)**	**Benchmark (%)**
MSPB-1 Medicare spending per beneficiary	Median Medicare spending per beneficiary ratio across all hospitals during performance period.	Mean of lowest decile of Medicare spending per beneficiary ratios across all hospitals during performance period.

Hospital Acquired Conditions Specifications
2017
Updated March 2016

Description	This program is a CMS incentive program for PPS hospitals to reduce harm and increase patient safety by tying payment to hospital acquired conditions. Domain scores are determined by percentile ranking with other PPS hospitals in nation. There are two domains and the scores are weighted to determine the Total HAC score for each hospital.
Methodology	Sources used for development of the individual measures are contained on QualityNet for the PSI 90 measure and CDC NHSN website for the HAI measures. The details for the Hospital Acquired Condition program is contained in the CMS IPPS final rule.
Measurement Period	The final HAC program results are published on Hospital Compare in December 2015. This will be the data source for measure scores, domain scores and total HAC score For FY2017, the fiscal year begins October 1, 2016 and includes discharges through September 30, 2017. The performance periods for individual measures are listed below.
Allowable Exclusions	• Less than 3 eligible discharges for at least one component indicator in the PSI 90 composite • Less than one predicted HAI event for any of the HAI measures (CLABSI, CAUTI, SSI colon procedures, SSI abdominal hysterectomy
Composite measure	Each measure within each domain is given a measure score that relates to its percentile ranking with other PPS hospitals in the nation. The domain score is determined by adding the measure scores. For Domain 1 the measure score and domain score are the same for FY2017. For Domain 2 SSI measure is based on the sum of the observed SSIs reported by hospitals following colon and abdominal hysterectomy procedures divided by the sum of the predicted SSIs for both procedures The three HAI measures are averaged to obtain the Domain 2 score. Each domain score is weighted as determined by the IPPS rule. Domain scores are weighted 15% for Domain 1 and 85% for Domain 2 to obtain the total HAC score.
Individual measures	Listed below by domain:

Hospital Acquired Conditions Specifications
2017
Updated March 2016

DOMAIN 1	
	Performance Period
	July 1, 2013 – June 30, 2015
AHRQ* PSI 90 Measure	**Score 1-10**
PSI 3 Pressure ulcer rate	
PSI 6 Iatrogenic pneumothorax rate	
PSI 7 Central venous catheter-related blood stream infection rate	
PSI 8 Postoperative hip fracture rate	
PSI 12 Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)	
PSI 13 Postoperative sepsis rate	
PSI 14 Wound dehiscence rate	
PSI 15 Accidental puncture and laceration rate	

*The Agency for Healthcare Research and Quality

DOMAIN 2	
	Performance Period
	January 1, 2014 – December 31, 2015
CDC NHSN* Measures	**Average Score 1-10**
CLABSI SIR rate	1-10
CAUTI SIR rate	1-10
SSI Colon Abdominal Hysterectomy	1-10†
MRSA SIR rate	1-10
C. difficile SIR rate	1-10

*Centers for Disease Control and Prevention National Healthcare Safety Network
†There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures

Appendix B: MBQIP Quality Domains

Quality Domain:	*Patient Safety*	*Patient Engagement*	*Care Transitions*	*Outpatient*
Instructions:	Grantees are required to work with all CAHs on all Core Improvement Activities, under each of the four quality domains. There are also Additional Improvement Activities that grantees may select to work on with any cohort of CAHs based on need and relevance (i.e. a Surgical Care initiative would only be relevant for those CAHs who perform inpatient surgeries). *This menu set outlines the quality improvement activities with associated measures that are to be reported by CAHs. Some quality activities are recognized as important areas for quality improvement; however, there are not currently standardized measure specifications or national reporting mechanisms available. These activities are identified as additional quality improvement activities that can be addressed at a state or regional level. States selecting to focus on any such activities will work with FORHP in year 1 to determine a standard set of reporting expectations for future years.* Please remember that these quality improvement and measurement activities are the means to the end goal of improving patient safety, patient engagement, care transitions, and outpatient care in your hospitals.			
Core Improvement Activities	**HCP / OP-27:** Influenza vaccination coverage among healthcare personnel *(Facilities report a single rate for inpatient and outpatient settings)* **Imm-2:** Influenza Immunization	**Hospital Consumer Assessment of Healthcare Providers and Systems** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:* • *communication with doctors,* • *communication with nurses,* • *responsiveness of hospital staff,* • *pain management,* • *communication about medicines,* • *discharge information,* • *cleanliness of the hospital environment,* • *quietness of the hospital environment,* • *transition of care* *The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.*	**Emergency Department Transfer Communication (EDTC)***** *7 sub-measures; 27 data elements* **EDTC-1:** Administrative Communication (2 data elements) **EDTC-2:** Patient Information (6 data elements) **EDTC-3**: Vital Signs (6 data elements) **EDTC-4:** Medication Information (3 data elements) **EDTC-5**: Physician or practitioner generated information (2 data elements) **EDTC-6:** Nurse generated information (6 data elements) **EDTC-7:** Procedures and Tests (2 data	**OP-1:** Median time to Fibrinolysis **OP-2:** Fibrinolytic Therapy Received within 30 minutes **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **OP-5:** Median time to ECG **OP-20:** Door to diagnostic evaluation by a qualified medical professional **OP-21:** Median time to pain management for long bone fracture **OP-22:** Patient left without being seen

