Minnesota Statewide Quality Reporting and Measurement System:

APPENDICES TO MINNESOTA ADMINISTRATIVE RULES, CHAPTER 4654

DECEMBER 2017

DEPARTMENT OF HEALTH

Minnesota Statewide Quality Reporting and Measurement System: Appendices to the Minnesota Administrative Rules, Chapter 4654

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Contents

Introduction

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

Measures that will be used for public reporting are identified in Appendices A and B. The standardized set of measures are defined in the body of the rule and include the measures identified in Appendices A, B, and D.

Appendix A. Required Physician Clinic Quality Measure Data

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
Diabetes		
Optimal Diabetes Care composite These measures are used to assess the percent of adult patients who have type I or type II diabetes with optimally managed modifiable risk factors: ▪ HbA1c control (less than 8 percent) ▪ Blood pressure control (less than 140/90 mmHg) ▪ Statin use unless allowed contraindications or exceptions are present ▪ Documented tobacco non-user ▪ For patients with a diagnosis of ischemic vascular disease (IVD), daily aspirin or anti-platelet use	Physician clinics submitting summary-level data must submit the following data for the Optimal Diabetes Care composite measure and for each of the five component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65-75), diabetes type (Type 1, Type 2), gender, race, ethnicity,	Optimal Diabetes Care Specifications, 2018 Report Year, 01/01/2017 to 12/31/2017 Dates of Service. MN Community Measurement, 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.u

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
unless allowed contraindications or exceptions are present *(Urgent Care Centers are not required to submit data on this measure.)*	preferred language, country of origin, and ZIP code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Optimal Diabetes Care composite measure	s/healthreform/measurement) Specifications for race, ethnicity, preferred language, and country of origin can be found on the website of the commissioner's designee, MN Community Measurement Supplemental DDS Specifications (mncm.org/supplemental-dds-specifications)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
	and for each of the five component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, diabetes type (Type 1, Type 2), gender, race, ethnicity, preferred language, country of origin, ZIP code, and patient identification methodology	
Cardiovascular Conditions		
Optimal Vascular Care composite These measures are used to assess the percent of adult patients who have ischemic vascular disease (IVD) with optimally managed modifiable risk factors: ▪ Blood pressure control (less than 140/90 mmHg) ▪ Statin use unless allowed contraindications or exceptions are present ▪ Documented tobacco non-user ▪ Daily aspirin or anti-platelet use unless allowed contraindications or exceptions are present	Physician clinics submitting summary-level data must submit the following data for the Optimal Vascular Care composite measure and for each of the four component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-	Optimal Vascular Care Specifications, 2018 Report Year, 01/01/2017 to 12/31/2017 Dates of Service. MN Community Measurement, 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
(Urgent Care Centers are not required to submit data on this measure.)	64, 65-75), gender, race, ethnicity, preferred language, country of origin, and ZIP code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the	Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement) Specifications for race, ethnicity, preferred language, and country of origin can be found on the website of the commissioner's designee, MN Community Measurement Supplemental DDS Specifications (mncm.org/supplemental-dds-specifications)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
	Optimal Vascular Care composite measure and for each of the four component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, race, ethnicity, preferred language, country of origin, ZIP code, and patient identification methodology	

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
Respiratory Conditions		
Optimal Asthma Control composite These measures are used to assess the percent of pediatric and adult asthma patients who are well controlled. Optimal control is defined as: ▪ Asthma is well controlled as demonstrated by specified assessment tools ▪ Patient is not at increased risk of exacerbations *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics submitting summary-level data must submit the following data for the Optimal Asthma Control composite measure and for each of the two component measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (5-11, 12-17, 18-34, 35-50), gender, race, ethnicity, preferred language, country of origin, and ZIP code: ▪ Denominator:	Optimal Asthma Control Specifications, 2018 Report Year, 01/01/2017 to 12/31/2017 Dates of Service. MN Community Measurement, 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
	Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample (NOTE: One sample per pediatric population and adult population is required for this measure.) ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Optimal Asthma Control composite measure and for each of the two	Specifications for race, ethnicity, preferred language, and country of origin can be found on the website of the commissioner's designee, MN Community Measurement Supplemental DDS Specifications (mncm.org/supplemental-dds-specifications)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
	component measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, race, ethnicity, preferred language, country of origin, ZIP code, and patient identification methodology	
Asthma Education and Self-management This measure is used to assess the percent of pediatric and adult asthma patients who have been educated about their asthma and self-management of their condition and also have a written asthma management plan present. *(Urgent Care Centers are not required to submit data on this measure.)*	Physician clinics submitting summary-level data must submit the following data for the asthma education and self-management measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (5-11, 12-17, 18-34, 35-50), gender, and ZIP code: ▪ Denominator:	Asthma Education & Self-Management Measure Specifications, 2018 Report Year, 01/01/2017 to 12/31/2017 Dates of Service. 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.u

