Chartbook Section 9

Minnesota Statewide Quality Reporting and Measurement System

MDH Minnesota Department *of* Health

Health Economics Program

Contents

A summary of the charts and graphs contained within is provided at Chartbook Summaries - Section 9. Direct links are listed on each page. Please contact the Health Economics Program at 651-201-3550 or health.hep@state.mn.us if additional assistance is needed for accessing this information.

CLINIC QUALITY MEASURES

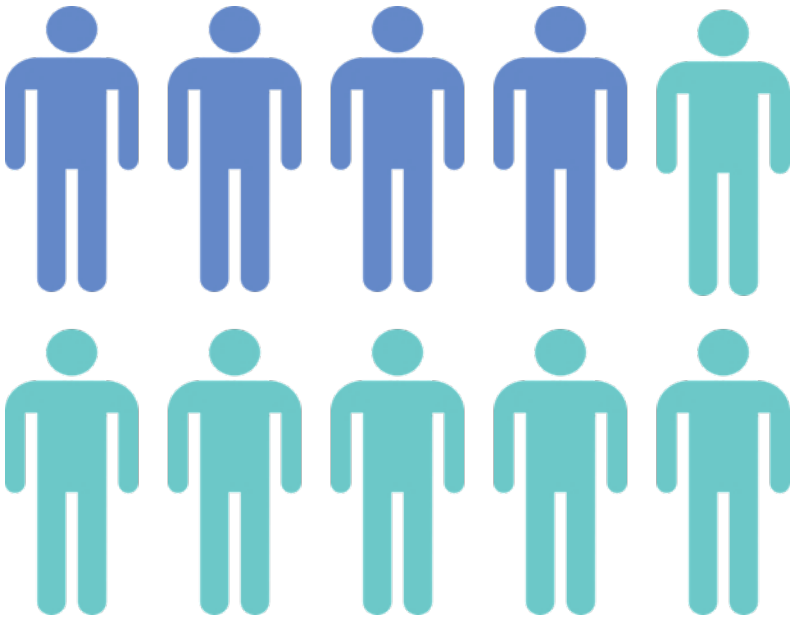
Optimal Diabetes Care

The percentage of diabetes patients, ages 18-75, who met ALL of the following five goals:

1) Blood sugar control
2) Blood pressure control
3) Cholesterol control
4) Daily aspirin use, if needed
5) No tobacco use

Measure steward: MN Community Measurement
National Quality Forum #0729

Optimal Diabetes Care, 2013
Statewide Rate



4 out of every **10**

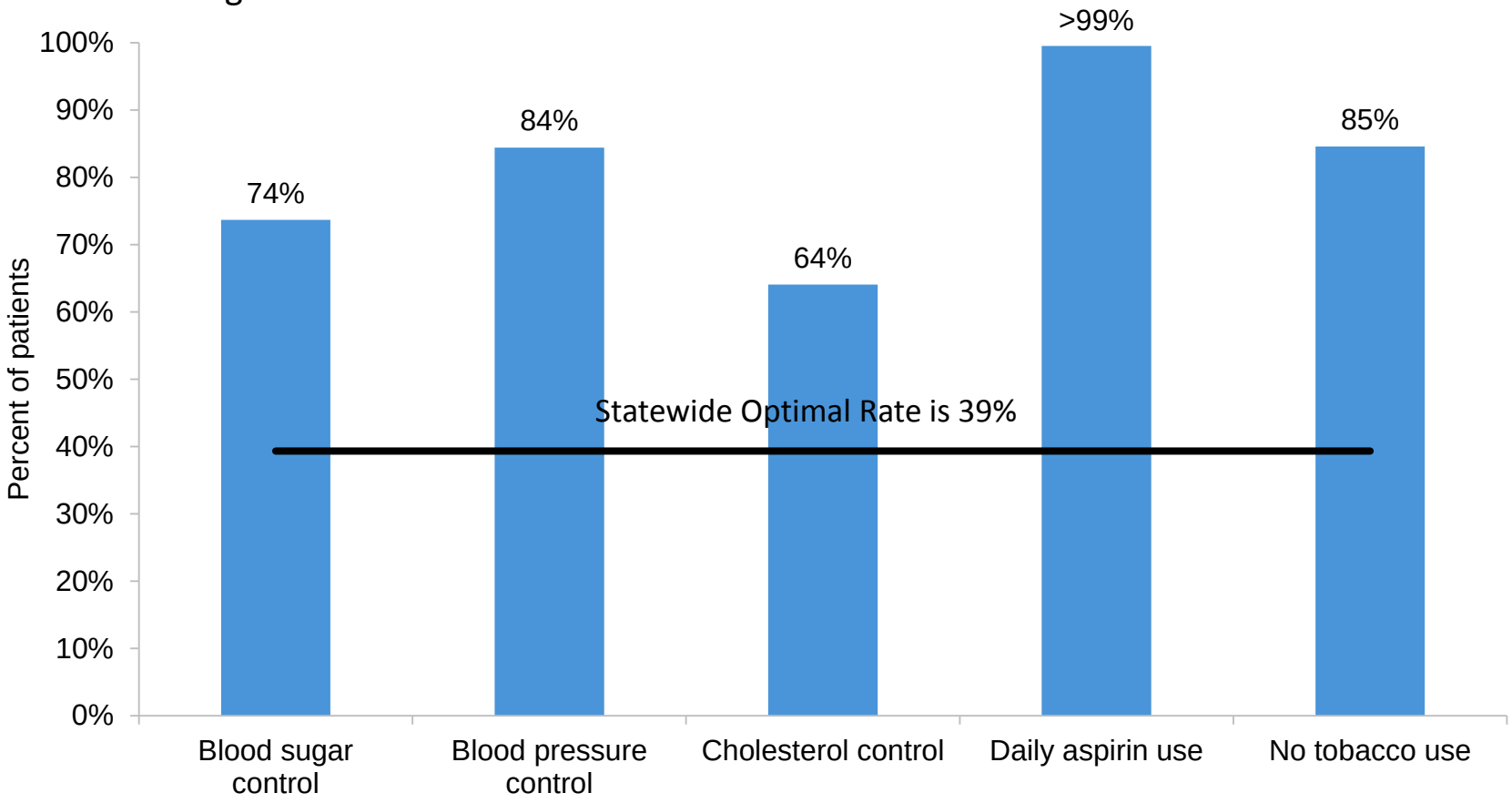
diabetic patients received optimal care

Source: medhealthstore.com

The 2013 statewide optimal care rate was 39%.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Optimal Diabetes Care, 2013 Component Rates

The percentage of diabetes patients that met all five goals was 39%, however, a greater share of patients met individual goals. Patients had high rates of blood pressure control, daily aspirin use, and not using tobacco.

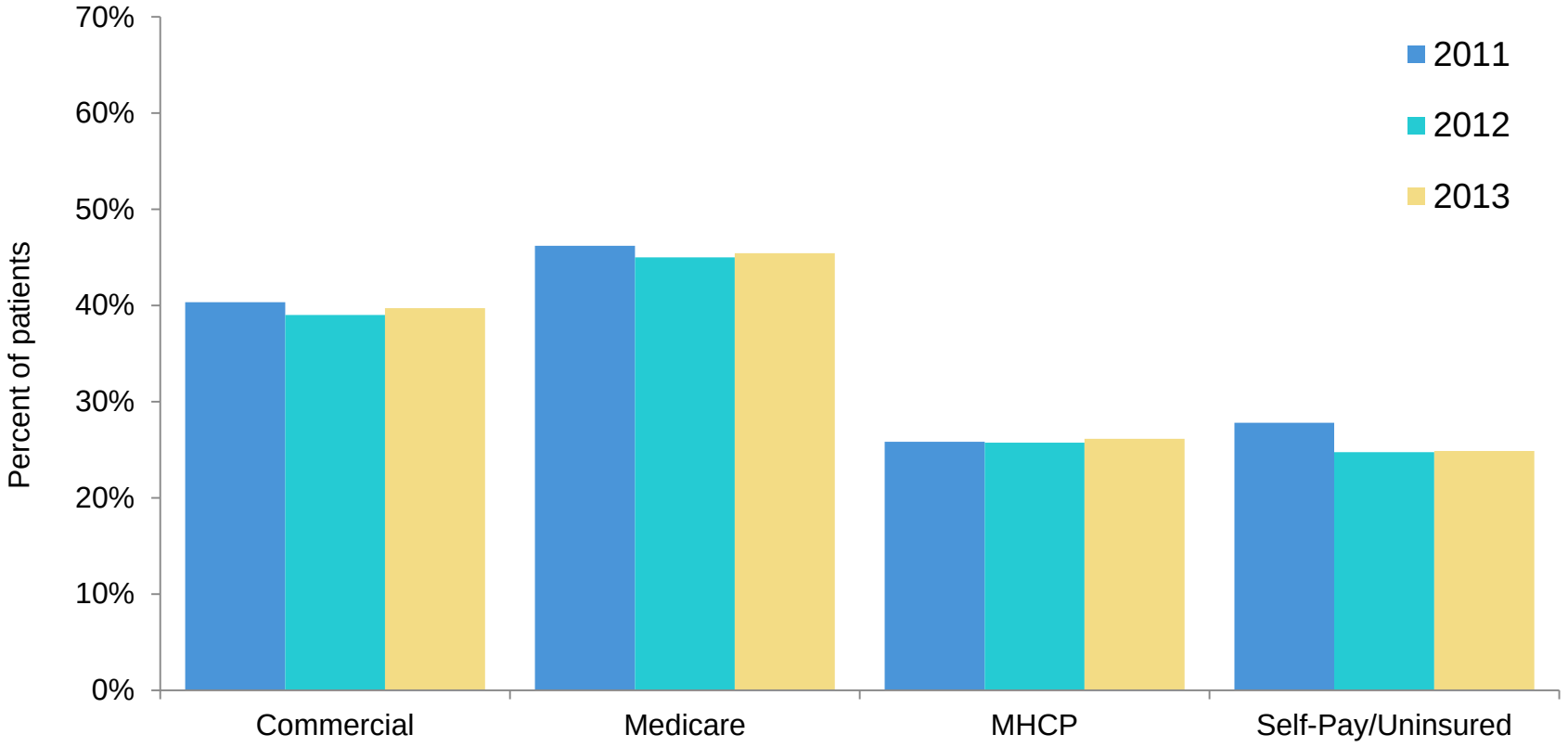


To be included in the statewide optimal rate, patients had to meet all of the above goals.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Optimal Diabetes Care, 2011-2013 Stratified by Health Insurance Type

Optimal care rates for patients with commercial insurance and Medicare were notably higher than rates for patients enrolled in MHCP and for self-pay/uninsured patients.

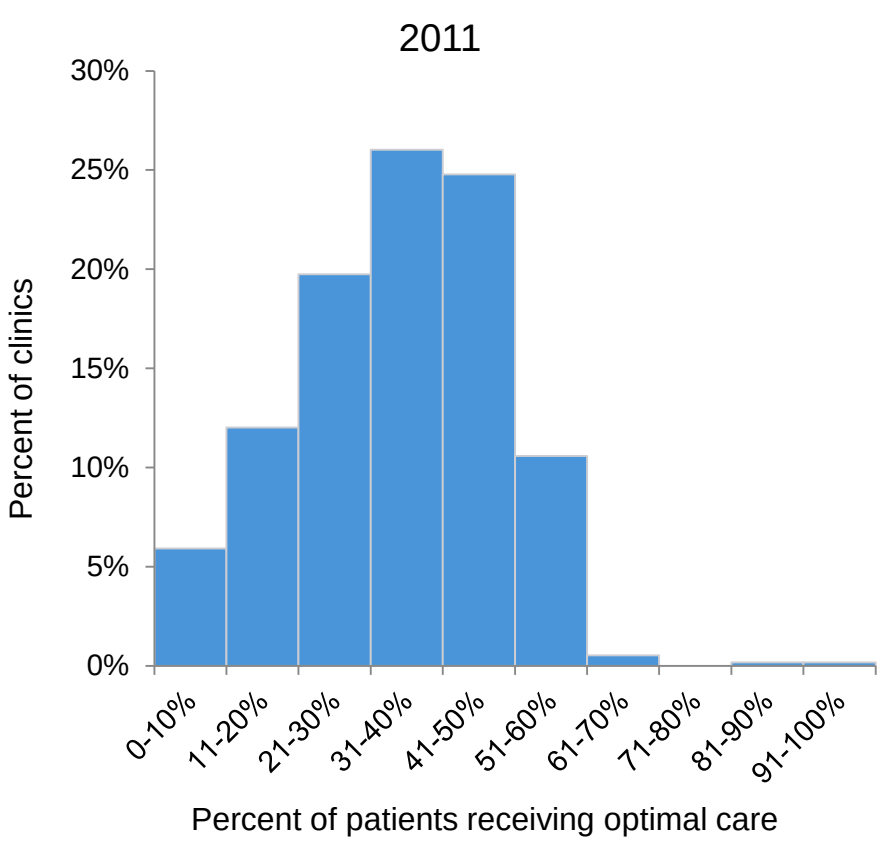


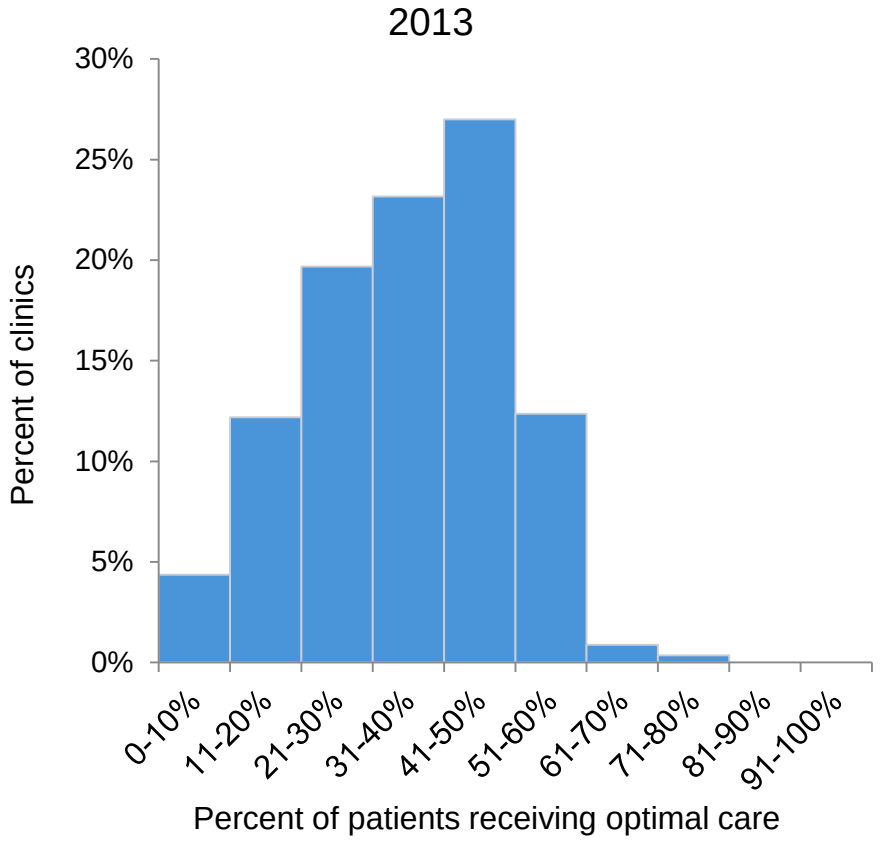
MHCP is Minnesota Health Care Programs, which includes: Medical Assistance, MinnesotaCare, Minnesota Family Planning Program, home and community-based waiver programs, and Medicare Savings Programs.
Service year: January 1 through December 31.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Optimal Diabetes Care, 2011 and 2013 Clinic Performance

In 2013, compared to 2011, the share of clinics that delivered optimal diabetes care to more than 50 percent of their patients increased by two percentage points.



