2022 Hospital Pay-for-Performance Program
(for peer groups 1 through 4)

Hospital CQI
Performance Index Scorecards

Program Guide

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2022 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohort 1 - 5** Measurement Period: 01/01/2022 - 12/31/2022			
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 January - November and by the 2nd Wednesday of the month for December. Data must be of high quality upon submission, >90% of diagnostics marked as 'Data Accurately Represented.'**	
		10 - 12/12 Months	5
		9 or Less Months	0
4	5	**Site Based Quality Meetings: Sites to hold an onsite in-person or virtual meeting following the three ASPIRE Collaborative meetings to discuss the data and plans for quality improvement at their site**	
		3 Meetings	5
		2 or less Meeting	0
5	10	**ACQR attendance at Fall ACQR Retreat**	
		Yes	10
		No	0
6	25	**Performance Measure: Pain (PAIN 02) Percentage of patients ≥ 18 years old who undergo a surgical or therapeutic procedure and receive a non-opioid adjunct preoperatively and/or intraoperatively.** (cumulative score January 1, 2022 - December 31, 2022)	
		Performance is ≥ 75%	25
		Performance is ≥ 70%	15
		Performance is ≥ 65%	10
		Performance is < 60%	0
7	20	**Performance 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**	
		Performance is ≥ 90%	20
		Performance is ≥ 85%	10
		Performance is ≥ 75%	0
8	25	**Performance Measure: Site Directed Measure: Sites choose a measure they are performing above/below ASPIRE threshold or needs improvement by December 10, 2022**	

2022 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohort 1 - 5** Measurement Period: 01/01/2022 - 12/31/2022			
Measure #	Weight	Measure Description	Points
		(cumulative score January 1, 2022 through December 31, 2022)	
		Performance is ≥90%; ≤10%; ≤5% or show ≥25% improvement	25
		Performance is ≥85%; ≤15%; ≤10% or show ≥15% improvement	15
		Performance is ≥80%; ≤20%; ≤15% or show ≥10% improvement	10
		Performance is <80%; >20%; >15% or show <10% improvement	0

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

2022 Performance Index Scorecard

Measure Explanation: Cohorts 1 – 5 (2015 – 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 2022. There are three total meetings with six opportunities for attendance:

1. MSQC / ASPIRE Meeting: Friday, April 8, 2022
2. ASPIRE Collaborative Meeting: Friday, July 15, 2022
3. MPOG Retreat: Friday, October 21, 2022

Measure #2: There will be six Quality Committee e-meetings in 2022. One representative (ASPIRE Quality Champion or ACQR) must attend the meetings:

1. Monday, January 24, 2022
2. Monday, March 28, 2022
3. Monday, May 23, 2022
4. Monday, July 25, 2022
5. Monday, September 26, 2022
6. Monday, November 28, 2022

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

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

Measure #5: ACQR must attend the Fall ACQR Retreat to be held on Friday, September 16, 2022.

Measure #6: Sites will be awarded points for compliance with the multimodal pain measure PAIN 02 (cumulative score January 1, 2022 through December 31, 2022). See P4P Scorecard for point distribution.

Measure #7: Sites will be awarded points for compliance with the sustainability measure SUS 01 (cumulative score January 1, 2022 through December 31, 2022). See P4P Scorecard for point distribution.

Measure #8: Sites will choose a measure where performance is above/below the ASPIRE threshold or a measure that needs improvement. Sites must submit their current measure score (November 1, 2020 through October 31, 2021) to the Coordinating Center by Friday, December 10, 2021 for review and approval (cumulative score January 1, 2022 through December 31, 2022). Measure selection form is located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section. See P4P Scorecard for point distribution.

2022 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohort 6** Measurement Period: 01/01/2022 - 12/31/2022			
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 3rd Wednesday of each month for January - November and by the 2nd Wednesday of the month for December. Data must be of high quality upon submission, >90% of diagnostics marked as 'Data Accurately Represented.'**	
		11 / 12 Months	20
		10 / 12 Months	10
		9 / 12 Months	5
		8 Months or Less	0
4	10	**ASPIRE Quality Champion and ACQR monthly meetings**	
		12 / 12 Months	10
		11 / 12 Months	5
		10 / 12 Months	0
5	10	**Site Based Quality Meetings: Sites to hold an onsite in-person or virtual meeting following the three ASPIRE Collaborative meetings to discuss the data and plans for quality improvement at their site**	
		3 Meetings	10
		2 Meetings	5
		1 or Less Meetings	0
6	10	**ACQR attendance at Fall ACQR Retreat**	
		Yes	10
		No	0
7	10	**Neuromuscular Blockage (NMB 01) Percentage of cases with a documented Train of Four (TOF) after last dose of non-depolarizing neuromuscular blocker** (cumulative score 1/1/2022 - 12/31/2022)	
		Performance is ≥ 90%	10
		Performance is < 90%	0

2022 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohort 6** Measurement Period: 01/01/2022 - 12/31/2022			
Measure #	Weight	Measure Description	Points
8	10	**Site Directed Measure: Sites choose a measure they are performing above/below ASPIRE threshold or needs improvement by December 10, 2022** (cumulative score January 1, 2022 through December 31, 2022)	
		Performance is ≥90%; ≤10%; ≤5% or show ≥25% improvement	10
		Performance <90%; >10%; >5% or show up to 25% improvement	5
		Performance <90%; >10%; >5% or shows no improvement	0

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)

2022 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 2022. There are three total meetings with six opportunities for attendance:

1. MSQC / ASPIRE Meeting: Friday, April 8, 2022
2. ASPIRE Collaborative Meeting: Friday, July 15, 2022
3. MPOG Retreat: Friday, October 21, 2022

Measure #2: There will be six Quality Committee e-meetings in 2022. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2022 meetings:

1. Monday, January 24, 2022
2. Monday, March 28, 2022
3. Monday, May 23, 2022
4. Monday, July 25, 2022
5. Monday, September 26, 2022
6. Monday, November 28, 2022

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

Measure #4: ASPIRE Quality Champion and ACQR need to meet 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 collaborative meetings (see Measure #1 for dates) to discuss site based and collaborative quality outcomes with clinical providers at their site. Sites must send the coordinating center the site-based collaborative meeting report located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section.

Measure #6: ACQR must attend the fall ACQR Retreat to be held on Friday, September 16, 2022.

Measure #7: Sites will be awarded points for compliance with the neuromuscular blockade NMB 01 measure (cumulative score January 1, 2022 through December 31, 2022). See P4P Scorecard for point distribution.

Measure #8: Sites will choose a measure where performance is above/below the ASPIRE threshold or a measure that needs improvement. Sites must submit their current measure score (November 1, 2020 through October 31, 2021) to the Coordinating Center by Friday, December 10, 2021 for review and approval (cumulative score January 1, 2022 through December 31, 2022). Measure selection form is located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section. See P4P Scorecard for point distribution.

2022 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined** Measurement Period: 01/01/2022 – 9/30/2022				
Measure #	Weight	Measure Description	PCI Points	VS Points
1	10	**Meeting Participation - Clinician Lead**		
		2 Meetings	5	5
		1 Meeting	2.5	2.5
		Did not participate	0	0
2	5	**Data Coordinator Expectations**		
		Meets all expectations	2.5	2.5
		Meets most expectations	1	1
		Does not meet expectations	0	0
3	2.5	**Internal Case Reviews**		
		Submitted reviews for ≥90% of cases	2.5	N/A
		Submitted reviews for <90% of cases	0	N/A
4	2.5	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**		
		Submitted reviews for 100% of cases	2.5	N/A
		Submitted reviews for <100% of cases	0	N/A
5	10	**Vascular Surgery Performance Goal – Documentation of EVAR† imaging (CT Angiogram or ultrasound) performed on the 1-year follow up form–**		
		≥70%	NA	10
		60% - <70%	NA	5
		<60%	NA	0
6	10	**Vascular Surgery Performance Goal – Completion of 1-year follow up forms**		
		≥90%	NA	10
		85% - <90%	NA	5
		<85%	NA	0
7	10	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with EVAR† at discharge**		
		≥70%	NA	10
		60% - <70%	NA	7.5
		<60%	NA	0
8	10	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with CEA* at discharge**		
		≥70%	NA	10
		60% - <70%	NA	7.5
		<60%	NA	0
9	10	**PCI Performance Goal – Documentation of recommended P2Y12 therapy duration–**		
		≥70%	10	NA
		60% - <70%	7.5	NA
		<60%	0	NA

2022 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Collaborative Quality Initiative Performance Index Scorecard **PCI & VS Combined** Measurement Period: 01/01/2022 – 9/30/2022				
Measure #	Weight	Measure Description	PCI Points	VS Points
10	10	**–PCI Performance Goal – Percent of cases with Air Kerma dose ≥5 Gray**		
		<1%, or >=50% reduction from Q4 YTD 2021 Air Kerma >=5 Gray	10	NA
		>1% - 2% or >=40% reduction from Q4 YTD 2021 Air Kerma >=5 Gray	7.5	NA
		>2% - 3% or >=30% reduction from 2021 Air Kerma >=5 Gray	5	NA
		>3%	0	NA
11	10	**PCI Performance Goal – Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).—**		
		≥50%	10	NA
		40% - <50%	5	NA
		<40%	0	NA
12	10	PCI Performance Goal – Major bleeding (within 72 hours of PCI, excludes patients with concurrent interventions)		
		<0.85%	10	NA
		>0.85% - 1%	5	NA
		>1%	0	NA

