Minnesota Statewide Quality Reporting and Measurement System:

Appendices to Minnesota Administrative Rules, Chapter 4654

Minnesota Department of Health

December 2009

MINNESOTA MDH DEPARTMENT OF HEALTH

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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 (MNCM) to lead a consortium of organizations, including Stratis Health, the Minnesota Medical Association (MMA), the Minnesota Hospital Association (MHA), and the University of Minnesota School of Public Health, to complete these tasks.

Measures that will be used for public reporting are identified in Appendices A, B and C. The standardized set of measures are defined in the body of the rule and include the measures identified in Appendices A, B, C, and D. The hospital measures in Appendix B and the outpatient surgery center measures in Appendix C are defined by the referenced national quality organizations and will likely change over time as modified by the national quality organizations.

APPENDIX A
REQUIRED PHYSICIAN CLINIC QUALITY MEASURE DATA

Measure Name and Purpose	Data Elements	Specification Information
Data Required for Reporting Beginning in January 2010 (2009 Dates of Service) and Every Year Thereafter **These measures are calculated from the previous calendar year dates of service.**		
Diabetes		
Optimal diabetes care (ODC) 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 (less than 8 percent) ▪ Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) ▪ Blood pressure control (less than 130/80 mm Hg) ▪ Daily aspirin use if age 41 years or older or contraindication to aspirin ▪ Documented tobacco free	Physician clinics must submit the following data for the optimal diabetes care measure and for each of the five component measures: ▪ Patient identification methodology ▪ Submit the following three data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay:): ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Denominator: Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	Specifications for optimal diabetes care: Dates of service: 01/01/2009 – 12/31/2009. Minnesota Community Measurement; 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Cardiovascular Conditions		
Optimal vascular care (OVC) composite These measures are used to assess the percent of adult patients who have ischemic vascular disease (IVD) with optimally managed	Physician clinics must submit the following data for the optimal vascular care measure and for each of the four component measures:	Specifications for optimal vascular care: Dates of service: 01/01/2009 –

Measure Name and Purpose	Data Elements	Specification Information
Data Required for Reporting Beginning in January 2010 (2009 Dates of Service) and Every Year Thereafter **These measures are calculated from the previous calendar year dates of service.**		
modifiable risk factors: ▪ Low-density lipoprotein (LDL) cholesterol (less than 100 mg/dL) ▪ Blood pressure control (less than 130/80 mm Hg) ▪ Daily aspirin use or contraindication to aspirin ▪ Documented tobacco free	▪ Patient identification methodology ▪ Submit the following three data elements by primary payer type (i.e., private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay): ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Denominator: Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	12/31/2009. Minnesota Community Measurement; 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform
Health Information Technology (HIT)		
Health information technology (HIT) This survey is used to assess a medical group's adoption and use of Health Information Technology (HIT) in their clinical practice.	Internet-based survey	Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

Measure Name and Description	Data Elements	Specification Information
Data Required for Reporting Beginning in January 2011 (2010 Dates of Service) and Every Year Thereafter		
Behavioral Health Conditions		
Improved mental health for patients with depression This measure is used to assess the percent of adult patients who have major depression or dysthymia who have reached remission at six months (+/- 30 days) after being identified as having an initial PHQ-9 score greater than 9. Remission is identified as a PHQ-9 score less than 5.	Physician clinics must submit the following data for the improved mental health for patients with depression measure: ▪ Patient identification methodology ▪ Submit the following three data elements by three bands of initial PHQ9 scores (10-14; 15-19; 20 and above): ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Denominator: Number of patients in data submission if submitting a sample ▪ Numerator: Number of patients meeting the targets in the measure ▪ Number of patients meeting the exclusion criteria ▪ Calculated rate	Specifications for depression: 2010 direct data submission. Minnesota Community Measurement; 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