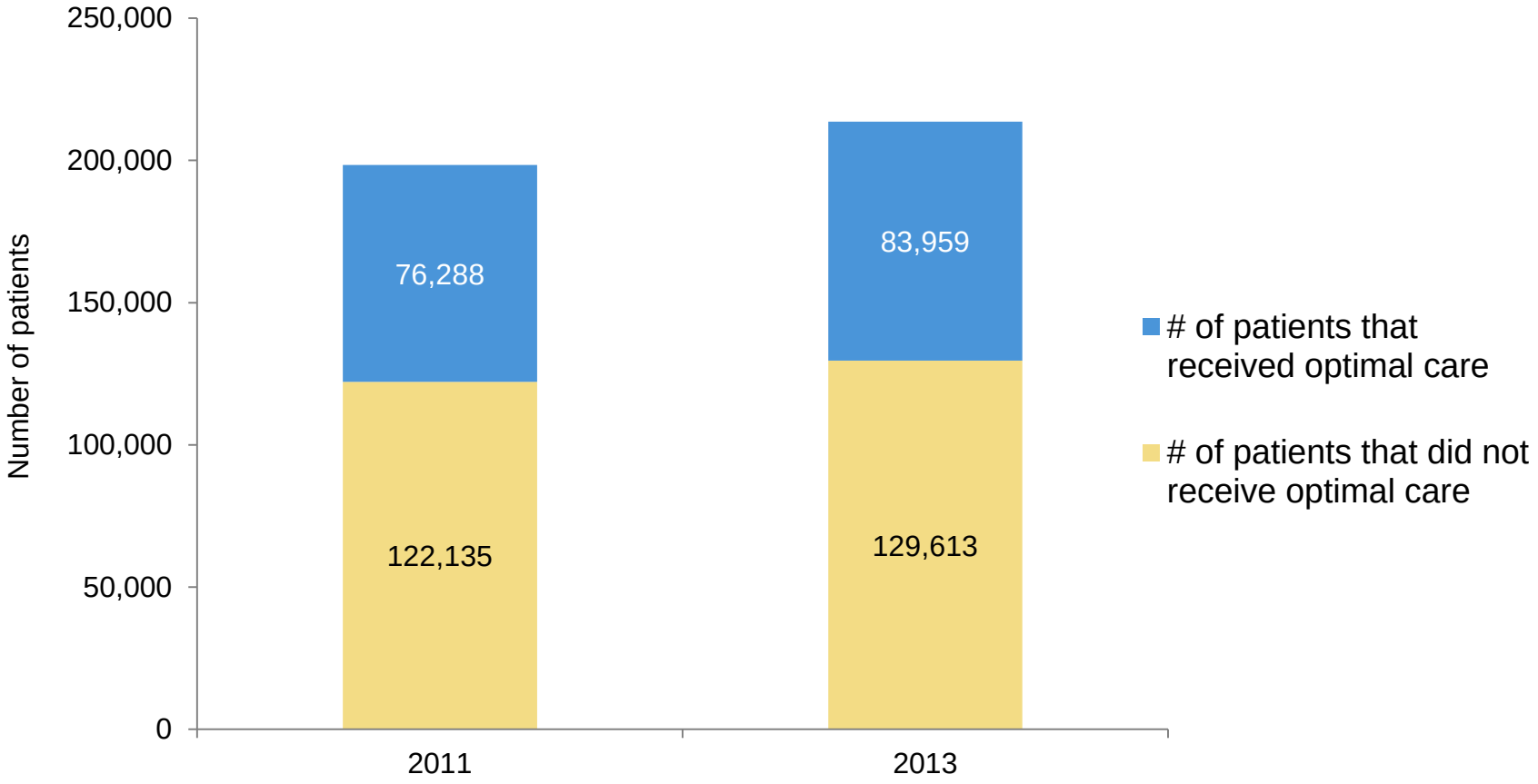


There were 557 reporting clinics in 2011, and 574 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Optimal Diabetes Care, 2011 and 2013 Patients

There was little change in the number of patients receiving optimal care for diabetes between 2011 and 2013. In 2011, the statewide optimal rate was 40% and in 2013 it was 39%.



There were 557 reporting clinics in 2011, and 574 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

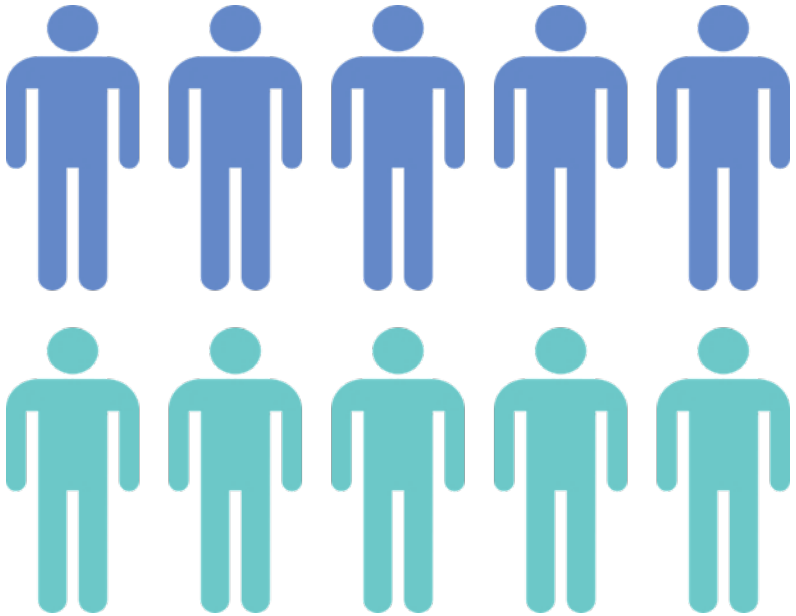
Optimal Vascular Care

The percentage of ischemic vascular disease patients, ages 18-75, who met ALL the following four goals:

1) Cholesterol control
2) Blood pressure control
3) Daily aspirin use, if needed
4) No tobacco use

Measure steward: MNCM
NQF# 0076

Optimal Vascular Care, 2013 Statewide Rate



5 out of every **10**

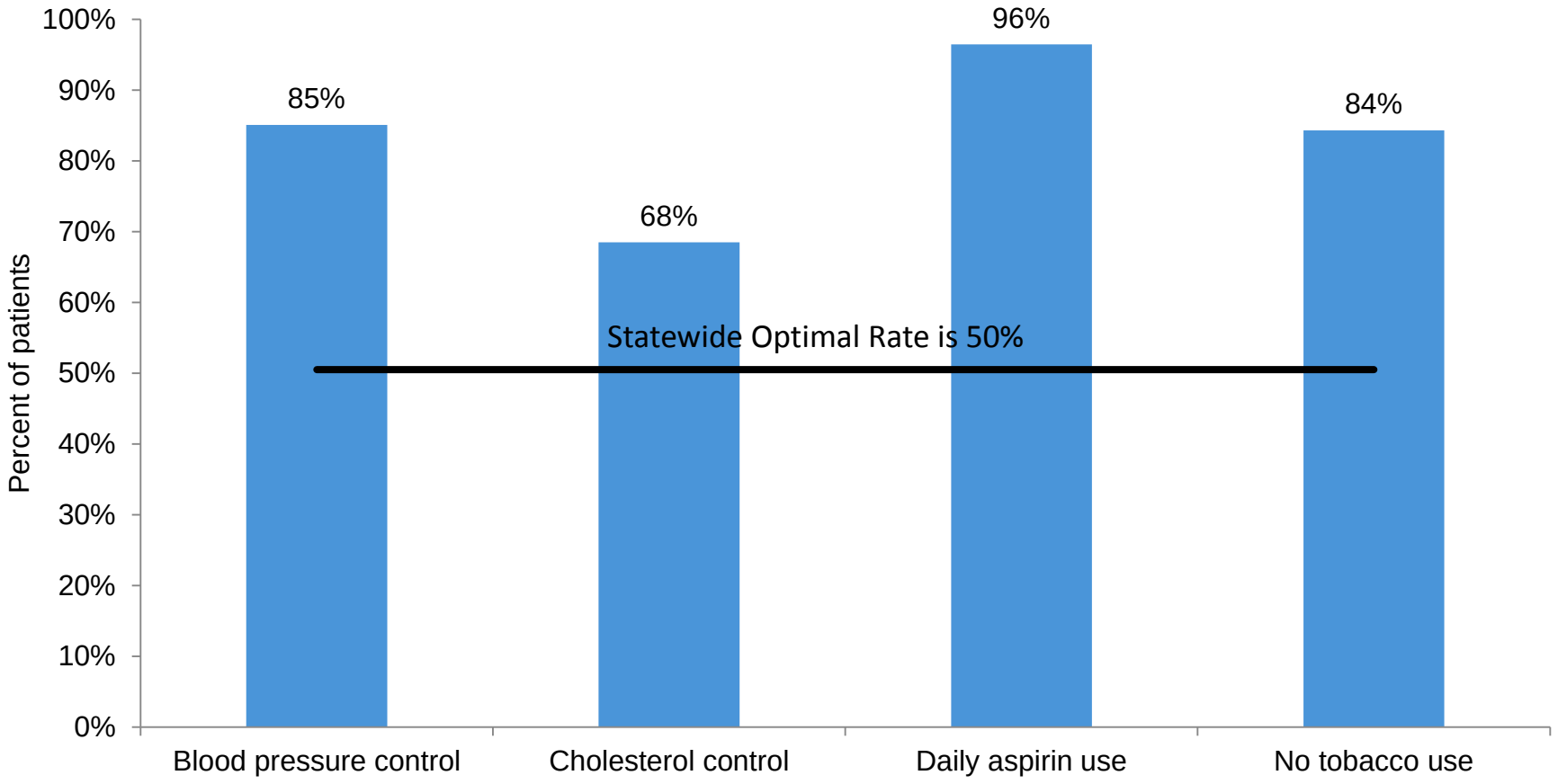
vascular patients received optimal care

Source: www.theguardian.com

The 2013 statewide optimal care rate was 50%.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Optimal Vascular Care, 2013 Component Rates

The percentage of vascular patients that met all four goals was 50%, however, a greater share of patients met individual goals. Patients had high rates of blood pressure control, daily aspirin use and not using tobacco.

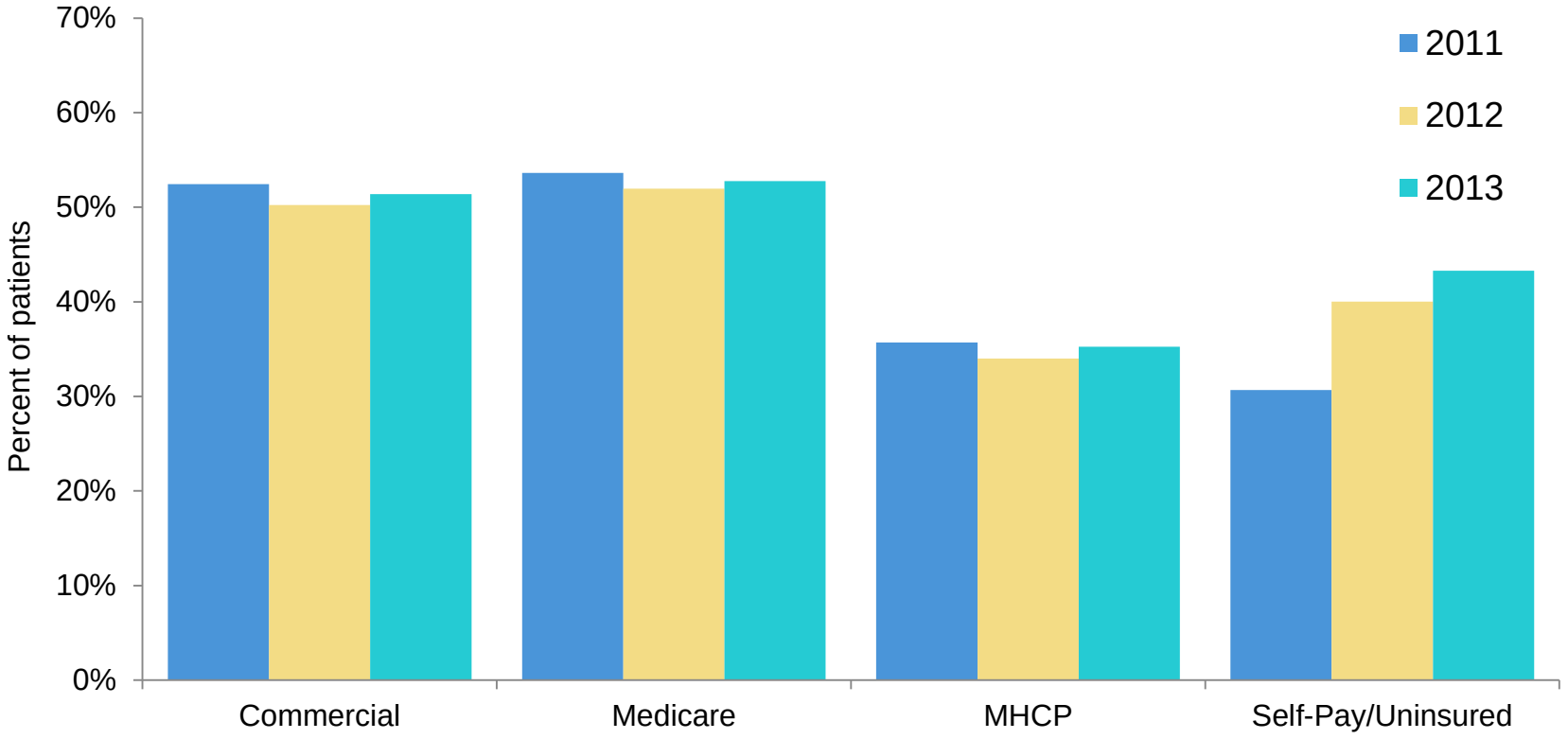


To be included in the statewide optimal rate, patients had to meet all of the above goals.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Optimal Vascular Care, 2011-2013 Stratified by Health Insurance Type

Optimal care rates for patients with commercial insurance and Medicare were notably higher than rates for MHCP and self-pay/uninsured patients.

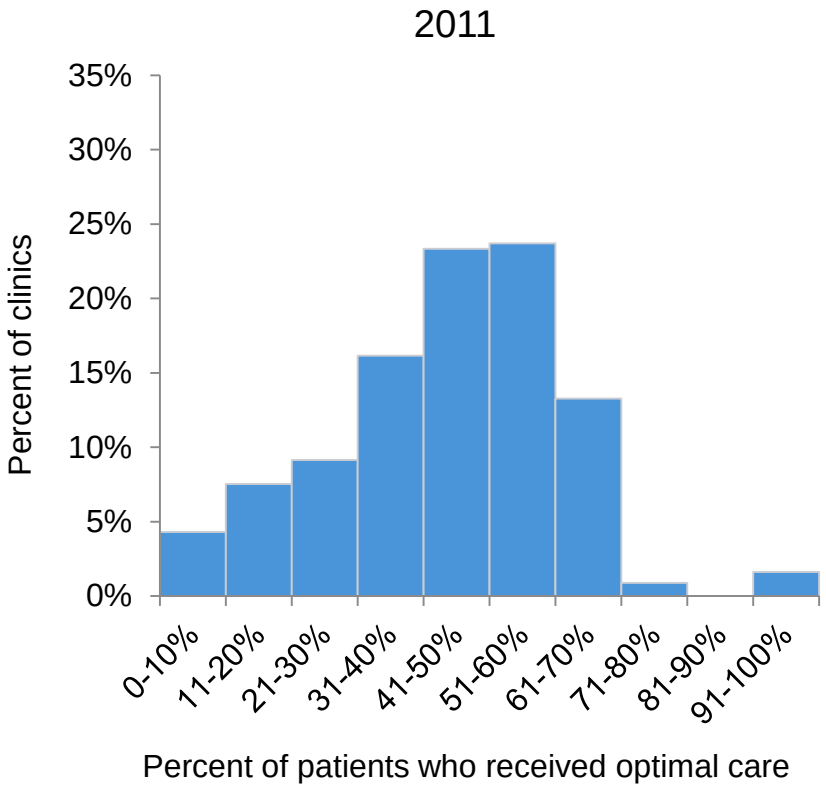


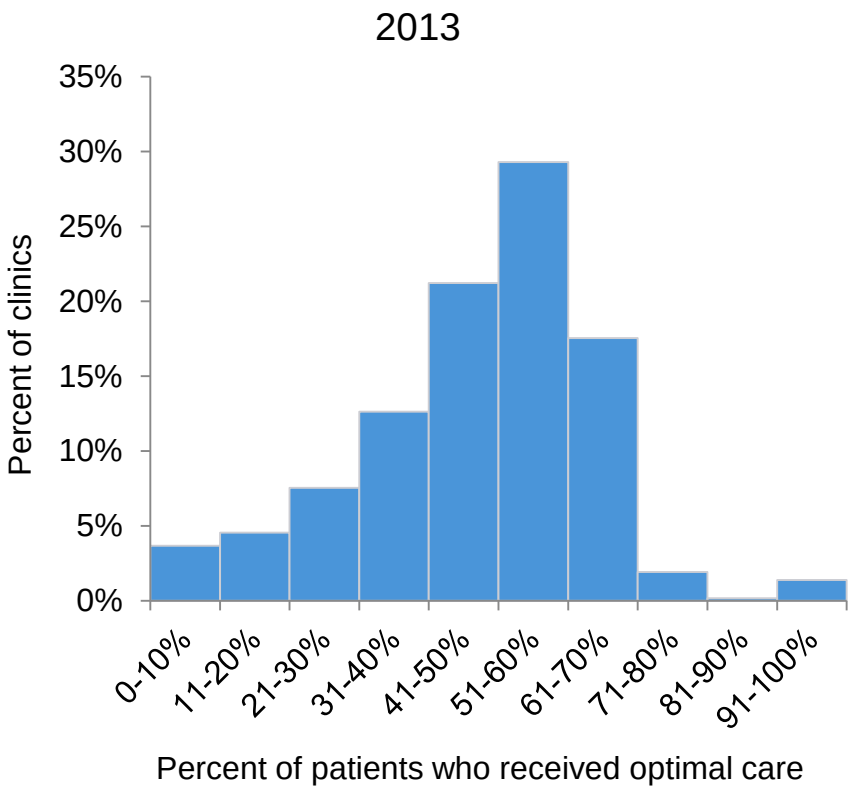
MHCP is Minnesota Health Care Programs, which includes: Medical Assistance, MinnesotaCare, Minnesota Family Planning Program, home and community-based waiver programs, and Medicare Savings Programs.
Service year: January 1 through December 31.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Optimal Vascular Care, 2011 and 2013 Clinic Performance

In 2013, compared to 2011, the share of clinics that delivered optimal vascular care to more than 50 percent of their patients increased by 11 percentage points.



