2024 Hospital Pay-for-Performance Program (for peer groups 1 through 4)

Hospital CQI Performance Index Scorecards

Hospital CQI Pay-for-Performance Program

Hospitals can earn up to 40% of their P4P points based on performance across Blue Cross-supported CQIs.

The CQI component of the P4P is weighted equally for all hospitals, regardless of the number of CQIs a hospital participates in. Therefore, hospitals participating in fewer CQIs will have a greater portion of their incentive allocated to each initiative, while hospitals participating in a greater number of CQIs will have a smaller portion allocated to each initiative. Hospitals participating in more than 10 CQIs will be scored using only the top 10 individual CQI performance scores.

The following chart provides the weight per CQI based on the number of initiatives a hospital participates in:

Number of CQIs	Overall potential incentive	Potential incentive per CQI
1	40%	40%
2	40%	20%
3	40%	13.33%
4	40%	10%
5	40%	8%
6	40%	6.67%
7	40%	5.71%
8	40%	5%
9	40%	4.44%
10+	40%	4%

CQI performance index scorecards

The CQI performance index scorecards will be made available as a separate addendum to the 2024 Pay-for-Performance program guide in mid- to late-December 2023. In addition, each CQI performance index scorecard will be made available through each coordinating center.

All performance index measures and weights are established by the CQI coordinating centers. The weights and measures of a specific CQI index may be adjusted for newly participating hospitals. The coordinating center for each CQI will evaluate and score each hospital's performance index and submit the final aggregate score to Blue Cross.

The measurement period for each performance index measure is January through December, unless otherwise noted in the scorecard.

Specific questions and comments pertaining to the performance index measures should be directed to the respective CQI coordinating center (refer to the following CQI coordinating center contact table).

CQI Program Manager Contacts

CQI	CQI Clinical Focus Area	Index Scorecard Section (click on page # to go to section)	Coordinating Center Program Manager	Email
ASPIRE	Anesthesiology	3-4	Tory Lacca Kate Buehler	lacca@umich.edu kjbucrek@med.umich.edu
BMC2	Angioplasty & Vascular Surgery	5-17	Annemarie Forrest	avassalo@med.umich.edu
HMS	Hospital Medicine	18-27	Elizabeth McLaughlin	emcnair@umich.edu
MAQI2	Anticoagulation	28-33	Brian Haymart	khaymart@umich.edu
MARCQI	Knee/Hip Arthroplasty	34-63	Tae Kim	taekk@med.umich.edu
MBSC	Bariatric Surgery	64-66	Rachel Ross	rachacoo@umich.edu
MEDIC	Emergency Department	67-73	Andy Scott	afscott@med.umich.edu
MROQC	Radiation Oncology	74-76	Melissa Mietzel	hillmel@umich.edu
MSQC	General Surgery	77-89	Amanda Stricklen	aoreilly@umich.edu
MSSIC	Spine Surgery	90-105	Jamie Myers	Jmyer8@hfhs.org
MSTCVS	Cardiac Surgery	106-107	Patty Theurer	ptheurer@umich.edu
MTQIP	Trauma Surgery	108-112	Judy Mikhail	jmikhail@umich.edu
OBI	Obstetrics	113-115	Helen Costis	hcostis@umich.edu

2024 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Performance Index Scorecard **Cohorts 1 – 7** Measurement Period: 01/01/2024 - 12/31/2024			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at meetings. Three total meetings with six opportunities for attendance.**	
		6 / 6 Meetings	10
		5 / 6 Meetings	5
		4 or Less Meetings	0
2	5%	**Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings**	
		5 - 6 / 6 Meetings	5
		4 or less Meetings	0
3	5%	**ACQR/ASPIRE Quality Champion perform data validation, case validation and submit data by the 3rd Wednesday of each month for January - November and by the 2nd Wednesday of the month for December. Data must be of high quality upon submission, >90% of diagnostics marked as 'Data Accurately Represented.'**	
		10 - 12/12 Months	5
		9 or Less Months	0
4	10%	**Site Based Quality Meetings: Sites to hold an onsite in-person or virtual meeting following the three ASPIRE Collaborative meetings to discuss the data and plans for quality improvement at their site**	
		3 Meetings	10
		2 Meetings	5
		1 Meeting	0
5	25%	**Sustainability (SUS 02) Percentage of cases where carbon dioxide equivalents (CO2 eq) normalized by hour for cases receiving halogenated agents and/or nitrous oxide is less than CO2 eq of 2% sevoflurane at 2L FGF = 2.83 kg CO2/hr during the maintenance period of anesthesia OR the Total CO2e is less than 2.83 kg CO2. (cumulative score January 1, 2024 - December 31, 2024)**	
		Performance is ≥ 45% or show improvement of 10 percentage points	25
		Performance is ≥ 40%	15
		Performance is ≥ 35%	10
		Performance is < 35%	0

2024 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Performance Index Scorecard **Cohorts 1 – 7** Measurement Period: 01/01/2024 - 12/31/2024			
Measure #	Weight	Measure Description	Points
6	20%	**Postoperative Nausea and Vomiting (PONV 05) Percentage of patients who had a procedure requiring general anesthesia or cesarean delivery and administered appropriate prophylaxis for PONV. (cumulative score January 1, 2024 - December 31, 2024)**	
		Performance is ≥ 70% or improvement of 15 percentage points	20
		Performance is ≥ 65%	15
		Performance is ≥ 60%	10
		Performance is < 60%	0
7	25%	**Site Directed Measure: Sites choose a measure they are performing above/below ASPIRE threshold or needs improvement by December 8, 2023 (cumulative score January 1, 2024 through December 31, 2024)**	
		Performance is ≥90%; ≤10%; ≤5% or show ≥15% improvement (absolute)	25
		Performance is ≥85%; ≤15%; ≤10% or show ≥10% improvement (absolute)	15
		Performance is ≥80%; ≤20%; ≤15% or show ≥5% improvement (absolute)	10
		Performance is <80%; >20%; >15% or show <5% improvement (absolute)	0

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & Vascular Surgery Sites** Measure identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
1	10	**Meeting Participation - Clinician Lead Measurement Period: 01/01/2024 – 12/31/2024**		
		2 Meetings (attendance at the collaborative-wide meeting earns 1 additional extra credit point)	5	5
		1 Meeting	2.5	2.5
		Did not participate	0	0
2	10	**Data Coordinator Expectations Measurement Period: 01/01/2024 – 12/31/2024**		
		Meets all expectations	5	5
		Meets most expectations	2.5	2.5
		Does not meet expectations	0	0
3	10	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality Measurement Period: 01/01/2024 – 12/31/2024**		
		Submitted reviews for 100% of cases	5	5
		Submitted reviews for <100% of cases	0	0
4	10	**Vascular Surgery Performance Goal - Documentation of EVAR* imaging performed on the 1-year follow up form Measurement Period: 01/01/2024 – 09/30/2024**		
		≥80%	NA	10
		70% - <80%	NA	5
		<70%	NA	0
5	10	**Vascular Surgery Performance Goal - Duplex ultrasound completed prior to asymptomatic carotid endarterectomy Measurement Period: 01/01/2024 – 09/30/2024**		
		≥90%	NA	10
		80% - <90%	NA	5
		<80%	NA	0
6	10	**Vascular Surgery Performance Goal - Vein mapping completed before elective lower extremity open bypass Measurement Period: 01/01/2024 – 09/30/2024**		
		≥50%	NA	10
		40% - <50%	NA	5
		<40%	NA	0
Sites select two measures for scoring from measures 4, 5, 6				

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & Vascular Surgery Sites** Measure identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
7	15	**Vascular Surgery Performance Goal - Smokers receive smoking cessation treatment prior to discharge Measurement Period: 01/01/2024 – 09/30/2024**		
		≥25%	NA	15
		20% - <25%	NA	10
		<20%	NA	0
8	10	**PCI Performance Goal - Use of IVUS/OCT^ for stent optimization Measurement Period: 01/01/2024 – 09/30/2024**		
		≥45% in EITHER all cases OR ≥45% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	10	NA
		≥10 percentage points absolute increase in all cases× from Q4 YTD 2023	5	NA
		<10 percentage points absolute increase in all cases from Q4 YTD 2023	0	NA
9	25	**PCI Performance Goal - Outcomes and Process Composite, inclusive of risk-adjusted mortality, risk-adjusted AKI, risk-adjusted major bleeding, guideline medications prescription at discharge (aspirin, statin, P2Y12), and referral to cardiac rehab. Measurement Period: 01/01/2024 – 09/30/2024**		
		Risk-adjusted mortality		
		A/P <1	5	NA
		A/P >1, <1.5	3	NA
		A/P >1.5	0	NA
		Risk-adjusted acute kidney injury		
		A/P <1	5	NA
		A/P >1, <1.5	3	NA
		A/P >1.5	0	NA
		Risk-adjusted major bleeding		
		A/P <1	5	NA
		A/P >1, <1.5	3	NA
		A/P >1.5	0	NA
		Guideline medications prescription at discharge		
		≥95%	5	NA
		90% - <95%	3	NA
		<90%	0	NA

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & Vascular Surgery Sites** Measure identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
		Referral to cardiac rehabilitation		
		≥95%	5	NA
		90% - <95%	3	NA
		<90%	0	NA
10	0	**PCI Performance Goal - Cardiac rehabilitation utilization within 90 days after PCI discharge†**		
		Site performance ≥40% or absolute increase of ≥5 points from baseline site performance. Baseline 1/1/2022 - 9/30/2022. Scored in 2025.	10	NA
		Site performance ≥37% - <40% or absolute increase of ≥3 points from baseline site performance. Scored in 2025.	5	NA
		Site performance <37% and absolute increase of <3 points from baseline site performance. Scored in 2025.	0	NA
11	n/a	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD	1-5	

*EVAR = endovascular aneurysm repair
^IVUS = intravascular ultrasound; OCT = optical coherence tomography
ˣDoes not apply to the LM, ISR, IST measure
†Cardiac rehabilitation utilization will be measured in 2024, but due to data lag, will be scored in 2025

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2)
Performance Index Scorecard
PCI only sites
Measurement Period identified in the measure

Measure #	Weight	Measure Description	PCI points
1	10	**Meeting Participation - Clinician Lead** **Measurement Period: 01/01/2024 – 12/31/2024**	
		2 Meetings (attendance at the collaborative-wide meeting earns 1 additional extra credit point)	10
		1 Meeting	5
		Did not participate	0
2	10	**Data Coordinator Expectations** **Measurement Period: 01/01/2024 – 12/31/2024**	
		Meets all expectations	10
		Meets most expectations	5
		Does not meet expectations	0
3	10	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement Period: 01/01/2024 – 12/31/2024**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
4	10	**PCI Performance Goal - Use of IVUS/OCT^ for stent optimization** **Measurement Period: 01/01/2024 – 09/30/2024**	
		≥45% in EITHER all cases OR ≥45% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	10
		≥10 percentage points absolute increase in all cases× from Q4 YTD 2023	5
		<10 percentage points absolute increase in all cases from Q4 YTD 2023	0
5	60	**PCI Performance Goal - Outcomes and Process Composite, inclusive of risk-adjusted mortality, risk-adjusted AKI, risk-adjusted major bleeding, guideline medications prescription at discharge (aspirin, statin, P2Y12), and referral to cardiac rehab.** **Measurement Period: 01/01/2024 – 09/30/2024**	
		Risk-adjusted mortality	
		A/P <1	12
		A/P >1, <1.5	8
		A/P >1.5	0
		Risk-adjusted acute kidney injury	
		A/P <1	12
		A/P >1, <1.5	8

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI only sites** Measurement Period identified in the measure			
Measure #	Weight	Measure Description	PCI points
		A/P >1.5	0
		Risk-adjusted major bleeding	
		A/P <1	12
		A/P >1, <1.5	8
Part of Measure 5		A/P >1.5	0
		Guideline medications prescription at discharge	
		≥95%	12
		90% - <95%	8
		<90%	0
		Referral to cardiac rehabilitation	
		≥95%	12
		90% - <95%	8
		<90%	0
6	0	**PCI Performance Goal - Cardiac rehabilitation utilization within 90 days after PCI discharge† Measurement Period: 01/01/2024 – 09/30/2024**	
		Site performance ≥40% or absolute increase of ≥5 points from baseline site performance. Baseline 1/1/2022 - 9/30/2022. Scored in 2025.	10
		Site performance ≥37% - <40% or absolute increase of ≥3 points from baseline site performance. Scored in 2025.	5
		Site performance <37% and absolute increase of <3 points from baseline site performance. Scored in 2025.	0
7	0	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD	1-5

^IVUS = intravascular ultrasound; OCT = optical coherence tomography
ˣDoes not apply to the LM, ISR, IST measure
†Cardiac rehabilitation utilization will be measured in 2024, but due to data lag, will be scored in 2025

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **Vascular Surgery only sites** Measurement Period identified in each measure			
Measure #	Weight	Measure Description	VS points
1	10	**Meeting Participation - Clinician Lead** **Measurement Period: 01/01/2024 – 12/31/2024**	
		2 Meetings (attendance at the collaborative-wide meeting earns 1 additional extra credit point)	10
		1 Meeting	5
		Did not participate	0
2	10	**Data Coordinator Expectations** **Measurement Period: 01/01/2024 – 12/31/2024**	
		Meets all expectations	10
		Meets most expectations	7.5
		Does not meet expectations	0
3	10	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement Period: 01/01/2024 – 12/31/2024**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
4	25	**Vascular Surgery Performance Goal - Documentation of EVAR* imaging performed on the 1-year follow up form** **Measurement Period: 01/01/2024 – 09/30/2024**	
		≥80%	25
		70% - <80%	15
		<70%	0
5	25	**Vascular Surgery Performance Goal - Duplex ultrasound completed prior to asymptomatic carotid endarterectomy** **Measurement Period: 01/01/2024 – 09/30/2024**	
		≥90%	25
		80% - <90%	15
		<80%	0
6	25	**Vascular Surgery Performance Goal - Vein mapping completed before elective lower extremity open bypass** **Measurement Period: 01/01/2024 – 09/30/2024**	
		≥50%	25
		40% - <50%	15
		<40%	0
Sites select two measures for scoring from measures 4, 5, 6			
7	20	**Vascular Surgery Performance Goal - Smokers receive smoking cessation treatment prior to discharge**	

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **Vascular Surgery only sites** Measurement Period identified in each measure			
Measure #	Weight	Measure Description	VS points
		Measurement Period: 01/01/2024 – 09/30/2024	
		≥25%	20
		20% - <25%	15
		<20%	0
11	0	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD	1-5
*EVAR = endovascular aneurysm repair			

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & YEAR 2 Vascular Surgery Sites** Measure identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
1	15	**Meeting Participation - Clinician Lead Measurement Period: 01/01/2024 – 12/31/2024**		
		2 Meetings (attendance at the collaborative-wide meeting earns 1 additional extra credit point)	5	10
		1 Meeting	2.5	5
		Did not participate	0	0
2	20	**Data Coordinator Expectations Measurement Period: 01/01/2024 – 12/31/2024**		
		Meets all expectations	5	15
		Meets most expectations	2.5	10
		Does not meet expectations	0	0
3	15	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality Measurement Period: 01/01/2024 – 12/31/2024**		
		Submitted reviews for 100% of cases	5	10
		Submitted reviews for <100% of cases	0	0
4	5	**Vascular Surgery Performance Goal - Documentation of EVAR* imaging performed on the 1-year follow up form Measurement Period: 01/01/2024 – 09/30/2024**		
		≥80%	NA	5
		70% - <80%	NA	2.5
		<70%	NA	0
5	5	**Vascular Surgery Performance Goal - Duplex ultrasound completed prior to asymptomatic carotid endarterectomy Measurement Period: 01/01/2024 – 09/30/2024**		
		≥90%	NA	5
		80% - <90%	NA	2.5
		<80%	NA	0
6	5	**Vascular Surgery Performance Goal - Vein mapping completed before elective lower extremity open bypass Measurement Period: 01/01/2024 – 09/30/2024**		
		≥50%	NA	5
		40% - <50%	NA	2.5
		<40%	NA	0
Sites select two measures for scoring from measures 4, 5, 6				
7	5	**Vascular Surgery Performance Goal - Smokers receive smoking cessation treatment prior to discharge**		

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & YEAR 2 Vascular Surgery Sites** Measure identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
		Measurement Period: 01/01/2024 – 09/30/2024		
		≥25%	NA	5
		20% - <25%	NA	2.5
		<20%	NA	0
8	10	**PCI Performance Goal - Use of IVUS/OCT^ for stent optimization** **Measurement Period: 01/01/2024 – 09/30/2024**		
		≥45% in EITHER all cases OR ≥45% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	10	NA
		≥10 percentage points absolute increase in all cases× from Q4 YTD 2023	5	NA
		<10 percentage points absolute increase in all cases from Q4 YTD 2023	0	NA
9	25	**PCI Performance Goal - Outcomes and Process Composite, inclusive of risk-adjusted mortality, risk-adjusted AKI, risk-adjusted major bleeding, guideline medications prescription at discharge (aspirin, statin, P2Y12), and referral to cardiac rehab.** **Measurement Period: 01/01/2024 – 09/30/2024**		
		Risk-adjusted mortality		
		A/P <1	5	NA
		A/P >1, <1.5	3	NA
		A/P >1.5	0	NA
		Risk-adjusted acute kidney injury		
		A/P <1	5	NA
		A/P >1, <1.5	3	NA
		A/P >1.5	0	NA
		Risk-adjusted major bleeding		
		A/P <1	5	NA
		A/P >1, <1.5	3	NA
		A/P >1.5	0	NA
		Guideline medications prescription at discharge		
		≥95%	5	NA
		90% - <95%	3	NA
		<90%	0	NA
		Referral to cardiac rehabilitation		

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & YEAR 2 Vascular Surgery Sites** Measure identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
		≥95%	5	NA
		90% - <95%	3	NA
		<90%	0	NA
10	0	**PCI Performance Goal - Cardiac rehabilitation utilization within 90 days after PCI discharge† Measurement Period: 01/01/2024 – 09/30/2024**		
		Site performance ≥40% or absolute increase of ≥5 points from baseline site performance. Baseline 1/1/2022 - 9/30/2022. Scored in 2025.	10	NA
		Site performance ≥37% - <40% or absolute increase of ≥3 points from baseline site performance. Scored in 2025.	5	NA
		Site performance <37% and absolute increase of <3 points from baseline site performance. Scored in 2025.	0	NA
11	0	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD	1-5	

*EVAR = endovascular aneurysm repair
^IVUS = intravascular ultrasound; OCT = optical coherence tomography
ˣDoes not apply to the LM, ISR, IST measure
†Cardiac rehabilitation utilization will be measured in 2024, but due to data lag, will be scored in 2025

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **VS only sites in Year 2 of consortium participation** Measure identified in each measure			
Measure #	Weight	Measure Description	VS points
1	25	**Meeting Participation - Clinician Lead** **Measurement Period: 01/01/2024 – 12/31/2024**	
		2 Meetings (attendance at the collaborative-wide meeting earns 1 additional extra credit point)	25
		1 Meeting	15
		Did not participate	0
2	25	**Data Coordinator Expectations** **Measurement Period: 01/01/2024 – 12/31/2024**	
		Meets all expectations	25
		Meets most expectations	15
		Does not meet expectations	0
3	20	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement Period: 01/01/2024 – 12/31/2024**	
		Submitted reviews for 100% of cases	20
		Submitted reviews for <100% of cases	0
4	10	**Vascular Surgery Performance Goal - Documentation of EVAR* imaging performed on the 1-year follow up form** **Measurement Period: 01/01/2024 – 09/30/2024**	
		≥80%	10
		70% - <80%	5
		<70%	0
5	10	**Vascular Surgery Performance Goal - Duplex ultrasound completed prior to asymptomatic carotid endarterectomy** **Measurement Period: 01/01/2024 – 09/30/2024**	
		≥90%	10
		80% - <90%	5
		<80%	0
6	10	**Vascular Surgery Performance Goal - Vein mapping completed before elective lower extremity open bypass** **Measurement Period: 01/01/2024 – 09/30/2024**	
		≥50%	10
		40% - <50%	5
		<40%	0
Sites select two measures for scoring from measures 4, 5, 6			
7	10	**Vascular Surgery Performance Goal - Smokers receive smoking cessation treatment prior to discharge** **Measurement Period: 01/01/2024 – 09/30/2024**	

