DATE: **June 21, 2013**

RE: **2014 Final Recommendations**
Physician Clinics, Ambulatory Surgical Centers, and Hospitals
Statewide Quality Reporting and Measurement System

The attached table summarizes MN Community Measurement's (MNCM's) final recommendations to the Minnesota Department of Health (MDH) for physician clinic, ambulatory surgical center, and hospital measures for the 2014 Statewide Quality Reporting and Measurement System. Stratis Health, in collaboration with the Minnesota Hospital Association, convened the Hospital Quality Reporting Steering Committee and facilitated its recommendations to MNCM regarding hospital measures. All recommendations were reviewed and approved by MNCM's Measurement and Reporting Committee.

Key proposed changes for the 2014 Statewide Quality Reporting and Measurement System as compared with the 2013 Statewide Quality Reporting and Measurement System include the following:

- The addition of two newly developed pediatric preventive care measures—Adolescent Mental Health and/or Depression Screening and Obesity/BMI & Counseling for reporting in 2015;
- Use of the CAHPS Clinic and Group 12-month Survey instead of the CAHPS Clinic and Group Visit Survey to better align with other state and federal reporting requirements;
- The addition of new risk adjustment variables for the Optimal Diabetes Care, Optimal Vascular Care, Depression Remission at 6 Months, Colorectal Cancer Screening, and Primary C-section measures;
- The requirement of all clinics that are part of a medical group in which the medical group has providers who perform C-sections to submit data on the Primary C-section measure, and the exclusion of pre-term deliveries from this measure.
- The addition of one new CMS hospital measure—Early elective deliveries (PC-1);
- The removal of several hospital measures;
- The suspension of the ED/Transfer Communication measure until 2015; and
- Shifting hospital data collection dates to align with the calendar year.

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

MDH invites interested stakeholders to review and comment on MNCM's final recommendations for physician clinic, ambulatory surgical center, and hospital measures for the 2014 Statewide Quality Reporting and Measurement System. Please send your comments to health.reform@state.mn.us through July 5, 2013.

Additionally, MDH and MNCM will hold a **public forum in St. Paul on June 26**, to present MNCM's final quality measure recommendations in connection with the annual update of the Statewide Quality Reporting and Measurement System. The public forum will include an opportunity for interested stakeholders to comment on the recommendations and to ask questions.

MDH will consider all public comments during the development of the proposed rule for the 2014 Statewide Quality Reporting and Measurement System. The proposed rule will be published in August.

SEE PUBLIC FORUM INFORMATION ON PAGE 2.

Public Forum Information:
June 26, 2012
10 a.m. – 12:00 p.m.
Minnesota Department of Health – Freeman Building
625 Robert St. N, B145
Saint Paul, MN 55164
Directions: http://www.health.state.mn.us/about/metro.html
Telephone: 1-888-742-5095
Passcode: 933-209-2697

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Physician Clinics**
2014 Report Year

Existing Measures

Measure	Eligible Specialties	Collection Date / Dates of Service	Data Elements	Risk Adjustment
Optimal Diabetes Care Composite: • HbA1c (less than 8 percent) • Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use if patient has diagnosis of IVD (or valid contraindication to aspirin documented if patient has IVD) • Documented tobacco free	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Endocrinology	Collecting January 1, 2014 on dates of service: January 1, 2013 through December 31, 2013	• Adults age 18 to 75. • Seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with a diabetes ICD-9 code. • Seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.	• Insurance Product Type: o Commercial o Medicare o MN Government Programs and Self-pay / Uninsured • Age o 18-25 o 26-50 o 51-65 o 66-75 • Diabetes Type o Type 1 o Type 2
Optimal Vascular Care Composite: • Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use or valid contraindication to aspirin documented • Documented tobacco free	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Cardiology	Collecting January 1, 2014 on dates of service: January 1, 2013 through December 31, 2013	• Adults age 18 to 75. • Seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with an ischemic vascular disease ICD-9 code. • Seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.	• Insurance Product Type: o Commercial o Medicare o MN Government Programs and Self-pay / Uninsured • Age o 18-25 o 26-50 o 51-65 o 66-75

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Physician Clinics**
2014 Report Year