APPENDIX B
REQUIRED HOSPITAL QUALITY MEASURE DATA

Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2010 and Every Year Thereafter		
Hospital Compare Quality Measures, Centers for Medicare & Medicaid Services (CMS) and The Joint Commission		
Acute myocardial infarction (AMI) – Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to heart attack care: ▪ Aspirin at arrival (AMI-1) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who received aspirin within 24 hours before or after hospital arrival. ▪ Aspirin prescribed at discharge (AMI-2) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who are prescribed aspirin at hospital discharge. ▪ ACEI or ARB for LVSD (AMI-3) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction. ▪ Adult smoking cessation advice/counseling (AMI-4) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this	Hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications manual for national hospital inpatient quality measures, version 2.6b, discharges 04-01-2009 (2Q09) through 09-30-09 (3Q09). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2009 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2010 and Every Year Thereafter		
measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival. ▪ Beta-blocker prescribed at discharge (AMI-5) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients who are prescribed a beta-blocker at hospital discharge. ▪ Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less. ▪ Primary PCI received within 90 minutes of hospital arrival (AMI-8a) – This measure is used to assess the percent of acute myocardial infarction (AMI) patients receiving primary percutaneous coronary intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.		
Heart failure (HF) – All heart failure (HF) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to heart failure care: ▪ Discharge instructions (HF-1) – This measure is used to assess the percent of heart failure patients discharged home with written discharge instructions or educational material given to patient or caregiver at discharge or during hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen. ▪ Evaluation of LVS function (HF-2) – This measure is used to assess the percent of heart failure patients with documentation in the hospital record that left ventricular	Hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications manual for national hospital inpatient quality measures, version 2.6b, discharges 04-01-2009 (2Q09) through 09-30-09 (3Q09). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2009 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2010 and Every Year Thereafter		
systolic (LVS) function was evaluated before arrival, during hospitalization, or is planned for after discharge. ▪ ACEI or ARB for LVSD (HF-3) – This measure is used to assess the percent of heart failure patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction. ▪ Adult smoking cessation advice/counseling (HF-4) – This measure is used to assess the percent of heart failure patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.		
Pneumonia (PN) – Pneumonia (PN) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to pneumonia care: ▪ Pneumococcal vaccination (PN-2) – This measure is used to assess the percent of pneumonia patients, age 65 and older, who were screened for pneumococcal vaccine status and were administered the vaccine prior to discharge, if indicated. ▪ Blood cultures performed in the emergency department prior to initial antibiotic received in hospital (PN-3b) – This measure is used to assess the percent of pneumonia patients whose initial emergency room blood culture specimen was collected prior to first hospital dose of antibiotics. This measure focuses on the treatment provided to Emergency	Hospitals must submit data for each of the hospital compare pneumonia process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications manual for national hospital inpatient quality measures, version 2.6b, discharges 04-01-2009 (2Q09) through 09-30-09 (3Q09). Centers for Medicare & Medicaid Services (CMS), The Joint Commission; January 2009 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2010 and Every Year Thereafter		
Department patients prior to admission orders. ▪ Adult smoking cessation advice/counseling (PN-4) – This measure is used to assess the percent of pneumonia patients with a history of smoking cigarettes who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival. ▪ Initial antibiotic received within 6 hours of hospital arrival (PN-5c) – This measure is used to assess the percent of pneumonia patients who received their first dose of antibiotics within 6 hours after arrival at the hospital. ▪ Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (PN-6) – This measure is used to assess the percent of immunocompetent patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines. ▪ Influenza vaccination (PN-7) – This measure is used to assess the percent of pneumonia patients age 50 years and older, hospitalized during October, November, December, January, February, or March who were screened for influenza vaccine status and were vaccinated prior to discharge, if indicated.		
Surgical care improvement project (SCIP) – All surgical care improvement project (SCIP) process of care measures for applicable hospital discharge dates The hospital process of care measures include the following measures related to surgical care improvement project: ▪ Prophylactic antibiotic received within one hour prior to surgical incision * (SCIP-Inf-1) – This measure set is used to assess the percent of surgical patients with prophylactic	Hospitals must submit data for each of the hospital compare surgical care improvement project (SCIP) process of care quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the	Specifications manual for national hospital inpatient quality measures, version 2.6b, discharges 04-01-2009 (2Q09) through 09-30-09 (3Q09). Centers for Medicare & Medicaid Services (CMS), The Joint Commission;

Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2010 and Every Year Thereafter		
antibiotics initiated within one hour prior to surgical incision. *Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time. ▪ Prophylactic antibiotic selection for surgical patients (SCIP-Inf-2) – This measure set is used to assess the percent of surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure). ▪ Prophylactic antibiotics discontinued within 24 hours after surgery end time * (SCIP-Inf-3) – This measure set is used to assess the percent of surgical patients whose prophylactic antibiotics were discontinued within 24 hours after surgery end time (within 48 hours for coronary artery bypass graft (CABG) or other cardiac surgery).. *The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery. ▪ Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (SCIP-Inf-4) – This measure is used to assess the percent of cardiac surgery patients with controlled 6 A.M. blood glucose (≤ 200 mg/dL) on postoperative day one (POD 1) and postoperative day two (POD 2) with Surgery End Date being postoperative day zero (POD 0). ▪ Surgery patients with appropriate hair removal (SCIP-Inf-6) – This measure is used to assess the percent of surgery patients with appropriate surgical site hair removal. No hair removal, or hair removal with clippers or depilatory is considered	targets in each of the quality measures ▪ Calculated rate	January 2009 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Measure Name and Purpose	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2010 and Every Year Thereafter		
appropriate. Shaving is considered inappropriate. ▪ Colorectal surgery patients with immediate postoperative normothermia (SCIP-Inf-7) – This measure is used to assess the percent of colorectal surgery patients with immediate normothermia (greater than or equal to 96.8º F) within the first fifteen minutes after leaving the operating room. ▪ Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period (SCIP-Card-2) – This measure is used to assess the percent of surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period. The perioperative period for the SCIP Cardiac measures is defined as 24 hours prior to surgical incision through discharge from post-anesthesia care/recovery area. ▪ Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1) – This measure is used to assess the percent of surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered anytime from hospital arrival to 24 hours after Surgery End Time. ▪ Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2) – This measure is used to assess the percent of surgery patients who received appropriate venous thromboembolism (VTE) prophylaxis within 24 hours prior to Surgical Incision Time to 24 hours after Surgery End Time.		

Measures Required for Reporting Beginning in January 2010 (2009 Dates of Service) and Every Year Thereafter		
Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI)		
Abdominal aortic aneurysm (AAA) repair volume (IQI 4) – This measure is used to assess the raw volume of provider-level abdominal aortic aneurysm (AAA) repair (surgical procedure).	Hospitals must submit data for the abdominal aortic aneurysm (AAA) repair volume (IQI 4) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) – This measure is used to assess the number of deaths per 100 discharges with procedure code of abdominal aortic aneurysm (AAA) repair.	Hospitals must submit data for the abdominal aortic aneurysm (AAA) repair mortality rate (IQI 11) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Coronary artery bypass graft (CABG) volume (IQI 5) – This measure is used to assess the raw volume of provider-level coronary artery bypass graft (CABG) (surgical procedure).	Hospitals must submit data for the coronary artery bypass graft (CABG) volume (IQI 5) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated.

Measures Required for Reporting Beginning in January 2010 (2009 Dates of Service) and Every Year Thereafter		
		Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Coronary artery bypass graft (CABG) mortality rate (IQI 12) – This measure is used to assess the number of deaths per 100 discharges with a procedure code of coronary artery bypass graft (CABG).	Hospitals must submit data for the coronary artery bypass graft (CABG) mortality rate (IQI 12) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) – This measure is used to assess the raw volume of provider-level percutaneous transluminal coronary angioplasty (PTCA) (surgical procedure).	Hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) volume (IQI 6) quality measure. This data includes the following information: ▪ Volume	Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov

Measures Required for Reporting Beginning in January 2010 (2009 Dates of Service) and Every Year Thereafter		
Percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) – This measure is used to assess the number of deaths per 100 percutaneous transluminal coronary angioplasties (PTCAs).	Hospitals must submit data for the percutaneous transluminal coronary angioplasty (PTCA) mortality rate (IQI 30) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Hip fracture mortality rate (IQI 19) – This measure is used to assess the number of deaths per 100 discharges with principal diagnosis code of hip fracture.	Hospitals must submit data for the hip fracture mortality rate (IQI 19) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI)		
Pressure ulcer (PSI 3) – This measure is used to assess the number of cases of decubitus ulcer per 1,000 discharges with a length of stay greater than 4 days.	Hospitals must submit data for the pressure ulcer (PSI 3) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality	Patient Safety Indicators (PSI) Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated.