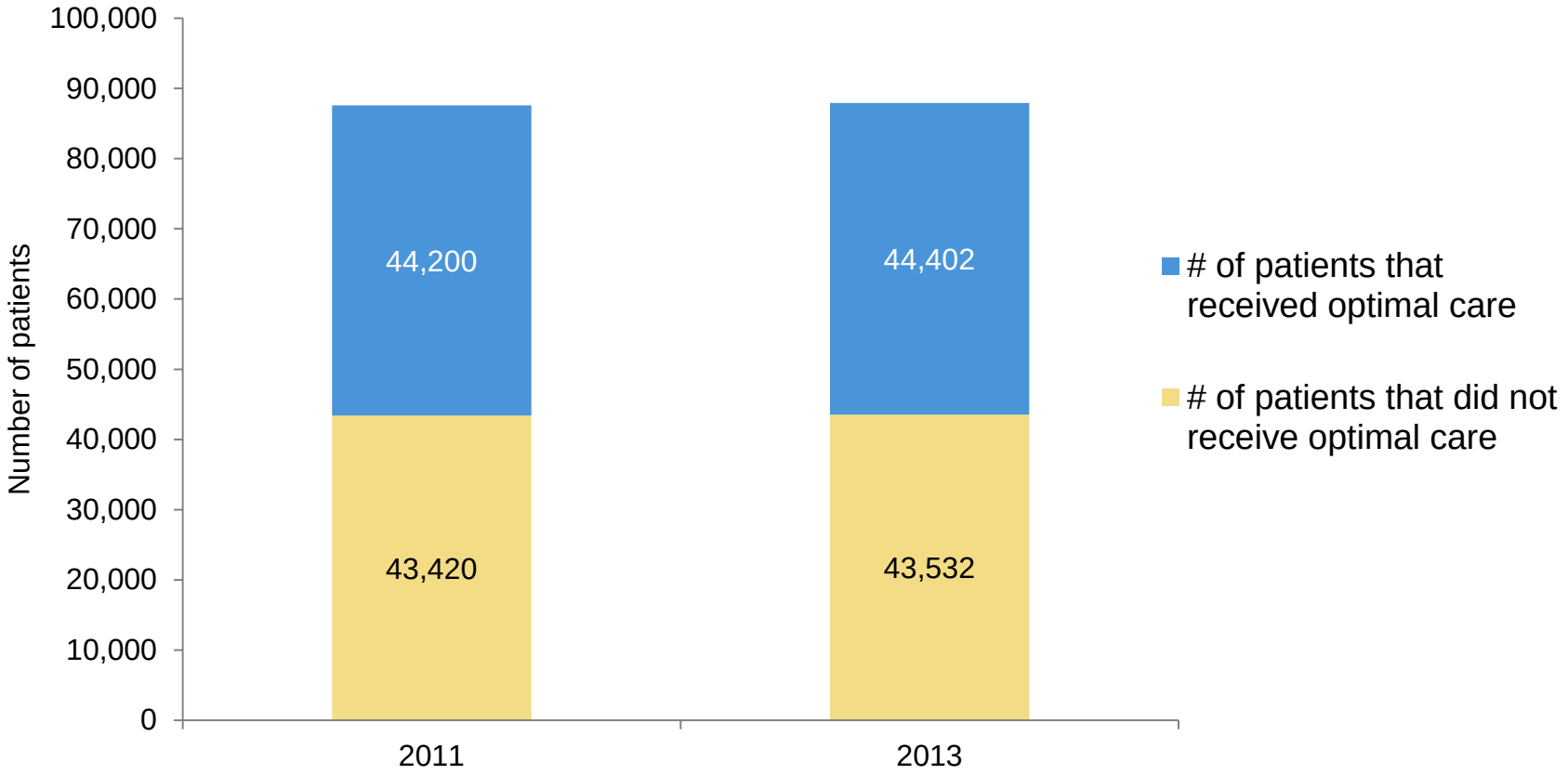


There were 557 reporting clinics in 2011, and 570 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Optimal Vascular Care, 2011 and 2013 Patients

There was little change in the number of patients receiving optimal care for diabetes between 2011 and 2013. In 2011 and 2013 the statewide optimal rate remained consistent at 50%.



There were 557 reporting clinics in 2011, and 570 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

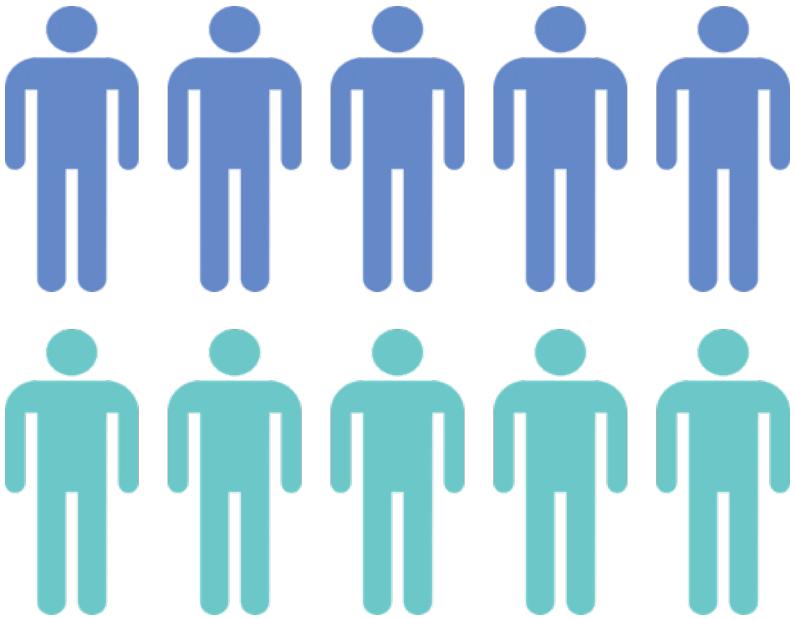
Optimal Asthma Care

The percentage of adult asthma patients, ages 18-50 or 5-17, who met the ALL following three goals:

1) Asthma under control
2) Asthma at low risk of worsening
3) Asthma education received and written management plan in place

Measure steward: MNCM

Adult Optimal Asthma Care, 2013 Statewide Rate



5 out of every **10**

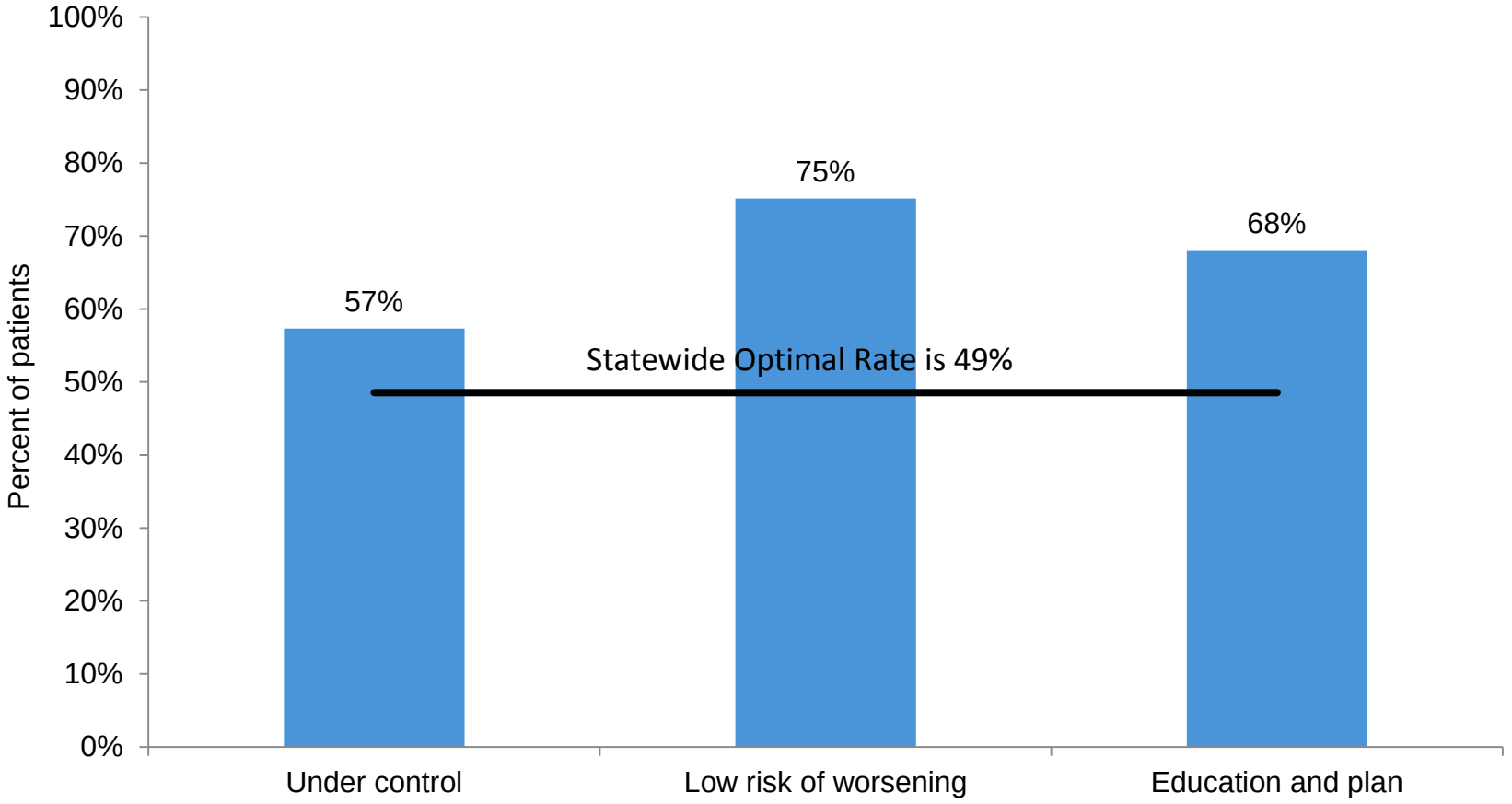
adult asthma patients received optimal care

Source: geckohealth.tumbler.com

The 2013 statewide optimal care rate was 49%.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Adult Optimal Asthma Care, 2013 Component Rates

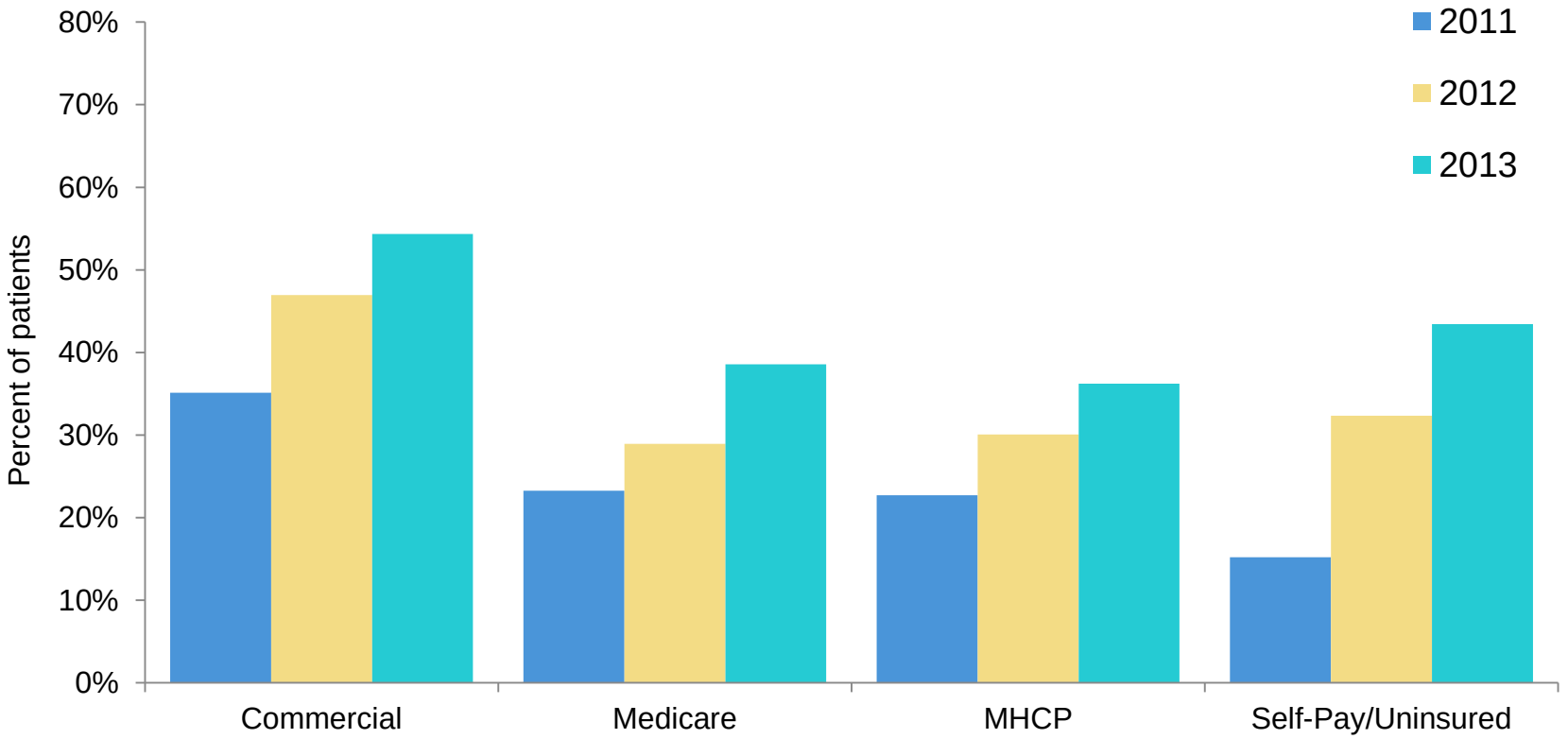
The percentage of adult asthma patients that met all three goals was 49%, however, a greater share of patients met individual goals. Of all the goals, patients were most likely to be at low risk of their asthma worsening.



To be included in the statewide optimal rate, patients had to meet all of the above goals.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

Adult Optimal Asthma Care, 2011-2013 Stratified by Health Insurance Type

Optimal care rates for patients with commercial insurance were notably higher than rates for patients with other insurance types.

