2021 Hospital Pay-for-Performance Program (for peer groups 1 through 4)

Hospital CQI Performance Index Scorecards

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2021 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 1) **Cohort 1 - 4 (2015 - 2019 Start)** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
1	5%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at meetings. Three total meetings with six opportunities for attendance.**	
		5 - 6 / 6 Meetings	5
		4 or Less Meetings	0
2	5%	**Attend Webex ASPIRE Quality Committee 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 Jan. - Nov. and by the 2nd Wednesday of the month for Dec.**	
		10 - 12/12 Months	5
		9 or Less Months	0
4	5%	**Site Based Quality Meetings: Sites to hold an onsite in-person or virtual meeting following the three ASPIRE Collaborative meetings to discuss the data and plans for quality improvement at their site**	
		3 Meetings	5
		2 or less Meeting	0
5	25%	**Performance Measure: Cross Cohort Measure Sustainability (SUS 01) percentage of cases with mean fresh gas flow (FGF) equal to, or less than 3L/min, during administration of halogenated hydrocarbons and/or nitrous oxide (cumulative score Jan. 1, 2021 - Dec. 31, 2021)**	
		17 - 19 sites (out of 19 total sites) ≥ 85%	25
		17 - 19 sites (out of 19 total sites) ≥ 80%	15
		17 - 19 sites (out of 19 total sites) ≥ 75%	10
		Less than 16 sites (out of 19 total sites) < 75%	0
6	25%	**Performance Measure: Blood Pressure (BP 03) percentage of cases where intraoperative hypotension (MAP < 65 mmHg) was sustained for less than 15 minutes (cumulative score Jan. 1, 2021 - Dec. 31, 2021)**	
		Performance is ≥ 87%	25
		Performance is ≥ 85%	15
		Performance is ≥ 80%	10
		Performance is < 80%	0
7	30%	**Site Directed Measure: Sites choose a measure they are performing below national ASPIRE threshold by Dec. 11, 2020 (cumulative score Jan. 1, 2021 through Dec. 31, 2021)**	
		Performance is ≥90%; ≤10%; ≤5%	30
		Performance is ≥85%; ≤15%; ≤10%	20
		Performance is ≥80%; ≤20%; ≤15%	10
		Performance is <80%; >20%; >15%	0

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

2021 Performance Index Scorecard

Measure Explanation: Cohorts 1 – 4 (2015 – 2019 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 2021. There are three total meetings with six opportunities for attendance:

1. MSQC / ASPIRE Meeting: Friday, April 23, 2021
2. ASPIRE Collaborative Meeting: Friday, July 16, 2021
3. MPOG Retreat: Friday, October 8, 2021

Measure #2: There will be six ASPIRE Quality Committee e-meetings in 2021. One representative (ASPIRE Quality Champion or ACQR) must attend the meetings:

1. Monday, January 25, 2021
2. Monday, March 22, 2021
3. Monday, May 24, 2021
4. Monday, July 26, 2021
5. Monday, September 27, 2021
6. Monday, November 22, 2021

Measure #3: Maintenance Schedule located on MPOG website in the resources tab of the quality section.

Measure #4: The site is expected to schedule a local meeting either in-person or virtually following each ASPIRE/MPOG collaborative meeting (dates in Measure #1) 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 cross cohort sustainability measure (SUS 01): Percentage of cases with mean fresh gas flow (FGF) equal to, or less than 3L/min, during administration of halogenated hydrocarbons and/or nitrous oxide (cumulative score January 1, 2021 - December 31, 2021). Points will be determined across 19 Cohort 1 – 4 dashboards on the following scale:

- 25 Points: 17 – 19 sites are performing equal to or above 85%, all 19 sites will receive 25 points
- 15 Points: 17 – 19 sites are performing equal to or above 80%, all 19 sites will receive 15 points
- 10 Points: 17 – 19 sites are performing equal to or above 75%, all 19 sites will receive 10 points
- 0 Points: 16 sites or less are performing less than 75%, all 19 sites will receive 0 points

Measure #6: Sites will be awarded points for compliance with the blood pressure measure BP 03: Percentage of cases where intraoperative hypotension (MAP < 65 mmHg) was sustained for less than 15 minutes (cumulative score January 1, 2021 through December 31, 2021). Points will be determined on the following scale:

- 25 Points: Performance is ≥ 87%
- 15 Points: Performance is ≥ 85%
- 10 Points: Performance is ≥ 80%
- 0 Points: Performance is < 80%

Measure #7: Sites will choose a measure they are performing below the ASPIRE threshold. Sites must submit the measure to the coordinating center by Friday, December 11, 2020 for review and approval (cumulative score January 1, 2021 through December 31, 2021). Points will be determined on the following scale:

<u>Measures with Threshold 90%</u> <u>Measure</u> <u>with Threshold 10%</u> <u>Measures with Threshold 5%</u>

- 30 Points: Performance is ≥90%•30 Points: Performance is ≤10% •30 Points: Performance is ≤5%
- 20 Points: Performance is ≥85%• 20 Points: Performance is ≤15%•20 Points: Performance is ≤10%
- 10 Points: Performance is ≥80%• 10 Points: Performance is ≤20%•10 Points: Performance is ≤15%
- 0 Points: Performance is <80% • 0 Points: Performance is >20% • 0 Points: Performance is >15%

2021 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard (pg.1 of 2) **Cohort 5 (2020 Start)** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at meetings. Three total meetings with six opportunities for attendance.**	
		5 - 6 / 6 Meetings	20
		4 / 6 Meetings	10
		3 or Less Meetings	0
2	10%	**Attend Webex ASPIRE Quality Committee Meetings: ASPIRE Quality Champion or ACQR attendance across six meetings**	
		6 Meetings	10
		5 Meetings	5
		4 or Less Meetings	0
3	20%	**ACQR/ASPIRE Quality Champion perform data validation, case validation and submit data by the third Wednesday of each month for Jan. - Nov. and by the second Wednesday of the month for Dec.**	
		11 / 12 Months	20
		10 / 12 Months	10
		9 / 12 Months	5
		8 Months or Less	0
4	10%	**ASPIRE Quality Champion and ACQR monthly meetings**	
		12 / 12 Months	10
		11 / 12 Months	5
		10 / 12 Months	0
5	10%	**Site based meetings: Sites to hold an onsite meeting following the ASPIRE Collaborative meetings to discuss the data and quality improvement**	
		3 Meetings	10
		2 Meetings	5
		1 or Less Meetings	0
6	10%	**Quality Improvement project presentation at ASPIRE monthly Quality Committee e-meeting or ASPIRE Collaborative Meeting**	
		Yes	10
		No	0
7	10%	**Performance Measure: Pulmonary (PUL 01) Percentage of cases with median tidal volumes less than 10ml/kg (cumulative score Jan. 1, 2021 through Dec. 31, 2021)**	
		Performance is ≥ 90%	10
		Performance is < 90%	0

2021 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard (pg.2 of 2) **Cohort 5 (2020 Start)** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
8	10%	**Site Directed Measure: Sites choose a measure they are performing below national ASPIRE threshold by Dec. 11, 2020 (cumulative score Jan. 1, 2021 through Dec. 31, 2021)**	
		Performance ≥90%; ≤10%; ≤5% by month 12	10
		Performance <90%; >10%; >5% but shows improvement month 1 to 12	5
		Performance <90%; >10%; >5% and shows no improvement month 1 to 12	0

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

2021 Performance Index Scorecard

Measure Explanation: Cohort 5 (2020 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 2021. There are three total meetings with six opportunities for attendance:

4. MSQC / ASPIRE Meeting: Friday, April 23, 2021
5. ASPIRE Collaborative Meeting: Friday, July 16, 2021
6. MPOG Retreat: Friday, October 8, 2021

Measure #2: There will be six ASPIRE Quality Committee e-meetings in 2021. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2021 meetings:

7. Monday, January 25, 2021
8. Monday, March 22, 2021
9. Monday, May 24, 2021
10. Monday, July 26, 2021
11. Monday, September 27, 2021
12. Monday, November 22, 2021

Measure #3: The Maintenance Schedule is located on the MPOG website in the resources tab of the quality section.

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

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

Measure #6: A designated member of the site will present a 'Quality Improvement (QI) Story' at either a ASPIRE Collaborative meeting or at one of the monthly Quality Committee e-meetings. The presentation will be approximately 15-minutes and will highlight the important QI work being done at the site. Presentations can be made by the ASPIRE Champion, ACQR or a site designee that is confirmed by the ASPIRE Coordinating Center.

Measure #7: Sites will be awarded points for compliance with the pulmonary (PUL 01) measure: Percentage of cases with median tidal volumes less than 10ml/kg (cumulative score January 1, 2021 through December 31, 2021). Points will be determined on the following scale:

- 10 Points: Performance is ≥ 90%
- 0 Points: Performance is < 90%

Measure #8: Sites will choose a measure they are performing below the ASPIRE threshold (cumulative score January 1, 2020 through December 31, 2020). Sites must submit the measure to the Coordinating Center by Friday, December 11, 2020 for review and approval, report log is located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section. Points will be determined on the following scale:

Measures with Threshold 90%

- 10 Points: Performance is ≥90%
- 5 Points: Performance is <90% but shows improvement from month 1 to 12
- 0 Points: Performance is <90% and shows no improvement from month 1 to 12

Measures with Threshold 10%

- 0 Points: Performance is ≤10%
- 5 Points: Performance is >10% but shows improvement from month 1 to 1
- 0 Points: Performance is >10% and shows no improvement from month 1 to 12

Measures with Threshold 5%

- 10 Points: Performance is ≤5%
- 5 Points: Performance is >5% but shows improvement from month 1 to 12
- 0 Points: Performance is >5% and shows no improvement from month 1 to 12

2021 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard (Pg. 1of 1) **Cohort 6 (2021 Start)** Measurement Period: 01/01/2021 - 12/31/2021			
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.**	
		5 - 6 / 6 Meetings	20
		4 / 6 Meetings	10
		3 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, 2021	10
		Submitted by May 1, 2021	5
		Submitted after May 1, 2021	0
4	10%	**Hiring an ACQR**	
		ACQR Start Date on or before February 1, 2021	10
		ACQR Start Date on or before April 1, 2021	5
		ACQR Start Date on or after April 2, 2021	0
5	20%	**Timeliness of data submission (with Case by Case Validation and Data Diagnostic Attestations Completed)**	
		Submitted by September 1, 2021	20
		Submitted by December 1, 2021	10
		Submitted after December 1, 2021	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)

2021 Performance Index Scorecard

Measure Explanation: Cohort 6 (2021 Start)

Measure #1: The ASPIRE Quality Champion (or a designated representative who must be an anesthesiologist) and the Anesthesiology Clinical Quality Reviewer (ACQR), combined must attend ASPIRE Collaborative Meetings in 2021. There are three total meetings with six opportunities for attendance, 2021 meeting dates:

1. MSQC / ASPIRE Meeting: Friday, April 23, 2021
2. ASPIRE Collaborative Meeting: Friday, July 16, 2021
3. MPOG Retreat: Friday, October 8, 2021

Measure #2: There will be six ASPIRE Quality Committee e-meetings in 2021. One representative (ASPIRE Quality Champion or ACQR) must attend the meetings. The 2021 meeting dates are as follows:

1. Monday, January 25, 2021
2. Monday, March 22, 2021
3. Monday, May 24, 2021
4. Monday, July 26, 2021
5.
6. Monday, September 27, 2021
7. Monday, November 22, 2021

Measure #3: All the following regulatory/legal documentation must be finalized by April 1, 2021:

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 February 1, 2021. 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, 2021. MPOG minimum data requirements can be found on the MPOG website.

Measure #6: Data must be of high quality before the September 1, 2021 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.