OP-4 Aspirin at arrival

EDTC-8 All or none

			elements) ***Reported to state Flex program and FORHP	
Additional Improvement Activities	**Healthcare Acquired Infections (HAI)** • **CLABSI:** NHSN Central line-associated Bloodstream Infection Outcome Measure (NHSN to IQR) ✱**CAUTI:** NHSN Catheter-associated Urinary Tract Infection Outcome Measure (NHSN to IQR) • **CDI**: NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection Outcome Measure (NHSN to IQR) • **MRSA:** NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphlococcus aureus* Bacteremia Outcome Measure (NHSN to IQR) **Stroke** • **Stroke-1:** Venous thromboembolism (VTE) prophylaxis • **Stroke-8:** stroke education • Proportion of patients hospitalized with Stroke – potentially avoidable complications ✱**OP-23:** ED – Head CT or MRI scan results for Acute Ischemic Stroke or Hemorrhagic Stroke who received Head		**Discharge Planning** *Potential measurement TBD with FORHP* **Medication Reconciliation** *Potential measurement TBD with FORHP*	**ED Throughput** ✱**ED-1:** Median Time from ED arrival to ED departure for admitted ED patients ✱**ED-2:** Admit decision time to ED departure time for admitted patients ✱**OP-18:** Median time from ED arrival to ED departure for discharged ED patients

	CT or MRI scan interpretation within 45 minutes of arrival **Venous thromboembolism (VTE)** • **VTE-1**: venous thromboembolism prophylaxis • **VTE-2**: intensive care unit venous thromboembolism prophylaxis • **VTE-3**: venous thromboembolism patients with anticoagulation therapy **Perinatal Care** * **PC-01**: Elective delivery **Surgery / Surgical Care** * **OP-25**: safe surgery checklist use **Pneumonia** • Proportion of patients hospitalized with Pneumonia – potentially avoidable complications **Falls** Potential measurement around: • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk **Adverse Drug Events (ADE)** Potential measurement around: • Opioids • Glycemic Control • Anticoagulant Therapy * **Reducing Readmissions** *(These measures are calculated for hospitals using Medicare*	Heart Failure Pneumonia COPD		

	Administrative Claims Data) **Patient Safety Culture Survey**			

MDH Minnesota Department of Health

Date: January 11, 2016

Subject: 2016 Statewide Quality Reporting Measurement System changes
Adopted Expedited Permanent Rules Governing Health Care Quality Measures
Minnesota Administrative Rules, Chapter 4654
Minnesota Statewide Quality Reporting and Measurement System

The Minnesota Department of Health (MDH) has updated the Minnesota Statewide Quality Reporting and Measurement System (Quality Reporting System). MDH continuously works with providers and other stakeholders to create an evolving set of standard quality measures that are rooted in evidence. MDH publishes changes to the measurement set annually. MDH contracts with MN Community Measurement (MNCM), Stratis Health, and the Minnesota Hospital Association to maintain measures, collect data, and recommend measures for statewide reporting.

Here is a summary of the 2016 changes to the state's health care quality measures.

