2025 Hospital Pay-for-Performance Program (for peer groups 1 through 4)

Hospital CQI Performance Index Scorecards

Hospital CQI Pay-for-Performance Program

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

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

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

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

CQI performance index scorecards

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

The measurement period for each performance index measure is noted in the respective scorecard.

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

CQI Program Manager Contacts

CQI	CQI Clinical Focus Area	Index Scorecard Section *	Coordinating Center Program Manager	Email
ASPIRE	Anesthesiology	3-7	Tory Lacca Kate Buehler	lacca@umich.edu kjbucrek@med.umich.edu
BMC2	Angioplasty & Vascular Surgery	8-14	Mollie Bodin	mbodin@med.umich.edu
HMS	Hospital Medicine	15-19	Elizabeth McLaughlin	emcnair@umich.edu
MAQI2	Anticoagulation	20-25	Brian Haymart	khaymart@umich.edu
MARCQI	Knee/Hip Arthroplasty	26-58	Tae Kim	taekk@med.umich.edu
MBSC	Bariatric Surgery	59-62	Amanda Stricklen Rachel Ross	aoreilly@umich.edu rachacoo@umich.edu
MEDIC	Emergency Department	63-69	Andy Scott	afscott@med.umich.edu
MROQC	Radiation Oncology	70-72	Melissa Mietzel	hillmel@umich.edu
MSQC	General Surgery	73-91	Amanda Stricklen Rachel Ross	aoreilly@umich.edu rachacoo@umich.edu
MSSIC	Spine Surgery	92-108	Jamie Myers	Jmyer8@hfhs.org
MSTCVS	Cardiac and General Thoracic Surgery	109-110	Melissa Clark	clarkmel@med.umich.edu
MTQIP	Trauma Surgery	111-115	Judy Mikhail	jmikhail@umich.edu
OBI	Obstetrics	116-123	Helen Costis	hcostis@umich.edu

*Select page range to navigate to desired scorecard section.

2025 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Performance Index Scorecard **Cohorts 1 – 7** Measurement Period: 01/01/2025 - 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at meetings. Three total meetings with six opportunities for attendance.**	
		6 / 6 Meetings	10
		5 / 6 Meetings	5
		4 or Less Meetings	0
2	5%	**Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings.**	
		5 - 6 / 6 Meetings	5
		4 or less Meetings	0
3	5%	**ACQR/ASPIRE Quality Champion perform data validation, case validation, and submit data by the 3rd Wednesday of each month for January - November and by the 2nd Wednesday of the month for December. Data must be of high quality upon submission, >90% of diagnostics marked as 'Data Accurately Represented.'**	
		10 - 12/12 Months	5
		9 or Less Months	0
4	10%	**Site Based Quality Meetings: Sites to hold an onsite in-person or virtual meeting following the three ASPIRE Collaborative meetings to discuss the data and plans for quality improvement at their site**	
		3 Meetings	10
		2 Meetings	5
		1 Meeting	0
5	25%	**Sustainability (SUS 02) Percentage of cases where carbon dioxide equivalents (CO2 eq) normalized by hour for cases receiving halogenated agents and/or nitrous oxide is less than CO2 eq of 2% sevoflurane at 2L FGF = 2.83 kg CO2/hr during the maintenance period of anesthesia OR the Total CO2e is less than 2.83 kg CO2. (Cumulative score January 1, 2025 - December 31, 2025)**	
		Performance is ≥ 55%	25
		Performance is ≥ 45%	15
		Performance is ≥ 40%	10
		Performance is < 40%	0

2025 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Performance Index Scorecard **Cohorts 1 – 7** Measurement Period: 01/01/2025 - 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
6	10%	**Race & Ethnicity: Race and ethnicity variables mapped to updated MPOG concepts to align with new OMB standards.**	
		All race & ethnicity variables mapped to updated MPOG concepts by December 31, 2025.	10
		Race & ethnicity variable mapping not updated to correspond to MPOG concepts by December 31, 2025.	0
7	10%	**Sexual Orientation, Sex, & Gender Identity: All sexual orientation and gender identity variables in electronic health record extracted and mapped to an accepted MPOG concept to align with updated OMB standards.**	
		All sexual orientation, sex, and gender identity fields extracted, mapped, and submitted to MPOG by December 31, 2025.	10
		All sexual orientation, sex, and gender identity fields extracted but not yet mapped and/or submitted to MPOG by December 31, 2025.	5
		All sexual Orientation, sex, and gender identity variables not yet included in the MPOG extract.	0
8	25%	**Site Directed Measure: Site chooses a measure they are performing below threshold for a process measure or above threshold for an outcome measure to improve for the year. (cumulative score January 1, 2025 through December 31, 2025)**	
		Performance is ≥ 90% for process or ≤5% for outcome, or shows ≥ 15% improvement (absolute)	25
		Performance is ≥ 85% for process or ≤10% for outcome, or shows ≥ 10% improvement (absolute)	15
		Performance is ≥ 80% for process or ≤ 20% for outcome, or shows ≥ 5% improvement (absolute)	10
		Performance is < 80% for process or > 20% for outcome, or shows < 5% improvement (absolute)	0

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)
2025 Performance Index Scorecard
Measure Explanation: Cohorts 1 – 7 (2015 – 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 2025. There are three total meetings with six opportunities for attendance:

1. MSQC (Michigan Surgical Quality Collaborative) / ASPIRE Meeting: Friday, April 11, 2025
2. ASPIRE Collaborative Meeting: Friday, July 18, 2025
3. MPOG (Multicenter Perioperative Outcomes Group) Retreat: Friday, October 10, 2025

Measure #2: There will be six Quality Committee e-meetings in 2025. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2025 meetings:

1. Monday, January 27, 2025
2. Monday, February 24, 2025
3. Monday, May 19, 2025
4. Monday, July 28, 2025
5. Monday, September 22, 2025
6. Monday, November 24, 2025

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 all 'High Priority' and 'Required' 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: Sites will be awarded points for compliance with the sustainability measure SUS 02 (cumulative score January 1, 2025, through December 31, 2025). See P4P Scorecard for point distribution.

Measure #6: Sites will be awarded points for mapping all race and ethnicity variables to updated MPOG concepts to align with MSHIELD recommendations. Scores will be determined based on submission of at least one month of data including race and ethnicity variables mapped to updated race and ethnicity MPOG concepts by the end of December 2025. See P4P Scorecard for point distribution.

Measure #7: Sites will be awarded points for extracting all sexual orientation, sex, and gender identity variables available in the electronic health record and mapping to updated MPOG concepts to align with MSHIELD recommendations. Scores will be determined based on submission of at least one month of data including sexual orientation, sex, and gender identity variables mapped to appropriate MPOG concepts by the end of December 2025. See P4P Scorecard for point distribution.

Measure #8: Sites will choose a measure where performance is above the ASPIRE threshold for inverse (outcome) measures (5 or 10%) or a process measure with performance less than threshold (90%) that needs improvement. Full list of measures available at: https://spec.mpog.org/Measures/Public

Sites must submit their current measure score (November 1, 2023, through October 31, 2024) to the Coordinating Center by Friday, December 6, 2024, for review and approval. Measure selection form is located on the MPOG website in the P4P subtab of the Michigan hospitals tab of the quality section. If the performance threshold is not met, ASPIRE Coordinating Center will assess initial 12-month average score for November 2023 – October 2024 and compare to 12-month average score for January – December 2025. Absolute percentage point improvement will be evaluated to allocate points. See P4P Scorecard for point distribution.

2025 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Performance Index Scorecard **Cohorts 8 (2025 Start)** Measurement Period: 01/01/2025 - 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at collaborative meetings. Three total meetings with six opportunities for attendance**.	
		6 / 6 Meetings	20
		5 / 6 Meetings	10
		4 or Less Meetings	0
2	10%	**ASPIRE Champion or ACQR attend Monthly ASPIRE Quality Committee e-Meetings**	
		5 - 6 / 6 Meetings	10
		4 / 6 Meetings	5
		3 or Less Meetings	0
3	10%	**Timeliness of Regulatory/Legal documentation: Business Associate Agreement (BAA), Data Use Agreement (DUA), Multicenter Perioperative Outcomes Group (MPOG) Bylaws & IRB**	
		Submitted by April 1, 2025	10
		Submitted by May 1, 2025	5
		Submitted after May 1, 2025	0
4	10%	**Hiring an ACQR**	
		ACQR Start Date on or before January 31, 2025	10
		ACQR Start Date on or before April 1, 2025	5
		ACQR Start Date on or after April 2, 2025	0
5	20%	**Timeliness of data submission (with Case-by-Case Validation and Data Diagnostic Attestations Completed)**	
		Submitted by September 1, 2025	20
		Submitted by December 1, 2025	10
		Submitted after December 1, 2025	0
6	20%	**Performance Metric: Accuracy of data of "High" and "Required" priority data diagnostics marked as "Data Accurately Represented" in Data Diagnostics Tool**	
		≥ 90% diagnostics marked as "Data Accurately Represented"	20
		≥ 75 - 90% marked as "Data Accurately Represented"	10
		< 75% marked as "Data Accurately Represented"	0
7	10%	**Timeliness of Responses to Coordinating Center Inquiry Requests**	
		Within 2 business days	10
		Within 5 business days	5
		Greater than 5 business days	0

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)
2025 Performance Index Scorecard
Measure Explanation: Cohort 8 (2025 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 2025. There are three total meetings with six opportunities for attendance:

1. MSQC / ASPIRE Meeting: Friday, April 11, 2025
2. ASPIRE Collaborative Meeting: Friday, July 18, 2025
3. MPOG Retreat: Friday, October 10, 2025

Measure #2: There will be six Quality Committee e-meetings in 2025. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2025 meetings:

1. Monday, January 27, 2025
2. Monday, February 24, 2025
3. Monday, May 19, 2025
4. Monday, July 28, 2025
5. Monday, September 22, 2025
6. Monday, November 24, 2025

Measure #3: All the following regulatory/legal documentation must be finalized by April 1, 2025:

1. Business Associate Agreement (BAA)
2. Data Use Agreement (DUA)
3. IRB
4. MPOG Bylaws

Measure #4: Must hire Anesthesiology Clinical Quality Reviewer (ACQR) by January 31, 2025. The success of the program is greater when the ACQR is hired early in the process.

Measure #5: The minimum data requirements must be uploaded into the Multicenter Perioperative Outcomes Group (MPOG) central repository by September 1, 2025. MPOG minimum data requirements can be found on the MPOG website.

Measure #6: Data must be of high quality before the September 1, 2025 upload. The ASPIRE team will assist in determining if data is approved for upload to MPOG.

Measure #7: Timeliness of responses to the coordinating center requests. The ASPIRE team will evaluate response rates.

2025 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & Vascular Surgery Sites** Measurement period identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
1	10%	**Meeting Participation - Clinician Lead** **Measurement Period: 01/01/2025 – 12/31/2025**		
		2 Meetings (attendance at the collaborative-wide meeting earns 1 additional extra credit point)	5	5
		1 Meeting	2.5	2.5
		Did not participate	0	0
2	10%	**Data Coordinator Expectations** **Measurement Period: 01/01/2025 – 12/31/2025**		
		Meets all expectations	5	5
		Meets most expectations	2.5	2.5
		Does not meet expectations	0	0
3	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement Period: 01/01/2025 – 12/31/2025**		
		Submitted reviews for 100% of cases	5	5
		Submitted reviews for <100% of cases	0	0
Sites select two measures for scoring from measures 4, 5, 6 **Measurement Period:** 01/01/2025 – 09/30/2025 **Baseline Period:** 01/01/2023 – 03/31/2024				
4	19%	**Vascular Surgery Performance Goal - Documentation of EVAR* imaging performed on the 1-year follow up form**		
		≥80%	NA	10
		70% - <80%	NA	5
		<70%	NA	0
5		**Vascular Surgery Performance Goal - Duplex ultrasound completed prior to asymptomatic carotid endarterectomy**		
		≥90%	NA	10
		80% - <90%	NA	5
		<80%	NA	0
6		**Vascular Surgery Performance Goal - Vein mapping completed before elective lower extremity open bypass** Baseline period: 1/1/2023-3/31/2024		
		≥75%	NA	10
		65% - <75%	NA	5
		<65%	NA	0

2025 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & Vascular Surgery Sites** Measurement period identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
7	10%	**Vascular Surgery Performance Goal - Smokers receive smoking cessation treatment prior to discharge Measurement Period: 01/01/2025 – 09/30/2025**		
		≥50%	NA	10
		40% - <50%	NA	5
		<40%	NA	0
8	10%	**PCI Performance Goal - Use of IVUS/OCT^ for stent optimization Measurement Period: 01/01/2025 – 09/30/2025**		
		≥50% in EITHER all cases OR ≥50% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	10	NA
		≥10 percentage points absolute increase in all Cases from Q4 YTD 2023	5	NA
		<10 percentage points absolute increase in all cases from Q4 YTD 2023	0	NA
9	24%	**PCI Performance Goal - Outcomes and Process Composite, inclusive of risk-adjusted mortality, risk-adjusted AKI, risk-adjusted major bleeding, guideline medications prescription at discharge (aspirin, statin, P2Y12), and referral to cardiac rehab. Measurement Period: 01/01/2025 – 09/30/2025**		
		Risk-adjusted mortality		
		A/P <1	5	NA
		A/P >1, ≤1.5	3	NA
		A/P >1.5	0	NA
		Risk-adjusted acute kidney injury		
		A/P <1	5	NA
		A/P >1, ≤1.5	3	NA
		A/P >1.5	0	NA
		Risk-adjusted major bleeding		
		A/P <1	5	NA
		A/P >1, ≤1.5	3	NA
		A/P >1.5	0	NA
		Guideline medications prescription at discharge		
		≥95%	5	NA
		90% - <95%	3	NA
		<90%	0	NA

2025 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & Vascular Surgery Sites** Measurement period identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
		Referral to cardiac rehabilitation		
		≥95%	5	NA
		90% - <95%	3	NA
		<90%	0	NA
10	10%	**PCI Performance Goal - Cardiac rehabilitation utilization within 90 days after PCI discharge Measurement period: 01/01/2024-12/31/2024 Baseline period: 10/01/2021-09/30/2022**		
		Site performance ≥40% or absolute increase of ≥5 points from baseline site performance. Scored in 2025.	10	NA
		Site performance ≥37% - <40% or absolute increase of ≥3 points from baseline site performance. Scored in 2025.	5	NA
		Site performance <37% and absolute increase of <3 points from baseline site performance. Scored in 2025.	0	NA
11	n/a	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD **Measurement period: 01/01/2025-12/31/2025**	1-5	
*EVAR = endovascular aneurysm repair ^IVUS = intravascular ultrasound; OCT = optical coherence tomography				

2025 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI only sites** Measurement period identified in the measure			
Measure #	Weight	Measure Description	PCI points
1	10%	**Meeting Participation - Clinician Lead** **Measurement Period: 01/01/2025 – 12/31/2025**	
		2 Meetings (attendance at the collaborative-wide meeting earns 1 additional extra credit point)	10
		1 Meeting	5
		Did not participate	0
2	10%	**Data Coordinator Expectations** **Measurement Period: 01/01/2025 – 12/31/2025**	
		Meets all expectations	10
		Meets most expectations	5
		Does not meet expectations	0
3	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement Period: 01/01/2025 – 12/31/2025**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
4	10%	**PCI Performance Goal - Use of IVUS/OCT^ for stent optimization** **Measurement Period: 01/01/2025 – 09/30/2025** **Baseline period: 01/01/2024-03/31/2024**	
		≥50% in EITHER all cases OR ≥50% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	10
		≥10 percentage points absolute increase in all cases from Q4 YTD2023	5
		<10 percentage points absolute increase in all cases from Q4 YTD 2023	0
5	50%	**PCI Performance Goal - Outcomes and Process Composite, inclusive of risk-adjusted mortality, risk- adjusted AKI, risk-adjusted major bleeding, guideline medications prescription at discharge (aspirin, statin, P2Y12), and referral to cardiac rehab. Measurement period: 1/1/2025 - 9/30/2025** **Baseline period: 4/1/2023 - 3/31/2024**	
		Risk-adjusted mortality	
		A/P <1	10
		A/P >1, ≤ 1.5	6
		A/P >1.5	0
		Risk-adjusted acute kidney injury	
		A/P <1	10
		A/P >1, ≤ 1.5	6
		A/P >1.5	0
		Risk-adjusted major bleeding	
		A/P <1	10
		A/P >1, ≤ 1.5	6
		A/P >1.5	0

2025 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI only sites** Measurement period identified in the measure			
Measure #	Weight	Measure Description	PCI points
		Guideline medications prescription at discharge	
		≥95%	10
		90% - <95%	6
		<90%	0
		Referral to cardiac rehabilitation	
		≥95%	10
		90% - <95%	6
		<90%	0
6	10%	**PCI Performance Goal - Cardiac rehabilitation utilization within 90 days after PCI discharge** **Measurement period: 1/1/2024 - 12/31/2024** **Baseline period: 10/01/2021 - 9/30/2022**	
		Site performance ≥40% or absolute increase of ≥5 points from baseline site performance. Scored in 2025.	10
		Site performance ≥37% - <40% or absolute increase of ≥3 points from baseline site performance. Scored in 2025.	5
		Site performance <37% and absolute increase of <3 points from baseline site performance. Scored in 2025.	0
7	n/a	**Extra credit:** 1 point per approved activity (maximum of 5 points) Examples include Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD Measurement period: 1/1/2025 - 12/31/2025	1-5
^IVUS = intravascular ultrasound; OCT = optical coherence tomography			

2025 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **Vascular Surgery only sites** Measurement period identified in each measure			
Measure #	Weight	Measure Description	VS points
1	10%	**Meeting Participation - Clinician Lead** **Measurement Period: 01/01/2025 – 12/31/2025**	
		2 Meetings (attendance at the collaborative-wide meeting earns 1 additional extra credit point)	10
		1 Meeting	5
		Did not participate	0
2	10%	**Data Coordinator Expectations** **Measurement Period: 01/01/2025 – 12/31/2025**	
		Meets all expectations	10
		Meets most expectations	7.5
		Does not meet expectations	0
3	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement Period: 01/01/2025 – 12/31/2025**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
Sites select two measures for scoring from measures 4, 5, 6			
4	25%	**Vascular Surgery Performance Goal - Documentation of EVAR* imaging performed on the 1-year follow up form** **Measurement Period: 01/01/2025 – 09/30/2025**	
		≥80%	25
		70% - <80%	15
		<70%	0
5	25%	**Vascular Surgery Performance Goal - Duplex ultrasound completed prior to asymptomatic carotid endarterectomy** **Measurement Period: 01/01/2025 – 09/30/2025**	
		≥90%	25
		80% - <90%	15
		<80%	0
6	25%	**Vascular Surgery Performance Goal - Vein mapping completed before elective lower extremity open bypass** **Measurement Period: 01/01/2025 – 09/30/2025**	
		≥75%	25
		65% - <75%	15
		<65%	0

2025 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **Vascular Surgery only sites** Measurement period identified in each measure			
Measure #	Weight	Measure Description	VS points
7	20%	**Vascular Surgery Performance Goal - Smokers receive smoking cessation treatment prior to discharge** **Measurement Period: 01/01/2025 – 09/30/2025**	
		≥50%	20
		40% - <50%	15
		<40%	0
8	0	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD Measurement period: 1/1/2025 - 12/31/2025	1-5
*EVAR = endovascular aneurysm repair			

2025 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard Measurement Periods: 07/31/2025-11/05/2025 (ABX Discharges) & 07/01/2025- 10/06/2025 (Sepsis Discharges)			
Measure #	Weight	Measure Description	Points
1	10%	**Timeliness[1], Completeness[2], and Accuracy[3] of HMS Data (5 metrics)** 1. ≥ 95% of registry data on time[1] and complete[2] at Mid-Year 2. ≥ 95% of registry data on time[1] and complete[2] at End-of-Year 3. ≥ 95% of registry data accurate[3] 4. Audit case corrections completed by due date[3] 5. Two semi-annual QI activity surveys completed[4]	
		5 of 5 metrics met	10
		4 of 5 metrics met	8
		3 of 5 metrics met	6
		2 of 5 metrics met	4
		1 of 5 metrics met	2
		0 of 5 metrics met	0
2	10%	**Consortium-wide Meeting Participation[5] – clinician lead or designee[6]**	
		3 meetings	10
		2 meetings	5
		1 meeting	3
		No meetings	0
3	10%	**Consortium-wide Meeting Participation[5] – data abstractor, QI staff, or other**	
		3 meetings	10
		2 meetings	5
		1 meeting	3
		No meetings	0
4	15%	**Increase Use of 5 Days of Antibiotic Treatment[7] in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e., reduce excess durations)[8,9]**	
		≥ 75% uncomplicated CAP cases receive 5 days[7] of antibiotics **OR** ≥ 75% relative increase in the number of uncomplicated CAP cases that receive 5 days[7] of antibiotics during the current performance year[9]	15
		54-74% uncomplicated CAP cases receive 5 days[7] of antibiotics **OR** 55-74% relative increase in the number of uncomplicated CAP cases that receive 5 days[7] of antibiotics during the current performance year[9]	8
		≤ 53% uncomplicated CAP cases receive 5 days[7] of antibiotics **AND** ≤ 54% relative increase in the number of uncomplicated CAP cases that receive 5 days[7] of antibiotics during the current performance year[9]	0

2025 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard Measurement Periods: 07/31/2025-11/05/2025 (ABX Discharges) & 07/01/2025- 10/06/2025 (Sepsis Discharges)			
Measure #	Weight	Measure Description	Points
5	15%	**Increase Antibiotics Delivered within 3 hours of Arrival for Septic Cases with Hypotension[8.10]**	
		≥ 68% sepsis cases with hypotension[10] receive antibiotics within 3 hours of arrival	15
		64 – 67% sepsis cases with hypotension[10] receive antibiotics within 3 hours of arrival	8
		≤ 63% sepsis cases with hypotension[10] receive antibiotics within 3 hours of arrival	0
6	15%	**Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to Home-like Setting[8,11,12]**	
		≥ 84% sepsis cases discharged to home-like setting[11] received at least 1 of 3 discharge/post- discharge coordination of care measures[12]	15
		69 – 83% sepsis cases discharged to home-like setting[11] received at least 1 of 3 discharge/post-discharge coordination of care measures[12]	8
		≤ 68% sepsis cases discharged to home-like setting[11] received at least 1 of 3 discharge/post-discharge coordination of care measures[12]	0
7	15%	**Increase Use of Balanced Solutions[13] over Normal Saline in Patients with Sepsis[8.14]**	
		≥ 17% sepsis cases who have ≥ 75% of their bolus and/or maintenance fluid as balanced solutions[13] in the first 48 hours of hospital arrival[14]	15
		9 – 16% sepsis cases who have ≥ 75% of their bolus and/or maintenance fluid as balanced solutions[13] in the first 48 hours of hospital arrival[14]	8
		≤ 8% sepsis cases who have ≥ 75% of their bolus and/ or maintenance fluid as balanced solutions[13] in the first 48 hours of hospital arrival[14]	0
8	10%	**Reduce Use of Antibiotics in Patients with ASB (Asymptomatic Bacteriuria)[15,16]**	
		≤ 10% collaborative-wide average[16] of positive urine culture cases treated with an antibiotic are ASB cases[15]	10
		> 10% collaborative-wide average[16] of positive urine culture cases treated with an antibiotic are ASB cases[15]	0

2025 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard Measurement Periods: 07/31/2025-11/05/2025 (ABX Discharges) & 07/01/2025- 10/06/2025 (Sepsis Discharges)			
Measure #	Weight	Measure Description	Points
Optional Bonus Points			
Optional	5%	Participation Bonus Points: Each site has the option of earning up to 5 bonus points toward their participation metrics (1-3) during the performance year. Each opportunity for bonus points is highlighted below with their point allowance: • Emergency Medicine Physician[17] attendance at the 2 in-person Collaborative Wide Meetings convened during the performance year (July & November) – 5 points • Present HMS data or about HMS at a national meeting (with approval)[18] – 3 points • Emergency Medicine Physician[17] attendance at 1 in-person Collaborative Wide Meeting convened during the performance year (July OR November) – 2 points • Emergency Medicine Physician[17] attendance at 1 in-person Collaborative Wide Meeting convened during the performance year (July OR November) – 2 points • Present at an HMS meeting, event, or webinar during the performance year[19] – 2 points	5
Optional	2.5%	Performance Bonus: Increase success of Patient Reported Outcomes (PROs – phone, email, or text) collection in patients eligible for PROs completion in Antimicrobial Use Cases[8.20]	
		≥ 85% success of Patient Reported Outcomes (PROs) collection in Antimicrobial Use cases[20]	2.5
		80-84% success of Patient Reported Outcomes (PROs) collection in Antimicrobial Use cases[20]	2
		75-79% success of Patient Reported Outcomes (PROs) collection in Antimicrobial Use cases[20]	1.5
Optional	2.5%	Performance Bonus: Increase success of Patient Reported Outcomes (PROs – phone, email, or text) collection in patients eligible for PROs completion in Sepsis Cases[8.20]	
		≥ 70% success of Patient Reported Outcomes (PROs) collection in Sepsis cases[20]	2.5
		65-69% success of Patient Reported Outcomes (PROs) collection in Sepsis cases[20]	2
		60-64% success of Patient Reported Outcomes (PROs) collection in Sepsis cases[20]	1.5
*Earned bonus points will be added to the scorecard total, with the final score not to exceed 100 points overall. Participation bonus points may only apply to participation-based measures (1-3) and performance bonus points may only apply to performance-based measures (4-7).			