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **VS only sites in Year 2 of consortium participation** Measure identified in each measure			
Measure #	Weight	Measure Description	VS points
		≥25%	10
		20% - <25%	5
		<20%	0
8	0	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD	1-5
*EVAR = endovascular aneurysm repair			

2024 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2)
Performance Index Scorecard
VS only sites in Year 1 of consortium participation
Measurement Period: 01/01/2024 – 12/31/2024

Measure #	Weight	Measure Description	VS Points
1	35	**Meeting Participation - Clinician Lead**	
		2 Meetings	35
		1 Meeting	20
		Did not participate	0
2	35	**Data Coordinator Expectations**	
		Meets all expectations	35
		Meets most expectations	20
		Does not meet expectations	0
3	30	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	30
		Submitted reviews for <100% of cases	0

2024 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard **PICC Insertions/Hospital Discharges-** **Hospitals Enrolled Prior to 2020** Measurement Period: 08/01/2024-11/06/2024			
Measure #	Weight	Measure Description	Points
1	5	**Timeliness of HMS Data at Mid-Year and End of Year[1]**	
		On time ≥ 95% at Mid-Year **AND** End of Year	5
		On time ≥ 95% at Mid-Year **OR** End of Year	3
		On time < 95% at Mid-Year **AND** End of Year	0
2	5	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, **AND** audit case corrections completed by due date	5
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed **OR** audit case corrections not completed by due date	0
3	10	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	1 0
		2 meetings	5
		1 meeting	0
		No meetings	0
4	10	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	1 0
		2 meetings	5
		1 meeting	0
		No meetings	0
5	10	**Increase Use of 5 Days of Antibiotic Treatment[5] in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e., reduce excess durations)[6,7]**	
		≥ 70% uncomplicated CAP cases receive 5 days[5] of antibiotics **OR** ≥ 70% relative increase in the number of uncomplicated CAP cases that receive 5 days[5] of antibiotics during the current performance year[8]	1 0
		55-69% uncomplicated CAP cases receive 5 days[5] of antibiotics **OR** 50-69% relative increase in the number of uncomplicated CAP cases that receive 5 days[5] of antibiotics during the current performance year[8]	5
		< 55% uncomplicated CAP cases receive 5 days[5] of antibiotics **AND** < 50% relative increase in the number of uncomplicated CAP cases that receive 5 days[5] of antibiotics during the current performance year[8]	0

2024 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard **PICC Insertions/Hospital Discharges-** **Hospitals Enrolled Prior to 2020** Measurement Period: 08/01/2024-11/06/2024			
Measure #	Weight	Measure Description	Points
6	10	**Reduce Use of Antibiotics in Patients with ASB (Asymptomatic Bacteriuria)[9] and Questionable Pneumonia[6,7,10]**	
		≤ 13% of positive urine culture cases treated with an antibiotic are ASB cases[9] **AND** ≤ 11% of pneumonia cases treated with an antibiotic are questionable pneumonia[10]	10
		≤ 13% of positive urine culture cases treated with an antibiotic are ASB cases[9] **OR** ≤ 11% of pneumonia cases treated with an antibiotic are questionable pneumonia[10]	5
		> 13% of positive urine culture cases treated with an antibiotic are ASB cases[9] **AND** > 11% of pneumonia cases treated with an antibiotic are questionable pneumonia[10]	0
7	15	**Increase Antibiotics Delivered within 3 hours of Arrival for Septic Shock Patients[11,21]**	
		≥ 67% septic shock cases[11] receive antibiotics within 3 hours of arrival	15
		55 – 66% septic shock cases[11] receive antibiotics within 3 hours of arrival	10
		< 55% septic shock cases[11] receive antibiotics within 3 hours of arrival	0
8	15	**Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to Home-like Setting[12,13,21]**	
		≥ 65% sepsis cases discharged to home-like setting[12] received at least 1 of 3 discharge/post- discharge coordination of care measures[13]	15
		45 – 64% sepsis cases discharged to home-like setting[12] received at least 1 of 3 discharge/post-discharge coordination of care measures[13]	10
		< 45% sepsis cases discharged to home-like setting[12] received at least 1 of 3 discharge/post-discharge coordination of care measures[13]	0
9	15	**Reduce Inappropriate PICC Placements in Special Populations – Active Malignancy[14] or Critical Care[15]**	
		Active Malignancy[14]	
		≤ 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for < 5 Days **AND** participation in special population workgroup[16,17,18]	15
		≤ 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for < 5 Days **OR** participation in special population workgroup[16,17,18]	10
		> 25% of PICCs placed in active malignancy cases[14] are triple lumens and in for < 5 Days **AND** No participation in special population workgroup[16,17,18]	0

2024 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard **PICC Insertions/Hospital Discharges-** **Hospitals Enrolled Prior to 2020** Measurement Period: 08/01/2024-11/06/2024			
Measure #	Weight	Measure Description	Points
		OR	
		Critical Care (ICU)[15]	
		≤ 30% of PICCs placed in critical care cases[15] are triple lumens **AND** Participation in special population workgroup[16,17,18]	15
		≤ 30% of PICCs placed in critical care cases[15] are triple lumens **OR** Participation in special population workgroup[16,17,18]	10
		> 30% of PICCs placed in critical care cases[15] are triple lumens **AND** No Participation in special population workgroup[16,17,18]	0
C	5	**Reduce Use of Inappropriate Empiric Broad-Spectrum Antibiotics[19] for Patients with Uncomplicated CAP (Community Acquired Pneumonia)[20]**	
		≤ 10% **collaborative-wide average**[20] of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically[19]	5
		> 10% **collaborative-wide average**[20] of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically[19]	0
Optional Bonus			
Optional	5	Specialist[18] attendance at 3 of the virtual special population workgroup meetings[17] during the calendar year in the hospital's pre-determined workgroup area **OR** Specialist[18] attendance at 1 or more of the special population workgroup meetings[17] that is not the hospital's pre-determined workgroup area during the calendar year	5
Optional	5	Emergency Medicine Physician attendance at the 2 in-person collaborative wide meetings convened during the calendar year (July & November)	5

HMS Supporting Documentation

Hospitals Enrolled Prior to 2020

[1] Registry data for all initiatives (Antimicrobial, PICC/Midline and Sepsis) assessed during mid-year performance evaluation review and at year end based on data submitted during calendar year 2024. All required cases must be completed by the mid-year performance evaluation review AND by year end. Mid-year due date and final due date will be announced by Coordinating Center.

[2] Assessed based on scores received for site audits conducted during performance year 2024. Scores are averaged if multiple audits take place during the year. Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[3] For audits conducted during the performance year, audit case corrections must be completed, or discrepancies addressed within 3 months of audit summary receipt (due date for case corrections provided in audit summary) or end of performance year deadline – whichever comes first.

[4] Based on all meetings scheduled during calendar year 2024. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] Duration is considered appropriate if 6 or fewer days of total antibiotic treatment (inpatient and outpatient) is administered.

[6] Assessed at year end based on final quarter of data entered (per the data abstraction calendar) in the data registry during the performance year 2024. To determine the final score, an adjusted statistical model will be utilized. The method for obtaining each hospital's adjusted performance measurement utilizes all available data from the most recent 4 quarters. The collaborative wide average and collaborative wide improvement or decline, as well as the average rate change over time of each individual hospital are incorporated into the final adjusted rate. Each hospital's adjusted rate reflects both change in performance over time and overall performance relative to the collaborative averages. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative as a whole, and reflects the improvement work each hospital is doing over a given performance year.

[7] The adjusted model for this measure includes all cohorts.

[8] Rate of change is based on the adjusted method between Q1 2024 and Q4 2024 and may not reflect raw rates from quarter to quarter.

[9] Antibiotic treatment for ASB is assessed based on treatment on day 2 or later of the entire hospital encounter. This portion of the measure is assessed out of all positive urine culture cases abstracted during the performance year.

[10] Questionable pneumonia is defined as cases abstracted into the pneumonia registry who do not meet the clinical and radiographic criteria to be classified as Community Acquired Pneumonia. Antibiotic treatment for these cases is assessed on day 3 or later of the hospital encounter. This portion of the measure is assessed out of all pneumonia cases abstracted during the performance year.

[11] Cases with septic shock are defined as those with hypotension (vasopressors initiated within two hours of arrival OR systolic blood pressure < 90 mmHg within two hours of arrival OR calculated MAP < 65 within two hours of arrival). Patients excluded from review in this measure include those with < 2 SIRS, normal WBC, no elevated lactate, and no symptoms of infection.

[12] Home-like Setting = home (with or without home services), assisted living, custodial nursing, temporary shelter.

[13] Discharge/post- discharge coordination of care measures:

- Hospital contact information provided at discharge (in discharge summary)

- Scheduled visit with Primary Care Physician (PCP) within 2 weeks (at time of discharge)
- Post-discharge telephone call or PCP visit/home health services within 3 calendar days of hospital discharge

[14] PICC placements where the medical record reflects a cancer diagnosis **AND** the PICC was placed for a cancer-related admission.

[15] PICC placements where the patient was in the ICU at the time of PICC insertion.

[16] Participation in Special Population Workgroup

- At least 3 individuals representing the following roles must attend 3 of the 3 tri-annual initiative specific work group meetings:
  - 1 Quality Professional
  - 1 Physician (the physician in attendance for at least 1 of the 3 meetings per year must be a specialist in the special population area)
  - 1 Vascular Access Team Member or Interventional Radiologist Representative

[17] Initiative specific workgroups will take place virtually during the calendar year 2024.

[18] Specialist is considered Critical Care, Oncology or Hematology Physician

- Oncology workgroup area = Oncology or Hematology Physician
- Critical Care (ICU) workgroup area = Critical Care Physician

If hospital does not have a specialist either employed at the hospital or contracted by the hospital, the HMS Physician Champion is acceptable, however, must be approved by the Coordinating Center.

[19] Empiric antibiotic therapy is assessed on day 2 of the hospital encounter for Uncomplicated CAP cases that are eligible for 5 days of antibiotic therapy.

[20] Assessed at year end based on the collaborative-wide average for the final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2024. This is different than the other performance measures in the index, which are applied to each individual hospital.

[21] Assessed at year end based on the raw rate for the individual site for the final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2024. This is different than the other site-only performance measures, which are based on the adjusted rate for the site.

2024 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard **(PICC Insertions/Hospital Discharges)- Hospitals Enrolled in 2020, 2021, 2022** Measurement Period: 08/01/2024-11/06/2024			
Measure #	Weight	Measure Description	Points
1	5	**Timeliness of HMS Data at Mid-Year and End of Year[1]**	
		On time ≥ 95% at Mid-Year **AND** End of Year	5
		On time ≥ 95% at Mid-Year **OR** End of Year	3
		On time < 95% at Mid-Year **AND** End of Year	0
2	5	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, **AND** audit case corrections completed by due date	5
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed **OR** audit case corrections not completed by due date	0
3	10	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	10
		2 meetings	5
		1 meeting	0
		No meetings	0
4	10	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	10
		2 meetings	5
		1 meeting	0
		No meetings	0
5	10	**Increase Use of 5 Days of Antibiotic Treatment[5] in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e., reduce excess durations)[6,7]**	
		≥ 70% uncomplicated CAP cases receive 5 days[5] of antibiotics **OR** ≥ 70% relative increase in the number of uncomplicated CAP cases that receive 5 days[5] of antibiotics during the current performance year[8]	10
		55-69% uncomplicated CAP cases receive 5 days[5] of antibiotics **OR** 50-69% relative increase in the number of uncomplicated CAP cases that receive 5 days[5] of antibiotics during the current performance year[8]	5
		< 55% uncomplicated CAP cases receive 5 days[5] of antibiotics **AND** < 50% relative increase in the number of uncomplicated CAP cases that receive 5 days[5] of antibiotics during the current performance year[8]	0
6	10	**Reduce Use of Antibiotics in Patients with ASB (Asymptomatic Bacteriuria)[9] and Questionable Pneumonia[6,7,10]**	

2024 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard **(PICC Insertions/Hospital Discharges)- Hospitals Enrolled in 2020, 2021, 2022** Measurement Period: 08/01/2024-11/06/2024			
Measure #	Weight	Measure Description	Points
		≤ 13% of positive urine culture cases treated with an antibiotic are ASB cases[9] **AND** ≤ 11% of pneumonia cases treated with an antibiotic are questionable pneumonia[10]	10
		≤ 13% of positive urine culture cases treated with an antibiotic are ASB cases[9] **OR** ≤ 11% of pneumonia cases treated with an antibiotic are questionable pneumonia[10]	5
		> 13% of positive urine culture cases treated with an antibiotic are ASB cases[9] **AND** > 11% of pneumonia cases treated with an antibiotic are questionable pneumonia[10]	0
7	15	**Increase Antibiotics Delivered within 3 hours of Arrival for Septic Shock Patients[11,19]**	
		≥ 67% septic shock cases[11] receive antibiotics within 3 hours of arrival	15
		55 – 66% septic shock cases[11] receive antibiotics within 3 hours of arrival	10
		< 55% septic shock cases[11] receive antibiotics within 3 hours of arrival	0
8	15	**Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to Home-like Setting[12,13,19]**	
		≥ 65% sepsis cases discharged to home-like setting[12] received at least 1 of 3 discharge/post- discharge coordination of care measures[13]	15
		45 – 64% sepsis cases discharged to home-like setting[12] received at least 1 of 3 discharge/post-discharge coordination of care measures[13]	10
		< 45% sepsis cases discharged to home-like setting[12] received at least 1 of 3 discharge/post-discharge coordination of care measures[13]	0
9	5	**Reduce PICCs (Peripherally-Inserted Central Catheters) in for ≤ 5 Days (excluding deaths)[6,14]**	
		≤ 10% of PICC cases in for ≤ 5 Days	5
		1115% of PICC cases in for ≤ 5 Days	3
		> 15% of PICC cases in for ≤ 5 Days	0
10	5	**Increase Use of Single Lumen PICCs in Non-ICU (Intensive Care Unit) Cases[6,14]**	
		≥ 85% of non-ICU PICC cases have a single lumen	5
		70-84% of non-ICU PICC cases have a single lumen	3
		< 70% of non-ICU PICC cases have a single lumen	0
11	5	**PICCs in Patients with eGFR (estimated glomerular filtration rate) <45 (without Nephrology approval)[6,14]**	

2024 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard **(PICC Insertions/Hospital Discharges)- Hospitals Enrolled in 2020, 2021, 2022** Measurement Period: 08/01/2024-11/06/2024			
Measure #	Weight	Measure Description	Points
		≤ 5% of cases with PICC have eGFR <45 without Nephrology approval	5
		6 -12% of cases with PICC have eGFR <45 without Nephrology approval	3
		>12% of cases with PICC have eGFR <45 without Nephrology approval	0
C	5	**Reduce Use of Inappropriate Empiric Broad-Spectrum Antibiotics[15] for Patients with Uncomplicated CAP (Community Acquired Pneumonia)[16]**	
		≤ 10% **collaborative-wide average**[16] of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically[15]	5
		> 10% **collaborative-wide average**[16] of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically[15]	0
Optional Bonus			
Optional	5	Specialist[17] attendance at 1 or more of the special population workgroup meetings[18] during the calendar year	5
Optional	5	Emergency Medicine Physician attendance at the 2 in-person collaborative wide meetings convened during the calendar year (July & November)	5

HMS Supporting Documentation

Hospitals Enrolled in 2020, 2021, 2022

[1] Registry data for all initiatives (Antimicrobial, PICC/Midline and Sepsis) assessed during mid-year performance evaluation review and at year end based on data submitted during calendar year 2024. All required cases must be completed by the mid-year performance evaluation review AND by year end. Mid-year due date and final due date will be announced by Coordinating Center.

[2] Assessed based on scores received for site audits conducted during performance year 2024. Scores are averaged if multiple audits take place during the year. Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[3] For audits conducted during the performance year, audit case corrections must be completed, or discrepancies addressed within 3 months of audit summary receipt (due date for case corrections provided in audit summary) or end of performance year deadline – whichever comes first.

[4] Based on all meetings scheduled during calendar year 2024. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] Duration is considered appropriate if 6 or fewer days of total antibiotic treatment (inpatient and outpatient) is administered.

[6] Assessed at year end based on final quarter of data entered (per the data abstraction calendar) in the data registry during the performance year 2024. To determine the final score, an adjusted statistical model will be utilized. The method for obtaining each hospital's adjusted performance measurement utilizes all available data from the most recent 4 quarters. The collaborative wide average and collaborative wide improvement or decline, as well as the average rate change over time of each individual hospital are incorporated into the final adjusted rate. Each hospital's adjusted rate reflects both change in performance over time and overall performance relative to the collaborative averages. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative as a whole, and reflects the improvement work each hospital is doing over a given performance year.

[7] The adjusted model for this measure includes all cohorts.

[8] Rate of change is based on the adjusted method between Q1 2024 and Q4 2024 and may not reflect raw rates from quarter to quarter.

[9] Antibiotic treatment for ASB is assessed based on treatment on day 2 or later of the entire hospital encounter. This portion of the measure is assessed out of all positive urine culture cases abstracted during the performance year.

[10] Questionable pneumonia is defined as cases abstracted into the pneumonia registry who do not meet the clinical and radiographic criteria to be classified as Community Acquired Pneumonia. Antibiotic treatment for these cases is assessed on day 3 or later of the hospital encounter. This portion of the measure is assessed out of all pneumonia cases abstracted during the performance year.

[11] Cases with septic shock are defined as those with hypotension (vasopressors initiated within two hours of arrival OR systolic blood pressure < 90 mmHg within two hours of arrival OR calculated MAP < 65 within two hours of arrival). Patients excluded from review in this measure include those with < 2 SIRS, normal WBC, no elevated lactate, and no symptoms of infection.

[12] Home-like Setting = home (with or without home services), assisted living, custodial nursing, temporary shelter.

[13] Discharge/post- discharge coordination of care measures:

- Hospital contact information provided at discharge (in discharge summary)

- Scheduled visit with Primary Care Physician (PCP) within 2 weeks (at time of discharge)
- Post-discharge telephone call or PCP visit/home health services within 3 calendar days of hospital discharge

[14] The adjusted model for this measure includes cohorts 2020, 2021 and 2022 only.

[15] Empiric antibiotic therapy is assessed on day 2 of the hospital encounter for Uncomplicated CAP cases that are eligible for 5 days of antibiotic therapy.

[16] Assessed at year end based on the collaborative-wide average for the final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2024. This is different than the other performance measures in the index, which are applied to each individual hospital.

[17] Specialist is considered Critical Care, Oncology or Hematology Physician

- Oncology workgroup area = Oncology or Hematology Physician
- Critical Care (ICU) workgroup area = Critical Care Physician

If hospital does not have a specialist either employed at the hospital or contracted by the hospital, the HMS Physician Champion is acceptable, however, must be approved by the Coordinating Center.

[18] Initiative specific workgroups will take place virtually during the calendar year 2024.

[19] Assessed at year end based on the raw rate for the individual site for the final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2024. This is different than the other site-only performance measures, which are based on the adjusted rate for the site.

