2023 Hospital Pay-for-Performance Program
(for peer groups 1 through 4)

Hospital CQI Performance Index Scorecards

2023 Hospital Collaborative Quality Initiative Performance Index Program Guide

The following program guide contains the scorecards and supporting documentation for the Blue Cross Blue Shield of Michigan's Collaborative Quality Initiatives (CQIs) to serve as a reference for the 2023 Hospital Pay-for-Performance program (2023 Hospital Pay-for-Performance Program (bcbsm.com)), which also contains general information about the CQI's portion of the P4P program.

Within this document you will find each CQI's individual CQI scorecards. Some of the CQIs will have multiple scorecards, each one representing a different year or set of years that various hospitals began their participation. Each scorecard contains a description of the measures, the scoring weight of each measure and points allotted per measure.

In addition, some CQIs have provided additional supporting documentation to provide further details on the measures.

Contact information has been provided for each of the individual CQI coordinating centers, if you have any clinically related questions about the measures or scoring.

If you have any participation or incentive related questions for BCBSM, please reach out to us at CQIprograms@bcbsm.com.

CQI Program Manager Contacts

CQI	Clinical Focus Area	Project Manager	Phone	E-mail	CQI Website
ASPIRE	Anesthesiology	Tory (Victoria) Lacca	734-936-8081	lacca@umich.edu	ASPIRE Website
BMC2	Angioplasty & Vascular Surgery	Annemarie Forrest	734-998-6444	avassalo@umich.edu	BMC2 Website
HMS	Hospitalist Medicine	Elizabeth McLaughlin	734-936-0354	emcnair@umich.edu	HMS Website
MAQI2	Anticoagulation	Brian Haymart	734-998-5631	khaymart@umich.edu	MAQI2 Website
MARCQI	Knee/Hip Arthroplasty	Tae Kim	734-998-0464	taekk@umich.edu	MARCQI Website
MBSC	Bariatric Surgery	Amanda Stricklen	734-998-7481	aoreilly@umich.edu	MBSC Website
		Rachel Ross	734-998-7502	rachacoo@umich.edu	
MEDIC	Emergency Department	Andrew Scott	734-812-0857	afscott@med.umich.edu	MEDIC Website
MROQC	Radiation Oncology	Melissa Mietzel	734-764-7821	hillmel@umich.edu	MROQC Website
MSQC	General Surgery	Kathy Bishop	734-764-3752	bishopk@umich.edu	MSQC Website
MSSIC	Spine Surgery	Jamie Myers	313-874-1892	JMyers8@hfhs.org	MSSIC Website
MSTCVS	Cardiac Surgery	Patty Theurer	734-998-5918	ptheurer@umich.edu	MSTCVS Website
MTQIP	Trauma Surgery	Judy Mikhail	734-763-8227	jmikhail@umich.edu	MTQIP Website
MVC	Care Episodes	Erin Conklin	-	erconkli@med.umich.edu	MVC Website
OBI	Obstetrics	Helen Costis	734-232-2175	hcostis@med.umich.edu	OBI Website

2023 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohorts 1 - 6** Measurement Period: 01/01/2023 - 12/31/2023			
Measure #	Weight	Measure Description	Points
1	5%	**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	5
		5 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	5%	**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	5
		2 or less Meeting	0
5	10%	**ACQR attendance at Fall ACQR Retreat**	
		Yes	10
		No	0
6	25%	**Glucose (GLU 03) Percentage of cases with perioperative glucose > 200 mg/dL with administration of insulin or glucose recheck within 90 minutes of original glucose measurement. (Cumulative score January 1, 2023 - December 31, 2023)**	
		Performance is ≥ 80%	25
		Performance is ≥ 75%	15
		Performance is ≥ 70%	10
		Performance is < 70%	0
7	20%	**Sustainability (SUS 01) percentage of cases with mean fresh gas flow (FGF) equal to, or less than 3L/min, during administration of halogenated hydrocarbons and/or nitrous oxide (cumulative score January 1, 2023 - December 31, 2023)**	
		Performance is ≥ 95%	20
		Performance is ≥ 92.5%	15
		<92.5%	0
8	25%	**Site Directed Measure: Sites choose a measure they are performing above/below ASPIRE threshold or needs improvement by December 9, 2023 (cumulative score January 1, 2023 through December 31, 2023)**	
		Performance is ≥90%; ≤10%; ≤5% or show ≥25% improvement	25
		Performance is ≥85%; ≤15%; ≤10% or show ≥15% improvement	15
		Performance is ≥80%; ≤20%; ≤15% or show ≥10% improvement	10
		Performance is <80%; >20%; >15% or show <10% improvement	0

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

2023 Performance Index Scorecard

Measure Explanation: Cohorts 1 – 6 (2015 – 2021 start)

Measure #1: The ASPIRE Quality Champion (or a designated representative who must be an anesthesiologist) and the Anesthesiology Clinical Quality Reviewer (ACQR), combined, must attend ASPIRE Collaborative meetings in 2023. There are three total meetings with six opportunities for attendance:

1. MSQC (Michigan Surgical Quality Collaborative) / ASPIRE Meeting: Friday, April 21, 2023
2. ASPIRE Collaborative Meeting: Friday, July 14, 2023
3. MPOG (Multicenter Perioperative Outcomes Group) Retreat: Friday, October 13, 2023

Measure #2: There will be six Quality Committee e-meetings in 2023. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2023 meetings:

1. Monday, January 23, 2023
2. Monday, February 27, 2023
3. Monday, May 22, 2023
4. Monday, July 24, 2023
5. Monday, September 25, 2023
6. Monday, November 27. 2023

Measure #3: Maintenance Schedule located on MPOG website in the resources tab of the quality section. Data must be of high quality upon submission, >90% of diagnostics marked as 'Data Accurately Represented.'

Measure #4: The site is expected to schedule a local meeting either in-person or virtually following each ASPIRE collaborative meeting (see Measure #1 for dates) to discuss site based and collaborative quality outcomes with clinical providers at their site. Sites must send the coordinating center the site-based collaborative meeting report located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section.

Measure #5: ACQR must attend the Fall ACQR Retreat to be held on Friday, September 15, 2023.

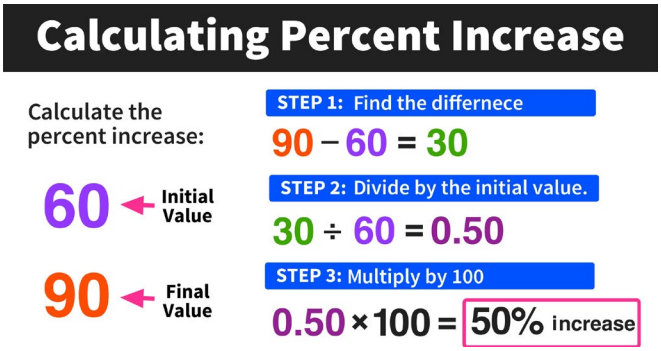
Measure #6: Sites will be awarded points for compliance with the multimodal pain measure GLU 03 (cumulative score January 1, 2023, through December 31, 2023). See P4P Scorecard for point distribution.

Measure #7: Sites will be awarded points for compliance with the sustainability measure SUS 01 (cumulative score January 1, 2023, through December 31, 2023). See P4P Scorecard for point distribution.

Measure #8: Sites will choose a measure where performance is above/below the ASPIRE threshold or a measure that needs improvement. Sites must submit their current measure score (November 1, 2021, through October 31, 2022) to the Coordinating Center by Friday, December 9, 2022, for review and approval (cumulative score January 1, 2023, through December 31, 2023). Measure selection form is located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section. See P4P Scorecard for point distribution.

How to calculate percentage increase: Subtract the original value from the new value, then divide the result by the original value. Multiply the rest by 100, see example:

$$\% \text{ Increase} = 100 \times \frac{(\text{Final} - \text{initial})}{\text{initial}}$$



2023 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohort 7** Measurement Period: 01/01/2023 - 12/31/2023			
Measure #	Weight	Measure Description	Points
1	20%	**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	20
		4 - 5 / 6 Meetings	10
		3 or Less Meetings	0
2	10%	**Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings**	
		6 Meetings	10
		5 Meetings	5
		4 or Less Meetings	0
3	20%	**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.'**	
		11 / 12 Months	20
		10 / 12 Months	10
		9 / 12 Months	5
		8 Months or Less	0
4	10%	**ASPIRE Quality Champion and ACQR monthly meetings**	
		12 / 12 Months	10
		11 / 12 Months	5
		10 / 12 Months	0
5	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 or Less Meetings	0
6	10%	**ACQR attendance at Fall ACQR Retreat**	
		Yes	10
		No	0
7	10%	**Neuromuscular Blockage (NMB 01) Percentage of cases with a documented Train of Four (TOF) after last dose of non-depolarizing neuromuscular blocker (cumulative score 1/1/2022 - 12/31/2022)**	
		Performance is ≥ 90%	10
		Performance is < 90%	0
8	10%	**Site Directed Measure: Sites choose a measure they are performing above/below ASPIRE threshold or needs improvement by December 9, 2023 (cumulative score January 1, 2022 through December 31, 2022)**	
		Performance is ≥90%; ≤10%; ≤5% or show ≥25% improvement	10
		Performance <90%; >10%; >5% or show up to 25% improvement	5
		Performance <90%; >10%; >5% or shows no improvement	0

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

2023 Performance Index Scorecard

Measure Explanation: Cohort 7 (2022 Start)

Measure #1: The ASPIRE Quality Champion (or a designated representative who must be an anesthesiologist) and the Anesthesiology Clinical Quality Reviewer (ACQR), combined, must attend ASPIRE Collaborative meetings in 2023. There are three total meetings with six opportunities for attendance:

1. MSQC (Michigan Surgical Quality Collaborative) / ASPIRE Meeting: Friday, April 21, 2023
2. ASPIRE Collaborative Meeting: Friday, July 14, 2023
3. MPOG (Multicenter Perioperative Outcomes Group) Retreat: Friday, October 13, 2023

Measure #2: There will be six Quality Committee e-meetings in 2023. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2023 meetings:

1. Monday, January 23, 2023
2. Monday, February 27, 2023
3. Monday, May 22, 2023
4. Monday, July 24, 2023
5. Monday, September 25, 2023
6. Monday, November 27. 2023

Measure #3: The Maintenance Schedule is located on the MPOG website in the resources tab of the quality section. Data must be of high quality upon submission,>90% of diagnostics marked as 'Data Accurately Represented.'

Measure #4: ASPIRE Quality Champion and ACQR need to meet monthly to discuss the data and plans for quality improvement. A log of the meeting must be submitted to the ASPIRE Coordinating Center each month. Logs are located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section.

Measure #5: The site is expected to schedule a local meeting either in-person or virtually following each ASPIRE collaborative meetings (see Measure #1 for dates) to discuss site based and collaborative quality outcomes with clinical providers at their site. Sites must send the coordinating center the site-based collaborative meeting report located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section.

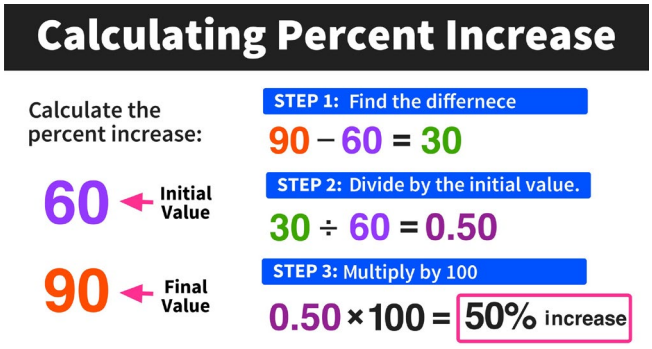
Measure #6: ACQR must attend the fall ACQR Retreat to be held on Friday, September 15, 2023.

Measure #7: Sites will be awarded points for compliance with the neuromuscular blockade NMB 01 measure (cumulative score January 1, 2023, through December 31, 2023). See P4P Scorecard for point distribution.

Measure #8: Sites will choose a measure where performance is above/below the ASPIRE threshold or a measure that needs improvement. Sites must submit their current measure score (November 1, 2021, through October 31, 2022) to the Coordinating Center by Friday, December 9, 2023, for review and approval (cumulative score January 1, 2023, through December 31, 2023). Measure selection form is located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section. See P4P Scorecard for point distribution.

How to calculate percentage increase: Subtract the original value from the new value, then divide the result by the original value. Multiply the rest by 100, see example:

$$\% \text{ Increase} = 100 \times \frac{(\text{Final} - \text{initial})}{\text{initial}}$$



2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined - #1** (VS sites with EVAR and CEA volumes >10 cases per year) Measurement Period: 01/01/2023 - 9/30/2023				
Measure	Weight	Measure Description	PCI Point	VS Point
1	10%	**Meeting Participation - Clinician Lead**		
		2 Meetings	5	5
		1 Meeting	2.5	2.5
		Did not participate	0	0
2	7.5%	**Data Coordinator Expectations**		
		Meets all expectations	3.75	3.75
		Meets most expectations	2.5	2.5
		Does not meet expectations	0	0
3	2.5%	**Internal Case Reviews**		
		Submitted reviews for ≥90% of cases	2.5	NA
		Submitted reviews for <90% of cases	0	NA
4	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**		
		Submitted reviews for 100% of cases	5	5
		Submitted reviews for <100% of cases	0	0
5	12.5%	**Vascular Surgery Performance Goal - Completion of 1-year follow up forms**		
		≥80%	NA	12.5
		70% - <80%	NA	7.5
		<70%	NA	0
6	(10%)	**Vascular Surgery Performance Goal - Documentation of EVAR† imaging performed on the 1-year follow up form**		
		≥70%	NA	10
		60% - <70%	NA	5
		<60%	NA	0
7	(10%)	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with EVAR† at discharge**		
		≥70%	NA	10
		60% - <70%	NA	5
		<60%	NA	0
8	(10%)	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with CEA* at discharge**		
		≥70%	NA	10
		60% - <70%	NA	5
		<60%	NA	0
Sites select two measures for scoring from measures 6, 7, and 8.				
9	12.5%	**PCI Performance Goal - Documentation of recommended P2Y12 therapy duration**		
		≥75%, or a >=20 percentage points absolute increase from Q4 YTD 2022	12.5	NA
		65% - <75%	7.5	NA
		<65%	0	NA
10	12.5%	**PCI Performance Goal - Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).**		
		≥70%, or a >=10 percentage points absolute increase from Q4 YTD 2022	12.5	NA
		60% - <70%	7.5	NA
		<60%	0	NA

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined - #1** (VS sites with EVAR and CEA volumes >10 cases per year) Measurement Period: 01/01/2023 - 9/30/2023				
Measure	Weight	Measure Description	PCI Point	VS Point
11	12.5%	**PCI Performance Goal - Use of IVUS/OCT* for stent optimization**		
		>=40% in EITHER all cases OR >=40% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	12.5	NA
		>=20 percentage points absolute increase in all cases from Q4 YTD 2022	10	NA
		10 - <20 percentage points absolute increase in all cases from Q4 YTD 2022	7.5	NA
		<10 percentage points absolute increase in all cases from Q4 YTD 2022	0	NA

**eGFR=estimated glomerular filtration rate

^^NYHA= New York Heart Association heart failure class

††STEMI=ST elevated myocardial infarction

†EVAR=endovascular aortic aneurysm repair

*CEA=carotid endarterectomy

* IVUS/OCT=intra-vascular ultrasound/optical coherence tomography

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined - #2** (VS sites performing <10 EVAR cases per year) Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
1	10%	**Meeting Participation - Clinician Lead**	
		2 Meetings	5
		1 Meeting	2.5
		Did not participate	0
2	7.5%	**Data Coordinator Expectations**	
		Meets all expectations	3.75
		Meets most expectations	2.5
		Does not meet expectations	0
3	2.5%	**Internal Case Reviews**	
		Submitted reviews for ≥90% of cases	2.5
		Submitted reviews for <90% of cases	0
4	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	5
		Submitted reviews for <100% of cases	0
5	17.5%	**Vascular Surgery Performance Goal - Completion of 1-year follow up forms**	
		≥80%	NA
		70% - <80%	NA
		<70%	NA
6	15%	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with CEA* at discharge**	
		≥70%	NA
		60% - <70%	NA
		<60%	NA
7	12.5%	**PCI Performance Goal - Documentation of recommended P2Y12 therapy duration**	
		≥75%, or a >=20 percentage points absolute increase from Q4 YTD 2022	12.5
		65% - <75%	7.5
		<65%	0
8	12.5%	**PCI Performance Goal - Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).**	
		≥70%, or a >=10 percentage points absolute increase from Q4 YTD 2022	12.5
		60% - <70%	7.5
		<60%	0
9	12.5%	**PCI Performance Goal - Use of IVUS/OCT˟ for stent optimization**	
		>=40% in EITHER all cases OR >=40% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	12.5
		>=20 percentage points absolute increase in all cases from Q4 YTD 2022	10
		10 - <20 percentage points absolute increase in all cases from Q4 YTD 2022	7.5
		<10 percentage points absolute increase in all cases from Q4 YTD 2022	0
	100		

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined - #2** (VS sites performing <10 EVAR cases per year) Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
**eGFR=estimated glomerular filtration rate ^^NYHA= New York Heart Association heart failure class ††STEMI=ST elevated myocardial infarction †EVAR=endovascular aortic aneurysm repair *CEA=carotid endarterectomy ˟ IVUS/OCT=intra-vascular ultrasound/optical coherence tomography			