HMS Supporting Documentation

[1] Registry data for all initiatives (Antimicrobial and Sepsis) assessed during mid-year performance evaluation review and at year end based on data submitted during performance year 2025. 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] Completeness of cases is assessed based upon completeness of ALL required forms (including patient reported outcomes in eligible cases) for each case that is marked as Completed in the registry.

[3] Assessed based on scores received for site audits conducted during performance year 2025. Scores are averaged if multiple audits take place during the year. For audits conducted during the performance year, audit case corrections must be completed or discrepancies addressed within 3 months of audit summary receipt (due date for case corrections provided in audit summary) or end of performance year deadline – whichever comes first.

[4] Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[5] Based on all Collaborative Wide Meetings scheduled during performance year 2025. Clinician leads or designees may only represent one (1) site per meeting. Data abstractors or other QI staff may only represent one (1) site per meeting.

[6] Clinician lead or designee must be a physician as outlined in Hospital Expectations. This does not include Residents, Fellows, Interns, or Advanced Practice Professionals.

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

[8] Assessed at year end based on final quarter of data entered (per the data abstraction calendar) in the data registry during the performance year 2025. 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, and reflects the improvement work each hospital is doing over a given performance year.

[9] Rate of change is based on the adjusted method between Q1 2025 and Q4 2025 and may not reflect raw rates from quarter to quarter.

[10] Hypotension is defined as: vasopressors initiated within two hours of arrival to the hospital encounter OR systolic blood pressure < 90 mmHg within two hours of arrival to the hospital encounter OR calculated MAP < 65 within two hours of arrival to the hospital encounter. Patients excluded from review in this measure include those with viral sepsis (COVID and Influenza), < 2 SIRS, normal WBC, no elevated lactate, and no symptoms of infection.

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

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

- Hospital contact information provided at discharge (in discharge paperwork)
- Scheduled for outpatient follow-up within 2 weeks (at time of discharge)
- Post-discharge telephone call **OR** visit with PCP or specialist within 3 calendar days of hospital discharge **OR** patient is discharged to a home-like setting with home health services

[13] Balanced Solutions are defined as Lactated Ringers or Plasma-Lyte.

[14] Sepsis cases eligible for this measure include all patients receiving ≥ 1 liter of bolus and/or maintenance fluid within the first 48 hours of hospital arrival.
[15] Antibiotic treatment for ASB is assessed based on treatment on day 2 or later of the entire hospital encounter. This portion of the measure is assessed out of all positive urine culture cases abstracted during the performance year.

[16] Assessed at year end based on the collaborative-wide average for the final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2025. This is different than the other performance measures in the index, which are applied to each individual hospital.
[17] The Emergency Medicine Physician in attendance at the in-person Collaborative Wide Meeting cannot be a resident, fellow, intern or Advanced Practice Professional. Emergency Medicine Physicians may only represent one (1) site per meeting. The Emergency Medicine Physician may not also be the Physician representing the site for Measure 2 of the Performance Index.
[18] Presenters who are interested in sharing HMS data at a national or international meeting must submit intent to present data to the HMS Coordinating Center and receive approval from our Data, Design, and Publications Committee. Guidelines in the most recent HMS Publication Policy must be followed.
[19] Bonus points will be awarded to sites who present at an HMS Collaborative Wide Meeting, HMS-sponsored event, HMS Abstractor Conference Call, or HMS webinar during the 2025 Performance Year when requested by the HMS Coordinating Center. Sites may only receive bonus points for 1 presentation per year.
[20] This section will be calculated by assessing the number of cases with successful Patient Reported Outcomes (PROs) out of those eligible for PROs.

2025 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Ascension St. John and Trinity Ann Arbor** Measurement period: 01/01/2025 – 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative-wide meeting participation -Clinical Champion** **Measurement period: 01/01/2025 - 12/31/2025**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
2	10%	**Collaborative-wide meeting participation - Coordinator/Lead Abstractor** **Measurement period: 01/01/2025 - 12/31/2025**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
3	10%	**Completeness and accuracy of data** **Measurement period: 01/01/2025 - 12/31/2025** **Baseline period: 01/01/2024 - 07/12/2024**	
		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
4	35%	**DOAC Dashboard utilization** **Measurement period: (01/01/2025) - (12/31/2025)** **Baseline period: (01/01/2024) - (07/12/2024)**	
		≥750 known/possible critical alerts addressed in 2025	35
		500-749 known/possible critical alerts addressed in 2025	25
		250-499 known/possible critical alerts addressed in 2025	15
		<250 known/possible critical alerts addressed in 2025	0
5	35%	**Inappropriate aspirin in patients on DOACs** **Measurement period: (01/01/2025) - (12/31/2025)** **Baseline period: (01/01/2024) - (07/12/2024)**	
		Protocol/process for de-prescribing aspirin (+ all of below)	35
		Protocol/process for contacting providers about aspirin de-prescribing (+ all of below)	25
		Protocol/process to determine appropriateness (+ below)	15
		Process for identifying patients on combination DOAC + aspirin therapy	5
		No process or protocols related to aspirin de-prescribing	0
*PPI prescribed in patients on aspirin; PPI or H2 receptor blocker prescribed in patients on P2Y12 inhibitor			

2025 Michigan Anticoagulation Quality Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **U of M, Henry Ford, Corewell East, Corewell West** Measurement period: 01/01/2025 – 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative-wide meeting participation -Clinical Champion**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
2	10%	**Collaborative-wide meeting participation - Coordinator/Lead Abstractor**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
3	10%	**Completeness and accuracy of data Baseline period: (01/01/2024) - (07/12/2024)**	
		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
4	10%	**Smoking status assessment and documentation Baseline period: (01/01/2024) - (07/12/2024)**	
		≥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	7
		50-69% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	4
		<50% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	0
5	10%	**Inappropriate aspirin use in patients on warfarin Baseline period: (01/01/2024) - (07/12/2024)**	
		≤9% or relative decrease of ≥15%	10
		16-10% or relative decrease of 10-14%	7
		22-17% or relative decrease of 5-9%	4
		>22% or relative decrease of <5%	0
6	10%	**Extended international normalized ratio (INR) testing interval Baseline period: (01/01/2024) - (07/12/2024)**	
		≥82% of eligible patients received extended intervals	10
		70-81% of eligible patients received extended intervals	7
		50-69% of eligible patients received extended intervals	4
		<50% of eligible patients received extended intervals	0

2025 Michigan Anticoagulation Quality Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **U of M, Henry Ford, Corewell East, Corewell West** Measurement period: 01/01/2025 – 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
7	10%	**Gastroprotection* in patients on warfarin at high-risk for upper GI bleeding (site level) Baseline period: (01/01/2024) - (07/12/2024)**	
		≥55% or relative increase of ≥10%	10
		40-54% or relative increase of 6-9%	7
		25-39% or relative increase of 2-5%	4
		<25% or relative increase of <2%	0
8	10%	**Gastroprotection* in patients on warfarin at high-risk for upper GI bleeding (consortium- level) Baseline period: (01/01/2024) - 07/12/2024)**	
		≥60%	10
		50-59%	7
		40-49%	4
		<40%	0
9	10%	**DOAC Dashboard utilization Baseline period: (07/01/2023) - (06/30/2024)**	
		≥750 known/possible critical alerts addressed in 2025	10
		500-749 known/possible critical alerts addressed in 2025	7
		250-499 known/possible critical alerts addressed in 2025	4
		<250 known/possible critical alerts addressed in 2025	0
10	10%	**Inappropriate aspirin in patients on DOACs Baseline period: (01/01/2024) - (07/12/2024)**	
		Protocol/process for de-prescribing aspirin (+ all of below)	10
		Protocol/process for contacting providers about aspirin de-prescribing (+ all of below)	7
		Protocol/process to determine appropriateness (+ below)	4
		Process for identifying patients on combination DOAC + aspirin therapy	2
		No process or protocols related to aspirin de-prescribing	0
*PPI prescribed in patients on aspirin; PPI or H2 receptor blocker prescribed in patients on P2Y12 inhibitor			

2025 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Memorial** Measurement Period: 01/01/2025 – 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative-wide meeting participation -Clinical Champion**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
2	10%	**Collaborative-wide meeting participation - Coordinator/Lead Abstractor**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
3	10%	**Completeness and accuracy of data Baseline period: (01/01/2024) - (07/12/2024)**	
		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
4	15%	**Smoking status assessment and documentation Baseline period: (01/01/2024) - (07/12/2024)**	
		≥90% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	15
		70-89% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	10
		50-69% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	5
		<50% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	0
5	15	**Inappropriate aspirin use in patients on warfarin Baseline period: (01/01/2024) - (07/12/2024)**	
		≤9% or relative decrease of ≥15%	15
		16-10% or relative decrease of 10-14%	10
		22-17% or relative decrease of 5-9%	5
		>22% or relative decrease of <5%	0
6	15%	**Extended international normalized ratio (INR) testing interval Baseline period: (01/01/2024) - (07/12/2024)**	
		≥82% of eligible patients received extended intervals	15
		70-81% of eligible patients received extended intervals	10
		50-69% of eligible patients received extended intervals	5
		<50% of eligible patients received extended intervals	0

2025 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Memorial** Measurement Period: 01/01/2025 – 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
7	15%	**Gastroprotection* in patients on warfarin at high-risk for upper GI bleeding (site level)** **Baseline period: (01/01/2024) - 07/12/2024)**	
		≥55% or relative increase of ≥10%	15
		40-54% or relative increase of 6-9%	10
		25-39% or relative increase of 2-5%	5
		<25% or relative increase of <2%	0
8	10%	**Gastroprotection* in patients on warfarin at high-risk for upper GI bleeding (consortium- level)** **Baseline period: (01/01/2024) - (07/12/2024)**	
		≥60%	10
		50-59%	7
		40-49%	4
		<40%	0
*PPI prescribed in patients on aspirin; PPI or H2 receptor blocker prescribed in patients on P2Y12 inhibitor			

2025 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **MyMichigan and Bronson** Measurement Period: 01/01/2025 – 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	20%	**Collaborative-wide meeting participation -Clinical Champion**	
		Attended all 3 meetings	20
		Attended 2 out of 3 meetings	10
		Attended 1 out of 3 meetings	5
		Did not attend any meetings	0
2	20%	**Collaborative-wide meeting participation - Coordinator/Lead Abstractor**	
		Attended all 3 meetings	20
		Attended 2 out of 3 meetings	10
		Attended 1 out of 3 meetings	5
		Did not attend any meetings	0
3	20%	**Completeness and accuracy of data**	
		Critical data elements are complete/accurate in ≥90% of cases	20
		Critical data elements are complete/accurate in 70-89% of cases	10
		Critical data elements are complete/accurate in 50-69% of cases	5
		Critical data elements are complete/accurate in <50% of cases	0
4	20%	**Volume of data abstraction year 1**	
		≥ 90% of expected volume entered by site*	20
		70-89% of expected volume entered by site*	10
		50-69% of expected volume entered by site*	5
		<50% of expected volume entered by site*	0
5	20%	**DOAC dashboard implementation**	
		Fully implemented DOAC dashboard	20
		Site IT staff fully engaged and programming process underway	15
		Organizational approval received and project added to IT project list	10
		Site team making demonstrable effort to get organizational approval	5
		No site engagement regarding DOAC dashboard implementation	0
*per abstractor FTE: enter baseline and follow-up on 250 new warfarin pts and 350 new DOAC patients			

2025 Michigan Arthroplasty /Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 1** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2025-11.15.2025) *Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
2	20%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2025-11.15.2025) *Attendance at both the CDA Breakout and Collaborative- wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
3	5%	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive new site kickoff meeting time on Wednesday, January 22, 2025, for: 1. Clinical Champion 2. Quality Administrator 3. Clinical Data Abstractor (if identified)	5
4	5%	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive new site kickoff meeting time on Wednesday, January 22, 2025, for: 1. Site IT Support	5
5	20%	**Accuracy and Completeness of Data Submission (01.30.2025 - 06.30.2025) - 4 metrics** 1. Complete data entry ≥ 97% - 100% of the time educational review complete with no concerns (e.g., greater than 97% accuracy) 2. On-time data entry (e.g., Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. First 10 cases abstracted by 05.31.2025 4. All cases performed or before May 4, 2025, abstracted by October 1, 2025	
		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

2025 Michigan Arthroplasty /Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 1** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
6	15%	**Access to Surgeon's Office Records (90-day events): (Surgery dates 01.01.2025-08.31.2025)**	
		90% + patient data captured	15
		75% - 89% patient data captured	7.5
		Less than 75% data captured	0
7	15%	**Site based Quality Meetings:(02.08.2025-11.15.2025)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site-based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	15
Extra Credit	n/a	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.08.2025-11.15.2025) --meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 0.5 extra credit points per site towards participation measures**	0.5
Extra Credit	n/a	**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, 2025 ***Maximum total of 0.5 extra credit points per site towards performance measures**	0.5
Extra Credit	n/a	**PROs Collection:** For surgeries performed on 01.01.2025-06.30.2025, **SITE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *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.* ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 90%+	2
		75 - 89%	1.5
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0

2025 Michigan Arthroplasty /Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 1** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
Extra Credit	n/a	**PROs Collection:** Completed primary Pre-op and 2–16-week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2025) at a **SITE** are 70% or greater for both primary hip and knee procedures combined *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.* ***Maximum total of 1 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	1
		60%	0.5
		The site is not awarded extra credit if collection is less than 60%	0

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2025-11.15.2025)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
Extra Credit	0	**Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team, Patient education, Optimization & Appropriateness, etc.)** **Maximum total 1-point extra credit per site towards participation measures*	1
2	15%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2025-11.15.2025)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	15
		2 out of 3 meetings attended	7.5
		<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, Patient education, etc.)** **Maximum total 0.5 point extra credit per site towards participation measures*	0.5
3	20%	**Accuracy and Completeness of Data Submission (audits 07.01.2024 - 06.30.2025) - 5 metrics** 1. Complete data entry (e.g., Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g., Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All cases completed on or before December 31, 2024, abstracted completely by 05.31.2025 4. All cases performed or before May 4, 2025 abstracted by October 1, 2025 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2025	

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0
Extra Credit	0	**Site level:** On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2024 - 06.30.2025) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) **Maximum total 0.5 point extra credit per site towards participation measures*	0.5
4	5%	**Site level**: Access to 90-day post-operative clinical office notes for every participating MARCQI surgeon at the site is demonstrated to be 99% or above for cases completed (07.01.2024 - 06.30.2025). If a MARCQI surgeon's rate for access to clinical office notes has been lower than 99% over the last few years, an attestation for the changes made and implemented will be required, and a demonstration may be requested.	5
Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.08.2025-11.15.2025) --meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. **Maximum total of 3 extra credit points per site towards participation measures*	3
5	20%	**Site based Quality Meetings:(02.08.2025-11.15.2025)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site-based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	20

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
6	5%	**90-Day Hip fracture:** Reduce or maintain **SITE** level rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) as seen on their April 2024 MARCQI Quarterly Report to 1.05% --If site is ≤ 1.05%, then goal is to reduce or maintain --If site is >1.05%, then the goal is to reduce by 10%	
		When April 2024 baseline is: **>1.05%**, the site meets a site-level reduction of 10% or meets the 1.05% rate of 90-day hip fractures **≤1.05%**, the site maintains baseline outcome or reduces hip fracture rate	5
		When April 2024 baseline is: **>1.05%**, the site meets a site-level reduction of ≥ 5% site- level rate of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of ≤ 2% site- level rate of 90-day hip fractures	3
		When April 2024 baseline is: **>1.05%**, the site attains a site-level reduction is <5% of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of >2% but ≤ 4% site-level rate of 90-day hip fractures	1
		When April 2024 baseline is: **>1.05%**, the site does not reduce the site-level rate of 90- day hip fractures **≤1.05%**, the site increases by >4% in the rate of the site- level 90-day hip fractures	0
7	5%	**30-Day Emergency Department (ED) visit:** Reduce **SITE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **HIP** procedures as seen on a site's April 2024 MARCQI Quarterly Report.	
		When April 2024 baseline is: **>3.60%**, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure **≤3.60%**, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary HIP procedure	5
		When April 2024 baseline is: **>3.60%**, the site meets a site-level reduction of ≥ 5% but <10% site-level rate of 30-Day ED visits following primary HIP procedure **≤3.60%**, the site sees a site-level increase of ≤ 2% site-level rate of 30-Day ED visits following primary HIP procedure	3
		When April 2024 baseline is: **>3.60%**, the site attains a site-level reduction is <5% the site-level rate of 30-Day ED visits following primary HIP procedure **≤3.60%**, the site sees a site-level increase of >2% but ≤ 4% of site-level rate of 30-Day ED visits following primary HIP procedure	1
		When April 2024 baseline is: **>3.60%**, the site maintains or does not reduce the site-level rate of 30-Day ED visits following primary HIP procedure **≤3.60%**, the site increases by >4% in the rate of the site-level 30-Day ED visits following primary HIP procedure	0

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
Extra Credit (Affiliate hospital & HOPD)	n/a	**30-Day Emergency Department (ED) visit:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal when April 2024 baseline is: >3.60%, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure **OR** ≤3.60%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary HIP procedure but the affiliate site/s or HOPD did meet the goal when April 2024 baseline is: >3.60%, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure **OR** ≤3.60%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary HIP procedure Then the flagship hospital's P4P scorecard will receive 1 extra credit point. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Extra Credit	0	**30-Day Emergency Department (ED) visit:** On January 2026 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **HIP** procedures is ≤ 5.31%. ***Maximum total of 0.5 extra credit points per site towards performance measures**	0.5
Extra Credit	n/a	**30-Day Emergency Department (ED) visit:** On January 2026 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **HIP** procedures increased from baseline in April 2024. The site will perform a deep dive into all 30-Day Emergency Department (ED) visits for all primary HIP procedures during the measurement period, and submit the deep dive details and 1 page report of the findings by 11:59PM ET December 31, 2025 via SRS ticket in the database. ***Maximum total of 1 extra credit points per site towards performance measures**	1
8	5%	**30-Day Emergency Department (ED) visit**: Reduce **SITE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary KNEE procedures as seen on a site's April 2024 MARCQI Quarterly Report.	
		When April 2024 baseline is: **>4.20%**, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure **≤4.20%**, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary KNEE procedure	5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
		When April 2024 baseline is: **>4.20%**, the site meets a site-level reduction of ≥ 5% but <10% site-level rate of 30-Day ED visits following primary KNEE procedure **≤4.20%**, the site sees a site-level increase of ≤ 2% site-level rate of 30-Day ED visits following primary KNEE procedure	3
		When April 2024 baseline is: **>4.20%**, the site attains a site-level reduction is <5% the site-level rate of 30-Day ED visits following primary KNEE procedure **≤4.20%**, the site sees a site-level increase of >2% but ≤ 4% of site-level rate of 30-Day ED visits following primary KNEE procedure	1
		When April 2024 baseline is: **>4.20%**, the site maintains or does not reduce the site-level rate of 30-Day ED visits following primary KNEE procedure **≤4.20%**, the site increases by >4% in the rate of the site-level 30-Day ED visits following primary KNEE procedure	0
Extra Credit (Affiliate hospital & HOPD)	n/a	**30-Day Emergency Department (ED) visit:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal when April 2024 baseline is: >4.20%, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure **OR** ≤4.20%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary KNEE procedure but the affiliate site/s or HOPD did meet the goal when April 2024 baseline is: >4.20%, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure **OR** ≤4.20%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary KNEE procedure Then the flagship hospital's P4P scorecard will receive 1 extra credit point. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Extra Credit	n/a	**30-Day Emergency Department (ED) visit:** On January 2026 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **KNEE** procedures is ≤ 6.03%. ***Maximum total of 0.5 extra credit points per site towards performance measures**	0.5
Extra Credit	n/a	**30-Day Emergency Department (ED) visit:** On January 2026 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **KNEE**	1

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
		procedures increased from baseline in April 2024. The site will perform a deep dive into all 30-Day Emergency Department (ED) visits for all primary KNEE procedures during the measurement period and submit the deep dive details and 1 page report of the findings by 11:59PM ET December 31, 2025, via SRS ticket in the database. ***Maximum total of 1 extra credit points per site towards performance measures**	
9	5%	**PROs Collection:** For surgeries performed on 07.01.2024-06.30.2025, **SITE** level primary PRE-OPERATIVE HOOS - JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		The site is awarded full points for collection rates of 90%+	5
		75 - 89%	3
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0
Extra Credit	n/a	**PROs Collection:** For surgeries performed on 07.01.2024-06.30.2025, **COLLABORATIVE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *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.* ***Maximum total of 2 extra credit points per site towards performance measures**	2
Extra Credit (Affiliate hospital & HOPD)	n/a	**PROs Collection:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal to collect 90% or more PRE-OPERATIVE HOOS-JR or KOOS JR + PROMIS10 for surgeries performed on 07.01.2024-06.30.2025, but the affiliate site/s or HOPD did meet the goal on the January 2026 Quarterly Reports, extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Extra Credit	n/a	**PROs Collection:** For surgeries performed on 06.01.2023 to 11.03.2024, **SITE** level primary PRE-OPERATIVE & 1 YEAR POST-OPERATIVE (300-425 days) HOOS -JR or KOOS-JR + PROMIS10 completion rate of 50% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate*	

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Measure #	Max. Weight	Measure Description	Points
		will be used for this metric.	
		The site is awarded full points for collection rates of 50%+	5
		40 - 49%	3
		30 - 39%	1
		The site is not awarded points if collection is less than 30%	0
Extra Credit (Affiliate hospital & HOPD)	n/a	**PROs Collection:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal to collect 50% or more PRE-OPERATIVE HOOS-JR or KOOS JR + PROMIS10 for surgeries performed on 06.01.2023-11.03.2024, but the affiliate site/s or HOPD did meet the goal on the January 2026 Quarterly Reports, extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Extra Credit	n/a	**PROs Collection:** Completed primary Pre-op and 2–16-week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2025) at a **SITE** are 70% or greater for both primary hip and knee procedures combined *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.* ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	2
		60%	1.5
		50%	1
		The site is not awarded extra credit if collection is less than 50%	0
Extra Credit	n/a	**Reverse Site-Visits:** If a site is **RED or YELLOW** in a quality improvement area on their VISUAL Scorecard and they complete a SITE VISIT to a site that is **GREEN** on their VISUAL Scorecard and vis-versa, the RED/YELLOW site and GREEN sites are both eligible for extra credit if: **--**Both sites must visit each other for the same quality improvement area (e.g., sites must observe what is going well and what may not be going as well) between 07.01.2024 - 09.30.2025 --Both sites submit a report regarding the lessons learned for the site visits by November 15, 2025 --Both sites must be willing to have their clinical champion share their findings with the collaborative if asked or results in -5 points on the FY2026 P4P Scorecard --Both sites must have their clinical champions and Clinical	5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
		Data Abstractors at both site visits --Sites are not part of the same health system or have an affiliate site/HOPD relationship --MARCQI Coordinating Center is alerted to the site visits and has the opportunity to join if requested ***Maximum total of 5 extra credit points per site towards performance measures**	