2022 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Collaborative Quality Initiative Performance Index Scorecard **Vascular Surgery Only** Measurement Period: 01/01/2022 – 9/30/2022			
Measure #	Weight	Measure Description	Points
1	15	**Meeting Participation - Clinician Lead**	
		2 Meetings	15
		1 Meeting	10
		Did not participate	0
2	15	**Data Coordinator Expectations**	
		Meets all expectations	15
		Meets most expectations	10
		Does not meet expectations	0
3	20	**Vascular Surgery Performance Goal - Documentation of EVAR† imaging performed on the 1-year follow up form**	
		≥70%	20
		60% - <70%	15
		50% - <60%	10
		<50%	0
4	20	**Vascular Surgery Performance Goal - Completion of 1-year follow up forms**	
		≥90%	20
		85% - <90%	15
		80% - <85%	10
		<80%	0
5	15	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with EVAR† at discharge**	
		≥70%	155
		60% - <70%	10
		<60%	0
6	15	**Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 4 opioid pills for opioid naïve patients with CEA* at discharge**	
		≥70%	15
		60% - <70%	10
		<60%	0

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

2022 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Collaborative Quality Initiative Performance Index Scorecard **PCI Only** Measurement Period: 01/01/2022 - 12/31/2022			
Measure #	Weight	Measure Description	Points
1	10	**Meeting Participation - Clinician Lead**	
		2 Meetings	5
		1 Meeting	2.5
		Did not participate	0
2	10	**Data Coordinator Expectations**	
		Meets all expectations	10
		Meets most expectations	7.5
		Does not meet expectations	0
3	10	**Internal Case Reviews**	
		Submitted reviews for ≥90% of cases	10
		Submitted reviews for <90% of cases	0
4	10	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
5	15	**PCI Performance Goal – Documentation of recommended P2Y12 therapy duration**	
		≥70%	15
		60% - <70%	10
		<60%	5
6	15	**PCI Performance Goal - Percent of cases with Air Kerma dose ≥5 Gray**	
		≤1%, or >=50% reduction from Q4 YTD 2021 Air Kerma >=5 Gray	15
		>1% - 2% or >=40% reduction from Q4 YTD 2021 Air Kerma >=5 Gray	10
		>2% - 3% or >=30% reduction from 2021 Air Kerma >=5 Gray	5
		>3%	0
7	15	**PCI Site Performance Goal - Pre PCI hydration (oral and/or IV) (volume/3ML/Kg) in patients with eGFR** < 60 (excludes dialysis, cardiac arrest, cardiogenic shock, PCI status of "salvage" and symptomatic heart failure NYHA^^ 2,3,4, and STEMI††).**	
		≥50%	15
		40% - <50%	10
		<40%	0
8	15	PCI Performance Goal - Major bleeding (within 72 hours of PCI, excludes patients with concurrent interventions)	
		<0.85%	15
		>0.85% - 1%	10
		>1%	0

5 sites participate in PCI only
**eGFR=estimated glomerular filtration rate
^^NYHA= New York Heart Association heart failure class
††STEMI=ST elevated myocardial infarction

2022 Michigan Hospital Medicine Safety Consortium (HMS) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 08/02/2022 - 11/9/2022 (PICC Insertions/Hospital Discharges)- Hospitals Enrolled Prior to 2021			
Measure #	Weight	Measure Description	Points
1	5	**Timeliness of HMS Data [1]**	
		On time > 95% at Mid-Year AND End of Year	5
		On time > 95% at Mid-Year OR End of Year	3
		On time < 95% at Mid-Year AND End of Year	0
2	5	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, AND audit case corrections completed by due date	5
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed OR audit case corrections not completed by due date	0
3	10	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	10
		2 meetings	5
		1 meeting	0
		No meetings	0
4	10	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	10
		2 meetings	5
		1 meeting	0
		No meetings	0
5	10	**Increase Use of 5 Days of Antibiotic Treatment[6] in Uncomplicated CAP (Community Acquired Pneumonia) Cases[5] (i.e., reduce excess durations)**	
		≥ 60% 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 Use6 in Patients with a Positive Urine Culture5 and Uncomplicated CAP (Community Acquired Pneumonia)**	
		≤ 10% of positive urine culture cases receive non-preferred Fluoroquinolone AND ≤ 10% of uncomplicated CAP received non-preferred Fluoroquinolone	10
		≤ 10% of positive urine culture cases receive non-preferred Fluoroquinolone OR ≤ 10% of uncomplicated CAP received non-preferred Fluoroquinolone	5
		> 10% of positive urine culture cases receive non-preferred Fluoroquinolone AND > 10% of uncomplicated CAP received non-preferred Fluoroquinolone	0

2022 Michigan Hospital Medicine Safety Consortium (HMS) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 08/02/2022 - 11/9/2022 (PICC Insertions/Hospital Discharges)- Hospitals Enrolled Prior to 2021			
Measure #	Weight	Measure Description	Points
7	10	**Reduce Use of Antibiotics[9] in Patients with ASB** (Asymptomatic Bacteriuria) [5,10]	
		≤ 12% of positive urine culture cases treated with an antibiotic are ASB cases **OR** > 33% relative decrease in the number of positive urine culture cases treated with an antibiotic are ASB cases	10
		13-22% of positive urine culture cases treated with an antibiotic are ASB cases **OR** 20- 32% relative decrease in the number of positive urine culture cases treated with an antibiotic are ASB cases	5
		> 22% of positive urine culture cases treated with an antibiotic are ASB cases AND < 20% relative decrease during the current performance year[7]	0
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	5
		> 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	**PICC and Midline Documentation- Catheter-to-Vein Ratio and Lumens**	
		≥ 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio AND ≥ 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	10
		≥ 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio OR ≥ 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	5
		< 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio AND < 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	0

2022 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index – Supporting Documentation

[1] Registry data assessed during mid-year performance evaluation review and at year end based on data submitted during calendar year 2022. All required cases must be completed by the mid-year performance evaluation review AND by year end. Mid-year due date and final due date will be announced by Coordinating Center. 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 2022. 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 2022. 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 2022. 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

[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 2022. This is different than the other performance measures in the index, which are applied to each individual hospital. New hospitals joining HMS in 2021 and 2022 will not be used to calculate the collaborative average.

2022 Michigan Hospital Medicine Safety Consortium (HMS) Collaborative Quality Initiative Performance Index Scorecard Cohort 2021 (Sites Starting in 2021)			
Measure #	Weight	Measure Description	Points
1	15	**Timeliness of HMS Data[1]**	
		On time > 95% at Mid-Year AND End of Year	15
		On time > 95% at Mid-Year OR End of Year	8
		On time < 95% at Mid-Year AND End of Year	0
2	15	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity 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	20	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
4	20	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
5	10	**PICC Quality Improvement[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	10
		Convene a vascular access committee to review PICC use and outcomes **OR** use MAGIC or a related decision-tool to determine PICC appropriateness	5
		No vascular access committee meetings convened AND no use of MAGIC or a related decision-tool to determine PICC appropriateness	0
6	5	**PICC/Midline Documentation[6]**	
		Submit PICC **AND** midline (if hospital inserts midlines) insertion template including documentation of catheter-to-vein ratio and # of lumens	5
		Local PICC **AND** midline (if hospital inserts midlines) insertion template including documentation of catheter-to-vein ratio and # of lumens not submitted	0
7	10	**Antimicrobial Quality Improvement- Intervention – Guidelines[6]**	
		Submit UTI and pneumonia guidelines developed locally (aligned with HMS recommendations)[5]	10
		Local UTI and pneumonia guidelines not submitted OR not aligned with HMS recommendations	0
8	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 unnecessary treatment of ASB • Decreasing inappropriate Fluoroquinolone (FQ) use for UTI/ASB and CAP	5
		Description of interventions not submitted	0

2022 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index – Supporting Documentation

[1] Registry data assessed during mid-year performance evaluation review and at year end based on data submitted during calendar year 2022. All required cases must be completed by the mid-year performance evaluation review AND by year end. Mid-year due date and final due date will be announced by Coordinating Center. 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 2022. 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 2022. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] CAP Institutional guidelines should:

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

UTI Institutional guidelines should:

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

[6] In December 2022/January 2023, 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.