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
	Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample (NOTE: One sample per pediatric population and adult population is required for this measure.) ▪ Numerator: Number of patients meeting the targets in the measure ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the asthma education and self-management measure: primary payer type (private	s/healthreform/measurement)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
	insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, ZIP code, and patient identification methodology	
Preventive Care		
Colorectal Cancer Screening This measure is used to assess the percent of adult patients, aged 50 to 75 years, who are up to date with appropriate colorectal cancer screening. The screening methods include: ▪ Colonoscopy within ten years ▪ Sigmoidoscopy within five years ▪ Computed tomography colonography within five years ▪ Fecal immunochemical test DNA test within three years ▪ Stool Blood Test within the measurement year	Physician clinics submitting summary level-data must submit the following data for the Colorectal Cancer Screening measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (50-64, 65-75), gender, race, ethnicity, preferred language, country of origin, and ZIP code: ▪ Denominator:	Colorectal Cancer Screening Specifications, 2018 Report Year, 01/01/2017 to 12/31/2017 Dates of Service. MN Community Measurement, 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.u

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
(Urgent Care Centers are not required to submit data on this measure.)	Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients with colorectal cancer screening ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Colorectal Cancer Screening measure: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, race, ethnicity, preferred language,	s/healthreform/measurement) Specifications for race, ethnicity, preferred language, and country of origin can be found on the website of the commissioner's designee, MN Community Measurement Supplemental DDS Specifications (mncm.org/supplemental-dds-specifications)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (2017 Dates of Service) and Every Year Thereafter		
	country of origin, ZIP code, and patient identification methodology	

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (12/01/2015 to 11/30/2016 Dates of Index) and Every Year Thereafter		
Behavioral Health Conditions		
Depression Remission at Six Months This measure is used to assess the percent of adult patients who have major depression or dysthymia who reached remission six months (+/- 30 days) after an index visit with a PHQ-9 score of greater than 9. Remission is defined as a PHQ-9 score of less than 5.	Physician clinics submitting summary-level data must submit the following data for the Depression Remission at Six Months measure: ▪ Patient identification methodology ▪ Submit the following two data elements by three bands of initial	Depression Care: Remission at Six Months Specifications, 2018 Report Year, 12/01/2015 to 11/30/2016 Dates of Index. MN Community Measurement, 2017 or as updated.

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (12/01/2015 to 11/30/2016 Dates of Index) and Every Year Thereafter		
(Urgent Care Centers are not required to submit data on this measure.)	PHQ-9 scores (10-14; 15-19; 20 and above), primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65 and over), gender, and ZIP code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients meeting the targets in the measure ▪ Number of patients meeting the exclusion criteria ▪ Number of patients for whom a follow-up six month (+/- 30 days) PHQ-9 assessment was not completed ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Depression Remission at Six Months measure: PHQ-9 score, primary payer type	Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in January 2018 (12/01/2015 to 11/30/2016 Dates of Index) and Every Year Thereafter		
	(private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, ZIP code, exclusion reason, and patient identification methodology	

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2017 Dates of Service) and Every Year Thereafter		
Pediatric Preventive Care		
Adolescent Mental Health and/or Depression Screening This measure is used to assess the percent of adolescent patients who receive mental health and/or depression screening as measured by specified assessment tools and have the screening tool result documented in the medical record.	Physician clinics submitting summary-level data must submit the following data for the Adolescent Mental Health and/or Depression Screening measure: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type	Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening Specifications, 2018 Report Year, 01/01/2017 to 12/31/2017 Dates of Service. MN Community

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2017 Dates of Service) and Every Year Thereafter		
(Clinics that provide well-child visit services are required to submit data on this measure.) *(Urgent Care Centers are not required to submit data on this measure.)*	(private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (12-17), gender, and ZIP code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients with mental health and/or depression screening and screening tool results documented ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Adolescent Mental Health and/or Depression Screening: primary payer type (private insurance, Medicare, Minnesota	Measurement, 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2017 Dates of Service) and Every Year Thereafter		
	Health Care Programs, self-pay, uninsured), age, gender, ZIP code, and patient identification methodology	

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2016 Dates of Procedure) and Every Year Thereafter		
Orthopedic Procedures		
Total Knee Replacement: Functional Status and Quality of Life outcome These measures are used to assess the average change between pre-operative and post-operative functional status and quality of life at one year as measured by specified assessment tools for patients who had a primary or revision total knee replacement surgery.	Physician clinics submitting summary-level data must submit the following data for the Total Knee Replacement Functional Status and Quality of Life outcome measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare,	Total Knee Replacement, Outcome Measures Specifications 2018 Report Year, 01/01/2016 to 12/31/2016 Dates of Procedure. MN Community