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined - #3** (VS sites performing <10 CEA cases per year) Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
1	10%	**Meeting Participation - Clinician Lead**	
		2 Meetings	5
		1 Meeting	2.5
		Did not participate	0
2	7.5%	**Data Coordinator Expectations**	
		Meets all expectations	3.75
		Meets most expectations	2.5
		Does not meet expectations	0
3	2.5%	**Internal Case Reviews**	
		Submitted reviews for ≥90% of cases	2.5
		Submitted reviews for <90% of cases	0
4	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	5
		Submitted reviews for <100% of cases	0
5	12.5%	**Vascular Surgery Performance Goal - Completion of 1-year follow up forms**	
		≥80%	NA
		70% - <80%	NA
		<70%	NA
6	10%	**Vascular Surgery Performance Goal - Documentation of EVAR† imaging performed on the 1-year follow up form**	
		≥70%	NA
		60% - <70%	NA
		<60%	NA
7	10%	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with EVAR† at discharge**	
		≥70%	NA
		60% - <70%	NA
		<60%	NA
8	12.5%	**PCI Performance Goal - Documentation of recommended P2Y12 therapy duration**	
		≥ 75%, or a > = 20 percentage points absolute increase from Q4 YTD 2022	12.5
		65% - < 75%	7.5
		< 65%	0
9	12.5%	**PCI Performance Goal - Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).**	
		≥ 70%, or a > = 10 percentage points absolute increase from Q4 YTD 2022	12.5
		60% - < 70%	7.5
		< 60%	0
10	12.5%	**PCI Performance Goal - Use of IVUS/OCT˟ for stent optimization**	
		>=40% in EITHER all cases OR >=40% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	12.5
		> = 20 percentage points absolute increase in all cases from Q4 YTD 2022	10
		10 - < 20 percentage points absolute increase in all cases from Q4 YTD 2022	7.5
		< 10 percentage points absolute increase in all cases from Q4 YTD 2022	0
	100		

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined - #3** (VS sites performing <10 CEA cases per year) Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
**eGFR=estimated glomerular filtration rate ^^NYHA= New York Heart Association heart failure class ††STEMI=ST elevated myocardial infarction †EVAR=endovascular aortic aneurysm repair *CEA=carotid endarterectomy ˟ IVUS/OCT=intra-vascular ultrasound/optical coherence tomography			

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined - #4** (VS sites in Year 1 of consortium participation) Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
1	20%	**Meeting Participation - Clinician Lead**	
		2 meetings PCI; 3 meetings VS	5
		1 meeting PCI; 2 meetings VS	2.5
		0 meetings PCI; 0-1 meetings VS	0
2	20%	**Data Coordinator Expectations**	
		Meets all expectations	5
		Meets most expectations	2.5
		Does not meet expectations	0
3	2.5%	**Internal Case Reviews**	
		Submitted reviews for ≥90% of cases	2.5
		Submitted reviews for <90% of cases	0
4	20%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	5
		Submitted reviews for < 100% of cases	0
5	12.5%	**PCI Performance Goal - Documentation of recommended P2Y12 therapy duration**	
		≥ 75%, or a > = 20 percentage points absolute increase from Q4 YTD 2022	12.5
		65% - < 75%	7.5
		< 65%	0
6	12.5%	**PCI Performance Goal - Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).**	
		≥70%, or a >=10 percentage points absolute increase from Q4 YTD 2022	12.5
		60% - < 70%	7.5
		< 60%	0
7	12.5%	**PCI Performance Goal - Use of IVUS/OCT˟ for stent optimization**	
		>=40% in EITHER all cases OR >=40% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	12.5
		> = 20 percentage points absolute increase in all cases from Q4 YTD 2022	10
		10 - < 20 percentage points absolute increase in all cases from Q4 YTD 2022	7.5
		< 10 percentage points absolute increase in all cases from Q4 YTD 2022	0
	100		

**eGFR=estimated glomerular filtration rate

^^NYHA= New York Heart Association heart failure class

††STEMI=ST elevated myocardial infarction

˟ IVUS/OCT=intra-vascular ultrasound/optical coherence tomography

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **PCI Only #5** Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
1	10%	**Meeting Participation - Clinician Lead**	
		2 Meetings	10
		1 Meetings	5
		Did not participate	0
2	10%	**Data Coordinator Expectations**	
		Meets all expectations	10
		Meets most expectations	7.5
		Does not meet expectations	0
3	10%	**Internal Case Reviews**	
		Submitted reviews for ≥90% of cases	10
		Submitted reviews for <90% of cases	0
4	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
5	20%	**PCI Performance Goal - Documentation of recommended P2Y12 therapy duration**	
		≥75%, or a >=20 percentage points absolute increase from Q4 YTD 2022	20
		65% - <75%	10
		<65%	0
6	20%	**PCI Performance Goal - Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).**	
		≥ 70%, or a > = 10 percentage points absolute increase from Q4 YTD 2022	20
		60% - < 70%	10
		< 60%	0
7	20%	**PCI Performance Goal - Use of IVUS/OCT˟ for stent optimization**	
		> = 40% in EITHER all cases OR > = 40% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	20
		> = 20 percentage points absolute increase in all cases from Q4 YTD 2022	10
		10 - < 20 percentage points absolute increase in all cases from Q4 YTD 2022	7.5
		< 10 percentage points absolute increase in all cases from Q4 YTD 2022	0
	100		

**eGFR=estimated glomerular filtration rate

^^NYHA= New York Heart Association heart failure class

††STEMI=ST elevated myocardial infarction

˟ IVUS/OCT=intra-vascular ultrasound/optical coherence tomography

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **VS Only #6** (VS sites with EVAR and CEA volumes >=10 cases per year) Participation Measurement Period: 01/01/23 – 12/31/2023 Performance Measurement Period: 01/01/23 – 09/30/2023			
Measure #	Weight	Measure Description	Points
1	15	**Meeting Participation – Clinician Lead**	
		2 Meetings	15
		1 Meeting	7.5
		Did not participate	0
2	15	**Data Coordinator Expectations**	
		Meets all expectations	15
		Meets most expectations	7.5
		Does not meet expectations	0
4	10	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
5	20	**Vascular Surgery Performance Goal – Completion of 1 year follow-up forms**	
		≥ 80%	20
		70% - <80%	10
		<70%	0
6	(20)	**Vascular Surgery Performance Goal – Documentation of EVAR+ imaging performed on the 1 year follow-up form**	
		≥ 70%	20
		70% - <70%	10
		<60%	0
7	(20)	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with EVAR+ at discharge**	
		≥ 70%	20
		70% - <70%	10
		<60%	0
8	(20)	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with CEA* at discharge**	
		≥ 70%	20
		70% - <70%	10
		<60%	0
Sites select two measures for scoring from measures 6, 7, and 8.			

+EVAR = endovascular aortic aneurysm repair

*CEA = carotid endarterectomy

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **VS Only #7** (VS sites performing <10 EVAR cases per year) Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
1	15%	**Meeting Participation - Clinician Lead**	
		2 Meetings	15
		1 Meeting	7.5
		Did not participate	0
2	15%	**Data Coordinator Expectations**	
		Meets all expectations	15
		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**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for < 100% of cases	0
4	30%	**Vascular Surgery Performance Goal - Completion of 1-year follow up forms**	
		≥ 80%	30
		70% - < 80%	15
		< 70%	0
5	30%	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with CEA* at discharge**	
		≥ 70%	30
		60% - < 70%	15
		< 60%	0
	100		
*CEA=carotid endarterectomy			

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **VS Only #8** (VS sites performing <10 CEA cases per year) Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
1	15%	**Meeting Participation - Clinician Lead**	
		2 Meetings	15
		1 Meeting	7.5
		Did not participate	0
2	15%	**Data Coordinator Expectations**	
		Meets all expectations	15
		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**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
4	20%	**Vascular Surgery Performance Goal - Completion of 1-year follow up forms**	
		≥ 80%	20
		70% - < 80%	10
		< 70%	0
5	20%	**Vascular Surgery Performance Goal - Documentation of EVAR† imaging performed on the 1-year follow up form**	
		≥ 70%	20
		60% - < 70%	10
		< 60%	0
6	20%	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with EVAR† at discharge**	
		≥ 70%	20
		60% - < 70%	10
		< 60%	0
	100		
†EVAR=endovascular aortic aneurysm repair			

2023 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard **VS Only #9** (VS sites in Year 1 of consortium participation) Measurement Period: 01/01/2023 - 9/30/2023			
Measure #	Weight	Measure Description	Points
1	35%	**Meeting Participation - Clinician Lead**	
		3 meetings	35
		2 meetings	20
		0-1 meetings	0
2	35%	**Data Coordinator Expectations**	
		Meets all expectations	35
		Meets most expectations	20
		Does not meet expectations	0
4	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

2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 08/03/2023-11/08/2023 (PICC Insertions/Hospital Discharges) Cohort - Hospitals Enrolled Prior to 2020			
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 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	15%	**Increase Use of 5 Days of Antibiotic Treatment[7] in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e. reduce excess durations)[5,6]**	
		≥ 65% uncomplicated CAP cases receive 5 days[7] of antibiotics **OR** ≥ 65% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[8]	15
		50-64% uncomplicated CAP cases receive 5 days[7] of antibiotics **OR** 45-64% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[8]	10
		< 50% uncomplicated CAP cases receive 5 days[7] of antibiotics **AND** < 45% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[8]	0
6	15%	**Reduce Use of Inappropriate Empiric Broad-Spectrum Antibiotics[11] for Patients with Uncomplicated CAP (Community Acquired Pneumonia)[5,6]**	
		≤ 15% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	15
		16-20% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	10
		> 20% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	0

2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 08/03/2023-11/08/2023 (PICC Insertions/Hospital Discharges) Cohort - Hospitals Enrolled Prior to 2020			
Measure #	Weight	Measure Description	Points
7	15%	**Reduce Use of Antibiotics[9] in Patients with ASB (Asymptomatic Bacteriuria)[5,6,10]**	
		≤ 10% of positive urine culture cases treated with an antibiotic are ASB cases **OR** ≥ 45% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[8]	15
		11-19% of positive urine culture cases treated with an antibiotic are ASB cases **OR** 30-44% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[8]	10
		> 19% of positive urine culture cases treated with an antibiotic are ASB cases **AND** < 30% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[8]	0
8/9	15%	**Reduce Triple Lumen PICCs in Special Populations – Oncology or Critical Care**	
		Oncology	
		≤ 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **AND** participation in special population workgroup[13,14,15]	15
		≤ 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **OR** participation in special population workgroup[13,14,15]	10
		> 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **AND** No participation in special population workgroup[13,14,15]	0
		OR	
		Critical Care (ICU)	
		≤ 30% of PICCs placed in critical care patients[16] are triple lumens **AND** Participation in special population workgroup[13,14,15]	15
		≤ 30% of PICCs placed in critical care patients[16] are triple lumens **OR** Participation in special population workgroup[13,14,15]	10
		> 30% of PICCs placed in critical care patients[16] are triple lumens **AND** No Participation in special population workgroup[13,14,15]	0
C	10%	**PICC and Midline Documentation- Catheter-to-Vein Ratio and Lumens**	
		≥ 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio AND ≥ 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	10
		≥ 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio OR ≥ 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	5
		< 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio AND < 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	0
Optional Bonus			
Optional	5%	Specialist[15] attendance at 3 of the special population workgroup meetings[13,14] during the calendar year in the hospital's pre-determined workgroup area **OR** Specialist[15] attendance at 1 or more of the special population workgroup meetings[14] that is not the hospital's pre-determined workgroup area during the calendar year	5
		Total (Max points=100)	

Supporting Documentation

[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 2023. 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 calendar year 2023. 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 calendar 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).

[4] Based on all meetings scheduled during calendar year 2023. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] Assessed at year end based on final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2023. 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.

[6] The adjusted model for this measure includes all cohorts except Cohort 2022.

[7] Considered appropriate if 6 or fewer days of antibiotic treatment are administered.

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

[9] Assessed based on treatment on day 2 or later of the entire hospital encounter.

[10] Out of all positive urine culture cases.

[11] Assessed based on treatment on day 2 of the hospital encounter.

[12] 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 calendar year 2023. This is different than the other performance measures in the index, which are applied to each individual hospital. New hospitals joining HMS in 2022 will not be used to calculate the collaborative average.

[13] 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

[14] Initiative-specific workgroup will take place at each of the 3 HMS Collaborative Wide Meetings during calendar year 2023 (March 15, July 12, November 1). A virtual option will be made available for this workgroup at in-person meetings and will be allowed for participation purposes.

[15] 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.

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

[17] PICC placements where one of the following is true:

- Chemotherapy was delivered through the PICC
- Documented placement indication was for chemotherapy
- If the medical record reflects a cancer diagnosis AND the PICC was placed for a cancer-related admission

HMS 2023 P4P PI Scorecard Supporting Documentation 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 2023. 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 calendar year 2023. 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 calendar 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).

[4] Based on all meetings scheduled during calendar year 2023. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] Assessed at year end based on final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2023. 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.

[6] The adjusted model for this measure includes all cohorts except Cohort 2022.

[7] Considered appropriate if 6 or fewer days of antibiotic treatment are administered.

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

[9] Assessed based on treatment on day 2 or later of the entire hospital encounter.

[10] Out of all positive urine culture cases.

[11] Assessed based on treatment on day 2 of the hospital encounter.

[12] 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 calendar year 2023. This is different than the other performance measures in the index, which are applied to each individual hospital. New hospitals joining HMS in 2022 will not be used to calculate the collaborative average.

[13] 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

[14] Initiative specific workgroup will take place at each of the 3 HMS Collaborative Wide Meetings during calendar year 2023 (March 15, July 12, November 1). A virtual option will be made available and will be allowed for participation purposes.

[15] 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.

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

[17] PICC placements where one of the following is true:

- Chemotherapy was delivered through the PICC
- Documented placement indication was for chemotherapy
- If the medical record reflects a cancer diagnosis **AND** the PICC was placed for a cancer-related admission

2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 08/03/2023-11/08/2023 (PICC Insertions/Hospital Discharges) Cohort - Hospitals Enrolled in 2020 & 2021			
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[8] in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e., reduce excess durations)[5,6]**	
		≥ 65% uncomplicated CAP cases receive 5 days[8] of antibiotics **OR** ≥ 65% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[9]	10
		50 – 64% uncomplicated CAP cases receive 5 days[8] of antibiotics **OR** 45 – 64% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year	5
		< 50% uncomplicated CAP cases receive 5 days[8] of antibiotics **AND** < 45% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[9]	0
6	10	**Reduce Use of Inappropriate Empiric Broad Spectrum Antibiotics[15] for Patients with Uncomplicated CAP (Community Acquired Pneumonia)[5,6]**	
		≤ 15% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	10
		16 – 20% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	5
		> 20% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	0
7	10	**Reduce Use of Antibiotics[10] in Patients with ASB (Asymptomatic Bacteriuria)[5,6,11]**	
		≤ 10% of positive urine culture cases treated with an antibiotic are ASB cases **OR** ≥ 45% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[9]	10
		11 – 19% of positive urine culture cases treated with an antibiotic are ASB cases **OR** 30 – 44%relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[9]	5

2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 08/03/2023-11/08/2023 (PICC Insertions/Hospital Discharges) Cohort - Hospitals Enrolled in 2020 & 2021			
Measure #	Weight	Measure Description	Points
		> 19% of positive urine culture cases treated with an antibiotic are ASB cases **AND** < 30% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[9]	0
8	10	**Reduce PICCs (Peripherally-Inserted Central Catheters) in for ≤ 5 Days (excluding deaths)[5,7]**	
		≤ 10% of PICC cases in for ≤ 5 Days	10
		11 – 15% of PICC cases in for ≤ 5 Days	5
		> 15% of PICC cases in for ≤ 5 Days	0
9	10	**Increase Use of Single Lumen PICCs in Non-ICU (Intensive Care Unit) Cases[5,7]**	
		≥ 77% of non-ICU PICC cases have a single lumen	10
		70 – 76% of non-ICU PICC cases have a single lumen	5
		< 70% of non-ICU PICC cases have a single lumen	0
10	10	**PICCs in Patients with eGFR (estimated glomerular filtration rate) <45 (without Nephrology approval)[5,7]**	
		≤ 7% of cases with PICC have a eGFR <45 without Nephrology approval	10
		8 – 12% of cases with PICC have eGFR <45 without Nephrology approval	5
		> 12% of cases with PICC have eGFR <45 without Nephrology approval	0
C	10	**PICC and Midline Documentation – Catheter-to-Vein Ratio and Lumens[12]**	
		≥ 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio **AND** ≥ 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	10
		≥ 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio **OR** ≥ 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	5
		< 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio AND < 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	0
Optional Bonus			
Optional	5	Specialist[13] attendance at 1 or more of the special population workgroup meetings[14] during the calendar year	
		Total (Max points = 100)	

Supporting Documentation

[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 2023. 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 calendar year 2023. Scores are average 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 calendar 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).

[4] Based on all meetings scheduled during calendar year 2023. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] Assessed at year end based on final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2023. 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.

[6] The adjusted model for this measure includes all cohorts except Cohort 2022.

[7] The adjusted model for this measure includes cohorts 2020 and 2021 only.

[8] Considered appropriate if 6 or fewer days of antibiotic treatment.

[9] Rate of change is based on the adjusted method and may not reflect raw rates from quarter to quarter.

[10] Assessed based on treatment on day 2 or later of the entire hospital encounter.

[11] Out of all positive urine culture cases.

[12] 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 calendar year 2023. This is different than the other performance measures in the index, which are applied to each individual hospital. New hospitals joining in 2022 will not be used to calculate the collaborative average.

[13] 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.

[14] Initiative specific workgroup will take place at each of the 3 HMS Collaborative Wide Meetings during calendar year 2023 (March 15, July 12, November 1). A virtual option will be made available and will be allowed for participation purposes.

[15] Assessed based on treatment on day 2 of the hospital encounter.

HMS 2023 P4P PI Scorecard Supporting Documentation Cohort 2020 and 2021

[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 2023. 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 calendar year 2023. 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 calendar 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).

[4] Based on all meetings scheduled during calendar year 2023. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] Assessed at year end based on final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2023. 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.

[6] The adjusted model for this measure includes all cohorts except Cohort 2022.

[7] The adjusted model for this measure includes cohorts 2020 and 2021 only.

[8] Considered appropriate if 6 or fewer days of antibiotic treatment.

[9] Rate of change is based on the adjusted method and may not reflect raw rates from quarter to quarter.

[10] Assessed based on treatment on day 2 or later of the entire hospital encounter.

[11] Out of all positive urine culture cases

[12] 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 calendar year 2023. This is different than the other performance measures in the index, which are applied to each individual hospital. New hospitals joining in 2022 will not be used to calculate the collaborative average.

[13] 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.

[14] Initiative specific workgroup will take place at each of the 3 HMS Collaborative Wide Meetings during calendar year 2023 (March 15, July 12, November 1). A virtual option will be made available and will be allowed for participation. Purposes.