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2025-11.15.2025)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	10
		2 out of 3 meetings attended	5
		<3 meetings attended	0
Extra Credit	n/a	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, Patient education, Optimization & Appropriateness, etc.) ***Maximum total 1-point extra credit per site towards participation measures**	1
2	4%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2025-11.15.2025)** **Attendance at both the CDA Breakout and Collaborative- wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	4
		2 out of 3 meetings attended	2
		<3 meetings attended	0
Extra Credit	n/a	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5-point extra credit per site towards participation measures**	0.5
3	10%	**Accuracy and Completeness of Data Submission (audits 07.01.2024 - 06.30.2025) - 5 metrics** 1. Complete data entry (e.g., Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g., Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All cases completed on or before December 31, 2024, abstracted completely by 05.31.2025 4. All cases performed or before May 4, 2025, abstracted by October 1, 2025 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2025	
		5 of 5 metrics met	8
		4 of 5 metrics met	6
		3 of 5 metrics met	4
		2 of 5 metrics met	2
		1 of 5 metrics met	1
		0 of 5 metrics met	0

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
Extra Credit	n/a	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2024 - 06.30.2025) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site towards participation measures**	0.5
4	3%	Site level: Access to 90-day post-operative clinical office notes for every participating MARCQI surgeon at the site is demonstrated to be 99% or above for cases completed (07.01.2024 - 06.30.2025). If a MARCQI surgeon's rate for access to clinical office notes has been lower than 99% over the last few years, an attestation for the changes made and implemented will be required, and a demonstration may be requested.	3
5	5%	**Site based Quality Meetings:(02.08.2025-11.15.2025)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site-based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	5
Extra Credit	n/a	87.5% of MARCQI surgeons at the site attend 3 of 3 site- based QI meetings (02.08.2025-11.15.2025) --meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 3 extra credit points per site towards participation measures**	3
6	10%	**90-Day Hip fracture:** Reduce or maintain **SITE** level rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) as seen on their April 2024 MARCQI Quarterly Report to 1.05% --If site is ≤ 1.05%, then goal is to reduce or maintain --If site is >1.05%, then the goal is to reduce by 10%	
		When April 2024 baseline is: **>1.05%**, the site meets a site-level reduction of 10% or meets the 1.05% rate of 90-day hip fractures **≤1.05%**, the site maintains baseline outcome or reduces hip fracture rate	10
		When April 2024 baseline is: **>1.05%**, the site meets a site-level reduction of ≥ 5% site- level rate of 90-day hip fractures **≤1.05%**, the site sees a site-level increase of ≤ 2% site- level rate of 90-day hip fractures	6
		When April 2024 baseline is: **>1.05%**, the site attains a site-level reduction is <5% of	4

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
		90-day hip fractures **≤1.05%**, the site sees a site-level increase of >2% but ≤ 4% site-level rate of 90-day hip fractures	
		When April 2024 baseline is: **>1.05%**, the site does not reduce the site-level rate of 90- day hip fractures **≤1.05%**, the site increases by >4% in the rate of the site- level 90-day hip fractures	0
7	10%	**30-Day Emergency Department (ED) visit:** Reduce **SITE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **HIP** procedures as seen on a site's April 2024 MARCQI Quarterly Report.	
		When April 2024 baseline is: • **>3.60%**, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure • **≤3.60%**, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary HIP procedure	10
		When April 2024 baseline is: • **>3.60%**, the site meets a site-level reduction of ≥ 5% but <10% site-level rate of 30-Day ED visits following primary HIP procedure • **≤3.60%**, the site sees a site-level increase of ≤ 2% site-level rate of 30-Day ED visits following primary HIP procedure	7
		When April 2024 baseline is: • **>3.60%**, the site attains a site-level reduction is <5% the site-level rate of 30-Day ED visits following primary HIP procedure • **≤3.60%**, the site sees a site-level increase of >2% but ≤ 4% of site-level rate of 30-Day ED visits following primary HIP procedure	4
		When April 2024 baseline is: • **>3.60%**, the site maintains or does not reduce the site- level rate of 30-Day ED visits following primary HIP procedure • **≤3.60%**, the site increases by >4% in the rate of the site- level 30-Day ED visits following primary HIP procedure	0
Extra Credit (Affiliate hospital & HOPD)	n/a	**30-Day Emergency Department (ED) visit:** If the combined data of the **flagship hospital, affiliate hospital, and/or HOPD** did not meet the goal when April 2024 baseline is: >3.60%, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure **OR** ≤3.60%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary HIP procedure but the affiliate site/s or HOPD did meet the goal when April 2024 baseline is: >3.60%, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure **OR** ≤3.60%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary HIP procedure Then the flagship hospital's P4P scorecard will receive 1 extra credit point. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met**	1

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
Extra Credit	n/a	**30-Day Emergency Department (ED) visit:** On January 2026 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **HIP** procedures is ≤ 5.31%. ***Maximum total of 0.5 extra credit points per site towards performance measures**	0.5
Extra Credit	n/a	**30-Day Emergency Department (ED) visit:** On January 2026 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **HIP** procedures increased from baseline in April 2024. The site will perform a deep dive into all 30-Day Emergency Department (ED) visits for all primary HIP procedures during the measurement period and submit the deep dive details and 1 page report of the findings by 11:59PM ET February 12, 2026, via SRS ticket in the database. ***Maximum total of 2 extra credit points per site towards performance measures**	2
8	10%	**30-Day Emergency Department (ED) visit:** Reduce **SITE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **KNEE** procedures as seen on a site's April 2024 MARCQI Quarterly Report.	
		When April 2024 baseline is: • **>4.20%**, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure • **≤4.20%**, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary KNEE procedure	10
		When April 2024 baseline is: • **>4.20%**, the site meets a site-level reduction of ≥ 5% but <10% site-level rate of 30-Day ED visits following primary KNEE procedure • **≤4.20%**, the site sees a site-level increase of ≤ 2% site-level rate of 30-Day ED visits following primary KNEE procedure	7
		When April 2024 baseline is: • **>4.20%**, the site attains a site-level reduction is <5% the site-level rate of 30-Day ED visits following primary KNEE procedure • **<4.20%**, the site sees a site-level increase of >2% but <4% of site-level rate of 30-Day ED visits following primary KNEE procedure	4
		When April 2024 baseline is: • **>4.20%**, the site maintains or does not reduce the site-level rate of 30-Day ED visits following primary KNEE procedure • **≤4.20%**, the site increases by >4% in the rate of the site-level 30-Day ED visits following primary KNEE procedure	0

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Measure #	Weight	Measure Description	Points
Extra Credit (Affiliate hospital & HOPD)	n/a	**30-Day Emergency Department (ED) visit:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal when April 2024 baseline is: • >4.20%, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure **OR** • ≤4.20%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary KNEE procedure but the affiliate site/s or HOPD did meet the goal when April 2024 baseline is: ○ >4.20%, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure **OR** ○ ≤4.20%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary KNEE procedure, then the flagship hospital's P4P scorecard will receive 1extra credit point. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Extra Credit	n/a	**30-Day Emergency Department (ED) visit:** On January 2026 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **KNEE** procedures is ≤ 6.03% ***Maximum total of 0.5 extra credit points per site towards performance measures**	0.5
Extra Credit	n/a	**30-Day Emergency Department (ED) visit:** On January 2026 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **KNEE** procedures increased from baseline in April 2024. The site will perform a deep dive into all 30-Day Emergency Department (ED) visits for all primary KNEE procedures during the measurement period and submit the deep dive details and 1 page report of the findings by 11:59PM ET February 12, 2026, via SRS ticket in the database. ***Maximum total of 2 extra credit points per site towards performance measures**	2

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
9	5%	**30-Day Emergency Department (ED) visit:** Reduce **COLLABORATIVE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **HIP** procedures from 5.9% to 5.31%.	
		30-Day ED visit COLLABORATIVE rate for all primary **HIP** procedures in ≤ 5.31%	5
		30-Day ED visit COLLABORATIVE rate for all primary HIP procedures is > 5.31% but < 5.60%	3
		30-Day ED visit COLLABORATIVE rate for all primary HIP procedures is > 5.60% but <5.90%	1
		No reduction in 30-Day ED visit COLLABORATIVE rate for all primary HIP procedures is seen	0
10	5%	**30-Day Emergency Department (ED) visit:** Reduce **COLLABORATIVE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **KNEE** procedures from 6.7% to 6.03%.	
		30-Day ED visit COLLABORATIVE rate for all primary **KNEE** procedures in < 6.03%	5
		30-Day ED visit COLLABORATIVE rate for all primary KNEE procedures is > 6.03% but < 6.37%	3
		30-Day ED visit COLLABORATIVE rate for all primary KNEE procedures is > 6.37% but <6.70%	1
11	5%	**PROs Collection:** For surgeries performed on 07.01.2024- 06.30.2025, **SITE** level primary PRE-OPERATIVE HOOS - JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		The site is awarded full points for collection rates of 90%+	5
		75 - 89%	3
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0
Extra Credit	n/a	**PROs Collection:** For surgeries performed on 07.01.2024-06.30.2025, **COLLABORATIVE** level primary PRE- OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *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.* ***Maximum total of 2 extra credit points per site towards performance measures**	2
Extra Credit (Affiliate hospital & HOPD)	n/a	**PROs Collection:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal to collect 90% or more PRE-OPERATIVE HOOS-JR or KOOS JR + PROMIS10 for surgeries performed on 07.01.2024-06.30.2025, but the affiliate site/s or HOPD did meet the goal on the January 2026 Quarterly Reports, extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** ship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1

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Measure #	Weight	Measure Description	Points
12	5%	**PROs Collection:** For surgeries performed on 06.01.2023 to 11.03.2024, **SITE** level primary PRE-OPERATIVE & 1 YEAR POST-OPERATIVE (300-425 days) HOOS -JR or KOOS-JR + PROMIS10 completion rate of 50% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		The site is awarded full points for collection rates of 50%+	5
		40 - 49%	3
		30 - 39%	1
		The site is not awarded points if collection is less than 30%	0
Extra Credit (Affiliate hospital & HOPD)	n/a	**PROs Collection:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal to collect 50% or more PRE-OPERATIVE HOOS-JR or KOOS JR + PROMIS10 for surgeries performed on 06.01.2023-11.03.2024, but the affiliate site/s or HOPD did meet the goal on the January 2026 Quarterly Reports, extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Extra Credit	n/a	**PROs Collection:** Completed primary Pre-op and 2–16-week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2025) at a **SITE** are 70% or greater for both primary hip and knee procedures combined *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.* ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	2
		60%	1.5
		50%	1
		The site is not awarded extra credit if collection is less than 50%	0
13	20%	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If red on scorecard of April 2024, 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 FY2024 site-based QI project topic, please discuss with the Program Manager. If no red, you will choose a 'yellow'. All projects must come from the April 2024 MARCQI Quarterly Report	

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Measure #	Weight	Measure Description	Points
		--Project goals must seek a ≥ 20% improvement unless otherwise approved by the Program Manager --Mid-Year Progress Report is due on May 23, 2025 & Final Progress report is due on February 12, 2026 --Clinical Champion must have a role in the Quality Improvement project plan --All sites are expected to complete a proposal, mid-year report, final report, A3, and presentation of their project by the clinical champion when asked. ***A clinical champion not presenting on a project when asked will yield -20 points on the FY2026 P4P scorecard --Final results are based on quarterly reports of January, 2025	
		Plan submitted and approved, reporting requirements & timelines met, A3 submitted, and goal met* *Clinical Champion must be available to present at June 2026 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2026 P4P scorecard*	20
		Plan submitted and approved Reporting requirements are met & timelines, but the target identified is not met. A3 submitted with final report and presentation by clinical champion given at June 2026 MARCQI Collaborative-wide sessions* *Clinical Champion must be available to present at June 2026 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2026 P4P scorecard*	10
		Plan submitted and approved All reporting requirements are NOT met within the communicated timelines Goal is not met *Clinical Champion must be available to present at June 2026 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2026 P4P scorecard*	5
		Plan is not developed, reports not done.	0
Extra Credit (Flagship hospital)	n/a	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If combined data of flagship, affiliate hospital, and/or HOPD do not meet full metric for full points, but the FLAGSHIP hospital met all metrics and site level goal, then extra credit is awarded. ***Maximum total of 3 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	3

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
Extra Credit (Affiliate hospital & HOPD)	n/a	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If combined data of flagship, affiliate hospital, and/or HOPD do not meet full metric for full points, but the AFFILATE hospital/HOPD met all metrics and site level goal, then extra credit is awarded. ***Maximum total of 3 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	3
Extra Credit	n/a	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If a site or flagship with its combined partners (affiliate and HOPD) does not meet the full metrics for points and the site performs a deep dive on all cases impacting the missed quality improvement goal at the site or flagship with its combined partners (affiliates and HOPD) and submits the deep dive findings with the final report submission in February 2026, then extra credit is awarded. ***Maximum total of 3 extra credit points per site or FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	3
Extra Credit	n/a	**Reverse Site-Visits:** If a site is **RED or YELLOW** in a quality improvement area on their VISUAL Scorecard and they complete a SITE VISIT to a site that is **GREEN** on their VISUAL Scorecard and vis-versa, the RED/YELLOW site and GREEN sites are both eligible for extra credit if: **--**Both sites must visit each other for the same quality improvement area (e.g., sites must observe what is going well and what may not be going as well) between 07.01.2024 - 09.30.2025 --Both sites submit a report regarding the lessons learned for the site visits by November 15, 2025 --Both sites must be willing to have their clinical champion share their findings with the collaborative if asked or results in -5 points on the FY2026 P4P Scorecard --Both sites must have their clinical champions and Clinical Data Abstractors at both site visits --Sites are not part of the same health system or have an affiliate site/HOPD relationship --MARCQI Coordinating Center is alerted to the site visits and has the opportunity to join if requested ***Maximum total of 5 extra credit points per site towards performance measures**	5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Center (ASC) - Year 1** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2025-11.15.2025)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
2	15%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2025-11.15.2025)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	15
		2 out of 3 meetings attended	7
		<3 meetings attended	0
3	5%	**Collaborative Meeting Participation*-Quality Administrator (01.01.2025-11.15.2025)** This person cannot be the same person filling the Clinical Data Abstractor (CDA) role at the site as a CDA or Quality Director CDA **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	5
		2 out of 3 meetings attended	2
		<3 meetings attended	0
4	5%	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive new site kickoff meeting time on Wednesday, January 22, 2025, for: 1. Clinical Champion 2. Quality Administrator 3. Clinical Data Abstractor (*if identified*)	5
5	5%	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive new site kickoff meeting time on Wednesday, January 22, 2025, for: 1. Site IT Support	5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Center (ASC) - Year 1** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
6	20%	**Accuracy and Completeness of Data Submission (01.30.2025 - 06.30.2025) - 5 metrics** 1. Complete data entry > 97% - 100% of the time; Educational review complete with no concerns (e.g., greater than 97% accuracy) 2. On-time data entry (e.g., Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. First 10 cases abstracted by 05.31.2025 4. All cases performed or before May 4, 2025, abstracted by October 1, 2025 5. Attestation of BCBSM ASF CQI participation funding utilization to support dedicated data abstraction support for effective and complete MARCQI data abstraction and quality improvement work to the MARCQI Coordinating Center by 11.30.2025	
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0
7	15%	**Site based Quality Meetings:(02.08.2025-11.15.2025)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site-based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	15
8	15%	**Access to Surgeon's Office Records (90-day events): (Surgery dates 01.01.2025-08.31.2025)**	
		90% + patient data captured	15
		75% - 89% patient data captured	7.5
		Less than 75% data captured	0

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Center (ASC) - Year 1** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.08.2025-11.15.2025) --meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 0.5 extra credit points per site towards participation measures**	0.5
Extra Credit	0	**MODB Data submission:** Provide site's written planned process for site's submission of all MARCQI eligible cases data to Michigan Health and Hospital Association's Michigan Outpatient Database (MODB) by August 31, 2025 ***Maximum total of 0.5 extra credit points per site towards performance measures**	0.5
Extra Credit	0	**PROs Collection:** For surgeries performed on 01.01.2025-06.30.2025, **SITE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *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.* ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 90%+	2
		75 - 89%	1.5
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0
Extra Credit	0	**PROs Collection:** Completed primary Pre-op and 2–16-week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2025) at a **SITE** are 70% or greater for both primary hip and knee procedures combined *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.* ***Maximum total of 1 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	1
		60%	0.5
		The site is not awarded extra credit if collection is less than 60%	0

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2025-11.15.2025)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In- person) for 80% of the meeting time*	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<3 meetings attended	0
Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team, Patient education, Optimization & Appropriateness, etc.) ***Maximum total 1-point extra credit per site towards participation measures**	1
2	15%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2025-11.30.2025)** **Attendance at both the CDA Breakout and Collaborative- wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	15
		2 out of 3 meetings attended	7.5
		<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, Patient education, etc.) **Maximum total 0.5 point extra credit per site towards participation measures*	0.5
Extra Credit	0	**Collaborative Meeting Participation*- Site Administrator** (01.01.2025-11.15.2025) **Attendance at 3 of 3 Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and* October 10, 2025 (In-person) for 80% of the meeting time Individual must be identified and confirmed to fill this role by 1st 2025 MARCQI Collaborative-wide meeting This person cannot be the same person filling the Clinical Data Abstractor (CDA) role at the site as a CDA or Quality Director CDA **Maximum total 0.5 point extra credit per site*	0.5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
3	20%	**Accuracy and Completeness of Data Submission (audits 07.01.2024 - 06.30.2025) - 5 metrics** 1. Complete data entry (e.g., Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g., Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All cases completed on or before December 31, 2024, abstracted completely by 05.31.2025 4. All cases performed or before May 4, 2025, abstracted by October 1, 2025 5. Attestation of BCBSM ASF CQI participation funding utilization to support dedicated data abstraction support for effective and complete MARCQI data abstraction and quality improvement work to the MARCQI Coordinating Center by 11.30.2025	
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0
Extra Credit	0	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2024 - 06.30.2025) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site towards participation measures**	0.5
4	20%	**Site based Quality Meetings:(02.08.2025-11.15.2025)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative- wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	20
5	5%	Site level: Access to 90-day post-operative clinical office notes for every participating MARCQI surgeon at the site is demonstrated to be 99% or above for cases completed (07.01.2024 - 06.30.2025). If a MARCQI surgeon's rate for access to clinical office notes has been lower than 99% over the last few years, an attestation for the changes made and implemented will be required, and a demonstration may be requested.	2

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
6	5%	**Site level PROS Collection:** For surgeries performed on 07.01.2024-06.30.2025, SITE LEVEL primary PRE- OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 50% or more. *When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		The site is awarded full points for collection rates of 70%+	5
		60%	3
		50%	1
		The site is not awarded points if collection is less than 50%	0
Extra Credit	0	**PROs Collection:** Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2025) at a **SITE** are 70% or greater for both primary hip and knee procedures combined. *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. *Maximum total of 3 extra credit points per site towards performance measures*	
		The site is awarded full points for collection rates of 60%+	3
		50%	1.5
		<50%	0
Extra Credit	0	**PROs Collection:** For surgeries performed on 06.01.2023 to 11.03.2024, **SITE** level primary PRE-OPERATIVE & 1 YEAR POST-OPERATIVE (300-425 days) HOOS -JR or KOOS-JR + PROMIS10 completion rate of 50% or more. *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. *Maximum total of 2 extra credit points per site towards performance measures*	
		The site is awarded full points for collection rates of 50%+	2
		40 - 49%	1
		<40%	0
7	5%	**% of Opioid naive THA patients at the SITE meet the MARCQI Pain control pathway guidelines (≤240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	5
		60-84% of THA patients prescribed **<240 OME**	2.5
		Less than 60% of patients meet the prescribing criteria	0

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Measure #	Max. Weight	Measure Description	Points
8	5%	**% of Opioid naive TKA patients at the SITE meet the MARCQI Pain control pathway guidelines (<320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	5
		70-89% of TKA patients prescribed **<320 OME**	2.5
		Less than 70% of patients meet the prescribing criteria	0
9	2.5%	**% of Opioid naive THA patients at the COLLABORTIVE meet the MARCQI Pain control pathway guidelines (<240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	2.5
		60-84% of THA patients prescribed **<240 OME**	1
		Less than 60% of patients meet the prescribing criteria	0
10	2.5%	**% of Opioid naive TKA patients at the COLLABORATIVE meet the MARCQI Pain control pathway guidelines (<320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	2.5
		70-89% of TKA patients prescribed **<320 OME**	1
		Less than 70% of patients meet the prescribing criteria	0
Extra Credit	0	**Reverse Site-Visits:** If a site is **RED or YELLOW** in a quality improvement area on their VISUAL Scorecard and they complete a SITE VISIT to a site that is **GREEN** on their VISUAL Scorecard and vis-versa, the RED/YELLOW site and GREEN sites are both eligible for extra credit if: **--**Both sites must visit each other for the same quality improvement area (e.g., sites must observe what is going well and what may not be going as well) between 07.01.2024 - 09.30.2025 --Both sites submit a report regarding the lessons learned for the site visits by November 15, 2025 --Both sites must be willing to have their clinical champion share their findings with the collaborative if asked or results in -5 points on the FY2026 P4P Scorecard --Both sites must have their clinical champions and Clinical Data Abstractors at both site visits --Sites are not part of the same health system or have an affiliate site/HOPD relationship --MARCQI Coordinating Center is alerted to the site visits and has the opportunity to join if requested ***Maximum total of 5 extra credit points per site towards performance measures**	5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
1	10%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2025-11.15.2025)** **Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time Baseline Period: 01/01/2023 - 11/30/2023*	
		3 out of 3 meetings attended	10
		2 out of 3 meetings attended	5
		<3 meetings attended	0
Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team, Patient education, Optimization & Appropriateness, etc.) ***Maximum total 1 point extra credit per site towards participation measures** Baseline Period: 01/01/2023 - 11/30/2023	1
2	5%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2025-11.30.2025)** **Attendance at both the CDA Breakout and Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time*	
		3 out of 3 meetings attended	5
		2 out of 3 meetings attended	2
		<3 meetings attended	0
Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site towards participation measures** **Baseline: 01/01/2023 - 11/30/2023**	0.5
Extra Credit	0	**Collaborative Meeting Participation*- Site Administrator** (01.01.2025-11.15.2025) **Attendance at 3 of 3 Collaborative-wide meeting on February 7, 2025 (Virtual); June 27, 2025 (In-person); and October 10, 2025 (In-person) for 80% of the meeting time* *Individual must be identified and confirmed to fill this role by 1st 2025 MARCQI Collaborative-wide meeting* *This person cannot be the same person filling the Clinical Data Abstractor (CDA) role at the site as a CDA or Quality Director CDA* ***This person cannot* be the same person filling the Clinical Data Abstractor (CDA) role at the site as a CDA or Quality Director CDA*Maximum total 0.5 point extra credit per site** **Measurement Period: 01/01/2025 - 11/30/2025** **Baseline Period: 01/01/2023 - 11/30/2023**	0.5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
3	8%	**Accuracy and Completeness of Data Submission (audits 07.01.2024 - 06.30.2025) - 5 metrics** 1. Complete data entry (e.g., Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g., Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All cases completed on or before December 31, 2024, abstracted completely by 05.31.2025 4. All cases performed or before May 4, 2025, abstracted by October 1, 2025 5. Attestation of BCBSM ASF CQI participation funding utilization to support dedicated data abstraction support for effective and complete MARCQI data abstraction and quality improvement work to the MARCQI Coordinating Center by 11.30.2025	
		5 of 5 metrics met	8
		4 of 5 metrics met	6
		3 of 5 metrics met	4
		2 of 5 metrics met	2
		1 of 5 metrics met	1
		0 of 5 metrics met	0
Extra Credit	0	Site level: On-time data entry score is greater than or equal to 99% during the measurement period (07.01.2024 - 06.30.2025) AND complete data entry score is greater than or equal to 99% (QA & CI review score average) ***Maximum total 0.5 point extra credit per site towards participation measures** Measurement Period: 07/01/2024 - 06/30/2025 Baseline Period: 01/01/2023 - 11/30/2023	0.5
4	5%	**Site based Quality Meetings:(02.08.2025-11.15.2025)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting. Baseline Period: 01/01/2023 - 11/30/2023	5
5	2%	Site level: Access to 90-day post-operative clinical office notes for every participating MARCQI surgeon at the site is demonstrated to be 99% or above for cases completed (07.01.2024 - 06.30.2025). If a MARCQI surgeon's rate for access to clinical office notes has been lower than 99% over	2