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2016 Dates of Procedure) and Every Year Thereafter		
Outcome measures are stratified by primary versus revision procedures.	Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and ZIP code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Average change between pre-operative and post-operative functional status or quality of life ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Total Knee Replacement Functional Status and Quality of Life outcome measures: primary payer type (private insurance, Medicare, Minnesota Health Care	Measurement, 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2016 Dates of Procedure) and Every Year Thereafter		
	Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, ZIP code, and patient identification methodology	
Spinal Surgery: Lumbar Fusion Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures These measures are used to assess the average change between pre-operative and post-operative functional status, quality of life, back pain, and leg pain at one year as measured by specified assessment tools.	Physician clinics submitting summary-level data must submit the following data for the Lumbar Fusion Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and ZIP code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure	Spinal Surgery: Lumbar Fusion, Outcome Measure Specifications 2018 Report Year, 01/01/2016 to 12/31/2016 Dates of Procedure. MN Community Measurement, 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.u

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2016 Dates of Procedure) and Every Year Thereafter		
	▪ Numerator: Average change between pre-operative and post-operative functional status, quality of life, back pain, or leg pain ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Lumbar Fusion Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, ZIP code, and patient identification methodology	s/healthreform/measurement)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2016 Dates of Procedure) and Every Year Thereafter		
Spinal Surgery: Lumbar Discectomy Laminotomy Functional Status, Quality of Life, Back Pain, and Leg Pain outcome These measures are used to assess the average change between pre-operative and post-operative functional status, quality of life, back pain, and leg pain at three months as measured by specified assessment tools.	Physician clinics submitting summary-level data must submit the following data for the Lumbar Discectomy Laminotomy Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures: ▪ Patient identification methodology ▪ Submit the following two data elements by primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and ZIP code: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Average change between pre-operative and post-operative functional status, quality of life, back pain, or leg pain	Spinal Surgery: Lumbar Discectomy Laminotomy, Outcome Measures Specifications 2018 Report Year, 01/01/2016 to 12/31/2016 Dates of Procedure. MN Community Measurement, 2017 or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in April 2018 (2016 Dates of Procedure) and Every Year Thereafter		
	▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate Physician clinics submitting patient-level data must submit the following data for the Lumbar Discectomy Laminotomy Functional Status, Quality of Life, Back Pain, and Leg Pain outcome measures: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, ZIP code, and patient identification methodology	

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Data Required for Reporting Beginning in September 2018 and Every Year Thereafter		
Health Information Technology		
Health Information Technology (HIT) Survey This survey is used to assess a physician clinic's adoption and use of HIT in their clinical practice.	Internet-based survey as updated in 2018	Health Information Technology (HIT) Ambulatory Clinic Survey. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement)

Removed Physician Clinic Measures		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Maternity Care: Cesarean Section Rate	Physician clinics are no longer required to report on this measure	This measure was removed effectively with 07/01/2016 dates of service
Patient Experience of Care Survey	Physician clinics are no longer required to report on this measure	This measure was removed effectively with 09/01/2016 dates of survey
Pediatric Preventive Care: Overweight Counseling	Physician clinics are no longer required to report on this measure	This measure was removed effectively with 01/01/2016 dates of service

Appendix B. Required Hospital Quality Measure Data

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2018 and Every Year Thereafter		
Prospective Payment System Hospital Measures		
Centers for Medicare & Medicaid Services' (CMS) Value-Based Programs		
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: ▪ Clinical Care ▪ Patient- and Caregiver-Centered Experience of Care/Care Coordination ▪ Patient Experience of Care ▪ Safety ▪ Efficiency and Cost Reduction	CMS calculates this score based on the quality measures and claims data submitted by each hospital, and results are published on the U.S. Department of Health & Human Services Hospital Compare website. 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 Hospital Compare website for all cases for each applicable quality measure.	Measure specifications for the individual component measures can be found on the CMS website QualityNet (www.qualitynet.org)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2018 and Every Year Thereafter		
Prospective Payment System Hospital Measures		
Hospital Readmissions Reduction Program Excess Readmission Rate This state-calculated composite is used to assess a hospital's risk standardized readmission rates (RSRR) for applicable hospital discharge dates based on the following principal diagnoses: ▪ Hospital 30-Day All Cause RSRR Following Acute Myocardial Infarction Hospitalization ▪ Hospital 30-Day All Cause RSRR Following Heart Failure Hospitalization ▪ Hospital 30-Day All Cause RSRR Following Pneumonia Hospitalization ▪ Hospital 30-Day All Cause RSRR Following Chronic Obstructive Pulmonary Disease Hospitalization ▪ Hospital 30-Day All Cause RSRR Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty ▪ Hospital 30-Day All Cause RSRR Following Coronary Artery Bypass Graft Surgery	The Minnesota Department of Health calculates this composite based on the CMS excess readmission ratio measures published on Hospital Compare. The readmission measures are calculated by CMS using Medicare enrollment and claims data submitted by hospitals for Medicare fee-for-service patients. 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.	Measure specifications for the individual risk standardized readmission rates can be found on the CMS website QualityNet (www.qualitynet.org) Measure specifications for the composite can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement)