2021 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) **PCI & VS Combined** Measurement Period: 01/01/2021 - 12/31/2021				
Measure #	Weight	Measure Description	PCI Points	VS Points
1	10	**Meeting Participation - Clinician Lead**		
		2 Meetings (Vascular Surgery); 3 Meetings (PCI)	5	5
		1 Meeting (Vascular Surgery); 2 Meetings (PCI)	2.5	2.5
		Did not participate	0	0
2	5	**Data Coordinator Expectations (Vascular Surgery: Includes 1 year follow-up ≥80%)**		
		Meets all expectations (1 Year FU ≥80%)	2.5	2.5
		Meets most expectations (1 Year FU 60-79%)	1	1
		Does not meet expectations (1 Year FU <60%)	0	0
3	5	**Internal Case Reviews**		
		Submitted reviews for ≥90% of cases	2.5	2.5
		Submitted reviews for <90% of cases	0	0
4	5	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**		
		Submitted reviews for 100% of cases	2.5	2.5
		Submitted reviews for <100% of cases	0	0
5	12.5	**Vascular Surgery Collaborative Goal - Statin at Discharge for Open Bypass, CEA* and CAS^ Discharges**		
		≥95%	NA	12.5
		93% - <95%	NA	10
		90% - <93%	NA	5
		<90%	NA	0
6	10	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 10 opioid pills for opioid naïve patients with EVAR† at discharge**		
		≥80%	NA	10
		75% - <80%	NA	7.5
		70% - <75%	NA	5
		<70%	NA	0
7	10	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 10 opioid pills for opioid naïve patients with CEA* at discharge**		
		≥80%	NA	10
		75% - <80%	NA	7.5
		70% - <75%	NA	5
		<70%	NA	0
8	12.5	**PCI Performance Goal - Peak Intra-Procedure ACT‡ recorded**		
		≥90%	12.5	NA
		80% - <90%	10	NA
		70% - <80%	5	NA
		<70%	0	NA

2021 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 2) **PCI & VS Combined** Measurement Period: 01/01/2021 - 12/31/2021				
Measure #	Weight	Measure Description	PCI Points	VS Points
9	10	**PCI Performance Goal - Percent of cases with peak ACT‡ ≥350 seconds for Heparin-only cases**		
		≤15%	10	NA
		>15 - 25%	7.5	NA
		>25% - 35%	5	NA
		>35%	0	NA
10	10	**NEW - PCI Performance Goal - Percent of cases with Air Kerma dose ≥5 Gray**		
		≤2%	10	NA
		>2% - 3%	7.5	NA
		>3% - 4%	5	NA
		>4%	0	NA
11	10	**NEW - PCI Collaborative Goal - Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).**		
		≥50%	10	NA
		40% - <50%	5	NA
		<40%	0	NA

2021 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 1) **Vascular Surgery Only** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
1	15	**Meeting Participation - Clinician Lead**	
		2 Meetings	15
		1 Meeting	10
		Did not participate	0
2	10	**Data Coordinator Expectations (Includes 1 year follow-up ≥80%)**	
		Meets all expectations (1 Year FU ≥80%)	10
		Meets most expectations (1 Year FU 60-79%)	5
		Does not meet expectations (1 Year FU <60%)	0
3	10	**NEW - Internal Case Reviews**	
		Submitted reviews for ≥90% of cases	10
		Submitted reviews for <90% of cases	0
4	10	**NEW - Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
5	20	**Vascular Surgery Collaborative Goal - Statin at Discharge for Open Bypass, CEA* and CAS^ Discharges**	
		≥95%	20
		93% - <95%	15
		90% - <93%	10
		<90%	0
6	17.5	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 10 opioid pills for opioid naïve patients with EVAR† at discharge**	
		≥80%	17.5
		75% - <80%	15
		70% - <75%	10
		<70%	0
7	17.5	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 10 opioid pills for opioid naïve patients with CEA* at discharge**	
		≥80%	17.5
		75% - <80%	15
		70% - <75%	10
		<70%	0

6 sites participate in Vascular Surgery only
*CAS=carotid artery stent
^CEA=carotid endarterectomy
†EVAR=endovascular aneurysm repair

2021 Blue Cross Blue Shield of Michigan Cardiovascular Consortium Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 1) **PCI Only** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
1	15	**Meeting Participation - Clinician Lead**	
		3 Meetings	15
		2 Meetings	10
		Did not participate	0
2	7.5	**Data Coordinator Expectations**	
		Meets all expectations	7.5
		Meets most expectations	5
		Does not meet expectations	0
3	7.5	**Internal Case Reviews**	
		Submitted reviews for ≥90% of cases	7.5
		Submitted reviews for <90% of cases	0
4	7.5	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	7.5
		Submitted reviews for <100% of cases	0
8	17.5	**PCI Performance Goal - Peak Intra-Procedure ACT‡ recorded**	
		≥90%	17.5
		80% - <90%	15
		70% - <80%	10
		<70%	0
9	15	**PCI Performance Goal - Percent of cases with peak ACT‡ ≥350 seconds for Heparin-only cases**	
		≤15%	15
		>15 - 25%	10
		>25% - 35%	5
		>35%	0
10	15	**NEW - PCI Performance Goal - Percent of cases with Air Kerma dose ≥5 Gray**	
		≤2%	15
		>2% - 3%	10
		>3% - 4%	5
		>4%	0
11	15	**NEW - PCI Collaborative Goal - Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).**	
		≥50%	15
		40% - <50%	10
		<40%	0

5 sites participate in PCI only
‡ACT=activated clotting time
**eGFR=estmated glomerular filtration rate
^^NYHA= New York Heart Association heart failure class
††STEMI=ST elevated myocardial infarction

2021 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) **Existing Sites** Measurement Period: 11/12/2020 - 11/10/2021 (PICC Insertions/Hospital Discharges)			
Measure #	Weight	Measure Description	Points
1	5	**Timeliness of HMS Data [1]**	
		On time ≥ 95%	5
		On time < 95%	0
2	5	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, AND audit case corrections completed by due date	5
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed OR audit case corrections not completed by due date	0
3	10	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	10
		2 meetings	5
		1 meeting	0
		No meetings	0
4	10	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	10
		2 meetings	5
		1 meeting	0
		No meetings	0
5	10	**Increase Use of 5 Days of Antibiotic Treatment[6] in Uncomplicated CAP (Community Acquired Pneumonia) Cases[5] (i.e. reduce excess durations)**	
		≥ 50% uncomplicated CAP cases receive 5 days[6] of antibiotics OR ≥ 50% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[7]	10
		35-49% uncomplicated CAP cases receive 5 days[6] of antibiotics OR 25-49% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotic during the current performance year[7]	5
		< 35% uncomplicated CAP cases receive 5 days[6] of antibiotics AND < 25% relative increase during the current performance year[7]	0
6	10	**Reduce Fluoroquinolone Use[8] in Patients with a Positive Urine Culture[5]**	
		≤ 12% of positive urine culture cases receive non-preferred Fluoroquinolone	10
		13-16% of positive urine culture cases receive non-preferred Fluoroquinolone	5
		> 16% of positive urine culture cases receive non-preferred Fluoroquinolone	0
7	10	**Reduce Use of Antibiotics[9] in Patients with ASB (Asymptomatic Bacteriuria) [5,10]**	
		≤ 15% of positive urine culture cases treated with an antibiotic are ASB cases	10
		16-25% of positive urine culture cases treated with an antibiotic are ASB cases	5
		> 25% of positive urine culture cases treated with an antibiotic are ASB cases	0

2021 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 2) **Existing Sites** Measurement Period: 11/12/2020 - 11/10/2021 (PICC Insertions/Hospital Discharges)			
Measure #	Weight	Measure Description	Points
8	15	**Reduce PICCs (Peripherally-Inserted Central Catheters) in for ≤ 5 Days (excluding deaths)[5]**	
		≤ 10% of PICC cases in for ≤ 5 Days	15
		11-15% of PICC cases in for ≤ 5 Days	10
		> 15% of PICC cases in for ≤ 5 Days	0
9	15	**Increase Use of Single Lumen PICCs in Non-ICU (Intensive Care Unit) Cases[5]**	
		≥ 80% of non-ICU PICC cases have a single lumen	15
		75-79% of non-ICU PICC cases have a single lumen	10
		< 75% of non-ICU PICC cases have a single lumen	0
10	10	**Reduce PICCs in Patients with eGFR (estimated glomerular filtration rate) < 45 (without Nephrology approval)[11,12]**	
		≤ 5% **collaborative-wide average** of PICC cases have eGFR < 45 without Nephrology approval	10
		> 5% **collaborative-wide average** of PICC cases have eGFR < 45 without Nephrology approval	0
		Total (Max points=100)	

[1] Registry data assessed at year end based on data submitted during calendar year 2021. All required cases must be completed by year end. Final due date will be announced by Coordinating Center. Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[2] Assessed based on scores received for site audits conducted during calendar year 2021. Scores are averaged if multiple audits take place during the year.

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

[4] Based on all meetings scheduled during calendar year 2021. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] Assessed at year end based on final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2021. 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 hospitals current performance, their performance relative to collaborative as a whole, and reflects the improvement work each hospital is doing over a given performance year.

[6] Considered appropriate if 6 or few days of antibiotic treatment

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

[8]Non preferred Fluoroquinolone use is either due to treatment of Asymptomatic Bacteriuria (ASB) or treatment of UTI when there is a safer oral antibiotic alternative

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

[10] Out of all positive urine culture cases

[11]Assessed based on all patients with eGFR available. If eGFR is not entered into the data registry, the Coordinating Center will calculate it if all elements necessary to do the calculation are available.

[12] Assessed at year end based on the collaborative-wide average for the final quarter of data entered (per the data collection calendar) in the data registry during the calendar year 2021. This is different than the other performance measures in the index, which are applied to each individual hospital. New hospitals joining HMS in 2020 and 2021 will not be used to calculate the collaborative average.

2021 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 1) **Cohort 2020 (Sites Starting in 2020)** Measurement Period: 11/12/2020 - 11/10/2021 (PICC Insertions/Hospital Discharges)			
Measure #	Weight	Measure Description	Points
1	25	**Timeliness of HMS Data[1]**	
		On time ≥ 95%	15
		On time < 95%	0
2	25	**Completeness[1] and Accuracy[2,3]of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, AND audit case corrections completed by due date	15
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed OR audit case corrections not completed by due date	0
3	25	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
4	25	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
5	15	**PICC Quality Improvement[6]**	
		Convene at least quarterly vascular access committee meetings to review PICC use and outcomes **AND** use MAGIC or a related decision-tool to determine PICC appropriateness	15
		Convene a vascular access committee to review PICC use and outcomes **OR** use MAGIC or a related decision-tool to determine PICC appropriateness	10
		No vascular access committee meetings convened AND no use of MAGIC or a related decision-tool to determine PICC appropriateness	0
6	10	**Antimicrobial Quality Improvement- Guidelines[6]**	
		Submit UTI and pneumonia guidelines developed locally[5]	10
		Local UTI and pneumonia guidelines not submitted	0
7	5	**Antimicrobial Quality Improvement- Intervention Description[6]**	
		Submit a description of one intervention you have done, are doing or plan on doing for each • Decrease antibiotic treatment for patients with uncomplicated CAP to 5 days • Decrease treatment of ASB • Decreasing inappropriate Fluoroquinolone (FQ) use for UTI	5
		Description of interventions not submitted	0
		Total (Max points=100)	

[1] Registry data assessed at year end based on data submitted during calendar year 2021. All required cases must be completed by year end. Final due date will be announced by Coordinating Center. Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[2] Assessed based on scores received for site audits conducted during calendar year 2021. Scores are averaged if multiple audits take place during the year.

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

[4] Based on all meetings scheduled during calendar year 2021. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] CAP Institutional guidelines should:

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

UTI Institutional guidelines should:

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

[6] In December 2021/January 2022, HMS will distribute a survey to all abstractors/quality leads to obtain the information required for this measure. It is the abstractor/quality leads responsibility to work with key stakeholders who are involved with and lead the quality improvement work at each hospital related to the area of assessment.

2021 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 1) **Cohort 2021 (Sites Starting in 2021)** Measurement Period: 01/01/2021-11/10/2021			
Measure #	Weight	Measure Description	Points
1	25	**Timeliness of HMS Data [1]**	
		On time ≥ 95%	25
		On time < 95%	0
2	25	**Completeness[1] and Accuracy[2,3]of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, AND audit case corrections completed by due date	25
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed OR audit case corrections not completed by due date	0
3	25	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	25
		2 meetings	13
		1 meeting	0
		No meetings	0
4	25	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	25
		2 meetings	13
		1 meeting	0
		No meetings	0
		Total (Max points=100)	

[1] Registry data assessed at year end based on data submitted during calendar year 2021. All required cases must be completed by year end. Final due date will be announced by Coordinating Center. Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[2] Assessed based on scores received for site audits conducted during calendar year 2021. Scores are averaged if multiple audits take place during the year.

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

[4] Based on all meetings scheduled during calendar year 2021. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

2021 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 4) **I-MPACT Year 5/6 (Cohorts 1-5)** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
1	5%	**Project Associate Only Conference Calls (Participation) - 4 calls per year[1,2]**	
		Project Associate misses no more than 1/4 required calls per calendar year.	5pts
		Project Associate misses no more than 2/4 required calls per calendar year.	2pts
		Project Associate misses >2/4 required calls per calendar year.	0pts
2	5%	**Collaborative-wide Conference Calls (Participation) - 4 calls per year[1,2]**	
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, present on 4/4 calls per calendar year.	5pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, present on 3/4 calls per calendar year.	2pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, on <3 required calls per calendar year.	0pts
3	5%	**Collaborative-wide meetings (Participation) - 3 meetings per year[1,3]**	
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at all three meetings per calendar year.	5pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at 2 of 3 meetings per calendar year.	2pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at <2 of 3 meetings per calendar year.	0pts
4	5%	**Provider champion measure[4]**	
		Each hospital and each PO in the cluster identifies a Provider Champion (MD, DO, NP, PA) and provides their information to I-MPACT by January 15, 2021. Additionally, all Provider Champions have answered an annual survey administered by the I-MPACT CC by the required deadline.	5pts
		One or more organizations in the cluster fails to identify a Provider Champion (MD, DO, NP, PA) by January 15, 2021 and/or one or more provider champions fails to respond to the annual survey by the required deadline.	0pts
5	5%	**Timely Submission of Data (Participation)**	
		The required # of cases for the cluster is submitted on time 11 of 12 months.	5pts
		The required # of cases for the cluster is submitted on time 10 of 12 months.	2pts
		The required # of cases for the cluster is submitted on time <9 of 12 months.	0pts
6	5%	**Data Accuracy (Participation)**	
		Cluster achieves ≥ 90% accuracy on annual audit(s).	5pts
		Cluster achieves >80% but <90% data accuracy on annual audit(s).	2pts
		Cluster achieves <80% data accuracy on annual audit(s).	0pts