Measure	Eligible Specialties	Collection Date / Dates of Service	Data Elements	Risk Adjustment
Depression Remission at 6 Months: • Patients with major depression or dysthymia and an initial PHQ-9 score > nine whose PHQ-9 score at six months (+/- 30 days) is less than 5	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Psychiatry • Licensed Behavioral Health (if physician on site)	Collecting January 1, 2014 on index dates: July 1, 2012 through June 30, 2013, allowing for 6 month (+/- 30 days) follow-up contact	• Adults age 18 and older. • Patient visits or contacts during the measurement period with Diagnosis of Major Depression or Dysthymia. • Initial PHQ-9 score is > nine.	• Initial PHQ-9 severity bands o Moderate (10-14) o Moderately severe (15-19) o Severe (20 and above) • Insurance Product Type: o Commercial o Medicare o MN Government Programs and Self-pay / Uninsured • Age o 18-25 o 26-50 o 51-65 o 66+
Optimal Asthma Care Composite • Asthma is well controlled (asthma control tool/test results indicate control) • Patient is not at risk for future exacerbations (patient reports less than two total emergency department visits and hospitalizations during previous 12 months) • Patient has been educated about asthma and has a current written asthma management plan containing information on medication doses and effects, what to do	• Family Medicine • General Practice • Internal Medicine • General Practice • Pediatrics • Allergy/Immunology • Pulmonology	Collecting July 1, 2014 on dates of service: July 1, 2013 through June 30, 2014	• Patient ages 5 to 17. • Patient ages 18 to 50. • Seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with an asthma ICD-9 code. • Seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.	• Insurance Product Type: o Commercial o Medicare o MN Government Programs and Self-pay / Uninsured

Measure	Eligible Specialties	Collection Date / Dates of Service	Data Elements	Risk Adjustment
during an exacerbation, and information on the patient's triggers (written/reviewed within the measurement period				
Colorectal Cancer Screening • Patient is current with colorectal cancer screening (allowable screens: colonoscopy within 10 years, sigmoidoscopy within 5 years, FOBT or FIT within the reporting period)	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Obstetrics /Gynecology	Collecting July 1, 2014 on dates of service: July 1, 2013 through June 30, 2014	• Adults ages 50 to75. • Seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years for any reason. • Seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.	• Insurance Product Type: o Commercial o Medicare o MN Government Programs and Self-pay / Uninsured • Age o 51-65 o 66-75

The Measurement and Reporting Committee approved the highlighted proposed changes below with the caveat that this measure would not be publicly reported until further testing completed and that this recommendation be shared with MDH. The committee charged MNCM staff to complete an analysis to address the referral practice among MN clinics, also assessing data collection burden before public reporting would resume in the future.

Measure	Eligible Specialties	Collection Date / Dates of Service	Data Elements	Risk Adjustment
Maternity Care- Primary C-Section Rate • Percentage of cesarean deliveries for first births *All clinics part of a medical group in which the medical group has providers who perform C-sections*	• Family Medicine • General Practice • Obstetrics/Gynecology • Perinatology	Collecting July 1, 2014 on dates of service: July 1, 2013 through June 30, 2014	All live, singleton, vertex, term (≥ 37 weeks gestation) deliveries to nulliparous women performed by a medical clinic site, including all cesarean and all vaginal deliveries.	• Insurance Product Type: o Commercial o Medicare o MN Government Programs and Self-pay / Uninsured • Age o 17 and under

Measure	Eligible Specialties	Collection Date / Dates of Service	Data Elements	Risk Adjustment
				o 18-20 o 21-25 o 26-30 o 31-35 o 36 and older
Patient Experience of Care Survey topics cover: • Getting care when needed / access to care • Communication • Helpfulness of office staff • Doctors with an exceptional rating CAHPS Clinician and Group 12-Month Survey	• All specialties except Psychiatry	Collecting February 25, 2015. Dates of service to survey: September 1, 2014 through November 30, 2014. Sample should be sufficient to achieve a 0.70 reliability threshold; sample size calculation based on provider-scaling/clinic size according to CAHPS protocol. **Measure is required every other year*	All patients ages 18 and older with a face-to-face visit at the clinic during the timeframe, are eligible for inclusion in the survey regardless of: • Physician specialty • Reason for visit • Duration of patient/physician relationship	Survey responses to: • Self-reported health status • Age • Education
Health Information Technology Survey • Survey topics cover adoption of HIT, use of HIT, exchange of information, and on-line services	All Specialties	Collecting February 15, 2014 on current HIT status	Clinic-level survey	Not applicable – data reported as descriptive statistics only

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Physician Clinics**
2014 Report Year

New Measures*

*Measures are currently in pilot testing, but are anticipated to be collected for the dates of service shown in the table.