Measures Required for Reporting Beginning in January 2010 (2009 Dates of Service) and Every Year Thereafter		
	measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Death among surgical inpatients with serious treatable complications (PSI 4) – This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization.	Hospitals must submit data for the death among surgical inpatients with serious treatable complications (PSI 4) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in each of the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) – This measure is used to assess the number of cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 1,000 surgical discharges with an operating room procedure.	Hospitals must submit data for the postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov

Measures Required for Reporting Beginning in January 2010 (2009 Dates of Service) and Every Year Thereafter		
Obstetric trauma – vaginal delivery with instrument (PSI 18) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries.	Hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Obstetric trauma – vaginal delivery without instrument (PSI 19) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 without instrument assistance.	Hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the quality measure ▪ Numerator: Number of patients meeting the targets in the quality measure ▪ Calculated rate	Patient Safety Indicators (PSI) Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Health Information Technology (HIT)		
Health information technology (HIT) This survey is used to assess ***a hospital's*** adoption and use of Health Information Technology (HIT) in ***its*** clinical practice.	Survey	

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2011 (2010 Dates of Service) and Every Year Thereafter		
Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI)		
Mortality for selected conditions composite measure This measure is used to assess the number of deaths for acute myocardial infarction (AMI), congestive heart failure (CHF), acute stroke, GI hemorrhage, hip fracture, and pneumonia. This composite measure includes the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) related to hospital inpatient mortality for specific conditions: ▪ Acute myocardial infarction (AMI) mortality rate (IQI 15) ▪ Congestive heart failure (CHF) mortality rate (IQI 16) ▪ Acute stroke mortality rate (IQI 17) ▪ GI Hemorrhage mortality rate (IQI 18) ▪ Hip fracture mortality rate (IQI 19) ▪ Pneumonia mortality rate (IQI 20)	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	See specific mortality for selected conditions composite measure component indicators for more information. Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI)		
Patient safety for selected indicators composite measure This measure is used to assess the number of potentially preventable adverse events for pressure ulcer, iatrogenic pneumothorax, selected infections due to medical care, postoperative hip fracture, postoperative deep vein thrombosis (DVT) or pulmonary embolism (PE), postoperative sepsis, postoperative wound dehiscence, and accidental puncture or laceration (separately). This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions:	Hospitals must submit data for the patient safety for selected indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures	See specific patient safety for selected indicators composite measure component indicators for more information. Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated.

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2011 (2010 Dates of Service) and Every Year Thereafter		
▪ Pressure ulcer (PSI 3) ▪ Iatrogenic pneumothorax (PSI 6) ▪ Selected infections due to medical care (PSI 7) ▪ Postoperative hip fracture (PSI 8) ▪ Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) ▪ Postoperative sepsis (PSI 13) ▪ Postoperative wound dehiscence (PSI 14) ▪ Accidental puncture or laceration (PSI 15)	▪ Calculated rate	Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov
Agency for Healthcare Research and Quality (AHRQ) Pediatric Patient Safety Indicators (PDI)		
Pediatric patient safety for selected indicators composite measure This measure is used to assess the number of potentially preventable adverse events for accidental puncture or laceration, pressure ulcer, iatrogenic pneumothorax, postoperative wound dehiscence, postoperative sepsis, and selected infections due to medical care (separately). This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: ▪ Accidental puncture or laceration (PDI 1) ▪ Pressure ulcer (PDI 2) ▪ Iatrogenic pneumothorax (PDI 5) ▪ Postoperative sepsis (PDI 10) ▪ Postoperative wound dehiscence (PDI 11) ▪ Selected infections due to medical care (PDI 12)	Hospitals must submit data for the pediatric patient safety for selected indicators composite measure and for each of the pediatric patient safety for selected indicators composite measure component indicators. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	See specific pediatric patient safety for selected indicators composite measure component indicators for more information. Inpatient Quality Indicators Technical Specifications, Version 4.0. Agency for Healthcare Research and Quality (AHRQ); June 2009 or as updated. Measure specifications can be found on the Agency for Healthcare Research and Quality (AHRQ), Quality Indicators website http://www.qualityindicators.ahrq.gov

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2011 (2010 Dates of Service) and Every Year Thereafter		
Patient Experience		
Patient experience – This measure is used to assess patients' perception of their hospital care using a national survey called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). *(This measure is not required for hospitals with less than 500 admissions in the previous calendar year.)*	Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey	Consumer assessment of healthcare providers and systems hospital survey (HCAHPS), Version 4.0. Centers for Medicare & Medicaid Services (CMS); February 2009 or as updated. Measure specifications can be found on the HCAHPS website http://www.hcahpsonline.org/