2024 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Ascension St. John and Trinity Ann Arbor - Year 2** **Measurement period: 01/01/2024 – 12/31/2024**			
Measure #	Weight	Measure Description	Points
1	10	**Implementation of DOAC dashboard* Ascension St. John and Trinity Ann Arbor Year 2 1/1-12/31**	
		Fully implemented DOAC dashboard	10
		Site IT staff fully engaged and programming process underway	8
		Organizational approval received and project added to IT project list	6
		Site team making demonstrable effort to get organizational approval	4
		No site engagement regarding DOAC dashboard implementation	0
2	10	**Inappropriate aspirin in patients on DOACs***	
		≤5% or a relative reduction of ≥10%	10
		6-10% or a relative reduction of 6-9%	5
		11-15% or a relative reduction of 2-5%	3
		>15% or a relative reduction of <2%	0
3	10	**Collaborative-wide meeting participation – Clinical Champion**	
		attended all 3 meetings	10
		attended 2 out of 3 meetings	7
		attended 1 out of 3 meetings	3
		did not attend any meetings	0
4	10	**Collaborative-wide meeting participation – Coordinator/Lead Abstractor**	
		attended all 3 meetings	10
		attended 2 out of 3 meetings	7
		attended 1 out of 3 meetings	3
		did not attend any meetings	0
5	30	**Completeness and Accuracy of data**	
		Critical data elements are complete/accurate in ≥90% of cases	10
		Critical data elements are complete/accurate in 70-89% of cases	5
		Critical data elements are complete/accurate in <70% of cases	0

2024 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Ascension St. John and Trinity Ann Arbor - Year 2** **Measurement period: 01/01/2024 – 12/31/2024**			
Measure #	Weight	Measure Description	Points
6	30	**Volume of data abstraction**	
		≥ 90% of expected volume entered by site (per 0.5 FTE: enter 500 new pts or maintain follow-ups in 300 active registry patients)	30
		70-89% of expected volume entered by site (per 0.5 FTE: enter 500 new pts or maintain follow-ups in 300 active registry patients)	20
		50-69% of expected volume entered by site (per 0.5 FTE: enter 500 new pts or maintain follow-ups in 300 active registry patients)	10
		<50% of expected volume entered by site (per 0.5 FTE: enter 500 new pts or maintain follow-ups in 300 active registry patients)	0
*Sites can chose to do one or both of these two initiatives. If one is chosen, it will be worth 20 maximum points.			

2024 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Epic Sites** **Measurement period: 01/01/2024 – 12/31/2024**			
Measure #	Weight	Measure Description	Points
1	10	**Smoking status assessment in newly enrolled patients**	
		≥90% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	10
		70-89% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	5
		50-69% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	3
		<50% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	0
2	10	**DOAC Dashboard Utilization**	
		≥750 known/possible critical alerts addressed^ in 2024	10
		500-749 known/possible critical alerts addressed in 2024	5
		250-499 known/possible critical alerts addressed in 2024	3
		<250 known/possible critical alerts addressed in 2024	0
3	20	**Inappropriate aspirin use in warfarin patients (updated 2024 criteria)**	
		≤12% or relative decrease of ≥15%	20
		13-19% or relative decrease of 10-14%	10
		20-24% or relative decrease of 5-9%	5
		>24% or relative decrease of <5%	0
4	10	**Extended International Normalized Ratio (INR) testing interval**	
		≥80% of eligible patients received extended intervals	10
		60-79% of eligible patients received extended intervals	5
		40-59% of eligible patients received extended intervals	3
		<40% of eligible patients received extended intervals	0
5	10	**Gastroprotection* in warfarin patients at high-risk for upper GI bleeding (site level)**	
		≥55% or relative increase of ≥10%	10
		40-54% or relative increase of 6-9%	5
		25-39% or relative increase of 2-5%	3
		<25% or relative increase of <2%	0
6	10	**Gastroprotection* in warfarin patients at high-risk for upper GI bleeding (consortium level)**	
		≥55% or relative increase of ≥10%	10
		40-54% or relative increase of 6-9%	5
		25-39% or relative increase of 2-5%	3
		<25% or relative increase of <2%	0

2024 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Epic Sites** **Measurement period: 01/01/2024 – 12/31/2024**			
Measure #	Weight	Measure Description	Points
7	10	**Collaborative-wide meeting participation -Clinical Champion**	
		attended all 3 meetings	10
		attended 2 out of 3 meetings	7
		attended 1 out of 3 meetings	3
		did not attend any meetings	0
8	10	**Collaborative-wide meeting participation – Coordinator/Lead Abstractor**	
		attended all 3 meetings	10
		attended 2 out of 3 meetings	7
		attended 1 out of 3 meetings	4
		did not attend any meetings	0
9	10	**Completeness and Accuracy of data**	
		Critical data elements are complete/accurate in ≥90% of cases	10
		Critical data elements are complete/accurate in 70-89% of cases	5
		Critical data elements are complete/accurate in <70% of cases	0
*PPI prescribed in patients on aspirin; PPI or H2 receptor blocker prescribed in patients on P2Y12 inhibitor ^Alerts addressed means the dashboard monitor staff (pharmacist/RN) notified provider or took other action (i.e., order labs, completing missing information).			

2024 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Memorial** **Measurement Period: 01/01/2024 – 12/31/2024**			
Measure #	Weight	Measure Description	Points
1	10	**Smoking status assessment in newly enrolled patients**	
		≥90% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	10
		70-89% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	5
		50-69% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	3
		<50% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	0
2	30	**Inappropriate aspirin use in warfarin patients (updated 2024 criteria)**	
		≤12% or relative decrease of ≥15%	30
		13-19% or relative decrease of 10-14%	20
		20-24% or relative decrease of 5-9%	10
		>24% or relative decrease of <5%	0
3	10	**Extended International Normalized Ratio (INR) testing interval**	
		≥80% of eligible patients received extended intervals	10
		60-79% of eligible patients received extended intervals	5
		40-59% of eligible patients received extended intervals	3
		<40% of eligible patients received extended intervals	0
4	10	**Gastroprotection* in warfarin patients at high-risk for upper GI bleeding (site level)**	
		≥55% or relative increase of ≥10%	10
		40-54% or relative increase of 6-9%	5
		25-39% or relative increase of 2-5%	3
		<25% or relative increase of <2%	0
5	10	**Gastroprotection* in warfarin patients at high-risk for upper GI bleeding (consortium level)**	
		≥55% or relative increase of ≥10%	10
		40-54% or relative increase of 6-9%	5
		25-39% or relative increase of 2-5%	3
		<25% or relative increase of <2%	0
6	10	**Collaborative-wide meeting participation -Clinical Champion**	
		attended all 3 meetings	10
		attended 2 out of 3 meetings	7
		attended 1 out of 3 meetings	3
		did not attend any meetings	0

2024 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Memorial** **Measurement Period: 01/01/2024 – 12/31/2024**			
Measure #	Weight	Measure Description	Points
7	10	**Collaborative-wide meeting participation – Coordinator/Lead Abstractor**	
		attended all 3 meetings	10
		attended 2 out of 3 meetings	7
		attended 1 out of 3 meetings	4
		did not attend any meetings	0
8	10	**Completeness and Accuracy of data**	
		Critical data elements are complete/accurate in ≥90% of cases	10
		Critical data elements are complete/accurate in 70-89% of cases	5
		Critical data elements are complete/accurate in <70% of cases	0
*PPI prescribed in patients on aspirin; PPI or H2 receptor blocker prescribed in patients on P2Y12 inhibitor			

2024 Michigan Arthroplasty /Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 1** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 01/01/2024 - 06/30/2024			
Measure #	Weight	Measure Description	Points
1	20	**Collaborative Meeting Participation*-Clinical Champions (01.01.2024-11.30.2024)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
2	20	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2024-11.30.2024)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	2
		<3 meetings attended	0
4	5	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive New site kickoff meeting time on Wednesday, January 17, 2024 for: 1. Clinical Champion 2. Quality Administrator 3. Clinical Data Abstractor (*if identified*)	5
5	5	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive New site kickoff meeting time on Wednesday, January 17, 2024 for: 1. Site IT Support	5
6	20	**Accuracy and Completeness of Data Submission (audits 01.01.2024-06.30.2024) - 5 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. Data abstraction started by May 31, 2024. 4. All cases performed or before May 4, 2024 abstracted by October 1, 2024 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2024	
		5 of 5 metrics met	20

2024 Michigan Arthroplasty /Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 1** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 01/01/2024 - 06/30/2024			
Measure #	Weight	Measure Description	Points
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0
7	15	**Access to Surgeon's Office Records (90 day events): (Surgery dates 01.01.2024-08.31.2024)**	
		90% + patient data captured	15
		75% - 89% patient data captured	7.5
		Less than 75% data captured	0
8	15	**Site based Quality Meetings:(02.03.2024-11.15.2024)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	15
Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.03.2024-11.15.2024)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 0.5 extra credit points per site**	0.5
Extra credit	0	**MODB data submission:** Provide site's written planned process for site's submission of all MARCQI eligible cases data to Michigan Health and Hospital Association's Michigan Outpatient Database (MODB) by August 31, 2024 ***Maximum total of 0.5 extra credit points per site**	0.5
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by June 30, 2024, extra credit points will be rewarded ***Maximum total of 0.5 extra credit points per site**	0.5

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
1	20	**Collaborative Meeting Participation*-Clinical Champions (01.01.2024-11.30.2024)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team) ***Maximum total 0.5 point extra credit per site**	0.5
2	20	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2024-11.30.2024)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site**	0.5
Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of January 31, 2024 who have at least one CDA attend the in-person CDA refresher training course. ***Maximum total 0.5 point extra credit per site**	0.5
3	20	**Accuracy and Completeness of Data Submission (audits 07.01.2023-06.30.2024) - 5 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All 2023 cases abstracted completely by 05.31.2024 4. All cases performed or before May 4, 2024 abstracted by October 1, 2024 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of	

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
		request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2024	
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0
Extra Credit	0	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2023 - 06.30.2024) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site**	0.5
4	20	**Site based Quality Meetings:(02.03.2024-11.15.2024)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	20
Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.03.2024-11.15.2024)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 3 extra credit points per site**	3
5	5	**Site level PROS Collection: Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2024)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 70%+	5
		60%	3
		50%	1

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
		The site is not awarded points if collection is less than 50%	0
6	2.5	**Site level PROS Collection: Completed primary Pre-op HOOS -JR or KOOS-JR + PROMIS10 (Surgeries on from July 1, 2023 to June 30, 2024)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 90%+	2.5
		75 - 89%	1.5
		60 - 74%	0.5
		The site is not awarded points if collection is less than 60%	0
7	2.5	**% of Opioid naive THA patients at the SITE meet the MARCQI Pain control pathway guidelines (<240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	2.5
		60-84% of THA patients prescribed **<240 OME**	1.5
		Less than 60% of patients meet the prescribing criteria	0
8	2.5	**% of Opioid naive TKA patients at the SITE meet the MARCQI Pain control pathway guidelines (<320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	2.5
		70-89% of TKA patients prescribed **<320 OME**	1.5
		Less than 70% of patients meet the prescribing criteria	0
9	2.5	**90-Day Hip fracture: Reduce COLLABORATIVE rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) by 10% (Baseline FY2023 = 1.17%; 10% reduction goal = 1.05%)**	
		1.05% or less of all primary HIPS experience a 90-Day hip fracture	2.5
		Greater than 1.05% but less than 1.17% of all primary HIPS experience a 90-Day hip fracture	1.5
		The site is not awarded points if there is no collaborative-wide improvement (>=1.17%) in all primary HIPS with 90-Day hip fractures	0

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
10	5	**90-Day Hip fracture: Reduce baseline FY2023 rate by 10%, achieve, or maintain SITE level rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) to 1.05%** **--**Reduce by 10%: If the site's April 2023 Quarterly report shows a 90-Day hip fracture rate for all primary HIP procedures (excluding conversion) that is greater than 1.05%, the site-level goal will be to reduce this rate by 10% or meet the 1.05% rate at their site. --Maintain site-level: If the site's April 2023 Quarterly report shows a 90-Day hip fracture rate for all primary HIP procedures (excluding conversion) to be less than or equal to 1.17%, the site-level goal will be to maintain or improve upon their baseline rate. --Final determination will be made by the January 2025 Quarterly Report	
		When April 2023 baseline is: **>1.05%**, the site meets a site-level reduction of 10% or meets the 1.05% rate of 90-day hip fractures **≤1.05%**, the site maintains baseline outcome or reduces hip fracture rate	5
		When April 2023 baseline is: **>1.05%**, the site meets a site-level reduction of ≥ 5% site-level rate of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of ≤ 2% site-level rate of 90-day hip fractures	2.5
		When April 2023 baseline is: **>1.05%**, the site attains a site-level reduction is <5% or increases the site-level rate of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of >2% site-level rate of 90-day hip fractures	0
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by December 31, 2023, extra credit points will be rewarded ***Maximum total of 2 extra credit points per site**	2

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Weight	Measure Description	Points
1	10	**Collaborative Meeting Participation*-Clinical Champions (01.01.2024-11.30.2024)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	10
		2 out of 3 meetings attended	5
		<3 meetings attended	0
Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team) ***Maximum total 0.5 point extra credit per site**	0.5
2	5	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2024-11.30.2024)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	5
		2 out of 3 meetings attended	2
		<3 meetings attended	0
Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site**	0.5
Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of January 31, 2024 who have at least one CDA attend the in-person CDA refresher training course. ***Maximum total 0.5 point extra credit per site**	0.5
3	10	**Accuracy and Completeness of Data Submission (audits 07.01.2023-06.30.2024) - 5 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All 2023 cases abstracted completely by 05.31.2024 4. All cases performed or before May 4, 2024 abstracted by October 1, 2024 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2024	
		5 of 5 metrics met	10

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Weight	Measure Description	Points
		4 of 5 metrics met	8
		3 of 5 metrics met	6
		2 of 5 metrics met	4
		1 of 5 metrics met	2
		0 of 5 metrics met	0
Extra Credit	0	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2023 - 06.30.2024) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site**	0.5
4	5	**Site based Quality Meetings:(02.03.2024-11.15.2024)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	5
Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.03.2024-11.15.2024)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 3 extra credit points per site**	3
5	10	**Site level PROS Collection: Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2024)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 70%+	10
		60%	5
		50%	2.5
		The site is not awarded points if collection is less than 50%	0

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Weight	Measure Description	Points
Extra Credit	0	**Site level PROS Collection: Completed primary Pre-op and 1-year post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on 06.01.2022 to 11.03.2023 and 1 year post op--300-425 days post-op accepted.)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 50%+	5
		40%	3
		30%	1
		<30%	0
6	5	**Site level PROS Collection: Completed primary Pre-op HOOS -JR or KOOS-JR + PROMIS10 (Surgeries on from July 1, 2023 to June 30, 2024)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 90%+	5
		75 - 89%	3
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0
7	5	**% of Opioid naive THA patients at the SITE meet the MARCQI Pain control pathway guidelines (<240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	5
		60-84% of THA patients prescribed **<240 OME**	2
		Less than 60% of patients meet the prescribing criteria	0
8	5	**% of Opioid naive TKA patients at the SITE meet the MARCQI Pain control pathway guidelines (<320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	5
		70-89% of TKA patients prescribed **<320 OME**	2
		Less than 70% of patients meet the prescribing criteria	0
9	15	**90-Day Hip fracture: Reduce COLLABORATIVE rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) by 10% (Baseline FY2023 = 1.17%; 10% reduction goal = 1.05%)**	
		1.05% or less of all primary HIPS experience a 90-Day hip fracture	15

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Weight	Measure Description	Points
		Greater than 1.05% but less than 1.17% of all primary HIPS experience a 90-Day hip fracture	7
		The site is not awarded points if there is no collaborative-wide improvement (>=1.17%) in all primary HIPS with 90-Day hip fractures	0
10	10	**90-Day Hip fracture: Reduce baseline FY2023 rate by 10%, achieve, or maintain SITE level rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) to 1.05%** **--**Reduce by 10%: If the site's April 2023 Quarterly report shows a 90-Day hip fracture rate for all primary HIP procedures (excluding conversion) that is greater than 1.05%, the site-level goal will be to reduce this rate by 10% or meet the 1.05% rate at their site. --Maintain site-level: If the site's April 2023 Quarterly report shows a 90-Day hip fracture rate for all primary HIP procedures (excluding conversion) to be less than or equal to 1.17%, the site-level goal will be to maintain or improve upon their baseline rate. --Final determination will be made by the January 2025 Quarterly Report	
		When April 2023 baseline is: **>1.05%**, the site meets a site-level reduction of 10% or meets the 1.05% rate of 90-day hip fractures **≤1.05%**, the site maintains baseline outcome or reduces hip fracture rate	10
		When April 2023 baseline is: **>1.05%**, the site meets a site-level reduction of ≥ 5% site-level rate of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of ≤ 2% site-level rate of 90-day hip fractures	5
		When April 2023 baseline is: **>1.05%**, the site attains a site-level reduction is <5% or increases the site-level rate of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of >2% site-level rate of 90-day hip fractures	0
11	20	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If red on scorecard of April, 2023, you must strongly consider choosing this as the project. If you have worked on this metric previously or have difficultly developing a goal, a yellow target area may be chosen with the Program Manager's approval. If you would like to continue with your FY2023 site based QI project topic, please discuss with the Program Manager. If no red, you will choose a 'yellow'. Progress Reports are due in May 2024 & January 2025.	

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Weight	Measure Description	Points
		Final results are based on quarterly reports of January, 2025	
		Plan submitted and approved, reporting requirements & timelines met, A3 submitted, and goal met* *Clinical Champion and Clinical Data Abstractor must be available to present at June 2025 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2025 P4P scorecard*	20
		Plan submitted and approved Reporting requirements are met & timelines, but the target identified is not met. A3 submitted with final report and presentation by clinical champion and clinical data abstractor given at June 2025 MARCQI Collaborative-wide sessions* *Clinical Champion and Clinical Data Abstractor must be available to present at June 2025 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2025 P4P scorecard*	10
		Plan submitted and approved All reporting requirements are met, but the identified goal and timelines are not met.	5
		Plan is not developed, reports not done.	0
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by December 31, 2023, extra credit points will be rewarded ***Maximum total of 2 extra credit points per site**	2

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Extra Credit** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023-06/30/2024				
Measure #	Max.		Points	Eligible P4P
Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team) ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+
Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+
Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of January 31, 2024 who have at least one CDA attend the in-person CDA refresher training course. ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+
Extra Credit	0	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2023 - 06.30.2024) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+
Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.03.2024-11.15.2024)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 3 extra credit points per site**	3	2, 3+

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Extra Credit** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023-06/30/2024				
Measure #	Max.		Points	Eligible P4P
Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.03.2024-11.15.2024)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 0.5 extra credit points per site**	0.5	1
Extra Credit	0	**Site level PROS Collection: Completed primary Pre-op and 1-year post-op HOOS - JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on 06.01.2022 to 11.03.2023 and 1 year post op--300-425 days post-op accepted.)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.		3+
		The site is awarded full points for collection rates of 50%+	5	
		40%	3	
		30%	1	
		<30%	0	
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by December 31, 2023, extra credit points will be rewarded ***Maximum total of 2 extra credit points per site**	2	2, 3+

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI)
Performance Index Scorecard
HOSPITAL - Extra Credit
Participation Measurement Period: 01/01/2024 - 11/30/2024
QI Measurement Period: 07/01/2023-06/30/2024

Measure #	Max.		Points	Eligible P4P
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by June 30, 2024, extra credit points will be rewarded ***Maximum total of 0.5 extra credit points per site**	0.5	1

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Facility/Center (ASF/ASC) - Year 1** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 01/01/2024 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
1	20	**COLLABORATIVE MEETING PARTICIPATION*-CLINICAL CHAMPIONS (01.01.2024-11.30.2024)** **ATTENDANCE AT BOTH THE MEDICAL ADVISORY COMMITTEE AND COLLABORATIVE-WIDE MEETING ON FEBRUARY 2, 2024 (VIRTUAL); JUNE 7, 2024 (GRAND RAPIDS, MI); AND SEPTEMBER 27, 2024 (ANN ARBOR, MI) FOR 80% OF THE MEETING TIME*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
2	20	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2024-11.30.2024)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	2
		<3 meetings attended	0
3	5	**Collaborative Meeting Participation*-Quality Administrator (01.01.2024-11.30.2024)** **Attendance at the Collaborative-wide meeting in February 2024; June 2024 and September 2024 for 80% of the meeting time*	
		3 out of 3 meetings attended	5
		2 out of 3 meetings attended	2
		<3 meetings attended	0
4	5	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive New site kickoff meeting time on Wednesday, January 17, 2024 for: 1. Clinical Champion 2. Quality Administrator 3. Clinical Data Abstractor (*if identified*)	5
5	5	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive New site kickoff meeting time on Wednesday, January 17, 2024 for: 1. Site IT Support	5