- Four quality measures for physician clinic performance were modified by MNCM, the measure steward, as part of routine maintenance activities. MDH accepted these modifications.
    - MNCM added a Statin Medication Use component measure to the Optimal Diabetes and Vascular Care composite measures.
    - MNCM implemented a technical change to the Depression Remission at Six Months measure. Previously, new patients became subject to the measure if they had an elevated PHQ-9 result and accompanying diagnosis of major depression or dysthymia, and returning patients only needed an elevated PHQ-9 result; the technical change requires that all patients—new and returning—have an elevated PHQ-9 result and a diagnosis to be included in the measure.
    - MNCM removed the word "Primary" from the "Cesarean Section Rate" measure title because the measure population is nulliparous[1].
- MDH largely accepted Stratis Health and the Hospital Quality Reporting Steering Committee's recommendation to restructure hospital reporting requirements to maintain alignment with other federal quality measurement programs, reduce reporting burden, and simplify measurement. MDH:

[1]Nulliparous is the medical term for a woman who has never given birth to a viable, or live, infant.

- Added three Centers for Medicare & Medicaid Services (CMS) incentive program composite measures in place of 13 individual measures used by the CMS inpatient and outpatient performance measurement for prospective payment system hospitals in the Quality Reporting System. CMS and the Minnesota Hospital Association will calculate the composites:
    - Hospital Value-Based Purchasing Total Performance Score,
    - Total Hospital-Acquired Condition (HAC) Score, and
    - Hospital Readmissions Reduction Program Composite Measure.
- Aligned critical access hospital measures with the requirements of the Medicare Beneficiary Quality Improvement Program (MBQIP). This alignment resulted in the removal of five CMS measures, the retention of eight CMS measures and the Emergency Department Transfer Communication composite, and the addition of 13 CMS measures.
- Removed five claims-based Agency for Healthcare Quality and Research (AHRQ) measures from, and retained three AHRQ measures—Mortality for Select Conditions composite, Death Rate among Surgical Inpatients with Serious Treatable Complications, and Patient Safety for Selected Indicators composite—to continue to directly monitor key areas of care quality.
- Retained two Minnesota Stroke Registry indicators—Door-to-Imaging Initiated Time and Time to Intravenous Thrombolytic Therapy—because they are key metrics used by the Minnesota Stroke Program to identify and close gaps in stroke care, and track the progress and impact of the Minnesota Stroke System.

Race, Hispanic Ethnicity, Preferred Language, and Country of Origin Stratification

To meet new legislative requirements to stratify five quality measures by Race, Hispanic Ethnicity, Preferred Language, and Country of Origin, MDH is requiring reporting of these socio-demographic factors beginning in July 2017 for Optimal Asthma Control–Adult, Optimal Asthma Control–Child, and Colorectal Cancer Screening for July 1, 2016 through June 30, 2017 dates of service, and Optimal Diabetes Care and Optimal Vascular Care beginning in January 2018 for January 1, 2017 through December 31, 2017 dates of service. MDH presented this plan during the proposed rule 30-day comment period, which ended on November 25. MDH received a total of 13 comments representing 61 organizations and five individuals that supported MDH's stratification proposal; MDH did not receive any unsupportive comments on the proposal. See the Stratifying Quality Measures Fact Sheet for more information.

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Statewide Quality Reporting and Measurement System
2016 Minnesota-Specific Measures

MN Stroke Registry: Door-to-Imaging Initiated Time

MN Stroke Registry: Time to Intravenous Thrombolytic Therapy

AHRQ Inpatient Quality Indicator: Mortality for Selected Conditions composite (IQI 91)

- 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)

AHRQ Patient Safety Indicator: Death Rate among Surgical Inpatients with Serious Treatable Complications (PSI 04)

AHRQ Patient Safety Indicator: Patient Safety for Selected Indicators composite (PSI 90)

- Pressure Ulcer Rate (PSI 03)
- Iatrogenic Pneumothorax Rate (PSI 06)
- 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) survey

This material was prepared by Stratis Health under a contract with MN Community Measurement through funding from the Minnesota Department of Health.

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Patient Safety Composite or Index
(2015 Hospital Quality Reporting Steering Committee Recommendation)

Why Measure?

Patient safety consistently emerges as a high priority for both health care delivery organizations and for patients and families. There are many hospital safety measures currently reported at a state and national level, yet they do not provide a comprehensive picture of how safe care is at a hospital or health system, nor do today's clinical only safety measures reflect the growing body of research related to organizational properties and systems which are essential for safety. Today's measures tend to be condition-specific or harm-specific (e.g., surgical site infection, falls, sepsis), and do not include how reliable a hospital's care is, or whether the culture is set up for reliability and learning.