[15] Assessed based on treatment on day 2 of the hospital encounter.

2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard **Cohort 2022 (Sites Starting in 2022)**			
Measure #	Weight	Measure Description	Points
1	15	**Timeliness of HMS. Data at Mid-Year and End of Year[1]**	
		On time ≥ 95% at Mid-Year **AND** End of Year	15
		On time ≥ 95% at Mid-Year **OR** End of Year	8
		On time< 95% at Mid-Year **AND** End of Year	0
2	15	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity survey not completed, **AND** audit case corrections completed by due date	15
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed **OR** audit case corrections not completed by due date	0
3	20	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
4	20	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
5	10	**PICC Quality Improvement**	
		Convene a vascular access committee at least quarterly to review PICC use and outcomes **AND** use MAGIC or a related decision-tool to determine PICC appropriateness	10
		Convene a vascular access committee at least quarterly to review PICC use and outcomes **OR** use MAGIC or a related decision-tool to determine PICC appropriateness	5
		No vascular access committee meetings convened **AND** no use of MAGIC or a related decision-tool to determine PICC appropriate	0
6	5	**PICC/Midline Documentation[6]**	
		Submit PICC **AND** midline (if hospital inserts midlines) insertion template including documentation of catheter-to-vein ratio and number of lumens	5
		Local PICC **AND** midline (if hospital inserts midlines) insertion template including documentation of catheter-to-vein ratio and number of lumens not submitted	0
7	10	**Antimicrobial Quality Improvement- Guidelines[6]**	
		Submit UTI and CAP guidelines developed locally (aligned with HMS recommendations)[5]	10
		Local UTI and CAP guidelines not submitted **OR** not aligned with HMS recommendations	0
8	5	**Antimicrobial Quality Improvement – Intervention Description**	
		Submit a description of one intervention you have done, are doing or plan on doing for each • Decrease antibiotic treatment for patients with uncomplicated CAP to 5 days • Decrease unnecessary treatment of ASB • Decreasing broad-spectrum use in patients with uncomplicated CAP	5
		Description of interventions not submitted	0

2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard **Cohort 2022 (Sites Starting in 2022)**			
Measure #	Weight	Measure Description	Points
Optional Bonus			
Optional	5	Specialist[7] attendance at 1 or more of the special population workgroup[8] meetings during the calendar year	5
		Total (Max points = 100)	

HMS 2023 P4P PI Scorecard Supporting Documentation Cohort 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 2023. 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 calendar year 2023. 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 calendar 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).

[4] Based on all meetings scheduled during calendar year 2023. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] CAP Institutional guidelines should:

- Recommend 5-day antibiotic treatment duration for uncomplicated CAP
- Review the risk factors for multi-drug resistant organisms (MDRO) (i.e. provide guidance on when anti-pseudomonal and anti MRSA coverage is needed)
- Provide recommendations for transition to oral therapy
- De-emphasize fluoroquinolones

UTI Institutional guidelines should:

- Recommend against sending urine cultures in the absence of urinary symptoms
- Recommend against treating a positive urine culture in the absence of urinary symptoms
- Provide recommendations for transition to oral therapy
- De-emphasize fluoroquinolones

[6] In December 2023/January 2024, HMS will distribute a survey to all abstractors/quality leads to obtain the information required for this measure. It is the abstractor/quality leads responsibility to work with key stakeholders who are involved with and lead the quality improvement work at each hospital related to the area of assessment.

[7] 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.

[8] Initiative specific workgroup will take place at each of the 3 HMS Collaborative Wide Meetings during calendar year 2023 (March 15, July 12, November 1). A virtual option will be made available and will be allowed for participation purposes.

2023 MAQI2 Collaborative Quality Initiative Performance Index Scorecard (Epic sites) Measurement Period: 1/01/2023-12/31/2023			
Measure #	Weight	Measure Description	Points
1	10%	**Smoking status assessment in newly enrolled patients (site-level) – *VBR-Hosp Level***	
		≥ 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**	
		Utilized the entire year (12 months)	10
		Utilized most of year (7-11 months)	5
		Utilized some of the year (1-6 months)	3
		Not utilized during the year	0
3	10%	**Inappropriate aspirin use in warfarin patients – *VBR Hosp Level***	
		≤ 12% of active patients	10
		13-17 % of active patients	5
		18-22% of active patients	3
		>22% of active patients	0
4	10%	**Extended International Normalized Ratio (INR) testing interval project – *VBR-Hosp Level***	
		≥ 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	20%	**Gastroprotection* in warfarin patients at high-risk for upper GI bleeding (site level)**	
		≥ 70% OR a relative increase of ≥40% from baseline	20
		45-69% OR a relative increase of 30-39% from baseline	15
		25-44% OR a relative increase of 20-29% from baseline	5
		< 25% OR a relative increase of <20% from baseline	0
6	10%	**Gastroprotection* in warfarin patients at high-risk for upper GI bleeding (consortium level)**	
		≥ 70% OR a relative increase of ≥40% from baseline	10
		45-69% OR a relative increase of 30-39% from baseline	5
		25-44% OR a relative increase of 20-29% from baseline	3
		< 25% OR a relative increase of <20% from baseline	0
7	10%	**Quarterly Meetings participation- Clinical Champion**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0
8	10%	**Quarterly Meeting participation – Coordinator/Lead Abstractor**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0

2023 MAQI2 Collaborative Quality Initiative Performance Index Scorecard (Epic sites) Measurement Period: 1/01/2023-12/31/2023			
Measure #	Weight	Measure Description	Points
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	

2023 MAQI2 Collaborative Quality Initiative Performance Index Scorecard (non-Epic sites) Measurement Period: 1/01/2023-12/31/2023			
Measure #	Weight	Measure Description	Points
1	10%	**Smoking status assessment in newly enrolled patients (site-level) – *VBR-Hosp Level***	
		≥ 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	15%	**Inappropriate aspirin use in warfarin patients - *VBR-Hosp Level***	
		≤ 12% of active patients	15
		13-17 % of active patients	10
		18-22% of active patients	5
		> 22% of active patients	0
3	15%	**Extended International Normalized Ratio (INR) testing interval project - *VBR-Hosp Level***	
		≥80% of eligible patients received extended intervals	15
		60-79% of eligible patients received extended intervals	10
		40-59% of eligible patients received extended intervals	5
		< 40% of eligible patients received extended intervals	0
4	20%	**Gastroprotection* in warfarin patients at high-risk for upper GI bleeding (site level)**	
		≥ 70% OR a relative increase of ≥40% from baseline	20
		45-69% OR a relative increase of 30-39% from baseline	15
		25-44% OR a relative increase of 20-29% from baseline	5
		< 25% OR a relative increase of <20% from baseline	0
5	10%	**Gastroprotection* in warfarin patients at high-risk for upper GI bleeding (consortium level)**	
		≥ 70% OR a relative increase of ≥40% from baseline	10
		45-69% OR a relative increase of 30-39% from baseline	5
		25-44% OR a relative increase of 20-29% from baseline	3
		< 25% OR a relative increase of <20% from baseline	0
6	10%	**Quarterly Meetings participation -Clinical Champion**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0
7	10%	**Quarterly Meeting participation – Coordinator/Lead Abstractor**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0

2023 MAQI2 Collaborative Quality Initiative Performance Index Scorecard (non-Epic sites) Measurement Period: 1/01/2023-12/31/2023			
Measure #	Weight	Measure Description	Points
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	

FY2023 MARCQI Collaborative Quality Initiative Performance Index Scorecard - Year 1 Participation Measurement Period: 01/01/2023 - 11/30/2023 QI Measurement Period: 01/01/2023-06/30/2023			
Measure #	Max. Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2023-11.30.2023)** ***Attendance at both the Medical Advisory Committee and Collaborative-wide meeting in February 2023; June 2023; and October 2023 for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<2 meetings attended	0
2	20%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2023-11.30.2023)** ***Attendance at both the CDA Breakout and Collaborative-wide meeting in February 2023; June 2023; and October 2023 for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<2 meetings attended	0
3	20%	**Accuracy and Completeness of Data Submission (audits 07.01.2022-06.30.2023) - 4 metrics** 1. On-time/Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. Data abstraction started by 05.31.2023 3. All cases performed or before May 4, 2023 abstracted by October 1, 2023 4. 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 11.30.2023	
		4 of 4 metrics met	20
		3 of 4 metrics met	15
		2 of 4 metrics met	10
		1 of 4 metrics met	5
		0 of 4 metrics met	0
4	5%	**IT Support attendance at Kick-off meeting & vendor webinar (2023)**	
4	15%	**Site based Quality Meetings:(02.04.2023-11.30.2023)** 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 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
3	20%	**Access to Surgeon's Office Records (90-day events): (Surgery dates 1/1/23-6/30/23)**	
		90% + patient data captured	20
		75% - 89% patient data captured	15
		Less than 75% data captured	10
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, 2023	1

FY2023 MARCQI Collaborative Quality Initiative Performance Index Scorecard - Year 2 Participation Measurement Period: 01/01/2023 - 11/30/2023 QI Measurement Period: 10/01/2022-06/30/2023			
Measure #	Max. Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2023-11.30.2023)** ***Attendance at both the Medical Advisory Committee and Collaborative-wide meeting in February 2023; June 2023; and October 2023 for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		<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 1 point extra credit per site**	1
2	20%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2023-11.30.2023)** ***Attendance at both the CDA Breakout and Collaborative-wide meeting in February 2023; June 2023; and October 2023 for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		<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, Hip fractures, Pain control) ***Maximum total 1 point extra credit per site**	1
3	20%	**Accuracy and Completeness of Data Submission (audits 07.01.2022-06.30.2023) - 4 metrics** 1. On-time/Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. All 2022 cases abstracted completely by 05.31.2023 3. All cases performed or before May 4, 2023 abstracted by October 1, 2023 4. 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 11.30.2023	
		4 of 4 metrics met	20
		3 of 4 metrics met	15
		2 of 4 metrics met	10
		1 of 4 metrics met	5
		0 of 4 metrics met	0
4	20%	**Site based Quality Meetings:(02.04.2023-11.30.2023)** 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 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

FY2023 MARCQI Collaborative Quality Initiative Performance Index Scorecard - Year 2 Participation Measurement Period: 01/01/2023 - 11/30/2023 QI Measurement Period: 10/01/2022-06/30/2023			
Measure #	Max. Weight	Measure Description	Points
5	5%	**% of Opioid naïve 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**	2.5
		Less than 60% of patients meet the prescribing criteria	0
6	5%	**% of Opioid naïve 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**	2.5
		Less than 70% of patients meet the prescribing criteria	0
Extra Credit	0%	**Site level PROS Collection:** Completed primary Pre-op and post-op HOOS -JR or KOOS-JR + PROMIS10 collected at a rate ≥ 70%. (Overall average as of surgeries on or before 06.30.2023. 2-16 week 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
7	10%	**90-Day Hip fracture: Reduce COLLABORATIVE rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) to 1.17%**	
		1.17% or less of all primary HIPS experience a 90-Day hip fracture	10
		Greater than 1.17% but less than 2% of all primary HIPS experience a 90-Day hip fracture	5
		The site is not awarded points if there is no collaborative-wide improvement (≥2%) in all primary HIPS with 90-day hip fractures	0
Extra Credit	0%	**MODB data submission:** Provide site's written 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, 2023	2

FY2023 MARCQI Collaborative Quality Initiative Performance Index Scorecard - Year 3+ Participation Measurement Period: 01/01/2023 - 11/30/2023 QI Measurement Period: 10/01/2022-06/30/2023			
Measure #	Max. Weight	Measure Description	Points
1	10%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2023-11.30.2023)** ***Attendance at both the Medical Advisory Committee and Collaborative-wide meeting in February 2023; June 2023; and October 2023 for 80% of the meeting time**	
		3 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 1 point extra credit per site**	1
2	5%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2023-11.30.2023)** ***Attendance at both the CDA Breakout and Collaborative-wide meeting in February 2023; June 2023; and October 2023 for 80% of the meeting time**	
		3 out of 3 meetings attended	5
		<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, Hip fractures, Pain control) ***Maximum total 1 point extra credit per site**	1
3	10%	**Accuracy and Completeness of Data Submission (audits 07.01.2022-06.30.2023) - 4 metrics** 1. On-time/Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. All 2022 cases abstracted completely by 05.31.2023 3. All cases performed or before May 4, 2023 abstracted by October 1, 2023 4. 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 11.30.2023	
		4 of 4 metrics met	10
		3 of 4 metrics met	7.5
		2 of 4 metrics met	5
		1 of 4 metrics met	2.5
		0 of 4 metrics met	0
4	5%	**Site based Quality Meetings:(02.04.2023-11.30.2023)** 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 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

FY2023 MARCQI Collaborative Quality Initiative Performance Index Scorecard - Year 3+ Participation Measurement Period: 01/01/2023 - 11/30/2023 QI Measurement Period: 10/01/2022-06/30/2023			
Measure #	Max. Weight	Measure Description	Points
5	15%	**Site level PROS Collection: Completed primary Pre-op and post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2023. 2-16 week 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 70%+	15
		60%	10
		50%	5
		The site is not awarded points if collection is less than 50%	0
6	5%	**% of Opioid naïve 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**	2.5
		Less than 60% of patients meet the prescribing criteria	0
7	5%	**% of Opioid naïve 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**	2.5
		Less than 70% of patients meet the prescribing criteria	0
8	15%	**90-Day Hip fracture: Reduce COLLABORATIVE rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) to 1.17%**	
		1.17% or less of all primary HIPS experience a 90-Day hip fracture	15
		Greater than 1.17% but less than 2% of all primary HIPS experience a 90-Day hip fracture	7.5
		The site is not awarded points if there is no collaborative-wide improvement (≥2%) in all primary HIPS with 90-Day hip fractures	0
9	10%	**90-Day Hip fracture: Reduce Site level rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) to 1.17%**	
		1.17% or less of all primary HIPS experience a 90-Day hip fracture	10
		Greater than 1.17% but less than 2% of all primary HIPS experience a 90-Day hip fracture	5
		The site is not awarded points if there is no site-level improvement (≥2%) in all primary HIPS with 90-Day hip fractures	0
10	20%	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If red on scorecard of April 2022, 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 FY2022 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 2023 & January 2024. Final results are based on quarterly reports of January, 2024	
		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 2024 Collaborative-wide session if asked **Not presenting if asked will yield -10 points on the FY2024 P4P scorecard*	20

FY2023 MARCQI Collaborative Quality Initiative Performance Index Scorecard - Year 3+ Participation Measurement Period: 01/01/2023 - 11/30/2023 QI Measurement Period: 10/01/2022-06/30/2023			
Measure #	Max. Weight	Measure Description	Points
		Plan submitted and approved Reporting requirements & timelines met, but the target identified is not met. A3 submitted with final report and presentation by clinical champion and clinical data abstractor given at June 2024 MARCQI Collaborative-wide sessions* **Not presenting at the June 2024 MARCQI Collaborative-wide sessions will yield -10 P4P points on the FY2024 P4P scorecard*	15
		Plan submitted and approved Reporting requirements are met, but the target and timelines are not met and A3 is not submitted.	10
		Plan is not developed, reports not done.	0
Extra Credit	0%	**Site based Quality Improvement Projects:** For sites FY2023 site based QI project goal--A case dive is completed for each case contributing to a site not meeting their target metric and submitted alongside the final report.	3
Extra Credit	0%	**MODB data submission:** Provide site's written 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, 2023	2

2023 Michigan Bariatric Surgery Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
1	10%	**Improvement/Excellence In Grade 1 Complication Rate:** (Improvement will be measured with a z-score rounded to the nearest whole number using data trended over a 3-yr period from October 1, 2020 to September 30, 2023; Excellence will be measured using OR Dates 10/1/2022 to 9/30/2023 and rounded to the nearest whole number). The better of the two scores will be used.	
		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:** (Improvement will be measured with a z-score rounded to the nearest whole number using data trended over a 3-yr period from October 1, 2020 to September 30, 2023; Excellence will be measured using OR Dates 10/1/2022 to 9/30/2023 and rounded to one decimal point). The better of the two scores will be used.	
		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** (For OR dates of October 1, 2021 to September 30, 2022) **Adjusted; Rounded to nearest whole number**	
		≥63% OR > 5% **relative** improvement from previous year (10/1/2020-/30/2021)	10
		Maintained 1-year follow-up rate/ >0 to <5% relative improvement from previous year (10/1/2020-9/30/2021)	5
		1-year follow-up rate decreased/No improvement in 1-year follow-up rate (10/1/2020-9/30/2021)	0
4	2.5%	**Compliance with VTE prophylaxis - Pre-operatively:**(Calendar Year 2023) **Unadjusted; Rounded to nearest whole number**	
		≥92% compliance with guidelines	2.5
		0 to 91% compliance with guidelines	0
5	2.5%	**Compliance with VTE prophylaxis - Post-operatively:** (Calendar Year 2023) **Unadjusted; Rounded to nearest whole number**	
		≥91% compliance with guidelines	2.5
		0 to 90% compliance with guidelines	0
6	10%	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs)** ***Collaborative wide measure, (October 1, 2022 to September 30, 2023); Baseline rate used to determine relative reduction 51 MME for OR Dates of 4/1/2021 to 3/31/2022	
		≤50 MME or ≥ 10% relative reduction in opioid use	10
		5-9% relative reduction in opioid use	5
		< 5% relative reduction	0

2023 Michigan Bariatric Surgery Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
7	10%	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs)** ***Hospital wide measure, Unadjusted; Rounded to the nearest whole number (October 1, 2022 to September 30, 2023)**;** Baseline rate used to determine relative reduction 51 MME for OR Dates of 4/1/2021 to 3/31/2022	
		≤50 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")** ***Collaborative wide measure, unadjusted and rounded to the nearest whole number, OR Dates October 1, 2022 to September 30, 2023	
		≤ 6% Avoidable ED visits	5
		> 6% Avoidable ED visits	0
9	5%	**Meeting Attendance - Surgeon:** (Calendar Year 2023) **In order for a surgeon to earn meeting attendance credit for a hospital, they must complete 10 bariatric surgery cases at that hospital for the dates of 1/1/2023 to 12/31/2023	
		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 2023)	
		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):** (Submitted to coordinating center by the last business day of each month - Please refer to 2023 Data Entry Deadlines Spreadsheet) (Calendar Year 2023) *****In order to be eligible for this measure, you must achieve >90% on the 2023 yearly audit when applicable. If the hospital does not reach >90% for the yearly audit, they will receive 0 points for this measure.	
		On time 11-12 months	5
		On time 10 months	3
		On time 9 months or less	0
12	5%	**Consent Rate:** (October 1, 2022 to September 30, 2023) **Unadjusted; Rounded to nearest whole number**	
		≥90% consented patients	5
		80-89% consented patients	3
		<80% consented patients	0

2023 Michigan Bariatric Surgery Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
13	10%	**Physician Engagement:** (January 1, 2023 to December 31, 2023)	10
		** 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 1/1/2023 to 12/31/2023	
		Following items count as 1 activity point:	
		Committee participation	
		MBSC survey response	
		Participate in a qualitative interview	
		Coauthor a paper	
		Participate in quality improvement initiatives (MPIRRE/FUTURE/MSHEILD/etc.)	
		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	
		Total	**100**

Michigan Bariatric Surgery Collaborative (MBSC)

2023 Performance Index Scorecard Measure Description

Measures #1: Improvement/Excellence in Grade 1 Complication Rate

This measure uses trended data over a three-year time period to determine if sites have had major improvement, moderate improvement/maintained their complication rate or have had no improvement or the rates of grade 1 complications have increased. Grade 1 complication rate calculates the percentage of patients who had a non-life-threatening complication with-in 30 days post-operatively of the bariatric surgery. Examples of these complications include, but are not limited to surgical site infection, anastomotic stricture, bleeding requiring blood transfusion less than 4 units or endoscopy, Pneumonia, hospital acquired infections of Clostridium Difficile and urinary tract infection, post- operative esophagogastroduodenoscopy (EGD), pancreatitis, thrush, ulcers and kidney stones.