2022 Michigan Hospital Medicine Safety Consortium (HMS) Collaborative Quality Initiative Performance Index Scorecard Cohort 2022 (Sites Starting in 2022)			
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

2022 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index – Supporting Documentation

[1] Registry data assessed at year end based on data submitted during calendar year 2022. 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 2022. 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 2022. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

2022 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard – **I-MPACT Year 6/7 (Cohorts 1-5)** Measurement Period: Patients abstracted 01/01/2022 - 12/31/2022 (patients discharged Oct. 2021 - Sept. 2022)			
Measure #	Weight	Measure Description	Points
1	2.5	**Project Associate Only Webinars (Participation)** [1,2]	
		Project Associate misses no more than 1 required calls per calendar year.	2.5
		Project Associate misses more than 1 required calls per calendar year.	0
2	5	**Collaborative-wide Webinars (CWW) (Participation) - 3 per year**[,2]	
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, present on 3 all webinars per calendar year.	5
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, present on 2 of 3 webinars per calendar year.	2
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, on <2 required webinars per calendar year.	0
3	5	**Collaborative-wide Meetings (CWM) (Participation) - 3 per year**[,2]	
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at all 3 meetings per calendar year.	5
		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.	2
		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.	0
4	5	**QI Log Submission and Patient/Advisor Engagement (Participation)**	
		2 out of 2 QI logs meet all of the following criteria: 1) Logs completed/updated fully and submitted on time AND 2) Each log contains least 2 NEW examples of patient/advisor engagement **AND** 3) Changes requested by I-MPACT CC submitted on time.	5
		1 out of 2 logs met all of the following criteria: 1) Are completed/updated fully and submitted on time AND 2) Each log contains least 2 NEW examples of patient/advisor engagement **AND** 3) Changes requested by I-MPACT CC submitted on time.	2
		All QI logs failed to met all of the following criteria: 1) Are completed/updated fully and submitted on time AND 2) Each log contains least 2 NEW examples of patient/advisor engagement **AND** 3) Changes requested by I-MPACT CC submitted on time.	0

2022 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard – **I-MPACT Year 6/7 (Cohorts 1-5)** Measurement Period: Patients abstracted 01/01/2022 - 12/31/2022 (patients discharged Oct. 2021 - Sept. 2022)			
Measure #	Weight	Measure Description	Points
5	5	**Provider Champion Measure3 - 2 parts**	7.5 max
		Part 1 - Local engagement	
		Each hospital and each PO in the cluster has a provider champion (MD, DO, NP, PA) AND all cluster provider champions complete the annual survey administered by the I-MPACT CC by the required deadline.	5
		One or more organizations in the cluster fails to identify a provider champion (PC) (MD, DO, NP, PA) AND/OR one or more PC fails to respond to the annual survey by the required deadline.	0
		Part 2 - CQI engagement	
	2.5	Every provider champion completes at least one of the following engagement activities in its entirety (i.e. cannot mix and match between items): 1) Actively attends Collaborative-wide meetings & Collaborative-wide Webinars (attends 3 out of 6 total events). 2) Actively participates in I-MPACT Steering Committee by attending at least 2/3 of planned meetings. (limited capacity, first come first served) 3) Actively participates in Data Review and Analysis Committee by attending at least 3/6 of planned meetings. (limited capacity, first come first served) 4) Presents at a Collaborative-wide meeting or Collaborative-wide Webinar 5) Listed as an author on a *submitted* paper, abstract, or poster.	2.5
		One or more provider champions fails to complete one or more engagement activities.	0
6	5	**Data Accuracy & Timely Submission (Participation)**	
		Submits the required # of cases on time 11 of 12 months AND achieves ≥ 90% accuracy on annual audit(s).	5
		Submits the required # of cases on time 11 of 12 months OR achieves ≥ 90% accuracy on annual audit(s).	2
		Does not submit the required # of cases on time 11 of 12 months AND does not achieve ≥ 90% accuracy on annual audit(s).	0
7	20	**Intervention Deployment (Performance) [4]**	
		Cluster maintains an average intervention rate of 80% or more based on data abstracted during Jan. - Dec. 2022.	20
		Cluster maintains an average intervention rate of <80% but ≥ 70% based on data abstracted during Jan. - Dec. 2022.	10
		Cluster maintains an average intervention rate of <70% based on data abstracted during Jan. - Dec. 2022.	0
8	20	**Collaborative-wide Goal: Provider Follow-up Visits (Performance) 5,[6]**	**21 max**
		Based on data entered into the registry during January-December 2022, the collaborative achieves the required 20% increase in follow-up appointments using the formula below6, compared to the average from data entered during 2021.	20
		Based on data entered into the registry during January-December 2022, collaborative achieves ≥ 15% but < 20% of the required increase in follow-up	10

2022 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard – **I-MPACT Year 6/7 (Cohorts 1-5)** Measurement Period: Patients abstracted 01/01/2022 - 12/31/2022 (patients discharged Oct. 2021 - Sept. 2022)			
Measure #	Weight	Measure Description	Points
		appointments for the year, based on the formula below6, compared to the average from data entered during 2021.	
		Based on data entered into the registry during January-December 2022, collaborative achieves ≥ 10% but < 15% of the required increase in follow-up appointments for the year, based on the formula below6, compared to the average from data entered during 2021.	4
		Based on data entered into the registry during January-December 2022, collaborative achieves < 10% of the required increase in follow-up appointments for the year, based on the formula below6, compared to the average from data entered during January-December 2021 OR rate of PCP follow-up visits drops compared to the average from data entered during 2021.	0
		BONUS POINT - Cluster beats 2022 collaborative average for 0-14 day follow-up.	1
9	15	**Emergency Department Utilization (Performance)[7] - 15 points max**	
		Z-score <-1. (improved rate compared to prior year).	15
		Z-score ≥-1 and ≤1. (no evidence of change compared to prior year).	7
		Z-score >1. (worse rate compared to prior year).	0
		OR	
		Cluster performs "Better than expected" using the Standardized Readmission Ratio (SEUR) which measures cluster rate compared to median for collaborative over a rolling 3 year period.	15
		Cluster performs "As expected" using the Standardized Readmission Ratio (SEUR) which measures cluster rate compared to median for collaborative over a rolling 3 year period.	7
		Cluster performs "Worse than expected" using the Standardized Readmission Ratio (SEUR) which measures cluster rate compared to median for collaborative over a rolling 3 year period.	0
10	15	Readmissions (Performance)8 - 15 points max	15 max
		Z-score <-1. (improved rate compared to prior year).	15
		Z-score ≥-1 and ≤1. (no evidence of change compared to prior year).	7
		Z-score >1. (worse rate compared to prior year).	0
		OR	
		Cluster performs "Better than expected" using the Standardized Readmission Ratio (SRR) which measures cluster rate compared to median for collaborative over a rolling 3 year period.	15
		Cluster performs "As expected" using the Standardized Readmission Ratio (SRR) which measures cluster rate compared to median for collaborative over a rolling 3 year period.	7
		Cluster performs "Worse than expected" using the Standardized Readmission Ratio (SRR) which measures cluster rate compared to median for collaborative over a rolling 3 year period.	0

I-MPACT Footnotes

Footnotes

[1]If a cluster only has one project associate (PA), they must be present for webinars 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(s) has their own), then at least one must be present for webinars and meetings to fulfill the requirements above.

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

[3]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. Provider champions from each hospital and PO participating with I-MPACT will be surveyed annually about topics related to engagement with I-MPACT partners and local quality improvement efforts. If an organization selects multiple provider champions, only one per organization will need to complete the survey and only one per organization will need to complete the CQI engagement activities to achieve full points.

[4]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.

[5]Provider can be primary care physician, specialist, or NP/PA.

[6] To calculate this metric, determine the difference between the collaborative's rate for patients *abstracted* during 2021 and the threshold of 90%; then add 20% of that difference to the 2021 rate to determine the goal for improvement in 2022.

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.

[7]Numerator will count patients abstracted for the registry during 2022 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.

Z-score uses year-over-year data to determine if cluster has had improvement compared to prior year, no evidence of change compared to prior year, worse rate compared to prior year. This measure compares a cluster to itself. Z-scores will be rounded to the nearest 100th decimal place.

Standardized Emergency Utilization Ratio (SEUR) uses a rolling time frame (3-year composite measurement) to compare the cluster to others in the collaborative. It is risk-adjusted based on LACE and other demographic variables such as gender, race, age, marital status, etc. SEUR will be rounded to the nearest 100th decimal place.

** Points will be awarded only for the method of measurement the cluster scores highest on; clusters cannot earn points for both measures.

[8]Numerator will count patients abstracted for the registry during 2022 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.

Z-score uses year-over-year data to determine if cluster has had improvement compared to prior year, no evidence of change compared to prior year, worse rate compared to prior year. This measure compares a cluster to itself. Z-scores will be rounded to the nearest 100th decimal place.

Standardized readmission ratio (SRR) uses a rolling time frame (3-year composite measurement) to compare the cluster to others in the collaborative. It is risk-adjusted based on LACE and other demographic variables such as gender, race, age, marital status, etc. SRR will be rounded to the nearest 100th decimal place.

** Points will be awarded only for the method of measurement the cluster scores highest on; clusters cannot earn points for both measures.