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
		the last few years, an attestation for the changes made and implemented will be required, and a demonstration may be requested. Measurement Period: 01/01/2025 - 11/15/2025 Baseline Period: 01/01/2023 - 11/30/2023	
6	20%	**Site level PROS Collection:** For surgeries performed on 07.01.2024-06.30.2025, SITE LEVEL primary PRE- OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 70% or more. *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.* **Measurement Period: 07/01/2024-06/30/2025 Baseline Period: 07/01/2022-06/30/2023**	
		The site is awarded full points for collection rates of 70%+	20
		60%	10
		50%	5
		The site is not awarded points if collection is less than 50%	0
Extra Credit	0	**PROs Collection:** Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2025) at a **SITE** are 60% or greater for both primary hip and knee procedures combined *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.* ***Maximum total of 3 extra credit points per site towards performance measures** **Measurement Period: 07/01/2024-06/30/2025 Baseline Period: 07/01/2022-06/30/2023**	
		The site is awarded full points for collection rates of 60%+	3
		50%	1.5
		<50%	0
Extra Credit	0	**PROs Collection:** For surgeries performed on 06.01.2023 to 11.03.2024, **SITE** level primary PRE-OPERATIVE & 1 YEAR POST-OPERATIVE (300-425 days) HOOS -JR or KOOS-JR + PROMIS10 completion rate of 50% or more. *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.* ***Maximum total of 2 extra credit points per site towards performance measures** **Measurement Period: 07/01/2024-06/30/2025 Baseline Period: 07/01/2022-06/30/2023**	
		The site is awarded full points for collection rates of 50%+	2

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
		40 - 49%	1
		<40%	0
7	10%	**% of Opioid naive THA patients at the SITE meet the MARCQI Pain control pathway guidelines (≤240 OME)** **Measurement Period: 07/01/2024-06/30/2025** **Baseline Period: 07/01/2022-06/30/2023**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	10
		60-84% of THA patients prescribed **<240 OME**	5
		Less than 60% of patients meet the prescribing criteria	0
8	10%	**% of Opioid naive TKA patients at the SITE meet the MARCQI Pain control pathway guidelines (≤320 OME)** **Measurement Period: 07/01/2024-06/30/2025** **Baseline Period: 07/01/2022-06/30/2023**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	10
		70-89% of TKA patients prescribed **<320 OME**	5
		Less than 70% of patients meet the prescribing criteria	0
9	5%	**% of Opioid naive THA patients at the COLLABORTIVE meet the MARCQI Pain control pathway guidelines (≤240 OME)** **Measurement Period: 07/01/2024-06/30/2025** **Baseline Period: 07/01/2022-06/30/2023**	
		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
10	5%	**% of Opioid naive TKA patients at the COLLABORATIVE meet the MARCQI Pain control pathway guidelines (≤320 OME)** **Measurement Period: 07/01/2024-06/30/2025** **Baseline Period: 07/01/2022-06/30/2023**	
		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

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
11	20%	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If red on scorecard of April 2024, 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 FY2024 site based QI project topic, please discuss with the Program Manager. If no red, you will choose a 'yellow'. All projects must come from the April 2024 MARCQI Quarterly Report --Project goals must seek a ≥ 20% improvement unless otherwise approved by the Program Manager --Mid-Year Progress Report is due on May 23, 2025 & Final Progress report is due February 12, 2026 --Clinical Champion must have a role in the Quality Improvement project plan --All sites are expected to complete a proposal, mid-year report, final report, A3, and presentation of their project by the clinical champion when asked. ***A clinical champion not presenting on a project when asked will yield -20 points on the FY2026 P4P scorecard --Final results are based on quarterly reports of January 2025 **Measurement Period: 07/01/2024-06/30/2025 Baseline Period: 07/01/2022-06/30/2023**	20
		Plan submitted and approved, reporting requirements & timelines met, A3 submitted, and goal met* *Clinical Champion must be available to present at June 2026 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2026 P4P scorecard*	
		Plan submitted and approved Reporting requirements are met & timelines, but the target identified is not met. A3 submitted with final report and presentation by clinical champion given at June 2026 MARCQI Collaborative-wide sessions* *Clinical Champion must be available to present at June 2026 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2026 P4P scorecard*	10
		Plan submitted and approved All reporting requirements are NOT met within the communicated timelines Goal is not met *Clinical Champion must be available to present at June 2026 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2026 P4P scorecard*	5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2025 - 11/15/2025 (unless specified otherwise) QI Measurement Period: 07/01/2024 - 06/30/2025 (unless specified otherwise)			
Measure #	Max. Weight	Measure Description	Points
Extra Credit	0	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If a site does with its combined partners (affiliate and HOPD) does not meet the full metrics for points and the site performs a deep dive on all cases impacting the missed quality improvement goal at the site and submits the deep dive findings with the final report submission in February 2026, then extra credit is awarded. ***Maximum total of 3 extra credit points per site or FLAGSHIP site towards performance measures**	3
Extra Credit	0	**Reverse Site-Visits:** If a site is **RED or YELLOW** in a quality improvement area on their VISUAL Scorecard and they complete a SITE VISIT to a site that is **GREEN** on their VISUAL Scorecard and vis-versa, the RED/YELLOW site and GREEN sites are both eligible for extra credit if: **--**Both sites must visit each other for the same quality improvement area (e.g., sites must observe what is going well and what may not be going as well) between 07.01.2024 - 09.30.2025 --Both sites submit a report regarding the lessons learned for the site visits by November 15, 2025 --Both sites must be willing to have their clinical champion share their findings with the collaborative if asked or results in -5 points on the FY2026 P4P Scorecard --Both sites must have their clinical champions and Clinical Data Abstractors at both site visits --Sites are not part of the same health system or have an affiliate site/HOPD relationship --MARCQI Coordinating Center is alerted to the site visits and has the opportunity to join if requested ***Maximum total of 5 extra credit points per site towards performance measures** **Measurement Period: 07/01/2024-06/30/2025 Baseline Period: 07/01/2022-06/30/2023**	5

2025 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
1	10%	**Improvement/Excellence in Grade 1 Complication Rate:** Improvement *(z-score)* will be measured using trended data from OR dates 10/1/2022 to 9/30/2025 and rounded to the nearest whole number. Excellence *(adjusted rate)* will be measured using OR dates 10/1/2024 to 9/30/2025 and rounded to the nearest whole number. The better of the two scores will be used. Measurement periods: Improvement - OR dates 10/1/2022 to 9/30/2025 Excellence - OR dates 10/1/2024 to 9/30/2025	
		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 (z-score) will be measured using trended data from OR dates 10/1/2022 to 9/30/2025 and rounded to the nearest whole number. Excellence *(adjusted rate)* will be measured using OR dates 10/1/2024 to 9/30/2025 and rounded to one decimal point. The better of the two scores will be used. Measurement periods: Improvement - OR dates 10/1/2022 to 9/30/2025 Excellence - OR Dates 10/1/2024 to 9/30/2025	
		Major improvement (z-score less than -1 or serious complication rate ≤2.0%)	20
		Moderate improvement/maintained complication rate (z-score between 0 and -1)	10
		No improvement/rates of serious complications increased (z-score ≥0)	0
3	10%	**1-Year Follow-up Rates** **Adjusted; Rounded to nearest whole number** Measurement period: OR dates 10/1/2023 to 9/30/2024 Baseline period: OR dates 10/1/2022 to 4/30/2023	
		≥67% OR > 5% **relative** improvement from previous year (10/1/2022-9/30/2023)	5
		Maintained 1-year follow-up rate/ >0 to <5% relative improvement from previous year (10/1/2022-9/30/2023)	3
		1-year follow-up rate decreased/No improvement in 1-year follow-up rate (10/1/2022-9/30/2023)	0
4	5%	**Compliance with VTE prophylaxis - pre-operatively and post-operatively:** must meet 95% compliance for both pre-op **AND** post-op to receive the points ***Hospital wide measure **Unadjusted; Rounded to nearest whole number** Measurement period: OR dates 10/01/2024 to 9/30/2025	
		≥95% compliance with guidelines	5
		0 to 94% compliance with guidelines	0

2025 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
5	5%	**Compliance with VTE prophylaxis - Post Discharge:** based on the post-discharge risk stratification recommendations for 1-month prophylaxis per the **new** VTE risk calculator ***Hospital wide measure **Unadjusted; Rounded to nearest whole number** Measurement period: OR dates 10/1/2024 to 9/30/2025 Baseline period: 10/1/2023 to 4/30/2024	
		≥70% compliance with guidelines or a >2.5% relative improvement from the previous year (1/1/2024 to 12/31/2024)	5
		0 to 69% compliance with guidelines	0
6	5%	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs)** ***Collaborative wide measure **Unadjusted; Rounded to nearest whole number** Measurement period: OR dates 10/1/2024 to 9/30/2025 Baseline period: 4/1/2023 to 3/31/2024. Baseline rate to determine relative reduction = **35 MME**	
		≤ 30 MME or ≥ 10% relative reduction in opioid use	5
		5-9% relative reduction in opioid use	2.5
		< 5% relative reduction	0
7	10%	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs)** ***Hospital wide measure **Unadjusted; Rounded to the nearest whole number** Baseline rate used to determine relative reduction 35 MME for OR Dates of 4/1/23-3/31/24 Measurement period: OR dates 10/1/2024 to 9/30/2025 Baseline period: 4/1/2023 to 3/31/2024 Baseline rate to determine relative reduction = **35 MME** ******No points will be awarded if your hospital is ≥ 70MME	
		≤ 30 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** Measurement period: OR dates 10/1/2024 to 9/30/2025	
		≤ 6% Avoidable ED visits	5
		> 6% Avoidable ED visits	0
9	5%	**Patient Reported Outcome Measure - Gallstone Prevention** ***Collaborative wide measure Patients who have a gallbladder following bariatric surgery will not experience a readmission or reoperation due to gallbladder disease within 1-year of their bariatric surgery (as reported on 1- year follow-up survey) To prevent this, surgeons are encouraged to discharge all patients with a gallbladder with a prescription for a gallstone dissolution agent - Ursodiol (Actigall, Reltone, Urso 250, Urso Forte) 300 mg BID for 6-months) following their bariatric surgery (RN abstracted) ****Patients reporting a readmission/reoperation for gallstone disease who received recommended prophylaxis will be excluded. Measurement period: OR dates 11/1/2024 to 1/31/2025 Survey completion dates: 11/1/2025 - 1/31/2026	

2025 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
9 cont.	5%	Baseline period: 1/1/2024 - 9/30/2024 Baseline rate = **3.1%**	
		≤ 2.5% of patients will report a hospital admission or operation for gallstone disease within 1-year of their bariatric surgery on their first year annual follow-up survey	5
		Between 2.5-2.8% of patients will report a hospital admission or operation for gallstone disease within 1-year of their bariatric surgery on their first year annual follow-up survey	3
		≥ 2.9% of patients will report a hospital admission or operation for gallstone disease within 1-year of their bariatric surgery on their first year annual follow-up survey	0
10	5%	**Meeting Attendance - Surgeon:** **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 1/1/2025 to 12/31/2025. Measurement period: OR Dates 1/1/2025 to 12/31/2025	
		Attended 3 out of 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended fewer than 2 meetings	0
11	5%	**Meeting Attendance - Abstractor/Coordinator:** Measurement period: OR Dates 1/1/2025 to 12/31/2025	
		Attended 3 out of 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended fewer than 2 meetings	0
12	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 2025 Data Entry Deadlines Spreadsheet) *****In order to be eligible for this measure, you must achieve >90% on the 2025 yearly audit when applicable. If the hospital does not reach >90% for the yearly audit, they will receive 0 points for this measure. Measurement period: OR Dates 1/1/2025 to 12/31/2025	
		On time 11-12 months	5
		On time 10 months	3
		On time 9 months or less	0
13	5%	**Consent Rate:** **Unadjusted; Rounded to nearest whole number** Measurement period: OR Dates 10/1/2024 to 9/30/2025	
		≥90% consented patients	5
		80-89% consented patients	3
		<80% consented patients	0

2025 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
14	10%	**Physician Engagement:**	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 1/1/2025 to 12/31/2025* **Measurement period: OR Dates 1/1/2025 to 12/31/2025** **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/MSH EILD/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	
		No participation	0

2025 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2024 – 10/31/2025 (unless specified otherwise) **Year 1 Sites**			
Measure #	Weight	Measure Description	Points
1	10%	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	10
		11 months of data transfers on time	8
		9-10 months of data transfers on time	4
		< 9 months of data transfers on time	0
2	10%	**Data Delivery: Adherence and Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	10
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	8
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	4
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	6%	**Electronic Data Dictionary Update**	
		Successful submission by deadline	6
		Successful submission within 1 month of deadline	3
		Submission more than 1 month after deadline	0
4	13%	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadline	13
		1 deadline missed	8
		2+ deadlines missed	0
5	12%	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0
6	12%	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0
7	14%	**Time from Agreement being signed to hiring of data abstractor**	
		<90 days	14
		91-120 days	8
		>120 days	0
8	14%	**Time from Agreement being signed to successful submission of electronic production data**	
		<90 days	14
		91-120 days	8
		>120 days	0

2025 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2024 – 10/31/2025 (unless specified otherwise) **Year 1 Sites**			
Measure #	Weight	Measure Description	Points
9	9%	**Intervention Planning for Year 2 (Intervention Templates, etc.)**	
		All Year 2 materials complete and submitted on time	9
		Year 2 materials incomplete and/or submitted late	0

2025 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2024 – 10/31/2025 (unless specified otherwise) **Year 2 Sites**			
Measure #	Weight	Measure Description	Points
1	12%	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	12
		11 months of data transfers on time	9
		9-10 months of data transfers on time	6
		< 9 months of data transfers on time	0
2	12%	**Data Delivery: Adherence and Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	12
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	9
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	6
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	6%	**Electronic Data Dictionary Update**	
		Successful submission by deadline	6
		Successful submission within 1 month of deadline	3
		Submission more than 1 month after deadline	0
4	10%	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadline	10
		1 deadline missed	5
		2+ deadlines missed	0
5	10%	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
6	10%	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
7	10%	**Annual Abstraction Audit: SNAP (Sharing Knowledge and Perspectives) Review**	
		≥ 90% of case cohort decisions are correct	4
		≥ 75% of case cohort decisions are correct	2

2025 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2024 – 10/31/2025 (unless specified otherwise) **Year 2 Sites**			
Measure #	Weight	Measure Description	Points
		< 75% of case cohort decisions are correct	0
		≥ 97% of abstracted registry data accurate	6
		95%-97% of abstracted registry data accurate	3
		<95% of abstracted registry data accurate	0
8a	10%	**Site Specific - Timely Administration of Steroids in Pediatric Asthma * Proportion of pediatric asthma cases that receive a steroid in the first 60 minutes of their ED visit with target of ≥ 60%**	
		QI Project developed and implemented, and site met or exceeded target	10
		QI Project developed and implemented, and site made improvement toward, but did not meet, the target	7
		QI Project developed and implemented but there was no improvement to the target	4
		QI Project not developed or implemented	0
8b	10%	**Site Specific - Adult Low Risk Chest Pain Safe Discharge Initiative *Performance for safe discharge of adult low risk chest pain cases with a target of >95%**	
		QI Project developed and implemented, and site met or exceeded target	10
		QI Project developed and implemented, and site made improvement toward, but did not meet, the target	7
		QI Project developed and implemented but there was no improvement to the target	4
		QI Project not developed or implemented	0
9	10%	**Collaborative-Wide Measure: Naloxone Distribution for Opioid Use Harm Reduction-Collaborative-Wide performance for increasing the number of naloxone kites distributed to patients at risk for harm from opioid overdoes with a target of > 43%**	
		Met Naloxone Distribution Target	10
		Did meet target	0
10	5%	**Collaborative-Wide Measure: Peds Chest Xray Utilization Collaborative Wide performance for reducing the utilization of chest x-rays for pediatric patients with asthma, bronchiolitis, and croup with a target of < 25%**	
		Met CXR Utilization Target	5
		Did meet target	0
11	5%	**Collaborative-Wide Measure: Adult Suspected PE CT Diagnostic Yield *Collaborative Wide performance for increasing the number of CT for PE scans that are positive with a target of > 8.5%**	
		Met Diagnostic Yield Target	5
		Did meet target	0

2025 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2024 – 10/31/2025 (unless specified otherwise) **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
1	4%	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	4
		11 months of data transfers on time	3
		9-10 months of data transfers on time	2
		< 9 months of data transfers on time	0
2	4%	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	4
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	3
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	2
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	2%	**Electronic Data Dictionary Update**	
		Successful submission by deadline	2
		Successful submission within 1 month of deadline	1
		Submission more than 1 month after deadline	0
4	5%	**Abstraction: Timeliness**	
		All cases abstracted by quarterly deadline	5
		1 deadline missed	3
		2+ deadlines missed	0
5	5%	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
6	5%	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
7	5%	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review**	
		≥ 90% of case cohort decisions are correct	2
		≥ 75% of case cohort decisions are correct	1
		< 75% of case cohort decisions are correct	0
		≥ 97% of abstracted registry data accurate	3

2025 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2024 – 10/31/2025 (unless specified otherwise) **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
		95%-97% of abstracted registry data accurate	2
		<95% of abstracted registry data accurate	0
8a	20%	**Site Specific - 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 with target of ≥ 60%**	
		QI Project developed and implemented, and site met or exceeded target	20
		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	8
		QI Project not developed or implemented	0
8b	20%	**Site Specific - Adult Low Risk Chest Pain Safe Discharge Initiative *Performance for safe discharge of adult low risk chest pain cases with a target of >95%**	
		QI Project developed and implemented, and site met or exceeded target	20
		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	8
		QI Project not developed or implemented	0
9	10%	**Collaborative-Wide Measure: Naloxone Distribution for Opioid Use Harm Reduction *Collaborative-Wide performance for increasing the number of naloxone kites distributed to patients at risk for harm from opioid overdoes with a target of ≥ 43%**	
		Met Naloxone Distribution Target	10
		Did meet target	0
10	10%	**Collaborative-Wide Measure: Peds Chest Xray Utilization *Collaborative Wide performance for reducing the utilization of chest x-rays for pediatric patients with asthma, bronchiolitis, and croup with a target of ≤ 25%**	
		Met CXR Utilization Target	10
		Did meet target	0
11	10%	**Collaborative-Wide Measure: Adult Suspected PE CT Diagnostic Yield * Collaborative Wide performance for increasing the number of CT for PE scans that are positive with a target of ≥ 8.5%**	
		Met Diagnostic Yield Target	10
		Did meet target	0

2025 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2024 – 10/31/2025 (unless specified otherwise) **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
12a	20%	**Site Specific - Quality Improvement Initiative: Adult Head Injury CT Appropriateness *Performance for appropriate CT use in adults with minor head injury with a target of ≥ 69%**	
		QI Project developed and implemented, and site met or exceeded target	20
		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	8
		QI Project not developed or implemented	0
12b	20%	**Site Specific - Quality Improvement Initiative: Pediatric Intermediate Risk Head Injury CT Utilization *Performance for CT utilization for pediatric intermediate risk minor heard injury with a target of ≤ 15%**	
		QI Project developed and implemented, and site met or exceeded target	20
		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	8
		QI Project not developed or implemented	0

2025 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2025-09/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	6%	**Clinical audit, CDA team meeting participation, and submission of clinical data[1] Measurement period: 01/01/2025-12/31/2025**	
		All Metrics Met	6
		Some Metrics Met	1-5
		No Metrics Met	0
2	6%	**Timely submission of high-quality physics & dosimetry data Measurement period: 01/01/2025-12/31/2025**	
		Three Metrics Met	6
		Two Metrics Met	4
		One Metric Met	2
		No Metrics Met	0
3	10%	**Collaborative Wide Goal - Increase the collaborative- wide utilization of prone positioning for breast cancer radiation treatment Measurement period: 01/01/2025-09/30/2025**	
		≥30% of breast cancer patients were treated in the prone position across MROQC	10
		20-29% of breast cancer patients were treated in the prone position across MROQC	5
		<20% of breast cancer patients were treated in the prone position across MROQC	0
4	8%	**Increase the baseline and post-radiation treatment (RT) completion rate of standard of care arm measurements for lymphedema assessment in node positive breast cancer patients A. ≥50% of patients with a baseline measurement (B7 or B9) in 2024 must have a follow-up measurement (B10 or B14) completed within Q1-Q3 of 2025. B. ≥50% of breast patients with an RT start date within Q1-Q3 of 2025 must have a baseline measurement (B7 or B9). Measurement period: 01/01/2025- 09/30/2025 Baseline period: Metric A: 03/01/2023-03/01/2024; Metric B: 06/01/2023-06/01/2024**	
		A and B were met	8
		Either A or B was met	5
		Neither A nor B was met	0
5	8%	**For lung cancer patients treated with conventional fractionation, the mean esophageal dose is <29 Gy AND the esophageal max dose (D2cc) is <61 Gy. Measurement period: 01/01/2025-09/30/2025 Baseline period: 01/01/2024-07/31/2024**	
		≥65% of lung cancer patients met both constraints	8
		50-64% of lung cancer patients met both constraints	5

2025 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2025-09/30/2025			
Measure #	Weight	Measure Description	Points
		<50% of lung cancer patients met both constraints	0
6	8%	**For SBRT treatment of lung cancer with a single PTV, the Paddick Conformity Index is ≥0.85. Measurement period: 01/01/2025-09/30/2025 Baseline period: 01/01/2024-07/31/2024**	
		≥80% of SBRT lung cancer patients met this PCI	8
		60-79% of SBRT lung cancer patients met this PCI	5
		<60% of SBRT lung cancer patients met this PCI	0
7	8%	**Increase the utilization rate of bone mets treatments consisting of 5 fractions or fewer. Measurement period: 01/01/2025-09/30/2025 Baseline period: 01/01/2024-07/31/2024**	
		≥75% rate achieved	8
		60-74% rate achieved	5
		<60% rate achieved	0
8	8%	**For 50% or more of bone mets reirradiation cases, it is documented that physics was consulted before final physician approval of a plan for Type 1 reirradiation** *(Overlap of irradiation volumes with or without concern for toxicity from cumulative doses)* **OR Type 2 reirradiation** *(No overlap of irradiated volumes but concern for toxicity from cumulative doses).* **Measurement period: 01/01/2025-09/30/2025**	
		≥50% of bone mets reirradiation cases received a physics consult	8
		<50% of bone mets reirradiation cases received a physics consult	0
9	10%	**Improve the percentage of patients with intact, localized, high-risk prostate cancer receiving definitive radiotherapy that are recommended to receive long-term androgen deprivation therapy (ADT). Measurement period: 01/01/2025-09/30/2025 Baseline period: 06/01/2023-06/01/2024**	
		≥60% of prostate cancer patients recommended to receive long-term ADT	10
		50-59% of prostate cancer patients recommended to receive long-term ADT	7
		<50% of prostate cancer patients recommended to receive long-term ADT	0
10	10%	**Increase MRI utilization for intact prostate cancer patients receiving definitive radiotherapy Measurement period: 01/01/2025-09/30/2025 Baseline period: 06/01/2023-06/01/2024**	