Measures #2: Improvement/Excellence in Serious Complication Rate

This measure uses trended data over a three-year time period to determine if sites have had major improvement, moderate improvement/maintained their complication rate or have had no improvement or the rates of serious complications have increased. Serious complication rate calculates the percentage of patients who had a potentially life-threatening complications with-in 30 days post- operatively of the bariatric surgery. Examples of these complications include, but are not limited to: abdominal abscess requiring percutaneous drainage or reoperation, bowel obstruction requiring reoperation, leak requiring percutaneous drainage or reoperation, bleeding requiring transfusion >4 units, reoperation, or splenectomy, band-related problems requiring reoperation, respiratory failure requiring 2-7 days intubation, renal failure requiring in-hospital dialysis, wound infection/dehiscence requiring reoperation, and venous thromboembolism); and life-threatening complications associated with residual and lasting disability or death (myocardial infarction or cardiac arrest, renal failure requiring long-term dialysis, respiratory failure requiring >7 days intubation or tracheostomy, and death.

Measures #3: 1-Year Follow-up Rates

Patients are followed annually for years 1, 2, 3, 4 and 5 post-operatively following bariatric surgery through electronic and paper surveys. Improving first year follow-up rates through patient reported outcomes allows practitioners to learn what is most important to our patients. It also helps the collaborative to engage patients and track comorbidity resolution and learn of the common long-term outcomes.

Measures #4: Compliance with VTE prophylaxis- pre-operatively

The measure will identify the percentage of patients undergoing bariatric surgery who received Low Molecular Weight Heparin (LMWH) prior to the incision time. This metric helps to determine the appropriateness of resource utilization.

Measures #5: Compliance with VTE prophylaxis- post-operatively

The measure will identify the percentage of patients undergoing bariatric surgery who received Low Molecular Weight Heparin (LMWH) while hospitalized. This metric helps to determine the appropriateness of resource utilization.

Measures #6: Opioid Use- Opioid Prescriptions within 30 days (measured by MMEs)

This measure will help the collaborative to decrease the amount of opioids patients are prescribed at the time of discharge from their primary bariatric surgery operation. The collaborative must achieve greater than or equal to a 10% relative reduction in opioid use to receive maximum points for this measure.

****Collaborative wide measure and will be measured in MMEs

Measures #7: Opioid Use- Opioid Prescriptions within 30 days (measured by MMEs)

This measure will help the collaborative to decrease the amount of opioids patients are prescribed at the time of discharge from their primary bariatric surgery operation. The collaborative must achieve greater than or equal to a 10% relative reduction in opioid use to receive maximum points for this measure.

****Hospital wide measure and will be measured in MMEs

Measures #8: ED Visits- not resulting in a readmission ("avoidable")

This measure will help the collaborative to decrease the ED visits that do not result in a readmission within 30 days following bariatric surgery.

****Collaborative wide measure and will be measured in MMEs

Measures #9: Meeting Attendance- Surgeon

A bariatric surgeon must attend MBSC Collaborative Meetings for 2023.

***In order for a surgeon to earn meeting attendance credit for a hospital, they must complete 10 bariatric surgery cases at that hospital for the dates of 1/1/2023 to 12/31/2023

Scoring:

- Attends 3 out of 3 meetings receive all points
- Attends 2 out of 3 meeting receives partial points- needs improvement
- Attends fewer than 2 meetings receive no points- needs improvement

Measures #10: Meeting Attendance- Abstractor/Coordinator

A bariatric abstractor or coordinator must attend MBSC Collaborative Meetings for 2023.

Scoring:

- Attends 3 out of 3 meetings receive all points
- Attends 2 out of 3 meeting receives partial points- needs improvement
- Attends fewer than 2 meetings receive no points- needs improvement

Measures #11: Timely Monthly Data Submissions

Please refer to the MBSC Data Entry Deadlines document for the 2023 monthly deadlines.

In order for a hospital to be eligible for this measure, the hospital must achieve >90% on the 2023 yearly audit. If the hospital does not reach >90% for the yearly audit, the hospital will receive 0 points for this measure.

Measures #12: Consent Rate

Patients are invited to the follow-up portion of MBSC prior to receiving bariatric surgery. This measure calculates the percentage of patients who agree to receive surveys on their 1, 2, 3, 4 and 5th year anniversary dates of their bariatric surgery reporting weight loss, comorbidity resolution, quality of life and patient satisfaction.

Measures #13: Physician Engagement

MBSC bariatric surgeons must complete two of the engagement activities listed below in order to receive the maximum points available for the measure. Physician engagement is key to the collaborative culture in order for learning and improvement to occur.

***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 1/1/2023 to 12/31/2023.

Below are the activities for this measure:

- Completing this activity, the MBSC surgeon will receive maximum points for this measure
    - Host a quality site visit
    - Present MBSC data at a national meeting
    - Be a lead author on an MBSC publication

- Completing the following activities, the MBSC surgeon will receive 1 activity point for each measure below completed
    - Committee participation- Examples of committee participation include Executive, Robotics and the Enhanced Recovery After Surgery (ERAS) Committee
    - MBSC survey response
    - Participate in a qualitative interview
    - Coauthor a paper using MBSC data
    - Participate in quality improvement initiatives (MPIRRE/FUTURE/MSHEILD/etc.)
    - 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
- No participation in any of the above measures results in zero points

2023 Michigan Emergency Department Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2022 – 10/31/23 Year 1 Sites			
Measure #	Weight	Measure Description	Points
1	13%	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	13
		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	13%	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	13
		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	13%	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadlines	13
		1 deadline missed	8
		2+ deadlines missed	0
4	12%	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0
5	12%	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss > 1 Meeting	0
6	14%	**Time from Agreement being signed to hiring date of data abstractor**	
		<90 days	14
		91-120 days	8
		>120 days	0
7	14%	**Time from Agreements signed to successful submission of electronic production data**	
		<90 days	14
		91-120 days	8
		>120 days	0
8	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

MEDIC 2023 Performance Index Scorecard - Year 1

Participation

Measure	Definition of Success		Max Point Value
Timeliness of Data Delivery	All 12 months = 13	9 or 10 months = 4	**13**
	11 months = 8	< 9 months = 0	
Accuracy of Data Delivery	All 12 months = 13	9 or 10 months = 4	**13**
	11 months = 8	< 9 months = 0	
Timeliness of Abstraction	All cases abstracted by quarterly deadlines = 13	1 deadline missed = 8	**13**
		2+ deadlines missed = 0	
CWM Attendance: Clinical Champion	Attend all meetings = 12	Miss one meeting = 6	**12**
		Miss > 1 meeting = 0	
CWM Attendance: Abstractor	Attend all meetings = 12	Miss one meeting = 6	**12**
		Miss > 1 meeting = 0	
Time to Abstractor Hire	< 90 days = 14	91 - 120 days = 8	**14**
		> 120 days = 0	
Time to Electronic Data Submission	< 90 days = 14	91 - 120 days = 8	**14**
		> 120 days = 0	
Intervention Planning for Year 2	Materials submitted on time = 9	Materials not submitted on time = 0	**9**

2023 Michigan Emergency Department Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2022 – 10/31/23 Year 2 Sites			
Measure #	Weight	Measure Description	Points
1	15%	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	15
		11 months of data transfers on tine	10
		9-10 months of data transfers on time	5
		< 9 months of data transfers on time	0
2	15%	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	15
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	10
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	5
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	10%	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadlines	10
		1 deadline missed	5
		2+ deadlines missed	0
4	10%	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
5	10%	**Meeting Attendance: Data Abstractor**	
		Attend All Meeting	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
6	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
		< 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
7a	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
7b	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

2023 Michigan Emergency Department Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2022 – 10/31/23 Year 2 Sites			
Measure #	Weight	Measure Description	Points
8	20%	**Collaborative-Wide Measure: Peds CXR Utilization AND Peds HI CT Utilization** ***Measures and targets identified in Appendix**	
		Met Pediatric CXR Utilization	10
		Met Pediatric Intermediate Risk HI	10
		Did not meet either target	0

MEDIC 2023 Performance Index Scorecard - Year 2

Participation

Measure	Definition of Success		Max Point Value
Timeliness of Data Delivery	All 12 months = 15	9 or 10 months = 5	15
	11 months = 10	< 9 months = 0	
Accuracy of Data Delivery	All 12 months = 15	9 or 10 months = 5	15
	11 months = 10	< 9 months = 0	
Timeliness of Abstraction	All cases abstracted by quarterly deadlines = 10	1 deadline missed = 5	10
		2+ deadlines missed = 0	
CWM Attendance: Clinical Champion	Attend all meetings = 10	Miss one meeting = 5	10
		Miss > 1 meeting = 0	
CWM Attendance: Abstractor	Attend all meetings = 10	Miss one meeting = 5	10
		Miss > 1 meeting = 0	
SNAP Review: Cohort Decisions	≥ 90% correct = 4	75% - <90% = 2	4
		< 75% = 0	
SNAP Review: Data Elements	≥ 97% correct = 6	95% - 97% = 3	6
		< 95% = 0	

Site Specific Discharge

Measure	Definition of Success		Max Point Value
Low Risk Chest Pain OR Timely Administration of Steroids in Pediatric Asthma	QI project and > 92% = 10	QI, no improvement = 4	10
	QI, improvement, < 92% = 7	No QI or improvement = 0	
	QI project and > 55% = 10	QI, no improvement = 4	
	QI, improvement, < 55% = 7	No QI or improvement = 0	

All In For Kids Collaborative Measures

Measure	Definition of Success		Max Point Value
Chest X-Ray	≤ 37% Utilization = 10	> 37% Utilization = 0	10
Peds Head Injury: Intermediate Risk	≤ 25% Utilization = 10	> 25% Utilization = 0	10

2023 Michigan Emergency Department Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2022 – 10/31/23 Year 3+ Sites			
Measure #	Weight	Measure Description	Points
1	5%	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	5
		11 months of data transfers on time	4
		9-10 months of data transfers on time	3
		< 9 months of data transfers on time	0
2	5%	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	5
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	4
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	3
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	5%	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadlines	5
		1 deadline missed	3
		2+ deadlines missed	0
4	5%	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss > 1 Meeting	0
5	5%	**Meeting Attendance: Data Abstractor**	
		Attend All Meeting	5
		Miss 1 Meeting	3
		Miss > 1 Meeting	0
6	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
		95-97% of abstracted registry data accurate	2
		< 95% of abstracted registry data accurate	0
7a	15%	**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	15
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	6
		QI Project not developed or implemented	0
7b	15%	**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	15
		QI Project develo9ped and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	6
		QI Project not developed or implemented	0

2023 Michigan Emergency Department Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2022 – 10/31/23 Year 3+ Sites			
Measure #	Weight	Measure Description	Points
8	40%	**Collaborative-Wide Measure: Peds CXR Utilization AND Peds HI CT Utilization *Measures and targets identified in Appendix**	
		Met Pediatric CXR Utilization	20
		Met Pediatric Intermediate Risk HI	20
		Did not meet either target	0
9a	15%	**Site Specific – Quality Improvement Initiative: Adult Head Injury CT Appropriateness**	
		QI Project developed and implemented and site met or exceeded target	15
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	6
		QI Project not developed or implemented	0
9b	15%	**Site Specific – Quality Improvement Initiative: Adult Suspected PE CT Diagnostic Yield**	
		QI Project developed and implemented and site met or exceeded target	15
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	6
		QI Project not developed or implemented	0
9c	15%	**Site Specific – Quality improvement initiative: CXR Utilization in Pediatric Respiratory Illness**	
		QI Project developed and implemented and site met or exceeded target	15
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project develo9ped and implemented but there was no improvement to the target	6
		QI Project not developed or implemented	0

MEDIC 2023 Performance Index Scorecard - Year 3+

Participation

Measure	Definition of Success		Max Point Value
Timeliness of Data Delivery	All 12 months = 5	9 or 10 months = 3	5
	11 months = 4	< 9 months = 0	
Accuracy of Data Delivery	All 12 months = 5	9 or 10 months = 3	5
	11 months = 4	< 9 months = 0	
Timeliness of Abstraction	All cases abstracted by quarterly deadlines = 5	1 deadline missed = 3	5
		2+ deadlines missed = 0	
CWM Attendance: Clinical Champion	Attend all meetings = 5	Miss 1 meeting = 3	5
		Miss > 1 meeting = 0	
CWM Attendance: Abstractor	Attend all meetings = 5	Miss 1 meeting = 3	5
		Miss > 1 meeting = 0	
SNAP Review: Cohort Decisions	≥ 90% correct = 2	75% - <90% = 1	2
		< 75% = 0	
SNAP Review: Data Elements	≥ 97% correct = 3	95% - 97% = 2	3
		< 95% = 0	

Site Specific Discharge

Measure	Definition of Success		Max Point Value
Low Risk Chest Pain OR Timely Administration of Steroids in Pediatric Asthma	QI project and > 92% = 15	QI, no improvement = 6	15
	QI, improvement, < 92% = 12	No QI or improvement = 0	
	QI project and > 55% = 15	QI, no improvement = 6	
	QI, improvement, < 55% = 12	No QI or improvement = 0	

All In For Kids Collaborative Measures

Measure	Definition of Success		Max Point Value
Chest X-Ray	≤ 37% Utilization = 20	> 37% Utilization = 0	20
Peds Head Injury: Intermediate Risk	≤ 25% Utilization = 20	> 25% Utilization = 0	20

Site Specific Imaging Measures

Measure	Definition of Success		Max Point Value
Adult Head Injury OR CT for Pulmonary Embolism OR Chest X-Ray	QI project and > 66% = 15	QI yes, improvement no = 6	15
	QI, improvement, < 66% = 12	No QI or improvement = 0	
	QI project and > 10% = 15	QI yes, improvement no = 6	
	QI, improvement, < 10% = 12	No QI or improvement = 0	
	QI project and < 20% = 15	QI yes, improvement no = 6	
	QI, improvement, > 20% = 12	No QI or improvement = 0	

Appendix				Michigan Emergency Department Improvement Collaborative (MEDIC)	
Year(s)	**Measure #**	**Measurement Type**	**Measure Condition/Category**	**Measure Description**	**Target**
2+	7	Site-Specific	Adult Chest Pain Safe Discharge	Performance for safe discharge of adult low risk chest pain cases	**≥ 92%**
			Timely Administration of Steroids in Pediatric Asthma	Proportion of pediatric asthma cases that receive a steroid in the first 60 minutes of their ED visit	**≥ 55%**
2+	8	Collaborative-Wide[1]	CXR for asthma, bronchiolitis, and croup	Collaborative Wide performance for reducing the utilization of chest xrays for pediatric patients with asthma, bronchiolitis, and croup	**≤ 37%**
			Pediatric Intermediate Risk Minor HI	Collaborative-Wide performance on CT utilization for pediatric intermediate risk minor head injury	**≤ 25%**
3+	9	Site-Specific	Adult Minor HI	Performance for appropriate CT use in adults with minor head injury	**≥ 66%**
			PE Diagnostic Yield	Performance for increasing the number of CT for PE scans that are positive	**≥ 10%**
			CXR for asthma, bronchiolitis, and croup	Performance for reducing the utilization of chest x-rays for pediatric patients with asthma, bronchiolitis, and croup	**≤ 20%**

[1]The Collaborative must collectively meet or exceed APPLICABLE Collaborative-wide measure targets in order for any site to receive full points. Each performance measurement includes all sites that see the specified.