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Facility/Center (ASF/ASC) - Year 1** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 01/01/2024 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
6	20	**Accuracy and Completeness of Data Submission (audits 01.01.2024-06.30.2024) - 5 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. Data abstraction started by May 31, 2024. 4. All cases performed or before May 4, 2024 abstracted by October 1, 2024 5. Attestation of BCBSM ASF CQI participation funding utilization to support dedicated data abstraction support for effective and complete MARCQI data abstraction and quality improvement work to the MARCQI Coordinating Center by 11.30.2024	
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0
7	12.5	**Access to Surgeon's Office Records (90 day events): (Surgery dates 01.01.2024-08.31.2024)**	
		90% + patient data captured	12.5
		75% - 89% patient data captured	6
		Less than 75% data captured	0
8	12.5	**Site based Quality Meetings:(02.03.2024-11.15.2024)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site-based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	12.5

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Facility/Center (ASF/ASC) - Year 1** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 01/01/2024 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
EXTRA CREDIT	0	**MODB data submission:** Provide site's written planned process for site's submission of all MARCQI eligible cases data to Michigan Health and Hospital Association's Michigan Outpatient Database (MODB) by August 31, 2024 ***Maximum total 0.5 point extra credit per site**	0.5
EXTRA CREDIT	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by June 30, 2024, extra credit points will be rewarded ***Maximum total 0.5 point extra credit per site**	0.5

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
1	20	**Collaborative Meeting Participation*-Clinical Champions (01.01.2024-11.30.2024)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team) ***Maximum total 0.5 point extra credit per site**	0.5
2	20	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2024-11.30.2024)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site**	0.5
Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of January 31, 2024 who have at least one CDA attend the in-person CDA refresher training course. ***Maximum total 0.5 point extra credit per site**	0.5
Extra Credit	0	**Collaborative Meeting Participation*- Site Administrator** (01.01.2024-11.30.2024) *Attendance at 3 of 3 Collaborative-wide meeting in February 2024; June 2024; and September 2024 Individual must be identified and confirmed to fill this role by 1st 2024 MARCQI Collaborative-wide meeting ***Maximum total 0.5 point extra credit per site**	0.5

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
3	20	**Accuracy and Completeness of Data Submission (audits 07.01.2023-06.30.2024) - 5 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All 2023 cases abstracted completely by 05.31.2024 4. All cases performed or before May 4, 2024 abstracted by October 1, 2024 5. Attestation of BCBSM ASF CQI participation funding utilization to support dedicated data abstraction support for effective and complete MARCQI data abstraction and quality improvement work to the MARCQI Coordinating Center by 11.30.2024	
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0
Extra Credit	0	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2023 - 06.30.2024) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site**	0.5
4	20	**Site based Quality Meetings:(02.03.2024-11.15.2024)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	20
Extra Credit	0	**Access to Surgeon's Office Records (90 day events): (Surgery dates 07.01.2023 - 06.30.2024):** 90% + patient data captured ***Maximum total 1 point extra credit per site**	1

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
5	5	**Site level PROS Collection: Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2024)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 70%+	5
		60%	3
		50%	1
		The site is not awarded points if collection is less than 50%	0
6	2.5	**Site level PROS Collection: Completed primary Pre-op HOOS -JR or KOOS-JR + PROMIS10 (Surgeries on from July 1, 2023 to June 30, 2024)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 90%+	2.5
		75 - 89%	1.5
		60 - 74%	0.5
		The site is not awarded points if collection is less than 60%	0
7	2.5	**% of Opioid naive THA patients at the SITE meet the MARCQI Pain control pathway guidelines (<240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	2.5
		60-84% of THA patients prescribed **<240 OME**	1.5
		Less than 60% of patients meet the prescribing criteria	0
8	2.5	**% of Opioid naive TKA patients at the SITE meet the MARCQI Pain control pathway guidelines (<320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	2.5
		70-89% of TKA patients prescribed **<320 OME**	1.5
		Less than 70% of patients meet the prescribing criteria	0
9	2.5	**90-Day Hip fracture: Reduce COLLABORATIVE rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) by 10% (Baseline FY2023 = 1.17%; 10% reduction goal = 1.05%)**	

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
		1.05% or less of all primary HIPS experience a 90-Day hip fracture	2.5
		Greater than 1.05% but less than 1.17% of all primary HIPS experience a 90-Day hip fracture	1.5
		The site is not awarded points if there is no collaborative-wide improvement (>=1.17%) in all primary HIPS with 90-Day hip fractures	0
10	5	**90-Day Hip fracture: Reduce baseline FY2023 rate by 10%, achieve, or maintain SITE level rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) to 1.05%** **--**Reduce by 10%: If the site's April 2023 Quarterly report shows a 90-Day hip fracture rate for all primary HIP procedures (excluding conversion) that is greater than 1.05%, the site-level goal will be to reduce this rate by 10% or meet the 1.05% rate at their site. --Maintain site-level: If the site's April 2023 Quarterly report shows a 90-Day hip fracture rate for all primary HIP procedures (excluding conversion) to be less than or equal to 1.17%, the site-level goal will be to maintain or improve upon their baseline rate. --Final determination will be made by the January 2025 Quarterly Report	
		When April 2023 baseline is: **>1.05%**, the site meets a site-level reduction of 10% or meets the 1.05% rate of 90-day hip fractures **≤1.05%**, the site maintains baseline outcome or reduces hip fracture rate	5
		When April 2023 baseline is: **>1.05%**, the site meets a site-level reduction of ≥ 5% site-level rate of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of ≤ 2% site-level rate of 90-day hip fractures	2.5
		When April 2023 baseline is: **>1.05%**, the site attains a site-level reduction is <5% or increases the site-level rate of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of >2% site-level rate of 90-day hip fractures	0

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by December 31, 2023, extra credit points will be rewarded ***Maximum total 2 point extra credit per site**	2

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **Ambulatory Surgery Facility/Center (ASF/ASC) - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
1	10	**Collaborative Meeting Participation*-Clinical Champions (01.01.2024-11.30.2024)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	10
		2 out of 3 meetings attended	5
		<3 meetings attended	0
Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team) ***Maximum total 0.5 point extra credit per site**	0.5
2	5	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2024-11.30.2024)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) for 80% of the meeting time*	
		3 out of 3 meetings attended	5
		2 out of 3 meetings attended	2
		<3 meetings attended	0
Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site**	0.5
Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of January 31, 2024 who have at least one CDA attend the in-person CDA refresher training course. ***Maximum total 0.5 point extra credit per site**	0.5
Extra Credit	0	**Collaborative Meeting Participation*- Site Administrator** (01.01.2024-11.30.2024) *Attendance at 3 of 3 Collaborative-wide meeting in February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) Individual must be identified and confirmed to fill this role by 1st 2024 MARCQI Collaborative-wide meeting ***Maximum total 0.5 point extra credit per site**	0.5

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **Ambulatory Surgery Facility/Center (ASF/ASC) - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
3	10	**Accuracy and Completeness of Data Submission (audits 07.01.2023-06.30.2024) - 5 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All 2023 cases abstracted completely by 05.31.2024 4. All cases performed or before May 4, 2024 abstracted by October 1, 2024 5. Attestation of BCBSM ASF CQI participation funding utilization to support dedicated data abstraction support for effective and complete MARCQI data abstraction and quality improvement work to the MARCQI Coordinating Center by 11.30.2024	
		5 of 5 metrics met	10
		4 of 5 metrics met	8
		3 of 5 metrics met	6
		2 of 5 metrics met	4
		1 of 5 metrics met	2
		0 of 5 metrics met	0
Extra Credit	0	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2023 - 06.30.2024) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site**	0.5
4	5	**Site based Quality Meetings:(02.03.2024-11.15.2024)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	5

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **Ambulatory Surgery Facility/Center (ASF/ASC) - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
Extra Credit	0	**Access to Surgeon's Office Records (90 day events): (Surgery dates 07.01.2023 - 06.30.2024):** 90% + patient data captured ***Maximum total 1 point extra credit per site**	1
5	15	**Site level PROS Collection: Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2024)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 70%+	15
		60%	10
		50%	5
		The site is not awarded points if collection is less than 50%	0
Extra Credit	0	**Site level PROS Collection: Completed primary Pre-op and 1-year post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on 06.01.2022 to 11.03.2023 and 1 year post op--300-425 days post-op accepted.)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 50%+	5
		40%	3
		30%	1
		<30%	0
6	10	**Site level PROS Collection: Completed primary Pre-op HOOS -JR or KOOS-JR + PROMIS10 (Surgeries on from July 1, 2023 to June 30, 2024)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 90%+	10
		75 - 89%	6
		60 - 74%	4
		The site is not awarded points if collection is less than 60%	0
7	15	**% of Opioid naive THA patients at the SITE meet the MARCQI Pain control pathway guidelines (<240 OME)**	

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **Ambulatory Surgery Facility/Center (ASF/ASC) - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
		85% or greater of THA patients meet the guidelines of **240 OME** or less	15
		60-84% of THA patients prescribed **<240 OME**	7
		Less than 60% of patients meet the prescribing criteria	0
8	15	**% of Opioid naive TKA patients at the SITE meet the MARCQI Pain control pathway guidelines (≤320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	15
		70-89% of TKA patients prescribed **<320 OME**	7
		Less than 70% of patients meet the prescribing criteria	0
9	5	**90-Day Hip fracture: Reduce COLLABORATIVE rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) by 10% (Baseline FY2023 = 1.17%; 10% reduction goal = 1.05%)**	
		1.05% or less of all primary HIPS experience a 90-Day hip fracture	5
		Greater than 1.05% but less than 1.17% of all primary HIPS experience a 90-Day hip fracture	2
		The site is not awarded points if there is no collaborative-wide improvement (>=1.17%) in all primary HIPS with 90-Day hip fractures	0
10	10	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** Using the April 2023 Quarterly reports, sites not performing equal to or better than their peers in PROS data collection, OME prescribing patterns, hip fractures, or 30-Day ED visits must choose one of those areas of focus as their project. If a site is performing better than their peers in PROS data collection, OME prescribing patterns, hip fractures, and 30-Day ED visits, they may choose a site specific quality initiative utilizing the April 2023 MARCQI Quarterly Report. Progress Reports are due in May 2024 & January 2025. Final results are based on quarterly reports of January, 2025	
		Plan submitted and approved, reporting requirements & timelines met, A3 submitted, and goal met* *Clinical Champion and Clinical Data Abstractor must be available to present at June 2025 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2025 Performance Incentive scorecard*	10

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **Ambulatory Surgery Facility/Center (ASF/ASC) - Year 3+** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023 - 06/30/2024			
Measure #	Max. Weight	Measure Description	Points
		Plan submitted and approved Reporting requirements are met & timelines, but the target identified is not met. A3 submitted with final report and presentation by clinical champion and clinical data abstractor given at June 2025 MARCQI Collaborative-wide sessions* *Clinical Champion and Clinical Data Abstractor must be available to present at June 2025 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2025 Performance Incentive scorecard*	6
		Plan submitted and approved All reporting requirements are met, but the identified goal and timelines are not met.	3
		Plan is not developed, reports not done.	0
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by December 31, 2023, extra credit points will be rewarded ***Maximum total 2 point extra credit per site**	2

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **Extra Credit for Ambulatory Surgery Facility/Center (ASF/ASC)** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023-06/30/2024				
Measure #	Max. Weight	Measure Description	Points	Eligible P4P Years
Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team) ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+
Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+
Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of January 31, 2024 who have at least one CDA attend the in-person CDA refresher training course. ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+
Extra Credit	0	**Collaborative Meeting Participation*- Site Administrator** (01.01.2024-11.30.2024) *Attendance at 3 of 3 Collaborative-wide meeting in February 2, 2024 (Virtual); June 7, 2024 (Grand Rapids, MI); and September 27, 2024 (Ann Arbor, MI) Individual must be identified and confirmed to fill this role by 1st 2024 MARCQI Collaborative-wide meeting ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+
Extra Credit	0	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2023 - 06.30.2024) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site**	0.5	2, 3+

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **Extra Credit for Ambulatory Surgery Facility/Center (ASF/ASC)** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023-06/30/2024				
Measure #	Max. Weight	Measure Description	Points	Eligible P4P Years
Extra Credit	0	**Access to Surgeon's Office Records (90 day events): (Surgery dates 07.01.2023 - 06.30.2024):** 90% + patient data captured ***Maximum total 1 point extra credit per site**	1	2, 3+
Extra Credit	0	**Site level PROS Collection: Completed primary Pre-op and 1-year post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on 06.01.2022 to 11.03.2023 and 1 year post op--300-425 days post-op accepted.)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.		3+
		The site is awarded full points for collection rates of 50%+	5	
		40%	3	
		30%	1	
		<30%	0	
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by December 31, 2023, extra credit points will be rewarded ***Maximum total of 2 extra credit points per site**	2	2, 3+
Extra Credit	0	**Site based Quality Improvement:** *Alignment with MARCQI's 2024 demographic variables (e.g., AMA's recommendations for gender, race, ethnicity, etc.)* If a site can document in their electronic health record that options for race, ethnicity, and gender are inclusive to	0.5	1

2024 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **Extra Credit for Ambulatory Surgery Facility/Center (ASF/ASC)** Participation Measurement Period: 01/01/2024 - 11/30/2024 QI Measurement Period: 07/01/2023-06/30/2024				
Measure #	Max. Weight	Measure Description	Points	Eligible P4P Years
		MARCQI's 2024 definition (AMA recommendations) are available for MARCQI patients by June 30, 2024, extra credit points will be rewarded ***Maximum total of 0.5 extra credit points per site**		
Extra credit	0	**MODB data submission:** Provide site's written planned process for site's submission of all MARCQI eligible cases data to Michigan Health and Hospital Association's Michigan Outpatient Database (MODB) by August 31, 2024 ***Maximum total 0.5 point extra credit per site**	0.5	1

2024 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
1	10	**Improvement/Excellence In Grade 1 Complication Rate (Adjusted)** **Measurement Periods:** **Improvement: OR dates 10/1/2021 to 9/30/2024** **Excellence: OR Dates 10/1/2023 to 9/30/2024**	
		Major improvement (z-score less than -1 or Grade 1 complication rate ≤4%)	10
		Moderate improvement/maintained complication rate (z-score between 0 and -1)	5
		No improvement/rates of grade 1 complications increased (z-score ≥0)	0
2	20	**Improvement/Excellence in Serious Complication Rate (Adjusted)** **Measurement Periods:** **Improvement: OR dates 10/1/2021 to 9/30/2024** **Excellence: OR Dates 10/1/2023 to 9/30/2024**	
		Major improvement (z-score less than -1 or serious complication rate ≤2.4%)	20
		Moderate improvement/maintained complication rate (z-score between 0 and -1)	10
		No improvement/rates of serious complications increased (z-score ≥0)	0
3	10	**1-Year Follow-up Rates (Adjusted)**	
		≥67% OR > 5% **relative** improvement from previous year (10/1/2021-9/30/2022)	10
		Maintained 1-year follow-up rate/ >0 to <5% relative improvement from previous year (10/1/2021-9/30/2022)	5
		1-year follow-up rate decreased/No improvement in 1-year follow-up rate (10/1/2021-9/30/2022)	0
4	5	**Compliance with VTE prophylaxis - Pre-operatively and Post-operatively (Unadjusted)** **Measurement Period: 01/01/2024 – 12/31/2024**	
		≥94% compliance with guidelines	5
		0 to 93% compliance with guidelines	0
5	5	**Compliance with VTE prophylaxis - Post Discharge (Unadjusted)** **Measurement Period: 01/01/2024 – 12/31/2024**	
		≥70% compliance with guidelines or a >2.5% relative improvement from the previous year (1/1/2023 to 12/31/2023)	5
		0 to 69% compliance with guidelines	0
6	5	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs) (Unadjusted)** **Measurement Period: 10/01/2023 – 09/30/2024**	
		≤42 MME or ≥ 10% relative reduction in opioid use	5
		5-9% relative reduction in opioid use	2.5
		< 5% relative reduction	0

2024 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
7	10	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs) (Unadjusted)** **Measurement Period: 10/01/2023 – 09/30/2024**	
		≤42 MME or ≥ 10% relative reduction in opioid use	10
		5-9% relative reduction in opioid use	5
		< 5% relative reduction	0
8	5	**ED Visits (not resulting in a readmission, "avoidable") (Unadjusted)** **Measurement Period: 10/01/2023 – 09/30/2024**	
		≤ 6% Avoidable ED visits	5
		> 6% Avoidable ED visits	0
9	5	**Meeting Attendance - Surgeon: (Calendar Year 2024)**	
		Attended 3 out of 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended fewer than 2 meetings	0
10	5	**Meeting Attendance - Abstractor/Coordinator: (Calendar Year 2024)**	
		Attended 3 out of 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended fewer than 2 meetings	0
11	5	**Timely Monthly Data Submissions (30-day information & registry paperwork) 01/01/2024 – 12/31/2024:**	
		On time 11-12 months	5
		On time 10 months	3
		On time 9 months or less	0
12	5	**Consent Rate (10/01/2023 – 09/30/2024) (Unadjusted):**	
		≥90% consented patients	5
		80-89% consented patients	3
		<80% consented patients	0
13	10	**Physician Engagement (01/01/2024 – 12/31/2024):**	10
		Following items count as 1 activity point: **** Note: For each site, a surgeon or surgeons must participate in at least 2 of the engagement activities listed below in order to receive the 10 points available for this measure.**** *****In order for a surgeon to earn points for a hospital, they must complete 10 bariatric surgery cases at that hospital for the dates of 1/1/2024 to 12/31/2024**	
		Committee participation	
		MBSC survey response	
		Participate in a qualitative interview	
		Coauthor a paper	
		Participate in quality improvement initiatives (MPIRRE/FUTURE/MSHEILD/etc.)	

