**DATE:** **June 9, 2011**

**RE:** **2012 Final Recommendations**
**Physician Clinics, Ambulatory Surgery Centers and Hospitals**
**Statewide Quality Reporting and Measurement System**

The attached table summarizes MN Community Measurement's (MNCM's) final recommendations for physician clinic, ambulatory surgery center and hospital measures for the 2012 Statewide Quality Reporting and Measurement System. These recommendations were reviewed and approved by MNCM's Measurement and Reporting Committee.

Proposed changes include the following:

- Physician Clinics
  - An update of the Optimal Vascular Care (OVC) measure to include a revised blood pressure component
  - The addition of Ischemic Vascular Disease and Diabetes as factors of comorbidity for risk adjustment of the Diabetes and OVC measures
  - The addition of Behavioral Health as a required group of providers for the Depression Remission measure regardless of whether a physician sees patients at the clinic
  - Modifications to measurement of Patient Experience
  - New measures of Optimal Maternity Care and Total Knee Replacement
- Hospitals
  - New measures of Emergency Department (ED) Throughput, Prevention Global Immunization, Acute Myocardial Infarction (AMI) / Heart Attack, Mortality Outcome and ED/Inpatient Stroke Registry
  - Retired measures of AMI / Heart Attack, Heart Failure (HF), Pneumonia (PN) and Surgical Care Improvement Project (SCIP)

Proposed changes are highlighted in yellow on the following pages.

**The Minnesota Department of Health (MDH) invites interested stakeholders to review and comment on MNCM's final recommendations for physician clinic, ambulatory surgical center and hospital measures for the 2012 Statewide Quality Reporting and Measurement System. Please send your comments to health.reform@state.mn.us through June 26.**

Additionally, MDH and MNCM will hold a **public forum in St. Paul on Tuesday, June 21,** to present MNCM's final quality measure recommendations in connection with the annual update and expansion of the Statewide Quality Reporting and Measurement System. MNCM will also present its measure concept recommendations for development of new measures related to Pediatric Preventive Care and Hospital Readmissions and Potentially Avoidable Admissions. The public forum will include an opportunity for interested stakeholders to comment on the recommendations and to ask questions.

**Public Forum Information:**
Tuesday, June 21, 2011
1-3 p.m.
Hamline Midway Branch Library Auditorium
Saint Paul Public Library*
1558 West Minnehaha Avenue
St. Paul, MN 55104
Directions:
http://www.stpaul.lib.mn.us/locations/hamline-midway.html

MDH will consider all public comments during the development of the 2011 proposed rule. The proposed rule will be published in August.

*Please note use of the Saint Paul Public Library System meeting facilities does not constitute endorsement of the beliefs, viewpoints, policies or affiliations of the user by the library board or staff.

## Revised Measures

| Measure | Eligible Providers | Collection Date / Dates of Service | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Optimal Vascular Care Composite (revised 2011):**<br>• Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL)<br>• Blood pressure control (less than 140/90 mm Hg)<br>• Daily aspirin use or contraindication to aspirin<br>• Documented tobacco free | • Family Medicine<br>• Internal Medicine<br>• Geriatric Medicine<br>• Cardiology | Collecting January 1, 2012 on calendar 2011 dates of service. | • Adults age 18 to 75<br>• 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.<br>• 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:<br>• Commercial/Private Insurance<br>• Medicare<br>• MN Health Care Programs, Self-pay, Uninsured<br><br>Diabetes co-morbidity |

## Existing Measures

| Measure | Eligible Providers | Collection Date / Dates of Service | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Optimal Diabetes Care Composite:**<br>• HbA1c (less than 8 percent)<br>• Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL)<br>• Blood pressure control (less than 140/90 mm Hg)<br>• Daily aspirin use if patient has diagnosis of IVD (or valid contraindication to aspirin)<br>• Documented tobacco free | • Family Medicine<br>• Internal Medicine<br>• Geriatric Medicine<br>• Endocrinology | Collecting January 1, 2012 on calendar 2011 dates of service. | • Adults age 18 to 75<br>• 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.<br>• 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:<br>• Commercial/Private<br>• Medicare<br>• MN Health Care Programs, Self-pay, Uninsured<br><br>Ischemic Vascular Disease co-morbidity |
| **Depression Remission at 6 Months:**<br>• 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<br>• Internal Medicine<br>• Geriatric Medicine<br>• Psychiatry<br>• Licensed Behavioral Health (regardless of physician on site) | Collecting January 1, 2012 on dates of service: February 1, 2011 - January 31, 2012 | • Adults age 18 and older<br>• Patient visits or contacts during the measurement period with Diagnosis of Major Depression or Dysthymia<br>• Initial PHQ-9 score is > nine | Initial PHQ-9 severity bands |