Appendix						
Year(s)	**Measure #**	**Measure Type**	**Measure Condition/Category**	**Measure Description**	**Target**	**Measure Calculation Methodology**
All	1	Site-Specific	Participation	Electronic data file must be delivered on a monthly schedule, as agreed upon by the Coordinating Center and site data resource. If a file cannot be delivered in a timely manner and email must be sent to the Coordinating Center prior to the due date.	100%	12 months of timely file transfers = Full points 11 months of timely file transfers = reduced points 9 – 10 months of timely file transfers = further reduced points 0 – 8 months of timely file transfers = no points
All	2	Site-Specific		Electronic data file transferred every month must adhere to the MEDIC electronic data dictionary and must be accurate.	100%	12 months of adherent file transfer = Full points 11 months of adherent file transfers = reduced points 9 – 10 months of adherent file transfers = further reduced points 0 – 8 months of adherent file transfers = no points
All	3	Site-Specific		All cases must be abstracted by the quarterly submission deadlines	All deadlines met	All deadlines met = Full points 1 deadline missed = reduced points 2+ deadlines missed = no points
All	4	Site-Specific		Clinical Champions from each site must attend all Collaborative Wide Meetings and Clinical Champion Quarterly Calls. Clinical Champions may send one physician proxy to a single Collaborative Wide Meeting per year without penalty. This proxy must be approved by MEDIC prior to the meeting, cannot already represent another MEDIC site, and cannot be a resident or fellow.	All meetings attended	Attend all meetings = Full points Miss one meeting = reduced points Miss more than one meeting = no points
All	5	Site-Specific		Abstractors from each site must attend all Collaborative Wide Meetings. Abstractors may send one appropriate proxy to a single Collaborative Wide Meeting per year without penalty. This proxy must be approved by MEDIC prior to the meeting and cannot already represent another MEDIC site.	All meetings attended	Attend all meeting = Full points Miss one meeting = reduced points Miss more than one meeting = no points

Appendix						
Year(s)	**Measure #**	**Measure Type**	**Measure Condition/Category**	**Measure Description**	**Target**	**Measure Calculation Methodology**
2,3+	6	Site-Specific		Abstracted registry data must pass an annual audit with >90% case cohort decisions correct and >97% data element accuracy.	> 97% data element accuracy > 90% cohort	60% of points are based off of data element accuracy, divided into 3 point levels. >97% = full points, > 95% = mid points, < 95% = no points. 40% of points for correct cohort decision. >90% = full points, >75% = mid points, < 75% = no points
2+	7a	Site-Specific	Timely Administration of Steroids in Pediatric Asthma	Increase the percentage of pediatric asthma patients who receive steroids within 60 minutes of arrival to the emergency department	≥ 55%	Number of pediatric patients with an asthma diagnosis who received steroids in the first 60 minutes of their ED visit divided by the total number of pediatric patients with an asthma diagnosis who received steroids at any point in their ED visit
2+	7b	Site-Specific	Safe Discharge Adult Low Risk Chest Pain	Performance on discharge rate for low risk adult chest pain patients.	≥ 92%	Number of ED visits for adult patients with low risk chest pain and an intended disposition of discharged from the ED divided by the number of ED visits for patients with low risk chest pain, calculated for an individual site
2+	8	Collaborative-Wide[1]	All in for Kids: CXR Utilization for asthma, bronchiolitis, and croup CT Utilization for intermediate risk head injury	Collaborative-Wide performance for reducing the utilization of chest xrays for pediatric patients with asthma, bronchiolitis, and croup	≤ 37%	Average CXR utilization of all year 2+ sites, weighted equally. For example, if site A has 10%, site B has 15%, and site C has 20%, the average rate is 15%, regardless of the volumes at each site.
				Collaborative-Wide performance for CT use in pediatric patients with intermediate risk minor head injury	≤ 25%	Average CT utilization of all year 2+ sites, weighted equally. For example, if site A has 10%, site B has 15%, and site C has 20%, the average rate is 15%, regardless of the volumes at each site.

Appendix						
Year(s)	**Measure #**	**Measure Type**	**Measure Condition/Category**	**Measure Description**	**Target**	**Measure Calculation Methodology**
3+	9	Site-Specific[2]	Adult Head Injury CT Appropriateness OR PE diagnostic yield OR CXR for asthma, bronchiolitis, croup	Performance for appropriate CT use in adults with minor head injury	≥ 66%	PE: Number of PE CT scans that are positive for pulmonary embolism divided by the number of ED visits with eligible PE CT scans after exclusions are applied, calculated for an individual site.
				Performance for increasing the number of CT for PE scans that are positive	≥ 10%	CXR: Number of ED visits of children with respiratory illness diagnoses receiving a CXR divided by the number of ED visits of children with respiratory illness diagnoses, calculated for an individual site
				Performance for reducing the utilization of chest x-rays for pediatric patients with asthma, bronchiolitis, and croup		

[1]The Collaborative must collectively meet or exceed APPLICABLE Collaborative-wide measure targets in order for any site to receive full points. Each performance measurement includes all sites that see the specified population.

[2]For 2023, sites will choose one of the following:

a) Increase the amount of CTs for Adult Minor Head Injury that are appropriate
b) Increase the diagnostic yield for CT for PE
c) Reduce the utilization of CXR for children with asthma, bronchiolitis, and croup

2023 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Measure	
Measure Number	7a
Measure Description	Increase the percentage of pediatric asthma patients who receive steroids within 60 minutes of arrival to the emergency department
What is the current performance for this measure?	43%
What is the current median for this measure?	31%
What is the time period and scoring methodology on which the current performance was determined? (e.g. The current distribution was determined based on average rate of all collaborative participants from 7/1/16 through 6/30/2017)	The current performance was determined based on the average rate of all collaborative participants from 4/1/2021 – 3/1/2022
What time period and scoring methodology will be used to calculate the final score for each measure to determine which scoring tier each site's performance corresponds to? (e.g. An average rate based on the final month of cases collected in the measurement period).	Sites will have from 11/1/2022 through 10/31/2023 to work on this QI. The score reported will be the site's average performance as of the end of Oct 2022 relative to the target of 55%. This will allow a full year for measurement/improvement, and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in early 2024.

2023 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Measure	
Measure Number	7b
Measure Description	Increase rate of safe discharge for adult low risk chest pain patients
What is the current performance for this measure?	92.0%
What is the current median for this measure?	96.0%
What is the time period and scoring methodology on which the current performance was determined? (e.g. The current distribution was determined based on average rate of all collaborative participants from 7/1/16 through 6/30/2017)	The current performance was determined based on the average rate of all collaborative participants from 4/1/2021 – 3/31/2022
What time period and scoring methodology will be used to calculate the final score for each measure to determine which scoring tier each site's performance corresponds to? (e.g. An average rate based on the final month of cases collected in the measurement period).	Sites will have from 11/1/2022 through 10/31/2023 to work on this QI. The score reported will be the site's average performance as of the end of Oct 2022 relative to the target of 90%. This will allow a full year for measurement/improvement, and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in early 2024.

2023 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Measure	
Measure Number	8,9
Measure Description	Decrease inappropriate use of head CTs in the adult and pediatric minor head injury population.
What is the current performance for this measure?	56% for adult head injury, 26% for pediatric head injury
What is the current median for this measure?	57% for adult head injury, 24% for pediatric head injury
What is the time period and scoring methodology on which the current performance was determined? (e.g. The current distribution was determined based on average rate of all collaborative participants from 7/1/16 through 6/30/2017)	The current performance was determined based on the mean and median rate of all collaborative participants from 4/1/2022 – 3/31/2023
What time period and scoring methodology will be used to calculate the final score for each measure to determine which scoring tier each site's performance corresponds to? (e.g. An average rate based on the final month of cases collected in the measurement period).	Sites will have from 11/1/2022 through 10/31/2023 to work on this QI. This will allow a full year for measurement/improvement, and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in early 2024.

2023 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Measure	
Measure Number	8,9
Measure Description	Sites must either select to work on the rate of chest x-ray utilization in pediatric respiratory patients **OR** the diagnostic yield of chest CTs performed for suspected pulmonary emboli
What is the current performance for this measure?	9.2% for PE, 37% for CXR
What is the current median for this measure?	9.8% for PE, 36% for CXR
What is the time period and scoring methodology on which the current performance was determined? (e.g. The current distribution was determined based on average rate of all collaborative participants from 7/1/16 through 6/30/2017)	The current performance was determined based on the average rate of all collaborative participants from 4/1/2021 – 3/31/2022
What time period and scoring methodology will be used to calculate the final score for each measure to determine which scoring tier each site's performance corresponds to? (e.g. An average rate based on the final month of cases collected in the measurement period).	Sites will have 11/1/2021 through 10/31/2023 to work on this QI. The score reported will be the site's average performance as of the end of Oct 2022 relative to the targets of 11% and 25%. This will allow a full year for measurement/improvement, and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in early 2023.

2023 Michigan Radiation Oncology Quality Consortium (MROQC) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2023 – 09/30/2023			
Measure #	Weight	Measure Description	Points
1	10	**High Quality Clinical and Physics Data Submission and Completeness[1]**	
		Four Data Quality Metrics Met	10
		Three Data Quality Metrics Met	8
		Two Data Quality Metrics Met	4
		One Data Quality Metric Met	2
		None of the Data Quality Metrics Met	0
2	5	**Submission of Technical Data *(Full DICOM RT data and Physics Radiotherapy Technical Details Survey)* for Breast, Lung, and Complex Bone Mets Cases**	
		> 85% of technical data submitted within six weeks of treatment completion	5
		> 85% of technical data submitted within eight weeks	4
		> 85% of technical data submitted within twelve weeks	3
		> 85% of technical data submitted after twelve weeks	2
		< 85% of technical data submitted after twelve weeks	0
3	10	**In node positive breast cancer patients for whom the supraclavicular (SCV) and/or infraclavicular (ICV) nodes are treated, the irradiated nodal group(s) is(are) contoured and named per TG-263 naming convention AND the dose is reported.**	
		Contours and dose reported in ≥60% of patients	10
		Contours and dose reported in 40 – 59% of patients	7
		Contours and dose reported in < 40% of patients	0
4	10	**Mean heart dose achieved in breast patients receiving conventionally fractionated radiotherapy to supraclavicular, infraclavicular, and/or internal mammary nodes[2]**	
		≥ 85% of patients meet heart sparing goals	10
		60 – 84% of patients meet heart sparing goals	7
		< 60% of patients meet heart sparing goals	0
5	10	**Collection rate of annual lung follow-up for those due for 1st year follow-up January 1, 2023 - September 30, 2023**	
		≥ 75% rate of annual lung follow-up	10
		60 – 74% rate of annual lung follow-up	7
		< 60% rate of annual lung follow-up	0
6	10	**For lung cancer patients: evaluate Task Group-263 compliance for the specified structures *(heart, PTV, GTV/IGTV/ITV, esophagus, spinal cord or canal, and normal lung)* for the initial DICOM entry.**	
		≥ 80% compliance for the specified structures	10
		60 – 79% compliance for the specified structures	7
		< 60% compliance for the specified structures	0

2023 Michigan Radiation Oncology Quality Consortium (MROQC) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2023 – 09/30/2023			
Measure #	Weight	Measure Description	Points
7	10	**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[3]** **B: Your site-level rate of ≤5 fraction treatment is at least 60% for all patients**	
		A and B are met	10
		Only B is met	7
		B is not met	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 prostate cancer may also receive a brachytherapy boost.**	
		≥ 60% of patients receive high value radiotherapy	10
		40 – 59% of patients receive high value radiotherapy	7
		< 40% of patients receive high value radiotherapy	0
9	10	**Prostate Working Group Performance Goal: Completion of 6-month follow-up form (P6)**	
		≥ 60% rate of prostate 6-month follow-up completed	10
		40 – 59% rate of prostate 6-month follow-up completed	7
		< 40% rate of prostate 6-month follow-up completed	0
10	5	**Collaborative Meeting Participation – Clinical Champion** ***(Per MROQC CC Attendance Policy)***	
		All meetings or two meetings with one meeting attended by an acceptable designee	5
		Two meetings	3
		One meeting or none attended	0
11	5	**Collaborative Meeting Participation – Physics Lead** ***(or designee)***	
		All meetings	5
		Two meetings	3
		One meeting or none attended	0
12	5	**Collaborative Meeting Participation – Clinical Data Abstractor** ***(CDA or designee)***	
		All meetings	5
		Two meetings	3
		One meeting or none attended	0

2023 Michigan Radiation Oncology Quality Consortium (MROQC)
Collaborative Quality Initiative Performance Index Scorecard
Measurement Period: 01/01/2023 – 09/30/2023

Measure #	Weight	Measure Description	Points

[1]Data Quality Metrics

A. Highly accurate data:
Overall data accuracy determined by audit of breast, lung, bone mets, and prostate data is ≥95%.

B. Sufficient audit preparation and follow-up:
Audit materials are available for review at the time of audit
Appropriate staff member (CDA for clinical data audit and physicist or dosimetrist for physics data audit) attends the audit
Corrections identified during clinical or physics data audit are completed within 2 weeks of the audit date.

C. Active use of clinical data quality reports in the Breast & Lung and Bone Mets databases
Fewer than 5% of 2023 cases have a quality report error

D. Active use of physics data quality reports in the Breast & Lung and Bone Mets databases
Fewer than 5% of 2023 cases have a quality report error

*****_2023 cases are defined as patients with an RT end date of 10/1/22-9/30/23 (unless otherwise specified by measure)_

[2]Cardiac Dose Thresholds
Left ≤2.0 Gy Right ≤1.0 Gy

[3]Uncomplicated bone mets definition: No prior radiation to same anatomic site; no cord compression, cauda compression or radicular pain at the site being treated; no prior surgery at the site being treated; no associated soft tissue mass; patient reports any pain (pain score 1-10); a non-curative treatment intention

2023 Michigan Surgical Quality Collaborative Performance Index Scorecard Project Time Period: 1/1/2023 – 12/31/2023			
Measure #	Weight	Measure Description	Points
1	8%	**Collaborative Meetings (4) – Surgical Clinical Quality Reviewer (SCQR)**	
		3 or more meetings	8
		2 meetings	4
		1 meeting	0
2	8%	**Collaborative Meetings (3) – Surgeon Champion**	
		3 meetings	8
		2 meetings	4
		1 meeting	0
3	4%	**Conference Calls (3) – SCQR**	
		2 or more calls	4
		1 call	2
		0 call	0
4	4%	**Conference Calls (3) – Surgeon Champion**	
		2 or more calls	4
		1 call	2
		0 call	0
5	6%	**Completeness of Data Abstraction (maximum 6 pts available)**	
		Sampled and incomplete cases $\leq$ 0.5% total volume	3
		30-day follow-up rate $\geq$ 80% for 1st quarter 2023 (Jan – March cases)	1
		30-day follow-up rate $\geq$ for 2nd quarter 2023 (April – June cases)	1
		30-day follow-up rate $\geq$ 80% for 3rd quarter 2023 (July – September cases)	1
6	20%	**Collaborative Wide Measure – Reduce % of all MSQC elective procedures performed on patients who have smoked within the last 30 days**	
		$\leq$ 13.9%	20
		14.0% - 14.4%	15
		14.5% - 15.0%	10
		15.1% - 15.6%	5
		$\geq$ 15.7%	0
7	20%	**Site Directed Measure: Sites choose a measure they are performing above/below MSQC threshold or needs improvement by December 10, 2022. Sites will choose an outcome measure such as SSI rate, Sepsis rate, pneumonia, readmissions, reoperations, ED visit rate, UTI, VTE**	
		Demonstrate $\geq$ 10% improvement in performance	20
		Demonstrate $\geq$ 7.5% improvement in performance	15
		Demonstrate $\geq$ 5% improvement in performance	10
		Demonstrate $\geq$ 2.5% improvement in performance	5
8	5%	Complete documentation of size and location of hernia $\geq$ 90%	5
9	25%	**Quality Improvement Initiative (QII) – Pilot study, choose:** SUCCESS Toolkit Implementation Appropriate Preoperative Screening for Low-Risk Surgeries Frailty Screening	25

2023 Michigan Surgical Quality Collaborative Performance Index Scorecard Project Time Period: 1/1/2023 – 12/31/2023			
Measure #	Weight	Measure Description	Points
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 2022 once more data is available.

Quality Improvement Implementation - SUCCESS 2023

Project Time Period: 1/1/2023-12/31/2023

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 – In collaboration with the Surgical Champion, and the departments of quality, surgery, and education, 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 of a toolkit 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.

Eligibility – Sites that captured data in the MSQC SUCCESS tab in 2022 are eligible to select this project as their 2023 QI Project.

QI Implementation Goals and Requirements:

Goal 1: Multidisciplinary kickoff meeting with key stakeholders by March 31, 2023 to review project requirements. (2 points)
- The Value Proposition/Leadership Engagement Briefing should be utilized during this meeting.
- Must submit minutes and attendees to the coordinating center with the final project submission.

Goal 2: Implement the SUCCESS toolkit and submit a narrative of how the following toolkit elements were implemented and/or utilized: (0-16 pts)
- Readiness Assessment: Urinary Catheter Care Guide to Patient Safety (GPS)
- Algorithm for standardized management of postoperative urinary retention
- MAP App, laminated cards, and/or MAP poster
- Strategies for safe catheter insertion: safe Insertion booklet, difficult insertion training videos, difficult catheter insertion kit, catheter alternatives

Goal 3: Refine and tailor the MSQC SUCCESS urinary care pathway. The final care pathway will be submitted with the project summary. (2 points)

Goal 4: Bi-annual (minimally) review of SUCCESS data during multidisciplinary meetings. Submit meeting minutes (2 points)

Goal 5: Capture all SUCCESS data in MSQC Workstation for eligible cases (3 points)

Goal 6: Submit the 2023 SUCCESS Project Summary to the MSQC Coordinating Center no later than **January 16, 2024.**

Implementation Points - An additional 0-5 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 20 project points.

References:

1. https://msqc.org/success/

   Michigan Appropriate Perioperative (MAP) criteria for urinary catheter use in common general and orthopedic surgeries: results obtained using the RAND/UCLA Appropriateness Method. (2019) https://qualitysafety.bmj.com/content/28/1/56

Quality Improvement Implementation - Frailty Pathway
Project Time Period: 1/1/2023-12/31/2023

Summary: The focus of this project will be to institute a system for screening vulnerable patients for the presence of frailty using a validated screening tool. The information gathered during the screening process will be used to guide discussion between the patient, family, caregivers and surgeon regarding the risks, benefits, and desired outcomes of surgical and non-surgical intervention. The site will monitor compliance with both using the selected validated screening tool as well as the documentation of a guided conversation following screening and prior to surgery between the surgeon and patient/caregivers. Moving forward, the information gathered during the pilot year of the frailty pathway will inform and direct the interventions for patients identified as frail in future projects.

QI implementation Requirements: For the frailty pathway, sites will continue to collect MSQC core data. In addition to this collection sites will implement and distribute to participating surgeons a frailty screening tool which will be obtained on all patients meeting criteria.