To make patient safety hospital measurement meaningful and comprehensive, and more understandable to consumers, SQRMS could build upon the reporting individual hospital safety measures with reporting of a multi-faceted patient safety index or composite measure. The index or composite would include a balanced set of process, outcome, and structural measures, and can at least somewhat be derived from existing measures and indices put together in a combination to meet community needs. The composite or index approach is consistent with both national measurement strategies from CMS (e.g., the Hospital Total Performance Score) and with composite measurement that MN Community Measurement has developed in the ambulatory setting (e.g., the D5 for diabetes).

A composite approach meets needs identified by the Hospital Quality Reporting Steering Committee for measuring the safety of hospital care in Minnesota. The intent is that a composite measure bring value – it is more than an additive list of measures, rather, that the whole is greater than the sum of its parts as the composite represents essential components of safer care. First, it is a single score, easy to understand by patients and consumers. Second, it brings a sharp focus to what is otherwise a long list of measures to help ensure that safety remains a priority for hospital leaders, clinicians, and staff. Lastly, the underlying data elements which comprise the composite score are available to hospitals, making it actionable for improvement.

Vision

Minnesota assesses and publicly reports the safety of its hospital care through a balanced set of measures that meaningfully reflects safety in a single composite score easily understood by consumers and actionable by hospitals.

Principles/Assumptions:

- Methodology and calculation of the composite are transparent
- Underlying elements of the composite will be available to the hospitals so that they can identify their performance by indicator to be able to improve

- Draw on existing measures for which data are available and are widely collected to the extent possible
- Expect the composite to evolve over time as measures, evidence, and infrastructure evolves
- Measure not only harm to patients but organizational and system characteristics of hospitals
  - Such as reliability, culture, transparency and learning systems
- Reflect evidence-based practices to the extent feasible
- Be attentive to rural and small volume hospitals, such that they are neither advantaged nor disadvantaged
- Consider unintended consequences
- Develop for an audience that is consumers and hospitals
  - Addresses patient safety in PPS and CAH (need to clarify if Children's hospitals would be included)
- Consider risk adjustment when appropriate
- Hospitals should be able to verify their results

Proposed Process/Timeline

- MNCM/Stratis Health would co-facilitate
- 18-24 month process
- Includes measure testing and pilot
- Opportunity for community and stakeholder involvement and endorsement
- Build in opportunity for consumer and hospital input and feedback
- Incorporate discussion and possibly measurement to ensure there are not harmful unintended consequence
- Explore NQF endorsement

This material was prepared by Stratis Health under a contract with MN Community Measurement through funding from the Minnesota Department of Health.

Minnesota Statewide Quality Reporting and Measurement System:

Appendices to Minnesota Administrative Rules, Chapter 4654

Minnesota Department of Health

December 2016

MDH
Minnesota Department of Health

Division of Health Policy
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0882
(651) 201-3550
www.health.state.mn.us

Appendix B

Required Hospital Quality Measure Data

Data Required for Reporting Beginning in Calendar Year 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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, 2017. Stratis Health; March 2016, 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, 2017. Stratis Health; March 2016, 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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) ▪ Hospital 30-day all cause risk-standardized readmission rate (RSRR) following coronary artery bypass graph (CABG) surgery		
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, 2017. Stratis Health; March 2016, 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 5.1, Discharges 7/01/16 (3Q16) through 012/31/16 (4Q16). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2016 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 5.1, Discharges 7/01/12 (3Q12) through 06/30/15 (2Q15). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2016 or as updated.

Data Required for Reporting Beginning in Calendar Year 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 5.1, Discharges 7/01/16 (3Q16) through 012/31/16 (4Q16). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2016 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 2015 A1,

Data Required for Reporting Beginning in Calendar Year 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 01/01/16 (1Q15) through 12/31/16 (4Q15). The Joint Commission; 2016 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 5.1, Discharges 7/01/16 (3Q16) through 012/31/16 (4Q16). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2016 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 9.1, Encounter

Data Required for Reporting Beginning in Calendar Year 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 07/01/16 (3Q16) through 12/31/16 (4Q16). Centers for Medicare & Medicaid Services (CMS); July 2016 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 9.1, Encounter