Measure	Eligible Specialties	Collection Date / Dates of Service	Data Elements	Risk Adjustment
Total Knee Replacement: • Average post-operative functional status improvement at one year post-operatively measured by the Oxford Knee Score tool • Average post-operative quality of life improvement at one year post-operatively measured using the EQ-5D tool	• Orthopedic Surgery	Collecting April 1, 2014 on dates of procedure: January 1, 2012 through December 31, 2012	Adult patients age 18 and older with no upper age limit undergoing a primary total knee replacement or a revision total knee replacement during the required dates of procedure.	• Insurance Product Type: o Commercial o Medicare o MN Government Programs and Self-pay / Uninsured • Body mass index (BMI) • Tobacco Status *Tentative based on pilot testing results, expected to be collected in May 2013.*
Spine Surgery: • Average change in post-operative functional status improvement at three months post operatively for patients undergoing lumbar discectomy/ laminotomy with a diagnosis of disc herniation as measured by the following functional status tools: Oswestry Disability Index (ODI), Visual analog pain scale (VAS), EQ5D self-reported health status, and/or EQ5D health status index • Average change in post-operative functional status	• Orthopedic Surgery • Neurosurgery	Collecting April 1, 2015 on dates of procedure: January 1, 2013 through December 31, 2013	Lumbar Disectomy/laminotomy: • Adult patients age 18 and older with no upper age limit undergoing a lumbar discectomy/ laminotomy procedure for a diagnosis of disc herniation with the date of procedure occurring within a fixed measurement period. Lumbar Spinal Fusion: • Adult patients age 18 and older with no upper age limit undergoing any level of lumbar spinal	• Insurance Product Type: o Commercial o Medicare o MN Government Programs and Self-pay / Uninsured • Body mass index (BMI) • Tobacco Status *Tentative based on pilot testing results, expected to be collected in April 2013 and April 2014.*

Measure	Eligible Specialties	Collection Date / Dates of Service	Data Elements	Risk Adjustment
improvement at one year post operatively for patients undergoing any level of lumbar spinal fusion as measured by the following functional status tools: Oswestry Disability Index (ODI) tool, Visual analog pain scale (VAS), EQ5D self-reported health status, and/or EQ5D health status index			fusion with a date of procedure occurring with a fixed measurement period.	
Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening • Patient has a mental health and/or depression screening documented in medical record *Clinics that provide well-child visit services*	• Family Medicine • General Practice • Internal Medicine • Pediatric/Adolescent Medicine	Collecting January 1, 2015 on dates of service: January 1, 2014 through December 31, 2014	• Patients ages 12 to 17. • Seen by an eligible provider in an eligible specialty face-to-face at least once for a well-child visit during the prior 12 months.	TBD
Pediatric Preventive Care: Obesity/BMI & Counseling • Patient has a BMI assessment documented in medical record • Patient with a BMI percentile >85% has documentation of both physical activity and	• Family Medicine • General Practice • Internal Medicine • Pediatric/Adolescent Medicine	Collecting January 1, 2015 on dates of service: January 1, 2014 through December 31, 2014	• Patients ages 3 to 17. • Seen by an eligible provider in an eligible specialty face-to-face at least once for a well-child visit during the prior 12 months.	TBD

Measure	Eligible Specialties	Collection Date / Dates of Service	Data Elements	Risk Adjustment
nutrition discussion, counseling or referral documented in the medical record *Clinics that provide well-child visit services*				

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Ambulatory Surgical Centers**
2014 Report Year