Data Required for Reporting Beginning in Calendar Year 2018 and Every Year Thereafter		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Measures Required for Reporting Beginning in January 2018 and Every Year Thereafter		
Prospective Payment System Hospital Measures		
Hospital Acquired Condition Reduction Program Score This score is used to assess a hospital's performance in reducing hospital acquired conditions. The score includes measures within the following domains: ▪ 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 ▪ Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia ▪ Clostridium difficile Infection (CDI)	CMS calculates this score based on the quality measures and claims data submitted by each hospital, and results are published on the U.S. Department of Health & Human Services Hospital Compare website. 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 Hospital Compare website for all cases for each applicable quality measure.	Measure specifications can be found on the CMS website QualityNet (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 Measures		
Centers for Medicare & Medicaid Services (CMS) Medicare Beneficiary Quality Improvement Project Quality Measures		
Inpatient Critical Access Hospital (CAH) measures		
Emergency Department (ED) Hospital ED process of care measures for applicable discharge dates include the following: ▪ ED-1a: Median time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate This measure is used to assess the median time from ED arrival to time of departure from the ED for patients admitted to the facility from the ED. ▪ ED-2a: Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate This measure is used to assess the median time from admit decision time to time of departure from the ED for admitted patients.	CAHs must submit data for each of the ED quality measures, including: Number of minutes for defined steps in patient flow.	Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.3, Discharges 01/01/18 (1Q18) through 06/30/18 (2Q18). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2017 or as updated. Measure specifications can be found on the CMS website

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 Measures		
		QualityNet (www.qualitynet.org)
Readmission Risk standardized readmission rates (RSRR) for applicable hospital discharge dates based on principal diagnosis, including: ▪ READM-30-HF: Hospital All Cause RSRR Following Heart Failure Hospitalization ▪ READM-30-PN: Hospital All Cause RSRR Following Pneumonia Hospitalization ▪ READM-30-COPD: Hospital All Cause RSRR Following Chronic Obstructive Pulmonary Disease Hospitalization	CMS calculates these measures using Medicare enrollment and claims data submitted by hospitals for Medicare fee-for-service patients and results are published on the U.S. Department of Health & Human Services Hospital Compare website. 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 Hospital Compare website for all cases for each applicable quality measure.	Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.3, Discharges 01/01/18 (1Q18) through 06/30/18 (2Q18). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2017 or as updated. Measure specifications can be found on the CMS website QualityNet (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 Measures		
Immunization ▪ IMM-2: Influenza Immunization 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 prior to the current hospitalization are captured as numerator events.	CAHs must submit data for the immunization process of care quality measure, including: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients meeting the targets in the measure	Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.3, Discharges 01/01/18 (1Q18) through 06/30/18 (2Q18). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; July 2017 or as updated. Measure specifications can be found on the CMS website QualityNet (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 Measures		
Perinatal Care ▪ PC-01: Elective Delivery 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.	CAHs must submit data for the perinatal process of care quality measure, including: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients with elective deliveries	Specifications Manual for Joint Commission National Quality Measures, Version 2017 A, Discharges 07/01/17 (3Q17) through 12/31/17 (4Q17). The Joint Commission; 2017 or as updated. Measure specifications can be found at The Joint Commission (manual.jointcommission.org)
Outpatient Critical Access Hospital (CAH) Measures		
Acute Myocardial Infarction (AMI) and Chest Pain The hospital outpatient process of care measures include the following measures related emergency department	CAHs must submit data for each of the outpatient AMI and chest pain ED care	Hospital Outpatient Quality Reporting Specifications 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		
Critical Access Hospital Measures		
(ED) care for patients presenting with AMI and/or chest pain: ▪ OP-1: Median Time to Fibrinolysis 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. ▪ OP-2: Fibrinolytic Therapy Received Within 30 Minutes 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. ▪ OP-3a: Median Time to Transfer to Another Facility for Acute Coronary Intervention – Overall Rate This measure is used to assess the median time	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	Version 11.0, Encounter Dates 01/01/18 (1Q18) through 12/31/18 (4Q18). Centers for Medicare & Medicaid Services (CMS); July 2017 or as updated. Measure specifications can be found on the CMS website QualityNet (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 Measures		
from ED arrival to time of transfer to another facility for acute coronary intervention. ▪ OP-4: Aspirin at Arrival 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. ▪ OP-5: Median Time to ECG 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).		
Emergency Department (ED) – Throughput The hospital outpatient process of care measures include the following measures related to hospital ED care: ▪ OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients This measure is used to assess the time (in minutes) from ED arrival to time of departure from	CAHs must submit data for each of the ED-Throughput quality measures, including: ▪ Median number of minutes **OR**	Hospital Outpatient Quality Reporting Specifications Manual, Version 11.0, Encounter Dates 01/01/18 (1Q18) through 12/31/18 (4Q18). Centers for Medicare &