Criteria for Frailty Screening:

- Age $\geq$ 60 on surgical date
- Currently on Hemodialysis
- Current diagnosis of Cancer
- Identified as “not independent”
- Current diagnosis of CHF

The SCQR will be responsible for education of surgeons and their staff in the use of this tool and assistance ensuring that a guided discussion of risks and benefits is had and documented in the electronic medical record. Frailty screening will occur on all patients meeting criteria who are undergoing an elective MSQC included procedure.

Additional resources: Sites participating in the frailty pathway will have access to the frailty toolkit with evidence based interventions to improve medical management.

Implementation goals: Implement all the following to improve upon and monitor the process measures for frailty screening in elective patients. Measurement period will include 7/1/2023-12/31/2023.

Pre-implementation & Planning	Implementation	Data collection	Follow up
Determine the frailty screening tool to be used at your facility	Disseminate Screening tool to surgeon offices	Review EMR for appropriate patients	Identify trends for gaps in documentation
Educate staff and surgeons regarding use of the tool and rationale for screening	Determine the location of screening results in the EMR	Abstract presence of screening, total score, name of tool used, and level of frailty	Follow up with outliers to determine barriers to completing or documenting tools
Develop tool to chart completion of risk assessment discussion	Review with surgeons the necessary elements of patient risk discussion with screening results	Abstract presence of charting discussion with patient/caregivers in EMR	Identify trends in missing documentation and follow up with outliers to identify barriers to discussion or charting

Goal 1: Pre-implementation and planning goals (6 points total)

1a: Determine a screening tool to be used across the institution.
Decision to be made with input from all stakeholders (surgeon, office staff, SCQR, etc.) The decided-on tool will be submitted to the coordinating center no later than May 1, 2023. (3 points)

- Validated screening tools:
  - RAI-C Score (appendix A)
  - FRAIL Scale (appendix A)
  - Edmonton Frail Scale (appendix A)
  - Groningen Frail Scale (appendix A)
  - Clinical Frailty Scale (appendix A)

Participating sites will work with their surgeons to determine which of the above frailty scales are best suited for their institution and patient needs. The decided-on tool will be submitted to the coordinating center on or before May 1, 2023.

After discussion with stakeholders, an alternate tool may be currently in use or desired for determination of frailty. Any tool used must be a validated screening tool. Any site wishing to use an alternate tool must submit to MSQC the name of the tool for approval on or before May 1, 2023.

1b: Multidisciplinary meeting to kick off data collection and implementation.

The kickoff meeting must include at least three individuals representing: MSQC, surgeon stakeholders or advanced practice individuals working with surgeons, anesthesia, quality department, perioperative staffing or management representation and any other group who will be impacted or needed for assistance with project completion. (3 points)

- An agenda outlining the planned discussion should be submitted with the final project submission. Minutes should be taken and submitted with the final project submission. Any power points or visual aids utilized in the presentation should be submitted with the final project submission.
- A synchronous meeting may take place in person or hybrid in person/virtual. Attendees and their role within the organization as well as within the project should be tracked and submitted to MSQC. Asynchronous participation via email or video may be utilized to share information with additional stakeholders, however the synchronous portion of the meeting must have at least three participants to encourage active participation and discussion.
- Tracking and documentation of communication with stakeholders regarding the utilization of the screening tool with stakeholders should be maintained. Communication includes introduction to the project as well as any assistance or problem solving with the surgeons/facility to ensure adequate utilization and appropriate use of tools. This tracking should be incorporated into the final project summary.

Goal 2: Implementation goals (6 points total)

2a: Disseminate screening tools to surgeon offices
Screening tool may be completed electronically, incorporated into the EMR or completed on paper at the preoperative appointment. (3 points)

When abstracted the tool name, total score and the level of frailty are to be obtained. Please refer to the selected screening tool in the frailty toolkit to determine level of frailty to be assigned based on scoring results. If you are not using an MSQC identified tool and have obtained permission to use an alternate

tool, you will be provided with the level of frailty to be assigned based on the scores obtained from the decided upon tool.

- ➢ Determine workflow for filling out the screening tool and identify staff responsibility in ensuring completion. Tools may be completed by surgeon or office staff as appropriate for training and scope of practice.
- ➢ Initiate any tools needed for placement of screening tool data in the EMR. You may work with your IT department for options to incorporate this or use the scanned document feature if the tool is to be completed on paper.
- ➢ The documentation of the frailty screening tool and discussion should be consistent in the EMR to facilitate abstraction. Work with IT if needed to identify and develop appropriate tools if needed. Use of "dot phrases" within the preoperative note may be useful for discussion documentation.
- ➢ You should identify a process for noting and completing any incomplete questions on the screening tool for accurate calculation of frailty. Failure to fully complete the necessary elements of the screening tool will be marked as "screening incomplete" unless the incomplete elements may be obtained by the SCQR from the medical record on abstraction.

2b: Develop standardized charting to attest a discussion with patient and family members regarding risk, benefit and expected outcomes. (3 points)

- ➢ Review with surgeons the necessary elements of preoperative risk assessment and discussion with patient and caregivers. This discussion should include review of the frailty screening, discussion of risks specific to the patient for both operative and non-operative management of patient condition and should include the patient as well as caregivers or family members identified by the patient as assisting with their care. Necessary elements and tips are available in the frailty toolkit.
  - When discussing possible outcomes patients and caregivers should be educated on potential negative outcomes including the possibility of postoperative delirium and loss of functioning either temporarily or permanently. The possibility of needing placement or increased assistance at home postoperatively should also be discussed.

Goal 3: Data collection goals (8 points total)

3a: Presence of complete frailty screening tool data for > 75% of patients who meet criteria for screening. (4 points)

3b: Presence of attestation of informed discussion between the surgeon and patient/caregivers regarding risks/benefits and expected outcomes for > 75% of patients meeting criteria for screening. (4 points)

Goal 4: Project Summary (5 points total)

Submit a QII Project Summary which includes a narrative description of the project and activity tracking of the steps to implementation of the frailty pathway, PDSA steps taken to address any deficiencies, successes and barriers to implementation and analysis, and next steps to improve performance. The template for this is available on the MSQC website. Documentation may include attachments as needed to exemplify steps taken. Any modifications made to any portion of the project including the rationale for modification and evaluation of success of the modified process should be included.

Quality Improvement Implementation -
Appropriate Preoperative Screening for Low-Risk Surgeries Pilot Study
Project Time Period: 1/1/2023 – 12/31/2023

Background: The Appropriate Preoperative Screening for Low-Risk Surgeries Pilot Study is based on 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. 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.

Project Goal and Summary – In collaboration with MVC and MPrOVE, this pilot project will work toward reducing unnecessary, routine preoperative testing for low-risk surgeries. Pilot study work performed by MSQC sites will be integral to identifying the underlying reasons for overuse of preoperative testing in low-risk surgeries, as well as interventions to heighten awareness and reduce variation among hospitals.

Through a multi-faceted approach, 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.

QI Implementation Goals and Requirements (25 total project points)

Goal 1: Baseline data collection of preoperative testing use (6 total points)

- **Goal 1a:** Abstract and capture preoperative diagnostic testing that was performed within 90 days prior to surgery date into the MSQC Workstation. Eligible low-risk surgery cases include minor hernia, laparoscopic cholecystectomy, and breast lumpectomy. **(2 points)**
- **Goal 1b:** Achieve 80% complete data collection of preop diagnostic testing for eligible procedures. Measurement period 1/1/2023 – 12/31/2023 cases. **(4 points)**

Presence/absence of all of the following preoperative diagnostic tests on an eligible case must be captured 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: Develop/implement a standard preoperative testing protocol for low-risk surgeries at your site. The protocol selected must be implemented no later than June 30, 2023. (14 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 facility. **(4 points)**
  - Adopt an existing protocol
    - American Society of Anesthesiologists' "Choosing Wisely" program)
    - United Kingdom's NICE (National Institute for Health and Care Excellence) preoperative testing guidelines for elective surgery)
  - Develop your own hospital preoperative testing protocol
  - Review and modify an existing protocol already in use at your hospital.
- **Goal 2b**: As part of the implementation process, sites must adopt clinical decision support tools to embed the preoperative testing protocol into practice. **(5 points)**
- **Goal 2c**: Achieve measurable progress toward reducing the use of low-value preoperative testing by 20% as compared to baseline rate **(5 points)**
  - Reduce the percentage of cases that receive one or more of the specified preoperative tests (as listed in Goal 1b) by 20% as compared to baseline.
    - Baseline period: 1/1/2023 – 3/31/2023
    - Measurement period: 4/1/2023 – 12/31/2023

Goal 3: **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 3a**: host a project kickoff meeting held no later than **March 31, 2023**. **(2 points)**
- **Goal 3b**: host at least one follow-up multidisciplinary meeting between July and December 2023 to discuss protocol implementation, progress and barriers to implementation, and monitoring of compliance data (including MVC and MSQC preoperative testing data). **(2 points)**

Goal 4: **Performance Data Monitoring (1 point total)**

- Sites will use data from several sources to monitor the progress of the protocol implementation
  - MVC Preoperative Testing Reports
  - MSQC case abstraction data on preoperative testing
  - Internal hospital data collection for monitoring compliance and adoption of the preoperative testing protocol.
- Sites will include brief feedback regarding the value of the MVC and MSQC data reports and how the data was utilized **(1 point)**

Goal 5: **Qualitative Survey participation** – MPrOVE plans to conduct qualitative interviews with 8-10 sites throughout the state. Site selection will be based on various criteria, to be determined by the Institute for Healthcare Policy and Innovation's MPrOVE study team. MSQC sites that select the MPrOVE pilot study QI project must agree to participate in the qualitative survey if they are asked for their feedback.

Goal 6: Submit the 2023 Appropriate Preoperative Screening Pilot Study Summary to the MSQC Coordinating Center no later than **January 16, 2024.**

Implementation Points

An additional 0-5 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 20 project points.

2023 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard **Cohort 1, 2, 3, 4 & 5 (27 sites)** Measurement Period: 10/01/2022-09/30/2023, unless otherwise stated			
Measure #	Weight	Measure Description	Points
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: Collection rate of baseline patient questionnaires (rates rounded to the nearest whole number) with due dates 1/1/23 – 12/31/23.**	
		80% or greater	5
		60% - 79%	3
		< 60%	0
8	5%	**Each site: Combined collection average rate of Post-operative Patient-Reported Outcome (PRO) questionnaires (rates rounded to the nearest whole number) with due dates 1/1/23 – 12/31/23**	
		60% or greater	5
		45% - 59%	3
		< 45%	0

2023 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard **Cohort 1, 2, 3, 4 & 5 (27 sites)** Measurement Period: 10/01/2022-09/30/2023, unless otherwise stated			
Measure #	Weight	Measure Description	Points
9	10%	**Collaborative-wide measure: % of Opioid naïve, 1-2 level lumbar decompression surgeries meeting the MSSIC Opioid Prescribing guideline (≤ 225 MME)**	
		80% or greater meeting the guideline of 225 MME or less	10
		65f – 79% of patients meet the guideline of 225 MME or less	5
		Less than 65% of patients meet the guideline of 225 MME or less	0
10	10%	**Collaborative-wide measure: % of Opioid naïve, 1-2 level anterior cervical surgeries meeting the MSSIC Opioid Prescribing guideline (≤ 225 MME)**	
		70% or greater meeting the guideline of 225 MME or less	10
		50 – 69% of patients meet the guideline of 225 MME or less	5
		Less than 50% of patients meet the guideline of 225 MME or less	0
11	5%	**% of Opioid naïve at the SITE with 1-2 level lumbar decompression surgeries meeting the MSSIC Opioid Prescribing guideline (≤ 225 MME)**	
		80% or greater meeting the guideline of 225 MME or less	5
		65 – 79% of patients meet the guideline of 225 MME or less	3
		Less than 65% of patients meet the guideline of 25 MME or less	0
12	5%	**% of Opioid naïve at the SITE with 1-2 level anterior cervical surgeries meeting the MSSIC Opioid Prescribing guideline (≤ 225 MME)**	
		70% or greater meeting the guideline of 225 MME or less	5
		50 – 69% of patients meet the guideline of 225 MME or less	3
		Less than 50% of patients meet the guideline of 225 MME or less	0
13	30%	**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	10
		80% or greater	5
		50% - 79%	0
		< 50%	
		2. Limited fasting with a carbohydrate-rich drink up to two hours before surgery	10
		80% or greater	5
		50% - 79%	0
		< 50%	
		3. Ambulation within 8 hours of surgery stop time	
		80% or greater	10
		60% - 79%	5
		< 60%	0

2023 Michigan Spine Surgery Improvement Collaborative Quality Initiative Performance Index – Supporting Documentation

Cohort 1, 2, 3, 4, & 5

The MSSIC Performance Index is separated into two areas of focus: participation, and performance. Each focus area is then divided into measures, with each measure being assigned a point value for a total of 100 points possible. Participation points total 30 and performance points total 70.

Participation: At least one Surgeon Champion and every Abstractor is expected to attend each triannual meeting. All abstractors are required to attend the annual Abstractor Symposium. At least one Surgeon Champion is expected to be on each of the three Surgeon calls and every Abstractor is expected to be on each Abstractor conference call. See exceptions for meeting attendance for surgeons below.

Meeting attendance for Surgeon Champions: We would like the MSSIC collaborative to be as equally balanced and interactive between orthopedic surgeons and neurosurgeons as it can possibly be, and strongly encourage both specialties to attend all meetings. However, we understand the difficulty of scheduling time off for two surgeons to attend the same meeting. Currently it is not a requirement for both Surgeon Champions to attend each meeting – a rotating schedule between specialties is acceptable, but each designated Surgeon Champion must attend at least one meeting and one conference call to avoid lost participation points. If a hospital currently has only one specialty, we would ask that the Surgeon Champion or a designee spine surgeon attempt to attend all meetings. A Nurse Practitioner or Physician Assistant is not an acceptable substitute for the Surgeon Champion – no points will be awarded if a spine surgeon is not in attendance. A surgeon cannot represent two hospitals at a meeting or on a conference call. Points earned for participation will only go to one hospital.

Meeting attendance for MSSIC Abstractors: The MSSIC Abstractor plays a vital role in communicating key information from meetings and serves as a conduit regarding QI Initiative requirements and keys to success. As such, each abstractor is required to attend all collaborative meetings, conference calls and the annual Abstractor Symposium. If an abstractor is unable to attend a collaborative meeting or be on a call, he or she will notify the coordinating center and will send a delegate abstractor to attend the meeting or call. Abstractor Symposium attendance is mandatory for all abstractors.

Meeting attendance for Administrative Leads: Each Administrative Lead is required to attend at least one triannual, MSSIC State-wide meeting per year. The purpose of this measure is to improve Administrative Lead knowledge and engagement regarding MSSIC initiatives and goals. Therefore, it is not permissible for an Administrative Lead to delegate this requirement to another individual.

Performance: In 2023, Cohorts 1, 2, 3, 4 and 5 have the same requirements and point distribution.

Patient questionnaires: Patients in the MSSIC registry are asked to complete a validated health status questionnaire prior to surgery and then at 3, 12, and 24 months after surgery. The questionnaires can be completed on paper, on the MSSIC website, through a site's EMR patient portal (if available), or by phone. Each participating site is responsible to reach out to their patients to collect this information. Questionnaires are an essential data element and collection is required as described in the Eligibility and Expectations document. Patient-reported Outcome (PRO) data is an important measure of success for Quality Improvement Initiatives (QII). Questionnaire data collection has always been an expectation and makes up half of the FTE model for abstractors. If a site has collection rates lower than the MSSIC-All rate, they will be required to complete a Performance Improvement Plan and will receive additional coaching to help improve their process. 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.

Questionnaire collection is divided into two performance measures: baseline collection and combined post-operative collection average.

Each site: Collection rate of baseline patient questionnaires (rates rounded to the nearest whole number) with due dates 1/1/23 – 12/31/23.	
80% or greater	5
60%-79%	3
< 60%	0
Each site: Combined collection average rate of Post-operative Patient-Reported Outcome (PRO) questionnaires (rates rounded to the nearest whole number) with due dates 1/1/23 – 12/31/23	
60% or greater	5
45%-59%	3
< 45%	0

Collaborative-wide and Site-Specific Opioid Prescribing Guideline Goals: The opioid epidemic continues to represent a significant public health crisis in the United States. Prescription opioid use has been recognized as a key contributor to this epidemic and surgeons play an important role in this epidemic. Opioids prescribed after surgery are associated with a well-documented risk of chronic opioid dependence, especially in opioid-naive patients.

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 with evidence-based practices, opioid prescribing recommendations, and more. 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. Also, patients with ≤ 225 MME are less likely to be on opioids 90 days after surgery. MSSIC analysis also showed a great deal of site variability in opioid prescribing patterns which represents an opportunity to make positive changes in discharge prescribing for opioid naïve patients. The MSSIC Opioid Prescribing Guideline measures for opioid naïve patients for certain procedures are as follows:

Collaborative-wide measure: % of Opioid naïve, 1-2 level lumbar decompression surgeries meeting the MSSIC Opioid Prescribing guideline (≤ 225 MME)	
80% or greater meeting the guideline of 225 MME or less	10
65-79% of patients meet the guideline of 225 MME or less	5
Less than 65% of patients meet the guideline of 225 MME or less	0
Collaborative-wide measure: % of Opioid naïve, 1-2 level anterior cervical surgeries meeting the MSSIC Opioid Prescribing guideline (≤ 225 MME)	
70% or greater meeting the guideline of 225 MME or less	10
50-69% of patients meet the guideline of 225 MME or less	5
Less than 50% of patients meet the guideline of 225 MME or less	0
% of Opioid naïve at the SITE with 1-2 level lumbar decompression surgeries meeting the MSSIC Opioid Prescribing guideline (≤ 225 MME)	
80% or greater meeting the guideline of 225 MME or less	5
65-79% of patients meet the guideline of 225 MME or less	3
Less than 65% of patients meet the guideline of 225 MME or less	0

% of Opioid naïve at the SITE with 1-2 level anterior cervical surgeries meeting the MSSIC Opioid Prescribing guideline (≤ 225 MME)	
70% or greater meeting the guideline of 225 MME or less	5
50-69% of patients meet the guideline of 225 MME or less	3
Less than 50% of patients meet the guideline of 225 MME or less	0

In addition, the following **"MSSIC Opioid Prescribing Guideline at Discharge"** tool has been developed to support quality improvement efforts in this regard.