Existing Measures

Measure	Collection Date / Dates of Service	Data Elements	Risk Adjustment
Prophylactic intravenous (IV) antibiotic timing	Collecting July 1, 2014 on dates of service: July 1, 2013 through June 30, 2014	• Numerator: ASC admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection, who received the prophylactic antibiotic on time (within one hour prior to the time of the initial surgical incision or the beginning of the procedure or two hours prior if vancomycin or fluoroquinolones are administered). • Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection	N/A
Hospital transfer/admission	Collecting July 1, 2014 on dates of service: July 1, 2013 through June 30, 2014	• Numerator: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC • Denominator: All ASC admissions	• American Society of Anesthesiologists (ASA) Physical Status classification categories
Appropriate surgical site hair removal	Collecting July 1, 2014 on dates of service: July 1, 2013 through June 30, 2014	• Numerator: ASC admissions with surgical site hair removal with clippers or depilatory cream • Denominator: All ASC admissions with surgical site hair removal	N/A

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for **Hospitals**
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Existing Measures

CMS Measures	Dates of Service	Data Elements
Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates • Aspirin prescribed at discharge (AMI-2) • Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a) • Primary PCI received within 90 minutes of hospital arrival (AMI-8a) • Statin prescribed at discharge (AMI-10)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All heart failure (HF) process of care measures for applicable hospital discharge dates • Discharge instructions (HF-1) • Evaluation of LVS function (HF-2) • ACEI or ARB for LVSD (HF-3)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Pneumonia (PN) process of care measures for applicable hospital discharge dates • Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN-3b) • Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (PN-6)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for each of the hospital compare pneumonia process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality

CMS Measures	Dates of Service	Data Elements
		measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All surgical care improvement project (SCIP) process of care measures for applicable hospital discharge dates • Prophylactic antibiotic received within one hour prior to surgical incision * (SCIP-Inf-1a) • Prophylactic antibiotic selection for surgical patients (SCIPInf-2a) • Prophylactic antibiotics discontinued within 24 hours after surgery end time * (SCIP-Inf-3a) • Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (SCIP-Inf-4) • Urinary catheter removed on postoperative day 1 or postoperative day 2 with day surgery being day zero (SCIP-Inf-9) • Surgery patients with perioperative temperature management (SCIP-Inf-10) • Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period (SCIP-Card-2) • Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for each of the hospital compare surgical care improvement project (SCIP) process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Outpatient acute myocardial infarction (AMI) and chest pain Measures The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: • Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the

CMS Measures	Dates of Service	Data Elements
• Median time to transfer to another facility for acute coronary intervention (OP-3) • Aspirin at arrival (OP-4) • Median time to ECG (OP-5)		targets in each of the quality measures • Calculated rate
Outpatient surgery department measures The hospital outpatient process of care measures include the following measures related to hospital outpatient surgery care: • Timing of antibiotic prophylaxis (OP-6) • Prophylactic antibiotic selection for surgical patients (OP-7)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for each of the outpatient surgery department quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All prevention global immunization process of care measures for applicable hospital discharge dates • Pneumococcal immunization-overall rate (Prev-Imm-1a) • Influenza immunization-overall rate (Prev-Imm-2)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for each of the inpatient prevention global immunization quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All mortality outcome of care measures for applicable hospital discharge dates • Acute myocardial infarction (AMI) 30-day mortality rate (MORT-30-AMI) • Heart failure (HF) 30-day mortality rate (MORT-30-HF) • Mortality pneumonia (PN) 30-day mortality rate(MORT-30-PN)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	CMS calculates using claims data. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures

CMS Measures	Dates of Service	Data Elements
		• Calculated rate
Appropriate Care Measures (ACM)		
Acute myocardial infarction appropriate care measure (AMI-ACM) Appropriate Care Measure (percent of patients that met ALL heart attack process of care measures, if eligible). The following individual measures are included in the AMI-ACM: • AMI-2: Aspirin prescribed at discharge • AMI-7a: Thrombolytic within 30 minutes of hospital arrival • AMI-8a: PCI within 90 minutes of hospital arrival • AMI-10: Statin prescribed at discharge	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	CMS calculates using claims data. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Heart failure appropriate care measure (HF-ACM) Appropriate Care Measure (percent of patients that met ALL heart failure process of care measures, if eligible). The following individual measures are included in the HF-ACM: • HF-1: Discharge instructions • HF-2: LVF assessment • HF-3: ACEI or ARB for LVSD	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	CMS calculates using claims data. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Pneumonia appropriate care measure (PN-ACM) Appropriate Care Measure (percent of patients that met ALL pneumonia process of care measures, if eligible). The following individual measures are included in the PN-ACM: • PN-3b: Blood cultures before antibiotics • PN-6: Initial antibiotic selection for CAP in immunocompetent patient	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	CMS calculates using claims data. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