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2011 and Every Year Thereafter		
Hospital Compare Quality Measures		
Outpatient acute myocardial infarction (AMI) and chest pain measures The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: ▪ Median time to fibrinolysis (OP-1) – This measure is used to assess the percent of patients with extended median time from emergency department (ED) arrival to administration of fibrinolytic therapy in ED acute myocardial infarction (AMI) patients with ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to ED arrival and prior to transfer.	Hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the targets in each of the quality measures ▪ Calculated rate	Specifications manual for hospital outpatient department quality measures, version 2.0c, encounter dates 01-01-09 (1Q09) through 06-30-09 (2Q09). Centers for Medicare & Medicaid Services (CMS); January 2009 or as updated. Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2011 and Every Year Thereafter		
▪ Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2) – This measure is used to assess the percent of emergency department (ED) acute myocardial infarction (AMI) patients receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less. ▪ Median time to transfer to another facility for acute coronary intervention (OP-3) – This measure is used to assess the percent of patients with extended median time from emergency department (ED) arrival to time of transfer to another facility for acute coronary intervention for ED acute myocardial infarction (AMI) patients. ▪ Aspirin at arrival (OP-4) – This measure is used to assess the percent of emergency department (ED) acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) without aspirin contraindications who received aspirin within 24 hours before ED arrival or prior to transfer. ▪ Median time to ECG (OP-5) – This measure is used to assess the percent of patients with extended median time from emergency department (ED) arrival to electrocardiogram (ECG) (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or chest pain patients (with Probable Cardiac Chest Pain).		
Outpatient surgery department measures The hospital outpatient process of care measures include the following measures related to hospital outpatient surgery care: ▪ Timing of antibiotic prophylaxis (prophylactic antibiotic initiated within one hour prior to surgical incision*) (OP-6) – This measure is used to assess the percent of surgical patients with prophylactic antibiotics initiated within one hour * prior	Hospitals must submit data for each of the outpatient surgery department quality measures. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures ▪ Numerator: Number of patients meeting the	Specifications manual for hospital outpatient department quality measures, version 2.0c, encounter dates 01-01-09 (1Q09) through 06-30-09 (2Q09). Centers for Medicare & Medicaid Services (CMS); January 2009 or as updated.

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2011 and Every Year Thereafter		
to surgical incision. *Patients who received vancomycin or a fluoroquinolone for prophylaxis should have the antibiotic initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time. ▪ Prophylactic antibiotic selection for surgical patients (OP-7) – This measure is used to assess the percent of surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	targets in each of the quality measures ▪ Calculated rate	Measure specifications can be found on the Centers for Medicare & Medicaid Services (CMS), QualityNet website http://qualitynet.org

APPENDIX C
REQUIRED OUTPATIENT SURGERY CENTER MEASURES

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2011 (2010 Dates of Service) and Every Year Thereafter		
Prophylactic intravenous (IV) antibiotic timing – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who were administered antibiotics for prevention of surgical site infection on time	Outpatient surgery centers must submit data for the prophylactic intravenous (IV) antibiotic timing quality measure. This data includes the following information: ▪ Denominator: Number of patients meeting the criteria for inclusion in the measure ▪ Numerator of patients meeting the criteria for inclusion in the quality measure ▪ Calculated rate	National voluntary consensus standards for ambulatory care – Part 2. National Quality Forum (NQF); March 2008. This measure was developed by the Ambulatory Surgery Centers Quality Collaboration. Measure specifications can be found on the National Quality Forum (NQF) website http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%93Part_2.aspx
Hospital transfer/admission – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who are transferred or admitted to a hospital upon discharge from the ASC.	Outpatient surgery centers must submit data for the hospital transfer/admission quality measure. This data includes the following information: ▪ Denominator of patients meeting the criteria for inclusion in the measure ▪ Numerator of patients meeting the criteria for inclusion in the quality measure ▪ Calculated rate	National voluntary consensus standards for ambulatory care – Part 2. National Quality Forum (NQF); March 2008. This measure was developed by the Ambulatory Surgery Centers Quality Collaboration. Measure specifications can be found on the National Quality Forum (NQF) website http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%