## Existing Measures

| Measure | Eligible Providers | Collection Date / Dates of Service | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Optimal Asthma Care**<br>• Asthma is well controlled (asthma control tool/test results indicate control)<br>• Patient is not at risk for future exacerbations (patient reports less than two total emergency department visits and hospitalizations during previous 12 months)<br>• Patient has been educated about asthma and has a current written asthma management plan containing information on medication doses and effects, what to do during an exacerbation, and information on the patient's triggers (written/reviewed within the measurement period) | • Family Medicine<br>• Internal Medicine<br>• General Practice<br>• Pediatrics<br>• Allergy / Immunology<br>• Pulmonology | Collecting July 1, 2012 on dates of service: July 1, 2011 – June 30, 2012 | • Patient ages 5-50<br>• 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<br>• 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:<br>• Commercial/Private<br>• Medicare<br>• MN Health Care Programs, Self-pay, Uninsured |

## Existing Measures

| Measure | Eligible Providers | Collection Date / Dates of Service | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Colorectal Cancer Screen**<br>• 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<br>• Internal Medicine<br>• Geriatric Medicine<br>• Obstetrics / Gynecology | Collecting July 1, 2012 on dates of service: July 1, 2011 – June 30, 2012 | • Adults age 50-75<br>• Seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years for any reason.<br>• 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:<br>• Commercial/Private<br>• Medicare<br>• MN Health Care Programs, Self-pay, Uninsured |
| **Health Information Technology Survey**<br>• Survey topics cover adoption of HIT, use of HIT, exchange of information, and on-line services | All Specialties | Collecting February 15 through March 15, 2012 on current HIT status. | Clinic-level survey | Not applicable – data reported as descriptive statistics only |

## New Measures

| Measure | Eligible Providers | Collection Date / Dates of Service* | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Patient Experience of Care**<br>Survey topics cover:<br>• Getting care when needed / access to care<br>• Communication<br>• Helpfulness of office staff<br>• Doctors with an exceptional rating<br><br>Clinic sites with fewer than 625 unique patients visiting the clinic during 9/1/11 through 11/30/11 are not required to submit survey results.<br><br>*See attached Patient Experience of Care Survey Specifications for more information* | All specialties except Psychiatry | Dates of service to survey: September 1 – November 30, 2012<br><br>Sample should achieve a minimum of 250 responses.<br>• Federally Qualified Health Centers may distribute surveys using in-office distribution.<br>• All other providers will use modes approved by the CAHPS Consortium.<br><br>** Measure will be required every other year* | All patients ages 18 and older with a face-to-face visit at the clinic during the timeframe, are eligible for inclusion in the survey regardless of:<br>• Physician specialty<br>• Reason for visit<br>• Duration of patient/physician relationship | Survey responses to:<br>• Health status<br>• Age |

## New Measures

| Measure | Eligible Providers | Collection Date / Dates of Service* | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Optimal Maternity Care:**<br><br>• Percentage of cesarean deliveries for first births<br><br>• Percentage of electively induced deliveries between 37 and 39 weeks gestational age | • Family Medicine<br>• Internal Medicine<br>• Obstetrics / Gynecology<br>• Perinatology | • Percentage Cesarean:<br>Collecting July 1, 2012 on dates of service: July 1, 2011 – June 30, 2012<br><br>• Elective Induction:<br>Collecting July 1, 2013 on dates of service: July 1, 2012 – June 30, 2013 | • Cesarean:<br>All live, singleton deliveries to nulliparous women performed by a medical clinic site, including all cesarean and all vaginal deliveries.<br>• Induction:<br>All live, singleton deliveries to women between =>37 and < 39 weeks completed gestational age. All cesarean and all vaginal deliveries. | Cesarean Section:<br>Insurance Product Type -<br>• Commercial/Private<br>• Medicare<br>• MN Health Care Programs, Self-pay, Uninsured<br><br>Elective Induction: TBD |