AHRQ Measures	Dates of Service	Data Elements
Mortality for selected conditions composite measure (IQI 91) This composite measure includes the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) related to hospital inpatient mortality for specific conditions: • Acute myocardial infarction (AMI) mortality rate (IQI 15) • Congestive heart failure (CHF) mortality rate (IQI 16) • Acute stroke mortality rate (IQI 17) • GI Hemorrhage mortality rate (IQI 18) • Hip fracture mortality rate (IQI 19) • Pneumonia mortality rate (IQI 20)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	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
Death among surgical inpatients with serious treatable complications (PSI 4) This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for the death among surgical inpatients with serious treatable complications (PSI 4) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in each of the quality measure • Calculated rate
Obstetric trauma – vaginal delivery with instrument (PSI 18) This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure

AHRQ Measures	Dates of Service	Data Elements
		• Calculated rate
Obstetric trauma – vaginal delivery without instrument (PSI 19) This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 without instrument assistance	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Patient safety for selected indicators composite measure (PSI 90) This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Pressure ulcer (PSI 3) • Iatrogenic pneumothorax (PSI 6) • Selected infections due to medical care (PSI 7) • Postoperative hip fracture (PSI 8) • Postoperative hemorrhage or hematoma (PSI 9) • Postoperative physiological and metabolic derangements (PSI 10) • Postoperative respiratory failure (PSI 11) • Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) • Postoperative sepsis (PSI 13) • Postoperative wound dehiscence (PSI 14) • Accidental puncture or laceration (PSI 15)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for the patient safety for selected indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Pediatric Heart Surgery Mortality Rate measure (PDI 6) This measures the number of in-hospital deaths in pediatric patients	Discharge dates First Quarter 2014 (January 1 - March	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: Pediatric patients

AHRQ Measures	Dates of Service	Data Elements
undergoing surgery for congenital heart disease	31) through Fourth Quarter 2014 (October 1 – December 31)	undergoing surgery for congenital heart disease • Numerator: Number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease • Calculated rate
Pediatric Heart Surgery Volume measure (PDI 7) This measures the number of in-hospital congenital heart surgeries for pediatric patients	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for the pediatric patient for selected indicators: Volume: Pediatric patients undergoing surgery for congenital heart disease
Pediatric patient safety for selected indicators composite measure (PDI 19) This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Accidental puncture or laceration (PDI 1) • Pressure ulcer (PDI 2) • Iatrogenic pneumothorax (PDI 5) • Postoperative hemorrhage or hematoma (PDI 8) • Postoperative respiratory failure (PDI 9) • Postoperative sepsis (PDI 10) • Postoperative wound dehiscence (PDI 11) • Selected infections due to medical care (PDI 12)	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for the pediatric patient safety for selected indicators composite measure and for each of the pediatric patient safety for selected indicators composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

Other Measures	Dates of Service	Data Elements
Late Sepsis or Meningitis in Neonates (Vermont Oxford Network) Measures the infection rate for inborn and outborn infants meeting certain age and weight requirements *Specification Information:* Late Sepsis or Meningitis in Very Low Birth Weight Neonates Specifications: Vermont Oxford Network	2013 dates of service	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: inborn and outborn infants meeting criteria (see full specifications) • Numerator: Infection criteria (see full specifications) • Calculated rate
Central line-associated bloodstream infection (CLABSI) event This measure is used to assess the infection rate of patients with a central line-associated bloodstream infection (CLABSI) event by inpatient hospital unit. *Specification Information:* Central Line-Associated Bloodstream Infection (CLABSI) Event Specifications: Center for Disease Control and Prevention	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals with neonatal intensive care unit (NICU) and/or a pediatric intensive care unit (PICU) must submit data for the central line-associated bloodstream infection (CLABSI) event by neonatal and pediatric intensive care units. This data includes the following information for each intensive care unit: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure. • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Patient experience – This measure is used to assess patients' perception of their hospital care using a national survey called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) *(This measure is not required for hospitals with less than 500 admissions in the previous calendar year)*	2014	Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey
Health Information Technology (HIT) This survey is used to assess ***a hospital's*** adoption and use of Health Information Technology (HIT) in ***its*** clinical practice	May 2014	Survey