2024 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
		Attend or present at a pre-meeting session (IH committee/surgeon skill/etc.) on the day of the MBSC tri-annual meeting	
		Present MBSC data at a MBSC tri-annual meeting	
		Attend quality site visit as a guest surgeon	
		Following items count as 2 activity points:	
		Host quality site visit	
		Present MBSC data at a national meeting	
		Lead author on an MBSC publication	
		No participation	0

2024 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2023 – 10/31/2024 **Year 1 Sites**			
Measure #	Weight	Measure Description	Points
1	10	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	10
		11 months of data transfers on time	8
		9-10 months of data transfers on time	4
		< 9 months of data transfers on time	0
2	10	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	10
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	8
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	4
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	6	**Electronic Data Dictionary Update**	
		Successful submission by deadline	6
		Successful submission within 1 month of deadline	3
		Submission more than 1 month after deadline	0
4	13	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadline	13
		1 deadline missed	8
		2+ deadlines missed	0
5	12	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0
6	12	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0
7	14	**Time from Agreement being signed to hiring date of data abstractor**	
		<90 days	14
		91-120 days	8
		>120 days	0
8	14	**Time from Agreements signed to successful submission of electronic production data**	
		<90 days	14
		91-120 days	8
		>120 days	0

2024 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2023 – 10/31/2024 **Year 1 Sites**			
Measure #	Weight	Measure Description	Points
9	9	**Intervention Planning for Year 2 (Intervention Templates, etc.)**	
		All Year 2 materials complete and submitted on time	9
		Year 2 materials incomplete and/or submitted late	0

2024 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2023 – 10/31/2024 **Year 2 Sites**			
Measure #	Weight	Measure Description	Points
1	12	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	12
		11 months of data transfers on time	9
		9-10 months of data transfers on time	6
		< 9 months of data transfers on time	0
2	12	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	12
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	9
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	6
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	6	**Electronic Data Dictionary Update**	
		Successful submission by deadline	6
		Successful submission within 1 month of deadline	3
		Submission more than 1 month after deadline	0
4	10	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadline	10
		1 deadline missed	5
		2+ deadlines missed	0
5	10	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
6	10	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
7	10	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review**	
		≥ 90% of case cohort decisions are correct	4
		≥ 75% of case cohort decisions are correct	2

2024 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2023 – 10/31/2024 **Year 2 Sites**			
Measure #	Weight	Measure Description	Points
		< 75% of case cohort decisions are correct	0
		≥ 97% of abstracted registry data accurate	6
		95%-97% of abstracted registry data accurate	3
		<95% of abstracted registry data accurate	0
8a	10	**Site Specific - Timely Administration of Steroids in Pediatric Asthma *Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	10
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	7
		QI Project developed and implemented but there was no improvement to the target	4
		QI Project not developed or implemented	0
8b	10	**Site Specific - Adult Low Risk Chest Pain Safe Discharge Initiative *Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	10
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	7
		QI Project developed and implemented but there was no improvement to the target	4
		QI Project not developed or implemented	0
9	10	**Collaborative-Wide Measure: Naloxone Distribution for Opioid Use Harm Reduction**	
		Met Naloxone Distribution Target	10
		Did meet target	0
10	5	**Collaborative-Wide Measure: Peds Chest Xray Utilization**	
		Met CXR Utilization Target	5
		Did meet target	0
11	5	**Collaborative-Wide Measure: Adult Suspected PE CT Diagnostic Yield**	
		Met Diagnostic Yield Target	5
		Did meet target	0

2024 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2023 – 10/31/2024 **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
1	4	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	4
		11 months of data transfers on time	3
		9-10 months of data transfers on time	2
		< 9 months of data transfers on time	0
2	4	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	4
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	3
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	2
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	2	**Electronic Data Dictionary Update**	
		Successful submission by deadline	2
		Successful submission within 1 month of deadline	1
		Submission more than 1 month after deadline	0
4	5	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadline	5
		1 deadline missed	3
		2+ deadlines missed	0
5	5	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
6	5	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
7	5	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review**	
		≥ 90% of case cohort decisions are correct	2
		≥ 75% of case cohort decisions are correct	1
		< 75% of case cohort decisions are correct	0
		≥ 97% of abstracted registry data accurate	3

2024 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2023 – 10/31/2024 **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
		95%-97% of abstracted registry data accurate	2
		<95% of abstracted registry data accurate	0
8a	25	**Site Specific - Timely Administration of Steroids in Pediatric Asthma *Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	25
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	15
		QI Project developed and implemented but there was no improvement to the target	10
		QI Project not developed or implemented	0
8b	25	**Site Specific - Adult Low Risk Chest Pain Safe Discharge Initiative *Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	25
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	15
		QI Project developed and implemented but there was no improvement to the target	10
		QI Project not developed or implemented	0
9	10	**Collaborative-Wide Measure: Naloxone Distribution for Opioid Use Harm Reduction**	
		Met Naloxone Distribution Target	10
		Did meet target	0
10	5	**Collaborative-Wide Measure: Peds Chest Xray Utilization**	
		Met CXR Utilization Target	5
		Did meet target	0
11	5	**Collaborative-Wide Measure: Adult Suspected PE CT Diagnostic Yield**	
		Met Diagnostic Yield Target	5
		Did meet target	0
12a	25	**Site Specific - Quality Improvement Initiative: Adult Head Injury CT Appropriateness**	
		QI Project developed and implemented and site met or exceeded target	25
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	15
		QI Project developed and implemented but there was no improvement to the target	10

2024 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2023 – 10/31/2024 **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
		QI Project not developed or implemented	0
12b	25	**Site Specific - Quality Improvement Initiative: Pediatric Intermediate Risk Head Injury CT Utilization**	
		QI Project developed and implemented and site met or exceeded target	25
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	15
		QI Project developed and implemented but there was no improvement to the target	10
		QI Project not developed or implemented	0

2024 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2024-09/30/2024			
Measure #	Weight	Measure Description	Points
1	6	**Clinical Audit, CDA Team Meeting Participation, and Submission of Clinical Data**	
		Three Metrics Met	6
		Two Metrics Met	4
		One Metric Met	2
		None Met	0
2	6	**Timely Submission of High-Quality Physics & Dosimetry Data**	
		Three Metrics Met	6
		Two Metrics Met	4
		One Metric Met	2
		None Met	0
3	10	**In node-positive breast cancer patients, the irradiated nodal group(s) is(are) contoured and named per TG-263 naming convention AND the dose to the SCV, ICV (Axillary Level 3), Axilla (Level 1 & 2), and/or IMN is reported.**	
		Contours and dose reported in ≥70% of patients	10
		Contours and dose reported in 50-69% of patients	7
		Contours and dose reported in <50% of patients	0
4	10	**For lung cancer patients treated with conventional fractionation, the mean esophageal dose is <29 Gy AND the esophageal max dose (D2cc) is <61 Gy.**	
		≥65% of lung patients met both constraints	10
		50-64% of lung patients met both constraints	7
		<50% of lung patients met both constraints	0
5	10	**For SBRT treatment of lung cancer with a single PTV, the Paddick Conformity Index is ≥0.85.**	
		≥80% of patients treated for lung cancer with a single PTV with SBRT met the criterion	10
		60-79% of patients treated for lung cancer with a single PTV with SBRT met the criterion	7
		<60% of patients treated for lung cancer with a single PTV with SBRT met the criterion	0
6	10	**(Collaborative-Wide Goal Metric A ONLY)** **Use of shorter course radiotherapy for bone metastasis treatment as shown by:** A: The MROQC **consortium-wide** rate of single fraction use is ≥45% for uncomplicated patients B: Your site-level rate of ≤5 fraction treatment is at least 75% for all patients	
		A and B are met	10

2024 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2024-09/30/2024			
Measure #	Weight	Measure Description	Points
		Only B is met	8
		B is not met	0
7	10	**For treatment of bone metastasis using stereotactic body radiotherapy (SBRT): A. Standardized dose constraints for organs at risk (OARs) are used B. Any violations of the standardized dose constraints are documented.**	
		≥80% of patients who received bone metastasis treatment with SBRT met both criteria	10
		<80% of patients who received bone metastasis treatment with SBRT met both criteria	0
8	10	**Percentage of patients with intermediate risk prostate cancer as defined by NCCN treated with EBRT or brachytherapy who received "high value radiotherapy", defined as moderately hypofractionated EBRT (28 fractions or less) OR ultrahypofractionated EBRT/SBRT (7 fractions or less) OR brachytherapy monotherapy. Patients with unfavorable intermediate risk prostate cancer may also receive a brachytherapy boost.**	
		≥70% of patients received high value radiotherapy	10
		50-69% of patients received high value radiotherapy	7
		<50% of patients received high value radiotherapy	0
9	10	**Prostate Working Group Performance Goal: Completion of 12-month follow-up form (P6)**	
		≥60% of prostate 12-month follow-up forms completed	10
		40-59% of prostate 12-month follow-up forms completed	7
		<40% of prostate 12-month follow-up forms completed	0
10	6	**Collaborative-Wide Meeting Participation – Clinical Champion (per MROQC CC Attendance Policy)***	
		All meetings or two meetings with one meeting attended by an acceptable designee	6
		Two meetings only	4
		One meeting or none attended	0
11	6	**Collaborative-Wide Meeting Participation – Physics Lead (or designee)**	
		All meetings	6
		Two meetings	4
		One meeting or none attended	0
12	6	**Collaborative-Wide Meeting Participation – Clinical Data Abstractor (or designee)**	

2024 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2024-09/30/2024			
Measure #	Weight	Measure Description	Points
		All meetings	6
		Two meetings	4
		One meeting or none attended	0
	100		
Bonus	10	**MROQC Physician Engagement**	
		• Lead author on an MROQC publication *(Counts as 2 items)* • Lead a skills workshop *(Counts as 2 items)* • Present at an MROQC collaborative-wide meeting *(Non-leadership role only)* • Present on MROQC at a national meeting *(Cannot be a resident)* • Attend 5 working group meetings in 2024 *(Total across practice physicians; 1 physician counts per meeting (i.e., no double points if 2 attend the same meeting)* • Coauthor on an MROQC publication • Participate in 3 case review sessions • Propose a new quality measure: provide reasoning to implement the measure, work with the MROQC data team to review supporting data and present the measure to the WG.	
		5 or more items achieved	10
		3-4 items achieved	5
		1-2 items achieved	1

2024 Michigan Surgical Quality Collaborative (MSQC) Performance Index Scorecard Project Time Period: 1/1/2024 – 12/31/2024			
Measure #	Weight	Measure Description	Points
1	6	**Collaborative Meetings (4 offered) – Surgical Clinical Quality Reviewer (SCQR)**	
		3 or more meetings	6
		2 meetings	3
		1 meeting	1
2	6	**Collaborative Meetings (3 offered) – Surgeon Champion (SC)**	
		2 or more meetings	6
		1 meeting	3
		0 meetings	0
3	4	**Conference Calls (3 offered) – SCQR**	
		2 or more calls	4
		1 call	2
		0 calls	0
4	4	**SCQR Participation/Engagement**	
		Participated in at least one MSQC activity listed in the supplement document.	4
		No Contribution: Did not participate in any activities listed in the supplement document.	0
5	4	**SC Participation/Engagement**	
		Participated in at least one MSQC activity listed in the supplement document.	4
		No Contribution: Did not participate in any activities listed in the supplement document.	0
6	6	**Completeness of Data (maximum 6 pts available)**	
		Sampled and incomplete cases ≤ 0.5% total volume	1
		Case Selection Audit with ≥ 95% agreement	1
		30 day follow-up rate ≥ 80% for 4th quarter 2023 (October – December cases)	1
		30 day follow-up rate ≥ 80% for 1st quarter 2024 (Jan – March cases)	1
		30 day follow-up rate ≥ 80% for 2nd quarter 2024 (April – June cases)	1
		30 day follow-up rate ≥ 80% for 3rd quarter 2024 (July – September cases)	1
7	20	**Collaborative Wide Measure*: Preop Optimization for elective abdominal hernia surgery:** • Reduce rate of persons with body mass index (BMI) ≥ 40kg/m2 undergoing elective surgery to < 10%. • Reduce rate of persons with active tobacco use undergoing elective surgery to < 15%.	
		Meet both measures	20
		Meet one measure	10
		No measures met	0

2024 Michigan Surgical Quality Collaborative (MSQC) Performance Index Scorecard Project Time Period: 1/1/2024 – 12/31/2024			
Measure #	Weight	Measure Description	Points
8	5	**Complete documentation of designated cancer variables** (CRC, Breast, Whipple, Thyroid)	
		90 - 100%	5
		< 90%	0
9	40	**Quality Improvement Initiative (QII)** - choose from one of the following: Option A: SUCCESS OR Option B: Frailty OR Option C: Breast Surgery OR Option D: Preoperative Testing (by invitation only)	40
10	5	**Submit project report** detailing local processes and structures and outcomes for improving adherence to Collaborative Wide Measure	5
Optional	5	Bonus points to be added^ to reflect active participation in MOQC over-sampling of hysterectomy cases. Points available when:	
		Site fully participates by over-sampling and abstracting all gyn-onc hysterectomy cases	5
		Site partially participates by over-sampling gyn-onc hysterectomy cases only	2
Total Available Points			**100**
^Earned bonus points will be added to Scorecard total, with final score not to exceed 100 points overall. See MSQC/MOQC Cross-Collaborative Project Summary document for details. *These goals may be updated at the end of 2023 once more data is available. Revised: 11/17/2023			

Quality Improvement Implementation, Option A: SUCCESS
2024 Project Time Period: 1/1/2024 – 12/31/2024

Background - Although infections related to urinary catheters have received a great deal of attention due to public reporting and hospital penalties, non-infectious complications of bladder catheters are also a serious concern. These include trauma from catheter placement and/or removal, which is as common as urinary tract infections. Furthermore, surgeons' feedback revealed that the most common catheter-related problem seen in their practices is urinary retention, for which there is a lack of standardized management.

Project Goal and Summary – The 2024 SUCCESS project will build on the work begun in 2023. In collaboration with the Surgical Champion and the multidisciplinary team, this intervention aims to (1) reduce inappropriate perioperative urinary catheter use, (2) reduce catheter-associated trauma, and (3) improve the management of postoperative urinary retention. The project focuses on four common general surgery procedures: appendectomy, cholecystectomy, colorectal surgery, and hernia repair. This project will include the implementation and/or evaluation of toolkit elements that will address clinician knowledge and urinary catheterization skills, as well as communication and implementation challenges anticipated to affect catheter use in different types of perioperative clinical settings. Continuing sites will continue the implementation of the toolkit elements, address barriers, meet process/outcome measures, and refine the care pathway.

Eligibility – Continuing sites that participated in the 2023 SUCCESS QI project and new sites that capture data in the MSQC SUCCESS tab starting from Cycle 35, 2023 are eligible to select this project as their 2024 QI Project. There is required variable training for the SCQRs new to the project.

QI Implementation Goals and Requirements: (40 points total)

1. Capture all SUCCESS data in MSQC Workstation for eligible cases (3 points)

2. Multidisciplinary team: Participating hospitals will establish a multidisciplinary team to review data, guide quality improvement and toolkit element implementation plans, and implement the MSQC SUCCESS urinary care pathway (6 points total)
    a. Suggested participants include surgeon leadership/surgeon champion, surgeons/residents (general & urology), executive leadership, anesthesiology, nursing supervisors for ER, Perioperative, PACU, and surgical units, quality department manager, patient safety, nursing education, and patient experience officer.
    b. Hold three (3) multidisciplinary meetings. Submit minutes and attendees to the coordinating center with your 2024 Project Summary.
        i. Kickoff meeting by March 29, 2024, to review project requirements and preliminary data. The SUCCESS Value Proposition/Leadership Engagement Briefing should be utilized during this meeting. New sites will complete the Readiness Assessment: Urinary Catheter Care Guide to Patient Safety (GPS) with the team (2 points).
        ii. Two (2) additional multidisciplinary meetings (minimally) before December 1, 2024, which include a review of SUCCESS data and a quality review for cases in goal 6 (2 points each).

3. New sites only: Implement the elements of the SUCCESS toolkit. Submit a narrative of how the following toolkit elements were implemented/utilized (15 points).

   Continuing sites only: Meet the below process/outcomes measures for appropriate catheter use and urinary retention diagnosis and management (15 points total, 3 points each measure). Measurement period 1/1/2024- 12/31/2024 OR dates:

   - *Catheter use measures*
     a. Avoid indwelling catheters intraoperatively in Category A*: < 10% of cases have an indwelling catheter
     b. Catheter is removed in OR for ≥ 75% of Category B* cases
   - *Urinary retention diagnosis and management measures*
     c. Bladder scan volume is documented ≥ 90% of the time if urinary catheterization for retention was performed
     d. No urinary catheter is used for bladder scan volumes < 300 ml for ≥ 90% of cases
     e. ISC was performed as opposed to an indwelling catheter (unless volume ≥ 500) for ≥ 90% of cases

4. With the multidisciplinary team, develop (new sites) or refine (continuing sites) the MSQC SUCCESS urinary care pathway template for your hospital's practices. This will be implemented and utilized by the care team to ensure the use of each element of the SUCCESS toolkit. Submit the final product to MSQC with your 2024 Project Summary (8 points).
   a. Continuing sites only: Include a narrative of how any processes and toolkit elements were modified from 2023. Also include in the modified care pathway the process of coudé catheter training and comfort of use by nurses, and how patients at higher risk for urinary catheter trauma are identified.

5. Perform a quality review of each case that meets any of the criteria below, new sites from 4/1/2024 to 12/1/2024 OR dates, continuing sites from 1/1/2024 to 12/1/2024 OR dates. An overall findings summary (trends identified, action plans implemented) should be submitted with your 2024 Project Summary (8 points).
   a. Patients in Category A who have an indwelling urinary catheter placed in the OR.
   b. Retention is assigned for patients who had a urinary catheter (ISC or indwelling) placed when < 300 ml is documented via a bladder scanner or the catheter use
   c. Patients who return to ED with Retention
   d. Patients who were discharged with an indwelling catheter or need for ISC
   e. Patients who have Urinary Catheter-Related Trauma assigned

6. Submit the 2024 SUCCESS Project Summary to the MSQC Coordinating Center no later than January 15, 2025. An additional 0-10 implementation points may be granted based on the detail of the project narrative, tracking log, and analysis; to be added to achieve the maximum of 40 project points.

* Category Definitions:
Category A: Avoid Placement: Avoid placing indwelling urinary catheter for these procedures: inappropriate to use a catheter or risks outweigh benefits (includes lap chole, lap/open appy, open groin hernia repair)
Category B: Remove in OR: Consider removing indwelling urinary catheter before leaving the operating room (includes open/lap abdominal hemicolectomy, open/lap transanal rectal tumor excision, open/lap enterectomy, ostomy, MIS groin/ventral hernia repair, open ventral hernia repair <3 hrs) ventral hernia repair >3 hrs)

Quality Improvement Implementation, Option B: Frailty
Project Time Period: 1/1/2024 – 12/31/2024

Background: Frailty develops through an accumulation of deficits over time that place patients at increased risk of suboptimal postoperative outcomes. Screening for frailty and discussion of the risks and benefits of moving forward with a surgical or non-surgical treatment pathway have been shown to improve both objective outcomes and patient satisfaction.

Project Goal and Summary: The 2024 frailty project will build on the work begun in 2023 which introduced a system to assess vulnerable patients for frailty using a validated screening tool with an informed discussion regarding the results of frailty screening during the surgical planning phase.

For 2024, the goal is to improve the surgical experience for patients identified as frail through interventions shown to potentially improve outcomes. This year will see an enhanced informed decision-making discussion with surgical candidates and caregivers and add interventions aimed at improving the surgical experience for candidates identified as frail. These interventions will include establishing patient overarching health goals and documenting this in the medical record, developing educational materials for patients and caregivers regarding care and expectations, and involvement of support persons throughout the surgical encounter to support those patients identified as frail.

QI Implementation Goals and Requirements (40 points total)

- *Continuing sites:* Measurement period is 1/1/2024-12/31/2024 OR dates
- *New sites:* Measurement period is 4/1/2024 to 12/31/2024 OR dates

1. Sites selecting the frailty pathway will collect MSQC data in the Frailty tab for eligible cases.

2. Hold three (3) multidisciplinary meetings. Submit minutes and attendees to the coordinating center with the final project submission (6 points):
    a. Kickoff meeting by March 29, 2024, to review project requirements and preliminary data. (2 points).
    b. Two (2) additional multidisciplinary meetings (minimally) before December 1, 2024, which include a review of data (2 points each).

3. Use of Frailty Tool for preoperative frailty screening in ≥ 75% of eligible patients (10 points). Sites will distribute and implement a frailty screening tool that will be completed during the preoperative planning period and be completed prior to the final decision to proceed with surgery on all elective surgery* patients meeting <u>any</u> of the following criteria:
    - Age ≥ 60 years on the day of surgery
    - Current dialysis as defined in MSQC core variable definitions.
    - Current cancer as defined in MSQC core variable definitions.
    - Functional health status identified as “Not Independent” in MSQC core variable definitions.
    - Current CHF as defined in MSQC core variable definitions.

    If frailty screening is not completed for a patient who qualifies:
    - The SCQR will discern the rationale for failure to use the frailty tool.
    - If this information is unavailable in the chart, the SCQR may also obtain this information by communication with office staff.

*A subset of participating surgeons may be identified if system-wide adoption is not feasible. This subset is to be defined using physician organization or affiliation. If a subset is to be used, a list of physicians who will be included in the data will be submitted when the quality improvement project declaration is provided to the coordinating center. All elective MSQC surgical cases performed by surgeons affiliated with the selected practice(s) will be assessed for use of the frailty screening tool.

4. A conversation between surgeon and patient/caregivers occurs for ≥ 75% of patients who screened as frail or pre-frail (7 points). The discussion will occur during the surgical planning process by a surgeon or an appropriate healthcare professional designee acting on behalf of the surgeon. This guided discussion and an attestation statement in the medical record are required and ensure that a conversation of the risks and benefits has taken place with the patient and/or caregivers.

   The conversation and attestation statement regarding frailty screening, goals, and surgical plan must include the following elements:
   1. General information on frailty
   2. Interpretation of the scoring results (pre-frail or frail) according to the frailty screening
   3. Discussion of the potential impact that frailty can have on surgical outcomes
   4. The participants in the discussion, i.e., patient, family, caregiver
   5. Any adjustments decided on in the plan of care (if applicable)

   Appropriate designees for this conversation are defined as:
   - An advanced practice provider (Nurse Practitioner or Physician Assistant) working in collaboration with the surgical team within the clinic setting.
   - A provider (MD, DO, NP, CRNA, or PA) acting in partnership with the surgical team to provide preoperative screening, evaluation, or treatment that may occur outside the surgical clinic, on a day prior to the surgical date to facilitate surgical planning.