Measure Name and Description	Data Elements	Specification Information
Measures Required for Reporting Beginning in January 2011 (2010 Dates of Service) and Every Year Thereafter		
		E2%80%93Part_2.aspx
Appropriate surgical site hair removal – This measure is used to assess the percent of ambulatory surgery center (ASC) patients who have appropriate surgical site hair removal.	Outpatient surgery centers must submit data for the appropriate surgical site hair removal quality measure. This data includes the following information: ▪ Denominator of patients meeting the criteria for inclusion in the measure ▪ Numerator of patients meeting the criteria for inclusion in the quality measure ▪ Calculated rate	National voluntary consensus standards for ambulatory care – Part 2. National Quality Forum (NQF); March 2008. This measure was developed by the Ambulatory Surgery Centers Quality Collaboration. Measure specifications can be found on the National Quality Forum (NQF) website http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%93Part_2.aspx

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 2009, 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) 2009 Volume 2: Technical Specifications. National Committee for Quality Assurance (NCQA); 2008 or as updated.
National Quality Forum (NQF) endorsed measures	All NQF-endorsed measures as of July 27, 2009, 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 on the National Quality Forum (NQF), website http://qualityforum.org

Measure Name	Measure Elements	Specification Information
Time-Limited Availability: These Measures are Available for Use for Four Years (2009 Dates of Service Through 2012 Dates of Service)		
Pediatric asthma	For patients, ages 5 to 19 years: ▪ At the last asthma visit, is the asthma severity level (intermittent or persistent) documented? ▪ If it is documented that the patient has persistent asthma, is the patient on an anti-inflammatory medication? ▪ If the patient is a smoker or exposed to second hand smoke, is advice regarding smoking cessation documented in the last year?	Clinical Review: Measure Specifications for Pediatric Asthma. Medica; Pediatric Asthma; July 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

	▪ If the patient is a smoker, or exposed to second hand smoke, is advice regarding smoking cessation documented at the last visit? ▪ Is the child's environment tobacco smoke free? ▪ Is there evidence in the medical records that the patient received a written Asthma Action Plan? ▪ Unless contraindicated, is there evidence in the medical record that the patient has received an influenza vaccine within the past year?	

Measure Name	Measure Elements	Specification Information
Time-Limited Availability: These Measures are Available for Use for Three Years (2009 Dates of Service Through 2011 Dates of Service)		
Adult depression	For adults, ages 19 years and older: ▪ At the time of initial diagnosis in the past year, was there documentation of at least 5 of the symptoms of depression, or that the patient met the criteria for depression using a standardized depression diagnosing tool? ▪ At the time of the initial diagnosis in the past year, is there documentation that the patient was assessed for alcohol consumption? ▪ If the patient was at the clinic for a primary care visit more than 6 weeks after the initial diagnosis, is there documentation of ongoing assessment of their depression status? ▪ Was the patient's depression status reassessed using the PHQ-9 tool at a follow up visit within 6 months after diagnosis? ▪ Was the PHQ-9 depression diagnostic tool used for the initial depression diagnosis?	Clinical Review: Measure Specifications for Adult Depression. Medica; Pediatric Asthma; July 2009. Measure specifications can be found on the Minnesota Department of Health website http://www.health.state.mn.us/healthreform

APPENDIX E
SUBMISSION SPECIFICATIONS

I. Submission Requirements for Physician Clinics

1. **Registration.** Each physician clinic, except outpatient surgery centers, must register electronically and obtain a login user ID and password from the commissioner or commissioner's designee beginning January 1, 2010 and no later than February 10, 2010 and no later than February 10 of each subsequent year, and must supply data elements, including the following:
    a. **Physician clinic information:** Name, mailing address, clinic national provider identifier (NPI);
    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, national provider identifier (NPI), board certifications for all 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.**
    f. **Medical group affiliation.**
2. **Data Submission.** Each physician clinic, except outpatient surgery centers, must submit the data required to calculate the applicable quality measures, as described in Appendix A and including the number of patients receiving the applicable health care services allocated according to primary payor type (private insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) to the commissioner or the commissioner's designee. Specifically, this includes patient identification methodology, numerator and denominator by primary payer type, number of patients meeting the exclusion criteria, and calculated rate. A physician clinic may work with a single subcontractor to submit the required data on their behalf. Data may be submitted beginning January 1, 2010 and no later than February 15, 2010 and beginning January 1 and no later than February 15 of each subsequent year.
    a. **Optimal diabetes care (ODC) and optimal vascular care (OVC)**. A physician clinic may satisfy the data submission requirements for these quality measures by completing the following steps:
        i. **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.