2021 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 4) **I-MPACT Year 5/6 (Cohorts 1-5)** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
7	10%	**Intervention Deployment for target population (Performance)[5]**	
		Cluster implements and maintains interventions on 80% or > of the target population, in 4/4 quarters throughout 2020, as measured by registry data entered during January-December 2021.	10pts
		Cluster implements and maintains interventions on 80% or > of the target population, in 3/4 quarters of 2021, as measured by registry data entered during January-December 2021.	4pts
		Cluster fails to implement interventions in 80% or > of the target population in a minimum of 3/4 quarters of 2021, as measured by registry data entered during January-December 2021.	0pts
8	5%	**Site Specific QI Log (Participation)**	
		Both QI logs completed/updated fully and submitted on time AND changes requested by I-MPACT CC submitted on time.	5pts
		1 or more QI logs completed/updated fully and submitted ≤7 calendar days past initial deadline and/or changes requested by I-MPACT CC submitted ≤7 calendar days past deadline.	2pts
		1 or more QI logs completed/updated fully and submitted >7 calendar days past initial deadline and/or changes requested by I-MPACT CC submitted >7 calendar days past deadline.	0pts
9	5%	**Patient/Caregiver Engagement or (SNF Clusters only) SNF Advisor Engagement (Participation)**	
		Cluster provides at least 2 NEW examples of patient/caregiver/SNF advisor utilization/engagement with submission of each QI log (exclusive of advisors coming to collaborative-wide meetings or participating in monthly calls).	5pts
		Cluster provides only one NEW example of patient/caregiver/SNF advisor utilization/engagement on 1 or more QI log submissions (exclusive of advisors coming to collaborative-wide meetings or participating in monthly calls).	2pts
		Cluster fails to provide any new examples of patient/caregiver/SNF advisor utilization/engagement on 1 or more QI log submissions (exclusive of advisors coming to collaborative-wide meetings or participating in monthly calls).	0pts
10	20%	**Collaborative-wide Goal: Provider Follow-up Visits (Performance)** [6,7,10]	
		Based on data entered into the registry during January-December 2021, the collaborative achieves the required 20% increase in follow-up appointments using the formula below[6], compared to the average from data entered during 2020.	20pts
		Based on data entered into the registry during January-December 2021, collaborative achieves ≥ 15% but < 20% of the required increase in follow-up appointments for the year, based on the formula below[6], compared to the average from data entered during 2020.	10pts

2021 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard (pg. 3 of 4) **I-MPACT Year 5/6 (Cohorts 1-5)** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
		Based on data entered into the registry during January-December 2021, collaborative achieves ≥ 10% but < 15% of the required increase in follow-up appointments for the year, based on the formula below[6], compared to the average from data entered during 2020.	4pts
		Based on data entered into the registry during January-December 2021, collaborative achieves < 10% of the required increase in follow-up appointments for the year, based on the formula below[6], compared to the average from data entered during January-December 2020 OR rate of PCP follow-up visits drops compared to the average from data entered during 2020.	0pts
11	15%	**Emergency Department Utilization (Performance)[8,10]**	
		Based on data entered into the registry during January-December 2021, Cluster achieves a 5% relative reduction in ED utilization in comparison to the average from data entered during 2020 (ex. If ED utilization is 23% then a 5% relative reduction would be 1.15% resulting in a new ED utilization rate of 21.85%).	20pts
		Based on data entered into the registry during January-December 2021, Cluster achieves a ≥3 but <5% relative reduction in ED utilization each year in comparison to the average from data entered during 2020 (ex. If ED utilization is 23% then a relative reduction of ≥3 but <5% would equal between .69% and 1.14% resulting in a new ED utilization rate between 22.31% and 21.86%).	10pts
		Based on data entered into the registry during January-December 2021, Cluster achieves a >0 and <3% relative reduction in ED utilization each year in comparison to the average from data entered during 2020 (ex. If ED utilization is 23% then a relative reduction of >0 and <3% would equal between .01% and 0.68% resulting in a new ED utilization rate between 22.99% and 22.32%).	4pts
		Based on data entered into the registry during January-December 2021, Cluster maintains ED utilization (e.g. 0% relative reduction in ED utilization) in comparison to the average from data entered during 2020 OR ED utilization rate increases over the average for data entered during January-December 2020.	0pts
12	15%	**Readmission (Performance)[9,10]**	
		Based on data entered into the registry during January-December 2021, Cluster achieves a 5% relative reduction in 30-day all-cause readmission rates each year in comparison to the average from data entered during 2020. (ex. If readmission rate is 23% then a 5% relative reduction would be 1.15% resulting in a new readmission rate of 21.85%).	20pts
		Based on data entered into the registry during January-December 2021, Cluster achieves a ≥3% but <5% relative reduction in 30-day all-cause readmission rates each year in comparison to the average from data entered 2020. (ex. If readmission rate is 23% then a relative reduction of ≥3 but <5% would equal between .69% and 1.14% resulting in a new readmission rate between 22.31% and 21.86%).	10pts

2021 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard (pg. 4 of 4) **I-MPACT Year 5/6 (Cohorts 1-5)** Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
		Based on data entered into the registry during January-December 2021, Cluster achieves a >0 but < 3% relative reduction in 30-day all-cause readmission rates each year in comparison to the average from data entered during 2020 (ex. If readmission rate is 23% then a relative reduction of >0 and <3% would equal between .01% and 0.68% resulting in a new readmission rate between 22.99% and 22.32%).	4pts
		Based on data entered into the registry during January-December 2021, Cluster achieves a 0% relative reduction in 30-day readmission rates each year in comparison to the average from data entered during 2020 OR readmission rate increases over the average for data entered during 2020.	0pts

I-MPACT Footnotes

[1]If a cluster only has one Project Associate (PA), they must be present for calls and meetings to fulfill the requirements above. If a cluster has more than one PA (i.e. the hospital has their own and the PO has their own), then at least one must be present for calls and meetings to fulfill the requirements above. Participants must be present for 75% of the call to get credit for attendance.

[2] Required participants must be present for 75% of the call for it to get credit for attendance.

[3]Required participants must be present for 75% of the meeting to get credit for attendance.

[4]Provider Champions are expected to attend local I-MPACT cluster meetings, providing expertise and actively engaging in the work related to I-MPACT while advocating for change in clinical practices and processes with organizational leadership when needed. Hospital Provider Champions will be surveyed annually regarding their engagement with the I-MPACT Physician Organization (PO) partner(s), their efforts to incorporate Transition of Care elements in discharge documentation and challenges/opportunities in transitions of care. PO Provider Champions will be surveyed annually regarding their engagement with the I-MPACT hospital partner(s), their efforts to improve 7-day follwo-up appointments scheduled & kept, and challenges/opportunities in transitions of care. If an organization selects multiple Provider Champions, only one per organization will need to complete the survey to achieve full points.

[5]The numerator for this measure is patients entered into the registry during the calendar year who were scheduled to receive a 7-day follow-up appointment or were identified as receiving any other I-MPACT related interventions (response options: yes, screened but didn't qualify); the denominator is all patients entered into the registry during the calendar year.

[6]Provider can be Primary Care Physician, Specialist, or NP/PA.

[7] To calculate this metric, determine the difference between the collaborative's rate for patients ***abstracted*** during 2020 and the threshold of 90%; then add 20% of that difference to the 2020 rate to determine the goal for improvement in 2021.

Example: if baseline rate of f/u appointments is 20%, then the formula would be: 90%-20%=70%; then calculate 20% of that 70% difference = 14%; so the collaborative's target goal for the next year would be 20% + 14% for a total f/u appointment rate of 34%.

The numerator will be all patients in the registry that were abstracted during the calendar year and who were scheduled to see a provider within 7 days of discharge from the hospital or, for the SNF target population, within 7 days of discharge from the SNF.

The denominator for this metric will be all patients in the registry that were abstracted during the calendar year with a discharge destination of Home plus those with a discharge destination of Assisted Living.

[8]Numerator will count patients abstracted for the registry during 2021 only once i.e. if one patient has multiple ED visits, they will be counted only once. Numerator will be based only on registry data for treat and release ED visits within 30 days of discharge from the index admission. Patients abstracted during the calendar year going to all discharge destinations will be included in the denominator.

Comparison will be made to the average ED visit rate for all registry patients abstracted during the prior year.

[9]Numerator will count patients abstracted for the registry during 2021 only once i.e. if one patient has multiple unplanned readmissions, they will be counted only once. Patients abstracted during the calendar year going to all discharge destinations will be included in the denominator. Planned readmissions will be excluded. Unplanned readmissions during the 30-day period that follow a planned readmission are counted in the outcome.

Comparison will be made to the average readmission rate for all registry patients abstracted during the prior year.

[10]Calculation of 2020 rate will exclude patients discharged March - June 2020 (cases abstracted during June-September 2020) during the peak COVID-19 period. Patients discharged October 2019 - February 2020 & July - September 2020 (cases abstracted January-May 2020 & October - December 2020) will be used to calculate 2020 rates used to determine goals for 2021. This is consistent with how final 2020 rates and 2020 P4P scores were calculated due to COVID-19.

2021 Michigan Anticoagulation Quality Improvement Initiative (MAQII) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) **Epic sites** Measurement Period: 1/01/2021-12/31/2021			
Measure #	Weight	Measure Description	Points
1	15	**Prompt retesting of extreme INRs (site level) (scoring based on 4th qtr performance)**	
		≥85% of extreme INRs are retested within 7 days	15
		75-84% of extreme INRs are retested within 7 days	10
		65-74% of extreme INRs are retested within 7 days	5
		<65% of extreme INRs are retested within 7 days	0
2	10	**Prompt retesting of extreme INRs (consortium level) (scoring based on 4th qtr performance)**	
		≥85% of extreme INRs are retested within 7 days	10
		75-84% of extreme INRs are retested within 7 days	5
		65-74% of extreme INRs are retested within 7 days	2
		<65% of extreme INRs are retested within 7 days	0
3	20	**DOAC Dashboard implementation**	
		DOAC Dashboard fully implemented and being used in the clinical setting	20
		Fully functional dashboard and clinical workflow	15
		Alpha version of Dashboard completed with approved preliminary clinical workflow	10
		Dashboard programming and development of clinical workflow underway	5
		Unable to begin dashboard programming	0
4	15	**Inappropriate aspirin use in warfarin patients**	
		≤7% of active patients	15
		8-9% of active patients	10
		10-11% of active patients	5
		>11% of active patients	0
5	10	**Extended International Normalized Ratio (INR) testing interval project**	
		≥75% of eligible patients received extended intervals	10
		55-74% of eligible patients received extended intervals	8
		35-54% of eligible patients received extended intervals	6
		15-34% of eligible patients received extended intervals	4
		<15% of eligible patients received extended intervals	0
6	10	**Quarterly Meetings participation -Clinical Champion**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0
7	10	**Quarterly Meeting participation – Coordinator/Lead Abstractor**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8

2021 Michigan Anticoagulation Quality Improvement Initiative (MAQII) Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 2) **Epic sites** Measurement Period: 1/01/2021-12/31/2021			
Measure #	Weight	Measure Description	Points
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0
8	10	**Completeness and Accuracy of data**	
		Critical data elements are complete/accurate in >90% of cases	10
		Critical data elements are complete/accurate in 70-89% of cases	5
		Critical data elements are complete/accurate in <70% of cases	0

2021 Michigan Anticoagulation Quality Improvement Initiative (MAQII) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 1) **Non-Epic sites** Measurement Period: 1/01/2021-12/31/2021			
Measure #	Weight	Measure Description	Points
1	20	**Prompt retesting of extreme INRs (site level) (scoring based on 4th quarter performance)**	
		≥85% of extreme INRs are retested within 7 days	20
		75-84% of extreme INRs are retested within 7 days	15
		65-74% of extreme INRs are retested within 7 days	10
		<65% of extreme INRs are retested within 7 days	0
2	10	**Prompt retesting of extreme INRs (consortium level) (scoring based on 4th quarter performance)**	
		≥85% of extreme INRs are retested within 7 days	10
		75-84% of extreme INRs are retested within 7 days	5
		65-74% of extreme INRs are retested within 7 days	2
		<65% of extreme INRs are retested within 7 days	0
3	20	**Inappropriate aspirin use in warfarin patients**	
		≤7% of active patients	20
		8-9% of active patients	15
		10-11% of active patients	10
		>11% of active patients	0
4	20	**Extended International Normalized Ratio (INR) testing interval project**	
		≥75% of eligible patients received extended intervals	20
		55-74% of eligible patients received extended intervals	15
		35-54% of eligible patients received extended intervals	10
		15-34% of eligible patients received extended intervals	5
		<15% of eligible patients received extended intervals	0
5	10	**Quarterly Meetings participation -Clinical Champion**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0
6	10	**Quarterly Meeting participation – Coordinator/Lead Abstractor**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0
7	10	**Completeness and Accuracy of data**	
		Critical data elements are complete/accurate in >90% of cases	10
		Critical data elements are complete/accurate in 70-89% of cases	5
		Critical data elements are complete/accurate in <70% of cases	0