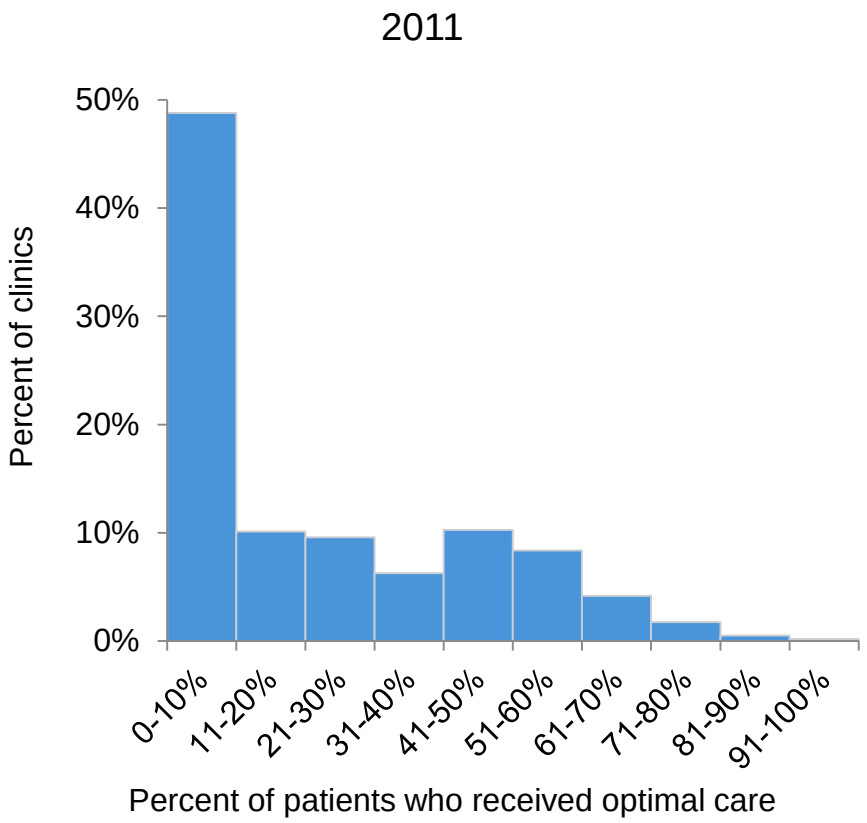


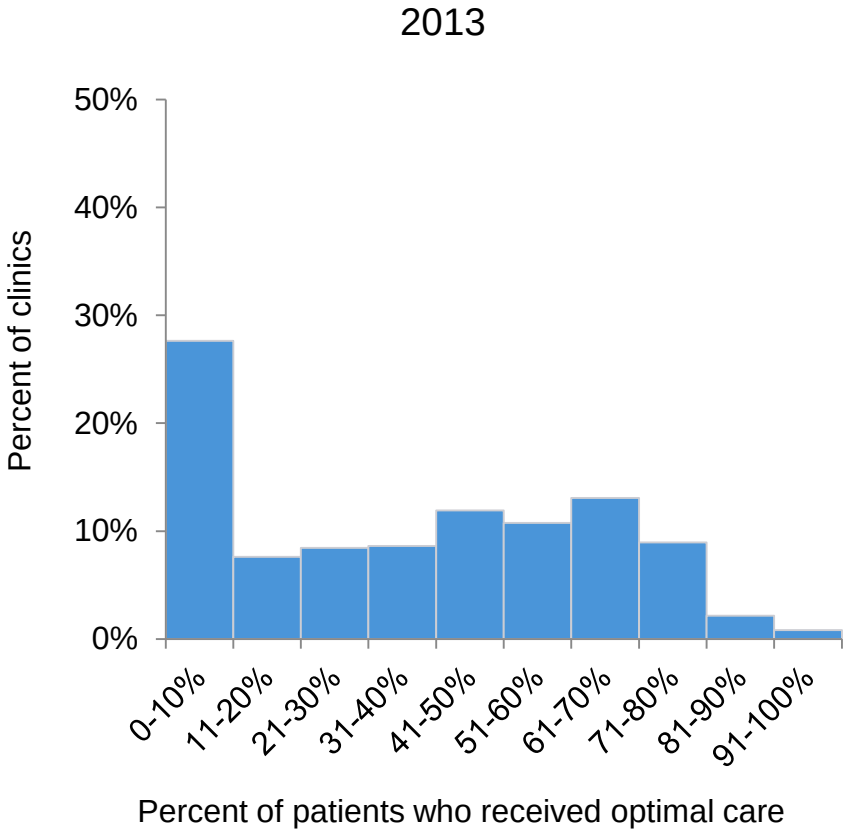
MHCP is Minnesota Health Care Programs, which includes: Medical Assistance, MinnesotaCare, Minnesota Family Planning Program, home and community-based waiver programs, and Medicare Savings Programs.
Service year: July 1 through June 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Adult Optimal Asthma Care, 2011 and 2013 Clinic Performance

In 2013, compared to 2011, the share of clinics that delivered optimal asthma care to more than 50 percent of their patients increased by 21 percentage points.



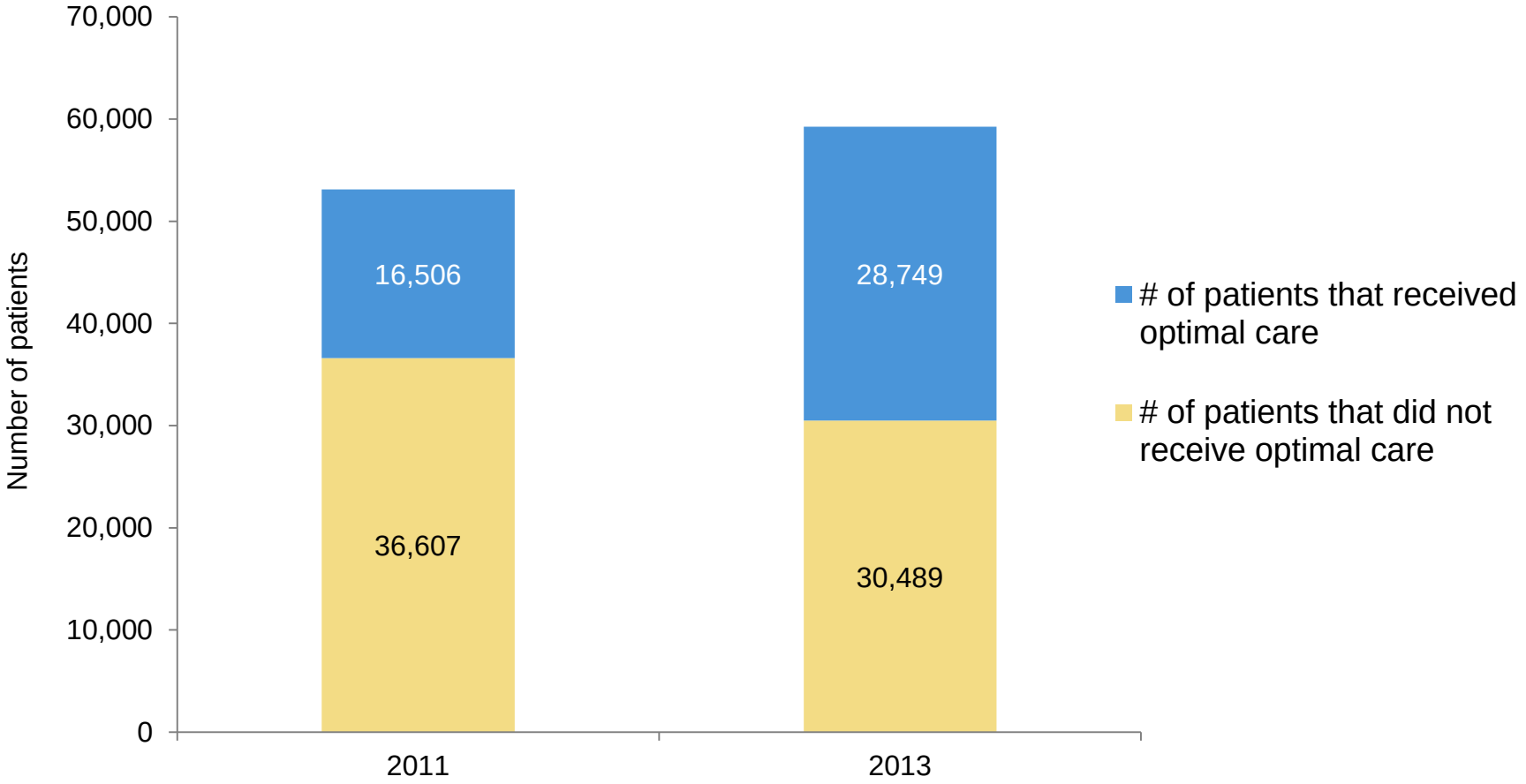


There were 574 reporting clinics in 2011, and 604 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

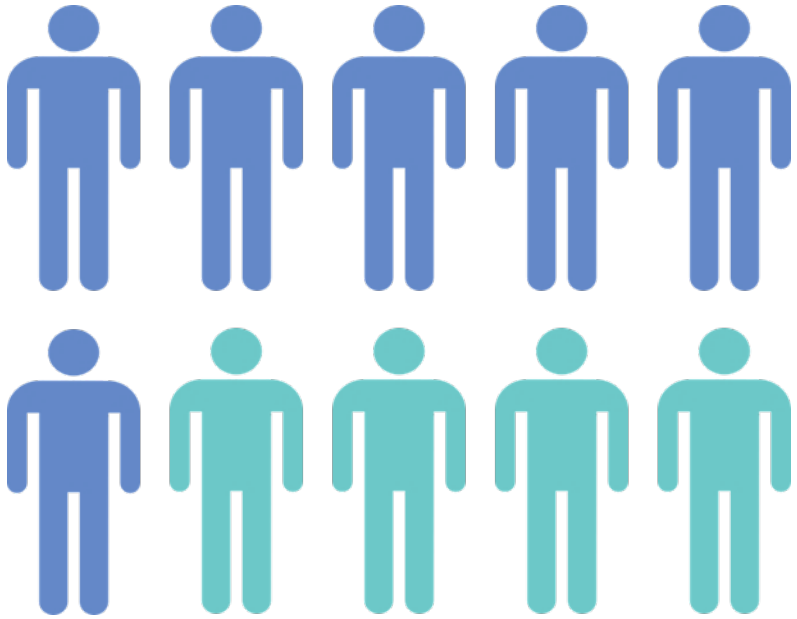
Adult Optimal Asthma Care, 2011 and 2013 Patients

Approximately 12,000 more patients received optimal care for asthma in 2013 as compared to 2011. In 2011, the statewide optimal rate was 31% and in 2013 it was 49%.



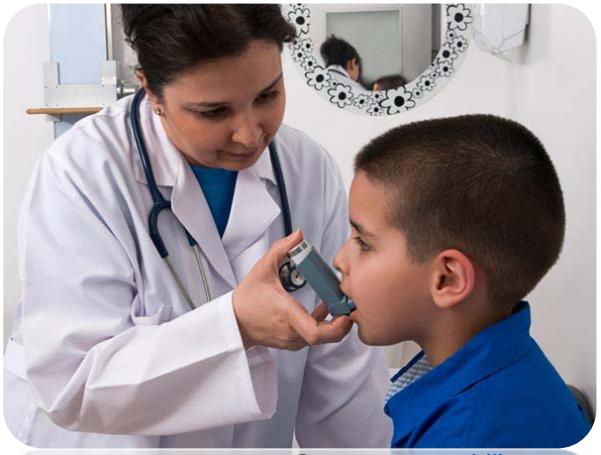
There were 574 reporting clinics in 2011, and 604 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

Child Optimal Asthma Care, 2013 Statewide Rate



6 out of every **10**

child asthma patients received optimal care

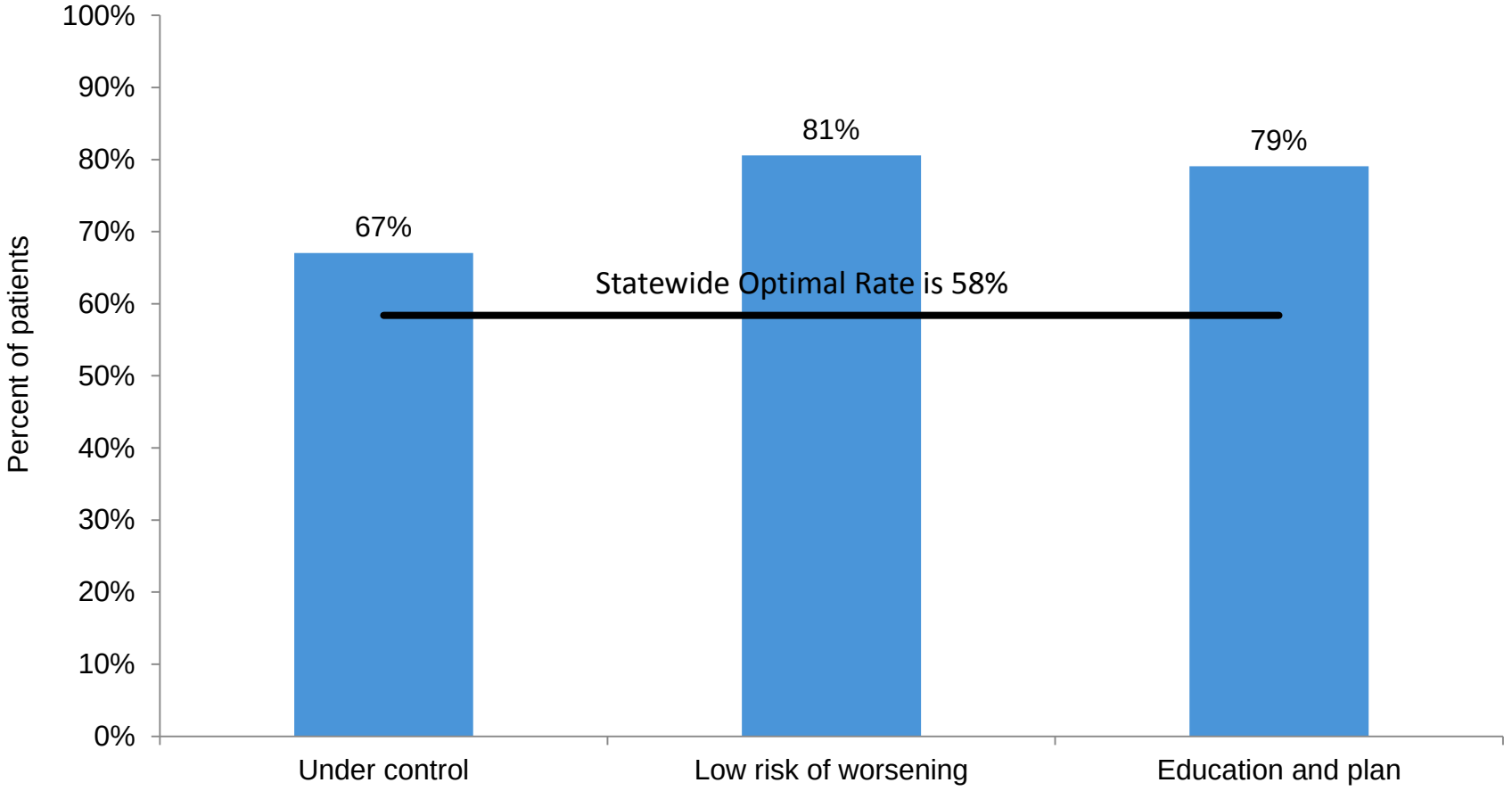


Source: www.philly.com

The 2013 statewide optimal care rate was 58%.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Child Optimal Asthma Care, 2013 Component Rates

The percentage of child asthma patients that met all three goals was 58%, however, a greater share of patients met individual goals. Of all the goals, patients were most likely to be at low risk of their asthma worsening and have received asthma education and a management plan.

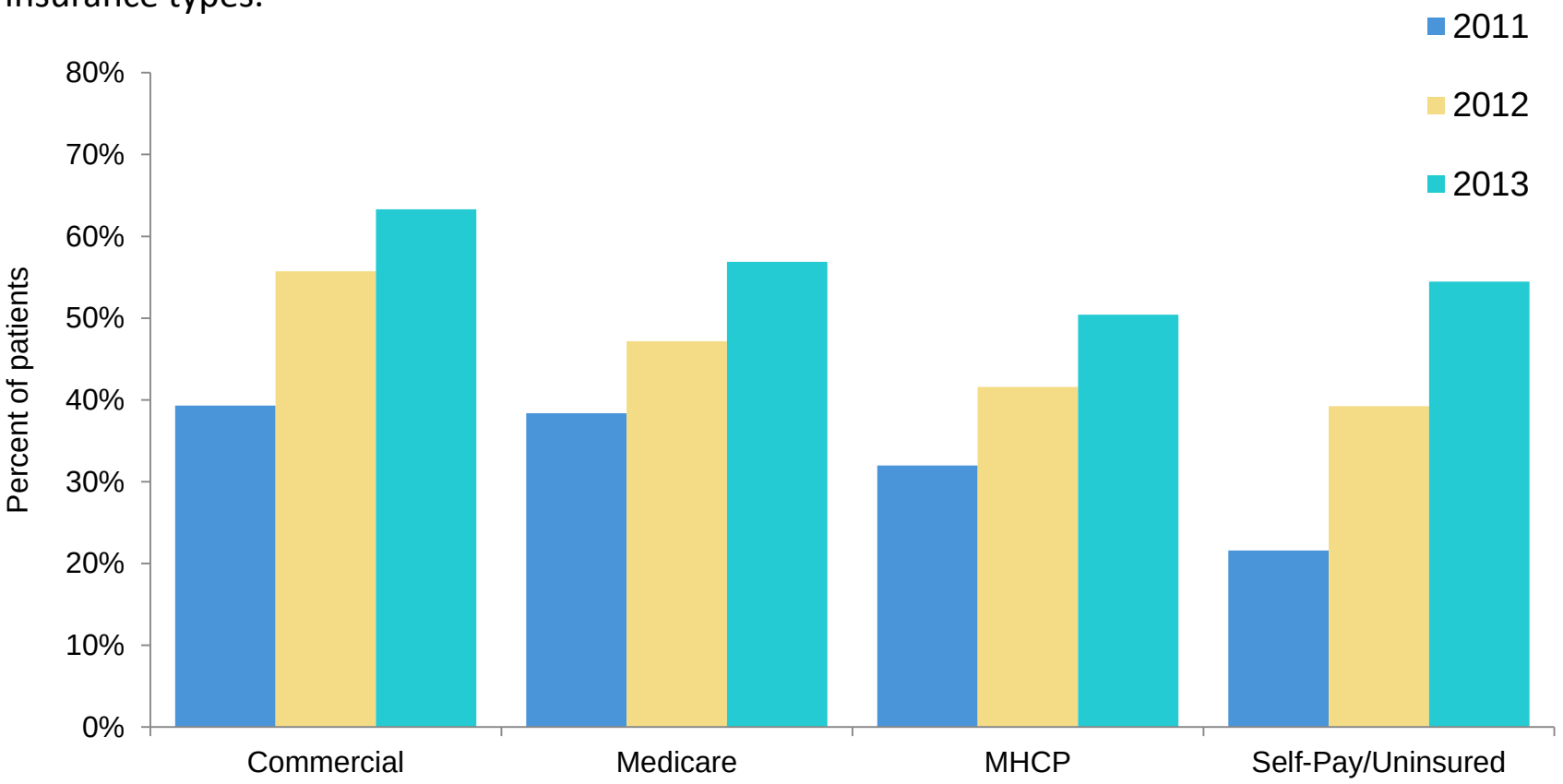


To be included in the statewide optimal rate, patients had to meet all of the above goals.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Child Optimal Asthma Care, 2011-2013 Stratified by Health Insurance Type

Optimal care rates for patients with commercial insurance were higher than rates for all other insurance types.