## New Measures

| Measure | Eligible Providers | Collection Date / Dates of Service* | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Total Knee Replacement:**<br><br>• Average post-operative functional status improvement at one year post-operatively measured by the Oxford Knee Score tool.<br><br>• 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 service:[1] 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 service. | • TBD |

[1] The collection date for the total knee replacement measures allows for a one year (± 3 months) post-operative follow up period.

## Existing Measures

| Measure | Eligible Providers | Collection Date / Dates of Service | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Prophylactic intravenous (IV) antibiotic timing** | Freestanding Ambulatory Surgical Centers (ASC) as defined by MDH Quality Rule. | Collecting July 1, 2012 on dates of service: July 1, 2011 – June 30, 2012 | • Numerator: Number of ASC admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection, who received the prophylactic antibiotic on time (within 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).<br>• Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection | N/A |

## Existing Measures

| Measure | Eligible Providers | Collection Date / Dates of Service | Data Elements | Risk Adjustment |
|---|---|---|---|---|
| **Hospital transfer/admission** | Freestanding Ambulatory Surgical Centers (ASC) as defined by MDH Quality Rule. | Collecting July 1, 2012 on dates of service: July 1, 2011 – June 30, 2012 | • Numerator: (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC<br>• Denominator: All ASC admissions | Insurance Product Type:<br>• Commercial/Private Insurance<br>• Medicare<br>• MN Health Care Programs, Self-pay, Uninsured |
| **Appropriate surgical site hair removal** | Freestanding Ambulatory Surgical Centers (ASC) as defined by MDH Quality Rule. | Collecting July 1, 2012 on dates of service: July 1, 2011 – June 30, 2012 | • Numerator: ASC admissions with surgical site hair removal with clippers or depilatory cream<br>• Denominator: All ASC admissions with surgical site hair removal | N/A |

## Existing Measures

| CMS Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Acute myocardial infarction (AMI) / heart attack** process of care measures for applicable hospital discharge dates<br>• Aspirin at arrival (AMI-1)<br>• Aspirin prescribed at discharge (AMI-2)<br>• ACEI or ARB for LVSD (AMI-3)<br>• Adult smoking cessation advice/counseling (AMI-4)<br>• Beta-blocker prescribed at discharge (AMI-5)<br>• Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a)<br>• Primary PCI received within 90 minutes of hospital arrival (AMI-8a)<br>• Appropriate Care Measure (percent of patients that met ALL heart attack process of care measures, if eligible) | (CMS schedule) / DOS ending 3rd Quarter 2012 | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |
| All **heart failure (HF)** process of care measures for applicable hospital discharge dates<br>• Discharge instructions (HF-1)<br>• Evaluation of LVS function (HF-2)<br>• ACEI or ARB for LVSD (HF-3)<br>• Adult smoking cessation advice/counseling (HF-4)<br>• Appropriate Care Measure (percent of patients that met ALL heart failure process of care measures, if eligible) | (CMS schedule) / DOS ending 3rd Quarter 2012 | Hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## Existing Measures

| CMS Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Pneumonia (PN)** process of care measures for applicable hospital discharge dates<br>• Pneumococcal vaccination (PN-2)<br>• Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN-3b)<br>• Adult smoking cessation advice/counseling (PN-4)<br>• Initial antibiotic received within 6 hours of hospital arrival (PN-5c)<br>• Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (PN-6)<br>• Influenza vaccination (PN-7)<br>• Appropriate Care Measure (percent of patients that met ALL pneumonia process of care measures, if eligible) | (CMS schedule) / DOS ending 3rd Quarter 2012 | Hospitals must submit data for each of the hospital compare pneumonia process of care quality measures. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## Existing Measures