Data Required for Reporting Beginning in Calendar Year 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 07/01/16 (3Q16) through 12/31/16 (4Q16). Centers for Medicare & Medicaid Services (CMS); July 2016 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 9.1, Encounter Dates 07/01/16 (3Q16) through 12/31/16 (4Q16). Centers for Medicare & Medicaid Services (CMS); July 2016 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 9.1, Encounter Dates 07/01/16 (3Q16) through 12/31/16 (4Q16). Centers for Medicare & Medicaid Services (CMS); July 2016 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 9.1, Encounter Dates 07/01/16 (3Q16) through 12/31/16 (4Q16). Centers for Medicare & Medicaid Services (CMS); July 2016 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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; February 2016 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, (10/01/2016 – 09/30/2017 Discharge Dates). Stratis Health; January 2016, 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 11.0. Centers for Medicare & Medicaid Services (CMS); February 2016or 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 2016, or as updated. Minnesota Stroke Registry; Time to Intravenous Thrombolytic Therapy; July 2016, or as updated.

Data Required for Reporting Beginning in Calendar Year 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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; October 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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; October 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; October 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 2017 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2017 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 2016	2016 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C with MN-Specific Additional Questions.

Appendix E

Submission Specifications

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.

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, 2016: July 1 – September 30	February 15, 2017
Fourth Quarter, 2016: October 1 – December 31	May 15, 2017
First Quarter, 2017: January 1 – March 31	August 15, 2017
Second Quarter, 2017: April 1 – June 30	November 15, 2017

Outpatient Quality Measures

Discharge Dates	Data Submission Deadline
Third Quarter, 2016: July 1 – September 30	February 1, 2017
Fourth Quarter, 2016: October 1 – December 31	May 1, 2017
First Quarter, 2017: January 1 – March 31	August 1, 2017
Second Quarter, 2017: April 1 – June 30	November 1, 2017

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, 2016: July 1 – September 30	February 15, 2017
Fourth Quarter, 2016: October 1 – December 31	May 15, 2017
First Quarter, 2017: January 1 – March 31	August 15, 2017
Second Quarter, 2017: April 1 – June 30	November 15, 2017

        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, 2016: October 1 – December 31	January 31, 2017
First Quarter, 2017: January 1 – March 31	April 30, 2017
Second Quarter, 2017: April 1 – June 30	July 31, 2017
Third Quarter, 2017: July 1 – September 30	October 31, 2017

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.

Discharge Dates	Data Submission Deadline
Third Quarter, 2016: July 1 – September 30	January 4, 2017
Fourth Quarter, 2016: October 1 – December 31	April 5, 2017
First Quarter, 2017: January 1 – March 31	July 5, 2017
Second Quarter, 2017: April 1 – June 30	October 4, 2017

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, 2016: July 1 – September 30	February 15, 2017
Fourth Quarter, 2016: October 1 – December 31	May 15, 2017
First Quarter, 2017: January 1 – March 31	August 15, 2017
Second Quarter, 2017: April 1 – June 30	November 15, 2017

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 2016 Dates of Service	April 30, 2017

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 2017 and each subsequent year.

Minnesota Department of Health

Division of Health Policy
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0882
(651) 201-3550
www.health.state.mn.us

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Hospital Value-based Purchasing Specifications
2017
Updated March 2016

Description	CMS incentive program for PPS hospitals. The purpose is to achieve value by tying payment to process, outcome, patient experience and efficiency measures. Measure scores are either determined by improvement as compared to the hospitals baseline performance or achievement as compared to the achievement and benchmark targets; whichever is greater. These are rolled up into domain scores, which are weighted to determine the total performance score
Methodology	Specifications of individual measures are on QualityNet. The details of the Value-based Performance program are contained in the CMS IPPS final rule.
Measurement Period	Data will be submitted on an annual basis on the following schedule. Final results are reported by CMS at the beginning of the fiscal year in the 2017 final rule tables. For FY2017 the fiscal year begins with October 1, 2016 discharges and ends with September 30, 2017 discharges. Results are published on Hospital Compare in December 2016. This will be the data source Performance periods for individual measures are listed below.
Allowable Exclusions	• Hospitals with less than 2 domain scores • Hospitals subject to payment reduction for the IQR program • Hospitals that have been cited for deficiencies that pose immediate jeopardy the health or safety of patients