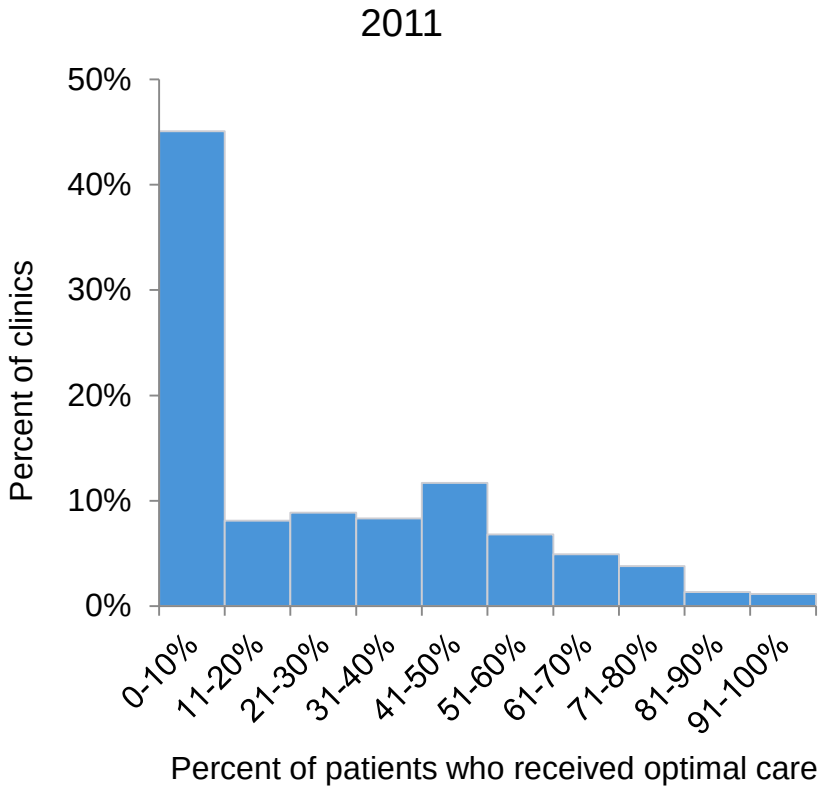


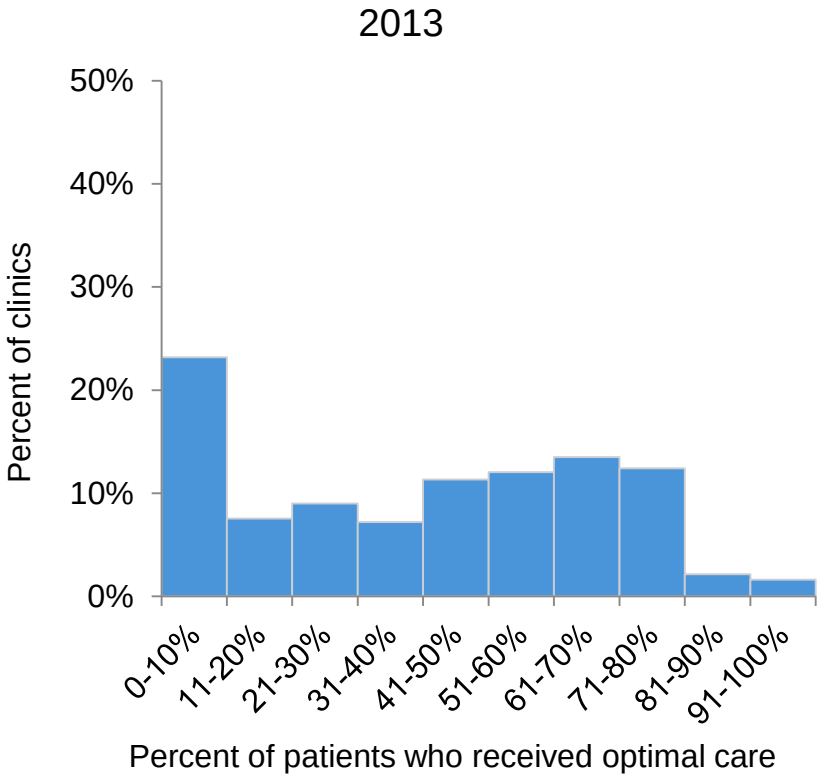
MHCP is Minnesota Health Care Programs, which includes: Medical Assistance , MinnesotaCare, Minnesota Family Planning Program, home and community-based waiver programs, and Medicare Savings Programs.
Service year: July 1 through June 30.
Source: MDH Health Economics Program analysis of **Quality Reporting System** data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Child Optimal Asthma Care, 2011 and 2013 Clinic Performance

In 2013, compared to 2011, the share of clinics that delivered optimal asthma care to more than 50 percent of their patients increased by 24 percentage points.



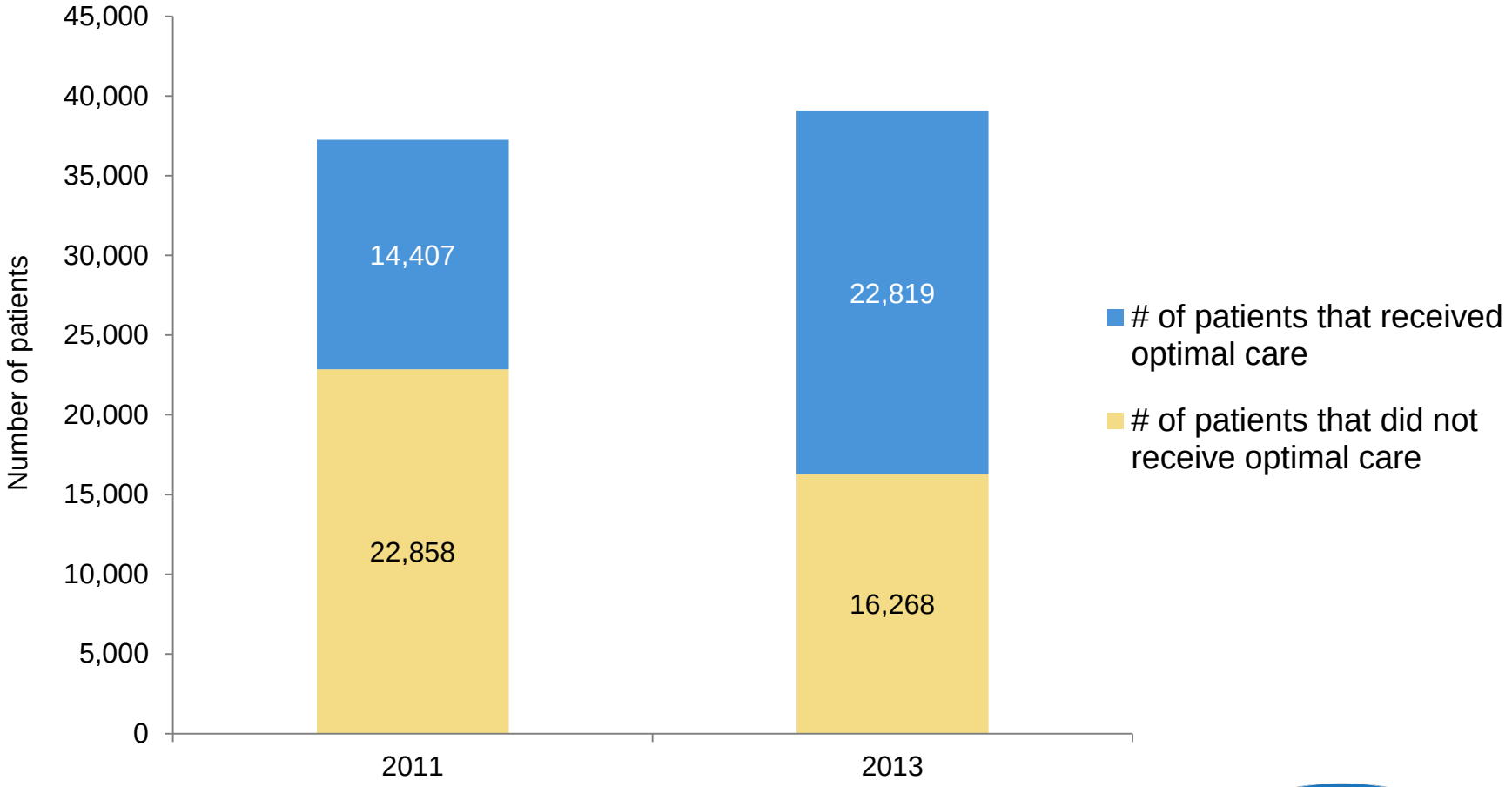


There were 530 reporting clinics in 2011, and 556 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Child Optimal Asthma Care, 2011 and 2013 Patients

Approximately 8,500 more patients received optimal care for asthma in 2013 as compared to 2011. In 2011, the statewide optimal rate was 38% and in 2013 it was 58%.



There were 530 reporting clinics in 2011, and 556 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

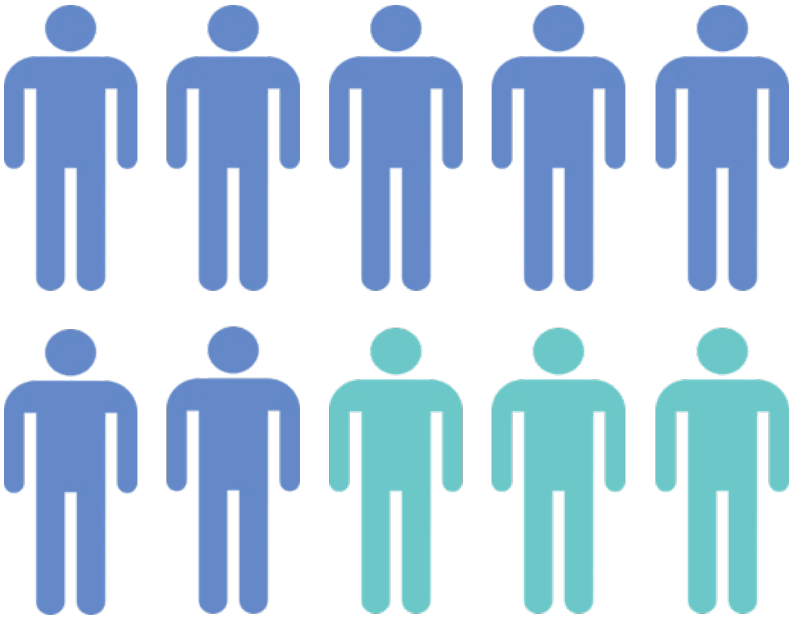
Colorectal Cancer Screening

The percentage of adult patients who are up to date with appropriate colorectal cancer screening exams, which include ANY of the following methods:

1) Colonoscopy within the measurement period or prior 9 years
2) Sigmoidoscopy within the measurement period or prior 4 years
3) Stool blood test within the measurement period

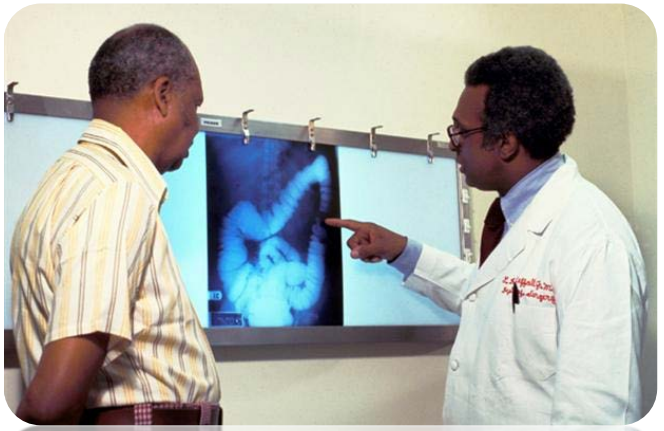
Definitions. (1) Colonoscopy: An exam used to detect changes or abnormalities in the large intestine (colon) and rectum. (2) Sigmoidoscopy: An exam used to evaluate the lower part of the large intestine (colon). (3) Stool blood test: A lab test used to check stool samples for hidden blood, which may be an indicator of colon cancer or polyps in the colon or rectum.
Measure steward: MNCM

Colorectal Cancer Screening, 2013 Statewide Rate



7 out of every **10**

patients aged 50-75 were screened for Colorectal Cancer

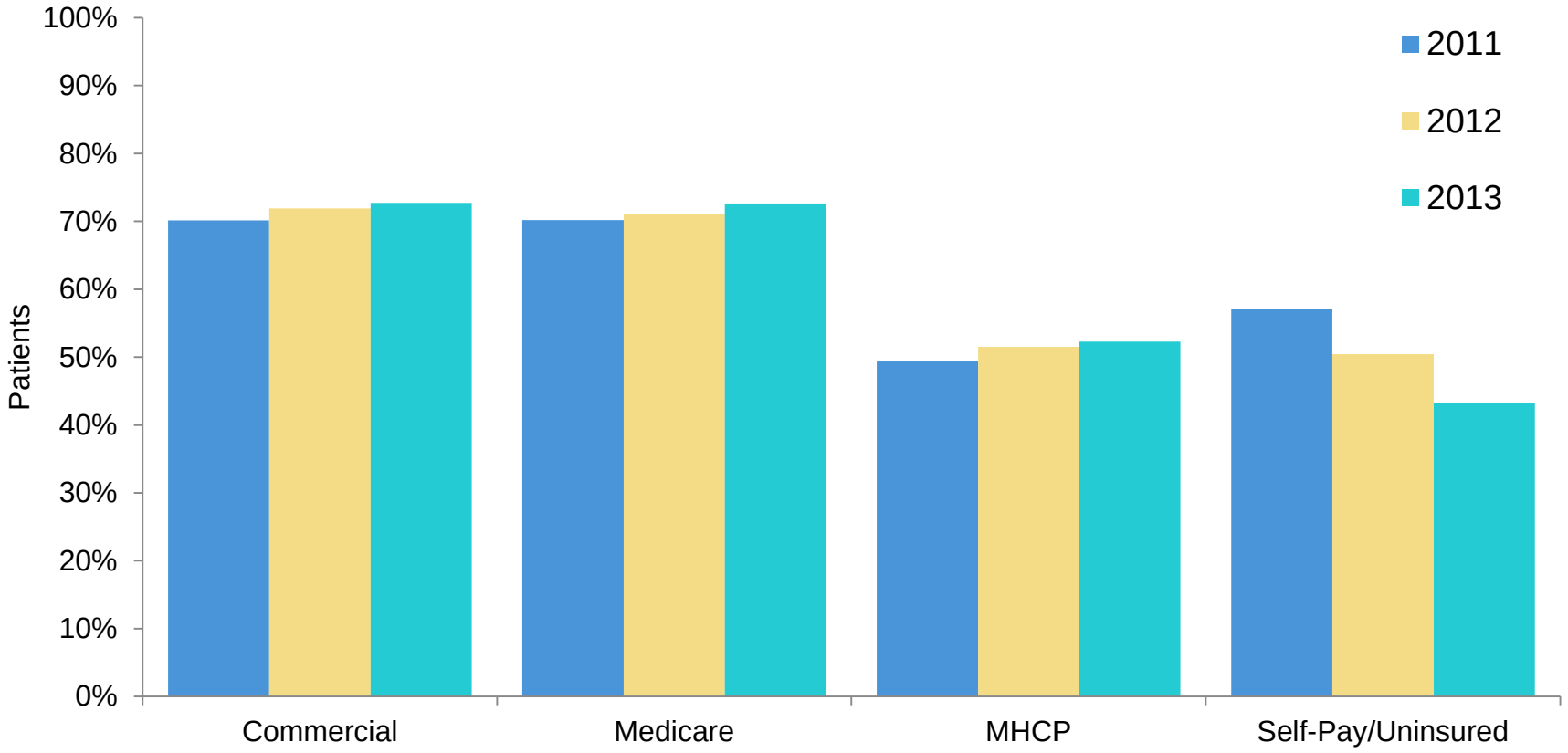


Source: latestnewslink.com

The 2013 statewide optimal care rate was 70%.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Colorectal Cancer Screening, 2011-2013 Stratified by Health Insurance Type

Optimal care rates for patients with commercial insurance and Medicare were notably higher than rates for MHCP and self-pay/uninsured patients.