2022 Michigan Anticoagulation Quality Improvement Initiative (MAQII) Collaborative Quality Initiative Performance Index Scorecard **Epic sites** Measurement Period: 1/01/2022-12/31/2022			
Measure #	Weight	Measure Description	Points
1	15	**Smoking status assessment in newly enrolled patients (site-level)**	
		≥85% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	15
		65-84% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	10
		45-64% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	5
		<45% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	0
2	10	**Smoking status assessment in newly enrolled patients (consortium-level)**	
		≥85% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	10
		65-84% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	8
		45-64% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	5
		<45% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	0
3	15	**DOAC Dashboard implementation**	
		DOAC Dashboard fully implemented and being used in the clinical setting	15
		Fully functional dashboard and clinical workflow	10
		Alpha version of Dashboard completed with approved preliminary clinical workflow	5
		Dashboard programming and development of clinical workflow underway	2
		Unable to begin dashboard programming	0
4	15	**Inappropriate aspirin use in warfarin patients (modified criteria)**	
		≤15% of active patients	15
		16-18% of active patients	10
		1921% of active patients	5
		>21% of active patients	0
5	15	**Extended International Normalized Ratio (INR) testing interval project**	
		≥75% of eligible patients received extended intervals	15
		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

2022 Michigan Anticoagulation Quality Improvement Initiative (MAQII) Collaborative Quality Initiative Performance Index Scorecard **Epic sites** Measurement Period: 1/01/2022-12/31/2022			
Measure #	Weight	Measure Description	Points
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0
7	10	**Quarterly Meeting participation – Coordinator/Lead Abstractor**	
		Attended all 4 meetings	10
		Attended 3 out of 4 meetings	8
		Attended 2 out of 4 meetings	6
		Attended 1 out of 4 meetings	4
		Did not attend any meetings	0
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

2022 Michigan Anticoagulation Quality Improvement Initiative (MAQII) Collaborative Quality Initiative Performance Index Scorecard **Non-Epic sites** Measurement Period: 1/01/2022-12/31/2022			
Measure #	Weight	Measure Description	Points
1	20	**Smoking status assessment in newly enrolled patients (site-level)**	
		≥85% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	20
		65-84% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	15
		45-64% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	10
		<45% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	0
2	10	**Smoking status assessment in newly enrolled patients (consortium-level)**	
		≥85% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	10
		65-84% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	8
		45-64% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	5
		<45% of newly enrolled patients in 2022 will have smoking status assessed and documented per site protocol	0
3	20	**Inappropriate aspirin use in warfarin patients (modified criteria)**	
		≤15% of active patients	20
		16-18% of active patients	15
		19-21% of active patients	10
		>21% 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

2022 Michigan Anticoagulation Quality Improvement Initiative (MAQII) Collaborative Quality Initiative Performance Index Scorecard **Non-Epic sites** Measurement Period: 1/01/2022-12/31/2022			
Measure #	Weight	Measure Description	Points
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 (MARCQI) Collaborative Quality Initiative Performance Index Scorecard – Years 6+ Measurement Period: 07/01/2021-06/30/2022			
Measure #	Weight	Measure Description	Points
1	10	**Collaborative Meeting Participation-Clinical Champions (01.01.2022-11.30.2022)** ***Attendance at both the Medical Advisory Committee and Collaborative-wide meeting in February 2022; June 2022; and October 2022**	
		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 (01.01.2022-11.30.2022)** ***Attendance at both the CDA Breakout and Collaborative-wide meeting in February 2022; June 2022; and October 2022**	
		3 out of 3 meetings attended	5
		2 out of 3 meetings attended	2.5
		<2 meetings attended	0
3	20	**Accuracy and Completeness of Data Submission (audits 07.01.2021-06.30.2022) - 3 metrics** 1. On-time/Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. All 2021 cases abstracted completely by 06.30.2022 3. All cases performed or before May 4, 2022 abstracted by October 1, 2022 4. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2022	
		4 of 4 metrics met	20
		3 of 4 metrics met	15
		2 of 4 metrics met	10
		1 of 4 metrics met	5
		0 of 4 metrics met	0
4	4	**Site based Quality Meetings:(02.04.2022-11.30.2022)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	4

Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 07/01/2021-06/30/2022			
Measure #	Weight	Measure Description	Points
5	10	**% of Opioid naïve THA patients in the COLLABORATIVE meet 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 meet the MARCQI Pain Optimization Protocol Prescribing guidelines (<320 OME)**	
		85% or greater of TKA patients meet the guidelines of **320 OME** or less	10
		60-84% of TKA patients prescribed **<320 OME**	5
		Less than 60% of patients meet the prescribing criteria	0
7	3	**% of Opioid naïve THA patients at the SITE meet the MARCQI Pain Optimization Prescribing guidelines (<240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	3
		60-84% of THA patients prescribed **<240 OME**	1.5
		Less than 60% of patients meet the prescribing criteria	0
8	3	**% of Opioid naïve TKA patients at the SITE meeting the MARCQI Pain Optimization Protocol Prescribing guidelines (<320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	3
		70-89% of TKA patients prescribed **<320 OME**	1.5
		Less than 70% of patients meet the prescribing criteria	0
9	10	**Site level PROS Collection: Completed Pre-op and post-op HOOS-JR or KOOS-JR + PROMIS10 (Overall average as of 06.30.2021. 2–16-week post-op accepted.)** When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		The site is awarded full points for collection rates of 60%+	10
		The site is awarded partial points for collection rates >35%-<60	5
		The site is not awarded points if collection is less than 35%	0
10	5	**90-Day Hip fracture: Reduce COLLBORATIVE rate of 90-Day Hip fracture for all primary HIP procedures by 10% from 1.31% to 1.17%**	
		1.17% or less of all primary HIPS experience a 90-Day hip fracture	5
		1.18% - 1.30% of all primary HIPS experience a 90-Day hip fracture	2.5
		The site is not awarded points if there is no improvement (>1.31%) in all primary HIPS with 90-Day hip fractures	0
11	20	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative). If red on scorecard of April 2021, you must choose this as the project. If no red, you will choose a 'yellow'. Progress Reports are due in May 2022 & January 2023. Final results are based on scorecard of <u>January, 2023</u>**	
		Plan submitted and approved, reporting requirements met, and goal met	20
		Plan submitted and approved Reporting requirements are met , but the target identified is not met. A3 submitted with final report and presentation given at June 2023 MARCQI Collaborative-wide sessions*	15

Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 07/01/2021-06/30/2022			
Measure #	Weight	Measure Description	Points
		*Not presenting at the June 2023 MARCQI Collaborative-wide sessions will yield -10 P4P points on the FY2023 P4P scorecard	
		Plan submitted and approved Reporting requirements are met , but the target identified is not met.	10
		Plan is not developed, reports not done.	0

2022 Michigan Bariatric Surgery Collaborative (MBSC) Collaborative Quality Initiative Performance Index Scorecard Measurement Periods: Specified below per Measure			
Measure #	Weight	Measure Description	Points
1	15	**Grade 1 Complication:** (October 1, 2021-September 30, 2022) **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, 2021-September 30, 2022) **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, 2019 to September 30, 2022) **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, 2019 to September 30, 2022) **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, 2020 to September 30, 2021) **Adjusted; Rounded to nearest whole number**	
		≥63% OR > 5% **relative** improvement from previous year (10/1/2019-9/30/2020)	10
		Maintained 1-year follow-up rate/ >0 to <5% relative improvement from previous year (10/1/2019-9/30/2020)	5
		1-year follow-up rate decreased/No improvement in 1-year follow-up rate (10/1/2019-9/30/2020)	0
6	2.5	**Compliance with VTE prophylaxis - Pre-operatively:**(Calendar Year 2022) **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 2022) **Unadjusted; Rounded to nearest whole number**	
		≥91% compliance with guidelines	2.5
		0 to 90% compliance with guidelines	0

2022 Michigan Bariatric Surgery Collaborative (MBSC) Collaborative Quality Initiative Performance Index Scorecard 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, 2021 to September 30, 2022)	
		≥ 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 2022) **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 1/1/2022 to 12/31/2022	
		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 2022) *****In order to be eligible for this measure, you must achieve >90% on the 2022 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, 2021 to September 30, 2022) **Unadjusted; Rounded to nearest whole number**	
		≥90% consented patients	5
		80-89% consented patients	3
		<80% consented patients	0

2022 Michigan Bariatric Surgery Collaborative (MBSC) Collaborative Quality Initiative Performance Index Scorecard Measurement Periods: Specified below per Measure			
Measure #	Weight	Measure Description	Points
13	10	**Physician Engagement:** (January 1, 2022 to December 31, 2022)	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 1/1/2022 to 12/31/2022	
		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	
		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)

2022 Performance Index Scorecard
Measure Supporting Documentation

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 2022.

***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 1/1/2022 to 12/31/2022

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 2022.

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 2022 monthly deadlines.

In order for a hospital to be eligible for this measure, the hospital must achieve >90% on the 2022 yearly audit. 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 1/1/2022 to 12/31/2022.