Total Performance Score	Measure scores are either determined by improvement as compared to the hospitals baseline performance or achievement as compared to the achievement and benchmark targets; whichever is greater. The domain score is determined by summing the measure scores and dividing by the potential points. Each domain score is weighted as determined by the IPPS rule. For FY2017, it is as follows
	• 30% - Clinical Care - Process
	  o 5% Clinical Care - Process
	  o 25% Clinical Care – Outcomes
	• 25% - Patient experience of care
	• 20% - Safety
	• 25% - Efficiency
	TPS = (Clinical Care Domain)(30%) + (Patient Experience Domain)(25%) +(Safety Domain)(20%) + (Efficiency Domain)(25%)

Individual measures	Listed below by domain:

Hospital Value-based Purchasing Specifications
2017
Updated March 2016

CLINICAL CARE - PROCESS		
Baseline Period	**Performance Period**	
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015	
Measures	**Threshold (%)**	**Benchmark (%)**
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival	95.4545	100
IMM-2 Influenza Immunization	95.1607	99.7739
PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation	3.1250	0.00

CLINICAL CARE -OUTCOME		
Mortality		
Baseline Period	**Performance Period**	
October 1, 2010 – June 30, 2012	October 1, 2013 – June 30, 2015	
Measure (Displayed as survival rate)	**Threshold (%)**	***Benchmark (%)***
30-day mortality, AMI	85.1458	87.1669
30-day mortality, heart failure	88.1794	90.3985
30-day mortality, pneumonia	88.2986	90.8124

Hospital Value-based Purchasing Specifications
2017
Updated March 2016

PATIENT EXPERIENCE OF CARE			
Baseline Period	**Performance Period**		
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015		
HCAHPS Survey Dimensions	**HCAHPS Performance Standard**		
	Floor (%)	**Threshold (%)**	**Benchmark (%)**
Communication with nurses	58.14	78.19	86.61
Communication with doctors	63.58	80.51	88.80
Responsiveness of hospital staff	37.29	65.05	80.01
Pain management	49.53	70.28	78.33
Communication about medications	41.42	62.88	73.36
Cleanliness and quietness	44.32	65.30	79.39
Discharge information	64.09	85.91	91.23
Overall rating of hospital	35.99	70.02	84.60

Hospital Value-based Purchasing Specifications
2017
Updated March 2016

SAFETY		
Complication/Patient Safety for Selected Indicators		
Baseline Period	**Performance Period**	
October 1, 2010 – June 30, 2012	October 1, 2013 – June 30, 2015	
Measure	**Threshold (%)**	**Benchmark (%)**
AHRQ PSI 90 composite	.777936	.547889
Healthcare-Associated Infections		
Baseline Period	**Performance Period**	
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015	
Measure	**Threshold (†)**	**Benchmark (†)**
CLABSI	0.457	0.000
CAUTI	0.845	0.000
SSI Colon‡	0.751	0.000
Abdominal Hysterectomy‡	0.698	0.000
C. difficile	0.750	0.000
MRSA	0.799	0.000

†Standardized infection ratio.
‡There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

Hospital Value-based Purchasing Specifications
2017
Updated March 2016

EFFICIENCY		
Baseline Period	**Performance Period**	
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015	
Measure	**Threshold (%)**	**Benchmark (%)**
MSPB-1 Medicare spending per beneficiary	Median Medicare spending per beneficiary ratio across all hospitals during performance period.	Mean of lowest decile of Medicare spending per beneficiary ratios across all hospitals during performance period.