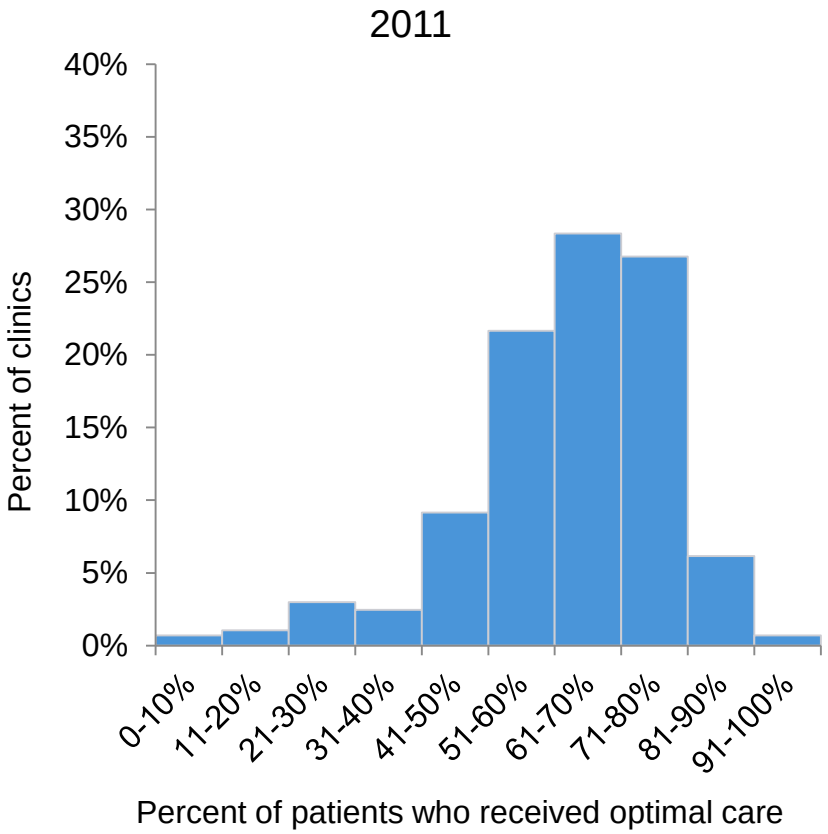


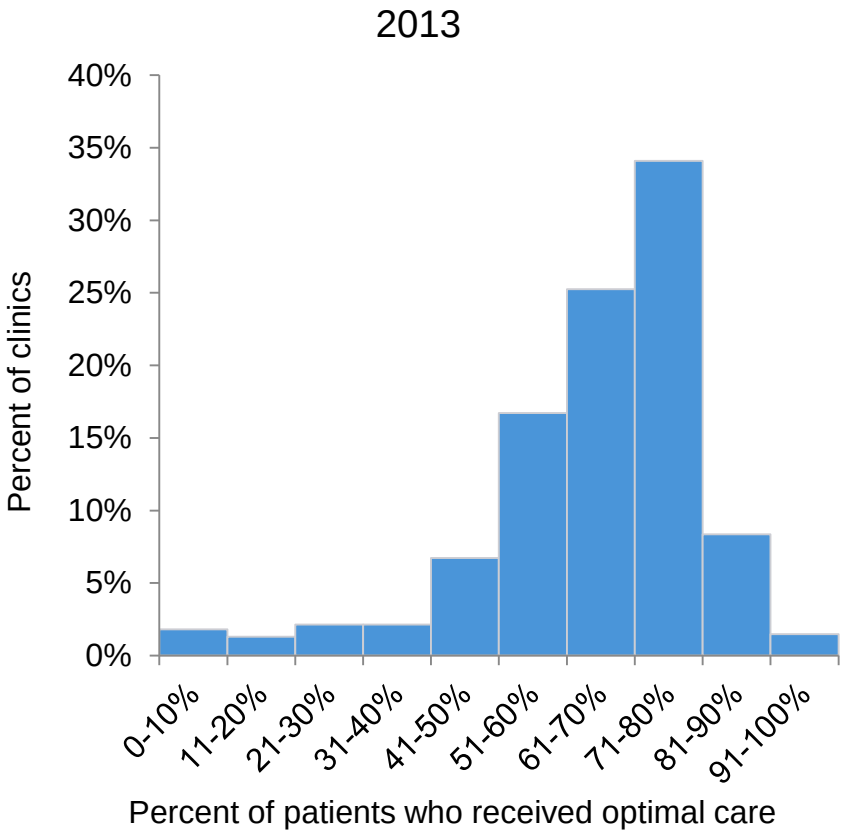
MHCP is Minnesota Health Care Programs, which includes: Medical Assistance, MinnesotaCare, Minnesota Family Planning Program, home and community-based waiver programs, and Medicare Savings Programs.
Service year: July 1 through June 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Colorectal Cancer Screening, 2011 and 2013 Clinic Performance

In 2013, compared to 2011, the share of clinics that screened more than 50 percent of their patients for colorectal cancer increased by 2 percentage points.



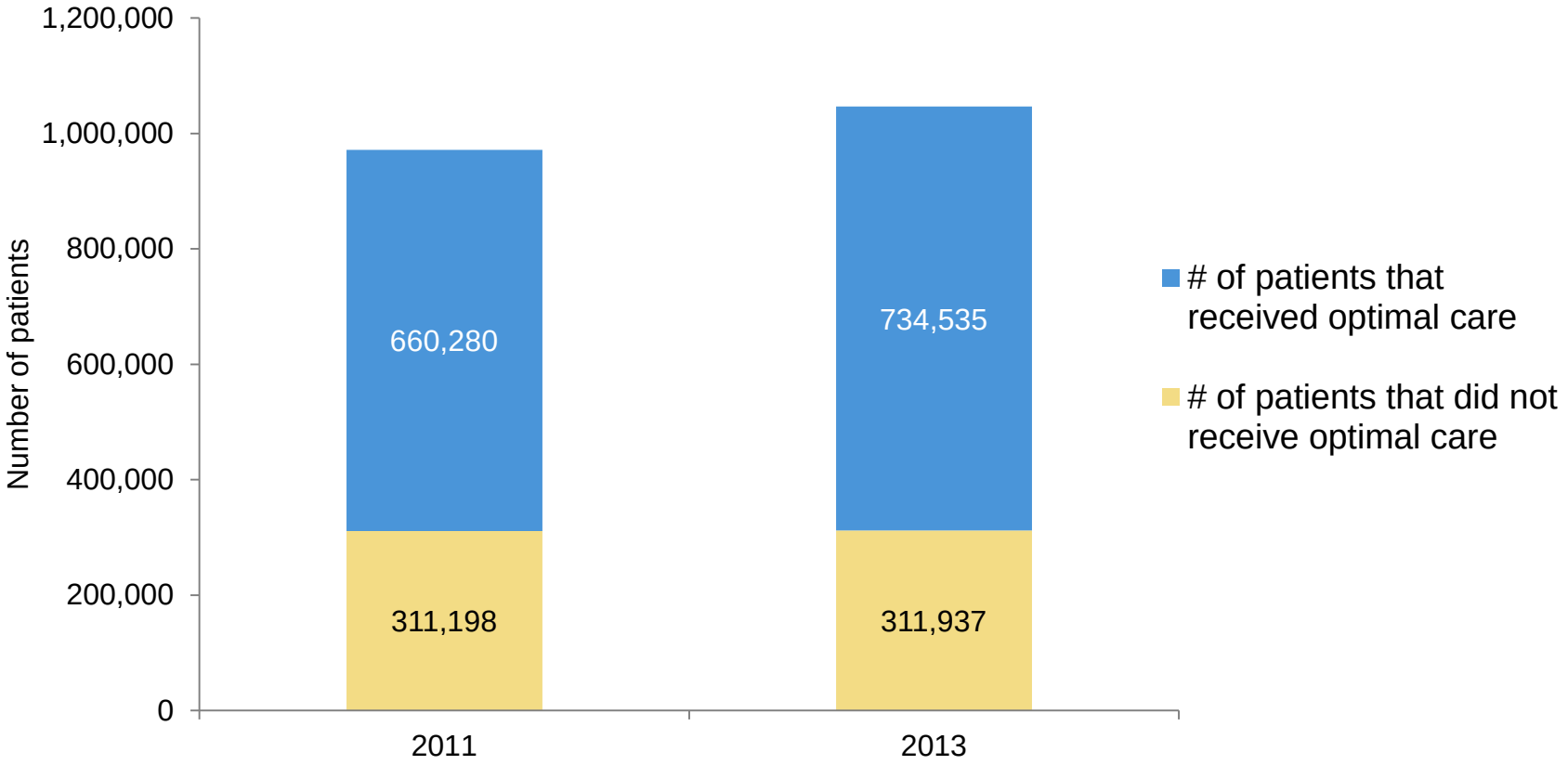


There were 568 reporting clinics in 2011, and 610 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Colorectal Cancer Screening, 2011 and 2013 Patients

Approximately 75,000 more patients were screened in 2013 as compared to 2011. In 2011, the statewide optimal rate was 68% and in 2013 it was 70%.



There were 568 reporting clinics in 2011, and 610 in 2013.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Patient Experience of Care

The Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) 12-month Survey collects data for the following domains:

1) Access to Care
2) Provider communication
3) Office Staff
4) Provider rating

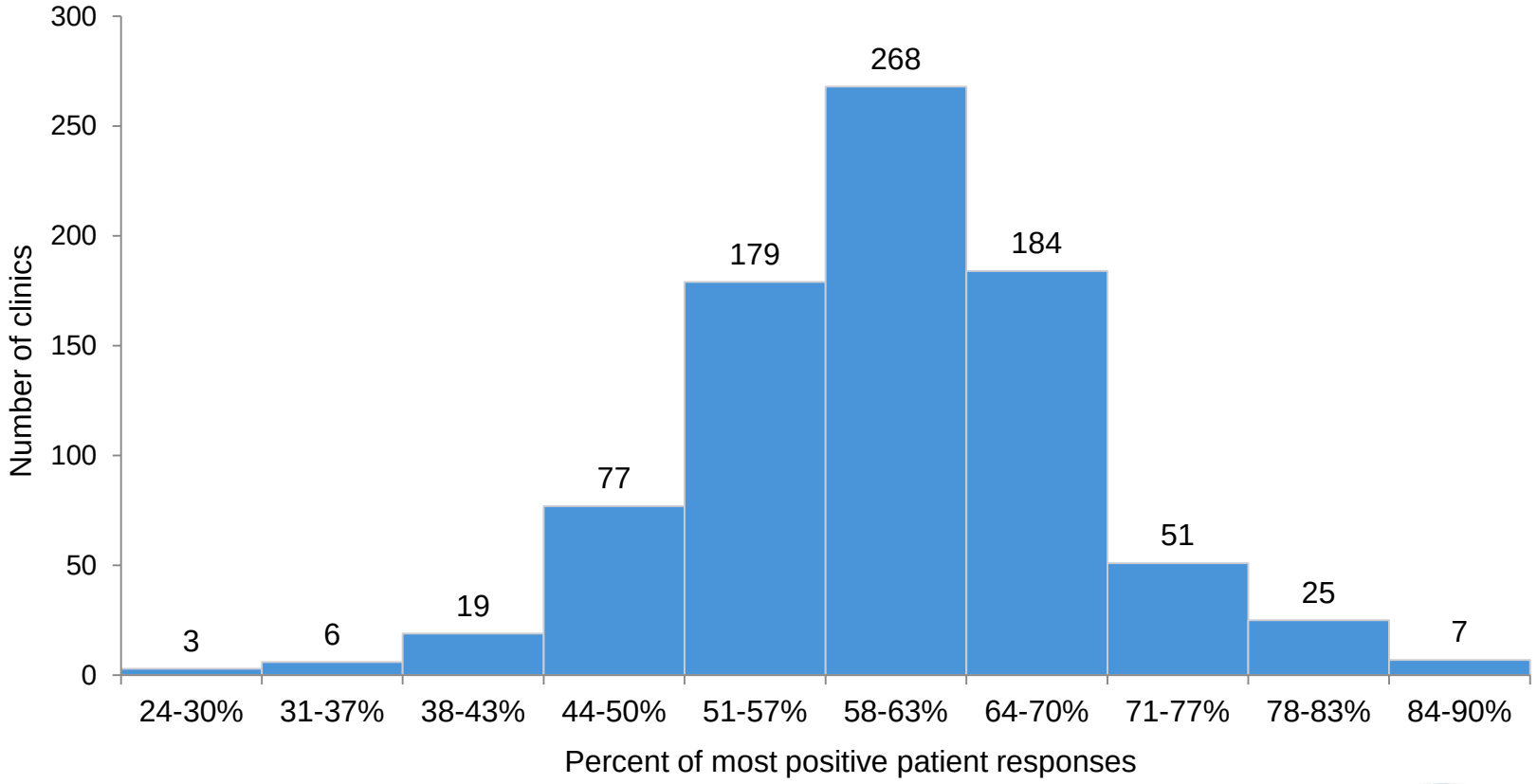
Note: Clinics will use the CG-CAHPS 6-Month Survey in 2016; data will be available in 2017.
Measure steward: Agency for Healthcare Research and Quality (AHRQ)
NQF# 0005

Patient Experience of Care

Domain	Description
Access to care	The survey asked patients how often they received: 1) appointments for care as soon as needed and 2) timely answers to questions when they called the office
Provider communication	The survey asked patients if their doctors explained things clearly, listened carefully, showed respect, provided easy to understand instructions, knew their medical history, and spent enough time with the patient.
Office staff	The survey asked patients if office staff were helpful and treated them with courtesy and respect.
Provider rating	The survey asked patients to rate their doctors on a scale of 0 to 10, with 0 being the worst and 10 being the best.

Percent of Patients Who Chose the Most Positive Response to Access to Care Questions, by Number of Clinics, 2014

For the majority of clinics, 51% to 70% of patients selected the highest possible positive response when asked about getting timely appointments, care, and information.