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

2022 Michigan Emergency Department Improvement Collaborative Quality Initiative (MEDIC) Performance Index Scorecard **Years 3+** Measurement Period: 11/1/2021 - 10/31/2022			
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 31 days of load	5
		75-99% of cohort cases abstracted within 31 days of load	3
		<75% of cohort cases abstracted within 31 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 or	30	**Site Specific - Timely Administration of Steroids in Pediatric Asthma** ***Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	30
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	20
		QI Project developed and implemented but there was no improvement to the target	15

2022 Michigan Emergency Department Improvement Collaborative Quality Initiative (MEDIC) Performance Index Scorecard **Years 3+** Measurement Period: 11/1/2021 - 10/31/2022			
Measure #	Weight	Measure Description	Points
		QI Project not developed or implemented	0
7b	30	**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	30
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	20
		QI Project developed and implemented but there was no improvement to the target	15
		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 HI	10
		Did not meet either target	0
9a or	20	**Site Specific - Quality Improvement Initiative: Adult Suspected PE**	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	15
		QI Project developed and implemented but there was no improvement to the target	10
		QI Project not developed or implemented	0

2022 Michigan Emergency Department Improvement Collaborative Quality Initiative (MEDIC) Performance Index Scorecard **Years 3+** Measurement Period: 11/1/2021 - 10/31/2022			
Measure #	Weight	Measure Description	Points
9b	20	**Site Specific - Quality Improvement Initiative: CXR Utilization in Pediatric Respiratory Illness**	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	15
		QI Project developed and implemented but there was no improvement to the target	10
		QI Project not developed or implemented	0

2022 Michigan Emergency Department Improvement Collaborative Quality Initiative (MEDIC) Performance Index Scorecard **Year 2** Measurement Period: 11/1/2021 - 10/31/2022			
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 31 days of load	10
		75-99% of cohort cases abstracted within 31 days of load	5
		<75% of cohort cases abstracted within 31 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 or	10	**Site Specific - Timely Administration of Steroids in Pediatric Asthma** ***Measures and targets identified in Appendix**	
		QI Project developed and implemented and site met or exceeded target	10
		QI Project developed and implemented and site's performance was lower than the target	8
		QI Project not developed or implemented	0

2022 Michigan Emergency Department Improvement Collaborative Quality Initiative (MEDIC) Performance Index Scorecard **Year 2** Measurement Period: 11/1/2021 - 10/31/2022			
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

2022 Michigan Emergency Department Improvement Collaborative Quality Initiative (MEDIC) Performance Index Scorecard **Year 1** Measurement Period: 11/1/2021 - 10/31/2022			
Measure #	Weight	Measure Description	Points
1	13	**Data Delivery: Timeliness**	
		All 12 months of data transfers on time	13
		11 months of data transfers on time	8
		9-10 months of data transfers on time	4
		< 9 months of data transfers on time	0
2	13	**Data Delivery: Adherence & Accuracy**	
		All 12 months of data transfers adhere to MEDIC data dictionary and are accurate	13
		11 months of data transfers adhere to MEDIC data dictionary and are accurate	8
		9-10 months of data transfers adhere to MEDIC data dictionary and are accurate	4
		< 9 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	13	**Abstraction: Timeliness**	
		All cohort cases abstracted within 31 days of load	13
		75-99% of cohort cases abstracted within 31 days of load	6
		<75% of cohort cases abstracted within 31 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	14	**Time from Agreement being signed to hiring date of data abstractor**	
		<90 days	14
		91-120 days	8
		>120 days	0
7	14	**Time from Agreements signed to successful submission of electronic production data**	
		<90 days	14
		91-120 days	8
		>120 days	0
8	9	**Intervention Planning for Year 2 (Intervention Templates, etc.)**	
		All Year 2 materials complete and submitted on time	9
		Year 2 materials incomplete and/or submitted late	0

Michigan Emergency Department Improvement Collaborative (MEDIC)

2022 Performance Index Scorecard

Measure Supporting Documentation

MEDIC (pg. 1 of 2)						
Year(s)	**Measure #**	**Measure Type**	**Measure Condition/ Category**	**Measure Description**	**Target**	**Measure Calculation Methodology**
All	1	Site-Specific	Participation	Electronic data file must be delivered on a monthly schedule, as agreed upon by the Coordinating Center and site data resource. If a file cannot be delivered in a timely manner 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	Site-Specific		Electronic data file transferred every month must adhere to the MEDIC electronic data dictionary and must be accurate.	100%	12 months of adherent file 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	Site-Specific		All cases must be abstracted within 31 days of the date they were loaded into the registry NOT the visit date.	100%	100% of cases abstracted on time = Full points 75-99% of cases abstracted on time = reduced points <75% of cases abstracted on time = no points
All	4	Site-Specific		Clinical Champions from each site must attend all Collaborative Wide Meetings and Clinical Champion Quarterly Calls. Clinical Champions may send one physician proxy to a single Collaborative Wide Meeting per year without penalty. This proxy must be approved by MEDIC prior to the meeting, cannot already represent another MEDIC site, and cannot be a resident or fellow.	All meetings attended	Attend all meetings = Full points Miss one meeting = reduced points Miss more than one meeting = no points
All	5	Site-Specific		Abstractors from each site must attend all Collaborative Wide Meetings. Abstractors may send one appropriate proxy to a single Collaborative Wide Meeting per year without penalty. This proxy must be approved by MEDIC prior to the meeting and cannot already represent another MEDIC site.	All meetings attended	Attend all meetings = Full points Miss one meeting = reduced points Miss more than one meeting = no points

MEDIC (pg. 2 of 2)						
Year(s)	**Measure #**	**Measure Type**	**Measure Condition/ Category**	**Measure Description**	**Target**	**Measure Calculation Methodology**
2,3+	6	Site-Specific		Abstracted registry data must pass an annual audit with >90% case cohort decisions correct and >97% data element accuracy.	>97% data element accuracy, >90% cohort	60% of points are based off of data element accuracy, divided into 3 point levels. >97% = full points, > 95% = mid points, < 95% = no points. 40% of points for correct cohort decision. >90% = full points, >75% = mid points, < 75% = no points
2+	7a	Site-Specific	Timely Administration of Steroids in Pediatric Asthma	Increase the percentage of pediatric asthma patients who receive steroids within 60 minutes of arrival to the emergency department	≥ 66%	Number of pediatric patients with an asthma diagnosis who received steroids in the first 60 minutes of their ED visit divided by the total number of pediatric patients with an asthma diagnosis who received steroids at any point in their ED visit
2+	7b	Site-Specific	Safe Discharge Adult Low Risk Chest Pain	Performance on discharge rate for low risk adult chest pain patients.	≥ 90%	Number of ED visits for adult patients with low risk chest pain and an intended disposition of discharged from the ED divided by the number of ED visits for patients with low risk chest pain, calculated for an individual site
2+	8	Collaborative-Wide[1]	Minor Head Injury	Collaborative-Wide performance for appropriate CT use in adults with minor head injury	≥ 57%	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+	11	Site-Specific[2]	PE diagnostic yield OR CXR for asthma, bronchiolitis, croup	Performance for increasing the number of CT for PE scans that are positive	PE ≥ 11%, Chest X-Ray ≤ 25%	PE: Number of PE CT scans that are positive for pulmonary embolism divided by the number of ED visits with eligible PE CT scans after exclusions are applied, calculated for an individual site
				Performance for reducing the utilization of chest xrays for pediatric patients with asthma, bronchiolitis, and croup		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

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

[2]For 2022, sites will choose one of the following:

a. Increase CT diagnostic yield in adult cases of suspected pulmonary embolism

b. Decrease chest x-ray utilization in pediatric cases of respiratory illness

2022 Michigan Radiation Oncology Quality Consortium (MROQC) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2022-09/30/2022			
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	12	**In node-positive breast cancer patients, the irradiated nodal group(s) is(are) contoured and named per TG-263 naming convention.**	
		≥60% of patients meet the appropriate threshold	12
		40-59% of patients meet the appropriate threshold	6
		<40% of patients meet the appropriate threshold	0
4	12	**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 is ≤ 1.0 for left-sided cases receiving moderate dose hypofractionation. ***	
		≥80% of patients meet target coverage and heart sparing goals	12
		50-79% of patients meet target coverage and heart sparing goals	6
		<50% of patients meet target coverage and heart sparing goals	0
5	10	**Collection rate of annual lung follow-up for those due 1/1/2022-9/30/2022**	
		75% or greater rate of annual lung follow-up	10
		60-74% rate of annual lung follow-up	7
		<60% rate of annual lung follow-up	0
6	10	**For lung cancer patients: evaluate Task Group-263 compliance for the specified structures (heart, PTV, GTV/IGTV/ITV, esophagus, spinal cord or canal, and normal lung) for the initial DICOM entry.**	
		80% or greater compliance for the specified structures	10
		60-79% compliance for the specified structures	7
		<60% compliance for the specified structures	0

2022 Michigan Radiation Oncology Quality Consortium (MROQC) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2022-09/30/2022			
Measure #	Weight	Measure Description	Points
7	14	**Use of shorter course radiotherapy for bone metastasis treatment as shown by:** A: The MROQC consortium-wide rate of single fraction use is ≥45% for uncomplicated patients B: Your site-level rate of ≤5 fraction treatment is at least 60% for all patients	
		A and B are met	14
		Only B is met	10
		B is not met	0
8	12	**Percentage of patients with favorable intermediate risk prostate cancer as defined by NCCN treated with EBRT or brachytherapy who received "high value radiotherapy", defined as moderately hypofractionated EBRT (28 fractions or less) OR ultrahypofractionated EBRT/SBRT (7 fractions or less) OR brachytherapy monotherapy.**	
		≥50% or more of patients receive high value radiotherapy	12
		40-49% of patients receive high value radiotherapy	6
		<40% of patients receive high value radiotherapy	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