2025 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2025-09/30/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
		≥60% of prostate cancer patients received an MRI	10
		50-59% of prostate cancer patients received an MRI	7
		<50% of prostate cancer patients received an MRI	0
11	6%	**Collaborative Meeting Participation – Clinical Champion** ***(Per MROQC CC Attendance Policy)*** **Measurement period: 01/01/2025-12/31/2025**	
		All meetings or two meetings with one meeting attended by an acceptable designee	6
		Two Meetings	4
		One Meeting or None Attended	0
12	6%	**Collaborative Meeting Participation – Physics Lead (or designee)** **Measurement period: 01/01/2025-12/31/2025**	
		All Meetings	6
		Two Meetings	4
		One Meeting or None Attended	0
13	6%	**Collaborative Meeting Participation – Clinical Data Abstractor (CDA or designee)** **Measurement period: 01/01/2025-12/31/2025**	
		All Meetings	6
		Two Meetings	4
		One Meeting or None Attended	0
Bonus	10	**MROQC Physician Engagement (not to exceed 100 points on total scorecard)** **Measurement period: 01/01/2025-12/31/2025**	
		• Lead author on an MROQC publication (Counts as 2 items) • Lead a skills workshop (Counts as 2 items) • Present at an MROQC collaborative-wide meeting (non-leadership role only) • Present on MROQC at a national meeting (Cannot be a resident) • Attend 5 working group meetings in 2025 (Total across practice physicians; 1 physician counts per meeting (i.e., no double points if 2 attend the same meeting)) • Coauthor on an MROQC publication • Participate in 3 case review sessions • Propose a new quality measure: provide reasoning to implement the measure, work with the MROQC data team to review supporting data and present the measure to the working group.	
		5 or more items achieved	10
		3-4 items achieved	5
		1-2 items achieved	1

2025 Michigan Surgical Quality Collaborative (MSQC) Performance Index Scorecard Measurement Period: 1/1/2025 – 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
1	6%	**Collaborative Meetings (4 offered) – Surgical Clinical Quality Reviewer (SCQR)**	
		3 or more meetings	6
		2 meetings	3
		1 meeting	1
2	6%	**Collaborative Meetings (3 offered) – Surgeon Champion (SC)**	
		2 or more meetings	6
		1 meeting	3
		0 meetings	0
3	4%	**Conference Calls (3 offered) – SCQR**	
		2 or more calls	4
		1 call	2
		0 calls	0
4	4%	**SCQR Participation/Engagement**	
		Participated in at least one MSQC activity listed in the supplement document.	4
		No Contribution: Did not participate in any activities listed in the supplement document.	0
5	4%	**SC Participation/Engagement**	
		Participated in at least one MSQC activity listed in the supplement document.	4
		No Contribution: Did not participate in any activities listed in the supplement document.	0
6	6%	**Completeness of Data (maximum 6 pts available)**	
		Sampled and incomplete cases ≤ 0.5% total volume	1
		Case Abstraction Audit with ≥ 95% agreement	1
		30 day follow-up rate ≥ 80% for 4th quarter 2024 (October – December cases)	1
		30 day follow-up rate ≥ 80% for 1st quarter 2025 (Jan – March cases)	1
		30 day follow-up rate ≥ 80% for 2nd quarter 2025 (April – June cases)	1
		30 day follow-up rate ≥ 80% for 3rd quarter 2025 (July – September cases)	1
7	10%	**Collaborative Wide Measure: Preop Optimization for elective abdominal hernia surgery:** • **Reduce rate of persons with body mass index (BMI) ≥ 40kg/m2 undergoing elective surgery to ≤ 11.5% or 10% relative reduction compared to 1/1/2023 to 12/31/2023 hospital rate** • **Reduce rate of persons with active tobacco use undergoing elective surgery to ≤ 14% or a 10% relative reduction compared to 1/1/2023 to 12/31/2023 hospital rate**	
		Meet both measures	10
		Meet one measure	5
		No measures met	0

2025 Michigan Surgical Quality Collaborative (MSQC) Performance Index Scorecard Measurement Period: 1/1/2025 – 12/31/2025 (unless specified otherwise)			
Measure #	Weight	Measure Description	Points
8	10%	**Hospital Wide Measure: Preop Optimization for elective abdominal hernia surgery:** **• Reduce rate of persons with body mass index (BMI) ≥ 40kg/m2 undergoing elective surgery to ≤ 11.5% or 10% relative reduction compared to 1/1/2023 to 12/31/2023 hospital rate** **• Reduce rate of persons with active tobacco use undergoing elective surgery to ≤ 14% or a 10% relative reduction compared to 1/1/2023 to 12/31/2023 hospital rate**	
		Meet both measures	10
		Meet one measure	5
		No measures met	0
9	5%	**Complete documentation of designated cancer variables** (CRC, Breast, Whipple, Thyroid)	
		90 - 100%	5
		< 90%	0
10	45%	**Quality Improvement Initiative (QII)** - choose from one of the following (fere to supporting documentation for further detail on each option): Option A: SUCCESS (by invitation only) Option B: Frailty Option C: Breast Surgery Option D: Preoperative Testing (by invitation only) Option E: Colorectal Option F: Hernia	45
Optional	5	Site may earn additional points by completing one of the following: - Complete an additional surgeon engagement activity - Bring an additional surgeon from procedure specific track - Submit a 2nd hernia video by a surgeon different from the first video submission (Must have completed an engagement activity)	5
Total Available Points			**100**
^** Earned bonus points may be added to the process measures component of the scorecard, with final score not to exceed 100 points overall.			

2025 Quality Improvement Implementation, Option A: SUCCESS (by invitation only) Project Time Period: 1/1/2025 – 12/31/2025

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 postoperative urinary retention (POUR), for which there is a lack of standardized management.

Project Goal and Summary – The 2025 SUCCESS project will build on the work that began in 2023 and continued in 2024. In collaboration with the Surgical Champion and the multidisciplinary team, this intervention aims to (1) reduce inappropriate perioperative urinary catheter use, (2) reduce catheter-associated trauma, and (3) improve the management of postoperative urinary retention. The project focuses on four common general surgery procedures: appendectomy, cholecystectomy, colorectal surgery, and hernia repair. This project will include the continued implementation and evaluation of toolkit elements that will address clinician knowledge and urinary catheterization skills, as well as communication and implementation challenges anticipated to affect catheter use in different types of perioperative clinical settings. Sites will also address barriers, meet process/outcome measures, refine the care pathway, and perform a quality review of cases that meet the criteria in Goal 5.

Eligibility – Sites that participated in the 2023 or 2024 SUCCESS QI project are eligible to select this project as their 2025 QI Project if at least 3 out of 5 process measures in 2025 Goal 3 were not met. Sites that never participated are not eligible in 2025.

QI Implementation Goals and Requirements: (45 points total)

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

2. Multidisciplinary team: Participating hospitals will work within the multidisciplinary team to review data, guide quality improvement and toolkit element implementation plans, and refine the MSQC SUCCESS urinary care pathway. Suggested participants include surgeon leadership/surgeon champion, surgeons/residents (general & urology), executive leadership, anesthesiology, nursing supervisors for ER, Perioperative, PACU, and surgical units, quality department manager, patient safety, nursing education, and patient experience officer.
    a. Hold three (3) multidisciplinary meetings. Submit minutes, slides, a list of attendees, and their roles with your 2025 SUCCESS Project Summary. (8 points total)
        1. Kickoff meeting by March 31, 2025, to review project requirements and preliminary data. This should be a working meeting with the multidisciplinary team members who will be participating in the project, not simply an announcement of the project. (4 points)
        2. Two (2) additional multidisciplinary team meetings (minimally) before December 1, 2025, which include a review of SUCCESS data and a quality review for cases in Goal 5. (2 points each)
3. Meet the process/outcome measures below for appropriate catheter use and urinary retention diagnosis and

management. (20 points total, 4 points each measure) Measurement period 1/1/2025-12/31/2025 OR dates:

- *Catheter use measures*
  a. Indwelling catheters are not used intraoperatively for ≥ 90% of Category A* cases
  b. Indwelling catheters, if used, are removed in OR for ≥ 90 % of Category B* cases
- *Urinary retention diagnosis and management measures*
  c. Bladder scan volume is documented ≥ 90 % of the time before urinary catheterization, if used, for POUR was performed
  d. No urinary catheter is used for bladder scan volumes < 300 ml for ≥ 90 % of cases with POUR
  e. ISC was performed as opposed to an indwelling catheter (unless volume ≥ 500) for ≥ 90 % of cases with POUR

4. With the multidisciplinary team, continue refining the MSQC SUCCESS urinary care pathway template for your hospital's practices. This will be utilized by the care team to ensure the use of each element of the SUCCESS toolkit. Include a narrative of how any processes and toolkit elements were modified from 2024, and include in the modified care pathway the process of educating about and using alternatives to catheters and coudé catheters, and how the voiding trial algorithm or similar was incorporated into practice. Submit the final care pathway with your 2025 SUCCESS Project Summary. (4 points)

5. Within multidisciplinary team meetings, perform a quality review of each case that meets any of the criteria below, from 1/1/2025 to 12/1/2025 OR dates. An overall findings summary (trends identified, action plans implemented) and tracking sheet should be submitted with your 2025 SUCCESS Project Summary. (10 points)
   a. Patients in Category A who have an indwelling urinary catheter placed in the OR.
   b. Retention is assigned for patients who had a urinary catheter (ISC or indwelling) placed when < 300 ml is documented via a bladder scanner or the catheter use
   c. Patients who return to ED with Retention
   d. Patients who were discharged with an indwelling catheter or need for ISC
   e. Patients who have Urinary Catheter-Related Trauma assigned

6. Submit the 2025 SUCCESS Project Summary to the MSQC Coordinating Center no later than January 16, 2026. An additional 0-10 implementation points may be granted based on the detail of the project narrative, tracking log, and analysis, to be added to achieve the maximum of 45 project points.

Resources:
SUCCESS webpage: https://msqc.org/success/

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

Quality Improvement Implementation, Option B: Frailty
Project Time Period: 1/1/2025 – 12/31/2025

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

Project Goal and Summary: The 2025 frailty project will build on the work begun in 2023 which introduced a system to assess vulnerable patients for frailty using a validated screening tool with an informed discussion regarding the results of frailty screening during the surgical planning phase.

For 2025, the goal is to improve the surgical experience for patients identified as frail through interventions shown to potentially improve outcomes. This year will see an enhanced informed decision-making discussion with surgical candidates and caregivers and add interventions aimed at improving the surgical experience for candidates identified as frail. These interventions will include establishing patient overarching health goals and documenting this in the medical record, developing educational materials for patients and caregivers regarding care and expectations, and involvement of support persons throughout the surgical encounter to support those patients identified as frail.

QI Implementation Goals and Requirements (45 points total)

- *Continuing sites:* Measurement period is 1/1/2025-12/31/2025 OR dates
- *Continuing sites:* Must include one new additional surgeon or group and will measure OR dates 4/1/2025 to 12/31/2025
- *New sites:* Measurement period is 4/1/2025 to 12/31/2025 OR dates

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

2. Hold three (3) multidisciplinary meetings. Submit minutes and attendees to the coordinating center with the final project submission (9 points):
    a. Kickoff meeting by March 29, 2025, to review project requirements and preliminary data. (3 points).
    b. Two (2) additional multidisciplinary meetings (minimally) before December 1, 2025, which include a review of data (3 points each).

3. Use of Frailty Tool for preoperative frailty screening in ≥ 75% of eligible patients (10 points). Sites will distribute and implement a frailty screening tool that will be completed during the preoperative planning period and be completed prior to the final decision to proceed with surgery on all elective surgery* patients meeting <u>any</u> of the following criteria:
    - Age ≥ 60 years on the day of surgery
    - Current dialysis as defined in MSQC core variable definitions.
    - Current cancer as defined in MSQC core variable definitions.
    - Functional health status identified as “Not Independent” in MSQC core variable definitions.
    - Current CHF as defined in MSQC core variable definitions. If frailty screening is not completed for a patient who qualifies:
    - The SCQR will discern the rationale for failure to use the frailty tool.
    - If this information is unavailable in the chart, the SCQR may also obtain this information by communication with office staff.

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

4. A conversation between surgeon and patient/caregivers occurs for ≥ 75% of patients who screened as frail or pre-frail (8 points). The discussion will occur during the surgical planning process by a surgeon or an appropriate healthcare professional designee acting on behalf of the surgeon. This guided discussion and an attestation statement in the medical record are required and ensure that a conversation of the risks and benefits has taken place with the patient and/or caregivers.

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

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

5. Patient/caregiver goals for surgery are documented for ≥ 75% of patients who screened as frail or pre-frail (8 points).

6. Provide preoperatively patient and/or caregiver education (10 points) measurement period 4/1/2025-12/31/2025 to ≥ 75% of patients who screen frail or pre-frail (positive for frailty). The education may be completed by the surgeon or an appropriate healthcare professional designee which may include a Registered Nurse or Advanced Practice provider and must
   - be provided <u>verbally</u> and in <u>writing</u> regarding the impact of frailty on surgical outcomes.
   - include how increased risk could be mediated pre- and postoperatively.

   Submit the educational materials that are being used to the MSQC coordinating center for approval by February 15, 2025.

7. Submit the 2025 Frailty Project Summary to the MSQC Coordinating Center no later than January 16, 2025. An additional 0-10 implementation points may be granted based on the detail of the project narrative, tracking log, and analysis: to be added to achieve the maximum of 45 project points.

Quality Improvement Implementation, Option C: Breast Surgical Quality Measures Project Time Period: 1/1/2025-12/31/2025

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

Project Goals: Each site will designate a surgeon lead who performs breast surgery for this project who, along with the multidisciplinary team, will help disseminate information at the hospital and be actively engaged in developing and implementing processes to improve the quality of Breast Surgery.

QI Implementation Goals and Requirements: (45 points total)

1. **Data collection:** For elective partial mastectomy and mastectomy surgical patients done for cancer, participating hospitals will perform supplemental data collection that will allow the measurement of breast surgical quality.
2. **Surgeon Champion:** Each site will designate a surgeon champion who performs breast surgery to lead this project. The expectations are the surgeon lead will help the SCQR disseminate information at the hospital and be actively engaged with MSQC for the Breast Surgery QI project, which may also include being a member of the Breast Care Committee meetings (either in person or virtual).
3. **Multidisciplinary team (6 points total):**
    - Participating hospitals will form a multidisciplinary team to review baseline data, guide quality improvement plans, and implement the care pathway. The multidisciplinary team should include the breast cancer surgeon champion, other surgeons who perform breast cancer surgery, nursing, patient navigator, plastics and reconstructive, breast radiology and others as relevant.
    - Hold a multidisciplinary meeting before March 31, 2025. Meeting notes, including attendees, must be submitted to the coordinating center with the final project submission. *(2 points).*
    - Two (2) additional multidisciplinary meetings (minimally) before December 1, 2025, which include a review of breast data *(2 points each).*
4. **Perioperative Process Goals (15 points):** Implement all the following process measures for each elective breast surgical patient as detailed below.
    - **Continuing Sites: Measurement Period is 1/1/2025– 12/31/2025**
    - **New sites: Measurement Period 4/1/2025-12/31/2025.**

    Preoperative Goals *(6 points total)*
    - **5a:** Preadmission teaching that discusses expectations after surgery, including multimodal pain management ≥ 80%, discussion of opioid-free surgery (if applicable), and expected use of surgical drains (if applicable) *(3 points)*
    - **5b:** Patient optimization discussion related to smoking cessation (if applicable) ≥ 80% *(3 points)*

Intraoperative Goals *(3 points total)*

- **5d:** Use of intraoperative multimodal pain management ≥ 80% *(3 points)*

Postoperative Goals *(6 points total)*

- **5e:** Postoperative order for multimodal pain management ≥ 80% *(3 points)*
- **5f:** Opioid prescriptions meeting M-OPEN recommendations ≥ 80% *(3 points)*

5. **Cancer-Specific Goals (24 points total):** Cancer and DCIS diagnoses which are listed in the breast tab of 2025 Program Manual.
    - **Continuing sites: Measurement Period is 1/1/2025 – 12/31/2025.**
    - **New Sites Measurement Period: 4/1/2025-12/31/2025**
    a. Preoperative MRI rate to ≤ 30% or a ≥10% relative reduction from baseline *(6 points)*
    b. Reduction of use of SLNB in women >70 years old to ≤ 40% or a ≥10% relative reduction from baseline *(6 points)*
    c. Reduction of re-excision rates for positive margin after lumpectomy to ≤ 12% or a ≥10% relative reduction from baseline *(6 points)*
    d. Increase in the use of outpatient mastectomy to > 25% or have a ≥10% relative increase from baseline. *(6 points)*
6. Submit a **QII Project Summary** on or before **January 16, 2026,** which includes a narrative and activity tracking of the steps to implementation of the breast cancer surgery care pathway, successes and barriers, and analysis and next steps (a template will be available on the MSQC website).
    - An additional 5 implementation points may be granted based on the detail of the project narrative, activity tracking log, successes and barriers, and analysis and next steps, to be added to achieve the maximum of 45 project points.
    - An additional 5 points may be granted if all breast cancer cases are abstracted which includes oversampling of all Not Sampled eligible cases, to be added to achieve the maximum of 45 project points. Oversampled cases will be included in the Process Improvement Goals.

Included CPT Codes:

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

Quality Improvement Implementation, Option D (by invitation only) Preoperative Testing for Low-Risk Surgeries
Project Time Period: 1/1/2025 – 12/31/2025

Background: 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].

Several organizations within Michigan – the Michigan Surgical Quality Collaborative (MSQC), the Michigan Program on Value Enhancement (MPrOVE), the Michigan Value Collaborative (MVC), and the Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) – have partnered to address unnecessary preoperative testing through a collaborative lens that includes data-driven approaches. these groups collaborate under the umbrella of RITE-Size (https://ritesizetesting.org/) to support de-implementation of low-value testing and develop resources for the benefit of their stakeholders.

Project Goal and Summary: Based on the past two years of work on this front, the MSQC project will continue into its third year to work toward reducing unnecessary, routine preoperative testing for low-risk surgeries, as well as implement interventions to heighten awareness and reduce variation among hospitals. This project has been modified and refined in response to participating site feedback and analysis of findings.

Continuing sites who participated in the pilot project in 2023 and/or in the 2024 QI project are eligible if their average rate of preoperative testing is >20% from their most recent set of measurement data. MSQC will analyze the data and reach out to eligible sites, inviting them to consider the preoperative testing project as one of their QI options for 2025.

Through a multi-faceted approach, invited sites will: 1) abstract preoperative testing variables on low-risk surgical cases, 2) evaluate the effectiveness of their current protocols and decision support tools to develop an action plan, 3) employ strategies to promote adherence to the protocol, and 4) analyze MSQC, MVC, and internal data reports to monitor progress.

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

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

QI Implementation Goals and Requirements (45 total project points)

Goal #1: **Data collection of 100% of preoperative tests** for eligible procedures that were performed within 30 days prior to the surgery date, including testing obtained preoperatively on the day of surgery. The measurement period is 1/1/2025 – 12/31/2025 OR dates for all sites. **(3 points)**

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

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

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

Goal #2: In-depth QI analysis of existing preoperative testing protocol and CDS tool implementation from prior year(s) to identify an action plan for the current project year. Using a quality tool of your choice (e.g., A3, failure mode effects analysis, 5 Whys, Fishbone, etc.), perform an in-depth analysis of your prior year performance to identify specific variables impacting your preoperative testing rate. Utilize your findings to develop an action plan to improve compliance for the project year. This analysis should be completed with the multidisciplinary team early in the project year. Include a copy of this analysis with your 2025 final project summary. **(15 points)**

Goal #3: Reduce the rate of unnecessary preoperative testing (10 points each; 20 points total)

- **Goal 3a: Reduce the percentage of cases that receive one or more of the specified preoperative tests** (as listed in Goal #1) by 20% (relative) as compared to the baseline rate
    - Baseline period will be your most recent measurement period from a prior project year:
        - 2024 project sites: 4/1/2024 – 12/31/2024 OR dates
        - 2023 project sites: 4/1/2023 – 12/31/2023 OR dates
    - Measurement period for all sites: 4/1/2025 – 12/31/2025 OR dates
- **Goal 3b: Preoperative testing performed on the day of surgery must have supporting clinical documentation to justify the need for testing (Goal ≥ 90%)**
    - Baseline period: 1/1/2025 – 3/31/2025
    - Measurement period: 4/1/2025 – 12/31/2025

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

- **Goal 4a**: host a project kickoff meeting held no later than **March 31, 2025**. **(2 points)**
- **Goal 4b**: host at least one follow-up multidisciplinary meeting **between July and December 2025** to discuss protocol implementation, progress and barriers to implementation, and monitoring of compliance data (including MVC and MSQC preoperative testing data). **(2 points)**
- Meeting participants must include a general surgeon, anesthesiologist, and MSQC/Quality dept representation; additional attendees can also include the hospital's MVC Site Coordinator (if applicable), a primary care provider (PCP), a representative from the preoperative clinic (if applicable), a surgical resident, and others as appropriate for your site.
- Meetings can be in person, virtual, or hybrid (project information shared over email, or multiple one-on-one meetings do not count toward this requirement).
- For each meeting, submit the meeting minutes and attendee list (with attendee name, credentials, and department represented) with your 2025 final project summary.

Goal #5 Performance Data Monitoring: Utilize the MSQC and MVC data reports to monitor your site's progress and identify when program adjustments are necessary. **(3 points total)**

- **Goal 5a:** Access regularly distributed MSQC QI push reports from your site's Dropbox account, monitor performance, and share results with the project team at multi-disciplinary meetings. Include documentation in meeting minutes (to be submitted with your 2025 final project summary) that addresses your data findings and interpretations. **(1 point)**
- **Goal 5b:** Access and download your site's interactive preoperative testing reports from the MVC data registry application and discuss the report findings with your team during the multi-disciplinary meetings. Meeting minutes should reflect discussion of the data findings. At a minimum, download the reports prior to each required multi-disciplinary meeting, and include a copy of each downloaded report as attachments to the meeting minutes. (**1 point for each** required meeting occurrence (prior to

3/31/2025, and again for July – December 2025)).

Note: MVC will be offering data registry training in early 2025. MSQC will notify sites of training availability.

Goal #6: **Submit the 2025 final project summary**, due to the MSQC Coordinating Center no later than **January 16, 2026.**

- The QII project summary will be submitted using the template available on the Quality Improvement page of the MSQC website. The document will contain a narrative describing the adoption, implementation, and monitoring of a preoperative testing protocol for low-risk surgeries, along with successes, barriers, plans for moving forward with the project. Additional documents to be submitted with the summary include:
    - Analysis using a quality tool of how the protocol and clinical decision support tools that were developed in the prior project year were modified or implemented differently to improve compliance with reducing preoperative testing (from Goal #2).
    - Meeting documents (minutes, participant list) from the project kickoff and subsequent follow-up multi-disciplinary meetings held during the project year (from Goal #4).
    - Discussion of MSQC QI push reports captured in multidisciplinary meeting minutes (from Goal #5a).
    - Copies of each of two (2) downloaded MVC registry interactive preoperative testing reports as attachments to the meeting minutes (from Goal #5b).

Implementation Points

An additional 0-10 implementation points may be granted based on the detail of the project narrative, tracking log and analysis, to be added to achieve the maximum of 45 project points.