Michigan Arthroplasty Registry Collaborative Quality Initiative Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) Measurement Period: 07/01/2020-06/30/2021			
Measure #	Weight	Measure Description	Points
1	10	**Collaborative Meeting Participation-Clinical Champions (01.01.2021-11.30.2021)**	
		3 out of 3 meetings attended	10
		2 out of 3 meetings attended	5
		<2 meetings attended	0
2	5	**Collaborative Meeting Participation-Clinical Data Abstractors (01.01.2021-11.30.2021)**	
		3 out of 3 meetings attended	5
		2 out of 3 meetings attended	2.5
		<2 meetings attended	0
3	10	**Accuracy and Completeness of Data Submission (audits 07.01.2020-06.30.2021)**	
		On time/complete ≥ 97-100% of the time	10
		On time/complete ≥85- <97% of the time	5
		On time/complete <85% of the time	0
4	5	**Site based Quality Meetings:(01.01.2021-11.30.2021)** 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 CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	5
5	10	**% of Opioid naïve THA patients in the COLLABORATIVE meeting the MARCQI Pain Optimization Prescribing guidelines (<240 OME)**	
		75% or greater of THA patients meet the guidelines of **240 OME** or less	10
		50-74% of THA patients prescribed **<240 OME**	5
		Less than 50% of patients meet the prescribing criteria	0
6	10	**% of Opioid naïve TKA patients in the COLLABORATIVE meeting the MARCQI Pain Optimization Protocol Prescribing guidelines (<320 OME)**	
		75% or greater of TKA patients meet the guidelines of **320 OME** or less	10
		50-74% of TKA patients prescribed **<320 OME**	5
		Less than 50% of patients meet the prescribing criteria	0
7	5	**% of Opioid naïve THA patients at the SITE meeting the MARCQI Pain Optimization Prescribing guidelines (<240 OME)**	
		75% or greater of THA patients meet the guidelines of **240 OME** or less	5
		50-74% of THA patients prescribed **<240 OME**	2.5
		Less than 50% of patients meet the prescribing criteria	0
8	5	**% of Opioid naïve TKA patients at the SITE meeting the MARCQI Pain Optimization Protocol Prescribing guidelines (<320 OME)**	
		75% or greater of TKA patients meet the guidelines of **320 OME** or less	5
		50-74% of TKA patients prescribed **<320 OME**	2.5
		Less than 50% of patients meet the prescribing criteria	0

Michigan Arthroplasty Registry Collaborative Quality Initiative Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 2) Measurement Period: 07/01/2020-06/30/2021			
Measure #	Weight	Measure Description	Points
9	20	**PROS Collection: Completed Pre-op and post-op HOOS -JR or KOOS-JR + PROMIS (Overall average as of 06.30.2021. 2-16 week post-op accepted.)**	
		The site is awarded full points for collection rates of 60%+	20
		The site is awarded partial points for collection rates >35%-<60	10
		The site is not awarded points if collection is less than 35%	0
10	20	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative). If red on scorecard of April 2020, you must choose this as the project. If no red, you will choose a 'yellow'. Progress Reports are due in May 2021 & January 2022. Final results are based on scorecard of <u>January, 2022</u>**	
		Plan submitted and goal met	20
		Reporting requirements are met, but the target identified is not met.	10
		Plan is not developed, reports not done.	0

2021 Michigan Bariatric Surgery Collaborative Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 3) Measurement Periods: Specified below per Measure			
Measure #	Weight	Measure Description	Points
1	15	**Grade 1 Complication:** (October 1, 2020-September 30, 2021) **Adjusted; Rounded to nearest whole number**	
		0% to ≤4% rate	15
		>4% to ≤6% rate	10
		>6% rate	0
2	10	**Serious Complication Rate:** (October 1, 2020-September 30, 2021) **Adjusted; Rounded to one decimal point**	
		0% to ≤2.4% rate	10
		>2.4% to ≤2.7% rate	5
		>2.7% rate	0
3	10	**Improvement/Excellence In Grade 1 Complication Rate:** (Data trended over a 3-yr period from October 1, 2018 to September 30, 2021) **Z-Score rounded to nearest whole number**	
		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
4	10	**Improvement/Excellence in Serious Complication Rate:** (Data trended over a 3-yr period from October 1, 2018 to September 30, 2021) **Z-Score rounded to nearest whole number**	
		Major improvement (z-score less than -1 or serious complication rate ≤2.4%)	10
		Moderate improvement/maintained complication rate (z-score between 0 and -1)	5
		No improvement/rates of serious complications increased (z-score ≥0)	0
5	10	**1-Year Follow-up Rates** (For OR dates of October 1, 2019 to September 30, 2020) **Adjusted; Rounded to nearest whole number**	
		≥63% OR > 5% **relative** improvement from previous year (10/1/2018-9/30/2019)	10
		Maintained 1-year follow-up rate/ >0 to <5% relative improvement from previous year (10/1/2018-9/30/2019)	5
		1-year follow-up rate decreased/No improvement in 1-year follow-up rate (10/1/2018-9/30/2019)	0
6	2.5	**Compliance with VTE prophylaxis - Pre-operatively:**(Calendar Year 2021) **Unadjusted; Rounded to nearest whole number**	
		≥92% compliance with guidelines	2.5
		0 to 91% compliance with guidelines	0
7	2.5	**Compliance with VTE prophylaxis - Post-operatively:**(Calendar Year 2021) **Unadjusted; Rounded to nearest whole number**	
		≥91% compliance with guidelines	2.5
		0 to 90% compliance with guidelines	0

2021 Michigan Bariatric Surgery Collaborative Collaborative Quality Initiative Performance Index Scorecard (pg 2 of 3) Measurement Periods: Specified below per Measure			
Measure #	Weight	Measure Description	Points
8	10	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs)** ***Collaborative wide measure, (October 1, 2020 to September 30, 2021)	
		≥ 10% relative reduction in opioid use	10
		5-9% relative reduction in opioid use	5
		< 5% relative reduction	0
9	5	**Meeting Attendance - Surgeon:** (Calendar Year 2021) **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 1/1/2021 to 12/31/2021	
		Attended 3 out of 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended fewer than 2 meetings	0
10	5	**Meeting Attendance - Abstractor/Coordinator:** (Calendar Year 2021)	
		Attended 3 out of 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended fewer than 2 meetings	0
11	5	**Timely Monthly Data Submissions (30-day information & registry paperwork):** (Submitted to coordinating center by the last business day of each month - Please refer to 2021 Data Entry Deadlines Spreadsheet) (Calendar Year 2021) *****In order to be eligible for this measure, you must achieve >90% on the 2021 yearly audit when applicable. If the hospital does not reach >90% for the yearly audit, they will receive 0 points for this measure.	
		On time 11-12 months	5
		On time 10 months	3
		On time 9 months or less	0
12	5	**Consent Rate:** (October 1, 2020 to September 30, 2021) **Unadjusted; Rounded to nearest whole number**	
		≥90% consented patients	5
		80-89% consented patients	3
		<80% consented patients	0
13	10	**Physician Engagement:** (January 1, 2020 to December 31, 2020)	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 1/1/2020 to 12/31/2020	
		Following items count as 1 activity point:	
		Committee participation	
		MBSC survey response	
		Coauthor a paper	
		Attend or present at the Education Committee session on the day of the MBSC tri-annual meeting	
		Present MBSC data at a MBSC tri-annual meeting	

2021 Michigan Bariatric Surgery Collaborative Collaborative Quality Initiative Performance Index Scorecard (pg 3 of 3) Measurement Periods: Specified below per Measure			
Measure #	Weight	Measure Description	Points
		Participate in a quality site visit as the visited hospital or visiting surgeon	
		Following items count as 2 activity points:	
		Present MBSC data at a national meeting	
		Lead author on an MBSC publication	
		No participation	0

Michigan Bariatric Surgery Collaborative (MBSC)

2021 Performance Index Scorecard

Measure Description

Measures #1: Grade 1 Complication Rate

This measure calculates the percentage of patients who had a non-life threatening complication with-in 30 days post-operatively of the bariatric surgery. Examples of these complications include, but are not limited to: surgical site infection, anastomotic stricture, bleeding requiring blood transfusion less than 4 units or endoscopy, Pneumonia, hospital acquired infections of Clostridium Difficile and urinary tract infection, post-operative esophagogastroduodenoscopy (EGD), pancreatitis, thrush and ulcers.

Measures #2: Serious Complication Rate

This measure calculates the percentage of patients who had a potentially life-threatening complications with-in 30 days post-operatively of the bariatric surgery. Examples of these complications include, but are not limited to: abdominal abscess requiring percutaneous drainage or reoperation, bowel obstruction requiring reoperation, leak requiring percutaneous drainage or reoperation, bleeding requiring transfusion >4 units, reoperation, or splenectomy, band-related problems requiring reoperation, respiratory failure requiring 2-7 days intubation, renal failure requiring in-hospital dialysis, wound infection/dehiscence requiring reoperation, and venous thromboembolism); and life-threatening complications associated with residual and lasting disability or death (myocardial infarction or cardiac arrest, renal failure requiring long-term dialysis, respiratory failure requiring >7 days intubation or tracheostomy, and death.

Measures #3: Improvement/Excellence in Grade 1 Complication Rate

This measure uses trended data over a three-year time period to determine if sites have had major improvement, moderate improvement/maintained their complication rate or have had no improvement or the rates of grade 1 complications have increased.

Measures #4: Improvement/Excellence in Serious Complication Rate

This measure uses trended data over a three-year time period to determine if sites have had major improvement, moderate improvement/maintained their complication rate or have had no improvement or the rates of serious complications have increased.

Measures #5: 1-Year Follow-up Rates

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

Measures #6: Compliance with VTE prophylaxis- pre-operatively
The measure will identify the percentage of patients undergoing bariatric surgery who received Low Molecular Weight Heparin (LMWH) prior to the incision time. This metric helps to determine the appropriateness of resource utilization.

Measures #7: Compliance with VTE prophylaxis- post-operatively
The measure will identify the percentage of patients undergoing bariatric surgery who received Low Molecular Weight Heparin (LMWH) while hospitalized. This metric helps to determine the appropriateness of resource utilization.

Measures #8: Opioid Use- Opioid Prescriptions within 30 days (measured by MMEs)
This measure will help the collaborative to decrease the amount of opioids patients are prescribed at the time of discharge from their primary bariatric surgery operation. The collaborative must achieve greater than or equal to a 10% relative reduction in opioid use to receive maximum points for this measure.
****Collaborative wide measure and will be measured in MMEs

Measures #9: Meeting Attendance- Surgeon
A bariatric surgeon must attend MBSC Collaborative Meetings for 2021.

***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 1/1/2021 to 12/31/2021

Scoring:

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

Measures #10: Meeting Attendance- Abstractor/Coordinator
A bariatric abstractor or coordinator must attend MBSC Collaborative Meetings for 2021.

Scoring:

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

Measures #11: Timely Monthly Data Submissions
Please refer to the MBSC Data Entry Deadlines document for the 2021 monthly deadlines.
In order for a hospital to be eligible for this measure, the hospital must achieve >90% on the 2021 yearly audit when applicable. If the hospital does not reach >90% for the yearly audit, the hospital will receive 0 points for this measure.

Measures #21: Consent Rate
Patients are invited to the follow-up portion of MBSC prior to receiving bariatric surgery. This measure calculates the percentage of patients who agree to receive surveys on their 1, 2, 3, 4 and 5th year anniversary dates of their bariatric surgery reporting weight loss, comorbidity resolution, quality of life and patient satisfaction.

Measures #13: Physician Engagement
MBSC bariatric surgeons must complete two of the engagement activities listed below in order to receive the maximum points available for the measure. Physician engagement is key to the collaborative culture in order for learning and improvement to occur.

***In order for a surgeon to earn points for a hospital, they must complete 10 bariatric surgery cases at that hospital for the dates of 1/1/2021 to 12/31/2021.

Below are the activities for this measure:

- Completing this activity, the MBSC surgeon will receive maximum points for this measure
    - Present MBSC data at a national meeting
    - Be a lead author on an MBSC publication
- Completing the following activities, the MBSC surgeon will receive 1 activity point for each measure below completed
    - Committee participation- Examples of committee participation include: Executive, Publications and the Enhanced Recovery After Surgery (ERAS) Committee
    - MBSC survey response
    - Coauthor a paper using MBSC data
    - Attend or present at the optional education committee session prior to MBSC tri-annual meeting
    - Attend or present at the interesting case conference session following the MBSC tri-annual meeting
    - Present MBSC data at a MBSC tri-annual meeting
    - Participate in a quality site visit as the visited hospital or visiting surgeon
- No participation in any of the above measures results in zero points

2021 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard (pg. 1 of 2) **Years 3+** Measurement Period: 11/1/2020 - 10/31/2021			
Measure #	Weight	Measure Description	Points
1	5	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	5
		11 months of data transfers on time	4
		9-10 months of data transfers on time	3
		< 9 months of data transfers on time	0
2	5	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	5
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	4
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	3
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	5	**Abstraction: Timeliness**	
		All cohort cases abstracted within 30 days of load	5
		75-99% of cohort cases abstracted within 30 days of load	3
		<75% of cohort cases abstracted within 30 days of load	0
4	5	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
5	5	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
6	5	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review**	
		≥ 90% of case cohort decisions are correct	2
		≥ 75% of case cohort decisions are correct	1
		< 75% of case cohort decisions are correct	0
		≥ 97% of abstracted registry data accurate	3
		95%-97% of abstracted registry data accurate	2
		<95% of abstracted registry data accurate	0
7a	10	**Site Specific - Pediatric Asthma Safe Discharge Initiative *Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	10
		QI Project developed and implemented and site's performance was lower than the target	8
		QI Project not developed or implemented	0