Readmission Reduction Program Specifications
2017
Updated March 2016

Description	The Readmission Reduction Program CMS incentive program for PPS hospitals to reduce unplanned rehospitalizations and cost by tying payment to excess readmissions. Excess readmissions are calculated as the ratio of predicted readmissions to expected readmissions. A composite measure will be calculated using the results from the CMS Readmission Reduction Program.
Methodology	Specifications for individual measures is located on QualityNet. The details of the Readmission Reduction Program (RRP) are contained in the CMS IPPS final rule.
Measurement Period	Data will be submitted on an annual basis on the following schedule: Final results are released by CMS in the beginning of the fiscal year which for FY2017 starts with October 1, 2016 discharges and ends with September 30, 2017 discharges. A final table of results is published on the 2016 IPPS rule page. It contains the excess readmission ratio for each condition for each hospital. This will be the source for data submission of the individual measures listed below. Final results are planned to be published in December 2016 on Hospital Compare. The composite measure will be calculated using these results
Denominator	Sum of the number of cases for each of the readmission measures included in the readmission reduction program that the hospital has 25 or more eligible discharges AMI Cases + Pneumonia Cases + Heart Failure Cases + Hip/Knee Cases + COPD Cases +CABG Cases
Allowable Exclusions	Less than 25 eligible discharges for a measure would impact the number of measures included in the composite measure.
Numerator	Number of readmission measures with excess readmissions (number of 1 or greater) for FY2017 which includes data from July 1, 2012 to June 30, 2015 (AMI Cases x excess ratio) +(Pneumonia Cases x excess ratio) + (Heart Failure Cases x excess ratio) + (Hip/Knee Cases x excess ratio)+ (COPD Cases x excess ratio) (CABG Cases x excess ratio)
Individual measures contained in the composite measure	• 30-day Readmissions Acute Myocardial Infarction (AMI), • 30-day Readmissions Heart Failure (HF) • 30-day Readmissions Pneumonia (PN); • 30-day Readmissions Chronic Obstructive Pulmonary Disease (COPD)

Readmission Reduction Program Specifications
2017
Updated March 2016

Description	The Readmission Reduction Program CMS incentive program for PPS hospitals to reduce unplanned rehospitalizations and cost by tying payment to excess readmissions. Excess readmissions are calculated as the ratio of predicted readmissions to expected readmissions. A composite measure will be calculated using the results from the CMS Readmission Reduction Program.
	• 30-day Readmissions Elective Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) • 30 day Readmissions Coronary Artery Bypass Graft (CABG) surgery

Hospital Acquired Conditions Specifications
2017
Updated March 2016

Description	This program is a CMS incentive program for PPS hospitals to reduce harm and increase patient safety by tying payment to hospital acquired conditions. Domain scores are determined by percentile ranking with other PPS hospitals in nation. There are two domains and the scores are weighted to determine the Total HAC score for each hospital.
Methodology	Sources used for development of the individual measures are contained on QualityNet for the PSI 90 measure and CDC NHSN website for the HAI measures. The details for the Hospital Acquired Condition program is contained in the CMS IPPS final rule.
Measurement Period	The final HAC program results are published on Hospital Compare in December 2015. This will be the data source for measure scores, domain scores and total HAC score For FY2017, the fiscal year begins October 1, 2016 and includes discharges through September 30, 2017. The performance periods for individual measures are listed below.
Allowable Exclusions	• Less than 3 eligible discharges for at least one component indicator in the PSI 90 composite • Less than one predicted HAI event for any of the HAI measures (CLABSI, CAUTI, SSI colon procedures, SSI abdominal hysterectomy
Composite measure	Each measure within each domain is given a measure score that relates to its percentile ranking with other PPS hospitals in the nation. The domain score is determined by adding the measure scores. For Domain 1 the measure score and domain score are the same for FY2017. For Domain 2 SSI measure is based on the sum of the observed SSIs reported by hospitals following colon and abdominal hysterectomy procedures divided by the sum of the predicted SSIs for both procedures The three HAI measures are averaged to obtain the Domain 2 score. Each domain score is weighted as determined by the IPPS rule. Domain scores are weighted 15% for Domain 1 and 85% for Domain 2 to obtain the total HAC score.
Individual measures	Listed below by domain:

Hospital Acquired Conditions Specifications
2017
Updated March 2016

DOMAIN 1	
	Performance Period
	July 1, 2013 – June 30, 2015
AHRQ* PSI 90 Measure	**Score 1-10**
PSI 3 Pressure ulcer rate	
PSI 6 Iatrogenic pneumothorax rate	
PSI 7 Central venous catheter-related blood stream infection rate	
PSI 8 Postoperative hip fracture rate	
PSI 12 Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)	
PSI 13 Postoperative sepsis rate	
PSI 14 Wound dehiscence rate	
PSI 15 Accidental puncture and laceration rate	

*The Agency for Healthcare Research and Quality

DOMAIN 2	
	Performance Period
	January 1, 2014 – December 31, 2015
CDC NHSN* Measures	**Average Score 1-10**
CLABSI SIR rate	1-10
CAUTI SIR rate	1-10
SSI Colon Abdominal Hysterectomy	1-10†
MRSA SIR rate	1-10
C. difficile SIR rate	1-10

*Centers for Disease Control and Prevention National Healthcare Safety Network
†There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures

Emergency Department Transfer Communication Specifications 2017 (10/01/2016 to 09/30/2017 Discharge Dates)
March 2016

Summary of Changes	Discharge dates and submission deadlines updated. All or none measure header added.