5. Patient/caregiver goals for surgery are documented for ≥ 75% of patients who screened as frail or pre-frail (7 points).

6. Provide preoperatively patient and/or caregiver education (10 points) *measurement period 4/1/2024-12/31/2024 to ≥ 75% of patients who screen frail or pre-frail (positive for frailty). The education may be completed by the surgeon or an appropriate healthcare professional designee which may include a Registered Nurse or Advanced Practice provider and must
   - be provided verbally and in writing regarding the impact of frailty on surgical outcomes.
   - include how increased risk could be mediated pre- and postoperatively.

   Submit the educational materials that are being used to the MSQC coordinating center for approval by February 15, 2024.

7. Submit the 2024 Frailty Project Summary to the MSQC Coordinating Center no later than January 15, 2025. An additional 0-10 implementation points may be granted based on the detail of the project narrative, tracking log, and analysis; to be added to achieve the maximum of 40 project points.

Quality Improvement Implementation, Option C: Breast Surgical Quality Measures
Project Time Period: 1/1/2024-12/31/2024

Summary: This project focuses on improving the performance of evidence-based quality measures for patients undergoing partial mastectomy and mastectomy. MSQC began capturing breast surgery data in 2023, so this project will lay the groundwork and encourage engagement from the multidisciplinary team to promote high-quality treatment to improve short- and long-term outcomes.

Project Goals: Each site will designate a surgeon lead who performs breast surgery for this project who, along with the multidisciplinary team, will help disseminate information at the hospital, and be actively engaged in developing and implementing a care pathway that includes the perioperative QI implementation goals.

QI Implementation Goals and Requirements: (40 points total)

1. Data collection: For elective partial mastectomy and mastectomy surgical patients, participating hospitals will perform supplemental data collection that will allow the measurement of breast surgical quality.

2. Surgeon Champion: Each site will designate a surgeon champion who performs breast surgery to lead this project. The expectations are the surgeon lead will help the SCQR disseminate information at the hospital, be actively engaged in developing and implementing a care pathway, and be engaged with MSQC for the Breast Surgery QI project, which includes being a member of the Breast Care Committee meetings (either in person or virtual).

3. Multidisciplinary team (6 points total):
    a. Participating hospitals will form a multidisciplinary team to review baseline data, guide quality improvement plans, and implement the care pathway. The multidisciplinary team should include the breast cancer surgeon champion, other surgeons who perform breast cancer surgery, nursing, patient navigator, plastics and reconstructive, breast radiology and others as relevant.
    b. Hold a multidisciplinary meeting before March 29, 2024. Meeting notes, including attendees, must be submitted to the coordinating center with the final project submission. (2 points).
    c. Two (2) additional multidisciplinary meetings (minimally) before December 1, 2024, which include a review of breast data (2 points each).

4. Implement Breast Surgery Care Pathway (4 points): Within the multidisciplinary team, create and modify the care pathway template to your hospital's practices. This will be implemented and utilized by the care team beginning in the preoperative period and extending into the postoperative period to ensure the implementation of each element of the breast surgery care pathway. Submit the final product to MSQC.

5. Perioperative Process Goals (20 points): Implement all the following process measures for each elective breast surgical patient as detailed below. Measurement Period is 4/1/2024 – 12/31/2024.

   Preoperative Goals (8 points total)

   - 5a: Preadmission teaching that discusses expectations after surgery, including multimodal pain management ≥ 70%, discussion of opioid-free surgery (if applicable), and expected use of surgical drains (if applicable) (4 points)
   - 5b: Patient optimization discussion related to smoking cessation (if applicable) ≥ 80% (4 points)

   Intraoperative Goals (4 points total)

   - 5d: Use of intraoperative multimodal pain management ≥ 80% (4 points)

   Postoperative Goals (8 points total)

   - 5e: Postoperative order for multimodal pain management ≥ 70% (4 points)
   - 5f: Opioid prescriptions meeting M-OPEN recommendations ≥ 70% (4 points)

6. Cancer-Specific Goals (10 points): Sites will pick two goals to focus on that need improvement. Included diagnosis codes: Cancer and DCIS diagnoses which are listed in the breast tab of 2024 Program Manual. Measurement Period is 4/1/2024 – 12/31/2024.
   a. Preoperative MRI rate to ≤ 30%
   b. Reduction of use of SLNB in women >70 years old to ≤ 50%
   c. Reduction of re-excision rates for positive margin after lumpectomy to ≤ 15%
   d. Increase in the use of outpatient mastectomy to > 25%

7. Submit a QII Project Summary on or before January 15, 2025, which includes a narrative and activity tracking of the steps to implementation of the breast cancer surgery care pathway, successes and barriers, and analysis and next steps (a template will be available on the MSQC website). An additional 0-10 implementation points may be granted based on the detail of the project narrative, tracking log, and analysis, to be added to achieve the maximum of 40 project points.

Included CPT Codes:

CPT® Code	CPT® Description
19301	19301: Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19302	19302: Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	19303: Mastectomy, simple, complete
19305	19305: Mastectomy, radical, including pectoral muscles, axillary lymph nodes
19306	19306: Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
19307	19307: Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

Quality Improvement Implementation, Option D (by invitation only): Preoperative Testing for Low-Risk Surgeries
Project Time Period: 1/1/2024 – 12/31/2024

Background: The Preoperative Testing for Low-Risk Surgeries QII project is a cross-collaborative project between MSQC, the Michigan Value Collaborative (MVC) and the Michigan Program on Value Enhancement (MPrOVE). Routine preoperative testing before low-risk surgery has no known benefit and is an important target for de-implementation as it is overused, costly, and can lead to downstream care cascades involving invasive diagnostic testing[1].

As part of the Choosing Wisely® campaign the American Society of Anesthesiologists, Society of General Internal Medicine, American College of Surgeons (ACS), and the American Society for Clinical Pathology recommend against the use of routine laboratory studies before low-risk surgery (Table 1). Given the high prevalence of these services, eliminating unnecessary preoperative testing before low-risk surgery represents a key opportunity to improve quality, safety, and value in surgery. The pilot study in 2023, amongst MSQC participating sites, demonstrated wide variation in preoperative testing in low-risk surgeries, and continued work is needed.

Project Goal and Summary: In collaboration with MVC and MPrOVE, this project will continue to work toward reducing unnecessary, routine preoperative testing for low-risk surgeries, as well as implement interventions to heighten awareness and reduce variation among hospitals. Continuing sites who participated in the pilot project in 2023 are eligible if their average rate of preoperative testing is >20% from 4/1/2023 to 6/30/2023, and sites who did not select preoperative testing as their QII in 2023 will be eligible to participate.

Through a multi-faceted approach, invited sites will: 1) abstract preoperative testing variables on low-risk surgical cases, 2) implement a standard protocol defining appropriate use of preoperative testing, 3) employ strategies to promote adoption of the protocol, and 4) analyze MSQC, MVC, and internal data reports to monitor progress.

Eligible low-risk surgery cases will meet the procedure inclusion criteria:

- Minor hernia, laparoscopic cholecystectomy, and breast lumpectomy (Table 2), AND
- ASA classes 1 and 2, AND
- Surgical Priority = Elective, AND
- Surgical Procedure Tab: *Is the CPT code the intended primary procedure* = Yes

QI Implementation Goals and Requirements (40 total project points)
Goal #1: Data collection of 95% of preoperative tests for eligible procedures that were performed within 30 days prior to the surgery date, including obtained preoperatively on the day of surgery. The measurement period is 1/1/2024 – 12/31/2024 OR dates for all sites. (3 points)

The presence or absence of all of the following preoperative diagnostic tests on an eligible case must be captured in the MSQC Workstation to meet the numerator requirement:

- ECG
- Trans-thoracic echocardiography
- Cardiac stress test
- Chest Xray

- Urinalysis
- Complete blood count
- Basic metabolic panel
- Coagulation tests
- Pulmonary function tests

Goal #2 New sites only: Develop and implement a standard preoperative testing protocol for low-risk surgeries at your site. The protocol selected must be implemented no later than June 30, 2024. (20 total points)

- Goal 2a: Adopt a preoperative testing guideline protocol to implement at your site. Sites may choose the approach that fits best at their hospital. (10 points)
    - Adopt an existing protocol
        - American Society of Anesthesiologists' "Choosing Wisely" program (https://www.choosingwisely.org/clinician-lists/american-society-anesthesiologists- baseline-laboratory-studies-for-low-risk-surgery)
        - United Kingdom's NICE (National Institute for Health and Care Excellence) preoperative testing guidelines for elective surgery (https://www.nice.org.uk/guidance/ng45)
        - MPrOVE's "Waive the Workup" protocol https://sites.google.com/umich.edu/waivetheworkupmichigan/home\
    - Develop your own hospital preoperative testing protocol
    - Review and modify an existing protocol already in use at your hospital. You must also describe the process used for monitoring compliance, and interventions put into place to improve compliance.
    - Submit a copy of the preoperative testing protocol for low-risk surgery adopted by your hospital with your 2024 final project summary.
- Goal 2b: As part of the implementation process, sites must adopt clinical decision support tools to embed the preoperative testing protocol into practice. (10 points)
    - Examples of decision support tools selected for implementation include order sets, care pathways, CPOE pop-up messages/suggestions, BPA (Best Practice Advisory), documented inventory indicating review of existing order sets for concurrence with adopted testing guidelines. This list is not exhaustive.
    - Submit an example of at least one clinical decision support tool that was implemented or modified at your site with your 2024 final project summary.

Goal #2 Continuing sites only: include an in-depth analysis using a quality tool of your choice (e.g., A3, failure mode effects analysis, 5 Whys, Fishbone, etc.) with your 2024 final project summary of how the protocol and clinical decision support tools that were developed in the pilot year were modified or implemented differently to improve compliance with reducing preoperative testing. This should be completed with the multidisciplinary team early in the project year. (10 points)

Goal #3: Reduce the percentage of cases that receive one or more of the specified preoperative tests (as listed in Goal #1) by 20% (relative) as compared to the baseline rate, without having an increase of preoperative testing on the same day as surgery. (20 points continuing sites, 10 points new sites)

- Baseline period, continuing sites: 4/1/2023 – 12/31/2023 OR dates
- Baseline period, new sites: 1/1/2024 – 3/31/2024 OR dates
- Measurement period, all sites: 4/1/2024 – 12/31/2024 OR dates

Goal #4: Conduct a minimum of two multidisciplinary meetings with key stakeholders to review project requirements, implement project components and monitor project performance. (4 total points)

- Goal 4a: host a project kickoff meeting held no later than March 31, 2024. (2 points)

- Goal 4b: host at least one follow-up multidisciplinary meeting between July and December 2024 to discuss protocol implementation, progress and barriers to implementation, and monitoring of compliance data (including MVC and MSQC preoperative testing data). (2 points)
- Meeting participants must include a general surgeon, anesthesiologist, MSQC/Quality dept representation; additional attendees can also include the hospital's MVC Site Coordinator (if applicable), a primary care provider (PCP), a representative from the preoperative clinic (if applicable), a surgical resident, and others as appropriate for your site.
- Meetings can be in person, virtual, or hybrid (project information shared over email, or multiple one- on-one meetings do not count toward this requirement).
- Designate a specific member of the team to serve as the Preoperative Testing for Low-Risk Surgeries QII project Point of Contact (POC). The POC will receive updated preoperative testing reports from MVC (in addition to your hospital's MVC point of contact). The POC will be responsible for sharing MVC reports with team members. The site must provide MVC (email address TBD) and MSQC (MSQC- Info@med.umich.edu) with the project designee's contact information no later than April 14, 2024.
- For each meeting, submit the meeting minutes and attendee list (with attendee name, credentials, and department represented) with your 2024 final project summary.

Goal #5 Performance Data Monitoring: Brief feedback regarding the value of the MVC and MSQC data reports and how the data was utilized must be submitted with your 2024 final project summary. (1 point)

- Sites will use data from several sources to monitor the progress of the protocol implementation.
    - MVC Preoperative Testing Reports (distributed to the POC and the MVC Site Contact)
    - MSQC case abstraction data on preoperative testing
    - Internal hospital data collection for monitoring compliance and adoption of the preoperative testing protocol.

Goal #6: Submit an analysis on cases that received testing on the day of surgery, prior to In Room Time (2 points).

Goal #7: Submit the 2024 final project summary, due to the MSQC Coordinating Center no later than January 15, 2025.

- The QII project summary will be submitted using the template available on the Quality Improvement page of the MSQC website. The document will contain a narrative describing the adoption, implementation, and monitoring of a preoperative testing protocol for low-risk surgeries, along with successes, barriers, plans for moving forward with the project. Additional documents to be submitted with the summary include:
    - Copy of the preoperative testing protocol for low-risk surgery adopted by your hospital (from Goal 2a).
    - Example of at least one clinical decision support tool that was implemented at your site (from Goal 2b)
    - Continuing sites only: analysis using a quality tool of how the protocol and clinical decision support tools that were developed in the pilot year were modified or implemented differently to improve compliance with reducing preoperative testing (from Goal #2)
    - Meeting documents (minutes, participant list) from the project kickoff and subsequent follow- up multi-disciplinary meetings held during the project year (from Goal #4)
    - Feedback on the MVC and MSQC data reports (from Goal #5)
    - Analysis of cases with testing on day of surgery (from Goal #6)

Implementation Points
An additional 0-10 implementation points may be granted based on the detail of the project narrative, tracking log and analysis, to be added to achieve the maximum of 40 project points.

Table 1. Selected Choosing Wisely® Recommendations for Preoperative Testing by Professional Society	
Professional Society	Recommendation
American Society of Anesthesiologists	Don't obtain baseline laboratory studies in patients without significant systemic disease undergoing low-risk surgery—specifically completed blood counts, metabolic panels, or coagulation studies. Don't obtain baseline diagnostic cardiac testing (e.g., echocardiography) in asymptomatic stable patients with known cardiac disease undergoing low or moderate risk surgery.
Society of General Internal Medicine	Don't perform routine pre-operative testing before low-risk surgical procedures.
American College of Surgeons	Avoid preoperative chest x-rays for ambulatory patients with unremarkable history and physical exam.
American Academy of Ophthalmology	Don't perform preoperative medical tests for eye surgery unless there are specific medical indications.
American Society for Clinical Pathology	Avoid routine preoperative testing for low-risk surgeries without a clinical indication.

Table 2. Eligible Pilot Study CPT codes	
Abdominal Hernias less than 3 cm and all Inguinal/Femoral Hernia Repairs ("Minor Hernia")	
49505	49505: Repair initial inguinal hernia, age 5 years or older; reducible.
49507	49507: Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated.
49520	49520: Repair recurrent inguinal hernia, any age; reducible.
49521	49521: Repair recurrent inguinal hernia, any age; incarcerated or strangulated.
49525	49525: Repair inguinal hernia, sliding, any age.
49550	49550: Repair initial femoral hernia, any age; reducible.
49553	49553: Repair initial femoral hernia, any age; incarcerated or strangulated.
49555	49555: Repair recurrent femoral hernia; reducible.
49557	49557: Repair recurrent femoral hernia; incarcerated or strangulated.
49591	49591: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
49592	49592: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated

49613	49613: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
49614	49614: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated
49650	49650: Laparoscopy, surgical; repair initial inguinal hernia
49651	49651: Laparoscopy, surgical; repair recurrent inguinal hernia
49659	49659: Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy.
Laparoscopic Cholecystectomy	
47562	47562: Laparoscopy, surgical; cholecystectomy
47563	47563: Laparoscopy, surgical; cholecystectomy with cholangiography
47564	47564: Laparoscopy, surgical; cholecystectomy with exploration of common duct
Breast Lumpectomy/Partial Mastectomy	
19301	19301: Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)

Resources

- Berlin NL, Yost ML, Cheng B, et al. Patterns and Determinants of Low-Value Preoperative Testing in Michigan. *JAMA Intern Med.* 2021;181(8):1115–1118. doi:10.1001/jamainternmed.2021.1653
- https://ihpi.umich.edu/featured-work/michigan-program-value-enhancement
- https://ihpi.umich.edu/news/routine-testing-surgery-remains-common-despite-low-value
- https://michiganvalue.org/our-work/mvc-value-coalition-campaigns-vccs/

References

[1]Berlin NL, Yost ML, Cheng B, et al. Patterns and Determinants of Low-Value Preoperative Testing in Michigan. *JAMA Intern Med.* 2021;181(8):1115–1118. doi:10.1001/jamainternmed.2021.1653

2024 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital - Year 1** Measurement Period: 10/01/2023-09/30/2024, unless otherwise stated			
Measure #	Weight	Measure Description	Points
Participation measures are based on calendar year meetings, calls, and audit (1/1/24 - 12/31/24).			
1	15%	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	15
		Attended 2 out of 3 meetings	10
		Attended 1 out of 3 meetings	5
		No Attendance	0
2	10%	**Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that <u>each</u> MSSIC Abstractor be present at MSSIC meetings and <u>all</u> abstractors are required to attend the Annual Abstractor Symposium.)**	
		Attended all 4	10
		Attended 3 out of 4	6
		Attended 2 out of 4	3
		Attend 1 or none	0
3	15%	**Conference Calls Surgeon Champion (3 calls/year)**	
		Attended 3 calls	15
		Attended 2 calls	10
		Attended 1 call	5
		No Calls	0
4	10%	**Conference Calls - Clinical Data Abstractor (8 calls/year)**	
		Participate on 8 calls	10
		Participate on 7 calls	6
		Participate on 6 calls	3
		Participate on less than 6 calls	0
5	10%	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one triannual MSSIC meeting	10
		No Attendance	0
6	10%	**Annual Audit Review – Data Review: Accuracy of data –**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
7	15%	**All official documents signed: IRB and Business Associate Agreement**	

2024 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital - Year 1** Measurement Period: 10/01/2023-09/30/2024, unless otherwise stated			
Measure #	Weight	Measure Description	Points
		Within 2 months of Coordinating Center approval date to proceed	15
		Within 3 months of Coordinating Center approval date to proceed	12
		Within 4 months of Coordinating Center approval date to proceed	8
		Within 5 months of Coordinating Center approval date to proceed	4
		6 or more months of Coordinating Center approval date to proceed	0
8	15%	**Hire Data Abstractor in a timely manner**	
		Within 2 months of Coordinating Center approval date to proceed	15
		Within 3 months of Coordinating Center approval date to proceed	12
		Within 4 months of Coordinating Center approval date to proceed	8
		Within 5 months of Coordinating Center approval date to proceed	4
		6 or more months of Coordinating Center approval date to proceed	0

Michigan Spine Surgery Improvement Collaborative (MSSIC)

2024 Performance Index Scorecard Measure Explanation:

Hospital Year 1

Measure number and description	Additional narrative describing the measure
Participation measures are based on calendar year meetings, calls, and audit (1/1/24 - 12/31/24).	
#1 - Meeting participation - Surgeon Champion: Three meetings per calendar year:	• April 26, 2024 • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#2 - Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that each MSSIC Abstractor be present at MSSIC meetings, and all abstractors are required to attend the Annual Abstractor Symposium.) Three meetings and Annual Abstractor Symposium per calendar year:	• April 26, 2024 • May 17, 2024 (Annual Abstractor Symposium) • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#3 - Conference Calls Surgeon Champion (3 calls per year)	Please refer to the 2024 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#4 - Conference Calls - Clinical Data Abstractor (8 calls per year)	Please refer to the 2024 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#5 - Meeting participation - Administrative Lead (no designee), at least one meeting per year.	• April 26, 2024 • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
#7 - All official documents signed: IRB and Business Associate Agreement	All required documents signed and returned to the MSSIC Program Manager. The timeframe associated with points earned begins with the email date from the

	MSSIC Program Manager notifying the site of approval to proceed with documents & hire.
#8 - Hire Data Abstractor in a timely manner	It is the site's responsibility to notify the MSSIC Program Manager, in writing, when the data abstractor is hired. A start date for the abstractor must also be communicated. The timeframe associated with points earned begins with the email date from the MSSIC Program Manager notifying the site of approval to proceed with documents & hire.