MICHIGAN SPINE SURGERY IMPROVEMENT COLLABORATIVE	**MSSIC Opioid Prescribing Guidelines at Discharge**
Patients	Opioid Naïve (No opioids 30 days or > before surgery)
Procedures	1-2 level lumbar decompression **or** 1-2 level Anterior Cervical (ACDF, ACCF, Arthroplasty)
Example Discharge Meds/Dosages	**Goal ≤ 225 MME -# Pills**
Codeine 30 mg, 1-2 pills Q 6 hrs.	50 or less
Hydrocodone 5 mg	45 or less
Hydrocodone 7.5 mg	30 or less
Hydrocodone 10 mg	22 or less
Oxycodone 5 mg	30 or less
Oxycodone 10 mg	15 or less
Tramadol 50 mg, 1-2 pills Q 6 hrs.	45 or less

Demonstration of compliance for the following 3 MSSIC ERAS components:

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 admitted emergently as defined in the Master Variable List are excluded from the denominator.

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 seen to 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.

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. The ERAS for spine surgery protocols/pathways all include early ambulation no later than 8 hours after surgery, and most within 4 to 6 hours after surgery. The current exclusions from the denominator: wheelchair bound (non-ambulatory) before surgery, CSF leak, durotomy, and fusions 4 levels or greater.

Demonstration of compliance for the following 3 MSSIC ERAS components (Phase 2 ERAS):	
1. Formal, pre-operative patient education that does not vary from surgeon to surgeon and is available to all spine patients	
80% or greater	10
50%-79%	5
<50%	0
2. Limited fasting with a carbohydrate-rich drink up to two hours before surgery	
80% or greater	10
50%-79%	5
<50%	0
3. Ambulation within 8 hours of surgery stop time	
80% or greater	10
60%-79%	5
<60%	0

Sites performing at or below the zero-point threshold at mid-year 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.

ERAS expectations not fulfilled in the 2022 Performance Year for either Phase 1 or Phase 2: ERAS pathways decrease surgical stress, maintain physiological homeostasis, and improve postoperative recovery. ERAS guidelines have been shown to substantially reduce postoperative complications, length of stay (LOS) and overall costs, and to increase both patient and staff satisfaction. MSSIC believes that ERAS is the right thing to do for spine surgery patients and that is why it is a high priority QI Initiative. Making ERAS a standard of care for every MSSIC site is necessary to facilitate the maximum clinical and financial gains. It is MSSIC's expectation that any unfulfilled ERAS element from the 2022 Performance Index will be completed no later than 12/31/22.

Expectations of the MSSIC Collaborative:

MSSIC is unique in that there are two specialties involved in the framework of the Collaborative. While it is our hope that participating sites have both Neuro and Ortho surgeons working actively together, we recognize the necessity to be flexible, as the makeup of sites may vary, or may unexpectedly change.

- **Both specialties at a site:** Participating sites that have both neurosurgeons and orthopedic surgeons performing spine surgery will provide a letter of commitment, assuring the willingness of the two specialties to work together in the collaborative.
- **Both specialties at site, one stops performing spine surgeries:** If a hospital joins MSSIC with both specialties active and one discontinues performing spine surgery, MSSIC would not drop the hospital. The hospital stays in as long as case volume stays above 150/year. The FTE model would adjust to 3/8 FTE for case volumes from 150-199. If case volume falls below 150, participation would continue only with special agreement between the hospital, coordinating center, and BCBSM.
- **One specialty at site, case volume is acceptable:** A site with only one specialty may participate in MSSIC if their case volume is acceptable (200 cases/year).

- **One specialty at a site, the other specialty joins:** If a participating hospital joins MSSIC with only one specialty performing spine surgery and then there is a change to both specialties performing surgeries, MSSIC will require the hospital to agree to recruit a new surgeon champion for the second specialty once the second specialty's case volume exceeds 50 cases a year.
- **Surgeon Champion leaves:**
  - Both specialties at site: If one of the two Surgeon Champions leaves, it would be an expectation that the participating site would reassign the Surgeon Champion role, and still have the second specialty participating in QI initiatives. MSSIC would not drop a site if a Surgeon Champion leaves.
  - One specialty at site: If the Surgeon Champions leaves, it would be an expectation that the participating site would reassign the Surgeon Champion role, and still have the specialty participating in QI initiatives. MSSIC would not drop a site if a Surgeon Champion leaves.
- **Surgeon Champion does not participate in at least one meeting and conference call during the year:** If a named Surgeon Champion does not participate in at least one collaborative-wide meeting and one surgeon conference call during the calendar year, not only is there a penalty in the participation measures, but it is expected that he or she will be removed from the role and a new Surgeon Champion will be named in his or her place.

2023 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard Cohort 6, Year 2 **(1 site)**			
Measure #	Weight	Measure Description	Points
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
8	15%	**No later than 9/30/23, 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

2023 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard Cohort 6, Year 2 **(1 site)**			
Measure #	Weight	Measure Description	Points
		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

Cohort 6, Year 2

The MSSIC Performance Index is separated into two areas of focus: participation, and performance. Each focus area is then divided into measures, with each measure being assigned a point value for a total of 100 points possible. Participation points total 80 and performance points total 20.

Participation: At least one Surgeon Champion and every Abstractor is expected to attend each triannual meeting. All abstractors are required to attend the annual Abstractor Symposium. At least one Surgeon Champion is expected to be on each of the three Surgeon calls and every Abstractor is expected to be on each Abstractor conference call. See exceptions for meeting attendance for surgeons below.

Meeting attendance for Surgeon Champions: We would like the MSSIC collaborative to be as equally balanced and interactive between orthopedic surgeons and neurosurgeons as it can possibly be, and strongly encourage both specialties to attend all meetings. However, we understand the difficulty of scheduling time off for two surgeons to attend the same meeting. Currently it is not a requirement for both Surgeon Champions to attend each meeting – a rotating schedule between specialties is acceptable, but each designated Surgeon Champion must attend at least one meeting and one conference call to avoid lost participation points. If a hospital currently has only one specialty, we would ask that the Surgeon Champion or a designee spine surgeon attempt to attend all meetings. A Nurse Practitioner or Physician Assistant is not an acceptable substitute for the Surgeon Champion – no points will be awarded if a spine surgeon is not in attendance. A surgeon cannot represent two hospitals at a meeting or on a conference call. Points earned for participation will only go to one hospital.

Meeting attendance for MSSIC Abstractors: The MSSIC Abstractor plays a vital role in communicating key information from meetings and serves as a conduit regarding QI Initiative requirements and keys to success. As such, each abstractor is required to attend all collaborative meetings, conference calls and the annual Abstractor Symposium. If an abstractor is unable to attend a collaborative meeting or be on a call, he or she will notify the coordinating center and will send a delegate abstractor to attend the meeting or call. Abstractor Symposium attendance is mandatory for all abstractors.

Meeting attendance for Administrative Leads: Each Administrative Lead is required to attend at least one triannual, MSSIC State-wide meeting per year. The purpose of this measure is to improve Administrative Lead knowledge and engagement regarding MSSIC initiatives and goals. Therefore, it is not permissible for an Administrative Lead to delegate this requirement to another individual.

Performance: In 2023, Cohort 6, year 2 has a 20-point performance distribution.

Patient questionnaires: Patients in the MSSIC registry are asked to complete a validated health status questionnaire prior to surgery and then at 3, 12, and 24 months after surgery. The questionnaires can be completed on paper, on the MSSIC website, through a site's EMR patient portal (if available), or by phone. Each participating site is responsible to reach out to their patients to collect this information. Questionnaires are an essential data element and collection is expected and required as a condition of participation, described in the Eligibility and Expectations document. Patient-reported Outcome (PRO) data is an important measure of success for Quality Improvement Initiatives (QII). While questionnaire data collection is not represented in the Cohort 6, year 2 Performance Index, it has always been an expectation and makes up half of the FTE model for abstractors. If a year 2 site has collection rates lower than the MSSIC-All rate, they will be required to complete a Performance Improvement Plan and will receive additional coaching to help improve their process. 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.

Enhanced Recovery After Surgery (ERAS) Phase 1:
During ERAS, Phase 1, Year 2 sites will demonstrate **site engagement** through the submission of quarterly meeting 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 **4 deliverables** are as follows:

- Meeting between October 1 – December 31, 2022. **Submit form by January 5, 2023.**
- Meeting between January 1 – March 31, 2023. **Submit form by April 5, 2023.**
- Meeting between April 1 – June 30, 2023. **Submit form by July 5, 2023.**
- Meeting between July 1 – September 30, 2023. **Submit form by October 5, 2023.**

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

Additionally, sites will **submit and obtain approval from the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program no later than 9/30/23**:

- 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.

No later than 9/30/23, 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

Expectations of the MSSIC Collaborative:
MSSIC is unique in that there are two specialties involved in the framework of the Collaborative. While it is our hope that participating sites have both Neuro and Ortho surgeons working actively together, we recognize the necessity to be flexible, as the makeup of sites may vary, or may unexpectedly change.

- **Both specialties at a site:** Participating sites that have both neurosurgeons and orthopedic surgeons performing spine surgery will provide a letter of commitment, assuring the willingness of the two specialties to work together in the collaborative.
- **Both specialties at site, one stops performing spine surgeries:** If a hospital joins MSSIC with both specialties active and one discontinues performing spine surgery, MSSIC would not drop the hospital. The hospital stays in as long as case volume stays above 150/year. The FTE model would adjust to 3/8 FTE for case volumes from 150-199. If case volume falls below 150, participation would continue only with special agreement between the hospital, coordinating center, and BCBSM.
- **One specialty at site, case volume is acceptable:** A site with only one specialty may participate in MSSIC if their case volume is acceptable (200 cases/year).

- **One specialty at a site, the other specialty joins:** If a participating hospital joins MSSIC with only one specialty performing spine surgery and then there is a change to both specialties performing surgeries, MSSIC will require the hospital to agree to recruit a new surgeon champion for the second specialty once the second specialty's case volume exceeds 50 cases a year.
- **Surgeon Champion leaves:**
    - Both specialties at site: If one of the two Surgeon Champions leaves, it would be an expectation that the participating site would reassign the Surgeon Champion role, and still have the second specialty participating in QI initiatives. MSSIC would not drop a site if a Surgeon Champion leaves.
    - One specialty at site: If the Surgeon Champions leaves, it would be an expectation that the participating site would reassign the Surgeon Champion role, and still have the specialty participating in QI initiatives. MSSIC would not drop a site if a Surgeon Champion leaves.
- **Surgeon Champion does not participate in at least one meeting and conference call during the year:** If a named Surgeon Champion does not participate in at least one collaborative-wide meeting and one surgeon conference call during the calendar year, not only is there a penalty in the participation measures, but it is expected that he or she will be removed from the role and a new Surgeon Champion will be named in his or her place.

2023 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard, **Cohort 7, Year 1** Measurement Period: 10/01/2022-09/30/2023, unless otherwise stated			
Measure #	Weight	Measure Description	Points
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, Data Use Agreement, Business Associate Agreement, and Software Agreement**	
		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

2023 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard, **Cohort 7, Year 1** Measurement Period: 10/01/2022-09/30/2023, unless otherwise stated			
Measure #	Weight	Measure Description	Points
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

Cohort 7, Year 1

The MSSIC Performance Index for year one sites are divided into measures, with each measure being assigned a point value for a total of 100 points possible. Participation points total 100% for Year 1 sites.

Participation: At least one Surgeon Champion and every Abstractor is expected to attend each triannual meeting. All abstractors are required to attend the annual Abstractor Symposium. At least one Surgeon Champion is expected to be on each of the three Surgeon calls and every Abstractor is expected to be on each Abstractor conference call. See exceptions for meeting attendance for surgeons below.

Meeting attendance for Surgeon Champions: We would like the MSSIC collaborative to be as equally balanced and interactive between orthopedic surgeons and neurosurgeons as it can possibly be, and strongly encourage both specialties to attend all meetings. However, we understand the difficulty of scheduling time off for two surgeons to attend the same meeting. Currently it is not a requirement for both Surgeon Champions to attend each meeting – a rotating schedule between specialties is acceptable, but each designated Surgeon Champion must attend at least one meeting and one conference call to avoid lost participation points. If a hospital currently has only one specialty, we would ask that the Surgeon Champion or a designee spine surgeon attempt to attend all meetings. A Nurse Practitioner or Physician Assistant is not an acceptable substitute for the Surgeon Champion – no points will be awarded if a spine surgeon is not in attendance. A surgeon cannot represent two hospitals at a meeting or on a conference call. Points earned for participation will only go to one hospital.

Meeting attendance for MSSIC Abstractors: The MSSIC Abstractor plays a vital role in communicating key information from meetings and serves as a conduit regarding QI Initiative requirements and keys to success. As such, each abstractor is required to attend all collaborative meetings, conference calls and the annual Abstractor Symposium. If an abstractor is unable to attend a collaborative meeting or be on a call, he or she will notify the coordinating center and will send a delegate abstractor to attend the meeting or call. Abstractor Symposium attendance is mandatory for all abstractors.

Meeting attendance for Administrative Leads: Each Administrative Lead is required to attend at least one triannual, MSSIC State-wide meeting per year. The purpose of this measure is to improve Administrative Lead knowledge and engagement regarding MSSIC initiatives and goals. Therefore, it is not permissible for an Administrative Lead to delegate this requirement to another individual.

Performance: In 2023, Cohort 7, Year 1 has a point distribution based only on participation measures.

Patient questionnaires: Patients in the MSSIC registry are asked to complete a validated health status questionnaire prior to surgery and then at 3, 12, and 24 months after surgery. The questionnaires can be completed on paper, on the MSSIC website, through a site's EMR patient portal (if available), or by phone. Each participating site is responsible to reach out to their patients to collect this information. Questionnaires are an essential data element and collection is expected and required as a condition of participation, described in the Eligibility and Expectations document. Patient-reported Outcome (PRO) data is an important measure of success for Quality Improvement Initiatives (QII). While questionnaire data collection is not represented in the Cohort 6, year 2 Performance Index, it has always been an expectation and makes up half of the FTE model for abstractors. 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.

Expectations of the MSSIC Collaborative:
MSSIC is unique in that there are two specialties involved in the framework of the Collaborative. While it is our hope that participating sites have both Neuro and Ortho surgeons working actively together, we recognize the necessity to be flexible, as the makeup of sites may vary, or may unexpectedly change.

- **Both specialties at a site:** Participating sites that have both neurosurgeons and orthopedic surgeons performing spine surgery will provide a letter of commitment, assuring the willingness of the two specialties to work together in the collaborative.

- **Both specialties at site, one stops performing spine surgeries:** If a hospital joins MSSIC with both specialties active and one discontinues performing spine surgery, MSSIC would not drop the hospital. The hospital stays in as long as case volume stays above 150/year. The FTE model would adjust to 3/8 FTE for case volumes from 150-199. If case volume falls below 150, participation would continue only with special agreement between the hospital, coordinating center, and BCBSM.
- **One specialty at site, case volume is acceptable:** A site with only one specialty may participate in MSSIC if their case volume is acceptable (200 cases/year).
- **One specialty at a site, the other specialty joins:** If a participating hospital joins MSSIC with only one specialty performing spine surgery and then there is a change to both specialties performing surgeries, MSSIC will require the hospital to agree to recruit a new surgeon champion for the second specialty once the second specialty's case volume exceeds 50 cases a year.
- **Surgeon Champion leaves:**
  - Both specialties at site: If one of the two Surgeon Champions leaves, it would be an expectation that the participating site would reassign the Surgeon Champion role, and still have the second specialty participating in QI initiatives. MSSIC would not drop a site if a Surgeon Champion leaves.
  - One specialty at site: If the Surgeon Champions leaves, it would be an expectation that the participating site would reassign the Surgeon Champion role, and still have the specialty participating in QI initiatives. MSSIC would not drop a site if a Surgeon Champion leaves.
- **Surgeon Champion does not participate in at least one meeting and conference call during the year:** If a named Surgeon Champion does not participate in at least one collaborative-wide meeting and one surgeon conference call during the calendar year, not only is there a penalty in the participation measures, but it is expected that he or she will be removed from the role and a new Surgeon Champion will be named in his or her place.