2021 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard (pg. 2 of 2) **Years 3+** Measurement Period: 11/1/2020 - 10/31/2021			
Measure #	Weight	Measure Description	Points
7b	10	**Site Specific - Adult Low Risk Chest Pain Safe Discharge Initiative *Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	10
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	8
		QI Project developed and implemented but there was no improvement to the target	5
		QI Project not developed or implemented	0
8	30	**Collaborative-Wide Measure: Adult HI & Intermediate Peds *Measures and targets identified in Appendix**	
		Met Adult HI	15
		Met Pediatric Intermediate HI	15
		Did not meet either target	0
9a	10	**Site Specific - Quality Improvement Initiative Head Injury: Adult Head Injury**	
		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	8
		QI Project developed and implemented but there was no improvement to the target	5
		QI Project not developed or implemented	0
9b	10	**Site Specific - Quality Improvement Initiative Head Injury: Intermediate Pediatric Head Injury**	
		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	8
		QI Project developed and implemented but there was no improvement to the target	5
		QI Project not developed or implemented	0
10	5	**Measure in Maintenance - Head CT overuse in children with low risk minor head injury**	
		Maintained performance	5
		Did not maintain performance	0
11	5	**Measure in *Temporary* Maintenance - PE diagnostic yield OR CXR for asthma, bronchiolitis, croup**	
		Maintained performance to within 10% of the target	5
		Did not maintain performance to within 10% of the target	0

2021 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard (pg. 1 of 2) **Year 2** Measurement Period: 11/1/2020 - 10/31/2021			
Measure #	Weight	Measure Description	Points
1	15	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	15
		11 months of data transfers on time	10
		9-10 months of data transfers on time	5
		< 9 months of data transfers on time	0
2	15	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	15
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	10
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	5
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	10	**Abstraction: Timeliness**	
		All cohort cases abstracted within 30 days of load	10
		75-99% of cohort cases abstracted within 30 days of load	5
		<75% of cohort cases abstracted within 30 days of load	0
4	10	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
5	10	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
6	10	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review**	
		≥ 90% of case cohort decisions are correct	4
		≥ 75% of case cohort decisions are correct	2
		< 75% of case cohort decisions are correct	0
		≥ 97% of abstracted registry data accurate	6
		95%-97% of abstracted registry data accurate	3
		<95% of abstracted registry data accurate	0
7a	10	**Site Specific - Pediatric Asthma Safe Discharge Initiative *Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	10
		QI Project developed and implemented and site's performance was lower than the target	8
		QI Project not developed or implemented	0

2021 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard (pg. 2 of 2) **Year 2** Measurement Period: 11/1/2020 - 10/31/2021			
Measure #	Weight	Measure Description	Points
7b	10	**Site Specific - Adult Low Risk Chest Pain Safe Discharge Initiative *Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	10
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	8
		QI Project developed and implemented but there was no improvement to the target	5
		QI Project not developed or implemented	0
8	20	**Collaborative-Wide Measure: Adult HI & Intermediate Peds *Measures and targets identified in Appendix**	
		Met Adult HI	10
		Met Pediatric Intermediate Risk HI	10
		Did not meet either target	0

2021 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard (pg. 1 of 1) **Year 1** Measurement Period: 1/1/2021- 10/31/21			
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	8
		9-10 months of data transfers on time	4
		< 9 months of data transfers on time	0
2	12	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	12
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	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	12	**Abstraction: Timeliness**	
		All cohort cases abstracted within 30 days of load	12
		75-99% of cohort cases abstracted within 30 days of load	6
		<75% of cohort cases abstracted within 30 days of load	0
4	12	**Meeting Attendance: Clinical Champion**	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0
5	12	**Meeting Attendance: Data Abstractor**	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0
6	8	**Completion of Agreements (including but not limited to Particiation Agreement, Business Associates Agreement, Data Use Agreement, and IRB if necessary)**	
		Agreements signed and returned to MEDIC within 30 days of receipt	8
		Agreements signed and returned to MEDIC >30 days after receipt	0
7	12	**Time from Agreement being signed to hiring date of data abstractor**	
		<90 days	12
		91-120 days	6
		>120 days	0
8	12	**Time from Agreements signed to successful submission of electronic production data**	
		<90 days	12
		91-120 days	6
		>120 days	0
9	8	**Intervention Planning for Year 2 (Intervention Templates, etc.)**	
		All Year 2 materials complete and submitted on time	8
		Year 2 materials incomplete and/or submitted late	0

MEDIC Appendix (pg. 1 of 2)					
Year(s)	**Measure #**	**Measure Category**	**Measure Description**	**Target**	**Measure Calculation Methodology**
All	1	Participation	Electronic data file must be delivered on a monthly schedule, as agreed upon by the Coordinating Center and site data resource. If a file cannot be delivered in a timely manner an email must be sent to the Coordinating Center prior to the due date.	100%	12 months of timely file transfers = Full points 11 months of timely file transfers = reduced points 9 - 10 months of timely file transfers = further reduced points 0 - 8 months of timely file transfers = no points
All	2		Electronic data file transferred every month must adhere to the MEDIC electronic data dictionary and must be accurate.	100%	12 months of adherent file transfers = Full points 11 months of adherent file transfers = reduced points 9 - 10 months of adherent file transfers = further reduced points 0 - 8 months of adherent file transfers = no points
All	3		All cases must be abstracted within 30 days of the date they were loaded into the registry NOT the visit date.	100%	N/A
All	4		Clinical Champions from each site must attend all Collaborative Wide Meetings and Clinical Champion Quarterly Calls. Clinical Champions may send one physician proxy to a single Collaborative Wide Meeting per year without penalty. This proxy must be approved by MEDIC prior to the meeting, cannot already represent another MEDIC site, and cannot be a resident or fellow.	All meetings attended	N/A
All	5		Abstractors from each site must attend all Collaborative Wide Meetings. Abstractors may send one appropriate proxy to a single Collaborative Wide Meeting per year without penalty. This proxy must be approved by MEDIC prior to the meeting and cannot already represent another MEDIC site.	All meetings attended	N/A
2,3+	6	Participation	Abstracted registry data must pass an annual audit with >90% case cohort decisions correct and >97% data element accuracy.	>97% data element accuracy, >90% cohort	60% of points are based off of data element accuracy, divided into 3 point levels. >97% = full points, > 95% = mid points, < 95% = no points. 40% of points for correct cohort decision. >90% = full points, >75% = mid points, < 75% = no points
1	6	Participation	Completion of the following documents within 30 days of receipt: 1. BCBSM-sponsored application for MEDIC participation 2. Participation Agreement 3. Business Associates Agreement 4. Data Use Agreement 5. IRB if necessary	All documents completed and submitted within 30 days of receipt	N/A
2+	7a	Safe Discharge Pediatric Uncomplicated Asthma	Performance on discharge rate for pediatric patients with uncomplicated asthma.	Improvement from site's 2020 baseline	Number of ED visits for patients with asthma discharged from the ED divided by the number of ED visits for patients with asthma, calculated for an individual site

MEDIC Appendix (pg. 2 of 2)					
Year(s)	**Measure #**	**Measure Category**	**Measure Description**	**Target**	**Measure Calculation Methodology**
2+	7b	Safe Discharge Adult Low Risk Chest Pain	Performance on discharge rate for low risk adult chest pain patients.	≥ 88%	Number of ED visits for adult patients with low risk chest pain and an intended disposition of discharged from the ED divided by the number of ED visits for patients with low risk chest pain, calculated for an individual site
2+	8	Minor Head Injury	Collaborative-Wide performance for appropriate CT use in adults with minor head injury	≥ 55%	Number of ED visits of patients that received an appropriate head CT divided by the number of ED visits of eligible minor head injury patients who received a head CT, calculated for the entire collaborative.
			Collaborative-Wide performance for CT use in pediatric patients with intermediate risk minor head injury	≤ 18%	Number of ED visits of intermediate risk minor head injury patients that received a head CT divided by the number of ED visits of eligible minor head injury patients with intermediate risk criteria, calculated for the entire collaborative.
3+	9	Adult Minor HI	Performance for appropriate CT use in adults with minor head injury	≥ 60%	Number of ED visits of patients that received an appropriate head CT divided by the number of ED visits of eligible minor head injury patients who received a head CT, calculated for an individual site
3+	9	Pediatric Intermediate Risk Minor HI	Performance on CT utilization for pediatric intermediate risk minor head injury	≤ 15%	Number of ED visits of intermediate risk minor head injury patients that received a head CT divided by the number of ED visits of eligible minor head injury patients with intermediate risk criteria, calculated for an individual site
3+	10	Measure in Maintenance - head CT overuse in children with low risk minor head injury	Maintained performance for head CT overuse in chidren with low risk minor head injury to match 2020 target	< 9%	Number of ED visits of eligible minor head injury patients with low risk criteria that received a head CT divided by the total number of ED visits of all eligible minor head injury patients who received a head CT, calculated for an individual site
3+	11	Measure in Temporary Maintenance - PE diagnostic yield OR CXR for asthma, bronchiolitis, croup	Maintained performance for PE diagnostic yield OR CXR for asthma, bronchiolitis, and group to within 10% of the target	PE ≥ 9.9% Chest X-Ray ≤ 27.5%	PE: Number of PE CT scans that are positive for pulmonary embolism divided by the number of ED visits with eligible PE CT scans after exclusions are applied, calculated for an individual site
					CXR: Number of ED visits of children with respiratory illness diagnoses receiving a CXR divided by the number of ED visits of children with respiratory illness diagnoses, calculated for an individual site

2021 Michigan Radiation Oncology Quality Consortium (MROQC) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) Measurement Period: 01/01/2021-09/30/2021			
Measure #	Weight	Measure Description	Points
1	10	**High Quality Clinical and Physics Data Submission[1]**	
		Four Metrics Met	10
		Three Metrics Met	8
		Two Metrics Met	4
		One Metric Met	2
		None Met	0
2	5	**Submission of Technical Data (Full DICOM-RT data and Physics Radiotherapy Technical Details Survey) for Breast, Lung, and Complex Bone Mets Cases**	
		>85% of technical data submitted within six weeks of treatment completion	5
		>85% of technical data submitted within eight weeks	4
		>85% of technical data submitted within twelve weeks	3
		>85% of technical data submitted after twelve weeks	2
		<85% of technical data submitted after twelve weeks	0
3	20	**Collaborative-wide Measure: Rate of single fraction treatment of uncomplicated[2] bone metastasis**	
		>20% of patients with an uncomplicated bone metastasis are treated with a single fraction	20
		11-20% of patients with an uncomplicated bone metastasis are treated with a single fraction	10
		≤10% of patients with an uncomplicated bone metastasis are treated with a single fraction	0
4	16	**Reduced use of breast boost in women age 70 years or older with early-stage breast cancer[3]**	
		30% or fewer of select patients receive boost	16
		31-50% of select patients receive boost	8
		>50% of select patients receive boost	0
5	16	**For node-negative breast cancer patients, ≥95% of the lumpectomy cavity PTV receives ≥95% of the whole breast prescription dose AND the heart mean dose meets threshold appropriate to laterality and fractionation[4]**	
		≥85% of patients meet target coverage and heart sparing goals	16
		60-84% of patients meet target coverage and heart sparing goals	8
		<60% of patients meet target coverage and heart sparing goals	0
6	6	**Mean heart dose achieved in breast patients receiving conventionally fractionated radiotherapy to supraclavicular, infraclavicular, and/or internal mammary nodes[5]**	
		≥85% of patients meet the appropriate threshold	6
		60-84% of patients meet the appropriate threshold	3
		<60% of patients meet the appropriate threshold	0

2021 Michigan Radiation Oncology Quality Consortium (MROQC) Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 2) Measurement Period: 01/01/2021-09/30/2021			
Measure #	Weight	Measure Description	Points
7	6	**For lung cancer patients, ≥ 95% of the Planning Target Volume (PTV) receives ≥100% of the prescription dose AND the heart mean dose is ≤20 Gray (Gy)**	
		65% or more patients meet target coverage and heart sparing goals	6
		50-64% of patients meet target coverage and heart sparing goals	3
		<50% of patients meet target coverage and heart sparing goals	0
8	6	**For lung cancer patients: evaluate Task Group-263 compliance for the specified structures (heart, PTV, esophagus, spinal cord or canal, and normal lung[6]) for the initial DICOM entry**	
		80% or greater compliance for the specified structures	6
		60-79% compliance for the specified structures	3
		<60% compliance for the specified structures	0
9	5	**Meeting Participation – Clinical Champion (per MROQC CC Attendance Policy)***	
		All meetings or two meetings with one meeting attended by an acceptable designee	5
		Two meetings only	3
		One meeting or none attended	0
10	5	**Meeting Participation – Physics Lead (or designee)**	
		All meetings	5
		Two meetings	3
		One meeting or none attended	0
11	5	**Meeting Participation – Clinical Data Abstractor (or designee)**	
		All meetings	5
		Two meetings	3
		One meeting or none attended	0

2021 Michigan Surgical Quality Collaborative Performance Index Scorecard (pg. 1 of 1) Project Time Period: 1/1/2021 – 12/31/2021			
Measure #	Weight	Measure Description	Points
1	8	**Collaborative Meetings (4) – Surgical Clinical Quality Reviewer (SCQR)**	
		3 or more meetings	8
		2 meetings	4
		1 meeting	0
2	8	**Collaborative Meetings (3) – Surgeon Champion**	
		3 meetings	8
		2 meetings	4
		1 meeting	0
3	4	**Conference Calls (3) – SCQR**	
		2 or more calls	4
		1 call	2
		0 calls	0
4	4	**Conference Calls (3) – Surgeon Champion**	
		2 or more calls	4
		1 call	2
		0 calls	0
5	6	**Accuracy and Completeness of Data**	
		Biennial IRR with score ≥95%	3
		OR	
		If no IRR in current year, >90% of eligible cases are captured on case upload for a targeted cycle	
		Sampled and incomplete cases ≤ 0.5% total volume	3
6	20	**Collaborative Wide Measure – Increase Use of Intraoperative Multimodal Pain Management Across All MSQC Procedures***	
		≥ 71%	20
		61-70%	15
		51-60%	10
		41-50%	5
		≤40%	0
7	50	**Quality Improvement Initiative (QII)**	
		Option A: Hysterectomy Care Pathway	50
		OR	
		Option B: Abdominal Hernia Repair Pathway	
		OR	
		Option C: Colorectal Cancer Surgery Pathway	
Total Available Points			**100**

*These goals may be updated at the end of 2020 once more data is available. Due to the COVID pandemic we had a limited amount of baseline data available.