Table 1: Project-Eligible CPT Codes

Abdominal Hernias less than 3 cm and all Inguinal/Femoral Hernia Repairs ("Minor Hernia")	
49505	49505: Repair initial inguinal hernia, age 5 years or older; reducible.
49507	49507: Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated.
49520	49520: Repair recurrent inguinal hernia, any age; reducible.
49521	49521: Repair recurrent inguinal hernia, any age; incarcerated or strangulated.
49525	49525: Repair inguinal hernia, sliding, any age.
49550	49550: Repair initial femoral hernia, any age; reducible.
49553	49553: Repair initial femoral hernia, any age; incarcerated or strangulated.
49555	49555: Repair recurrent femoral hernia; reducible.
49557	49557: Repair recurrent femoral hernia; incarcerated or strangulated.
49591	49591: Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
49592	49592: Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated
49613	49613: Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
49614	49614: Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated

49650	49650: Laparoscopy, surgical; repair initial inguinal hernia
49651	49651: Laparoscopy, surgical; repair recurrent inguinal hernia
49659	49659: Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy.
Laparoscopic Cholecystectomy	
47562	47562: Laparoscopy, surgical; cholecystectomy
47563	47563: Laparoscopy, surgical; cholecystectomy with cholangiography
47564	47564: Laparoscopy, surgical; cholecystectomy with exploration of common duct
Breast Lumpectomy/Partial Mastectomy	
19301	19301: Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)

Goal Description	2024 Project Points		2025 Project Points	Project Changes
	New Sites	Continuing Sites		
Data collection of 100% of preoperative testing use	3	3	3	Increased from 95%
Develop/implement a standard preoperative testing protocol for low-risk surgeries (20 points total for new sites; 10 points total for continuing sites)				Retired; must be a continuing site to participate in project
Adopt a preoperative testing guideline protocol to implement at your site	10			
Adopt clinical decision support tools to embed preoperative testing protocol into practice	10			
In-depth QI analysis of existing protocol and CDS tool implementation from prior year(s) to identify action plan for current project year		10	15	Increased point value
Reduce rate of preoperative testing by 20% as compared to baseline	10	20	10	Decreased point value
Preoperative testing performed on the day of surgery must have supporting clinical documentation to justify the need for testing (Goal ≥ 90%)			10	New measure
Conduct a minimum of two multidisciplinary meetings with key stakeholders (4 points total)				
Host a project kickoff meeting held no later than March 31, 2025	2	2	2	n/a
Host at least one follow-up multidisciplinary meeting between July and December 2025	2	2	2	n/a
Performance Data Monitoring	1	1	3	Increased point value
Analyze preoperative testing on day of surgery (prior to In Room Time)	2	2		Retired
Total	40	40	45	Increased point value
Optional Implementation Points (based on detail of project narrative, tracking log and analysis)	0-10	0-10	0-10	n/a

Table 2: Comparison of Preoperative Testing QI Project P4P Point Distribution, 2024 to 2025

Resources

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

References

[1]Berlin NL, Yost ML, Cheng B, et al. Patterns and Determinants of Low-Value Preoperative Testing in Michigan. *JAMA Intern Med.* 2021;181(8):1115–1118. doi:10.1001/jamainternmed.2021.1653
1001/jamainternmed.2021.1653

Quality Improvement Implementation, Option F: Abdominal Hernia Surgeon Engagement Project Time Period: 1/1/2025 – 12/31/2025

Summary: The focus of this project will continue to build upon the gains of the past MSQC hernia project and to garner the engagement of more hernia surgeons across the state of Michigan to increase the quality of care for hernia surgery patients.

QI Implementation Requirements: For abdominal hernia repair patients, in addition to MSQC core data collection, participating hospitals should collect the complete hernia variable tab. This should already be in practice but is essential for a successful project.

Surgeon Champion: Each site will designate a surgeon champion who performs hernia surgery to lead this project. The expectations are the surgeon lead will help the SCQR disseminate information at the hospital, be engaged with MSQC for the Hernia Surgery QI project, which may also include attending the 2025 MSQC Meetings pertaining to hernia surgery and the 2025 Hernia Summitt.

Multidisciplinary team (10 points total):

- Participating hospitals will form a multidisciplinary team to discuss implementation of the risk communication tool. The multidisciplinary team should include the hernia surgeon champion, other surgeons who perform hernia surgery, nursing, patient navigator, IT to help with the dot phrase into the electronic medical record (EMR).
- Hold a multidisciplinary meeting before March 29, 2025. Meeting notes, including attendees, must be submitted to the coordinating center with the final project submission. **(4 points).**
- Two (2) additional multidisciplinary meetings (minimally) before December 1, 2025, which include a review of the implementation of the HErOIQ tool into practice **(3 points each=6 points).**

QI Surgeon Goals:

- All hernia surgeons at your site will watch the training video **(10 points)**
- Have all your hernia surgeons start using the HerOIQ risk communication tool (Measurement starts 4/1/2025 cases) **(10 points)–**
  - This would be documented by a dot phrase that could be abstracted from the EMR like the preop optimization pathway. This will need to be built into the EMR which will take some time.
  - While waiting for the dot phrase to be built you will need to document in the preop note that the HerOIQ risk communication tool was used.
  - The goal would be to integrate the HerOIQ risk communication tool into your practice.
  - ***The 2025 goal would be the use of the tool >50% of the time***.

- Hernia video submission and review **(15 points)-** your hernia surgeon champion will need to submit a hernia surgery video for review and participate in the review of other videos from surgeons across the state.

Submit a **QII Project Summary** on or before **January 16, 2026**, which includes a narrative and activity

tracking of the steps to implementation, successes and barriers, and analysis and next steps (a template is available on MSQC website).

CPT Codes included in the project:

49560	Repair initial incisional or ventral hernia; reducible.
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated.
49565	Repair recurrent incisional or ventral hernia; reducible.
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated.
49570	Repair epigastric hernia; reducible.
49572	Repair epigastric hernia; incarcerated or strangulated.
49585	Repair umbilical hernia, age 5 years or older; reducible.
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated.
49590	Repair Spigelian hernia.
49652	Laparoscopy, surgical, repair, ventral, umbilical, Spigelian or epigastric hernia; reducible.
49653	Laparoscopy, surgical, repair, ventral, umbilical, Spigelian or epigastric hernia; incarcerated or strangulated.
49654	Laparoscopy, surgical, repair, incisional hernia; reducible.
49655	Laparoscopy, surgical, repair, incisional hernia; incarcerated or strangulated.
49656	Laparoscopy, surgical, repair, recurrent incisional hernia; reducible.
49657	Laparoscopy, surgical, repair, recurrent incisional hernia; incarcerated or strangulated

Quality Improvement Implementation, Option E: Colorectal Cancer Surgical Quality Measures Project
Time Period: 1/1/2025-12/31/2025

Project Goal and Summary: In collaboration with the colorectal surgeon lead, hospital multidisciplinary team, and MSQC, this project focuses on improving the performance of evidence- based quality measures for patients undergoing colorectal cancer surgery. We anticipate this project will promote high-quality treatment to improve short- and long-term outcomes.

QI Implementation Goals and Requirements: (45 points total)

1. **Data collection:** For colorectal cancer surgeries, participating hospitals will contribute to the mandatory colorectal tab data collection that will allow the measurement of colorectal cancer surgical quality. In addition, participating hospitals will capture supplemental data collection.

2. **Colorectal Surgeon Lead:** Each site will designate a surgeon lead who performs colorectal cancer surgery. The expectations are that the surgeon lead will help the SCQR disseminate information at the hospital, be active in developing and implementing a multidisciplinary engagement, and be engaged with MSQC for the Colorectal Cancer Surgery QII project.

3. **Multidisciplinary team and Meetings (9 points):**
    - Participating hospitals will form a multidisciplinary team to review baseline data, guide quality improvement plans, disseminate information at the hospital, and be actively engaged in meeting project goals. The multidisciplinary team must include providers from: General or Colorectal Surgery, Medical Oncology, Pathology, Radiology, and nursing or cancer patient navigator. Other suggested specialties include Radiation Oncology, Gastroenterology, Primary Care, or others as relevant to the particular hospital.
    - Hold three (3) multidisciplinary meetings with all members of the above described team present. Submit minutes and attendees to the coordinating center with your 2025 QII Project Report for each meeting.
        - Kickoff meeting before March 29, 2025, to review project requirements and preliminary data. **(5 points).**
        - At least three (3) quarterly multidisciplinary meetings before December 1, 2025, which include a review of colorectal cancer data, progress and plans to reach Process Improvement goals, and review of all positive margin cases **(2 points for each meeting)**.

4. **Perform Case Review of Positive Margins Cases (10 points):** Perform an internal quality review of each colorectal cancer case that results in a positive margin from 1/1/2025 to 12/1/2025 OR dates. In each quarterly multidisciplinary meeting (required participants described above), any positive margin case during the prior quarter must be reviewed and the checklist at the end of this document must be filled out for each case. The multidisciplinary team should identify any underlying trends among cases and apply that knowledge toward process improvement efforts. All checklists and the overall findings summary (trends identified, action plans implemented) should be submitted with your

2025 QII Project Report. The number of checklists will be confirmed against the number of positive margin cases

collected at the participating hospital.

5. **Process Improvement Goals (16 points):** Implement the following processes to meet the goals for colorectal cancer surgical patients. Measurement Period is 4/1/2025 – 12/31/2025 OR dates.
   - Pre-treatment imaging within 90 days before surgery for cancer staging for ≥ 80% of elective colorectal cancer surgical patients **(4 points)**:
     - For elective colon resections, this includes (1) CT of the Chest with or without contrast and (2) CT with IV contrast of the Abdomen and Pelvis or MRI of the abdomen and pelvis with or without IV contrast.
     - For elective rectal resections, this includes (1) CT of the Chest with or without contrast and (2) CT with IV contrast of the Abdomen and Pelvis or MRI of the abdomen with or without IV contrast, and (3) MRI of the pelvis or endorectal ultrasound.
   - Examination of ≥ 12 lymph nodes on the surgical specimen for ≥ 95% elective colon cancer patients. Excludes rectal local tumor excision cases with CPT codes 0184T, 45171, 45172. **(4 points)**
   - MMR or MSI testing performed on the colon or rectal specimen either before (on biopsy) or after (on surgical specimen) surgery for ≥ 95% of all colorectal cancer surgical patients. **(4 points)**
   - Increase or maintain the rate of PRO responses to the colorectal-specific questions from Q1 2025 compared to Q2 & Q3 2025. **(4 points)**

6. **Participate in the Colorectal Cancer Tumor Board Project (10 points):** The MSQC team is conducting site visits and focus groups with multidisciplinary providers who participate in colorectal cancer tumor boards to understand the opportunities for quality improvement through multidisciplinary tumor board discussion. The surgeon lead and SCQR will work with the MSQC Coordinating Center to facilitate contact with the Tumor Board coordinator for observation of 3 tumor board sessions (**2 points each**) and conduct a focus group with at least 5 multidisciplinary providers from your hospital (**4 points**). If the participating hospital does not have an independent Tumor Board, then this can include observation of the Tumor Board of another hospital at which the participating hospital's patients may be presented if needed. The focus group should include multidisciplinary providers at the participating hospital.

7. Submit the **2025 QII Project Report** on or before **January 15, 2026,** which includes multidisciplinary meeting notes and attendees, Process Improvement Goals activity tracking, checklist(s) for positive margins case, successes and barriers, and analysis and next steps (a template is available on the MSQC website).
   - An additional 0-5 implementation points may be granted based on the detail of the project narrative, activity tracking log, successes and barriers, and analysis and next steps, to be added to achieve the maximum of 45 project points.
   - An additional 5 points may be granted if all colorectal cancer cases are abstracted which includes oversampling of all eligible cases (including those that were Not Sampled), to be added to achieve the maximum of 45 project points. Oversampled cases will be included in the Process Improvement Goals.

Colorectal Cancer Case Eligibility

- All surgical priority except for Process Improvement Goals measures a and b
- Adenocarcinoma is 'Yes-diagnosis & resected'
- ICD-10 Diagnosis Codes (listed below)
- CPT Codes (listed below)

ICD Code	Colorectal Cancer Surgery ICD-10-CM Description (* denotes rectal cancer code)
C18.0	Malignant neoplasm of cecum
C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of transverse colon
C18.5	Malignant neoplasm of splenic flexure
C18.6	Malignant neoplasm of descending colon

ICD Code	Colorectal Cancer Surgery ICD-10-CM Description (* denotes rectal cancer code)
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C18.9	Malignant neoplasm of colon, unspecified
C19	Malignant neoplasm of rectosigmoid junction
C20*	Malignant neoplasm of rectum

CPT Code	Colorectal Cancer Surgery CPT Description
0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (i.e., TEMS), including muscularis propria (i.e., full thickness)
44140	44140: Colectomy, partial; with anastomosis
44141	44141: Colectomy, partial; with skin level cecostomy or colostomy
44143	44143: Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)
44144	44144: Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula
44145	44145: Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
44146	44146: Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy
44150	44150: Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy
44155	44155: Colectomy, total, abdominal, with proctectomy; with ileostomy
44158	44158: Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed
44160	44160: Colectomy, partial, with removal of terminal ileum with ileocolostomy
44204	44204: Laparoscopy, surgical; colectomy, partial, with anastomosis
44205	44205: Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy
44206	44206: Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)
44207	44207: Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)
44208	44208: Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy
44210	44210: Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy
44211	44211: Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed
44212	44212: Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy
45110	45110: Proctectomy; complete, combined abdominoperineal, with colostomy
45111	45111: Proctectomy; partial resection of rectum, transabdominal approach
45113	45113: Proctectomy, partial, with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy
45119	45119: Proctectomy, combined abdominoperineal pull-through procedure (e.g., colo-anal anastomosis), with creation of colonic reservoir (e.g., J-pouch), with diverting enterostomy when performed
45171	45171: Excision of rectal tumor, transanal approach; not including muscularis propria (i.e., partial

CPT Code	Colorectal Cancer Surgery CPT Description
	thickness) (=”local excision”)
45172	45172: Excision of rectal tumor, transanal approach; including muscularis propria (i.e., full thickness) (=”local excision”)
45395	45395: Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy
45397	45397: Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (e.g., colo-anal anastomosis), with creation of colonic reservoir (e.g., J-pouch), with diverting enterostomy, when performed

Positive Margin Multidisciplinary Case Review Checklist:

A group (tumor board or other) should discuss every case with a positive margin (≤ 1 mm), to see what might have been improved to prevent it. There will be some positive margin cases for which everyone will agree “nothing was done wrong,” but for most there will be room for improvement.

MSQC Case # _____

- Was preoperative imaging performed within 90 days that showed risk of a positive margin?
  - Did this include:
    - Abdomen/pelvis CT or MRI?
    - Chest CT?
    - Pelvic MRI or endorectal ultrasound (if rectal or rectosigmoid cancer)?
  - Were these performed at the same facility or another facility?
  - Did there appear to be:
    - Local invasion of another structure? If so, which structure?
    - Bulky lymphadenopathy?
    - Metastatic disease? If so, where?
    - Perforation?
    - Obstruction?
- Was this thought to be a colon, rectosigmoid, or rectal cancer preoperatively?
  - For colon cancers, was a tattoo performed preoperatively to mark the location of the cancer?
  - For rectal or rectosigmoid cancers, did the operating surgeon repeat a flexible sigmoidoscopy or a rigid proctoscopy prior to surgery (for a rectal or rectosigmoid tumor)? Why or why not?
  - Was a diagnosis of colon cancer changed to rectal cancer intraoperatively?
- Was the patient reviewed in a multidisciplinary tumor board pre-operatively?
  - Did the review include:
    - Pathology (with review of physical slides)?
    - Imaging (with review of actual images)?
  - Did the diagnosis change in the tumor board?
  - Did the treatment plan change in the tumor board?
- Were biopsies performed before surgery?
  - Was MMR or MSI testing performed? Preoperatively on biopsy or postoperatively on the surgical specimen?
  - Were there any other high-risk features identified:
    - LVI/EMVI?
    - PNI?
    - Tumor budding?
- Was chemotherapy, radiation, or immunotherapy given preop? If so, what therapy and how much?
- In the operating room, was a positive margin suspected?
  - Did it seem avoidable? Why or why not?
  - Were frozen specimens obtained?

        - Was the specimen grossly reviewed by the surgeon with a pathologist to indicate margins of concern?
        - Was a second surgeon of the **same** specialty (general or colorectal) planned to be in the operating room? Were they consulted intraoperatively?
        - Was another surgeon of a **different** specialty planned to be in the operating room? Were they consulted intraoperatively?
        - Was the site of suspected positive margin marked by clips or other modality?
        - Was bowel diversion **in lieu of resection** considered? Why or why not?
    - What patient factors contributed to the positive margin?
        - Intended non-curative resection for palliative intent?
        - Body habitus?
        - Social factors such as financial constraints or limited access to healthcare?
        - Comorbidities?
        - Other?
    - What institutional factors contributed to the positive margin (e.g., cancer volume, surgeon experience, available expertise, etc.)?

Resources

- Gutsche N, et. al. Toward 0% Positive Margins for Colorectal Cancer Surgery in Michigan. Pre-recorded session for the MSQC Collaborative Meeting December 10, 2021.
- Operative Standards in Cancer Surgery - Defining the Critical Elements for Surgical Success; Kelly Hunt, MD, FACS, FSSO Presentation at December 4, 2020 MSQC Collaborative Meeting
    - Video Slides
- Presentations at December 10, 2021 MSQC Collaborative Meeting (video)
    - The CRM as a Quality Improvement Target for Rectal Cancer Treatment (11:32-57:10) George Chang, MD, MS
    - Panel Discussion- Best Practices for Low Positive Margins (1:28:43-2:11:29)

2025 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital - Year 1** (measurement period specified below)			
Measure #	Weight	Measure Description	Points
Participation measures are based on calendar year meetings, calls, and audit (01/01/25 - 12/31/25).			
1	15%	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	15
		Attended 2 out of 3 meetings	10
		Attended 1 out of 3 meetings	5
		No Attendance	0
2	10%	**Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that <u>each</u> MSSIC Abstractor be present at MSSIC meetings and <u>all</u> abstractors are required to attend the Annual Abstractor Symposium.)**	
		Attended all 4	10
		Attended 3 out of 4	6
		Attended 2 out of 4	3
		Attend 1 or none	0
3	15%	**Conference Calls Surgeon Champion (3 calls/year)**	
		Attended 3 calls	15
		Attended 2 calls	10
		Attended 1 call	5
		No Calls	0
4	10%	**Conference Calls - Clinical Data Abstractor (8 calls/year)**	
		Participate on 8 calls	10
		Participate on 7 calls	6
		Participate on 6 calls	3
		Participate on less than 6 calls	0
5	10%	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one triannual MSSIC meeting	10
		No Attendance	0
6	10%	**Annual Audit Review – Data Review: Accuracy of data**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
7	15%	**All official documents signed: IRB and Business Associate Agreement**	

2025 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital - Year 1**			
Measure #	Weight	Measure Description	Points
		Within 2 months of Coordinating Center approval date to proceed	15
		Within 3 months of Coordinating Center approval date to proceed	12
		Within 4 months of Coordinating Center approval date to proceed	8
		Within 5 months of Coordinating Center approval date to proceed	4
		6 or more months of Coordinating Center approval date to proceed	0
8	15%	**Hire Data Abstractor in a timely manner**	
		Within 2 months of Coordinating Center approval date to proceed	15
		Within 3 months of Coordinating Center approval date to proceed	12
		Within 4 months of Coordinating Center approval date to proceed	8
		Within 5 months of Coordinating Center approval date to proceed	4
		6 or more months of Coordinating Center approval date to proceed	0

Michigan Spine Surgery Improvement Collaborative (MSSIC)
2025 Performance Index Scorecard Measure Explanation: Hospital Year 1

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Measure number and description	Additional narrative describing the measure
Participation measures are based on calendar year meetings, calls, and audit (1/1/25 - 12/31/25).	
#1 - Meeting participation - Surgeon Champion: Three meetings per calendar year	Please refer to the 2025 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#2 - Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that each MSSIC Abstractor be present at MSSIC meetings, and all abstractors are required to attend the Annual Abstractor Symposium.) Three meetings and Annual Abstractor Symposium per calendar year	Please refer to the 2025 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#3 - Conference Calls Surgeon Champion (3 calls per year)	Please refer to the 2025 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#4 - Conference Calls - Clinical Data Abstractor (8 calls per year)	Please refer to the 2025 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#5 - Meeting participation - Administrative Lead (no designee), at least one meeting per year.	Please refer to the 2025 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
#7 - All official documents signed: IRB and Business Associate Agreement	All required documents signed and returned to the MSSIC Program Manager. The timeframe associated with points earned begins with the email date from the MSSIC Program Manager notifying the site of approval to proceed with documents & hire.

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

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

2025 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 2 (1 site)** (measurement period specified in measure)			
Measure #	Weight	Measure Description	Points
Participation measures are based on calendar year meetings, calls, and audit (01/01/25 - 12/31/25).			
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

2025 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 2 (1 site)** (measurement period specified in measure)			
Measure #	Weight	Measure Description	Points
8	15%	**No later than 9/30/25, 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:** **Measurement period: 10/1/24 - 9/30/25** **Baseline period: n/a, new process**	
		1.) ERAS protocol document outlining how each of the 6 required components will be implemented. Template provided by the Coordinating Center. 2.) Submission of ERAS supporting documents that support all 6 required components, including but not limited to: 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.	15
		One of the 6 required ERAS elements was not submitted and approved as demonstrated by the above documents.	7
		More than one of the 6 required ERAS elements was not submitted and approved as demonstrated by the above documents.	0
9	Bonus	**<u>Optional Bonus Participation Points</u>**: Bonus points are awarded to sites with above and beyond participation efforts as demonstrated by one of below activities. 1.) Surgeon Champion sits on a MSSIC Committee and demonstrates full engagement and participation as outlined in the support document. 2.) Abstractor sites on a MSSIC Committee and demonstrates full engagement and participation as outlined in the support document. **(*Sites will not exceed 100%. The bonus participation measure will only assist where points were lost on other participation measures.)**	5

Michigan Spine Surgery Improvement Collaborative (MSSIC)
2025 Performance Index Scorecard Measure Explanation: Hospital & ASF Year 2

Measure number and description	Additional narrative describing the measure
Participation measures are based on calendar year meetings, calls, and audit (1/1/25 - 12/31/25).	
#1 - Meeting participation - Surgeon Champion: Three meetings per calendar year	Please refer to the 2025 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#2 - Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that each MSSIC Abstractor be present at MSSIC meetings, and all abstractors are required to attend the Annual Abstractor Symposium.) Three meetings and Annual Abstractor Symposium per calendar year	Please refer to the 2025 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#3 - Conference Calls Surgeon Champion (3 calls per year)	Please refer to the 2025 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#4 - Conference Calls - Clinical Data Abstractor (8 calls per year)	Please refer to the 2025 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#5 - Meeting participation - Administrative Lead (no designee), at least one meeting per year.	Please refer to the 2025 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
Enhanced Recovery After Surgery (ERAS), Phase 1 Performance Measures	

#7 - Demonstration of multidisciplinary team engagement through the submission of quarterly meeting attendance sheet and minutes supporting discussion and establishment of ERAS.	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 **four deliverables** are as follows: • Meeting between October 1 – December 31, 2024. **Submit form by January 5, 2025.**
	• Meeting between January 1 – March 31, 2025. **Submit form by April 5, 2025.** • Meeting between April 1 – June 30, 2025. **Submit form by July 5, 2025.** • Meeting between July 1 – September 30, 2025. **Submit form by October 5, 2025.**
#8 - No later than 9/30/25, each site will have submitted and obtained approval by the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program:	• MSSIC ERAS Protocol Document (template provided by the Coordinating Center) outlining the process of how each of the 6 required components 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.), applicable screenshots from the EMR, comprehensive discharge instructions, 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.