MSSIC Patient questionnaires: Questionnaires are an essential data element and collection is expected and required as a condition of participation, described in the Eligibility and Expectations document. MSSIC defines a complete case as a fully abstracted medical record and entry into the registry as well as the collection and entry into the registry of a completed baseline questionnaire. All spine patients are asked to complete a validated health status questionnaire prior to surgery and then sampled patients in the MSSIC registry are asked to complete validated health status questionnaires at 3, 12, and 24 months after surgery. Each participating site is responsible for collecting this information. Patient-reported Outcome (PRO) data is an important measure of success for Quality Improvement Initiatives (QII).

2024 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 2 (1 site)** Measurement Period: 10/01/2023-09/30/2024, unless otherwise stated			
Measure #	Weight	Measure Description	Points
Participation measures are based on calendar year meetings, calls, and audit (1/1/24 - 12/31/24).			
1	15%	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	15
		Attended 2 out of 3 meetings	10
		Attended 1 out of 3 meetings	5
		No Attendance	0
2	15%	**Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that <u>each</u> MSSIC Abstractor be present at MSSIC meetings and <u>all</u> abstractors are required to attend the Annual Abstractor Symposium.)**	
		Attended all 4	15
		Attended 3 out of 4	10
		Attended 2 or less	0
3	15%	**Conference Calls - Surgeon Champion (3 calls/year)**	
		Attended 3 calls	15
		Attended 2 calls	10
		Attended 1 call	5
		No Calls	0
4	10%	**Conference Calls - Clinical Data Abstractor (8 calls/year)**	
		Participate on 8 calls	10
		Participate on 7 calls	6
		Participate on 6 calls	3
		Participate on less than 6 calls	0
5	15%	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one triannual MSSIC meeting	15
		No Attendance	0
6	10%	**Annual Audit Review – Data Review: Accuracy of data -**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
Enhanced Recovery After Surgery (ERAS), Phase 1 Performance Measures - (20 points below)			
7	5%	**Demonstration of multidisciplinary team engagement through the submission of quarterly meeting attendance sheet and minutes supporting discussion and establishment of ERAS.**	
		4/4 meeting submissions	5
		3/4 meeting submissions	3
		2 or less/4 meeting submissions	0

2024 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 2 (1 site)** Measurement Period: 10/01/2023-09/30/2024, unless otherwise stated			
Measure #	Weight	Measure Description	Points
8	15%	**No later than 9/30/24, each site will have submitted and obtained approval by the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program:**	
		ERAS protocol document outlining how each required component will be implemented. Template provided by the Coordinating Center.	7
		Submission of all ERAS supporting documents including pre-surgical patient education, order sets, protocols, applicable screen shots from EMR, discharge instructions, and risk-assessment tools implemented in support of the ERAS program.	8

Michigan Spine Surgery Improvement Collaborative (MSSIC)

2024 Performance Index Scorecard Measure Explanation:

Hospital & ASF Year 2

Measure number and description	Additional narrative describing the measure
Participation measures are based on calendar year meetings, calls, and audit (1/1/24 - 12/31/24).	
#1 - Meeting participation - Surgeon Champion: Three meetings per calendar year:	• April 26, 2024 • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#2 - Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that each MSSIC Abstractor be present at MSSIC meetings, and all abstractors are required to attend the Annual Abstractor Symposium.) Three meetings and Annual Abstractor Symposium per calendar year:	• April 26, 2024 • May 17, 2024 (Annual Abstractor Symposium) • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#3 - Conference Calls Surgeon Champion (3 calls per year)	Please refer to the 2024 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#4 - Conference Calls - Clinical Data Abstractor (8 calls per year)	Please refer to the 2024 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#5 - Meeting participation - Administrative Lead (no designee), at least one meeting per year.	• April 26, 2024 • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
Enhanced Recovery After Surgery (ERAS), Phase 1 Performance Measures	
#7 - Demonstration of multidisciplinary team	During ERAS, Phase 1, Year 2 sites will demonstrate site engagement through the submission of quarterly meeting

engagement through the submission of quarterly meeting attendance sheet and minutes supporting discussion and establishment of ERAS.	attendance and minutes which support the development and implementation of ERAS. The Coordinating Center will supply a "MSSIC Quarterly ERAS Meeting Minutes" template for sites to communicate meeting discussions concisely and provide a list of meeting attendees. Content should be high-level, and we are only interested in ERAS related discussion. The due dates for the **four deliverables** are as follows: • Meeting between October 1 – December 31, 2023. **Submit form by January 5, 2024.** • Meeting between January 1 – March 31, 2024. **Submit form by April 5, 2024.** • Meeting between April 1 – June 30, 2024. **Submit form by July 5, 2024.** • Meeting between July 1 – September 30, 2024. **Submit form by October 5, 2024.**
#8 - No later than 9/30/24, each site will have submitted and obtained approval by the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program:	• MSSIC ERAS Protocol Document (template provided by the Coordinating Center) outlining the process of how each required component will be implemented at the site. The content should be high-level, and the template will provide fields for specific information that is requested. • Submission of applicable ERAS supporting documents: ○ Order sets, protocols, pre-surgical patient education (booklets, class PowerPoints, online education links, etc.) and risk-assessment tools implemented in support of the ERAS program. These supporting documents will also be listed in each section of the ERAS Protocol Document to assist you.

MSSIC Patient questionnaires: Questionnaires are an essential data element and collection is expected and required as a condition of participation, described in the Eligibility and Expectations document. MSSIC defines a complete case as a fully abstracted medical record and entry into the registry as well as the collection and entry into the registry of a completed baseline questionnaire. All spine patients are asked to complete a validated health status questionnaire prior to surgery and then sampled patients in the MSSIC registry are asked to complete validated health status questionnaires at 3, 12, and 24 months after surgery. Each participating site is responsible for collecting this information. Patient-reported Outcome (PRO) data is an important measure of success for Quality Improvement Initiatives (QII).

2024 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older (29 sites)** Measurement Period: 10/01/2023-09/30/2024, unless otherwise stated			
Measure #	Weight	Measure Description	Points
Participation measures are based on calendar year meetings, calls, and audit (1/1/24 - 12/31/24).			
1	5%	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended 1 out of 3 meetings	1
		No Attendance	0
2	3%	**Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that <u>each</u> MSSIC Abstractor be present at MSSIC meetings and <u>all</u> abstractors are required to attend the Annual Abstractor Symposium.)**	
		Attended all 4	3
		Attended 3 out of 4	2
		Attended 2 or less	0
3	5%	**Conference Calls - Surgeon Champion (3 calls/year)**	
		Attended 3 calls	5
		Attended 2 calls	3
		Attended 1 call	1
		No Calls	0
4	3%	**Conference Calls - Clinical Data Abstractor (8 calls/year)**	
		Participate on 8 calls	3
		Participate on 7 calls	2
		Participate on 6 calls	1
		Participate on less than 6 calls	0
5	4%	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one triannual MSSIC meeting	4
		No Attendance	0
6	10%	**Annual Audit Review – Data Review: Accuracy of data -**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
7	5%	**Each site: Dual collection rate of both a baseline and 90-day questionnaire (rounded to the nearest whole number) for cases with due dates 1/1/24 – 12/31/24.**	
		Dual collection rate of 66% or more **OR** ≥ 20 percentage points of absolute improvement in the site's 2022 dual collection rate	5

2024 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older (29 sites)** Measurement Period: 10/01/2023-09/30/2024, unless otherwise stated			
Measure #	Weight	Measure Description	Points
		Dual collection rate of 51%-65% **OR** 10-19 percentage points of absolute improvement in the site's 2022 dual collection rate	3
		Dual collection rate of less than 50% AND < 10 percentage points of absolute improvement in the site's 2022 dual collection rate	0
8	5%	**Each site: Dual collection rate of both a baseline and 1-year questionnaire (rounded to the nearest whole number) for cases with 1 year questionnaire due dates 1/1/24 – 12/31/24.**	
		Dual collection rate of 45% or more **OR ≥** 15 percentage points of absolute improvement in the site's 2022 dual collection rate	5
		Dual collection rate of 36%-44% **OR** 10-14 percentage points of absolute improvement in the site's 2022 dual collection rate.	3
		Dual collection rate of < 36% AND less than 10 percentage points of absolute improvement in the site's 2022 dual collection rate.	0
9	20%	**Collaborative-wide measure: % of Opioid naïve, 1-2 level lumbar fusions meeting the MSSIC Opioid Prescribing guideline (≤ 320 MME) (score rounded to the nearest whole number)**	
		80% or greater meeting the guideline of ≤ 320 MME or less	20
		65-79% of patients meet the guideline of ≤ 320 MME or less	10
		Less than 65% of patients meet the guideline of ≤ 320 MME or less	0
10	20%	**Demonstration of compliance for the following 3 MSSIC ERAS components:** *Baseline rate is determined using cases with surgery dates 7/1/22-6/30/23.	
		1. Formal, pre-operative patient education that does not vary from surgeon to surgeon and is available to all spine patients	
		80% or greater, **OR** ≥ 25 percentage points of absolute improvement in the *baseline rate	8
		50%-79%, **OR** 15-24 percentage points of absolute improvement from *baseline rate	4
		<50%, **OR** < 15 percentage points of absolute improvement from *baseline rate	0
		2. Limited fasting with a carbohydrate-rich drink up to two hours before surgery	

2024 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older (29 sites)** Measurement Period: 10/01/2023-09/30/2024, unless otherwise stated			
Measure #	Weight	Measure Description	Points
		80% or greater, **OR** ≥ 25 percentage points of absolute improvement in the *baseline rate	8
		50%-79%, **OR** 15-24 percentage points of absolute improvement from *baseline rate	4
		<50%, **OR** < 15 percentage points of absolute improvement from *baseline rate	0
		3. Ambulation within 8 hours of surgery stop time	
		80% or greater, **OR** ≥ 25 percentage points of absolute improvement in the *baseline rate	4
		60%-79%, **OR** 15-24 percentage points of absolute improvement from *baseline rate	2
		<60%, **OR** < 15 percentage points of absolute improvement from *baseline rate	0
11	20	**Site Specific: Implementation of one Quality Improvement Initiative** using MSSIC data. Sites may choose a site-specific initiative and submit it to the Coordinating Center no later than 9/8/23 for approval. The percentage goal of improvement is determined by the Coordinating Center and is communicated to the site via email after approval.	
		The QI Plan was developed, implemented and there was improvement in the target goal. In addition, both QI Reports were submitted on time. The breakdown is as follows:	
		Site met 100% or greater of the target goal	20
		Site met 75-99% of the target goal	18
		Site met 50-74% of the target goal	16
		Site met 1-49% of the target goal	14
		The QI Plan was developed and implemented, but there was no improvement to the target goal. In addition, both QI reports were submitted on time.	12
		The QI Plan was developed, implemented, and improvement could even have been made, but one of the QI reports was not submitted on time.	6
		The QI Plan was not developed or implemented; **or** both QI reports were not submitted on time.	0

2024 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older (29 sites)** Measurement Period: 10/01/2023-09/30/2024, unless otherwise stated			
Measure #	Weight	Measure Description	Points
12	**Bonus**	**<u>Optional Bonus Performance Points</u>:** Bonus points are awarded to sites with above and beyond engagement and QI work as demonstrated by any of the following Coordinating Center approved activities: 1.) Host a MSSIC site visit 2.) Participate in, or develop and implement, an approved MSSIC pilot 3.) Complete an additional, approved site-level QI initiative and submit a MSSIC QI report template describing the initiative (see Support Document). 4.) Submit all 4 quarterly meeting minutes where multidisciplinary team (see Support Document) engagement is shown and MSSIC data and QI initiatives are being discussed (see Support Document). **(*Sites will not exceed 100%. The bonus performance measure will only assist where points were lost on other performance measures.)**	10

Michigan Spine Surgery Improvement Collaborative (MSSIC)

2024 Performance Index Scorecard Measure Explanation:
Hospital & ASF Year 3 & Older

Measure number and description	Additional narrative describing the measure
Participation measures are based on calendar year meetings, calls, and audit (1/1/24 - 12/31/24).	
#1 - Meeting participation - Surgeon Champion: Three meetings per calendar year:	• April 26, 2024 • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#2 - Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that each MSSIC Abstractor be present at MSSIC meetings, and all abstractors are required to attend the Annual Abstractor Symposium.) Three meetings and Abstractor Symposium:	• April 26, 2024 • May 17, 2024 (Annual Abstractor Symposium) • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#3 - Conference Calls Surgeon Champion (3 calls per year)	Please refer to the 2024 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#4 - Conference Calls - Clinical Data Abstractor (8 calls per year)	Please refer to the 2024 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#5 - Meeting participation - Administrative Lead (no designee), at least one meeting per year.	• April 26, 2024 • August 9, 2024 (virtual) • November 8, 2024 Please refer to the 2024 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
#7 - Each site: Dual collection rate of both a baseline and 90-day questionnaire (rounded to the nearest whole number) for	MSSIC has modified its patient survey collection performance metric to help improve patient-reported outcomes data collection and quality. To measure change in patients and see if they improved in pain or physical

cases with due dates 1/1/24 – 12/31/24.	function - both a baseline survey and a post-operative survey must be collected. Sites will maintain responsibility for collecting post-op surveys for all sampled patients (including those without a baseline) at all time periods, however the performance metric will target patients with pre and post surveys. Collection of post-operative surveys, even when the baseline is missing, is still critical for MSSIC data as it shares information on items like satisfaction, opioid usage, and return to work.
#8 - Each site: Dual collection rate of both a baseline and 1-year questionnaire (rounded to the nearest whole number) for cases with 1 year questionnaire due dates 1/1/24 – 12/31/24.	See explanation above for Measure #7.
#9 - Collaborative-wide measure: % of Opioid naïve, 1-2 level lumbar fusions meeting the MSSIC Opioid Prescribing guideline (≤ 320 MME). (Rounded to the nearest whole number.)	In recent years, MSSIC has collaborated the BCBSM CQI, Michigan-OPEN (https://michigan-open.org), whose mission is to support providers in combating opioid misuse. Both MSSIC data and the literature, including a study out of Mayo Clinic, support the judicious use of opiates as beneficial. Our data shows there is no evidence of decreased satisfaction or increased healthcare utilization with less prescribing. MSSIC analysis also showed a great deal of site variability in opioid prescribing patterns which represents an opportunity to make positive changes for opioid naïve patients. In 2023, MSSIC successfully implemented discharge prescribing guidelines in opioid naïve patients having 1-2 level lumbar decompression or 1-2 level Anterior Cervical fusion or arthroplasty. MSSIC Leadership and the MSSIC Executive Committee agreed that our opioid prescribing guidelines at discharge should be expanded to include lumbar fusion, 1-2 levels in 2024. It makes sense to broaden our scope of impact when it comes to discharge prescribing practices with opioid naïve patients.
#10 - Demonstration of compliance for the following 3 MSSIC ERAS components (*Baseline rate is determined using cases with surgery dates 7/1/22-6/30/23): 1.) Formal, pre-operative patient education that does not vary from surgeon to surgeon and is available to all spine patients	**Demonstration of compliance for the following 3 MSSIC ERAS components:** 1.) Formal, pre-operative patient education that does not vary from surgeon to surgeon and is available to all spine patients. For a site to mark “yes” for this variable, the patient must participate in that site’s MSSIC approved, ERAS pre-operative patient education program. The aim is to educate the patient about ERAS protocols, to set realistic expectations for postoperative recovery, and to psychologically prepare the patient and family for the care program. Written and oral information must be taught and should be provided in detail. Patients that are

2.) Limited fasting with a carbohydrate-rich drink up to two hours before surgery 3.) Ambulation within 8 hours of surgery stop time	admitted emergently as defined in the Master Variable List are excluded from the denominator. 2.) Limited fasting with a carbohydrate-rich drink up to two hours before surgery. Carbohydrate loading not only reduces insulin resistance but also improves muscle function by reducing nitrogen and protein loss. It is also associated with reduce preoperative thirst, hunger, and anxiety. Patients that are admitted emergently as defined in the Master Variable List, or are a Type 1 Diabetic, or are a Type 2 on insulin are excluded from the denominator. 3.) Ambulation within 8 hours of surgery stop time. Literature review of Enhanced Recovery After Surgery (ERAS) protocols, specific for spine surgery, all strongly support early ambulation as defined within hours of surgery stop time. A recently published MSSIC study correlated ambulation within 8 hours of spine surgery with fewer adverse events and improved outcomes. Exclusions from the denominator include wheelchair bound (non-ambulatory) before surgery, CSF leak, durotomy, and fusions four levels or greater.
#11- Site Specific: Implementation of one Quality Improvement Initiative using MSSIC data. Sites may choose a site-specific initiative and submit it to the Coordinating Center no later than 9/8/23 for approval. The Coordinating Center will determine the percentage goal of improvement and is communicated to the site via email after approval.	No later than **9/8/23**, sites will **submit for approval**, a QII proposal to the Coordinating Center using the MSSIC Site-specific QI Project Submission Form. The measurement period for improvement is 10/1/23-9/30/24. Utilizing the MSSIC QI Report template, sites are to **submit progress reports twice a year** to communicate the project's development and movement. **Sections 1-9 are due May 31, 2024**, and the **complete MSSIC QI Report, including the outcome of the project, is due January 31, 2025**.
#12- **Optional, Bonus Performance Points**: Bonus points are awarded to sites with above and beyond engagement and/or QI work as demonstrated by any of the following Coordinating Center approved activities: 1.) Host a MSSIC site visit 2.) Participate in, or develop and implement, an approved MSSIC pilot 3.) Complete an additional, approved site-level QI initiative and submit a MSSIC QI report template describing the initiative	You can earn ten bonus points. The bonus is all or nothing. Descriptions for each numbered "Bonus" activity: 1.) A fully executed, in-person site visit must take place between 10/1/23-9/30/24. Sites will contact the MSSIC QI team to coordinate the details and obtain approval for the visit. It may be either a MSSIC Coordinating Center site visit or an expanded site visit where additional MSSIC sites are guests. 2.) Please contact the MSSIC QI team with a site-level pilot proposal or if interested in a pilot offered by the Coordinating Center. **3.)** No later than 1/1/24, sites will submit for approval, an additional QII proposal to the Coordinating Center using the MSSIC Site-specific QI Project Submission Form. The Coordinating Center will determine the percentage goal of improvement. There must be at least nine full months of data in the measurement

4.) Submit all four quarterly meeting minutes where multidisciplinary team (see Support Document) engagement is shown and MSSIC data and QI initiatives are being discussed	period to determine the outcome, ending with OR date 9/30/24. Sections 1-9 are due three months after project approval and the final MSSIC QI Report is due no later than January 31, 2025. **A site must submit all QI reports on time and achieve at least 75% or greater of their goal in order to obtain bonus points.** 4.) Sites will demonstrate, through the submission of quarterly meeting minutes and multidisciplinary attendance, MSSIC QI initiative discussion, and the sharing of MSSIC data. The Coordinating Center will supply a "MSSIC Quarterly Meeting Minutes" template for sites to communicate meeting discussions concisely and provide a list of meeting attendees. Content should be high-level, and we are only interested in MSSIC related discussion. All four due dates must be met to receive credit. The due dates for the **four deliverables** are as follows: • Meeting between October 1 – December 31, 2023. **Submit form by January 5, 2024.** • Meeting between January 1 – March 31, 2024. **Submit form by April 5, 2024.** • Meeting between April 1 – June 30, 2024. **Submit form by July 5, 2024.** • Meeting between July 1 – September 30, 2024. **Submit form by October 5, 2024.**
***Sites will not exceed 100% on the Performance Index. The bonus performance measure will only add ten points where points were lost on other performance measures. It will not assist where points were lost on participation measures.**	

Performance Improvement Plans: Sites performing at or below the zero-point threshold for any performance measure will be asked to complete a Performance Improvement Plan (PIP). The PIP will be used to guide additional coaching and determine the most helpful means of support and resources to the site.