ii. **Patient identification methodology.** 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. Physician clinics may choose one of the following options:

1. Full patient population. Physician clinics are encouraged to submit data using their full patient population for each measure, but may use a random sampling methodology, as described in below.
2. Random sampling methodology. At a minimum, physician clinics must select 60 patients for the random sample population and must oversample by at least 20 patients. If a physician clinic's total population for a particular measure is less than 60, the physician clinic must submit data using their full patient population for that measure.

iii. 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.

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

v. 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 and auditing and must make the information available for auditors as necessary.

b. Health information technology (HIT) survey. Each physician clinic must complete the internet-based survey available annually from the commissioner or commissioner's designee beginning February 15, 2010 and no later than March 15, 2010 and beginning February 15 and no later than March 15 of each subsequent year.

II. Submission Requirements for Hospitals

1. **Data Submission for Hospital Compare Measures, Centers for Medicare & Medicaid Services (CMS) and The Joint Commission.** Each hospital 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 the Centers for Medicare & Medicaid Services (CMS), using the Centers for Medicare & Medicaid Services' (CMS) existing schedule, specifications, and processes, and continues to do so, the hospital will have satisfied their data submission requirements for these quality measures provided that the hospital also signs an authorization form allowing the state's quality improvement organization (QIO) to access the Centers for Medicare & Medicaid Services (CMS) national data repository and the hospital's data for all cases for each applicable quality measure and submit the required data to the commissioner or the commissioner's designee on the behalf of the hospital; or

    b. **Submission directly to commissioner or commissioner's designee.** If a hospital does not submit data for these quality measures to the Centers for Medicare & Medicaid Services (CMS), the hospital must submit data to the commissioner or the commissioner's designee according to the following schedule:

Discharge Dates	Data Submission Deadline
Third Quarter, 2009: July 1 – September 30	February 15, 2010
Fourth Quarter, 2009: October 1 – December 31	May 15, 2010
First Quarter, 2010: January 1 – March 31	August 15, 2010
Second Quarter, 2010: April 1 – June 30	November 15, 2010

        i. Data collection and analysis.

            1. Hospitals must use the CMS Abstraction & Reporting Tool (CART), available from the Centers for Medicare & Medicaid Services (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 eligibile for inclusion in the measurement calculation.

        ii. Data validation. At their own expense, hospitals must have their data validated by a third-party vendor using protocols and standards consistent with those of the Centers for Medicare & Medicaid Services (CMS) to verify that the data is consistent and reproducible.

iii. Data submission. Submit data electronically to the commissioner or the commissioner's designee on a form provided by the commissioner or the commissioner's designee.

2. **Data Submission for Inpatient Quality Indicators (IQI), Patient Safety Indicators (PSI), and Pediatric Patient Safety Indicators (PDI), Agency for Healthcare Research and Quality.** 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
Third Quarter, 2009: July 1 – September 30	January 29, 2010
Fourth Quarter, 2009: October 1 – December 31	April 30, 2010
First Quarter, 2010: January 1 – March 31	July 24, 2010
Second Quarter, 2010: April 1 – June 30	October 23, 2010

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. Apply the Quality Indicator software, available from the Agency for Healthcare Research and Quality's (AHRQ), to the hospital's discharge data. A hospital must participate in verifying the results of the analysis as needed.

ii. Validate the data.

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. Submit the data to the commissioner or the commissioner's designee.

b. Each hospital may perform the following steps itself:

i. Apply the Quality Indicator softward, available from the Agency for Healthcare Research and Quality's (AHRQ), to its discharge data.

ii. Validate the data submission through a third-party vendor.

iii. Submit data electronically to the commissioner or the commissioner's designee on a form provided by the commissioner or the commissioner's designee.

3. Health information technology (HIT) survey. Each hospital must complete the survey available annually from the commissioner or commissioner's designee beginning February 15, 2010 and no later than March 15, 2010 and beginning February 15 and no later than March 15 of each subsequent year.

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