Description	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (SUBSECTION 1) or within 60 minutes of transfer (SUBSECTION 2-7) Measurement collection is done by the sending hospital. This measure assesses the sending hospital's completeness of communication to a receiving facility. The elements are separated into seven subcategories to facilitate improvement.
Methodology	Sources used for development of measure: Coordination of Care Record (CCR), EMTALA.
Measurement Period	Data will be submitted on a quarterly basis on the following schedule: **Discharge Date:** Fourth Quarter, 2016: October 1 – December 3, **Data Submission Deadline** 01/31/2017 **Discharge Date:** First Quarter, 2017: January 1 – March 31, **Data Submission Deadline** 04/30/2017 **Discharge Date:** Second Quarter, 2017: April 1 – June 30, **Data Submission Deadline** 7/31/2017 **Discharge Date:** Third Quarter, 2017: July 1 – September 30, **Data Submission Deadline** 10/31/2017
Denominator	All patients who are transferred to another healthcare facility. This is for all seven of the subcategories. Include patients with these discharge status codes: • 3 Hospice – Health Care Facility • 4a Acute Care Facility – General Inpatient Care • 4b Acute Care Facility – Critical Access Hospital • 4c Acute Care Facility – Cancer Hospital or Children's Hospital • 4d Acute Care Facility – Department of Defense or Veteran's Administration • 5 Other Health Care Facility
Allowable Exclusions	Exclude patients with these discharge status codes: • 1 Home • 2 Hospice – Home • 6 Expired • 7 Left Against Medical Advice/AMA • 8 Not Documented or Unable to Determine (UTD)

Emergency Department Transfer Communication Specifications 2017 (10/01/2016 to 09/30/2017 Discharge Dates) March 2016

Description	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (SUBSECTION 1) or within 60 minutes of transfer (SUBSECTION 2-7) Measurement collection is done by the sending hospital. This measure assesses the sending hospital's completeness of communication to a receiving facility. The elements are separated into seven subcategories to facilitate improvement.
Numerator	**All or None** Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the relevant elements for each patient were communicated to the receiving hospital within the appropriate timeframe. **Administrative (i.e., pre-transfer) communication** Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital prior to transfer. Total of 2 elements: • Healthcare facility to healthcare facility communication • Physician communication with receiving physician **Patient information** Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of transfer. Total of 6 elements: • Name • Address • Age • Gender • Significant others contact information • Insurance **Vital signs** Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of transfer. Total of 6 elements: • Pulse • Respiratory rate • Blood pressure

Description	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (SUBSECTION 1) or within 60 minutes of transfer (SUBSECTION 2-7) Measurement collection is done by the sending hospital. This measure assesses the sending hospital's completeness of communication to a receiving facility. The elements are separated into seven subcategories to facilitate improvement.
	• Oxygen saturation • Temperature • Neurological assessment **<u>Medication information</u>** Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of transfer. Total of 3 elements: • Medications given in ED • Allergies/Reactions • Medications from home **<u>Physician or practitioner generated information</u>** Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of transfer. Total of 2 elements: • History and physical • Reason for transfer/plan of care **<u>Nurse generated information</u>** Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of transfer. Total of 6 elements: Nurse documentation includes: • Nursing notes • Sensory status • Catheters • Immobilizations • Respiratory support • Oral restrictions **<u>Procedures and tests</u>**

Emergency Department Transfer Communication Specifications
2017 (10/01/2016 to 09/30/2017 Discharge Dates)
March 2016

Description	Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that REQUIRED information was communicated to the receiving facility prior to departure (SUBSECTION 1) or within 60 minutes of transfer (SUBSECTION 2-7) Measurement collection is done by the sending hospital. This measure assesses the sending hospital's completeness of communication to a receiving facility. The elements are separated into seven subcategories to facilitate improvement.
	Number of patients transferred to another acute care hospital whose medical record documentation indicated that all of the applicable elements were communicated to the receiving hospital within 60 minutes of transfer, or were sent when available. Total of 2 elements: • Tests and procedures performed • Tests and procedure results