2022 Michigan Surgical Quality Collaborative (MSQC) Performance Index Scorecard Project Time Period: 1/1/2022 – 12/31/2022			
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	**Completeness of Data**	
		Sampled and incomplete cases ≤0.5% total volume	3
		30 day follow-up rate ≥80% for 1st quarter 2022 (Jan – March cases)	1
		30 day follow-up rate ≥80% for 2nd quarter 2022 (April – June cases)	1
		30 day follow-up rate ≥80% for 3rd quarter 2022 (July – September cases)	1
6	20	**Collaborative Wide Measure – Reduce Excess Oral Morphine Equivalent (OME) Prescribing Across All MSQC Procedures***	
		OME excess reduction ≥10% over 2021 baseline OME excess	20
		OME excess reduction 9.0 - 9.99% over 2021 baseline OME excess	15
		OME excess reduction 8.0 - 8.99% over 2021 baseline OME excess	10
		OME excess reduction 7.0 - 7.99% over 2021 baseline OME excess	5
		OME excess reduction <7.0% over 2021 baseline OME excess	0
7 (refer to details in the following table)	50	**Quality Improvement Initiative (QII) (**refer to following appendix for more detail on measure)	
		Option A: Hysterectomy Care Pathway	50
		OR	
		Option B: Abdominal Hernia Repair Pathway	
		OR	
		Option C: Colorectal Cancer Surgery Pathway	
Optional	5	Bonus points to be added to reflect active participation in MOQC over-sampling of hysterectomy cases. Points available to any hospital who successfully captures	
		Site fully participates by over-sampling and abstracting all gyn onc cases	5
		Site partially participates by over-sampling cases only	2

*These goals may be updated at the end of 2021 once more data is available.

2021 YTD OME excess 29.4 as of 9/8/2021; 11.7% decrease over 2020 OME excess of 33.3.

2022 Michigan Surgical Quality Collaborative (MSQC) Performance Index Scorecard Measure 7: Quality Improvement Initiative (QII) Details	
Measure 7, Option A: Hysterectomy Care Pathway	**Points**
Goal #1: Preoperative Measures (5 points each) 1a. Preadmission teaching includes multimodal pain management. Goal ≥90% 1b. Alternative treatments offered/tried/declined, or contraindications documented, before undergoing a hysterectomy (if applicable). Goal ≥90% 1c. HbA1c if diabetic; random blood sugar if not diabetic. Goal ≥80% 1d. Use of appropriate antibiotics. Goal ≥90% 1e. Patient education related to smoking cessation. Goal ≥80% 1f. Patient education related to weight/obesity. Goal ≥80%	30
Goal #2: Postoperative Measures (5 points each) 2a. Postoperative order for multimodal pain management if discharged on POD zero. Goal ≥90% 2b. Postoperative use of multimodal pain management if discharged on or after POD one. Goal ≥90% 2c. Discharge education includes multimodal pain management teaching. Goal ≥90%	15
Perform internal quality review of all elective hysterectomy cases with SSI or return to ED related to surgery.	5
Total Available Points	**50**

Measure 7, Option B: Abdominal Hernia Repair Pathway	**Points**
Goal #1: Preoperative Measures (5 points each) 1a. Preadmission teaching includes multimodal pain management. Goal ≥90% 1b. HbA1c if diabetic; random blood sugar if not diabetic. Goal ≥80% 1c. Patient education related to smoking cessation. Goal ≥80% 1d. Patient education related to weight/obesity. Goal ≥80%	20
Goal #2: Intraoperative Measures (5 points each) 2a. Hernia and mesh documentation includes all required elements. Goal ≥90% 2b. Use of intraoperative multimodal pain management. Goal ≥90%	10

Goal #3: Postoperative Measures (5 points each) 3a. Postoperative order for multimodal pain management if discharged on POD zero. Goal ≥90% 3b. Postoperative use of multimodal pain management if discharged on or after POD one. Goal ≥90% 3c. Discharge education includes multimodal pain management teaching. Goal ≥90%	15
Perform internal quality review of all abdominal hernia cases with SSI or return to ED related to surgery.	5
Total Available Points	**50**

Measure 7, Option C: Colorectal Cancer Surgery Pathway	**Points**
Goal #1: Preoperative Measures (3 points each) 1a. Pre-treatment Staging Testing: MRI or endorectal U/S (Rectal CA cases only). Goal ≥90% 1b. Ostomy site Marked (Rectal CA cases only). Goal ≥90% 1c. Neoadjuvant therapy (Rectal CA cases only). Goal ≥90% 1d. CEA level obtained after diagnosis (All cases). Goal ≥90% 1e. OA/MBP (All cases). Goal ≥90%	15
Goal #2: Intraoperative Measures 2a. ≥90% compliance with each of the following (3 points each) • Mesorectal Excision performed (Rectal CA cases only). • ≥12 Lymph Nodes examined (All cases) • Intraoperative use of multimodal pain management (All cases) 2b. Positive margin rate (3 points) • Maintain or decrease positive margin rate from 2021 compared to 2022 *(continuing sites only)* • Maintain or decrease positive margin rate from Q1 2022 compared to Q3 & Q4 2022 (*new sites*)	12
Goal #3: Postoperative Measures (3 points each) 3a. TME grading (Rectal CA cases only). Goal=100% 3b. Postoperative order for multimodal pain management if discharged on POD zero. Goal ≥90% 3c. Postoperative use of multimodal pain management if discharged on or after POD one. Goal ≥90%	9
Goal #4: QII Project Summary containing the following items (14 points total) 4a. Multi-disciplinary meeting documentation (4 points) 4b. Care Pathway (5 points) 4c. Summary of findings from internal quality review of all CRC cases with SSI or return to ED related to surgery. (5 points)	14
Total Available Points	**50**

2022 Michigan Spine Surgery Improvement Collaborative (MSSIC) Collaborative Quality Initiative Performance Index Scorecard **Cohort 1, 2, 3 & 4 (25 sites)** Measurement Period: 10/01/2021-09/30/2022, 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) with due dates 1/1/22 – 12/31/22..**	
		80% or greater	5
		60%-79%	3
		< 60%	0

2022 Michigan Spine Surgery Improvement Collaborative (MSSIC) Collaborative Quality Initiative Performance Index Scorecard **Cohort 1, 2, 3 (24 sites)** Measurement Period: 10/01/2021-09/30/2022, 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) with due dates 1/1/22 – 12/31/22**	
		60% or greater	5
		45%-59%	3
		< 45%	0
9	15	**Collaborative-wide Measure Goal:** Reduce the MSSIC-All ED/Observation visit rate (both lumbar & cervical) to 11.2% or less.	
		11.2% or less	15
		11.3%-12.3%	8
		12.4% or greater	0
10	25	**Demonstration of 80% compliance for the following 3 MSSIC ERAS components (Phase 2 ERAS):**	
		Formal, pre-operative patient education that does not vary from surgeon to surgeon and is available to all spine patients	8
		Limited fasting with a carbohydrate-rich drink up to two hours before surgery	8
		Ambulation within 8 hours of surgery stop time	9
11	20	**No later than 9/30/22, each site will develop and have approved by the Coordinating Center, at least four ERAS risk assessments for the optimization of spine surgery patients. Three of the four required must be Smoking Cessation, Glycemic Control (both diabetics and non-diabetics at risk), and Pain Medication/Opioid screening. The fourth is a choice of either Nutritional screening or Anemia screening.**	
		All four ERAS risk assessments, developed, approved, and implemented	20
		Three ERAS risk assessments, developed, approved, and implemented	10
		Two or fewer ERAS risk assessments, developed, approved, and implemented	0
12		**Bonus or Penalty Performance Measure:** In 2021, Cohorts 1, 2, 3, & 4 were to develop and submit for approval, 6 required ERAS components (Phase 1). This measure rewards sites that worked diligently in 2021 and met the 9/30/21 due date for all 6 Phase 1 ERAS components, with 10 bonus points. If a site fell short, it is vital that they continue to move forward and complete Phase 1 of ERAS for spine surgery by 12/31/21 to maintain neutral for this measure. However, if a site fails to get approval of the 6 Phase 1 ERAS components by 9/30/21 and fails to do so by 12/31/21, the site will be penalized 10 points on the 2022 Performance Index. (*Sites will not exceed 100%. The bonus performance measure will only assist where points were lost on other performance measures.)	
		All 6 Phase 1 ERAS components were submitted and approved by 9/30/21.	10
		Did not submit and get approval for all 6 Phase 1 ERAS components by 9/30/21 but did submit and get approval by 12/31/21.	neutral
		Did not submit and get approval for all 6 Phase 1 ERAS components by 9/30/21 and failed to do so by 12/31/21.	-10

Michigan Spine Surgery Improvement Collaborative (MSSIC)
2022 Performance Index
Measure Description

Cohort 1, 2, 3 & 4

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 to avoid points lost in participation. 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 2022, Cohorts 1, 2, 3 and 4 have the same requirements and point distribution.

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

MSSIC defines a complete case as a fully abstracted medical record and entry into the registry as well as the collection and entry into the registry of a completed baseline questionnaire.