Quality Improvement Implementation, Option A: Hysterectomy Care Pathway

Project Time Period: 1/1/2021-12/31/2021

Summary: The focus of this project is to work toward the implementation of the MSQC Hysterectomy Care Pathway, improving the care of patients undergoing elective hysterectomy surgery. Based on widely accepted clinical practice guidelines, hospitals will implement the Hysterectomy Care Pathway, making adjustments to meet the practice needs at their site. We hope that this project will inspire multidisciplinary discussions to standardize, document and drive implementation of best practices at each hospital, ultimately improving Hysterectomy patient care.

QI Implementation Requirements: For elective hysterectomy patients, in addition to MSQC core data collection, participating hospitals will collect the variables outlined in this project. Hospitals will be required to ensure documentation of cases is complete with all the elements of best practices for hysterectomy patients. Hospitals will also need to describe their process for reviewing and monitoring uterine surgical specimens without pathology findings supporting the need for hysterectomy. * Identifying an OB/GYN surgeon champion for this QI project will also be required.

QI Implementation Goals: Implement/document all of the following steps for elective hysterectomy patients as specified below. Measurement period will be 4/1/2021 – 12/31/2021 (unless otherwise indicated).

Preoperative	Intraoperative	Postoperative
Preadmission teaching includes multimodal pain management	Intraoperative use of multimodal pain management	Order for multimodal pain management
Alternative treatments offered/ tried/ declined, or contraindications documented (if applicable)	Intraoperative nausea and vomiting prophylaxis for PONV	Discharge education includes pain management teaching
Glycemic control: • HgbA1C if diabetic • fasting blood sugar (if not diabetic)		
Appropriate antibiotics (see Table A)		

- Demonstrate 80% compliance with the **identified preoperative measures (10 points):**
    - Preadmission teaching that discusses expectations after surgery including multimodal pain management
    - Alternative treatments tried before undergoing a hysterectomy
    - HgbA1C for diabetics or fasting blood sugar for non-diabetic patients
    - Appropriate antibiotics (see Table A)

- Demonstrate 80% compliance with the **identified intraoperative measures (10 points):**
    - Intraoperative use of multimodal pain management
        - 2 or more non-opioid pain medications given
    - Intraoperative nausea and vomiting prophylaxis for PONV
        - 2 or more anti-emetics given

- Demonstrate 80% compliance with the **identified postoperative measures (10 points):**

- Order for multimodal pain management
- Discharge education includes multimodal pain management teaching

In addition, sites will be required to:

- Meet **M-OPEN opioid prescribing recommendations** for 90% of hysterectomy cases (measurement period 1/1/2021 – 12/31/2021) **(5 points)**

- Conduct and document at least one **multidisciplinary meeting by March 31, 2021** that includes OB/GYN physicians, nurses, quality, pharmacy and other relevant staff to discuss the Hysterectomy Care Pathway, create a plan to ensure complete documentation of hysterectomy cases and distribute/discuss the hysterectomy surgical approach algorithm. Submit documentation of the meeting to the MSQC Coordinating Center with the 2021 QI project submission. **(5 points)**

- Submit the hysterectomy **QI project summary report** using the MSQC report template (including the methods used to ensure completeness of medical record documentation, and process of uterine surgical specimen review) to the MSQC Coordinating Center by **January 17, 2022**. (**10 points**)
  - Create a plan for ensuring **completeness of documentation** in the medical record (H&P and OR note) at your hospital that includes:
    - Indications for hysterectomy
    - Alternatives offered / tried / declined before having surgery (if appropriate, in non-cancerous diagnoses)
    - Contraindications to any alternative treatments
    - Preoperative ultrasound/imaging findings (except for prolapse)
    - Planned surgical approach and rationale
  - Describe your hospital's **process for reviewing and monitoring uterine surgical specimens without pathology findings supporting the need for hysterectomy**. (*Guidance note: These cases are those with pathology findings (e.g. normal, unremarkable, physiologic, reactive, or of minor importance) amenable to medical or surgical treatment less invasive than hysterectomy. In general, these changes would rarely require hysterectomy to relieve a patient of symptoms.

Table A

Appropriate IV Prophylactic Antibiotics for Hysterectomy*
MSQC Recommendation: Cefazolin 2g IV for patients <120kg Cefazolin 3g IV for patients ≥120kg **AND** Metronidazole 500mg IV -Administer 15 to 60 minutes before incision See ASHP guidelines for other acceptable antibiotic regimens and beta-lactam alternatives
*From MSQC Hysterectomy Care Pathway (2019)

Quality Improvement Implementation, Option B: Abdominal Hernia Care Pathway

Project Time Period: 1/1/2021-12/31/2021

Summary: The focus of this project is to work toward the implementation of the MSQC Hernia Care Pathway to improve care of patients undergoing abdominal hernia surgery. Using widely accepted clinical practice guidelines as a starting point, hospitals will implement the care pathway and adjust to meet the practice needs at their hospital. We hope that this project will inspire multidisciplinary discussions to standardize, document and drive implementation of best practices at each hospital, ultimately improving patient care.

QI Implementation Requirements: For abdominal hernia repair patients, in addition to MSQC core data collection, participating hospitals should collect the complete hernia variable set. Hospitals will also be asked to develop a standard "template" for surgeon documentation/charting (Surgeon's Operative Report), that includes all the elements of best practices for hernia surgery. This includes preadmission education, smoking cessation (if applicable), glycemic control, weight loss discussion (if applicable), hernia location, type, and hernia measurements, use of mesh including placement location, fixation method, mesh description (product name, brand and product id#) and mesh measurements, and myofascial/component technique (if applicable). An example template will be provided by MSQC, which your facility will need to adapt to work for your surgeons and with your EMR.

QI Implementation Goals: Implement steps to improve upon and monitor the process measures for abdominal hernia patients as specified below. Measurement Period will be 4/1/2021 – 12/31/2021 (unless otherwise indicated).

Preoperative	Intraoperative	Postoperative
Preadmission teaching includes multimodal pain management	Hernia documentation: • Measurements (length & width, or diameter) • Location	Order for multimodal pain management
Glycemic Control: • HgbA1C if diabetic • Fasting blood sugar (if not diabetic)	Mesh documentation: • Measurements (length & width, or diameter) • Product name/product ID# • Brand/manufacturer • Placement location • Fixation technique/device	Discharge education includes pain management teaching
When applicable, documented patient education provided on: • Smoking cessation • Weight/obesity		

- Demonstrate 80% compliance with the identified **preoperative measures (10 points)**
  - Preadmission teaching that discusses expectations of surgical pain and pain management strategies after surgery
  - Patient optimization discussion related to smoking cessation and weight/obesity, if applicable
  - HgbA1C (Hernia Care Pathway algorithm) or FBS for all patients

- Demonstrate 80% compliance with the identified **intraoperative measures (10 points)**
  - Hernia documentation to include:
    - Measurement(s)
    - Location of hernia (example: epigastric, infraumbilical or M2, M4)

    - Mesh documentation to include:
        - Measurement(s), product name/product ID#, brand/manufacturer
        - Placement (example: sublay-preperitoneal)
        - Fixation technique and device (if applicable)

- Demonstrate 80% compliance with the identified **postoperative measures (10 points)**
    - Postop order for multimodal pain management
    - Discharge education to include postop multimodal pain management teaching

In addition, sites will be required to:

- Meet **M-OPEN opioid prescribing recommendations** for 90% of abdominal hernia cases (measurement period 1/1/2021 – 12/31/2021) **(5 points)**
- Conduct and document at least one **multidisciplinary meeting** that includes surgeons, nurses, quality, pharmacy and other relevant staff to discuss and establish a comprehensive hernia care pathway and a standardized template for charting on abdominal hernia repair patients **by March 31, 2021.** Submit documentation of the meeting to the MSQC Coordinating Center with the 2021 QI project submission. **(5 points)**
- Submit the abdominal hernia QI project summary report using the MSQC report template (including the comprehensive template for standardized charting) to the MSQC Coordinating Center by **January 17, 2022. (10 points)**
    - Create a **comprehensive template** for standardized charting at your hospital that includes preadmission teaching that was done, hernia occurrence (initial or recurrent), hernia type (reducible, incarcerated or strangulated) and location, measurements of hernia, and mesh description including measurements, location of placement, product name and brand. Submit this abdominal hernia repair surgery standardized template to the MSQC Coordinating Center with 2021 project submission.

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 C: Colorectal Cancer Surgical Quality Measures

Project Time Period: 1/1/2021-12/31/2021

Summary: The focus of this project will be improving performance on evidence-based quality measures for cancer patients undergoing surgery for colorectal cancer. We anticipate this project will promote high-quality treatment to improve short- and long-term outcomes.

QI Implementation Requirements:

1. Data collection: For elective colorectal cancer surgical patients, participating qualified hospitals will perform supplemental data collection that will allow the colorectal cancer-specific quality measures in the table below to be calculated. These include measures specific to rectal cancer are in blue, measures for all colorectal cancer patients in orange, and measures from the Colorectal Care Pathway in green.
2. Multidisciplinary team: Participating hospitals will form a multidisciplinary team to review baseline data and guide quality improvement plans. The multidisciplinary team may include specialists from the following specialties (at least 2 required): surgeons who perform colorectal cancer surgery, nursing, medical oncology, pathology, radiation oncology, cancer patient navigator, gastroenterology, anesthesiology, ostomy nursing, or others as relevant to the particular hospital.

QI Implementation Goals: Implement all of the following process measures for each elective colorectal cancer patient as detailed below. Measurement Period will be 4/1/2021 – 12/31/2021.

Preoperative	Intraoperative	Postoperative
Pre-treatment Staging Testing: MRI or endorectal U/S (Rectal CA only)	Mesorectal Excision performed (Rectal CA only)	TME Grading (Rectal CA only)
Ostomy site Marked (Rectal CA only)		
Neoadjuvant therapy (Rectal CA only		
CEA level obtained after diagnosis (All cases)	>12 lymph nodes(All cases)	
OA/MBP	Intraoperative use of multimodal pain management (2 or more non-opioid medications)	• Postoperative order for multimodal pain management (2 or more non-opioid medications) if d/c on POD 0 • Postoperative use of multimodal pain management (2 or more non-opioid medications) if d/c ≥ POD 1

- Goal #1: Demonstrate 75% compliance with the identified **preoperative measures**. **(10 points)**
- Goal #2: Demonstrate 80% compliance with the identified **intraoperative measures**. **(10 points)**
- Goal #3: Demonstrate 60% compliance with the identified **postoperative measures**. **(10 points)**

- Goal #4: Submit a **QII Project Summary** on or before **January 17, 2022** which includes a narrative and activity tracking of the steps to implementation of the colorectal cancer surgery care pathway, successes and barriers, and analysis and next steps (a template will be available on MSQC website). **(5 points)**

- The QII Project Summary submission must include the following, provided separately or integrated within the Summary:

    - Goal #5: Conduct at least one **multidisciplinary meeting** before **March 31, 2021** that includes surgeons who perform colorectal cancer surgery, nurses, quality specialists, pathologists, radiologists, oncologists, ostomy/wound care staff, anesthesia, pharmacy, and/or other relevant staff. Meeting notes including attendees must be submitted.
      (5 points)

    - Goal #6: With the multidisciplinary team, create a **patient care plan, order set or care pathway template** to be utilized by the multidisciplinary team beginning in the preoperative period and extending into the postoperative period for ensuring implementation of each element of the colorectal cancer surgery care pathway. Submit the final product to MSQC. **(10 points)**

2021 Michigan Spine Surgery Improvement Collaborative (MSSIC) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) Cohort 1, 2, 3 (24 sites) Measurement Period: 10/01/2020-09/30/2021, unless otherwise stated			
Measure #	Weight	Measure Description	Points
1	5	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended 1 out of 3 meetings	1
		No Attendance	0
2	3	**Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (If > 1 abstractor at site, only 1 abstractor need attend triannual meetings, however, <u>all</u> abstractors are required to attend the annual Abstractor Symposium)**	
		Attended all 4	3
		Attended 3 out of 4	2
		Attended 2 or less	0
3	5	**Conference Calls Surgeon Champion (3 calls/year)**	
		Attended 3 calls	5
		Attended 2 calls	3
		Attended 1 call	1
		No Calls	0
4	3	**Conference Calls - Clinical Data Abstractor (8 calls/year)**	
		Participate on 8 calls	3
		Participate on 7 calls	2
		Participate on 6 calls	1
		Participate on less than 6 calls	0
5	4	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one triannual MSSIC meeting	4
		No Attendance	0
6	10	**Annual Audit Review – Data Review: Accuracy of data -**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
7	5	**Each site: Collection rate of baseline patient questionnaires (rates rounded to the nearest whole number) for those due 1/1/21 – 12/31/21.**	
		75% or greater	5
		55%-74%	3
		< 55%	0