#9 - **Optional, Bonus Participation Points:** Bonus points are awarded to sites with above and beyond participation efforts as demonstrated by one of described activities.	e bonus points are available, and it is all or nothing. Surgeon Champion sits on a MSSIC Committee and demonstrates full engagement and participation as defined by the Committee upon which they will sit. • For the Executive Committee this is defined as: Attend 2 out of the 3 Executive Committee meetings that follow the Collaborative-wide meetings. Respond in timely matter to email request for review of Coordinating Center proposals, questions, and/or concerns. Attend at least 75% of ad hoc conference calls and/or virtual meetings. Participate constructively, collaboratively, and cordially. • For the Publication Committee this is defined as meeting criteria outlined in the Committee Expectations document provided to Publication Committee members. 2.) Abstractor sits on a MSSIC Committee and demonstrates full engagement and participation as defined by the Committee upon which they will sit. • For Abstractor Committee this is defined as: Attendance at 75% of committee meetings and timely email response to 75% of committee requests.
***Sites will not exceed 100%. The bonus participation measure will only assist where points were lost on other attendance participation measures for calls and meetings. Bonus participation points will not count towards lost points on the audit score.**	

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

2025 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older (30 sites)** (measurement period specified in measure)			
Measure #	Weight	Measure Description	Points
Participation measures are based on calendar year meetings, calls, and audit (01/01/25 - 12/31/25).			
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

Patient Questionnaire Measures: A site will either do measure 7a & 7b, or they will do only 7c for performance points. This is determined by the site's complete, baseline questionnaire rate at baseline. If a site had ≥ 50% complete, baseline questionnaires, they complete both 7a & 7b for 20 possible points. If they had < 50% complete, baseline questionnaires, they will complete only 7c for 20 possible points.

2025 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older (30 sites)** (measurement period specified in measure)			
Measure #	Weight	Measure Description	Points
7a	15%	**Each qualifying site: Complete, baseline questionnaire collection rate (rounded to the nearest whole number).** **Measurement period: cases with due dates 1/1/25 – 12/31/25.** **Baseline period: Surgeries with dates of 9/1/2022 to 3/27/2024**	
		Collection rate of 75% or more **OR** ≥ 10 percentage points of absolute improvement in the site's 2023 collection rate	15
		Collection rate of 60%-74% **OR** 5-9 percentage points of absolute improvement in the site's 2023 collection rate	7
		Collection rate of less than 60% AND < 5 percentage points of absolute improvement in the site's 2023 collection rate	0
7b	5%	**Each qualifying site: Dual collection rate of both a baseline and 90-day questionnaire (rounded to the nearest whole number).** **Measurement period: cases with 90-day questionnaire due dates 1/1/25 – 12/31/25.** **Baseline period: Surgeries with dates of 9/1/2022 to 3/27/2024**	
		Dual collection rate of 56% or more **OR ≥** 10 percentage points of absolute improvement in the site's 2023 dual collection rate	5
		Dual collection rate of 45%-55% **OR** 5-9 percentage points of absolute improvement in the site's 2023 dual collection rate.	3
		Dual collection rate of < 45% AND less than 5% percentage points of absolute improvement in the site's 2023 dual collection rate.	0
7c	20%	**Each qualifying site: Complete, baseline questionnaire collection rate (rounded to the nearest whole number). Measurement period: cases with due dates 1/1/25 – 12/31/25.** **Baseline period: Surgeries with dates of 9/1/2022 to 3/27/2024**	
		Collection rate of 75% or more	20
		Collection rate of 74%-50%	10
		Collection rate of less than 50%	0
8	20%	**Collaborative-wide measure Goal: Reduce the MSSIC- All, ED Occurrence rate within 0-30 days after surgery to ≤ 7.73%.** **Measurement period: 10/1/24 - 9/30/25 Baseline period: 4/1/23 - 3/31/24**	
		ED occurrence within 0-30 days rate ≤ 7.73%	20
		ED occurrence within 0-30 days rate 7.74% - 8.39%	10
		ED occurrence within 0-30 days rate ≥ 8.40%	0
9	20%	**Each Site: Quality Improvement Initiative - Risk Assessment/Optimization Process Improvement.** Utilizing the MSSIC Process Improvement template, each site will demonstrate a formal QI Initiative to improve their	

2025 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older (30 sites)** (measurement period specified in measure)			
Measure #	Weight	Measure Description	Points
		ERAS Risk Assessment/Optimization process. No later than 10/15/24, sites will submit for approval, a Process Improvement proposal to the Coordinating Center using the MSSIC QI Project Submission Form. Sites are to submit progress reports twice a year to communicate the project's development and movement. Sections 1-9 are due 2/28/25, and the complete MSSIC QI Report, including the outcome of the project, is due 9/30/25. **Measurement period: 10/1/24 - 9/30/25 Baseline period: 10/1/23 - 3/31/24**	
		Both QI reports were approved and submitted on time.	20
		One of the QI reports was either not approved or submitted on time.	10
		Both QI reports were not submitted on time.	0
10	10%	**Presurgical Risk Assessment/Optimization Compliance** **Measurement period: 10/1/24 - 9/30/25** **Baseline period: 10/1/23 - 3/31/24**	
		65% or greater, **OR** ≥ 20 percentage points of absolute improvement in the *baseline rate	10
		25%-64%, **OR** 11-19 percentage points of absolute improvement from *baseline rate	5
		<25%, **OR** < 10 percentage points of absolute improvement from *baseline rate	0
11	Bonus	**Optional Bonus Performance Points:** Bonus points are awarded to sites with above and beyond QI efforts as demonstrated by one of the two Coordinating Center approved activities. Please see the Support Document for details on each option. 1.) Participate in a MSSIC pilot (Centralized Pain or Bone Health Optimization). 2.) Reduce the site-level, ED Occurrence rate within 0-30 days after surgery to ≤ 7.73%, or reduce the site's baseline rate by ≥ 8%. Measurement period: 10/1/24 - 9/30/25 Baseline period: 4/1/23 - 3/31/24 **(*Sites will not exceed 100%. The bonus performance measure will only assist where points were lost on other performance measures.)**	10
12	Bonus	**Optional Bonus Participation Points**: Bonus points are awarded to sites with above and beyond participation efforts as demonstrated by one of below activities. 1.) Surgeon Champion sits on a MSSIC Committee and demonstrates full engagement and participation as outlined in the support document. 2.) Abstractor sites on a MSSIC Committee and demonstrates full engagement and participation as outlined in the support document. (*Sites will not exceed 100%. The bonus participation measure will only assist where points were lost on other participation measures.)	2

Michigan Spine Surgery Improvement Collaborative (MSSIC) 2025 Performance Index Scorecard Measure Explanation: Hospital & ASF Year 3 & Older

Measure number and description	Additional narrative describing the measure
Participation measures are based on calendar year meetings, calls, and audit (1/1/25 - 12/31/25).	
#1 - Meeting participation - Surgeon Champion: Three meetings per calendar year	Please refer to the 2025 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#2 - Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (It is required that each MSSIC Abstractor be present at MSSIC meetings, and all abstractors are required to attend the Annual Abstractor Symposium.) Three meetings and Abstractor Symposium	Please refer to the 2025 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#3 - Conference Calls Surgeon Champion (3 calls per year)	Please refer to the 2025 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#4 - Conference Calls - Clinical Data Abstractor (8 calls per year)	Please refer to the 2025 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements.
#5 - Meeting participation - Administrative Lead (no designee), at least one meeting per year.	Please refer to the 2025 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
Patient Questionnaire Measures - 7a, 7b, & 7c: A site will either do measure 7a & 7b, or they will do only 7c for performance points. This is determined by the site's complete, baseline questionnaire rate for the baseline surgery dates: 9/1/2022 to 3/27/2024. MSSIC has selected a baseline of the last 18 months instead of the last 12 months due to the change in registry. This will ensure that rates were based on performance from a longer period to set sites up for success. If a site had ≥ 50% complete, baseline questionnaires, they complete both 7a & 7b for 20 possible points. If they had < 50% complete, baseline questionnaires, they will complete only 7c for 20 possible points.	

#7a. Each qualifying site: Complete, baseline questionnaire collection rate (rounded to the nearest whole number). Measurement period: cases with due dates 1/1/25 – 12/31/25.	MSSIC has modified its patient survey collection performance metric to help improve patient-reported outcomes data collection and quality. For this metric, a complete status for surveys will include surveys that have a scoreable PROMIS Physical Function form, a scoreable
Baseline period: Surgeries with dates of 9/1/2022 to 3/27/2024	PHQ-2 form, and a scoreable pain scale for either cervical or lumbar surgery. This is a change from MSSIC's prior complete status which allowed for any survey response to count as a complete status. The change in what is countable as a complete survey reflects coding changes that are present in the new MSSIC registry. Additionally, MSSIC is focused on increasing collection of data that provides the Minimal Clinically Important Difference (MCID) outcome measures. By focusing on the validated tools that are present in the surveys, MSSIC hopes to improve patient-reported outcomes data collection and quality.
#7b. Each qualifying site: Dual collection rate of both a baseline and 90-day questionnaire (rounded to the nearest whole number). Measurement period: cases with 90-day questionnaire due dates 1/1/25 – 12/31/25. Baseline period: Surgeries with dates of 9/1/2022 to 3/27/2024	MSSIC has modified its patient survey collection performance metric to help improve patient-reported outcomes data collection and quality. To measure change in patients and see if they improved in pain or physical function - both a baseline survey and a post-operative survey must be collected. For this metric, a complete status for surveys will include surveys that have a scoreable PROMIS Physical Function form, a scoreable PHQ-2 form, and a scoreable pain scale for either cervical or lumbar surgery. For a site to meet dual collection they must have scoreable outcomes data on all three tools for both baseline and post-operative surveys. Sites will maintain responsibility for collecting post-op surveys for all sampled patients (including those without a baseline) at all time periods, however the performance metric will target patients with pre and post surveys. Collection of post-operative surveys, even when the baseline is missing, is still critical for MSSIC data as it shares information on items like satisfaction, opioid usage, and return to work.
#7c. Each qualifying site: Complete, baseline questionnaire collection rate (rounded to the nearest whole number). Measurement period: cases with due dates 1/1/25 – 12/31/25. Baseline period:	Please see explanation for 7a.

#8 - Collaborative-wide measure Goal: Reduce the MSSIC-All, ED Occurrence rate within 0-30 days after surgery to ≤ 7.73%. Measurement period: 10/1/24 - 9/30/25 Baseline period: 4/1/23 - 3/31/24 (baseline rate 8.40%)	Emergency department (ED) visits after spine surgery are a common, costly, and often unrecognized source of post-discharge hospital reutilization. Even when not associated with readmission, a return to the ED following spine surgery can be indicative of adverse postsurgical events. It is MSSIC's intention to identify methods to reduce this adverse event and improve the value of care for these patients. Our goal is to safely reduce or redirect ED visits to a more appropriate level of care after spine surgery where possible. Importantly, ED visits are associated with long wait times, high cost, low patient satisfaction, and generate almost half of all hospital readmissions. Therefore, ED visits after elective surgery constitute an important determinant of quality and cost of care. Although not yet targeted by large scale initiatives like the CMS Hospital Readmission Reduction Program, ED visits will matter in future bundled payment models. Emergency department (ED) visits cost ~$328.1 billion per year to the health care system, of which 19.6%, or $64.4 billion is potentially avoidable. (Galarraga JE, Pines JM. Costs of ED episodes of care in the United States. Am J Emerg Med. 2016; 34:357–365.) The average cost for an ED visit after elective, lumbar spine surgery was $1,455 (Jain, Nikhil MD*; Brock, John L. BA†; Phillips, Frank M. MD‡; Weaver, Tristan MD*; Khan, Safdar N. MD* 30-Day Emergency Department Visits After Primary Lumbar Fusion, Clinical Spine Surgery: April 2019 - Volume 32 - Issue 3 - p 113-119 doi: 10.1097/BSD.0000000000000766).
#9 - Each Site: Quality Improvement Initiative - Risk Assessment/Optimization Process Improvement.	Utilizing the MSSIC Process Improvement template, each site will demonstrate a formal QI Initiative to improve their ERAS Risk Assessment/Optimization process, targeted to improve one or more of the following: standardization, compliance, or overall workflow and documentation. No later than **10/15/24**, sites will **submit for approval, a Process Improvement proposal** to the Coordinating Center using the MSSIC QI Project Submission Form. Sites are to submit progress reports twice a year to communicate the project's development and movement. **Sections 1-9 are due 2/28/25**, and **the complete MSSIC Process Improvement form**, including the outcome of the project, **is due 9/30/25.**

#10 – Each site: Presurgical Risk Assessment/Optimization Compliance	One of the six, required components of MSSIC Enhanced Recovery After Spine Surgery is standardized risk assessment and optimization. Given the physiologic and physical strain that can be associated with spine surgery, it is important to optimize patients pre-operatively to improve outcomes and reduce the risk of post-operative complications (*Wang TY, Price M, Mehta VA, Bergin SM, Sankey EW, Foster N, Erickson M, Gupta DK, Gottfried ON, Karikari IO, Than KD, Goodwin CR, Shaffrey CI, Abd-El-Barr MM. Preoperative optimization for patients undergoing elective spine surgery. Clin Neurol Neurosurg. 2021 Mar;202:106445. doi: 10.1016/j.clineuro.2020.106445. Epub 2021 Jan 14. PMID: 33454498.*) MSSIC requires at least the following standardized risk assessments with optimization interventions: Blood sugar, Smoking, Opioids, and then a choice of either Nutrition or Anemia (however, both are encouraged). Risk assessments and optimization interventions must include a standardized assessment, defined thresholds that trigger or indicate optimization is needed, and standardized optimization interventions. They must be evidence based and supported in peer-reviewed literature. Risk assessment and optimization protocols must be submitted to the Coordinating Center and approved prior to capture in the registry. The cases that fall in the numerator for this measure are those where "yes" was captured for the variable: "*Were all ERAS risk assessments administered as agreed upon by your site*?" Patients that are admitted emergently, as defined in the Master Variable List, are excluded from the denominator.
#11- **Optional, Bonus Performance Points**: Bonus points are awarded to sites with above and beyond QI efforts as demonstrated by one of the two Coordinating Center approved activities.	n bonus points are available, and it is all or nothing. Descriptions for each numbered "Bonus" activity: 1.) Participate in a MSSIC pilot (Centralized Pain or Bone Health Optimization). Please contact the MSSIC QI team to participate no later than 10/15/24. Tool collection must begin no later than surgery dates 11/1/24. 2.) Site-level, ED occurrence rate within 0-30 days after surgery is ≤ 7.73% or the *baseline rate is reduced by ≥ 8%. Measurement period: 10/1/24 - 9/30/25 *Baseline period: 4/1/23 - 3/31/24
***Sites will not exceed 100% on the Performance Index. The bonus performance measure will only add ten points where points were lost on other performance measures. It will not assist where points were lost on participation measures.**	

#12 - **Optional, Bonus Participation Points:** Bonus points are awarded to sites with above and beyond participation efforts as demonstrated by one of described activities.	Two bonus points are available, and it is all or nothing. 1.) Surgeon Champion sits on a MSSIC Committee and demonstrates full engagement and participation as defined by the Committee upon which they will sit. • For the Executive Committee this is defined as: Attend 2 out of the 3 Executive Committee meetings that follow the Collaborative-wide meetings. Respond in timely matter to email request for review of Coordinating Center proposals, questions, and/or concerns. Attend at least 75% of ad hoc conference calls and/or virtual meetings. Participate constructively, collaboratively, and cordially. • For the Publication Committee this is defined as meeting criteria outlined in the Committee Expectations document provided to Publication Committee members. 3.) Abstractor sits on a MSSIC Committee and demonstrates full engagement and participation as defined by the Committee upon which they will sit. • For Abstractor Committee this is defined as: Attendance at 75% of committee meetings and timely email response to 75% of committee requests.
Sites will not exceed 100%. The bonus participation measure will only assist where points were lost on other attendance participation measures for calls and meetings. Bonus participation points will not count towards lost points on the audit score.	

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

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

2025 Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative Performance Index Scorecard Measurement period: January 1, 2025 – December 31, 2025 (unless otherwise specified)			
Measure #	Weight	Measure Description	Points
1	10%	**Accuracy of Data**	
		5-star audit score	10
		4-star audit score	8
		3-star audit score	6
		≤ 2-star audit score	0
2	8%	**Quarterly collaborative meeting participation – Surgeon and Data Manager Combined Attendance (January 1, 2025–December 31, 2025)**	
		Surgeon and data manager attended 4 quarterly meetings	8
		Surgeon and data manager attended 3 quarterly meetings	6
		Surgeon and data manager attended 2 quarterly meetings	4
		Surgeon and data manager attended 1 quarterly meeting	2
		Attended 0 quarterly meetings	0
3	4%	**Quarterly collaborative meeting participation – Alternate Surgeon (January 1, 2025–December 31, 2025)**	
		Alternate surgeon attended 1 quarterly meeting	4
		Alternate surgeon attended 0 quarterly meetings	0
		** Alternate surgeon performs cardiac surgery at the site and is not the physician champion*	
4	4%	**Quarterly data manager educational meeting - Data Manager (January 1, 2025–December 31, 2025)**	
		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, 2025–December 31, 2025) *A PERForm Data Quality Report must be submitted to receive any points**	
		Attended 3 PERForm meetings + Data Quality Report Submission	4
		Attended 2 PERForm meetings + Data Quality Report Submission	3
		Attended 1 PERForm meetings + Data Quality Report Submission	2
		Attended 0 PERForm meetings	0
6	15%	**Collaborative-wide quality initiative 2024: All Risk Adjusted Procedures – Initial Ventilator Hours <6 (January 1, 2025–December 31, 2025)**	
		Collaborative mean Initial Ventilator Hours <6 rate 73% or greater	15
		Collaborative mean Initial Ventilator Hours <6 rate less than 73%	0

2025 Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative Performance Index Scorecard Measurement period: January 1, 2025 – December 31, 2025 (unless otherwise specified)			
Measure #	Weight	Measure Description	Points
7	15%	**Site specific quality initiative (January 1,2025-December 31, 2025)**	
		Met improvement goal	15
		Improved but did not meet goal	10
		Implemented plan but did not improve	5
		Unable to implement plan	0
8	20%	**Isolated CAB: O/E mortality for 12 months (January 1, 2025–December 31, 2025)**	
		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, 2023–December 31, 2025)**	
		O/E ≤ 1.0	20
		O/E ≤ 1.5	10
		O/E > 1.5	0
10		**Extra Credit Opportunities (Maximum of 5 Points; Index cannot exceed 100 points)** • **1 point per approved activity for surgeons** • **5 points if target achieved at the hospital level in all 3 Cardiac Surgery VBR Measures**	

2025 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard (measurement period specified in measure)			
Measure #	Weight	Measure Description	Points
1	10%	**Data Submission** **Measurement period: 01/01/2025 – 12/31/2025**	
		On time and complete 3 of 3 times	10
		On time and complete 2 of 3 times	5
		On time and complete 1 of 3 times	0
2	10%	**Meeting Participation** Measurement period: 01/01/2025 – 12/31/2025	
		Surgeon and Trauma Program Manager or MTQIP Clinical Reviewer attend 3 of 3 mtgs	9
		Surgeon and Trauma Program Manager or MTQIP Clinical Reviewer attend in 2 of 3 mtgs	6
		Surgeon and Trauma Program Manager or MTQIP Clinical Reviewer attend 0-1 of 3 mtgs	0
		Registrar or MTQIP Clinical Reviewer attend the annual June data abstractor meeting	1
3	10%	**Data Validation Error Rate** **Measurement period: 01/01/2025 – 12/31/2025**	
		0-3.0%	10
		3.1-4.0%	8
		4.1-5.0%	5
		> 5.0%	0
4	5%	**Performance Improvement Death Determination Documentation** (12 months: 7/1/24-6/30/25)	
		0-2 Missing Documentation	5
		3-4 Missing Documentation	3
		> 4 Missing Documentation	0
5a	8%	**Timely Low-Molecular Weight-Heparin Venous Thromboembolism Prophylaxis** (18 months: 1/1/24-6/30/25)	
		≥ 52.5% of patients (≤ 48 hr)	8
		≥ 50.0% of patients (≤ 48 hr)	6
		≥ 45.0% of patients (≤ 48 hr)	3
		< 45.0% of patients (≤ 48 hr)	0
5b	2%	**Weight-Based Low Molecular Weight Heparin Protocol Use** (12mo: 7/1/24-6/30/25)	
		Yes	2
		No	0
6	10%	**Timely Surgical Repair (Age ≥ 65) Isolated Hip Fractures** (12 months: 7/1/24-6/30/25)	
		≥ 92.0% of patients (≤ 42 hr)	10

2025 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard (measurement period specified in measure)			
Measure #	Weight	Measure Description	Points
		≥ 87.0% of patients (≤ 42 hr)	8
		≥ 85.0% of patients (≤ 42 hr)	5
		< 85.0% of patients (≤ 42 hr)	0
7	10%	**Massive Transfusion Red Blood Cell to Plasma Ratio Weighted Mean** (18 months: 1/1/24-6/30/25)	
		≤1.5	10
		1.6-2.0	10
		2.1-2.5	5
		>2.5	0
8	10%	**Serious Complication Z-Score Trend** (3 years: 7/1/22-6/30/25)	
		< -1 (major improvement)	10
		-1 to 1 or serious complications low outlier (average or better rate)	7
		> 1 (rates of serious complications increased)	5
9	10%	**Mortality Z-Score Trend** (3 years: 7/1/22-6/30/25)	
		< -1 (major improvement)	10
		-1 to 1 or mortality low outlier (average or better)	7
		> 1 (rates of mortality increased)	5
10	5%	**Patient Reported Outcomes Participation** (12 months: 7/1/24-6/30/25)	
		Signed agreement and ≥90% of patients contact information submitted	5
		No agreement OR Signed agreement and <90% of patients contact information submitted	0
11	10%	**Collaborative-wide measure: Timely Antibiotic Femur/Tibia Open Fracture** (12 months: 7/1/24-6/30/25)	
		≥ 85% patients (≤ 90 min)	10
		< 85% patients (≤ 90 min)	0
		Total	**100**

2025 MTQIP P4P PI Scorecard Supporting Documentation

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

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

Measure 3: Data Validation Error Rate:

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

Measure 7: Massive Transfusion Blood Ratio of Packed Red Blood Cells (PRBC) to Plasma

Step 1: Assign (weighted points) to each massive transfusion patient's 1st 4 hours PRBC/Plasma ratio via the tier shown below.

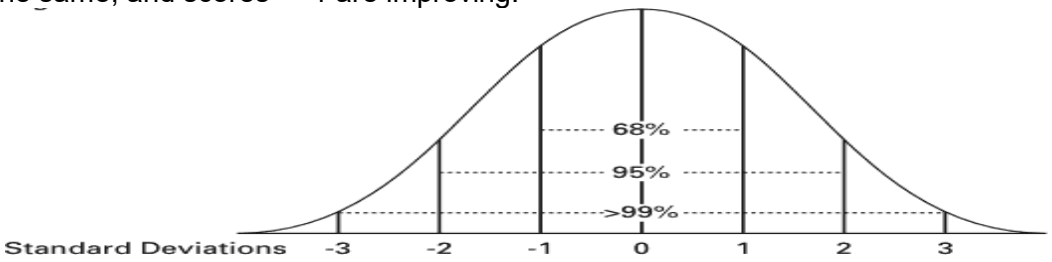
Step 2: Add the points and divide by the number of patients (weighted average). See the example below.