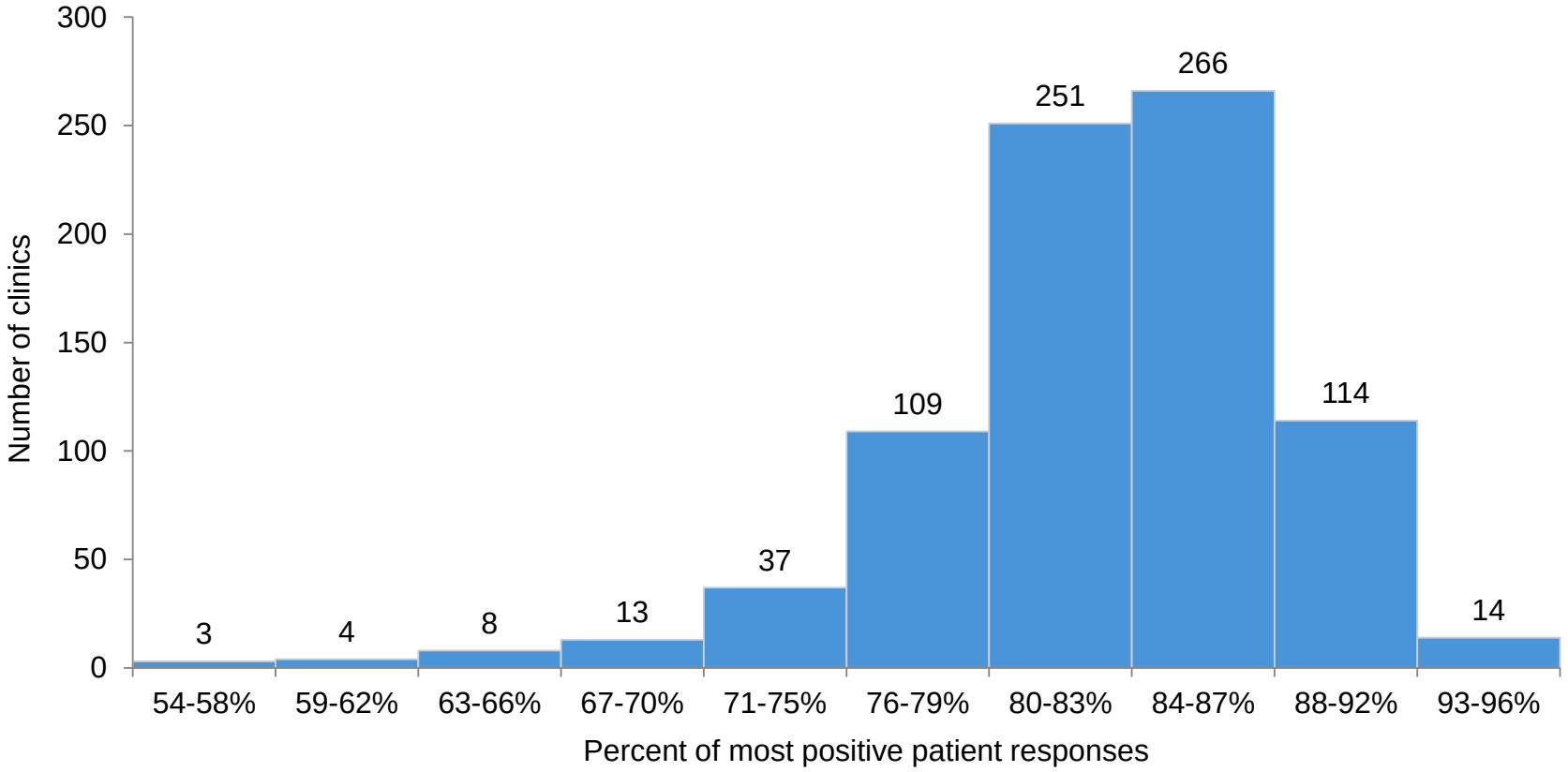
Source: MDH Health Economics Program analysis of Quality Reporting System data.

[Summary of graph]

HEALTH ECONOMICS PROGRAM

Percent of Patients Who Chose the Most Positive Response to Provider Communication Questions, by Number of Clinics, 2014

For the majority of clinics, 76% to 92% of patients selected the highest possible positive response when asked how well providers communicate with patients.



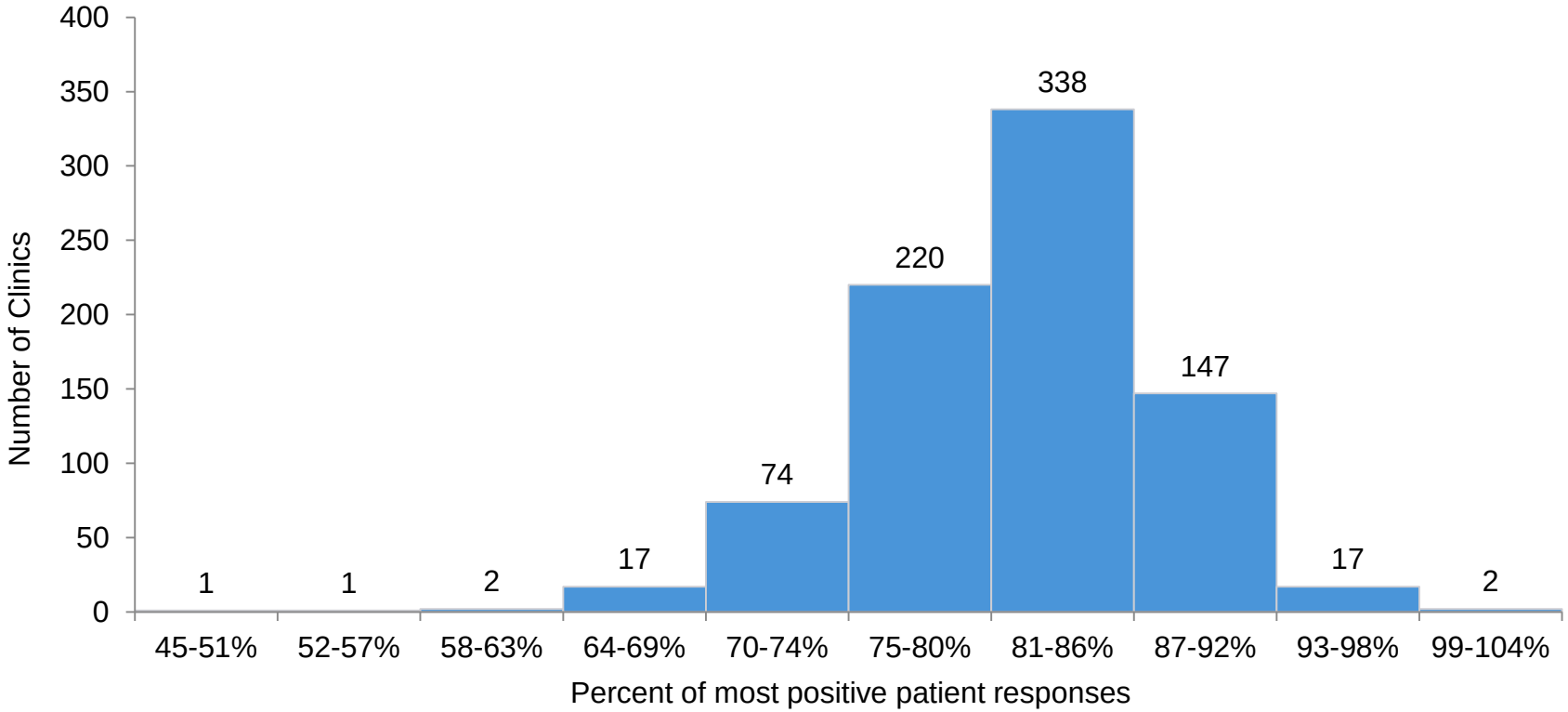
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Summary of graph

HEALTH ECONOMICS PROGRAM

Percent of Patients Who Chose the Most Positive Response to Office Staff Questions, by Number of Clinics, 2014

For the majority of clinics, 75% to 92% of patients selected the highest possible positive response when asked about how often office staff were helpful, courteous, and respectful.



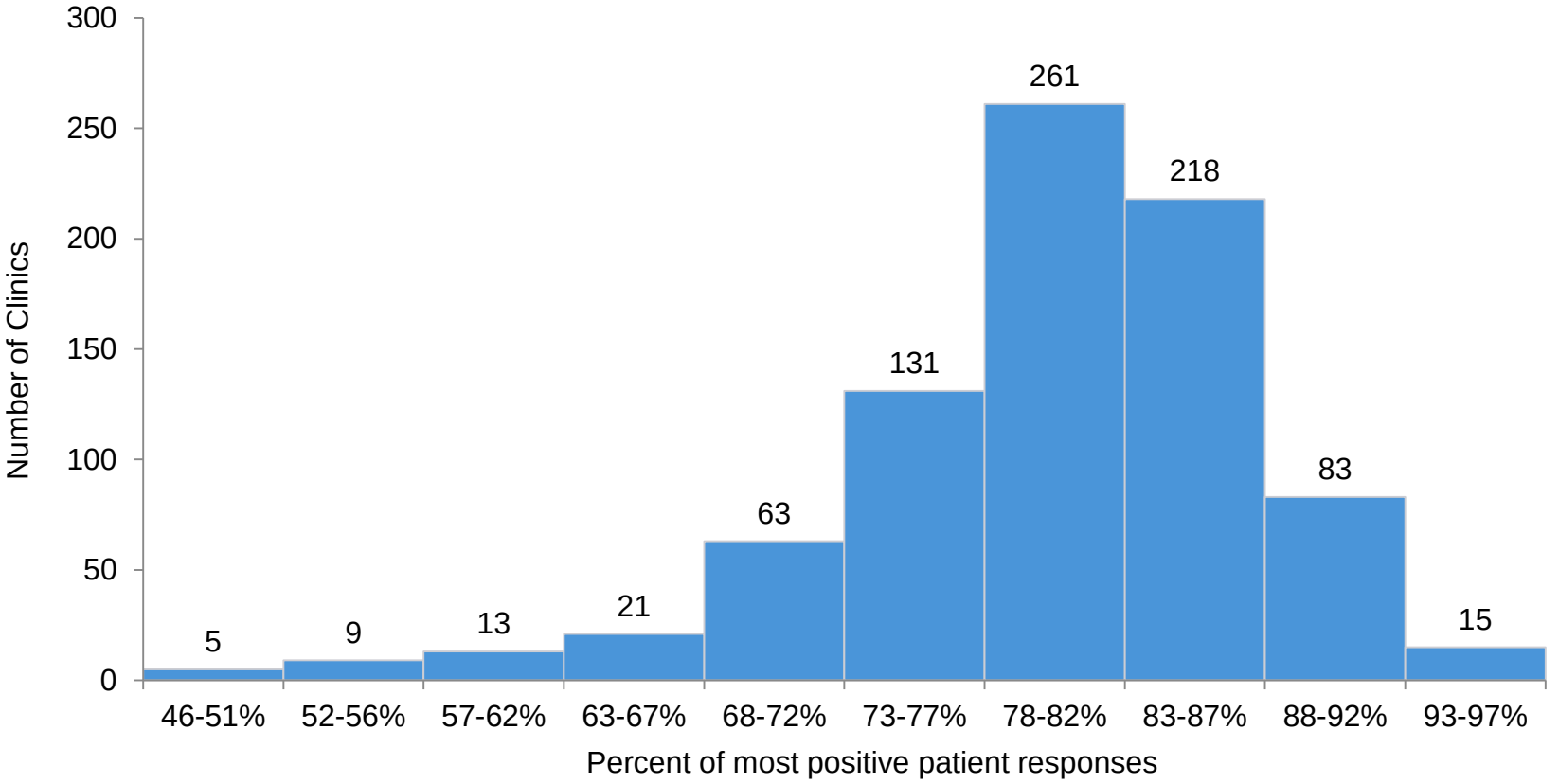
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Summary of graph

HEALTH ECONOMICS PROGRAM

Percent of Patients Who Chose the Most Positive Response to Provider Rating Question, by Number of Clinics, 2014

For the majority of clinics, 73% to 87% of patients selected the highest possible positive response when asked to rate their doctor.



Source: MDH Health Economics Program analysis of Quality Reporting System data.

Summary of graph

HEALTH ECONOMICS PROGRAM

HOSPITAL QUALITY MEASURES

Agency for Healthcare Research and Quality (AHRQ) Measures

- AHRQ measures show:
  1. **The rate expected from a hospital based on the performance of other similar hospitals around the country** and
  2. **Whether results were significantly different from the hospital's expected performance compared to other similar hospitals around the country.** Performance rates are risk adjusted to an average case-mix which takes into account the severity of patient illness.
- AHRQ measures report whether hospitals performed better than expected (i.e., lower), the same as expected, or worse (i.e., higher) than expected considering their patient mix.
- Results are broken out for Prospective Payment System and Critical Access hospitals.

Mortality for Selected Conditions (IQI 91)

This composite measure is a **weighted average of the mortality indicators** for patients admitted for selected conditions and is used to **assess the number of deaths for the selected conditions**. It includes the following indicators:

- Acute myocardial infarction mortality rate (IQI 15)
- Congestive heart failure mortality rate (IQI 16)
- Acute stroke mortality rate (IQI 17)
- Gastrointestinal hemorrhage mortality rate (IQI 18)
- Hip fracture mortality rate (IQI 19)
- Pneumonia mortality rate (IQI 20)

Measure steward: AHRQ
NQF# 530

Mortality for Selected Conditions, 2012 to 2014

Most hospitals had mortality rates as expected during 2012, 2013, and 2014.

	Prospective Payment System Hospitals				Critical Access Hospitals			
Year	**Lower**	**Same**	**Higher**	**No Results**	**Lower**	**Same**	**Higher**	**No Results**
2012	16	37	0	2	0	77	1	0
2013	19	35	0	1	0	78	0	0
2014	3	49	0	3	0	78	0	0

- "Lower" = Performance was better than expected
- “Same” = Performance was as expected
- “Higher“ = Performance was worse than expected

Service year: October 1 through September 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Patient Safety for Selected Indicators (PSI 90)

This measure is a **weighted average of most of the patient safety indicators** and is used to **assess the number of potentially preventable adverse events.** It includes the following indicators:

- Pressure ulcer (PSI 3)
- Iatrogenic pneumothorax (PSI 6)
- Central venous catheter-related bloodstream infections (PSI 7)
- Postoperative hip fracture (PSI 8)
- Postoperative hemorrhage or hematoma (PSI 9)
- Postoperative physiologic and metabolic derangements (PSI 10)
- Postoperative respiratory failure (PSI 11)
- Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12)
- Postoperative sepsis (PSI 13)
- Postoperative wound dehiscence (PSI 14)
- Accidental puncture or laceration (PSI 15)

Measure steward: AHRQ
NQF# 531

Patient Safety for Selected Indicators, 2012 to 2014

Most hospitals had patient safety rates as expected during 2012, 2013, and 2014.

	Prospective Payment System Hospitals				Critical Access Hospitals			
Year	**Lower**	**Same**	**Higher**	**No Results**	**Lower**	**Same**	**Higher**	**No Results**
2012	16	37	2	0	9	78	0	0
2013	16	38	1	0	0	78	0	0
2014	7	47	0	1	0	78	0	0

- "Lower" = Performance was better than expected
- “Same” = Performance was as expected
- “Higher“ = Performance was worse than expected

Service year: October 1 through September 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Pediatric Patient Safety for Select Indicators (PDI 19)

This composite measure is a **weighted average of most of the pediatric quality indicators** and is used to **assess the number of potentially preventable adverse events**. It includes the following indicators:

- Accidental puncture or laceration (PDI 1)
- Pressure ulcer (PDI 2)
- Latrogenic pneumothorax (PDI 5)
- Postoperative hemorrhage or hematoma (PDI 8)
- Postoperative respiratory failure (PDI 9)
- Postoperative sepsis (PDI 10)
- Postoperative wound dehiscence (PDI 11)
- Central venous catheter-related bloodstream infections (PDI 12)

Measure steward: AHRQ
NQF# 532

Pediatric Patient Safety for Select Indicators, 2012 to 2014

Most hospitals had pediatric patient rates as expected during 2012, 2013, and 2014.

	Prospective Payment System Hospitals				Critical Access Hospitals			
Year	**Lower**	**Same**	**Higher**	**No Results**	**Lower**	**Same**	**Higher**	**No Results**
2012	1	54	0	0	0	66	0	12
2013	0	55	0	0	0	69	0	9
2014	0	53	2	0	0	78	0	0

- "Lower" = Performance was better than expected
- “Same” = Performance was as expected
- “Higher“ = Performance was worse than expected

Service year: October 1 through September 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Death Among Surgical Inpatients with Serious Treatable Complications (PSI 4)

- This measure assesses the **number of deaths per 1,000 patients having developed specified complications of care during hospitalization** (e.g., pneumonia, deep vein thrombosis/pulmonary embolism, sepsis, shock/cardiac arrest, or GI hemorrhage/acute ulcer).
- This measure is a **nursing-sensitive indicator** which means it reflects the structure, process, and outcomes of nursing care.

Measure steward: AHRQ
NQF# 531

Death Among Surgical Inpatients with Serious Treatable Complications, 2012 to 2014

Most hospitals had death rates from complications as expected during 2012, 2013, and 2014.