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 Measures		
the emergency room for patients discharged from the ED. ▪ OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional This measure is used to assess the time (in minutes) from ED arrival to provider contact for ED patients. ▪ OP-22: ED-patient Left without Being Seen 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.	▪ 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	Medicaid Services (CMS); July 2017 or as updated. Measure specifications can be found on the CMS website QualityNet (www.qualitynet.org)
Pain Management The hospital outpatient process of care measures include the following measure related to pain management care: ▪ OP-21: Median Time to Pain Management for Long Bone Fracture (LBF) This measure is used to assess the time (in minutes) from emergency department (ED) arrival	CAHs must submit data for the pain management quality measure, including: ▪ Median number of minutes	Hospital Outpatient Quality Reporting Specifications Manual, Version 11.0, Encounter Dates 01/01/18 (1Q18) through 12/31/18 (4Q18). Centers for Medicare &

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 Measures		
to time of initial oral, intranasal, or parenteral pain medication administration for ED patients with a principal diagnosis of LBF.		Medicaid Services (CMS); July 2017 or as updated. Measure specifications can be found on the CMS website QualityNet (www.qualitynet.org)
Stroke The hospital outpatient process of care measures include the following measure related to stroke care: ▪ OP-23: 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 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	CAHs must submit data for the outpatient stroke quality measure, including: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator: Number of patients meeting the targets in the measure	Hospital Outpatient Quality Reporting Specifications Manual, Version 11.0, Encounter Dates 01/01/18 (1Q18) through 12/31/18 (4Q18). Centers for Medicare & Medicaid Services (CMS); July 2017 or as updated. Measure specifications can be found on the CMS website

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 Measures		
stay and having a time from ED arrival to interpretation of the Head CT or MRI scan within 45 minutes of arrival.		QualityNet (www.qualitynet.org)
Structural The hospital outpatient process of care measures include the following structural measure related to surgery: ▪ OP-25: Safe Surgery Checklist Use 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.	CAHs must submit data for outpatient safe surgery checklist measure, by answering the question: ▪ Does/did your facility use a safety checklist based on accepted standards of practice? (Y/N)	Hospital Outpatient Quality Reporting Specifications Manual, Version 11.0, Encounter Dates 01/01/18 (1Q18) through 12/31/18 (4Q18). Centers for Medicare & Medicaid Services (CMS); July 2017 or as updated. Measure specifications can be found on the CMS website QualityNet (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 Measures		
Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN) Reported Measures		
Patient Safety Component The hospital patient safety component includes the following healthcare-associated infection measure: ▪ CAUTI: Catheter Associated Urinary Tract Infection This measure assesses the number of patients with observed healthcare-associated CAUTI in bedded inpatient care locations.	CAHs must submit data for the CAUTI measure, including: ▪ 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	Guidance and reporting requirements for National Healthcare Safety Network (NHSN) reported quality measures can be found on the CDC website National Healthcare Safety Network, Patient Safety Component Manual (https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf)

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 Measures		
Healthcare Personnel Safety Component The hospital healthcare personnel safety component includes the following surveillance measure: ▪ OP-27/HCP: Healthcare Personnel Influenza Vaccination Coverage This measure assesses the percent of healthcare personnel who receive the influenza vaccination.	CAHs must submit data for the healthcare personnel influenza vaccination measure, including: ▪ Denominator: Number of healthcare personnel meeting the inclusion criteria ▪ Numerator: Number of healthcare personnel meeting the target	Guidance and reporting requirements for National Healthcare Safety Network (NHSN) reported quality measures can be found on the CDC website National Healthcare Safety Network, Patient Safety Component Manual (https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf)
Care Coordination		
Emergency Department Transfer Communication (EDTC) composite This measure is used to assess the percent of patients transferred to another healthcare facility whose medical	CAHs must submit the following data for each of the seven EDTC sub-measures and the calculated rate for the All or None Composite measure:	Data Specifications Manual: Emergency Department Transfer Communication Measures,

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 Measures		
record documentation indicated that required information was communicated to the receiving facility prior to departure or within 60 minutes of transfer as defined by the specifications and includes: ▪ EDTC-SUB-1: Administrative Communication ▪ EDTC-SUB-2: Patient Information ▪ EDTC-SUB-3: Vital Signs ▪ EDTC-SUB-4: Medication Information ▪ EDTC-SUB-5: Physician or Practitioner Generated Information ▪ EDTC-SUB-6: Nurse Generated Information ▪ EDTC-SUB-7: Procedures and Tests	▪ Denominator: Number of patients meeting the criteria for inclusion in the measure if submitting on the full population **OR** Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Calculated rate	June 2017, or as updated, can be found on the Stratis Health website Stratis Health (www.stratishealth.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		
Prospective Payment System Hospital and Critical Access Hospital Measures		
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 ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Emergency Department Stroke Registry Indicator Specifications, 2018 (07/01/2017 to 06/30/2018 Discharge Dates); July 2017, or as updated. Measure specifications can be found on the Minnesota Department of Health website Health Care Quality Measures (www.health.state.mn.us/healthreform/measurement)