2021 Michigan Spine Surgery Improvement Collaborative (MSSIC) Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 2) Cohort 1, 2, 3 (24 sites) Measurement Period: 10/01/2020-09/30/2021, unless otherwise stated			
Measure #	Weight	Measure Description	Points
8	5	**Each site: Combined collection average rate of Post-operative Patient-Reported Outcome (PRO) questionnaires (rates rounded to the nearest whole number) for PROs due 1/1/21 – 12/31/21**	
		55% or greater	5
		40%-54%	3
		< 40%	0
9	10	**Collaborative-wide Measure Goal: Risk-adjusted, Surgical Site Infection (SSI) rate of lumbar patients, MSSIC-All**	
		≤ 2.0%	10
		2.01-2.25%	5
		>2.25%	0
Enhanced Recovery After Spine Surgery (ERASS), Phase 1 Performance Measures - (50 points below)			
10	10	**Demonstration of site/team engagement through the submission of quarterly meeting attendance sheet and minutes supporting discussion and establishment of ERASS.**	
		4/4 meeting submissions	10
		3/4 meeting submissions	5
		2 or less/4 meeting submissions	0
11	30	**No later than 9/30/21, each site will submit the following deliverables as evidence of a fully developed and implemented ERASS program:**	
		ERASS protocol document outlining how each required component will be implemented. Template provided by the Coordinating Center.	10
		Submission of applicable ERASS supporting documents: order sets, protocols, and risk-assessment tools implemented in support of the ERASS program.	10
		Submission of site's formal, pre-surgical patient education content	10
12	10	**Site Specific, benchmark goal: Early Ambulation- % of all spine patients (cervical and lumbar) with first ambulation within 8 hours of surgery stop time (rates rounded to the nearest whole number)**	
		70% or greater	10
		54-69%	5
		< 54%	0

Cohort 1, 2, & 3
The MSSIC Performance Index is separated into two areas of focus, participation and performance. Each focus area is then divided into measures, with each measure being assigned a point value for a total of 100 points possible. Participation points total 30 and performance points total 70.

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

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

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

Performance: In 2021, Cohorts 1, 2 and 3 have the same requirements and point distribution.

Patient questionnaires: Patients in the MSSIC registry are asked to complete a validated health status questionnaire prior to surgery and then at 3, 12, and 24 months after surgery. The questionnaires can be completed on paper, on the MSSIC website, or by phone. Each participating site is responsible to reach out to their patients to collect this information. Questionnaires are an essential data element and collection is required as described in the Eligibility and Expectations document. As we continue to move forward, Patient-reported Outcome (PRO) data will be used as a measure of success for Quality Improvement Initiatives (QII). Questionnaire data collection has always been an expectation and makes up half of the FTE model for abstractors.

Questionnaires are divided into two measures: baseline collection and post-operative collection average. COVID-19 has impacted questionnaire collection for both baseline and post-op. We are giving sites a year to reevaluate and implement new processes that may be more effective. Currently, we are dropping the points from 10 points to 5 points each. The goals for full points in both measures were established based upon the top 50% performing sites.

Enhanced Recovery After Spine Surgery (ERASS) Phase 1:
During ERASS, Phase 1, sites will demonstrate **site engagement** through the submission of quarterly meeting attendance and minutes which support the development and implementation of ERASS. The Coordinating Center will supply a "MSSIC Quarterly ERASS Meeting Minutes" template to help sites communicate meeting discussions concisely and provide a list of meeting attendees. Content should be high-level, and we are only interested in ERASS related discussion. The due dates for the **4 deliverables** are as follows:

- Meeting between October 1 – December 31, 2020. **Submit form by January 4, 2021.**
- Meeting between January 1 – March 31, 2021. **Submit form by April 5, 2021.**
- Meeting between April 1 – June 30, 2021. **Submit form by July 5, 2021.**
- Meeting between July 1 – September 30, 2021. **Submit form by September 30, 2021.**

Additionally, sites will submit for approval by the Coordinating Center the following deliverables as evidence of a fully developed and implemented ERASS program **no later than 9/30/21**:

- ERASS Protocol Document (template provided by the Coordinating Center) outlining how each required component will be implemented at the site. The content should be high-level, and the template will provide fields for specific information that is requested.
- Submission of applicable ERASS supporting documents:
    - Order sets, protocols, and risk-assessment tools implemented in support of the ERASS program. These supporting documents will also be listed in each section of the ERASS Protocol Document to assist you.
- Submission of formal, pre-surgical patient education content. Examples:
    - If a site offers a "live" class (in person or virtually), submit the class outline/content and any resources given
    - If a site offers a pre-recorded education video or education link via the computer, submit the link or DVD.

2021 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) Cohort 4, Year 2 **(2 sites)** Measurement Period: 10/01/2020-09/30/2021, unless otherwise stated			
Measure #	Weight	Measure Description	Points
1	15	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	15
		Attended 2 out of 3 meetings	10
		Attended 1 out of 3 meetings	5
		No Attendance	0
2	15	**Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (If > 1 abstractor at site, only 1 abstractor need attend triannual meetings, however, <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 Spine Surgery (ERASS), Phase 1 Performance Measures - (20 points below)			
7	5	**Demonstration of site/team engagement through the submission of quarterly meeting attendance sheet and minutes supporting discussion and establishment of ERASS.**	
		4/4 meeting submissions	5
		3/4 meeting submissions	3
		2 or less/4 meeting submissions	0

2021 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 2) Cohort 4, Year 2 **(2 sites)** Measurement Period: 10/01/2020-09/30/2021, unless otherwise stated			
Measure #	Weight	Measure Description	Points
8	15	**No later than 9/30/21, each site will submit the following deliverables as evidence of a fully developed and implemented ERASS program:**	
		ERASS protocol document outlining how each required component will be implemented. Template provided by the Coordinating Center.	5
		Submission of applicable ERASS supporting documents: order sets, protocols, and risk-assessment tools implemented in support of the ERASS program.	5
		Submission of site's formal, pre-surgical patient education content	5

Cohort 4, Year 2
The MSSIC Performance Index is separated into two areas of focus, participation and performance. Each focus area is then divided into measures, with each measure being assigned a point value for a total of 100 points possible. Participation points total 80 and performance points total 20.

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

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

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

Performance: In 2021, Cohort 4, year 2 has a 20-point performance distribution.

Patient questionnaires: Patients in the MSSIC registry are asked to complete a validated health status questionnaire prior to surgery and then at 3, 12, and 24 months after surgery. The questionnaires can be completed on paper, on the MSSIC website, or by phone. Each participating site is responsible to reach out to their patients to collect this information. Questionnaires are an essential data element and collection is required as described in the Eligibility and Expectations document. As we continue to move forward, Patient-reported Outcome (PRO) data will be used as a measure of success for Quality Improvement Initiatives (QII). While questionnaire data collection is not represented in the Cohort 4, year 2 Performance Index, it has always been an expectation and makes up half of the FTE model for abstractors.

Enhanced Recovery After Spine Surgery (ERASS) Phase 1:
During ERASS, Phase 1, sites will demonstrate **site engagement** through the submission of quarterly meeting attendance and minutes which support the development and implementation of ERASS. The Coordinating Center will supply a "MSSIC Quarterly ERASS Meeting Minutes" template to help sites communicate meeting discussions concisely and provide a list of meeting attendees. Content should be high-level, and we are only interested in ERASS related discussion. The due dates for the **4 deliverables** are as follows:

- Meeting between October 1 – December 31, 2020. **Submit form by January 4, 2021.**
- Meeting between January 1 – March 31, 2021. **Submit form by April 5, 2021.**
- Meeting between April 1 – June 30, 2021. **Submit form by July 5, 2021.**
- Meeting between July 1 – September 30, 2021. **Submit form by September 30, 2021.**

Additionally, sites will submit the following deliverables as evidence of a fully developed and implemented ERASS program **no later than 9/30/21**:

- ERASS Protocol Document (template provided by the Coordinating Center) outlining how each required component will be implemented at the site. The content should be high-level, and the template will provide fields for specific information that is requested.
- Submission of applicable ERASS supporting documents:
    - Order sets, protocols, and risk-assessment tools implemented in support of the ERASS program. These supporting documents will also be listed in each section of the ERASS Protocol Document to assist you.
- Submission of formal, pre-surgical patient education content. Examples:
    - If a site offers a "live" class (in person or virtually), submit the class outline/content and any resources given
    - If a site offers a pre-recorded education video or education link via the computer, submit the link or DVD.

2021 Michigan Spine Surgery Improvement Collaborative Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) Cohort 5, Year 1 Measurement Period: 10/01/2020-09/30/2021, unless otherwise stated			
Measure #	Weight	Measure Description	Points
1	15	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	15
		Attended 2 out of 3 meetings	10
		Attended 1 out of 3 meetings	5
		No Attendance	0
2	10	**Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (If > 1 abstractor at site, only 1 abstractor need attend triannual meetings, however, <u>all</u> abstractors are required to attend the annual Abstractor Symposium)**	
		Attended all 4	10
		Attended 3 out of 4	6
		Attended 2 out of 4	3
		Attend 1 or none	0
3	15	**Conference Calls Surgeon Champion (3 calls/year)**	
		Attended 3 calls	15
		Attended 2 calls	10
		Attended 1 call	5
		No Calls	0
4	10	**Conference Calls - Clinical Data Abstractor (8 calls/year)**	
		Participate on 8 calls	10
		Participate on 7 calls	6
		Participate on 6 calls	3
		Participate on less than 6 calls	0
5	10	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one triannual MSSIC meeting	10
		No Attendance	0
6	10	**Annual Audit Review – Data Review: Accuracy of data -**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
7	15	**All official documents signed: IRB, Data Use Agreement, Business Associate Agreement, and Software Agreement**	
		Within 2 months of Coordinating Center approval date to proceed	15
		Within 3 months of Coordinating Center approval date to proceed	12
		Within 4 months of Coordinating Center approval date to proceed	8
7	15	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

2021 Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 1) Measurement Period: 1/01/2021-12/31/2021, unless otherwise stated			
Measure #	Weight	Measure Description	Points
1	10	**Accuracy of Data**	
		5-star audit score	10
		4-star audit score	8
		3-star audit score	6
		≤ 2-star audit score	0
2	10	**Quarterly collaborative meeting participation - surgeon lead**	
		Attended 4 quarterly meetings; one alternate surgeon*	10
		Attended 4 quarterly meetings	8
		Attended 3 quarterly meetings; one alternate surgeon*	7
		Attended 3 quarterly meetings	6
		Attended 2 quarterly meetings; one alternate surgeon*	5
		Attended 2 quarterly meetings	4
		Attended 1 quarterly meeting; one alternate surgeon*	3
		Attended 1 quarterly meeting	2
		Attended 0 quarterly meetings	0
3	5	**Quarterly collaborative meeting participation - data manager/representative**	
		Attended 4 quarterly meetings	5
		Attended 3 quarterly meetings	4
		Attended 2 quarterly meetings	2
		Attended 1 quarterly meeting	1
		Attended 0 quarterly meetings	0
4	5	**Quarterly data manager educational meeting - data manager**	
		Attended 4 data manager meetings	5
		Attended 3 data manager meetings	4
		Attended 2 data manager meetings	2
		Attended 1 data manager meeting	1
		Attended 0 data manager meetings	0
5	15	**Collaborative-wide quality initiative 2021: Left Atrial Appendage Ligation for patients with history of atrial fibrillation/flutter – All Risk Model Procedures**	
		Collaborative mean rate >75 %	15
		Collaborative mean > 60-74%	5
		Collaborative mean < 60%	0
6	15	**Site Specific Quality Initiative**	
		Met improvement goal	15
		Improved but did not meet goal	10
		Implemented plan but did not improve	5
		Unable to implement plan	0
7	20	**Isolated CABG: O/E mortality for 12 months**	
		O/E ≤ 1.0	20
		O/E ≤ 1.5	10
		O/E > 1.5	0
8	20	**Isolated AVR: O/E mortality for 36 months** (January 1, 2019–December 31, 2021)	
		O/E ≤ 1.0	20
		O/E ≤ 1.5	10
		O/E > 1.5	0