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

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

Measure 8 and 9: Z-Score Trend Calculation

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



Measure 8: Serious Complication is Any Complication with a Severity Grade of 2 or 3 (Defined Below)

Complication Severity Grade 2

Definition: Potentially life-threatening complications

Complications: catheter-related bloodstream infection, central line-associated bloodstream infection, clostridium difficile, decubitus ulcer, deep vein thrombosis, enterocutaneous fistula, pneumonia, pulmonary embolism, unplanned return to intensive care unit, unplanned return to the operating room

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/cerebral vascular accident, systemic sepsis, unplanned intubation, ventilator-associated pneumonia

Collaborative Wide Measure:

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

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

Filters
#4 Performance Improvement Death Determination
Cohort: 2 (Admit Trauma Services)
No Signs of Life: Exclude dead on arrival
Default Period: Custom (7/1/24 to 6/30/25)

#5a: Timely Low Molecular Weight Heparin (LMWH) Venous Thromboembolism (VTE) Prophylaxis
Practices > VTE Prophylaxis Metric
LMWH ≤ 48 hours
Cohort: 2 (Admit to Trauma Service) > 2-day length of stay
No Signs of Life: Exclude dead on arrival
Transfers Out: Exclude transfers out
Default Period: Custom (1/1/24 to 6/30/25)

#5b: Weight-Based Low Molecular Weight Heparin (LMWH) Protocol Use
Points are awarded based on the submission of the following:
Screenshot of the center's protocol with the weight-based criteria visible in the image AND
Screenshots of 5 patients using the protocol with the date and dosage visible in the image.
Submit screenshots to the MTQIP submission portal. For further instruction, see Video demonstration.
Default Period: Submit by 12/5/25.

#6: Timely Surgical Repair in Geriatric (Age ≥ 65) Isolated Hip Fracture
Cohort: 8 (Isolated hip fracture)
Age: ≥ 65
No Signs of Life: Exclude dead on arrival
Exclude: Transfers out, non-operative isolated hip fractures
Default Period: Custom (7/1/24 to 6/30/25)

#7: Red Blood Cell to Plasma Ratio in Massive Transfusion
Hemorrhage
Cohort: 1 (All)
No Signs of Life: Include dead on arrival
Transfers Out: Include transfers out
Default Period: Custom (1/1/24 to 6/30/25)

#8: Serious Complication
Cohort: 2 (Admit to Trauma Service)
No Signs of Life: Exclude dead on arrival
Transfers Out: Exclude transfers out
Default Period: Custom (7/1/22 to 6/30/25)

#9: Mortality
Cohort: 2 (Admit to Trauma Service)
No Signs of Life: Exclude dead on arrival
Transfers Out: Exclude transfers out
Default Period: Custom (7/1/22 to 6/30/25)

#10: Patient-Reported Outcomes Participation
Points are awarded based on a signed agreement, and ≥ 90% of patients submit contact information defined as a validly formatted email or telephone number.
Cohort: 1 (All)
No Signs of Life: Exclude dead on arrival and all Deaths/Discharge to Hospice
Transfers Out: Include transfers out
Default Period: Custom (7/1/24 to 6/30/25)

#11: Timely Antibiotic in Femur/Tibia Open Fractures - COLLABORATIVE WIDE MEASURE
Points are awarded based on the total collaborative result, not the individual hospital result.
Type of antibiotic administered along with date and time for open femur or tibia fracture
Eligible: Presence of acute open femur or tibia fracture based on Abbreviated Injury Score (AIS) or International Classifications of Disease (ICD-10) codes (available on mtqip.org)
Exclude: Direct admissions, Transfers in, and Deaths in the emergency department
Cohort: 1 (All)
No Signs of Life: Exclude dead on arrival
Transfers Out: Include transfers out
Default Period: Custom (7/1/24 to 6/30/25)

2025 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard - Year 1 Measurement Period: 01/01/2025 - 12/31/2025			
Measure #	Weight	Measure Description	Points
1	18%	**OBI Semiannual Meeting Attendance**	
		OBI Physician Champion (MD or DO actively practicing inpatient maternity care) AND Midwife or Nurse Champion (actively practicing inpatient maternity care), AND Clinical Data Abstractor combined attendance (i.e. all three individuals must attend each meeting to obtain full points)	
		Spring Semiannual meeting	9
		Fall Semiannual meeting	9
2	25%	**Quality Initiative Engagement**	
		Site-based Champion Team:	
		1) Submits a quarterly Program Progress and Monitoring (PPM) Report	10
		2) Holds, at minimum, 6 QI meetings in the measurement period to discuss OBI initiatives, review metric progress, and develop improvement plans	10
		3) Disseminates OBI information, at minimum, on a quarterly to unit staff and clinicians to share education, data, and progress	5
3	22%	**Data Integrity**	
		1) CDA successfully completes OBI training program and 1:1 follow up meeting with an OBI coordinator	5
		2) CDA signs attestation confirming Data Manual and NTSV Case Inclusionary/Exclusionary List have been read and understood	2
		3) Accuracy of Abstracted Data	
		Data Quality Review score ≥ 90%	10
		Data Quality Review score between 80.0 - 89.0%	5
		4) Timeliness of Abstracted Data	
		≥ 95% of cases submitted within 90 days of delivery	5
		Between 80 - 94% of cases submitted within 90 days of delivery	3
4	10%	**Quality Improvement Planning**	
		Site-based Champion Team attends the 3 workgroup meetings throughout the measurement period	10
5	5%	**Severe Maternal Morbidity**	
		Submit eCQM Severe Maternal Complications (SMM) data to OBI for all 2024 births by 3/31/2025	5
6	5%	**Pain Management**	
		Submission of signed form attesting to site's adoption of national guideline-concordant protocol for pain management after childbirth	5

2025 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard - Year 1 Measurement Period: 01/01/2025 - 12/31/2025			
Measure #	Weight	Measure Description	Points
7	15%	**Health Equity: Patient Voices**	
		Data element of "Race and Ethnicity" = "Not Documented" ≤ 2%	2
		Email address included on ≥ 60% of patients abstracted from 01/01/2025 - 09/30/2025	3
		Establish a process to collect the Patient Voices Survey in patient setting by the end of the measurement period	10
Optional		Optional Bonus Points Sites can earn up to 5 bonus points total. Sites cannot exceed 100 points total.	
		Author an OBI publication	1
		Present OBI data at a national meeting	
		Present (or identify a patient who presents) at an OBI Semiannual meeting	
		Share a patient story (with patient's permission) selected by OBI for dissemination to OBI members (e.g. via newsletter or social media)	
		100% of cases submitted and complete by 60 days postpartum for neonatal birth dates from 01/01/24 - 10/31/24	
		Actively participate on an OBI Committee	

2025 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard - Year 2+ Measurement Period: 01/01/2025 - 12/31/2025			
Measure #	Weight	Measure Description	Points
1	16%	**OBI Semiannual Meeting Attendance**	
		OBI Physician Champion AND Midwife or Nurse Champion AND Clinical Data Abstractor (CDA) combined attendance	
		Spring Semiannual meeting	8
		Fall Semiannual meeting	8
2	4%	**Quality Initiative Engagement**	
		During the measurement period, site-based Champion Team 1) Submits a quarterly Program Progress and Monitoring Report AND 2) Holds, at minimum, 6 QI meetings to discuss OBI initiatives AND 3) Disseminates OBI information at least quarterly to unit	4
3	10%	**Data Accuracy and Completeness of Abstracted Data**	
		1) Data Quality Review Score ≥ 97% 2) 100% of cases from 01/01/2025 - 09/30/2025 completed and submitted prior to 90 days postpartum 3) Primary CDA signs OBI CDA attestation by 03/31/2025 4) Primary CDA attendance at OBI's CDA training 5) Primary CDA attendance at 4 CDA meetings in the measurement period	
		5 of 5 metrics met	10
		4 of 5 metrics met	7
		3 of 5 metrics met	4
4	10%	**NTSV Cesarean Quality Improvement Planning**	
		All Sites: Entire site-specific Champion Team attends 3 NTSV Cesarean Optimization Group meetings throughout the measurement period	3
		Group 1 Sites: Site-specific Champion Team and at least one hospital leader have 1 in-person meeting with an OBI Quality and Outreach Coordinator and complete OBI's QI Blueprint, which is a plan for driving reduction in the cesarean rate, in the measurement period **Group 2 Sites**: If site's NTSV cesarean rate demonstrates a substantial rise or change in trend, the site-specific Champion Team and at least one hospital leader will then meet at least 2 times with an OBI Quality and Outreach Coordinator and complete OBI's QI Blueprint, which is a plan for driving reduction in the cesarean rate, before the end of the measurement period	7

2025 Obstetrics Initiative (OBI) Collaborative
Quality Initiative Performance Index Scorecard - Year 2+
Measurement Period: 01/01/2025 - 12/31/2025

Measure #	Weight	Measure Description	Points
5	25%	**NTSV Cesarean Measures**	
		Labor Dystocia Compliance Site-specific rate of NTSV cesareans performed for dystocia that meet national criteria for dystocia	
		≥ 80% compliance OR ≥ 15 percentage points of improvement* from baseline**	10
		Between 70 - 79% compliance OR ≥ 10 percentage points of improvement* from baseline**	5
		Management of Category II Fetal Heart Tracings	
		≥ 80% compliance OR ≥ 15 percentage points of improvement* from baseline**	5
		Between 70 - 79% compliance OR ≥ 10 percentage points of improvement* from	3
		Case Reviews	
		Site-specific Champion Team conducts the required number of NTSV cesarean case reviews annually and completes OBI's Case Review Submission Form	7
		Site submits OBI's Case Review Submission form quarterly	3
6	5%	**Severe Obstetric Complications PC-07 eCQM**	
		Submit PC-07 Severe Obstetric Complications eCQM data to OBI for all 2024 births by 3/31/2025	5
7	10%	**Pain Management Measures**	
		Opioid Sparing Medications for NTSV Cesarean Births Site-specific rate of scheduled acetaminophen AND oral NSAID ordered on patients without contraindication after NTSV cesarean birth	
		≥ 90% compliance	5
		Between 80 - 89% compliance	3
		Total oral morphine equivalent (OME) prescribed appropriate with delivery method (excluding people with history of opioid use disorder)	
		At the site-specific level: 1) ≥ 95% of vaginal births with no advanced laceration: total OME prescribed = 0 2) ≥ 90% of vaginal births with advanced laceration: total OME prescribed ≤ 38 3) ≥ 90% of cesarean births: total OME prescribed ≤ 113	
		3 of 3 metrics met	5
		2 of 3 metrics met	3
8	10%	**Health Equity**	
		Data element of "Race and Ethnicity" = "Not Documented" ≤ 2%	2
		Email address included on ≥ 90% OR ≥ 10 percentage points of improvement from baseline** of patients with a delivery date between 01/01/2025 - 09/30/2025	3
		Shift Patient Voices Survey data collection to an inpatient setting by the end of the measurement period, achieving a site-specific, inpatient response rate of ≥ 4% for deliveries between 10/01/25 - 12/31/25	5

2025 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard - Year 2+ Measurement Period: 01/01/2025 - 12/31/2025			
Measure #	Weight	Measure Description	Points
9	10%	**Quality Initiative Project**	
		Following project placement by the OBI Coordinating Center, sites will designate project champion(s) who participate(s) in at least 2 of 3 virtual workgroup meetings during the measurement period. Project options include: 1) Induction of Labor Guidance 2) Severe Obstetric Complications PC-07 eCQM Optimization 3) Social Determinants of Health Screening and Referral	10
Optional		Optional Bonus Points Sites can earn up to 5 bonus points total for the measurement period. Sites cannot exceed 100 points total. Participation bonus points may only be applied to Participation-based measures and may not exceed the Participation-based points total of 30. Performance bonus points may only be applied to Performance-based measures and may not exceed the Performance-based points total of 70.	
		Participation-based Bonus Points	
		Author an OBI publication	1
		Present OBI data at a national meeting	
		Present (or identify a patient who presents) at an OBI Semiannual meeting	
		Share a patient story (with patient's permission) selected by OBI for dissemination to OBI members (e.g. via newsletter or social media)	
		100% of cases submitted and complete by 60 days postpartum for neonatal birth	
		Actively participate on an OBI Committee	
		Performance-based Bonus Points	
		Implement the data integration process and utilize it as a method of abstraction by 12/31/25 (only sites not currently utilizing this process are eligible)	2
		Collaborative-wide NTSV Cesarean rate is ≤ 26.8%, achieved by 9/30/2025, without a rise in collaborative wide SNM/ SMM (based on state's expected average)	5
	100%		20

*For sites with ≥ 30 births in the denominator for the measurement period
**Baseline set using data from 01/01/2024 - 09/30/2024

Obstetrics Initiative (OBI)
2025 Performance Index Scorecard Measure Explanation

Measure number and description	Additional narrative describing the measure
Measure #1: OBI Semiannual Meeting Attendance	Champion engagement at each site is essential 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 BOTH OBI Collaborative Meetings. All 3 individuals must attend to obtain the 8 points allocated to each meeting. OBI member hospitals must declare and provide contact information for their 2025 OBI Champions on the OBI Designation Form (submitted by 12/13/2024). During each Semiannual 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 Semiannual 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 Semiannual meeting registration period. A clinical champion (physician, midwife, nurse) cannot represent two hospitals at a Semiannual 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: Quality Initiative Engagement	OBI recognizes that progress for quality improvement work happens on a daily basis at the site level. The site will be awarded 4 points when the OBI Champions 1) Submit quarterly Program Progress and Monitoring (PPM) Reports AND 2) Hold ≥ 6 meetings to discuss OBI initiatives, review metric progress, and develop improvement plans. The site will submit a copy of each meeting's agenda with a list of attendees to OBI. AND 3) Disseminate OBI data and discuss OBI initiative progress with unit staff and clinicians to share education, data, and progress at least quarterly in the measurement period.
Measure #3: Data Accuracy and Completeness of Abstracted Data	OBI's quality initiatives depend on superb data integrity, relying on accurate and thorough case abstraction. With annual changes to the data manual and scorecard, interpretations of the data elements and quality initiatives may become varied. Therefore, education is paramount to the database's success. A site will be awarded the full 10 points for completing all 5 elements of the measure and partial points may be attained for completing 3-4 elements. 1) Site Data Quality Reviews will ensure that abstracted data is consistent with the Data Collection Manual. The Site Data Quality Reviews will review cases from the previous measurement period. Full points will be awarded if the final score is ≥ 97%. Reviews must be completed by 10/31/2025. 2) Completeness and Timeliness will be measured for cases with delivery dates between 1/1/2025 and 9/30/2025. Full points will be awarded if 100% of cases in the reporting period are completed and submitted prior to 90 days postpartum. 3) The primary CDA must sign an attestation confirming the 2025 Data Manual and NTSV Case Inclusionary/ Exclusionary List have been reviewed and are understood by 03/31/2025 to be submitted along with the Q1 PPM. 4) The primary CDA must attend the annual CDA training. If a CDA is the primary abstractor at multiple sites, credit for attendance will be allocated to each site. 5) The primary CDA must attend ≥ 4 CDA meetings (e.g., CDA calls, in-person CDA meeting at the Semiannual) in the measurement period. If a CDA is the primary abstractor at multiple sites, credit for attendance will be allocated to each site.

Measure #4: Quality Improvement Planning	**NTSV Cesarean Quality Improvement Planning**: OBI offers a variety of activities to support member sites in their local quality improvement efforts. For the 2025 Scorecard, the OBI Coordinating Center will continue to assign each site to Group 1 or Group 2 for targeted quality initiatives. This measure will provide focused OBI Coordinating Center resources to the partnering site's specific needs. Meetings/ calls may include discussion of meaningful improvement goals, response to NTSV case review findings, and identification of barriers and site-specific improvement strategies. Sites with fewer resources (e.g., little or no quality improvement support) may request more QI planning calls and/ or site visits. Sites will be notified of their assigned group no later than November 2024. Sites will be awarded points for this measure by completing the activities designated for their assigned group.

	• All Sites: Each site-based Champion Team (i.e., the three individuals defined in Measure 1) must attend the 3/ 3 NTSV Cesarean Optimization Group meetings throughout the measurement period. • Group 1 sites: The entire site-based Champion Team and at least 1 hospital leader (e.g., a C-suite member, Executive leadership, Quality Director) will have 1 in-person meeting with an OBI Quality and Outreach Coordinator in the measurement period. The site must also complete OBI's QI Blueprint, which is a plan for driving reduction in the cesarean rate. If the NTSV Cesarean rate fails to fall or rises, further outreach would be encouraged. • Group 2 sites: Each Group 2 site will have their NTSV Cesarean rate evaluated throughout the measurement period. If there is a substantial rate rise or other significant rate trend, as determined by the OBI Coordinating Center, the site-based Champion Team and at least 1 hospital leader (e.g. a C-suite member, Executive leadership, Quality Director) will meet 2 times with an OBI Quality and Outreach Coordinator before the end of the measurement period. The site must also complete OBI's QI Blueprint, which is a plan for driving reduction in the cesarean rate.
Measure #5: NTSV Cesarean Measures	**Labor Dystocia Compliance**: 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 meet the national criteria for dystocia as defined by ACOG/SMFM. All cases with latent phase arrest as the primary indication for dystocia will be considered non-compliant. This metric helps to determine the appropriateness of the decision for surgery. Sites will be awarded 10 points if their overall rate is ≥ 80% OR improvement from baseline is ≥ 15 absolute percentage points for NTSV CSs performed for dystocia meet the national criteria. 5 points will be awarded if the overall rate is between 70 – 79% OR improvement from baseline is ≥ 10 absolute percentage points. Baseline is calculated using data from 01/01/2024 – 09/30/2024.
	Management of Category II Fetal Heart Tracings: This measure tracks the proportion of NTSV patients undergoing unplanned cesarean birth for a primary indication of Category II or indeterminate fetal heart rate tracing who have documentation that an evidence-based algorithm was completed before the decision for cesarean. The goal of this measure is to increase the use of a standardized process for interpreting and responding to Category II tracings and thereby safely decrease the rate of fetal heart tracing abnormalities as a primary indication for cesarean births. Sites will have a measurement period of 01/01/2025 – 09/30/2025 and will be awarded 5 points if their Cat II algorithm compliance rate is ≥ 80% OR improvement from baseline is ≥ 15 absolute percentage points. 3 points will be awarded to a site if their Cat II algorithm compliance rate is between 70 – 79% OR improvement from baseline is ≥ 10 absolute percentage points. Baseline is calculated using data from 01/01/2024 – 09/30/2024.

	Case Review: This measure is a critical process that supports clinicians in lifelong learning and fosters continuous organizational improvement. High-volume sites (sites that max out every month at 100 cases) are required to conduct 32 reviews annually with quarterly submissions. Lower volume sites (sites that never max out at 100 cases) are required to conduct 20 reviews annually with quarterly submissions. Extremely small volume sites may be allowed to review fewer cases, with permission of the OBI Coordinating Center. Sites will be awarded 7 points for conducting the required number of Case Reviews annually (the number is dependent on the hospital's case volume) and completing OBI's Case Review Submission Form. 3 points will be awarded when a site submits OBI's Case Review Submission Form on a quarterly basis. Documentation for successful Case Reviews may be found on the OBI Website.
Measure #6: Severe Obstetric Complications	**Severe Obstetric Complications** are often preventable. Reducing maternal morbidity and inequities in maternal morbidity burden across the population are key national and statewide priorities. Sites will be awarded points for submitting Severe Obstetric Complications PC-07 eCQM data for all 4 quarters of 2024, as specified by the Centers for Medicare and Medicaid Services (CMS), to the OBI Coordinating Center by 03/31/2025.
Measure #7: Pain Management Measures	**Pain Management Measures:** Excessive opioid prescribing is harmful to patients and communities. This measure will help OBI decrease the amount of opioids prescribed to patients after childbirth while achieving and maintaining a high degree of patient-centeredness and patient satisfaction with their care experience. **Scheduled Acetaminophen and oral NSAID**: Sites will be awarded points for ordering scheduled acetaminophen AND oral NSAID between post-delivery and discharge for all NTSV cesarean births, for patients without contraindication. If there is a contraindication to acetaminophen, an oral NSAID should

	be scheduled; and if there is a contraindication to oral NSAIDs, acetaminophen should be scheduled. The only cases excluded from the denominator will be patients with a contraindication to BOTH acetaminophen AND oral NSAIDs. The full 5 points will be awarded to the site for ≥ 90% compliance for cases between 01/01/2025 and 09/30/2025, 3 points will be awarded to the site for compliance between 80 – 89%, and no points will be awarded if compliance is ≤ 79%.
	Total Oral Morphine Equivalent (OME) Prescribed Appropriate with Delivery Method: Sites will be awarded points for prescribing opioids within set thresholds based on type of birth for cases between 01/01/2025 and 09/30/2025. Patients with opioid use disorder will be excluded (as defined by the data element, "History of Opioid Use Disorder" and an answer of "Yes" in the OBI Database). The full 5 points will be awarded to the site for prescribing 0 total OME for ≥ 95% of vaginal births with no advanced laceration (defined as a 3rd of 4th degree laceration), prescribing ≤ 38 total OME for ≥ 90% of vaginal births with advanced laceration, and prescribing ≤ 113 total OME for ≥ 90% of cesarean births. If only 2 of 3 metrics are met, the site will be awarded 3 points. If a site does not have cases in the denominator of a birth type category, full points may still be attained if compliance is met for the other birth type categories.
Measure #8: Health Equity	**Race-Ethnicity Variable:** The metric seeks to improve the quality of race-ethnicity data in the OBI registry, thereby enabling meaningful goal setting to correct perinatal outcomes. The site will be awarded 2 points for reducing the missingness (i.e., "Not Documented") of the data element "Race and Ethnicity" to ≤ 2%.
	Patient Voices: Collecting patient survey data allows OBI to incorporate patient feedback directly into performance measurement and quality improvement activities, thereby promoting patient-centeredness and health equity. Sites will be awarded 5 points for shifting their survey collection to an inpatient model prior to the end of the measurement period. The site's Response Rate (RR) in only Q4 2025 must be ≥ 4% to ensure the successful transition to an inpatient model. Email address collection will continue while sites transition to an inpatient mode. Sites will be awarded 3 points for collecting email addresses from 01/01/25 - 09/30/25 for ≥ 90% of eligible cases OR improvement from baseline is at least ≥ 10 absolute percentage points. Baseline is calculated using data from 01/01/2024 - 09/30/2024. RR for surveys collected for births between 01/01/2025 and 09/30/2025 are not tied to points.

Measure #9: Quality Initiative Projects	**Quality Initiative Projects**: OBI recognizes that sites may have differing priorities and a singular project may not satisfy each site in the collaborative. Sites will submit their project preference in rank order to the Coordinating Center by 12/13/2024 via the OBI Designation Form. Sites will then receive their project assignment by 01/17/2025 for work to be completed by the end of the measurement period.
	Induction of Labor Guidance: Sites assigned to the Induction of Labor Guidance project will prepare to implement induction of labor management practices. The practices will focus on dual-agent ripening, cessation of futile interventions in early labor, early amniotomy, and exam frequency. Sites participating in this project will aid the Coordinating Center in determining best practices and developing materials to promote the use of evidence-based practices. Sites assigned to the Induction of Labor Guidance Project will 1) designate a Project Champion (the Project Champion does not have to be on the OBI Champion Team) AND 2) the Project Champion must participate in 2/ 3 project-specific workgroup meetings in the measurement period. Sites will be awarded 10 points when all activities are satisfied.
	Severe Obstetric Complications PC-07 eCQM Optimization: Sites assigned to this project will work on how best to code visits with severe obstetric complications and interpret eCQM data. Sites participating in this project will aid the Coordinating Center in determining best practices and disseminate guidance to the other sites participating in the collaborative. Sites assigned to the Severe Obstetric Complications PC-07 eCQM Optimization Project will 1) designate a Project Champion (the Project Champion does not have to be on the OBI Champion Team) AND 2) the Project Champion must participate in 2/ 3 project-specific workgroup meetings in the measurement period. Sites will be awarded 10 points when all activities are satisfied.
	Social Determinants of Health Screening and Referral: Sites assigned to this project will work on connecting or preparing to connect patients to needed services in their community by integrating their electronic health record system with Michigan 2-1-1. Sites participating in this project will aid the Coordinating Center in determining best practices and disseminate guidance to the other sites participating in the collaborative. Sites assigned to the Social Determinants of Health Screening and Referral Project will 1) designate a Project Champion (the Project Champion does not have to be on the OBI Champion Team) AND an IT Champion 2) each Champion must participate in 2/ 3 project-specific workgroup meetings in the measurement period. Sites will be awarded 10 points when all activities are satisfied.