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 Hospital and Critical Access Hospital Measures		
Agency for Healthcare Research and Quality (AHRQ)		
Inpatient Quality Indicators (IQIs) The AHRQ IQIs include the following measure: ▪ IQI-91: Mortality for Selected Conditions 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 AHRQ IQI related to hospital inpatient mortality for specific conditions: o IQI-15: Acute Myocardial Infarction Mortality Rate o IQI-16: Congestive Heart Failure Mortality Rate o IQI-17: Acute Stroke Mortality Rate	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 6.0, Inpatient Quality Indicators #91, Technical Specifications, Mortality for Selected Conditions; March 2017 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website Inpatient Quality Indicators Technical Specifications (www.qualityindicators.ahrq.gov/Modules/IQI_TechSpec_ICD10_v60.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 Hospital and Critical Access Hospital Measures		
o IQI-18: Gastrointestinal Hemorrhage Mortality Rate o IQI-19: Hip Fracture Mortality Rate o IQI-20: Pneumonia Mortality Rate		
Patient Safety Indicators (PSIs) The AHRQ PSIs include the following measures: ▪ PSI-04: Death Rate among Surgical Inpatients with Serious Treatable Complications This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization. ▪ PSI-90: Patient Safety for Selected Indicators 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, hospital falls with hip fracture, perioperative hemorrhage or hematoma,	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 6.0, Patient Safety Indicators 04 & 90, Technical Specifications; July 2017 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website Patient Safety Indicators Technical Specifications Updates (www.qualityindicators.ahr

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 Hospital and Critical Access Hospital Measures		
postoperative acute kidney injury, postoperative respiratory failure, perioperative 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: o PSI-03: Pressure Ulcer Rate o PSI-06: Iatrogenic Pneumothorax Rate o PSI-08: In-Hospital Fall With Hip Fracture Rate o PSI-09: Perioperative Hemorrhage or Hematoma Rate o PSI-10: Postoperative Acute Kidney Injury Rate o PSI-11: Postoperative Respiratory Failure Rate		q.gov/Modules/PSI_TechSpec_ICD10_v60.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 Hospital and Critical Access Hospital Measures		
o PSI-12: Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate o PSI-13: Postoperative Sepsis Rate o PSI-14: Postoperative Wound Dehiscence Rate o PSI-15: Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate		
Health Information Technology		
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 2017	2017 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C with MN-Specific Additional Questions

Removed Hospital Measures		
Measure Name and Purpose	**Data Elements**	**Specification Information**
Hospital Consumer Assessment of Healthcare Providers and Systems Survey	Hospitals are no longer required to submit data for this measure	This measure will be removed effective with July 1, 2016 discharges

Appendix C. Required Ambulatory Surgical Center Quality Measure Data – Retired

Appendix D. Other Standardized Quality Measures

Measure Name	Measure Elements	Specification Information
Unlimited Availability		
Healthcare Effectiveness Data and Information Set (HEDIS)	All Healthcare Effectiveness Data and Information Set (HEDIS) measures as of HEDIS 2017, or as updated, that are applicable to physician clinics, are included in the standardized set of quality measures.	Healthcare Effectiveness Data and Information Set (HEDIS) 2017 Volume 1: Technical Specifications. National Committee for Quality Assurance (NCQA); 2017 or as updated
National Quality Forum (NQF) endorsed measures	All NQF-endorsed measures as of September 1, 2017, or as updated that are applicable to physician clinics and hospitals, are included in the standardized set of quality measures, excluding those requiring use of proprietary databases or registries.	More information about these measures can be found at National Quality Forum (www.qualityforum.org)

Appendix E. Submission Specifications

I. Submission Requirements for Physician Clinics

1. **Registration.** Each physician clinic, regardless of the number of full-time equivalent (FTE) clinical staff or shared ownership with another clinic, must register electronically and obtain a login user ID and password from the commissioner or commissioner's designee beginning January 1, 2018 and no later than February 10, 2018 and no later than February 10 of each subsequent year, and must supply data elements, including the following:

    a. **Physician clinic information:** Name, street address, unique clinic national provider identifier (NPI) regardless of the physician clinic's number of full-time equivalent (FTE) clinical staff or shared ownership with another clinic (i.e. satellite clinics);

    b. **Contact information for individual(s) responsible for submitting data:** Company, name, title, mailing address, telephone number, fax number, e-mail address;

    c. **Contact information for physician clinic general contact:** Name, title, mailing address, telephone number, fax number, e-mail address;

    d. **Clinical staff information for the previous calendar year:** Name, unique national provider identifier (NPI), full-time equivalent (FTE) status, license number, board certifications for each clinical staff that have provided health care services at the physician clinic during the previous calendar year;

    e. **Description of health care services provided by the physician clinic; and**

    f. **Medical group affiliation.**

NOTE: If multiple physician clinic locations meet the criteria in MN Rules 4654.0200 subp. 13 and choose to submit data as a single entity, each individual physician clinic location must still register and indicate under which entity their data will be submitted.