| CMS Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| All **surgical care improvement project (SCIP)** process of care measures for applicable hospital discharge dates<br>• Prophylactic antibiotic received within one hour prior to surgical incision * (SCIP-Inf-1)<br>• Prophylactic antibiotic selection for surgical patients (SCIPInf-2)<br>• Prophylactic antibiotics discontinued within 24 hours after surgery end time * (SCIP-Inf-3)<br>• Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (SCIP-Inf-4)<br>• Surgery patients with appropriate hair removal (SCIP-Inf-6)<br>• Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period (SCIP-Card-2)<br>• Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1)<br>• Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2) | (CMS schedule) / DOS ending 3rd Quarter 2012 | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## Existing Measures

| CMS Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Outpatient acute myocardial infarction (AMI) and chest pain measures.** The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care:<br>• Median time to fibrinolysis (OP-1)<br>• Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2)<br>• Median time to transfer to another facility for acute coronary intervention (OP-3)<br>• Aspirin at arrival (OP-4)<br>• Median time to ECG (OP-5) | (CMS schedule) / DOS ending 3rd Quarter 2012 | Hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |
| **Outpatient surgery department measures.** The hospital outpatient process of care measures include the following measures related to hospital outpatient surgery care:<br>• Timing of antibiotic prophylaxis (prophylactic antibiotic initiated within one hour prior to surgical incision*) (OP- 6)<br>• Prophylactic antibiotic selection for surgical patients (OP-7) | (CMS schedule) / DOS ending 3rd Quarter 2012 | Hospitals must submit data for each of the outpatient surgery department quality measures. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Abdominal aortic aneurysm (AAA) repair volume (IQI 4)**<br>This measure is used to assess the raw volume of provider-level abdominal aortic aneurysm (AAA) repair (surgical procedure). | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the abdominal aortic aneurysm (AAA) repair volume (IQI 4) quality measure. This data includes the following information:<br>• Volume |
| **Abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11)**<br>This measure is used to assess the number of deaths per 100 discharges with procedure code of abdominal aortic aneurysm (AAA) repair. | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) quality measure. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in the quality measure<br>• Calculated rate |
| **Coronary artery bypass graft (CABG) volume (IQI 5)**<br>This measure is used to assess the raw volume of provider-level coronary artery bypass graft (CABG) (surgical procedure). | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the coronary artery bypass graft (CABG) volume (IQI 5) quality measure. This data includes the following information:<br>• Volume |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Coronary artery bypass graft (CABG) mortality rate (IQI 12)**<br>This measure is used to assess the number of deaths per 100 discharges with a procedure code of coronary artery bypass graft (CABG). | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the coronary artery bypass graft (CABG) mortality rate (IQI 12) quality measure. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in the quality measure<br>• Calculated rate |
| **Percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6)**<br>This measure is used to assess the raw volume of provider level percutaneous transluminal coronary angioplasty (PTCA) (surgical procedure). | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) quality measure. This data includes the following information:<br>• Volume |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30)**<br>This measure is used to assess the number of deaths per 100 percutaneous transluminal coronary angioplasties (PTCAs). | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) quality measure. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in the quality measure<br>• Calculated rate |
| **Hip fracture mortality rate (IQI 19)**<br>This measure is used to assess the number of deaths per 100 discharges with principal diagnosis code of hip fracture. | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the hip fracture mortality rate (IQI 19) quality measure. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in the quality measure<br>• Calculated rate |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Pressure ulcer (PSI 3)**<br>This measure is used to assess the number of cases of decubitus ulcer per 1,000 discharges with a length of stay greater than 4 days. | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the pressure ulcer (PSI 3) quality measure. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in the quality measure<br>• Calculated rate |
| **Death among surgical inpatients with serious treatable complications (PSI 4)**<br>This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization. | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the death among surgical inpatients with serious treatable complications (PSI 4) quality measure. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in each of the quality measure<br>• Calculated rate |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12)**<br>This measure is used to assess the number of cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 1,000 surgical discharges with an operating room procedure. | DOS 4th Quarter 2010 through 3rd quarter 2012 | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in the quality measure<br>• Calculated rate |
| **Obstetric trauma – vaginal delivery with instrument (PSI 18)**<br>This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries. | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in the quality measure<br>• Calculated rate |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Obstetric trauma – vaginal delivery without instrument (PSI 19)**<br>This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 without instrument assistance. | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in the quality measure<br>• Numerator: Number of patients meeting the targets in the quality measure<br>• Calculated rate |
| **Mortality for selected conditions composite measure**<br>This composite measure includes the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) related to hospital inpatient mortality for specific conditions:<br>• Acute myocardial infarction (AMI) mortality rate (IQI 15)<br>• Congestive heart failure (CHF) mortality rate (IQI 16)<br>• Acute stroke mortality rate (IQI 17)<br>• GI Hemorrhage mortality rate (IQI 18)<br>• Hip fracture mortality rate (IQI 19)<br>• Pneumonia mortality rate (IQI 20) | DOS 4th Quarter 2010 through 3rd quarter 2012 | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Patient safety for selected indicators composite measure.**<br>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:<br>• Pressure ulcer (PSI 3)<br>• Iatrogenic pneumothorax (PSI 6)<br>• Selected infections due to medical care (PSI 7)<br>• Postoperative hip fracture (PSI 8)<br>• Postoperative pulmonary embolism (PE) or deep vein<br>• thrombosis (DVT) (PSI 12)<br>• Postoperative sepsis (PSI 13)<br>• Postoperative wound dehiscence (PSI 14)<br>• Accidental puncture or laceration (PSI 15) | DOS 4th Quarter 2010 through 3rd quarter 2012 | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Pediatric patient safety for selected indicators composite measure.** This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions:<br>• Accidental puncture or laceration (PDI 1)<br>• Pressure ulcer (PDI 2)<br>• Iatrogenic pneumothorax (PDI 5)<br>• Postoperative sepsis (PDI 10)<br>• Postoperative wound dehiscence (PDI 11)<br>• Selected infections due to medical care (PDI 12) | DOS 4th Quarter 2010 through 3rd quarter 2012 | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |
| **Pediatric Heart Surgery Volume measure. (PDI 7)** This measures the number of in-hospital congenital heart surgeries for pediatric patients. | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the pediatric patient for selected indicators:<br>• Volume: Pediatric patients undergoing surgery for congenital heart disease |