Other Measures	Dates of Service	Data Elements
Specification Information: 2013 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C. with MN-Specific Additional Questions		
All ED throughput process of care measures for applicable hospital discharge dates ED Measure: Transfer Communication • Administrative communication (NQF 0291) • Vital signs (NQF 0292) • Medication information (NQF 0293) • Patient information (NQF 0294) • Physician information (NQF 0295) • Nursing information (NQF 0296) • Procedures and tests (NQF 0297) *Specification Information:* Transfer Communication Measure Specifications, University of Minnesota Rural Health Research Center	Discharge dates First Quarter 2015 (January 1 – March 1) through Fourth Quarter 2015 (October 1 – December 31)	Hospitals must submit data for each of the transfer communication quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All ED/ inpatient stroke registry process of care measures for applicable hospital discharge dates • Door-to-imaging performed time *Specification Information:* Emergency Department Stroke Registry Process of Care Indicator Specifications. Minnesota Stroke Registry	Discharge dates Third Quarter 2013 (July - September 30) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for patients discharge from the emergency department or inpatient with diagnosis of ischemic stroke, subarachnoid hemorrhage, intracerebral hemorrhage, ill-defined stroke (MN Stroke Registry specifications). This data includes the following information: • Number of minutes for defined steps in patient flow

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FINAL Slate of Proposed Measures for **Hospitals**
2014 Report Year

New Measures

CMS Measures	Dates of Service	Data Elements
Early elective deliveries - Early elective delivery prior to 39 completed weeks of gestation (PC-1) process of care measure for applicable hospital discharge dates	Discharge dates First Quarter 2014 (January 1 - March 31) through Fourth Quarter 2014 (October 1 – December 31)	Hospitals must submit data for the early elective delivery process of care quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the measure • Numerator: Number of patients with elective deliveries • Calculated rate

Removed Measures

CMS Measures	Data Elements
Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1)	Hospitals must submit data for the hospital compare surgical care improvement project (SCIP) process of care quality measure. 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
Troponin results for Emergency Department AMI patients or chest pain patients received within 60 minutes of arrival (OP-16)	Hospitals must submit data for the outpatient acute myocardial infarction (AMI) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures

CMS Measures	Data Elements
	• Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Median time from ED arrival to ED departure for admitted ED patients (ED-1a) Median time from admit decision time to ED departure time for admitted patients (ED-2a)	Hospitals must submit data for each of the emergency room throughput quality measures. This data includes the following information: • Number of minutes for defined steps in patient flow.

***The Measurement and Reporting Committee (MARC) did not originally approve the removal of all individual AHRQ measures identified below. The committee charged MNCM staff to assess the volume of cases per hospital for each measure and to keep those measures that had a sufficient volume as "existing" measures. MNCM worked with Stratis Health and the Minnesota Hospital Association to identify those measures and provide more information to MDH the week of June 17th.**

On June 18th, Stratis Health, MHA, and MNCM met to review the individual AHRQ measures based on direction from the MARC. The review assessed volume, but based equal priority on whether or not the measure met the following: NQF endorsement, is part of the composite measure, is part of CMS Inpatient Quality Reporting, has been retired by CMS, and identified as a measure suitable for comparative reporting based on criteria set forth by AHRQ.

AHRQ Measures	Data Elements
Abdominal aortic aneurysm (AAA) repair volume (IQI 4) This measure is used to assess the raw volume of provider-level abdominal aortic aneurysm (AAA) repair (surgical procedure)	Hospitals must submit data for the abdominal aortic aneurysm (AAA) repair volume (IQI 4) quality measure. This data includes the following information: • Volume
Abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) This measure is used to assess the number of deaths per 100 discharges with procedure code of abdominal aortic aneurysm (AAA) repair	Hospitals must submit data for the abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

AHRQ Measures	Data Elements
Coronary artery bypass graft (CABG) volume (IQI 5) This measure is used to assess the raw volume of provider-level coronary artery bypass graft (CABG) (surgical procedure)	Hospitals must submit data for the coronary artery bypass graft (CABG) volume (IQI 5) quality measure. This data includes the following information: • Volume
Coronary artery bypass graft (CABG) mortality rate (IQI 12) This measure is used to assess the number of deaths per 100 discharges with a procedure code of coronary artery bypass graft (CABG)	Hospitals must submit data for the coronary artery bypass graft (CABG) mortality rate (IQI 12) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) This measure is used to assess the raw volume of provider level percutaneous transluminal coronary angioplasty (PTCA) (surgical procedure)	Hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) quality measure. This data includes the following information: • Volume
Percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) This measure is used to assess the number of deaths per 100 percutaneous transluminal coronary angioplasties (PTCAs)	Hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