2. **Data Submission.**

    a. **Measures for which physician clinics may submit on their full patient population or a random sample in 2018. (NOTE: Physician clinics with electronic medical records in place for the prior full measurement period are required to submit data on their full patient population.)**

    Optimal Diabetes Care composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

    For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65-75),

diabetes type (Type 1, Type 2), gender, race, ethnicity, preferred language, country of origin, and ZIP code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, diabetes type, gender, race, ethnicity, preferred language, country of origin, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type, age, diabetes type, gender, and ZIP code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, diabetes type (Type 1, Type 2), gender, race, ethnicity, preferred language, country of origin, and ZIP code. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2018 and no later than March 31, 2018, and beginning January 1 and no later than March 31 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since January 1, 2016 are required to submit data on their full patient population for this measure.)

Optimal Vascular Care composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65-75), gender, race, ethnicity, preferred language, country of origin, and ZIP code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type age, gender, race, ethnicity, preferred language, country of origin, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type, age, gender, race, ethnicity, preferred language, country of origin, and ZIP code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, race, ethnicity, preferred language, country of origin, and ZIP code. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2018 and no later than March 31, 2018, and beginning January 1 and no later than March 31 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place

since January 1, 2016 are required to submit data on their full patient population for this measure.)

Optimal Asthma Control composite. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (5-11, 12-17, 18-34, 35-50), gender, race, ethnicity, preferred language, country of origin, and ZIP code. Specifically, this includes: patient identification methodology; separation of the data by pediatric population and adult population; numerator and denominator by primary payer type, age, gender, race, ethnicity, preferred language, country of origin, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type, age, gender, race, ethnicity, preferred language, country of origin, and ZIP code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, race, ethnicity, preferred language, country of origin, and ZIP code. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2018 and no later than March 31, 2018, and beginning January 1 and no later than March 31 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since January 1, 2016 are required to submit data on their full patient population for this measure.)

Asthma Education and Self-management. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (5-11, 12-17, 18-34, 35-50), gender, and ZIP code. Specifically, this includes: patient identification methodology; separation of the data by pediatric population and adult population; numerator and denominator by primary payer type, age, gender, and ZIP code; number of patients meeting the exclusion criteria; and calculated

rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type, age, gender, and ZIP code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, and ZIP code. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2018 and no later than March 31, 2018, and beginning January 1 and no later than March 31 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since January 1, 2016 are required to submit data on their full patient population for this measure.)

Colorectal Cancer Screening. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (50-64, 65-75), gender, race, ethnicity, preferred language, country of origin, and ZIP code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, gender, race, ethnicity, preferred language, country of origin, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type, age, gender, race, ethnicity, preferred language, country of origin, and ZIP code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, race, ethnicity, preferred language, country of origin, and ZIP code. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2018 and no later than March 31, 2018, and beginning January 1 and no later than March 31 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since January 1, 2016 are required to submit data on their full patient population for this measure.)

Adolescent Mental Health and/or Depression Screening. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (12-17), gender, and ZIP code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, gender, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate. If submitting a sample, the denominator for the entire patient population does not need to be allocated by primary payer type, age, gender, and ZIP code.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, and ZIP code. Physician clinics must also submit the patient identification methodology

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning April 1, 2018 and no later than May 15, 2018, and beginning April 1 and no later than May 15 of each subsequent year. (NOTE: Physician clinics with electronic medical records in place since April 1, 2016 are required to submit data on their full patient population for this measure.)

b. Measures for which physician clinics may only submit data on their full patient population in 2018.

Depression Remission at Six Months. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, data elements must be submitted by three bands of initial PHQ-9 scores (10-14; 15-19; 20 and above), primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age (18-44, 45-64, 65 and over), gender, and ZIP code. Specifically, this includes: patient identification methodology; numerator and denominator separated by three bands of initial PHQ-9 scores, primary payer type, age, gender, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate.

For physician clinics submitting patient-level data, additional data elements include: PHQ-9 score, primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, gender, ZIP code, and exclusion reason. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2018 and no later than March 31, 2018, and beginning January 1 and no later than March 31 of each subsequent year.

Total Knee Replacement: Functional Status and Quality of Life outcome. Each physician clinic, except ambulatory surgical centers, must submit the data required

to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and ZIP code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, body mass index, tobacco status, gender, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, and ZIP code. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning April 1, 2018 and no later than May 15, 2018, and beginning April 1 and no later than May 15 of each subsequent year.