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

Each site: Collection rate of baseline patient questionnaires (rates rounded to the nearest whole number) with due dates 1/1/22 – 12/31/22.	
80% or greater	5
60%-79%	3
< 60%	0

Each site: Combined collection average rate of Post-operative Patient-Reported Outcome (PRO) questionnaires (rates rounded to the nearest whole number) with due dates 1/1/22 – 12/31/22	
60% or greater	5
45%-59%	3
< 45%	0

Collaborative-wide Measure Goal: Reduce the MSSIC-All ED/Observation visit rate (both lumbar & cervical) to 11.2% or less. Emergency department (ED) visits after spine surgery are a common, costly, and often unrecognized source of post-discharge hospital reutilization. Even when not associated with readmission, a return to the ED following spine surgery can be indicative of adverse postsurgical events. It is MSSIC's intention to identify methods to reduce this adverse event and improve the value of care for these patients. Our goal is to safely reduce or redirect ED visits to a more appropriate level of care after spine surgery.

Collaborative-wide Measure Goal: Reduce the MSSIC-All ED/Observation visit rate (both lumbar & cervical) to 11.2% or less.	
11.2% or less	10
11.3%-12.3%	5
12.4% or greater	0

Demonstration of 80% compliance for the following 3 MSSIC ERAS components (Phase 2 ERAS):

Formal, pre-operative patient education that does not vary from surgeon to surgeon and is available to all spine patients. For a site to mark "yes" for this variable, the patient must participate in that site's MSSIC approved, ERAS pre-operative patient education program. The aim is to educate the patient about ERAS protocols, to set realistic expectations for postoperative recovery, and to psychologically prepare the patient and family for the care program. Written and oral information must be taught and should be provided in detail. Patients that are admitted through the Emergency Department are excluded from the denominator.

Limited fasting with a carbohydrate-rich drink up to two hours before surgery. Carbohydrate loading not only reduces insulin resistance but also improves muscle function by reducing nitrogen and protein loss. It is also seen to reduce preoperative thirst, hunger, and anxiety. Patients that are admitted through the Emergency Department or are insulin dependent diabetics are excluded from the denominator.

Ambulation within 8 hours of surgery stop time. Literature review of Enhanced Recovery After Surgery (ERAS) protocols, specific for spine surgery, all strongly support early ambulation as defined within hours of surgery stop time. The ERAS for spine surgery protocols/pathways all include early ambulation no later than 8 hours after surgery, and most within 4 to 6 hours after surgery. The current exclusions from the denominator: wheelchair bound (non-ambulatory) before surgery, CSF leak, durotomy, and fusions 4 levels or greater.

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

No later than 9/30/22, each site will develop and have approved by the Coordinating Center, at least four ERAS risk assessments for the optimization of spine surgery patients (Phase 2 ERAS). For the 2021 Performance Index (Phase 1 of ERAS), Cohorts 1, 2, 3, & 4 were encouraged to develop and get approved at least 2 risk assessments for optimization. All sites chose smoking cessation and most chose some form of glycemic control. In the published literature, effective ERAS protocols include at least the formal risk assessments for optimization listed below in measure 11 of the 2022 Performance Index. Sites will work to expand their ERAS risk assessments to better optimize spine patients for surgery as part of Phase 2 of ERAS implementation.

No later than 9/30/22, each site will develop and have approved by the Coordinating Center, at least four ERAS risk assessments for the optimization of spine surgery patients. The three required are: Smoking Cessation, Glycemic Control (both diabetics and non-diabetics at risk), and Pain Medication/Opioid screening. The fourth is a choice of either Nutritional screening or Anemia screening.	
All four ERAS risk assessments, developed, approved, and implemented	20
Three ERAS risk assessments, developed, approved, and implemented	10
Two or fewer ERAS risk assessments, developed, approved, and implemented	0

Bonus or Penalty Performance Measure: MSSIC has been preparing our sites since August of 2019 for the roll out of ERAS at all MSSIC sites. ERAS pathways decrease surgical stress, maintain physiological homeostasis, and improve postoperative recovery. ERAS guidelines have been shown to substantially reduce postoperative complications, length of stay (LOS) and overall costs, and to increase both patient and staff satisfaction.

This surgical transformation significantly improves system performances both clinically and financially. MSSIC strongly believes that ERAS is the right thing to do for spine surgery patients and that is why it is our current primary focus. For our CQI to enjoy the clinical and financial gains across all hospital settings, making the spread and scale of ERAS protocols an expectation for every MSSIC hospital is necessary to facilitate those gains more quickly. ERAS is the current surgical revolution to improve clinical outcomes and economic efficiency in health care systems, and MSSIC is proud to support our sites in this effort.

Bonus or Penalty Performance Measure: In 2021, Cohorts 1, 2, 3, & 4 were to develop and submit for approval, 6 required ERAS components (Phase 1). This measure rewards sites that worked diligently in 2021 and met the 9/30/21 due date for all 6 Phase 1 ERAS components, with 10 bonus points. If a site fell short, it is vital that they continue to move forward and complete Phase 1 of ERAS for spine surgery by 12/31/21 to maintain neutral for this measure. However, if a site fails to get approval of the 6 Phase 1 ERAS components by 9/30/21 and fails to do so by 12/31/21, the site will be penalized 10 points on the 2022 Performance Index. (*Sites will not exceed 100%. The bonus performance measure will only assist where points were lost on other performance measures.)	
All 6 Phase 1 ERAS components were submitted and approved by 9/30/21.	10
Did not submit and get approval for all 6 Phase 1 ERAS components by 9/30/21 but did submit and get approval by 12/31/21.	neutral
Did not submit and get approval for all 6 Phase 1 ERAS components by 9/30/21 and failed to do so by 12/31/21.	-10

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

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

- **One specialty at site, case volume is acceptable:** A site with only one specialty may participate in MSSIC if their case volume is acceptable (200 cases/year).
- **One specialty at a site, the other specialty joins:** If a participating hospital joins MSSIC with only one specialty performing spine surgery and then there is a change to both specialties performing surgeries, MSSIC will require the hospital to agree to recruit a new surgeon champion for the second specialty once the second specialty's case volume exceeds 50 cases a year.
- **Surgeon Champion leaves:**
    - Both specialties at site: If one of the two Surgeon Champions leaves, it would be an expectation that the participating site would reassign the Surgeon Champion role, and still have the second specialty participating in QI initiatives. MSSIC would not drop a site if a Surgeon Champion leaves.
    - One specialty at site: If the Surgeon Champions leaves, it would be an expectation that the participating site would reassign the Surgeon Champion role, and still have the specialty participating in QI initiatives. MSSIC would not drop a site if a Surgeon Champion leaves.

Surgeon Champion does not participate in at least one meeting and conference call during the year: If a named Surgeon Champion does not participate in at least one collaborative-wide meeting and one surgeon conference call during the calendar year, not only is there a penalty in the participation measures, but it is expected that he or she will be removed from the role and a new Surgeon Champion will be named

2022 Michigan Spine Surgery Improvement Collaborative (MSSIC) Collaborative Quality Initiative Performance Index Scorecard **Cohort 5, Year 2 (4 sites)** Measurement Period: 10/01/2021-09/30/2022, 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
8	15	**No later than 9/30/22, each site will have submitted and obtained approval by the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program:**	

2022 Michigan Spine Surgery Improvement Collaborative (MSSIC) Collaborative Quality Initiative Performance Index Scorecard Cohort 5, Year 2 (4 sites) Measurement Period: 10/01/2021-09/30/2022, unless otherwise stated			
Measure #	Weight	Measure Description	Points
		ERAS protocol document outlining how each required component will be implemented. Template provided by the Coordinating Center.	7
		Submission of all ERAS supporting documents including pre-surgical patient education, order sets, protocols, applicable screen shots from EMR, discharge instructions, and risk-assessment tools implemented in support of the ERAS program.	8

Michigan Spine Surgery Improvement Collaborative (MSSIC)
2022 Performance Index
Measure Description

Cohort 5, 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 to avoid points lost in participation. 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 2022, Cohort 5, year 2 has a 20-point performance distribution.

Patient questionnaires: Patients in the MSSIC registry are asked to complete a validated health status questionnaire prior to surgery and then at 3, 12, and 24 months after surgery. The questionnaires can be completed on paper, on the MSSIC website, through a site's EMR patient portal (if available), or by phone. Each participating site is responsible to reach out to their patients to collect this information. Questionnaires are an essential data element and collection is expected and required as a condition of participation, described in the Eligibility and Expectations document. Patient-reported Outcome (PRO) data is an important measure of success for Quality Improvement Initiatives (QII). While questionnaire data collection is not represented in the Cohort 5, year 2 Performance Index, it has always been an expectation and makes up half of the FTE model for abstractors. MSSIC defines a complete case as a fully abstracted medical record and entry into the registry as well as the collection and entry into the registry of a completed baseline questionnaire.