2021 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 1) Measurement Period: 01/01/2021-12/31/2021			
Measure #	Weight	Measure Description	Points
1	10	**Data Submission**	
		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**	
		Surgeon, and TPM or MCR participate in 3 of 3 meetings	9
		Surgeon, and TPM or MCR participate in 2 of 3 meetings	6
		Surgeon, and TPM or MCR participate in 0-1 of 3 meetings	0
		Registrar or MCR participate in annual data abstractor meeting	1
3	10	**Data Validation Error Rate**	
		0-3.0%	10
		3.1-4.0%	8
		4.1-5.0%	5
		> 5.0%	0
4	10	**Timely LMWH VTE Prophylaxis Trauma Admits** (18 mo: 1/1/20-6/30/21)	
		≥ 52.5% of patients (≤ 48 hr)	10
		≥ 50.0% of patients (≤ 48 hr)	8
		≥ 45.0% of patients (≤ 48 hr)	5
		< 45.0% of patients (≤ 48 hr)	0
5	10	**Timely Surgical Repair Geriatric (Age ≥ 65) Isolated Hip Fxs** (12 mo: 7/1/20-6/30/21)	
		≥ 92.0% of patients (≤ 48 hr)	10
		≥ 87.0% of patients (≤ 48 hr)	8
		≥ 85.0% of patients (≤ 48 hr)	5
		< 85.0% of patients (≤ 48 hr)	0
6	10	**RBC to Plasma Ratio in Massive Transfusion** (18 mo: 1/1/20-6/30/21) Weighted Mean Points in Patients Transfused ≥ 5 Units 1st 4 hr	0-10
7	10	**Serious Complication Z-Score Trend Trauma Admits** (3 yr: 7/1/18-6/30/21)	
		< -1 (major improvement)	10
		-1 to 1 or serious complications low-outlier (average or better rate)	7
		> 1 (rates of serious complications increased)	5
8	10	**Mortality Z-Score Trend Trauma Admits** (3 yr: 7/1/17-6/30/20)	
		< -1 (major improvement)	10
		-1 to 1 or mortality low-outlier (average or better)	7
		> 1 (rates of mortality increased)	5
9	10	**Timely Head CT TBI Patients on Anticoagulation Pre-Injury** (12 mo: 7/1/20-6/30/21)	
		≥ 90% patients (≤ 120 min)	10
		≥ 80% patients (≤ 120 min)	7
		≥ 70% patients (≤ 120 min)	5
		< 70% patients (≤ 120 min)	0
10	10	**Collaborative Wide Measure: Timely Antibiotic Femur/Tibia Open Fractures**	
		(12 mo: 7/1/20-6/30/21)	
		≥ 85% patients (≤ 120 min)	10
		< 85% patients (≤ 120 min)	0

2021 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard (pg. 1 of 2) Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
1	5	**MI AIM/ OBI Hospital Structure Survey**	**5**
		Complete the 2021 MI AIM OBI Hospital Structure Survey	5
2	10	**Attendance at the OBI Collaborative SemiAnnual Meetings**	**10**
		At least one Multistakeholder Team Member attends both SemiAnnual Collaborative Meetings (Spring SemiAnnual on April 23, 2021 & Fall SemiAnnual on November 12, 2021)	5
		Clinical Data Abstractor (CDA) or designee attends both SemiAnnual Collaborative Meetings (Spring SemiAnnual on April 23, 2021 & Fall SemiAnnual on November 12, 2021)	5
3	20	**Maternity Unit Culture**	**20**
		Shared Decision Making:	
		Adopt the TeamBirth Model: Attend trainings and implement core program components* by June 30, 2021	15
		Adopt the TeamBirth Model: Attend trainings but did not fully implement core project components* by June 30, 2021	10
		OR	
		Implement a shared decision-making training for physicians, CNMs, and Nurses by June 30, 2021	
		Demonstrate >80% Percent maternity care staff participation in this activity	15
		Achieved 50 - 80% participation	10
		Achieved <50% participation	5
		Labor Culture Survey:	
		If your hospital DID NOT participate in the 2020 Labor Culture Survey, offer the survey by March 31, 2021ŸŸ	5
		If your hospital DID participate in 2020 Labor Culture Survey, report on team activities you have done to address your team culture via the OBI Workstation by June 30, 2021	
4	40	**Performance Measure: Quality Improvement Initiative (QII)**	**40**
		QII Choice 1: Early Labor Admission Screening Checklist	
		OR	
		QII Choice 2: Supporting Labor Progress	
		Scores ≥ 90 points on selected QII	40
		Scores 75-89 points on selected QII	35
		Scores 50-74 points on selected QII	25
		Scores 1-49 points on selected QII	10
		No implementation	0

2021 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard (pg. 2 of 2) Measurement Period: 01/01/2021 - 12/31/2021			
Measure #	Weight	Measure Description	Points
5	15	**Education**	**15**
		Peer-to-Peer Engagement: Video Workgroups	
		Attend 4 out of 6 monthly video peer-to-peer workgroups	8
		Webinars	
		Disseminate each of the 4 quarterly OBI Webinars to unit staff	7
		***CME and CEU available*	
6	10	**Site NTSV Case Selection Audit**	**10**
		Completed case selection audit with coordinating center by December 1, 2021	10
		TOTAL	**100**

Additional Details on Options for OBI Performance Measure

Quality Improvement Implementation Choice 1: Early Labor Admission Screening Checklist	
Project Time Period:	1/1/2021 – 12/31/2021
Target population	**Inclusion criteria:** NTSV cases who are admitted in spontaneous labor with or without rupture of membranes **Exclusion criteria:** Admission for induction of labor OR Planned cesareans **<u>Numerator</u>:** Triage visit that resulted in labor admission where cervical dilation was <4cm *with documentation of checklist use* **OR** Triage visit for labor evaluation (that did not result in admission) within 72 hours of labor admission with *documentation of checklist use* **<u>Denominator</u>:** Triage visit that resulted in labor admission where cervical dilation was <4cm meeting above inclusion/exclusion criteria **OR** Triage visit for labor evaluation (that did not result in admission) within 72 hours of labor admission meeting above inclusion/exclusion criteria
Goal	1. Reduce the NTSV CD rate attributed to early admission in labor 2. Standardize the admission process 3. Increase use of checklist that supports outpatient management with cervical dilation <4cm and reduce the number of women admitted in early spontaneous labor without indication. 4. Review the indications for early admission to optimize strategies for labor management for these patients
Baseline data	In a rapid review of unadjusted 2019 OBI data*, 37% of women who presented to triage in spontaneous labor with intact membranes and had a cervical exam were admitted with less than 4cm dilation. The women who were admitted at less than 4cm dilation had a 1.6 higher risk of cesarean delivery than those who were admitted at 4 cm or greater dilation. *based on 30% sample of OBI participating hospitals 2019 NTSV delivery volume.

Background:
The Admission Screening Checklist is a guide to promote safe outpatient management of early labor. The California Maternal Quality Clinical Collaborative (CMQCC) published the checklist, and the Obstetrics Initiative subsequently modified and then promoted its use among its OBI member hospitals as Option A (see Appendix A). The data in the OBI Workstation is consistent with many analyses published in the literature and suggest that optimizing the timing of inpatient admission is a strategy to reduce the NTSV cesarean delivery rate.

Project Goal:
This work will be an ongoing process of building quality improvement activities into practice. These activities will evolve and change over time based on individual sites needs and successes, and will also extend beyond the measurement timeframes outlined in the implementation goals section below. (Many sites have asked for a goal cesarean delivery rate for which to aim. We recognize that there is no medically established ideal cesarean birth rate. Instead we have chosen to focus less on the CD rate as a goal, but data driven process measures that will ultimately lead to the right sizing of your individual hospital rate.) For those that still wish to have a number in mind as a goal, we point you to the Healthy People 2020 goal rate of 24.7%**, as well as the newly established Joint Commission public reporting hospital quality indicator reporting guidelines.

***The Healthy People 2020 goal was revised in 2019 from a goal of 23.9% to 24.7%. The goal was set to achieve a 10% reduction in NTSV cesarean births between 2010 and 2020. The baseline cesarean birth rate from 2010 was recalculated and this led to the change in the 2020 target. See https://www.healthypeople.gov/2020/topics-objectives/objective/mich-71 for more information*.

QI Implementation Requirements:
NTSV patients presenting in early spontaneous labor with or without rupture of membranes should be screened with the checklist to determine if they can continue outpatient management safely. Given that many patients who present to rule out labor will not be admitted, OBI will track the use of the checklist with each triage visit within 72 of the delivery admission time. Participating hospitals using this metric should develop a plan for providing OBI with how they will make checklist tracking data available to OBI. If this is not in your EHR, then an alternative method will need to be created. Points for implementation of the QI program will be awarded on a prorated basis. Partial points will be awarded based upon actual performance. The maximum allowable points for each deliverable are listed in brackets.

QI Implementation Goals:

Implement the following process measure for NTSV patients that present to your hospital in spontaneous labor as specified below:

	PROCESS MEASURE	HOW IT WILL BE MEASURED	TIME FRAME	POINTS AVAILABLE
A	The screening checklist is used in 80% of NTSV triage visits presenting for labor evaluation. Each labor evaluation will be counted in the denominator. (See Appendix A for minimum Checklist requirements)	A per case question will be added to the Workstation for patients admitted in spontaneous labor <4cm and for patients with a triage visit within 72 hours of labor admission.	March 1, 2021 – October 31, 2021 delivery dates	≥80%: 40 pts 70-79%: 30 pts 60-69%: 20 pts 50-59%: 10 pts <50%: 0 pts
B	Conduct quarterly multidisciplinary team meetings to discuss project progress, including data related to this measure. Two of these quarterly meetings must involve disseminating relevant OBI data and implementation progress with the maternity care team (i.e. using a grand rounds format for these meetings, early and mid-year preferred to help kick off your project and inform the full maternity care team of project progress).	Sites will submit an agenda and roster to the OBI Coordinating Center by quarterly deadlines.	January – December 2021 Quarterly	4 mtgs: 30 Pts 3 mtgs: 20 pts 2 mtgs: 10 pts
C	Submit program implementation progress reports quarterly. Include specific barriers to checklist uptake if target goals are not being met.	OBI Workstation Program Progress Reports submitted by quarterly deadlines.	January – December 2021 Quarterly	4 reports: 30 Pts 3 reports: 20 pts 2 reports: 10 pts
			TOTAL	100 points

Quality Improvement Implementation Choice 2: Supporting Labor Progress	
Project Time Period:	1/1/2021 – 12/31/2021
Target population	**Inclusion criteria:** NTSV cases where a cesarean Delivery (CD) was performed for *one* of the following primary indications: ● Failed Induction ● Latent Phase Arrest ● Active Phase Arrest ● Arrest of Descent **Exclusion criteria:** ● Planned Cesarean Delivery without Labor ● Cesarean Deliveries undertaken for reasons other than the primary indications outlined above **Numerator:** NTSV CDs undertaken for a primary indication of Failed Induction, Latent Phase Arrest, Active Phase Arrest, OR Arrest of Descent that were reviewed by one of the processes outlined below. **Denominator:** NTSV CDs undertaken for a primary indication of Failed Induction, Latent Phase Arrest, Active Phase Arrest, OR Arrest of Descent
Goal	Increase the number of sites that have a standardized process for team review of CD decision making for dystocia. With use of a standardized review process (criteria checklist or two provider review, or quality improvement review), there will be a decrease in the number of NTSV Cesarean Deliveries that do not meet criteria as defined by ACOG and SMFM for arrest disorders.
Baseline data	The criteria for dystocia in labor as defined by ACOG/SMFM were not met in 52% of NTSV cesarean deliveries (CD) performed in Michigan maternity hospitals in 2019 (OBI Workstation) with 62% of those not meeting criteria when performed during latent phase labor, 24% during active phase, and 65% when performed for arrest of descent. For failed induction of labor, 60% did not meet ACOG/SMFM criteria for CD.

Background:
The focus of this project is to provide a structure for the review of cesarean births performed for arrest disorders. This work will be an ongoing process of building quality improvement activities into practice. These activities will evolve and change over time based on individual sites needs and successes, and will also extend beyond the measurement timeframes outlined in the implementation goals section below.

QI Implementation Requirements:
All NTSV cases where decision for cesarean delivery was made, should be reviewed either before the cesarean delivery or during a retrospective peer review process. In addition to OBI core data collection, participating hospitals should develop a plan for providing OBI with evidence of this review process. If this is not in your EHR, then an alternative method will need to be created. Points for implementation of the QI program will be awarded on a prorated basis. Partial points will be awarded based upon actual performance. The maximum allowable points for each deliverable are listed in brackets.

QI Implementation Goals:

Implement the following process measure for review cesarean births performed for arrest disorders for the NTSV patient population:

	PROCESS MEASURE	HOW IT WILL BE MEASURED	TIME FRAME	POINTS AVAILABLE
A	NTSV Cesarean Deliveries performed for dystocia are reviewed using a standardized process to determine if ACOG/SMFM criteria for the diagnosis are met. The review should include evidence that ACOG guidelines have been met or the indication to deviate from guidelines is documented. Select one of the review options outlined in **Table 2.** (Refer to Appendix B for template option and necessary review components)	The proportion of NTSV CDs for dystocia that were reviewed using the standardized process.	March 1, 2021 – October 31, 2021 delivery dates	≥80%: 40 pts 70-79%: 30 pts 60-69%: 20 pts 50-59%: 10 pts <50%: 0 pts
B	Conduct quarterly multidisciplinary team meetings to discuss project progress, including data related to this measure. Two of these quarterly meetings must involve disseminating relevant OBI data and implementation progress with the full maternity care team (i.e. using a grand rounds format for these meetings, early and mid-year preferred to help kick off your project and inform the full maternity care team of project progress).	Sites will submit an agenda and roster to OBI Coordinating Center by quarterly deadlines.	January – December 2021 Quarterly	4 mtgs: 30 Pts 3 mtgs: 20 pts 2 mtgs: 10 pts
C	Submit program implementation progress reports quarterly. Include specific barriers to checklist uptake if target goals are not being met.	OBI Workstation Program Progress Reports submitted by quarterly deadlines.	January – December 2021 Quarterly	4 reports: 30pts 3 reports: 20 pts 2 reports: 10 pts
			TOTAL	100