Spinal Surgery: Lumbar Fusion Functional Status, Quality of Life, Back Pain, and Leg Pain outcome. Each physician clinic, except ambulatory surgical centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and ZIP code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, body mass index, tobacco status, gender, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, and ZIP code. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning April 1, 2018 and no later than May 15, 2018, and beginning April 1 and no later than May 15 of each subsequent year.

Spinal Surgery: Lumbar Discectomy Laminotomy Functional Status, Quality of Life, Back Pain, and Leg Pain outcome. Each physician clinic, except ambulatory surgical

centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A to the commissioner or the commissioner's designee.

For physician clinics submitting summary-level data, additional data elements include the number of patients receiving the applicable health care services allocated according to primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay uninsured), age (18-44, 45-64, 65 and over), body mass index, tobacco status, gender, and ZIP code. Specifically, this includes: patient identification methodology; numerator and denominator by primary payer type, age, body mass index, tobacco status, gender, and ZIP code; number of patients meeting the exclusion criteria; and calculated rate.

For physician clinics submitting patient-level data, additional data elements include: primary payer type (private insurance, Medicare, Minnesota Health Care Programs, self-pay, uninsured), age, body mass index, tobacco status, gender, and ZIP code. Physician clinics must also submit the patient identification methodology.

A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning April 1, 2018 and no later than May 15, 2018, and beginning April 1 and no later than May 15 of each subsequent year.

i. **Data submission requirements.** A physician clinic may satisfy the data submission requirement for these quality measures by completing the following steps:

1. **Patient identification methodology.** Identify patients meeting the criteria for inclusion in the measure. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. Develop a list of the eligible patients for each measure using a practice management, billing system, or electronic medical record.

2. **Data collection: Total population.** Identification of the population of patients eligible for the denominator for each measure is accomplished via a query of a practice management system or an electronic medical record. Use the measurement specifications referenced in Appendix A to determine eligibility for each patient, only including patients that meet denominator criteria for each measure in the list. For this measure physician clinics must submit data using their full patient population.

3. **Data submission template**. Use the data submission template supplied annually by the commissioner or the commissioner's designee as a data collection tool. Data elements may be either extracted from an electronic medical record system or abstracted through medical record review.

4. **Data file upload.** Submit data electronically to the commissioner or the commissioner's designee.

5. **Data validation.** Physician clinics must maintain documentation for the data described in Appendix A, including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

3. Health Information Technology Survey. Each physician clinic must complete the internet-based survey available annually from the commissioner or commissioner's designee beginning September 15, 2018 and no later than October 15, 2018, and beginning September 15 and no later than October 15 of each subsequent year.

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, 2018.

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.** Hospitals must maintain documentation for the data described in Appendix B, including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

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

Discharge Dates	Data Submission Deadline
Third Quarter, 2017: July 1 – September 30	February 15, 2018
Fourth Quarter, 2017: October 1 – December 31	May 15, 2018
First Quarter, 2018: January 1 – March 31	August 15, 2018
Second Quarter, 2018: April 1 – June 30	November 15, 2018

Outpatient Quality

Discharge Dates	Data Submission Deadline
Third Quarter, 2017: July 1 – September 30	February 1, 2018
Fourth Quarter, 2017: October 1 – December 31	May 1, 2018
First Quarter, 2018: January 1 – March 31	August 1, 2018
Second Quarter, 2018: April 1 – June 30	November 1, 2018

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.

iv. **Data validation.** Hospitals must maintain documentation for the data described in Appendix B, including the methodology used to determine

patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

ii. **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, 2017: July 1 – September 30	February 15, 2018
Fourth Quarter, 2017: October 1 – December 31	May 15, 2018
First Quarter, 2018: January 1 – March 31	August 15, 2018
Second Quarter, 2018: April 1 – June 30	November 15, 2018

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.

v. **Data validation.** Hospitals must maintain documentation for the data described in Appendix B, including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

ii. **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 composite.** 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, 2017: October 1 – December 31	January 31, 2018
First Quarter, 2018: January 1 – March 31	April 30, 2018
Second Quarter, 2018: April 1 – June 30	July 31, 2018
Third Quarter, 2018: July 1 – September 30	October 31, 2018

   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 validation.** Hospitals must maintain documentation for the data described in Appendix B, including the methodology used to determine patients meeting the criteria for inclusion in each measure and the data submission template, for purposes of data validation.

   c. **Data submission.** Submit summary level data electronically to the commissioner or the commissioner's designee.

5. **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, 2017: July 1 – September 30	February 15, 2018
Fourth Quarter, 2017: October 1 – December 31	May 15, 2018
First Quarter, 2018: January 1 – March 31	August 15, 2018
Second Quarter, 2018: April 1 – June 30	November 15, 2018

   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).

6. 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 2017 Dates of Service	April 30, 2018

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 6.0.1 for SAS or 6.0.2 for WinQI, 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 6.0, 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.

7. Health information technology survey. Each hospital must complete the survey available annually from the commissioner or commissioner's designee in calendar year 2018 and each subsequent year.