## Existing Measures

| AHRQ Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Pediatric Heart Surgery Mortality Rate measure (PDI 6)**<br>This measures the number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the pediatric patient for selected indicators:<br>• Denominator: Pediatric patients undergoing surgery for congenital heart disease<br>• Numerator: Number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease<br>• Calculated rate |
| **Central Venous Catheter-related Bloodstream Infections (PDI 12)**<br>This measures the number of patients with specific infection codes per 1,000 eligible admissions (population at risk). | DOS 4th Quarter 2010 through 3rd quarter 2012 | Hospitals must submit data for the pediatric patient for selected indicators:<br>• Denominator: All medical and surgical patients (defined by DRG), age 0-17 years<br>• Numerator: Other infection (Infection, sepsis or septicemia following infusion, injection, transfusion, or vaccination) and<br>• Infection and inflammatory reaction due to other vascular device, implant, and graft<br>• Calculated rate |

## Existing Measures

| Other Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Home Management Plan of Care Given to Patient/Caregiver for Pediatric Asthma (Joint Commission CAC-3)**<br>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 | DOS ending 3rd Quarter 2012 | Hospitals must submit data for the pediatric patient for selected indicators:<br>• Denominator: Pediatric asthma inpatients (ages 2-17) discharged home<br>• 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:<br>1. Arrangements for follow-up care<br>2. Environmental control and control of other triggers<br>3. Method and timing of rescue actions<br>4. Use of controllers<br>5. Use of relievers<br>• Calculated rate |
| **Late Sepsis or Meningitis in Neonates (Vermont Oxford Network)**<br>Measures the infection rate for inborn and outborn infants meeting certain age and weight requirements. | September 2012 | Hospitals must submit data for the pediatric patient for selected indicators:<br>• Denominator: inborn and outborn infants meeting criteria (see full specifications)<br>• Numerator: Infection criteria (see full specifications)<br>• Calculated rate |