2023 **MSTCVS** Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2023-07/30/2023) Cohort (place cohort year, if applicable)			
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	10	**Quarterly collaborative meeting participation – Surgeon and Data Manager Combined Attendance (January 1, 2023–December 31, 2023)**	
		Surgeon and data manager attended 4 quarterly meetings	10
		Surgeon and data manager attended 3 quarterly meetings	8
		Surgeon and data manager attended 2 quarterly meetings	6
		Surgeon and data manager attended 1 quarterly meeting	4
		Attended 0 quarterly meetings	0
3	2	**Quarterly collaborative meeting participation – Alternate Surgeon (January 1, 2023–December 31, 2023)**	
		Alternate surgeon attended 1 quarterly meeting	2
		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, 2023–December 31, 2023)**	
		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, 2023–December 31, 2023)**	
		Attended 4 PERForm meetings	4
		Attended 3 PERForm meetings	3
		Attended 2 PERForm meetings	2
		Attended 1 PERForm meeting	1
		Attended 0 PERForm meetings	0
6	15	**Collaborative-wide quality initiative 2023: Isolated CABG – Multiple Arterial Grafting (January 1, 2023–December 31, 2023)***	
		2023 Calendar Year Mean is 3% higher than 2022 Calendar Year Mean	15
		2023 Calendar Year Mean is 2% higher than 2022 Calendar Year Mean	8
		2023 Calendar Year Mean is <2 % higher than 2022 Calendar Year Mean	0
7	15	**Site specific quality initiative**	
		Met improvement goal	15
		Improved but did not meet goal	10
		Implemented plan but did not improve	5
		Unable to implement plan	0

2023 MSTCVS Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2023-07/30/2023) Cohort (place cohort year, if applicable)			
Measure #	Weight	Measure Description	Points
8	20	**Isolated CAB: O/E mortality for 12 months (January 1, 2023–December 31, 2023)**	
		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, 2021–December 31, 2023)**	
		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**	

Michigan Trauma Quality Improvement Program (MTQIP) 2023 Performance Index January 1 – December 31, 2023				
Measure	Weight	Measure Description	Points	
1	10	**Data Submission**		PARTICIPATION (30%)
		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**	0-10	
		Surgeon and TPM or MCR participate in 3 of 3 Collaborative meetings	9	
		Surgeon and TPM or MCR participate in 2 of 3 Collaborative meetings	6	
		Surgeon and TPM or MCR participate in 0-1 of 3 Collaborative meetings	0	
		Registrar or MCR participate in the annual June Data Abstractor meeting	1	
3	10	**Data Validation Error Rate**		
		0.0 – 3.0%	10	
		3.1 – 4.0%	8	
		4.1 – 5.0%	5	
		> 5.0%	0	
4	5	**PI Death Determination Documentation (12 mo. 7/1/22 – 6/30/23)**		PERFORMANCE (70%)
		0 – 2 Deceased patients missing documentation	5	
		3 – 4 Deceased patients missing documentation	3	
		> 4 Deceased patients missing documentation	0	
5	10	**Timely LMWH VTE Prophylaxis in Trauma Admits** (18 mo: 1/1/22 – 6/30/23)		
		≥ 52.5% of patients (≤ 48 hr)	10	
		≥ 50.0% of patients (≤ 48 hr)	8	
		≥ 45.0% of patients (≤ 48 hr)	5	
		< 45.0% of patients (≤ 48 hr)	0	
6	10	**Timely Surgical Repair in Geriatric (Age ≥65) Isolated Hip Fxs** (12 mo: 7/1/22 – 6/30/23)		
		≥ 92.0% of patients (≤ 48 hr)	10	
		≥ 87.0% of patients (≤ 48 hr)	8	
		≥ 85.0% of patients (≤ 48 hr)	5	
		< 85.0% of patients (≤ 48 hr)	0	
7	10	**RBC to Plasma Ratio in Massive Transfusion** (18 mo: 1/122 – 6/30/23)	0-10	
		Weighted Mean Points in Patients Transfused ≥ 5 Units 1st 4 hr		
8	10	**Serious Complication Z-Score Trend in Trauma Admits** (3 yr: 7/1/20 – 6/30/23)		
		< -1 (major improvement)	10	
		-1 to 1 or serious complications low outlier (average or better rate)	7	
		> 1 (rates of mortality increased)	5	
9	10	**Mortality Z-Score Trend in Trauma Admits** (3 yr: 7/1/20 – 6/30/23)		
		< -1 (major improvement)	10	
		-1 to 1 or mortality low outlier (average or better)	7	
		> 1 (rates of mortality increased)	5	

Michigan Trauma Quality Improvement Program (MTQIP) 2023 Performance Index January 1 – December 31, 2023				
Measure	Weight	Measure Description	Points	
10	5	**Timely Head CT in TBI Patients on Anticoagulation Pre-Injury** (12 mo: 7/1/22 – 6/30/23)		
		≥ 90% patients (≤ 120 min)	5	
		≥ 80% patients (≤ 120 min)	4	
		≥ 70% patients (≤ 120 min)	3	
		< 70% patients (≤ 120 min)	0	
11	10	**Timely Antibiotic in Femur/Tibia Open Fractures – COLLABORATIVE WIDE MEASURE** (12 mo: 7/1/22 – 6/30/23)		
		≥ 85% patients (≤ 90 min)	10	
		< 85% patients (≤ 90 min)	0	
		Total (Max Points) =	100	

Michigan Trauma Quality Improvement Program (MTQIP) 2023

Performance Index – 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: Surgeon represents one center only; Alternate must be an attending level equivalent.

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:

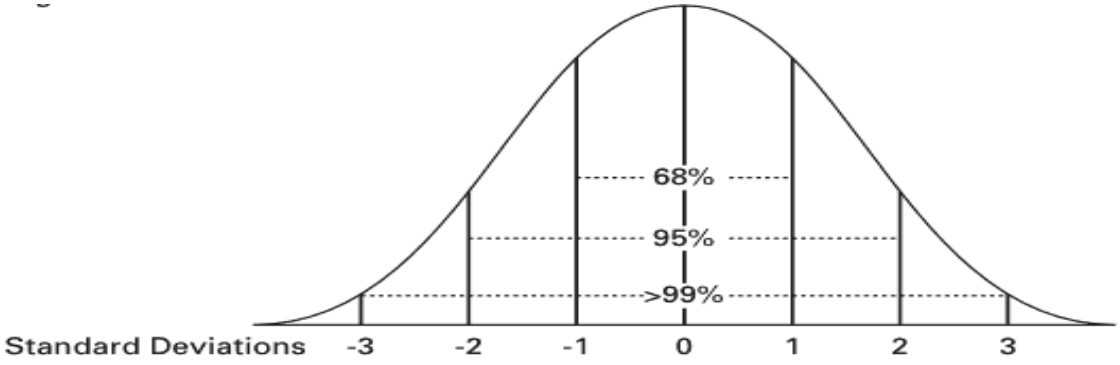
Step 1: Assign (weight) to each MTP patients 4 hr PRBC/FPP ratio to designated tier and points using the chart below.

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 is a measure of a hospital's trend in [serious complications, mortality] over the three-year time period. The z-score is an estimate of 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 has a trend in one of these directions (as opposed to being flat). Scores >1 are worsening, scores between 1 to -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 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 their 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 (7/1/22 to 6/30/23)

#5: 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 (1/1/22 to 6/30/23)

#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 (7/1/1/22 to 6/30/23)

#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 (1/1/2022 to 6/30/23)

#8: Serious Complication
Cohort: 2 (Admit to Trauma Service)
No signs of life: Exclude DOA
Transfers out: Exclude transfers out
Default period: Custom (7/1/20 to 06/30/23)

#9: Mortality
Cohort: 2 (Admit to Trauma Service)
No signs of life: Exclude DOA
Transfers out: Exclude transfers out
Default period: Custom (7/1/20 to 6/30/23)

#10: Timely Head CT in Anticoagulated TBI
First Head CT performed during hospital stay: date, time from procedures data. Patients who receive a head CT prior to arrival, such as those ordered by a PCP, enter under the ICD-10 Hospital Procedures, with the exact date and time.
Eligible: Presence of prehospital anticoagulant use. One or more of the following variables captured as yes: Warfarin, direct thrombin inhibitor, factor Xa inhibitor. Presence of blunt head injury based on AIS codes (available on mtqip.org)
Cohort: 1(All)
No signs of life: Exclude DOAs
Exclude: Transfers in and direct admissions
Transfers out: Include transfers out
Default period: Custom (7/1/22 to 6/30/23)

#11 Timely Antibiotic in Femur/Tibia Open Fractures – COLLABORATIVE WIDE MEASURES
Points awarded based on the total collaborative result, not the individual hospital results. 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 mtquip.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 (7/1/22 to 6/30/23)

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

2023 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2023 - 12/31/2023			
Measure	**Weight**	**Measure Description**	**Points**
1	20%	**OBI Semi-Annual 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 Semi-Annual meeting	10
		Fall Semi-Annual meeting	10
2	20%	**QI Engagement**	
		***Group 1 sites**:* Physician or Midwife/nurse Champion 1) hosts in person OBI site visit AND 2) attends 4, one-hour, one-on-one, virtual sessions with OBI staff for QI planning, AND 3) submits and fully executes QI plan	
		3 / 3 activities completed	20
		2 / 3 activities completed	10
		***Group 2 sites*:** Physician Champion, Midwife/nurse Champion, or CDA 1) attends 4 out of 4 peer-to-peer QI workgroups AND 2) presents at 1 of 4 workgroups, AND 3) submits and fully executes QI plan	
		3 / 3 activities completed	20
		2 / 3 activities completed	10
3	10%	**Accuracy of Abstracted Data**	
		Data audit score ≥97%	5
		Data audit score 90.0-96.9%	3
		Completeness and Timeliness of Abstracted Data (Jan 1-Sept 30, 2023)	
		100% of cases completed and submitted prior to 90 days postpartum	5
		90-99.9% of cases completed and submitted prior to 90 days postpartum	3
4	10%	**OBI Patient Voices initiative**	
		Email address included on ≥70% of eligible abstracted patients (measured for cases delivering May 1-Sep 30, 2023)	10
5	20%	**Labor Dystocia Compliance** Percentage of NTSV cesareans performed for dystocia that meet national criteria for dystocia	
		≥70% compliance	20
		50-69.9% compliance	15
		<50% compliance	0
6	15%	**Option 1: Management of Category II Fetal Tracings***	
		≥ 80% of NTSV cesarean births with Category II fetal heart rate tracing as primary indication have documentation of use of an algorithm	15
		70-79.9% of NTSV cesarean births with Category II fetal heart rate tracing as primary indication have documentation of use of an algorithm	10
		<70% of NTSV cesarean births with Category II fetal heart rate tracing as primary indication have documentation of use of an algorithm	0
		Option 2: Intermittent Auscultation (IA)	
		≥ 80% of NTSV births have IA ordered at admission for eligible patients	15
		70-79.9% of NTSV births have IA ordered at admission for eligible patients	10
		<70% of NTSV births have IA ordered at admission for eligible patients	0
		Option 3: TeamBirth**	
		≥ 60% of NTSV births have patient-centered huddle documented for admission AND at least once per 12 hours	15
		50-59% of NTSV births have patient-centered huddle documented for admission AND at least once per 12 hours	10
		<50% of NTSV births have patient-centered huddle documented for admission AND at least once per 12 hours	0
7	5%	**Post-birth Pain Management**	
		Submission of signed form attesting to site's adoption, by December 31, 2023, of national guideline-concordant protocol for pain management after childbirth	5
Optional		**Optional Bonus Points** (**applied only to participation-based measures** January 1, 2023-December 31, 2023).	
		Sites can earn 2.5 bonus points for participating in each of the following activities, up to 5 bonus points total. Sites cannot exceed 100 points total. • Complete a Listening Tour call (30-60 minute call via telephone or zoom) • Participate on an OBI Committee • Present (or identify a patient who presents) at an OBI Semi-Annual meeting • Identify a patient who participates in an OBI interview to inform QI activities • Share a patient story (with patient's permission) selected by OBI for dissemination to OBI members (e.g., via newsletter, social media)	5
	Key:	Participation Measure / Performance Measure	**Total (Max points = 100)**

2023 Obstetrics Initiative (OBI) Performance Index Scorecard Supporting Documentation

Measure 1	Champion engagement at each site is key to collaborative culture in order for learning and improvement to occur. The OBI Physician Champion (or a designated representative who must be an obstetrician or family physician actively practicing inpatient maternity care), Midwife or Nurse Champion (or a designated representative who must be actively providing inpatient maternity care) and Clinical Data Abstractor (CDA; or a designated representative), combined, must attend OBI Collaborative Meetings: April 14, 2023; November 10, 2023 All 3 individuals must attend to obtain the 10 points allocated to each meeting. OBI member hospitals must declare and provide contact information for their 2023 OBI Champions on the OBI designation form (submitted by 1/13/2023). During each Semi-Annual meeting registration period, sites will be able to identify designated representatives, to replace declared Champions' attendance, if needed. Small volume hospitals wishing for one individual to fulfill Semi-Annual attendance requirements for both the Nurse Champion and the CDA, or for both the Midwife Champion and the Physician Champion, can seek approval from the OBI Coordinating Center during the Semi-Annual meeting registration period. A clinical champion (physician, midwife, nurse) cannot represent two hospitals at a Semi-Annual meeting; points earned for attendance will go entirely to one hospital. Conversely, CDAs abstracting data for multiple sites can obtain attendance credit for multiple sites, with permission from the Coordinating Center.
Measure 2	OBI offers a variety of activities to support member sites in their local quality improvement efforts. For the 2023 scorecard, the OBI Coordinating Center will assign each site to Group 1 or Group 2. Sites will be notified of their assigned group by 12/9/2022. When selecting sites for each group, the Coordinating Center will seek to optimize variation in delivery volume, NTSV cesarean rate, and hospital characteristics within each group. Sites can earn points for this measure by completing the activities designated for their assigned group between 1/1/2023 and12/31/2023. ➢ Group 1 sites: Physician or Midwife Champion 1) hosts OBI site visit AND 2) attends 4, one hour, one-on-one, virtual sessions with OBI staff for QI planning, coaching, and execution, AND 3) submits and fully executes QI plan. The site visit will involve OBI staff visiting and conducting interviews with the Physician or Midwife champion and 5-10 individuals identified by the champion as having an important perspective about QI efforts at that site (e.g., Medical Director, Nurse Manage, frontline healthcare workers, QI expert). During the 4 virtual sessions, OBI staff will provide individualized consultation with the site Champion(s) to select and execute improvement activities, support interactive problem-solving, and identify highly customized, local solutions to challenges encountered. ➢ Group 2 Sites: Physician Champion, Midwife/nurse Champion, or CDA 1) attends 4 out of 4 peer-to-peer QI workgroups AND 2) presents at 1 of 4 workgroups, AND 3) submits and fully executes QI plan. These group-based activities are designed to promote sharing of best practices, peer mentorship, and collective problem-solving across hospitals.
Measure 3	Data audit score is based on 2022 cases and must be completed by 9/30/23. Completeness and Timeliness will be measured for cases with delivery dates 1/1/2023-9/30/2023.
Measure 4	Eligible abstracted cases exclude cases meeting certain clinical circumstances or opting out, as outlined in the abstraction manual. Collecting patient survey data allows OBI to incorporate patient voices directly into performance measurement and QI activities, and thereby promote patient-centeredness and health equity.
Measure 5	Sites will be awarded points for compliance with the labor dystocia measure (cumulative score 1/1/2023 – 9/30/2023). This measure will track the proportion of NTSV patients undergoing unplanned cesarean for a primary indication of dystocia (including latent phase arrest, active phase arrest, arrest of descent, and failed induction) who met national criteria for dystocia (as defined by ACOG/SMFM). This metric helps to determine the appropriateness of the decision for surgery.
Measure 6	Sites will be awarded points for compliance with the QII project measure (cumulative score 1/1/2023 – 9/30/2023). **Option 1: Management of Category II Fetal Tracings.** This measure tracks the proportion of NTSV patients undergoing unplanned cesarean birth for non-reassuring fetal status who have documentation that an evidence-based algorithm was completed prior to the decision for cesarean delivery. The goal of this measure is to increase use of a standardized process for interpreting and responding to Category II tracings, and thereby safely decrease the rate of fetal tracing abnormalities as a primary indication for cesarean births. **Option 2: Intermittent Auscultation.** This measure tracks the proportion of eligible patients who have intermittent auscultation ordered at admission. The goal of this measure is to de-implement continuous fetal monitoring when it is unindicated, and safely reduce the number of primary cesareans performed for fetal distress. **Option 3: TeamBirth.** TeamBirth is a care process designed to operationalize best practices in communication, teamwork, and respectful care on maternity units. TeamBirth involves two key interventions: 1) regular team huddles involving the birthing person, nurse, and delivering provider, and 2) a shared whiteboard in the delivery room, with a goal of providing consistent opportunities for shared decision-making during the assessment of labor progress and maternal and fetal well-being. The goal of this QII project is to increase the proportion of NTSV births with evidence of shared decision-making. This measure will track the proportion of NTSV patients with planned labor/vaginal birth who have evidence of a patient-centered huddle documented for admission (defined as within 3 hours of time of admission to the birthing unit) AND at least once per every 12 hour period after the admission window and before the time of delivery. **Sites in Year 3 of the TeamBirth project will be required to meet a target 10 percentage points higher for each point allocation (i.e., threshold for full points is >70%).
Measure 7	Excessive opioid prescribing is harmful to patients and communities. This measure will help OBI decrease the amount of opioids prescribed to patients upon discharge from the childbirth hospitalization while achieving and maintaining a high degree of patient-centeredness and patient satisfaction with their care experience. Currently, OBI is developing the first national guidelines for acute pain management, including opioid prescribing, after childbirth. These will be shared with OBI member sites by 8/31/2023. To obtain points for this measure, sites will need to sign an attestation, by 12/31/2023, stating that they have adopted a protocol for pain management after childbirth that is concordant with these new national guidelines.

Program Year 2023 Michigan Value Collaborative (MVC)
Collaborative Quality Initiative Performance Index Scorecard
Cohorts 1 – 5
Measurement Period: 01/01/2022 – 12/31/2022

MVC Scoring Summary

Possible Episode Payment Points	Possible Bonus Points	Total Possible Points
5 possible points per condition (10 total possible episode payment points)	1 possible per condition (2 total possible bonus points)	12 possible points (scored out of 10)

Measure #	Measure Description	Improvement **OR** Achievement Points
Measure Condition Options: Coronary artery bypass graft (CABG); congestive heart failure (CHF); colectomy (non-cancer); chronic obstructive pulmonary disease (COPD); joint replacement (hip and knee); pneumonia; spine surgery		
1	**Condition Selection #1:** Condition-specific price-standardized, risk-adjusted total episode payment* assessed for year-over-year improvement compared to hospital's baseline and achievement respective to MVC cohort **Hospitals receive the higher of their improvement of achievement points.**	
	Z-score = <0	1
	Z-score = 0 - <0.05	2
	Z-score = 0.05 - <0.10	3
	Z-score = 0.10 - <0.15	4
	Z-score = 0.15 - <0.2	5
2	**Condition Selection #2:** Condition-specific price-standardized, risk-adjusted total episode payment* assessed for year-over-year improvement compared to hospital's baseline and achievement respective to MVC cohort. **Hospitals receive the higher of their improvement of achievement points.**	
	Z-score = <0	1
	Z-score = 0 - <0.05	2
	Z-score = 0.05 - <0.10	3
	Z-score = 0.10 - <0.15	4
	Z-score = 0.15 - <0.2	5
	Earned by returning questionnaire for first condition to the MVC Coordinating Center by November 1, 2023	
	Earned by returning questionnaire for second condition to the MVC Coordinating Center by November 1, 2023	

**Episodes with a confirmed diagnosis of COVID-19 illness in an inpatient setting in the first three positions on a facility claim are excluded from scoring.*