	Prospective Payment System Hospitals				Critical Access Hospitals			
Year	**Lower**	**Same**	**Higher**	**No Results**	**Lower**	**Same**	**Higher**	**No Results**
2012	6	47	0	2	0	24	1	53
2013	8	44	0	3	0	28	1	49
2014	4	45	1	5	0	31	0	47

- "Lower" = Performance was better than expected
- “Same” = Performance was as expected
- “Higher“ = Performance was worse than expected

Service year: October 1 through September 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Hospital Patient Experience of Care

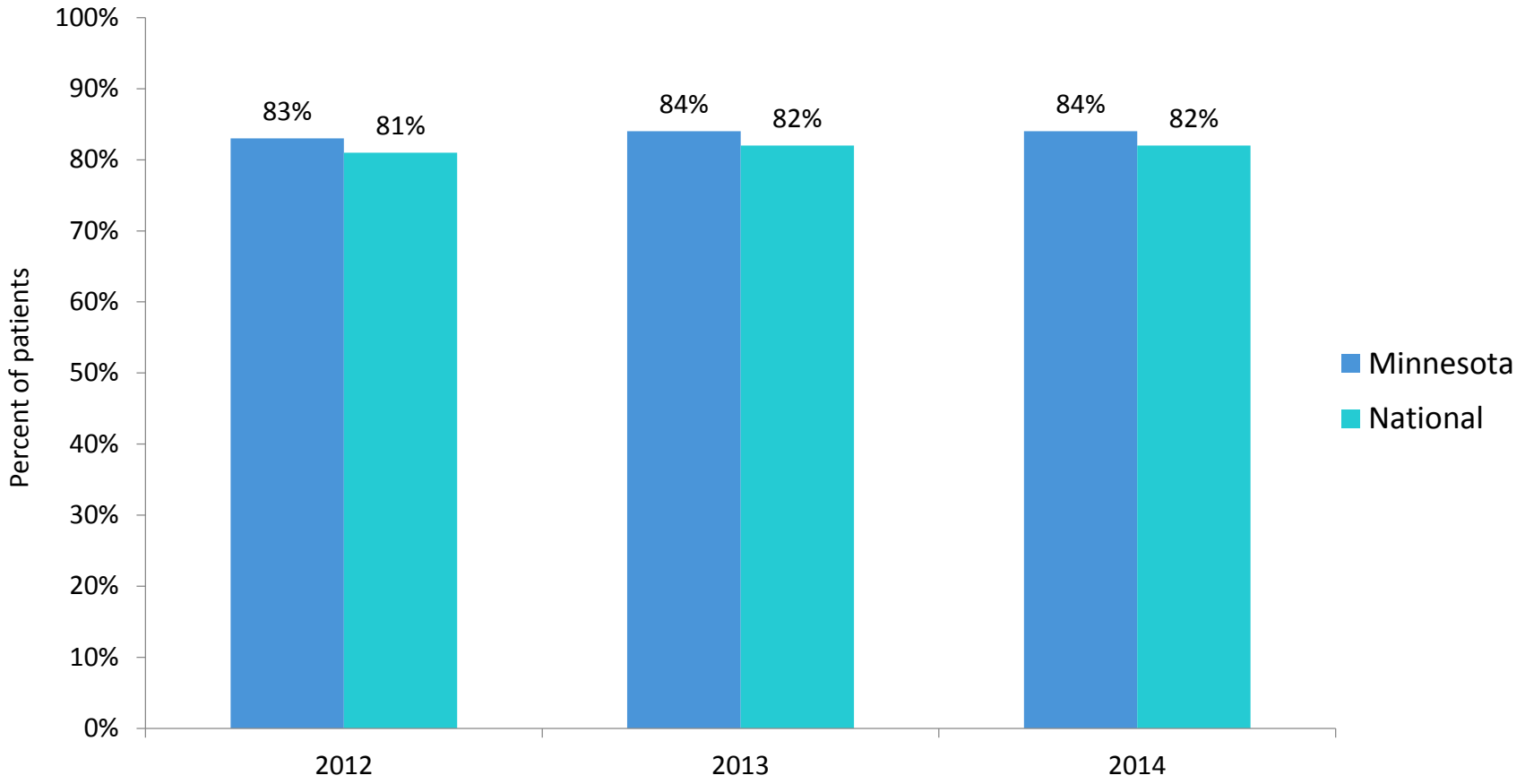
The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measures **patients' perspectives on hospital care** and covers nine topics:

1) Communication with doctors
2) Communication with nurses
3) Responsiveness of hospital staff
4) Pain management
5) Communication about medicines
6) Discharge information
7) Cleanliness of the hospital environment
8) Quietness of the hospital environment
9) Transition of care

Measure steward: CMS
NQF #0166

Percent of Patients Who Reported That Their Doctors "Always" Communicated Well, 2012 to 2014

Minnesota hospitals performed slightly better than the national average from 2012 to 2014.

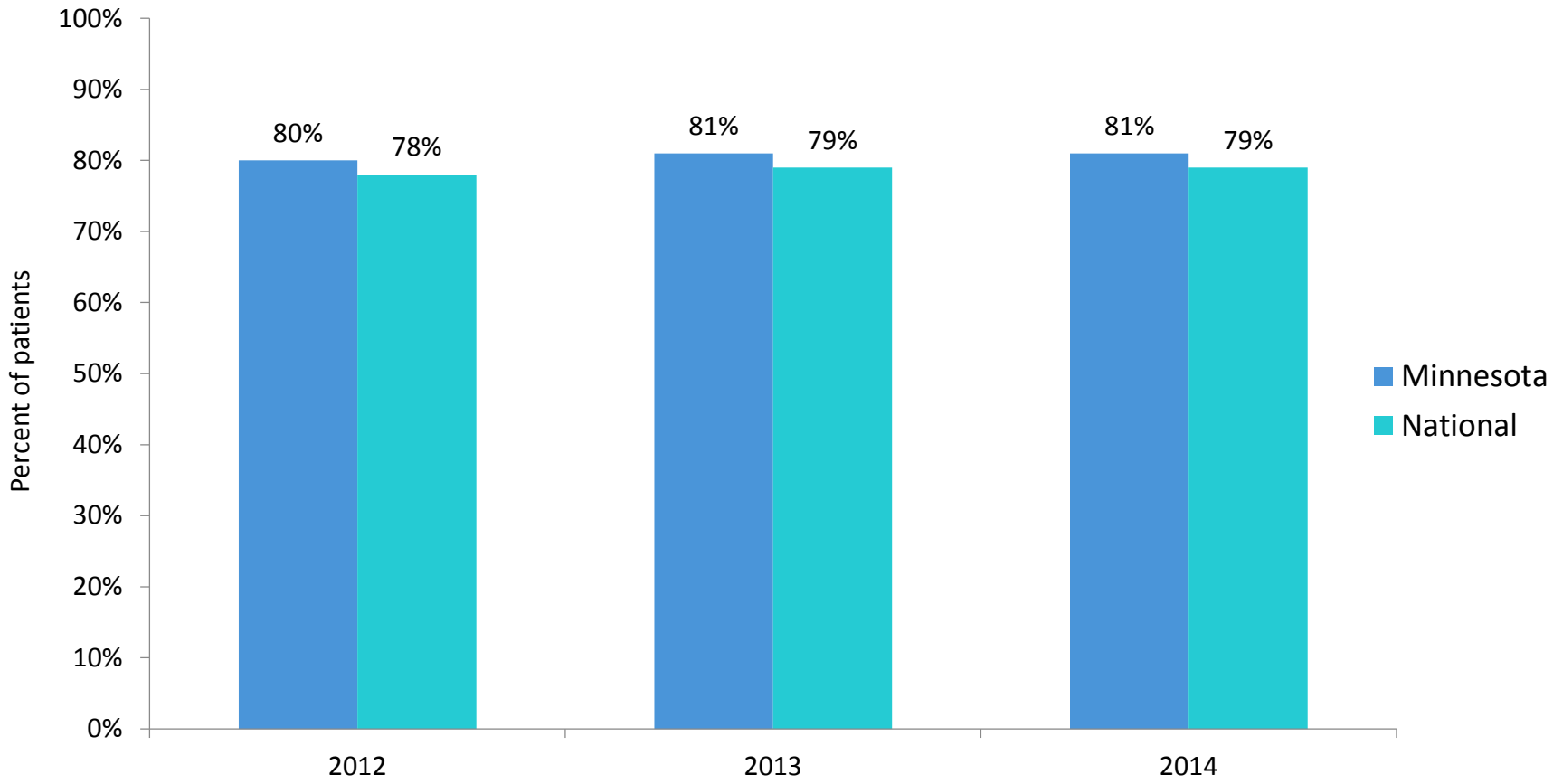


Service year: October 1 through September 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Percent of Patients Who Reported That Their Nurses "Always" Communicated Well, 2012 to 2014

Minnesota hospitals perform slightly better than the national average from 2012 to 2014.

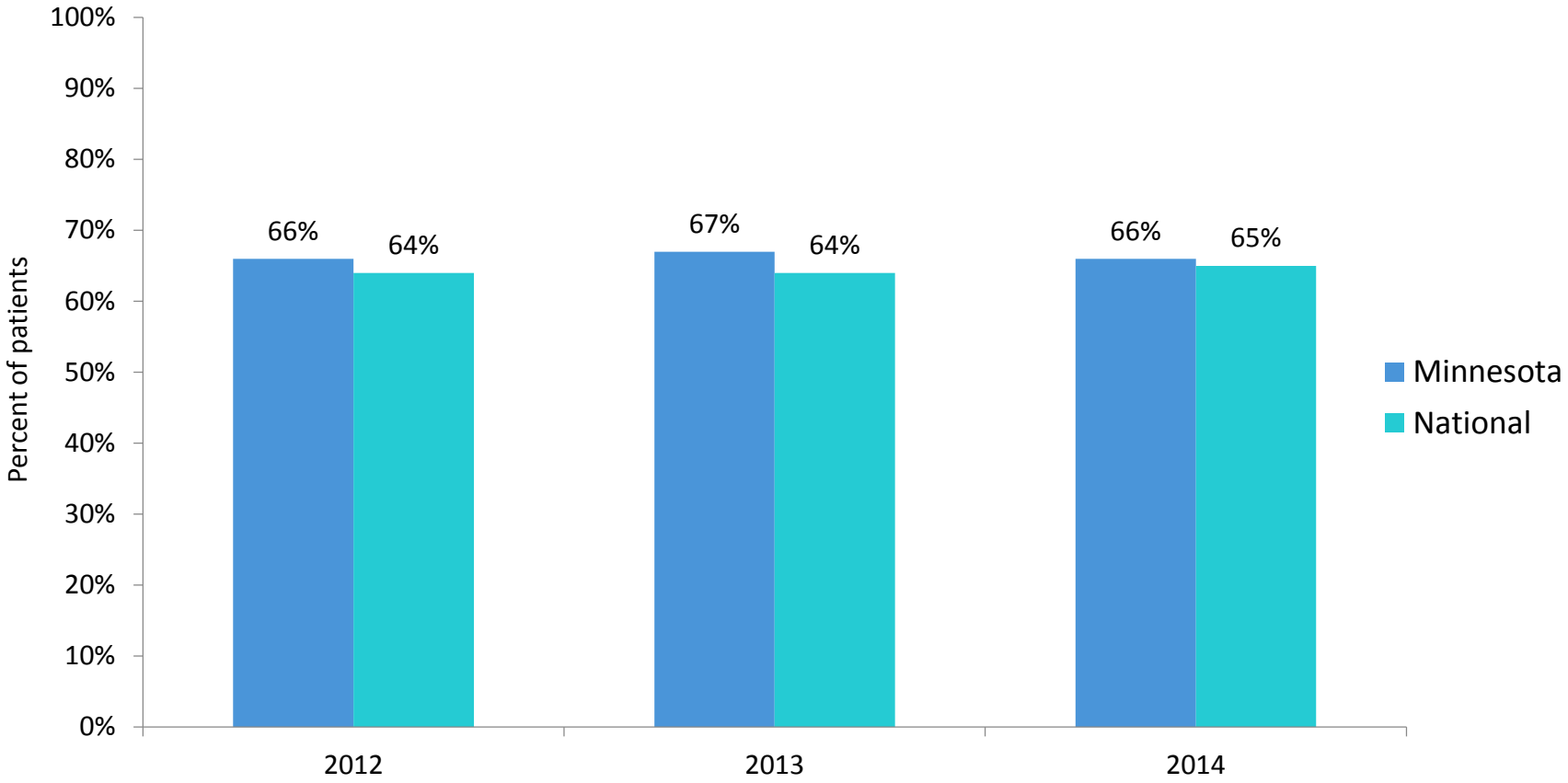


Service year: October 1 through September 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data
Summary of graph

HEALTH ECONOMICS PROGRAM

Percent of Patients Who Reported That Staff "Always" Explained About Medicines Before Giving Them, 2012 to 2014

Minnesota hospitals performed slightly better than the national average from 2012 to 2014.



Service year: October 1 through September 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data.
Summary of graph

HEALTH ECONOMICS PROGRAM

Appendix:
SQRMS MEASURES

2014 Reporting Year
Clinic Quality Measures

Measure	Steward
Data Source: Medical Record	
Optimal Diabetes Care	MNCM
Optimal Vascular Care	MNCM
Depression Remission at 6 Months	MNCM
Optimal Asthma Care – Adult and Child	MNCM
Colorectal Cancer Screening	MNCM
Primary C-section Rate	MNCM
Total Knee Replacement: Functional Status and Quality of Life Outcome	MNCM
Data Source: Patient Survey	
Patient Experience of Care Survey: Clinician and Group Consumer Assessment of Healthcare Providers and Systems 12-Month Survey – Adult	AHRQ
Data Source: Health Care Claims	
Healthcare Effectiveness Data and Information Set (HEDIS) measures	NCQA
Data Source: Clinic Survey	
Health Information Technology Survey	MNCM/MDH

Medical record data is obtained from electronic health records or paper records.
A Measure Steward is an organization that owns and is responsible for maintaining the measure. Measure stewards are often the same as measure developers, but not always.
Source: Quality Reporting System, 2014.

2015 Reporting Year
Hospital Quality Measures

Measure	Steward	Hospital Type
Data Source: Medical Record		
Acute myocardial infarction: Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a)	CMS	PPS hospitals, voluntary for CAHs
Surgical care improvement project: Cardiac surgery patients with controlled postoperative blood glucose (SCIP-Inf-4)	CMS	PPS and CAHs
Influenza immunization: Influenza immunization (IMM-2)	CMS	PPS and CAHs
Emergency Department Measures Median time from ED arrival to ED departure for admitted ED patients - Overall rate (ED-1a) Admit decision time to ED departure time for admitted patients - Overall rate (ED-2a)	CMS	PPS hospitals, voluntary for CAHs
Elective delivery (PC-01)	CMS	PPS and CAHs
Outpatient acute myocardial infarction and chest pain Fibrinolytic therapy received within 30 minutes of emergency department arrival (OP-2) Median time to transfer to another facility for acute coronary intervention (OP-3) Aspirin at arrival (OP-4) Median time to ECG (OP-5)	CMS	PPS and CAHs

Medical record data is obtained from electronic health records or paper records.
A Measure Steward is an organization that owns and is responsible for maintaining the measure. Measure stewards are often the same as measure developers, but not always.
Source: Quality Reporting System, 2015.

2015 Reporting Year
Hospital Quality Measures

Measure	Steward	Hospital Type
Data Source: Medical Record		
Emergency department stroke registry indicators Door-to-imaging initiated time Time to intravenous thrombolytic therapy	Minnesota Stroke Registry Program American Heart Association/ American Stroke Association	PPS and CAHs
Emergency department transfer communication	University of Minnesota Rural Health Research Center	CAHs only
Late sepsis or meningitis in very low birth weight neonates	Vermont Oxford Network	PPS and CAHs
Central line-associated bloodstream infection event by inpatient hospital unit for hospitals with a neonatal intensive care unit and/or pediatric intensive care unit	Centers for Disease Control and Prevention	PPS and CAHs
Data Source: Patient Survey		
Patient experience of care	CMS	PPS and CAHs

2015 Reporting Year
Hospital Quality Measures

Measure	Steward	Hospital Type
Data Source: Health Care Claims		
Mortality Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction hospitalization (MORT-30-AMI) Hospital 30-day, all-cause, RSMR following heart failure hospitalization (MORT-30-HF) Hospital 30-day, all-cause, RSMR following pneumonia hospitalization (MORT-30-PN)	CMS	PPS and CAHs
Mortality for selected conditions composite (IQI 91)	AHRQ	PPS and CAHs
Death among surgical inpatients with serious treatable complications (PSI 4)	AHRQ	
Obstetric trauma- vaginal delivery with instruments (PSI 18)	AHRQ	
Obstetric trauma - vaginal delivery without instrument (PSI 19)	AHRQ	
Patient safety for selected indicators composite (PSI 90)	AHRQ	
Pediatric heart surgery mortality (PDI 6)	AHRQ	
Pediatric heart surgery volume (PDI 7)	AHRQ	
Pediatric patient safety for selected indicators composite (PDI 19)	AHRQ	
Data Source: Hospital Survey		
Health Information Technology Survey	American Hospital Association/ MDH	PPS and CAHs

RESOURCES

Additional Information from the Health Economics Program Available Online

Health Economics Program
www.health.state.mn.us/divs/hpsc/hep/index.html

Publications
www.health.state.mn.us/divs/hpsc/hep/publications/index.html

Health Care Markets Chartbook
www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html

Statewide Quality Reporting and Measurement System
www.health.state.mn.us/healthreform/measurement

Quality Measurement Resources

MN Community Measurement (MNCM) and HealthScores

- mncm.org
- www.mnhealthscores.org

Stratis Health

- www.stratishealth.org

Minnesota Hospital Association (MHA)

- www.mnhospitals.org

Hospital Compare

- www.medicare.gov/hospitalcompare/search.html

National Quality Forum (NQF)

- www.qualityforum.org
- www.qualityforum.org/QPS/QPSTool.aspx

Agency for Healthcare Research and Quality (AHRQ)

- www.ahrq.gov
- www.cahps.ahrq.gov