MSSIC Patient questionnaires: Questionnaires are an essential data element and collection is expected and required as a condition of participation, described in the Eligibility and Expectations document. MSSIC defines a complete case as a fully abstracted medical record and entry into the registry as well as the collection and entry into the registry of a completed baseline questionnaire. All spine patients are asked to complete a validated health status questionnaire prior to surgery and then sampled patients in the MSSIC registry are asked to complete validated health status questionnaires at 3, 12, and 24 months after surgery. Each participating site is responsible for collecting this information. Patient-reported Outcome (PRO) data is an important measure of success for Quality Improvement Initiatives (QII).

2024 Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
1	10	**Accuracy of Data**	
		5-star audit score	10
		4-star audit score	8
		3-star audit score	6
		≤ 2-star audit score	0
2	8	**Quarterly collaborative meeting participation – Surgeon and Data Manager Combined Attendance (January 1, 2024–December 31, 2024)**	
		Surgeon and data manager attended 4 quarterly meetings	8
		Surgeon and data manager attended 3 quarterly meetings	6
		Surgeon and data manager attended 2 quarterly meetings	4
		Surgeon and data manager attended 1 quarterly meeting	2
		Attended 0 quarterly meetings	0
3	4	**Quarterly collaborative meeting participation – Alternate Surgeon (January 1, 2024–December 31, 2024)**	
		Alternate surgeon attended 1 quarterly meeting	4
		Alternate surgeon attended 0 quarterly meetings	0
		** Alternate surgeon performs cardiac surgery at the site and is not the physician champion*	
4	4	**Quarterly data manager educational meeting - Data Manager (January 1, 2024–December 31, 2024)**	
		Attended 4 data manager meetings	4
		Attended 3 data manager meetings	3
		Attended 2 data manager meetings	2
		Attended 1 data manager meeting	1
		Attended 0 data manager meetings	0
5	4	**Quarterly PERForm educational meeting - Perfusionist (January 1, 2024–December 31, 2024) ***	
		Attended 3 PERForm meetings + Data Quality Report Submission	4
		Attended 2 PERForm meetings + Data Quality Report Submission	3
		Attended 1 PERForm meetings + Data Quality Report Submission	2
		Attended 0 PERForm meetings	0
6	15	**Collaborative-wide quality initiative 2024: Isolated CABG – Initial Ventilator Hours <6 (January 1, 2024–December 31, 2024)**	
		Collaborative mean Initial Ventilator Hours <6 rate 70% or greater	15
		Collaborative mean Initial Ventilator Hours <6 rate less than 70%	0

2024 Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
7	15	**Site specific quality initiative**	
		Met improvement goal	15
		Improved but did not meet goal	10
		Implemented plan but did not improve	5
		Improved but unable to implement plan or did not submit plan/progress report	0
8	20	**Isolated CAB: O/E mortality for 12 months (January 1, 2024–December 31, 2024)**	
		O/E ≤ 1.0	20
		O/E ≤ 1.5	10
		O/E > 1.5	0
9	20	**Isolated Valve +/- CAB Mortality and Major Morbidity OE for 36 months (January 1, 2022–December 31, 2024)**	
		O/E ≤ 1.0	20
		O/E ≤ 1.5	10
		O/E > 1.5	0
10		**Extra Credit Opportunities: 1 point per approved activity for surgeons**	
* Data Quality Reports are a new on line tool with no baseline to report			

2024 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
1	10	**Data Submission** **Measurement period: 01/01/2024 – 12/31/2024**	
		On time and complete 3 of 3 times	10
		On time and complete 2 of 3 times	5
		On time and complete 1 of 3 times	0
2	10	**Meeting Participation** **Measurement period: 01/01/2024 – 12/31/2024**	
		Surgeon, and Manager (TPM) or Abstractor (MCR) attend 3 of 3 mtgs	9
		Surgeon, and Manager (TPM) or Abstractor (MCR) attend in 2 of 3 mtgs	6
		Surgeon, and Manager (TPM) or Abstractor (MCR) attend 0-1 of 3 mtgs	0
		Registrar or Abstractor (MCR) attend annual data abstractor mtg	1
3	10	**Data Validation Error Rate** **Measurement period: 01/01/2024 – 12/31/2024**	
		0-3.0%	10
		3.1-4.0%	8
		4.1-5.0%	5
		> 5.0%	0
4	5	**Performance Improvement (PI)Death Determination Documentation (defined as number of cases/people the hospital misses (does not submit) a PI death determination)** **Measurement period: 07/01/2023 – 06/30/2024**	
		0-2 Missing Documentation	5
		3-4 Missing Documentation	3
		> 4 Missing Documentation	0
5a	8	**Timely Low Molecular Weight Heparin (LMWH) Venous Thromboembolism (VTE) Prophylaxis Trauma Admits** **Measurement period: 07/01/2023 – 06/30/2024**	
		≥ 52.5% of patients (≤ 48 hr)	8
		≥ 50.0% of patients (≤ 48 hr)	6
		≥ 45.0% of patients (≤ 48 hr)	3
		< 45.0% of patients (≤ 48 hr)	0
5b	2	**Weight Based LMWH Protocol in Use** **Measurement period: 07/01/2023 – 06/30/2024**	
		Yes	2
		No	0
6	10	**Timely Surgical Repair Geriatric (Age ≥ 65) Isolated Hip Fracture (Fx)** **Measurement period: 07/01/2023 – 06/30/2024**	
		≥ 92.0% of patients (≤ 42 hr)	10

2024 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
		≥ 87.0% of patients (≤ 42 hr)	8
		≥ 85.0% of patients (≤ 42 hr)	5
		< 85.0% of patients (≤ 42 hr)	0
7	10	**RBC to Plasma Ratio in Massive Transfusion** **Measurement period: 01/01/2023- 06/30/2024**	
		Weighted Mean Points in Patients Transfused ≥ 5 Units 1st 4 hr	0-10
8	10	**Serious Complication Z-Score Trend Trauma Admits** **Measurement period: 07/01/2021- 06/30/2024**	
		< -1 (major improvement)	10
		-1 to 1 or serious complications low-outlier (average or better rate)	7
		> 1 (rates of serious complications increased)	5
9	10	**Mortality Z-Score Trend Trauma Admits** **Measurement period: 07/01/2021- 06/30/2024**	
		< -1 (major improvement)	10
		-1 to 1 or mortality low-outlier (average or better)	7
		> 1 (rates of mortality increased)	5
10	5	**Patient Reported Outcomes Participation** **Measurement period: 07/01/2023 – 06/30/2024**	
		Signed agreement and >90% of patients contact information submitted	5
		No agreement OR Signed agreement and <90% of patients contact information submitted	0
11	10	**Collaborative: Timely Antibiotic Femur/Tibia Open Fx** **Measurement period: 07/01/2023 - 06/30/2024**	
		≥ 85% patients (≤ 90 min)	10
		< 85% patients (≤ 90 min)	0
		Total	100

2024 MTQIP P4P PI Scorecard Supporting Documentation

Measure 1: Data Submission: Partial/incomplete submissions receive no points. Complete data submission is defined as all cases submitted for the requested interval. To be considered complete, cohort 1 cases should have a missing rate of <10% for first name, last name, and MRN variables for 1/1/20 cases forward.

Measure 2: Meeting Participation: A surgeon may represent one trauma center only. Alternate surgeons are allowed but must be consistent (not rotating). The alternate surgeon must be an attending-level equivalent from the trauma call panel.

Measure 3: Data Validation Error Rate:

Centers not selected for validation this year will receive full points. Centers that are selected but do not schedule a visit will receive 0 points for the validation measure.

Measure 7: RBC to Plasma Ratio in Massive Transfusion

Step 1: Assign (weight) to each MTP patient's 4 hr PRBC/FPP ratio to the designated tier and points using the chart below.

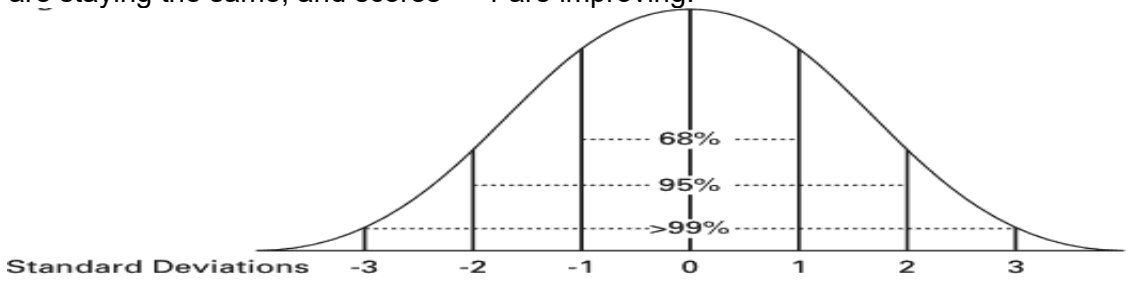
Step 2: Add the points and divide by the number of patients (weighted average). See the example below:

Step One		
PRBC to Plasma Ratio	Tier	Points
<1.5	1	10
1.6 – 2.0	2	10
2.1 – 2.5	3	5
>2.5	4	0

Step Two (Example)					
Patient	PRBC	FFP	PRBC/FFP	Tier	Points
1	10	10	1.0	1	10
2	5	2	2.5	3	5
3	9	2	4.5	4	0
					Total 15
Total Points/Total #Patients = 15/3 = 5 points earned					

Measure 8 and 9: Z-Score Trend Calculation

The z-score measures a hospital's trend in #8 serious complications and #9 mortality over a three-year period. The z-score estimates the slope of a hospital's own linear trend line over time, standardized by the error estimate. The score indicates whether the hospital's performance is flat or trending upwards or downwards. If the z-score is one standard deviation away (either >1 or <-1), there is evidence that the hospital's performance is trending in one of these directions as opposed to being flat. Scores >1 are worsening, scores between 1 and -1 are staying the same, and scores < -1 are improving.



Measure 8: Serious Complication is Any Complication with a Severity Grade of 2 or 3

(Defined Below)

Complication Severity Grade 2

Definition: Potentially life-threatening complications
Complications: catheter-related bloodstream infection, central line-associated bloodstream infection, clostridium difficile, decubitus ulcer, deep vein thrombosis, enterocutaneous fistula, pneumonia, pulmonary embolism, unplanned return to ICU, unplanned return to OR

Complication Severity Grade 3

Definition: Life-threatening complications with a residual or lasting disability
Complications: acute renal failure, acute respiratory distress syndrome, cardiac arrest, myocardial infarction, renal insufficiency, stroke/CVA, systemic sepsis, unplanned intubation, ventilator-associated pneumonia.

Collaborative Wide Measure:

Points are awarded based on the total collaborative result, not individual hospital result

Scoring When Center Has No Patients Meeting Measure Criteria

When a center has no patients to score for a measure, that measure will be excluded from its performance index denominator. Example: A center with no massive transfusion patients will have the measure (worth 10 points) excluded, and their maximum total numerator will be 90 points, the denominator will be 90 points, and a new % (points) calculated by dividing the numerator by the denominator

Filters

#4 PI Death Determination

Cohort: 2 (Admit Trauma Services)
No Signs of Life: Exclude DOAs
Default Period: Custom (7/1/23 to 6/30/24)

#5a: Timely LMWH VTE Prophylaxis in Trauma Service Admits

Practices > VTE Prophylaxis Metric
LMWH ≤ 48 hr
Cohort: 2 (Admit to Trauma Service) > 2-day LOS
No Signs of Life: Exclude DOAs
Transfers Out: Exclude Transfers Out
Default Period: Custom (1/1/23 to 6/30/24)

#5b: Weight-Based LWMH Protocol in Use

Points are awarded based on the submission of the following:
Screenshot of the center's protocol with the weight-based criteria visible in the image AND Screenshots of 5 patients using the protocol with the date and dosage visible in the image.
Submit screenshots to the MTQIP submission portal. For further instruction, see Video demonstration.
Default Period: Submit by 12/6/24.

#6: Timely Surgical Repair in Geriatric (Age ≥ 65) Isolated Hip Fracture

Cohort: 8 (Isolated hip fracture)
Age: ≥ 65
No Signs of Life: Exclude DOAs
Exclude: Transfers out, non-operative isolated hip fractures
Default Period: Custom (7/1/23 to 6/30/24)

#7: Red Blood Cell to Plasma Ratio in Massive Transfusion

Hemorrhage
Cohort: 1 (All)
No Signs of Life: Include DOAs
Transfers Out: Include Transfers Out

Default Period: Custom (1/1/23 to 6/30/24)

#8: Serious Complication
Cohort: 2 (Admit to Trauma Service)
No Signs of Life: Exclude DOA
Transfers Out: Exclude Transfers Out
Default Period: Custom (7/1/21 to 6/30/24)

#9: Mortality
Cohort: 2 (Admit to Trauma Service)
No Signs of Life: Exclude DOA
Transfers Out: Exclude Transfers Out
Default Period: Custom (7/1/21 to 6/30/24)

#10: Patient-Reported Outcomes Participation
Points are awarded based on the following:
A signed agreement and ≥ 90% of patients have contact information submitted defined as a validly formatted email or telephone number.
Cohort: 1 (All)
No Signs of Life: Exclude DOAs and all Deaths/Discharge to Hospice
Transfers Out: Include Transfers Out
Default Period: Custom (7/1/23 to 6/30/24)

#11: Timely Antibiotic in Femur/Tibia Open Fractures - COLLABORATIVE WIDE MEASURE
Points awarded based on the total collaborative result, not the individual hospital result.
Type of antibiotic administered along with date and time for open fracture of femur or tibia.
Eligible: Presence of acute open femur or tibia fracture based on AIS or ICD-10 codes (available on mtqip.org)
Exclude: Direct admissions, Transfers in, and Death in ED
Cohort: 1 (All)
No Signs of Life: Exclude DOAs
Transfers Out: Include Transfers Out
Default Period: Custom (7/1/23 to 6/30/24)

Abbreviations Key
AIS – abbreviated injury score CT- computed tomography
CVA - cerebral vascular accident DOA - dead on arrival
ED - emergency department FFP – fresh frozen plasma FX – fracture
HR – hour
ICD – international classification of diseases
ICU - intensive care unit
LMWH – low molecular weight heparin LOS – length of stay
MCR – MTQIP clinical reviewer MIN - minute
MO - month
OR - operating room
PCP - primary care physician PI – performance improvement RBC – red blood cell
TBI – traumatic brain injury
TPM – trauma program manager VTE – venous thromboembolism YR - year

2024 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard Measurement Period:01/01/2024 – 12/31/2024, unless otherwise specified			
Measure #	Weight	Measure Description	Points
1	20%	**OBI Semiannual Meeting Attendance**	
		OBI Physician Champion (MD or DO actively practicing inpatient maternity care) AND Midwife or Nurse Champion (actively practicing inpatient maternity care), AND Clinical Data Abstractor *combined* attendance (i.e. all three individuals must attend each meeting to obtain full points)	
		Spring Semiannual meeting	10
		Fall Semiannual meeting	10
2	5%	**Quality Initiative Engagement**	
		Site-based Champion Team 1) Holds 6 quality meetings throughout the measurement period AND 2) Disseminates OBI data and discusses OBI initiative progress with unit staff and clinicians at least twice in the measurement period AND 3) Submits quarterly Program Progress and Monitoring (PPM) Reports	5
3	5%	**Data Accuracy and Completeness of Abstracted Data**	
		1) Data Quality Review Score ≥ 97%	
		2) 100% of cases from 01/01/2024 - 09/30/2024 completed and submitted prior to 90 days postpartum	
		2 of 2 metrics met	5
		1 of 2 metrics met	3
4	50%	**NTSV Cesarean Measures**	
		Labor Dystocia Compliance Site-Specific percentage of NTSV cesareans performed for dystocia that meet national criteria for dystocia	
		≥ 80% compliance OR ≥ 20 percentage points of improvement* from baseline	15
		≥ 70% compliance OR ≥ 15 percentage points of improvement* from baseline	10
		Management of Category II Fetal Tracings Site-Specific percentage of NTSV cesareans performed for Cat II or indeterminate fetal heart rate tracing that have documentation of management with an algorithm	
		Sites who previously selected Cat II as their OBI QII project	
		≥ 80% compliance OR ≥ 25% improvement** from baseline to at least 60%	10
		Between 70 - 79% compliance OR ≥ 20% improvement** from baseline to at least 50%	5
		≤ 69% compliance	0

2024 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard Measurement Period:01/01/2024 – 12/31/2024, unless otherwise specified			
Measure #	Weight	Measure Description	Points
		Sites who have NOT previously selected Cat II as their OBI QII project	
		≥ 60% compliance	10
		Between 50 - 59% compliance	5
		≤ 49% compliance	0
		Case Reviews	
		Group 1 Sites	
		Site-based Champion Team conducts 32 NTSV case reviews annually with submissions at least quarterly	5
		Group 2 Sites	
		Site-based Champion Team conducts 40 NTSV case reviews annually with submissions at least quarterly	10
		All Sites	
		At least 2 of 3 site Champions participate in a case review training webinar at the beginning of the measurement period	3
		Provide clinician to clinician feedback for those involved in cases deemed likely inappropriate or indeterminate at least quarterly	4
		Distribute summary feedback of case review findings to entire unit staff/ clinicians and to the OBI Coordinating Center at least quarterly	3
		Quality Improvement Planning	
		Group 1 Sites	
		Site-based Champion Team hosts in-person OBI site visit within the first 2 quarters of 2024 AND meets virtually at least 3 times in the measurement period with an OBI Quality and Outreach Coordinator	10
		Group 2 Sites	
		Site-based Champion Team meets virtually at least 2 times in the measurement period with an OBI Quality and Outreach Coordinator	5
5	10%	**Pain Management Measures**	
		Scheduled acetaminophen and oral NSAID Scheduled acetaminophen AND oral NSAID ordered on patients without contraindication after NTSV cesarean birth	
		≥ 80% compliance	5
		Between 60 - 79% compliance	3
		≤ 59% compliance	0

2024 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard Measurement Period:01/01/2024 – 12/31/2024, unless otherwise specified			
Measure #	Weight	Measure Description	Points
		Total oral morphine equivalent (OME) prescribed appropriate with delivery method (excluding people with history of opioid use disorder) 1) 90% of vaginal births with no 3rd/4th degree laceration: total OME prescribed = 0 2) 90% of vaginal births with 3rd/4th degree laceration: total OME prescribed ≤ 75 3) 90% of cesarean births: total OME prescribed ≤ 113	
		3 of 3 metrics met	5
		2 of 3 metrics met	3
		≤ 1 of 3 metrics met	0
6	5%	**Health Equity**	
		Patient Voices	
		Email address included on ≥ 90% OR ≥ 20 percentage points of improvement from baseline*** of patients abstracted from 01/01/2024 - 09/30/2024	2
		Race-Ethnicity Variable	
		Data element of "Race and Ethnicity" = "Unknown" ≤ 2%	3
7	5%	**Severe Maternal Morbidity**	
		Submission of 2023 eCQM Severe Maternal Complications data to OBI Coordinating Center by 07/01/2024	5
Optional		**Optional Bonus Points** Sites can earn up to 5 bonus points total. Sites cannot exceed 100 points total.	
		Co-author an OBI publication	1
		Submit eCQM Severe Maternal Complications data to OBI Coordinating Center for first 2 quarters of 2024 before the end of the measurement period	
		Share a patient story (with patient's permission) selected by OBI for dissemination to OBI members (e.g. via newsletter or social media)	
		100% of cases submitted and complete by 60 days postpartum for neonatal birthdates from 01/01/24 - 10/31/24	2
		Participate on an OBI Committee	
		Response rate for the OBI Patient Voices survey ≥ 40%	
		Lead author (first/ senior) an OBI publication	
		Present OBI data at a national meeting	
		Present (or identify a patient who presents) at an OBI Semiannual meeting	

**For sites with ≥ 30 births in the denominator for the measurement period; baseline set using data from 01/01/2023 - 09/30/2023*
***Baseline set using data from 01/01/2023 - 09/30/2023*
****Baseline set using data from 05/01/2023 - 09/30/2023*