## Existing Measures

| Other Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Late Sepsis or Meningitis in Very Low Birth Weight Neonates (Vermont Oxford Network)**<br>Measures the infection rate for inborn and outborn infants meeting certain age and weight requirements. | September 2012 | Hospitals must submit data for the pediatric patient for selected indicators:<br>• Denominator: inborn and outborn infants meeting criteria (see full specifications)<br>• Numerator: Infection criteria (see full specifications)<br>• Calculated rate |
| **Patient experience**<br>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).<br><br>*(This measure is not required for hospitals with less than 500 admissions in the previous calendar year.)* | 2012 | Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey |
| **Health Information Technology (HIT)**<br>This survey is used to assess ***a hospital's*** adoption and use of Health Information Technology (HIT) in ***its*** clinical practice. | May 2012 | Survey |

## New Measures

| CMS Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| All **ED throughput** process of care measures for applicable hospital discharge dates<br>• Median time from ED arrival to ED departure for admitted ED patients (ED-1)<br>• Median time from admit decision time to ED departure time for admitted patients (ED-2) | (CMS Schedule)/DOS ending 3rd Quarter 2012 | Hospitals must submit data for each of the emergency room throughput quality measures. This data includes the following information:<br>• Number of minutes for defined steps in patient flow. |
| All **prevention global immunization** process of care measures for applicable hospital discharge dates<br>• Pneumococcal immunization-overall rate (Prev-Imm-1a)<br>• Influenza immunization-overall rate (Prev-Imm-2a) | (CMS Schedule)/DOS ending 3rd Quarter 2012 | Hospitals must submit data for each of the inpatient prevention global immunization quality measures. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## New Measures

| CMS Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Acute myocardial infarction (AMI) / heart attack** process of care measures for applicable hospital discharge dates<br>• Statin prescribed at discharge (AMI-10) | (CMS Schedule)/DOS ending 3rd Quarter 2012 | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |
| **PPS only: All mortality outcome** of care measures for applicable hospital discharge dates<br>• Acute myocardial infarction (AMI) 30-day mortality rate (MORT-30-AMI)<br>• Heart failure (HF) 30-day mortality rate (MORT-30-HF)<br>• Mortality pneumonia (PN) 30-day mortality rate (MORT-30-PN) | (CMS Schedule)/DOS July 1, 2008 to June 30, 2011 reported in April 2012 | CMS calculates using claims data. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## New Measures

| Other Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| All **ED throughput** process of care measures for applicable hospital discharge dates<br><br>**ED Measure: Transfer Communication**<br>• Administrative communication (NQF 0291)<br>• Vital signs (NQF 0292)<br>• Medication information(NQF 0293)<br>• Patient information(NQF 0294)<br>• Physician information(NQF 0295)<br>• Nursing information(NQF 0296)<br>• Procedures and tests(NQF 0297) | TBD | Hospitals must submit data for each of the transfer communication quality measures. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |
| All **ED/inpatient stroke registry** process of care measures for applicable hospital discharge dates<br>• Documentation that NIH stroke scale performed in initial evaluation | TBD | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

## New Measures

| Other Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| All **ED/inpatient stroke registry** process of care measures for applicable hospital discharge dates<br>• Door-to-imaging performed time | TBD | 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:<br>• Number of minutes for defined steps in patient flow. |

## Retired Measures

| CMS Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Acute myocardial infarction (AMI) / heart attack** process of care measures for applicable hospital discharge dates<br>• Aspirin at arrival (AMI-1)<br>• ACEI or ARB for LVSD (AMI-3)<br>• Adult smoking cessation advice/counseling (AMI-4)<br>• Beta-blocker prescribed at discharge (AMI-5) | N/A | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |
| All **heart failure (HF)** process of care measures for applicable hospital discharge dates<br>• Adult smoking cessation advice/counseling (HF-4) | N/A | Hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |

### Retired Measures

| CMS Measures | Collection Date / Dates of Service | Data Elements |
|---|---|---|
| **Pneumonia (PN)** process of care measures for applicable hospital discharge dates<br>• Adult smoking cessation advice/counseling (PN-4)<br>• Initial antibiotic received within 6 hours of hospital arrival (PN-5c) | N/A | Hospitals must submit data for each of the hospital compare pneumonia process of care quality measures. This data includes the following information:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |
| All **surgical care improvement project (SCIP)** process of care measures for applicable hospital discharge dates<br>• Surgery patients with appropriate hair removal (SCIP-Inf-6) | N/A | 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:<br>• Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures<br>• Numerator: Number of patients meeting the targets in each of the quality measures<br>• Calculated rate |