AHRQ Measures	Data Elements
Hip fracture mortality rate (IQI 19) This measure is used to assess the number of deaths per 100 discharges with principal diagnosis code of hip fracture	Hospitals must submit data for the hip fracture mortality rate (IQI 19) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Pressure ulcer (PSI 3) This measure is used to assess the number of cases of decubitus ulcer per 1,000 discharges with a length of stay greater than 4 days	Hospitals must submit data for the pressure ulcer (PSI 3) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) This measure is used to assess the number of cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 1,000 surgical discharges with an operating room procedure	Hospitals must submit data for the postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

AHRQ Measures	**Data Elements**
Central Venous Catheter-related Bloodstream Infections (PDI 12) This measures the number of patients with specific infection codes per 1,000 eligible admissions (population at risk)	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: All medical and surgical patients (defined by DRG), age 0-17 years • Numerator: Other infection (Infection, sepsis or septicemia following infusion, injection, transfusion, or vaccination) and Infection and inflammatory reaction due to other vascular device, implant, and graft • Calculated Rate

Other Measures	**Data Elements**
Home Management Plan of Care Given to Patient/Caregiver for Pediatric Asthma (Joint Commission CAC-3) Measures the number of pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care (HMPC) document. *Specification Information:* Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.0. Centers for Medicare and Medicaid Services (CMS), The Joint Commission	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: Pediatric asthma inpatients (ages 2-17) discharged home • Numerator: Pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care (HMPC) document that addresses **all** of the following: 1. Arrangements for follow-up care 2. Environmental control and control of other triggers 3. Method and timing of rescue actions 4. Use of controllers 5. Use of relievers • Calculated rate

All ED/inpatient stroke registry process of care measures for applicable hospital discharge dates Documentation that NIH stroke scale performed in initial evaluation	Hospitals must submit data for patients discharge from the emergency department or inpatient with diagnosis of ischemic stroke, subarachnoid hemorrhage, intracerebral hemorrhage, ill defined stroke (MN Stroke Registry specifications). This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

Submission Deadlines for Hospitals

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

Inpatient Quality Measures

Discharge Dates; Data Submission Deadline
First Quarter, 2014: January 1 – March 31; August 15, 2014
Second Quarter, 2014: April 1 – June 30; November 15, 2014
Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015

Outpatient Quality Measures

Discharge Dates Data Submission Deadline
First Quarter, 2014: January 1 – March 31; August 15, 2014
Second Quarter, 2014: April 1 – June 30; November 15, 2014
Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015

Appropriate Care Measures (ACM)

Discharge Dates Data Submission Deadline
First Quarter, 2014: January 1 – March 31; August 15, 2014
Second Quarter, 2014: April 1 – June 30; November 15, 2014

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Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015

Data Submission for Inpatient Quality Indicators (IQI), Patient Safety Indicators (PSI), and Pediatric Patient Safety Indicators (PDI), Agency for Healthcare Research and Quality
Discharge Dates; Data Submission Deadline
First Quarter, 2014: January 1 – March 31; August 15, 2014
Second Quarter, 2014: April 1 – June 30; November 15, 2014
Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015

Data Submission for Vermont Oxford Network (VON)
Discharge Dates: Data Submission Deadline
All 2013 Dates of Service June 30, 2014

Data Submission for the Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures
Event Dates; Data Submission Deadline
First Quarter, 2014: January 1 – March 31; August 15, 2014
Second Quarter, 2014: April 1 – June 30; November 15, 2014
Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015

Data Submission for Minnesota Stroke Registry Indicator
Discharge Dates Data; Submission Deadline
Third Quarter, 2013: July 1 – September 30; February 15, 2014
Fourth Quarter, 2013: October 1 – December 31; May 15, 2014
First Quarter, 2014: January 1 – March 31; August 15, 2014
Second Quarter, 2014: April 1 – June 30; November 15, 2014
Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015