Enhanced Recovery After Surgery (ERAS) Phase 1:

During ERAS, Phase 1, Year 2 sites will demonstrate **site engagement** through the submission of quarterly meeting attendance and minutes which support the development and implementation of ERAS. The Coordinating Center will supply a "MSSIC Quarterly ERAS Meeting Minutes" template for sites to communicate meeting discussions concisely and provide a list of meeting attendees. Content should be high-level, and we are only interested in ERAS related discussion. The due dates for the **4 deliverables** are as follows:

- Meeting between October 1 – December 31, 2021. **Submit form by January 5, 2022.**
- Meeting between January 1 – March 31, 2022. **Submit form by April 5, 2022.**
- Meeting between April 1 – June 30, 2022. **Submit form by July 5, 2022.**
- Meeting between July 1 – September 30, 2022. **Submit form by October 5, 2022.**

Demonstration of multidisciplinary team engagement through the submission of quarterly meeting attendance sheet and minutes supporting discussion and establishment of ERAS.	
4/4 meeting submissions	5
3/4 meeting submissions	3
2 or less/4 meeting submissions	0

Additionally, sites will **submit and obtain approval from the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program no later than 9/30/22**:

- MSSIC ERAS Protocol Document (template provided by the Coordinating Center) outlining the process of how each required component will be implemented at the site. The content should be high-level, and the template will provide fields for specific information that is requested.
- Submission of applicable ERAS supporting documents:
    - Order sets, protocols, pre-surgical patient education (booklets, class PowerPoints, online education links, etc.) and risk-assessment tools implemented in support of the ERAS program. These supporting documents will also be listed in each section of the ERAS Protocol Document to assist you.

No later than 9/30/22, each site will have submitted and obtained approval by the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program:	
ERAS protocol document outlining how each required component will be implemented. Template provided by the Coordinating Center.	7
Submission of all ERAS supporting documents including pre-surgical patient education, order sets, protocols, applicable screen shots from EMR, discharge instructions, and risk-assessment tools implemented in support of the ERAS program.	8

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

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

2022 Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative (MSTCVS) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2022-12/31/2022			
Measure #	Weight	Measure Description	Points
1	10	**Accuracy of data**	
		5-star audit score	10
		4-star audit score	8
		3-star audit score	6
		≤ 2-star audit score	0
2	10	**Quarterly collaborative meeting participation – Surgeon and Data Manager Combined Attendance (January 1, 2022–December 31, 2022)**	
		Surgeon and data manager attended 4 quarterly meetings	10
		Surgeon and data manager attended 3 quarterly meetings	8
		Surgeon and data manager attended 2 quarterly meetings	6
		Surgeon and data manager attended 1 quarterly meeting	4
		Attended 0 quarterly meetings	0
		**Alternate surgeon attendance counts towards this measure*	
3	2	**Quarterly collaborative meeting participation –Alternate Surgeon (January 1, 2022–December 31, 2022)**	
		Alternate surgeon attended 1 quarterly meeting	2
		Alternate surgeon attended 0 quarterly meetings	0
		** alternate surgeon performs cardiac surgery at the site and is not the physician champion*	
4	4	**Quarterly data manager educational meeting - Data Manager (January 1, 2022–December 31, 2022)**	
		Attended 4 data manager meetings	4
		Attended 3 data manager meetings	3
		Attended 2 data manager meetings	2
		Attended 1 data manager meeting	1
		Attended 0 data manager meetings	0
5	4	**Quarterly PERForm educational meeting - Perfusionist (January 1, 2022–December 31, 2022)**	
		Attended 4 PERForm meetings	4
		Attended 3 PERForm meetings	3
		Attended 2 PERForm meetings	2
		Attended 1 PERForm meeting	1
		Attended 0 PERForm meetings	0
6	15	Collaborative-wide quality initiative 2022: Isolated CABG – Multiple Arterial Grafting (January 1, 2020–December 31, 2020)	
		Collaborative mean readmission rate > 33%	15
		Collaborative mean readmission rate 30 - 32%	8
		Collaborative mean readmission rate < 30%	0
		*2020 Baseline 26.3%	
		Site specific quality initiative **	

2022 Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative (MSTCVS) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2022-12/31/2022			
Measure #	Weight	Measure Description	Points
7	15	Met improvement goal	15
		Improved but did not meet goal	10
		Implemented plan but did not improve	5
		Unable to implement plan	0
8	20	Isolated CAB: O/E mortality for 12 months (January 1, 2012 – December 31, 2022)	
		O/E ≤ 1.0	20
		O/E ≤ 1.5	10
		O/E > 1.5	0
9	20	Isolated Valve ± CAB Mortality and Major Morbidity OE for 36 months (January 1, 2020–December 31, 2022)	
		O/E ≤ 1.0	20
		O/E ≤ 1.5	10
		O/E > 1.5	0
10	1	Extra Credit Opportunities: 1 point per approved activity for surgeons. Examples include:	
		Site visits	
		Presentation at quarterly collaborative meeting	
		Work group participation	

**

- Sites are allowed to choose any quality initiative they wish based on thoracic or cardiac surgery registry data or special projects (e.g. opioids).
- The Quality Committee (consisting of Clinical Champions from each site) then reviews to ensure high quality measures and stringent targets are selected.
- This process has been in place since before 2016, and follows these steps:
  1) Sites receive their STS Jan -Sep data back by mid Jan
  2) Sites submit their QI projects to us with benchmarks and targets.
  3) Quality Committee reviews the site specific lists and targets at February meeting.
     a. Site Champion presents their QI project, baseline data and target.
     b. Committee then votes to accept or asks for altered project/target if not a stretch goal.
     Rigorous review encourages sites to only present high quality projects and stretch goals.

2022 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2022-12/31/2022			
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: 1/1/21-6/30/22)	
		≥ 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: 7/1/21-6/30/22)	
		≥ 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: 1/1/21-6/30/22) Weighted Mean Points in Patients Transfused ≥ 5 Units 1st 4 hr	0-10
7	10	**Serious Complication Z-Score Trend Trauma Admits** (3 yr: 7/1/19-6/30/22)	
		< -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: 7/1/19-6/30/22)	
		< -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: 7/1/21-6/30/22)	
		≥ 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: 7/1/21-6/30/22)	
		≥ 85% patients (≤ 90 min)	10
		< 85% patients (≤ 90 min)	0

2022 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2022 - 12/31/2022			
Measure #	Weight	Measure Description	Points
1	5	**OBI Hospital Survey**	**5**
		Complete the 2022 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 (April 15, 2022 & November 4, 2022)	5
		Clinical Data Abstractor (CDA) or designee attends both SemiAnnual Collaborative Meetings (April 15, 2022 & November 4, 2022)	5
3	5	**Maternity Unit Culture**	**5**
		>50% labor and delivery (L&D) staff completed the labor culture survey by June 1, 2022	5
		>30% L&D staff completed the labor culture survey by June 1, 2022	2
4	10	**Education**	**10**
		Peer-to-Peer Engagement: Video Workgroups	**7**
		Attend 6 out of 6 monthly video peer-to-peer workgroups	7
		Webinars*	**3**
		Disseminate each of the 3 OBI Webinars to unit staff	3
5	10	**Nulliparous, Singleton, Term, Vertex (NTSV) Case Selection Audit**	**10**
		Audit Accuracy	**10**
		>97% Case Selection Accuracy	10
		92 - 97% Case Selection Accuracy	6
		< 92% Case Selection Accuracy	2
		No Audit Participation	0
6	20	**Dystocia Compliance Measure**	**20**
		60% compliance or above	20
		40-59.9% compliance OR If a site scored between 0-39.9% compliance and had an NTSV cesarean delivery rate average for 2020-2021 below the OBI collaborative goal of 24.7%	10
		0-39.9% compliance	0
7	40	**Assessment of Fetal Well-Being and Patient Engagement QI Implementation** **Choose one of the following projects:** **1. Implementation of RPC IA Bundle** **2. Management of Category II Fetal Heart Rate Tracings** **3. Continue or Initiate TeamBirth**	**40**
		Scores 95 - 100 points on selected QII	40
		Scores 81 - 94 points on selected QII	35
		Scores 70 - 80 points on selected QII	30
		Scores 60-69 points on selected QII	25
		Scores 1 - 59 on selected QII	15
		No implementation	0

Obstetrics Initiative (OBI)

2022 Performance Index

Measure Description

Quality Improvement Implementation: Management of Category II Fetal Heart Tracings (FHTs)	
Project Time Period	1/1/2022 - 12/31/2022
Target Population	**Inclusion criteria:** NTSV with a category II tracing or FHR tracing abnormality (non-reassuring or indeterminate) **Exclusion criteria:** NTSV with Category I or III tracings or emergent situations **Numerator:** Documentation of algorithm or checklist (including patient centered huddles) used to manage category II fetal heart rate tracngs. **Denominator:** NTSV cesarean birth where abnormal or indeterminate fetal heart rate tracing (fetal intolerance of labor, or non-reassuring fetal heart tracing) was selected as primary indication and a was category II or category not documented (non-reassuring or indeterminate). Category III tracings are excluded.
Goal	Increase the use of a standardized process of interpreting and responding to category II fetal heart tracings through the use of an algorithm or checklist (and includes patient centered huddles). The use of the algorithmor checklist is intended to decrease the number of NTSV cesarean deliveries that do not align with ACOG recommendations for management of abnormal fetal heart tracings, thereby safely decreasing FHTs as a primary indication for cesarean deliveries.
2020 OBI Baseline Data	Of 6,697 cesarean deliveries for planned vaginal births in 2020, 2,902 (43.3%) had a primary indication ofabnormal or indeterminate fetal heart rate tracing, which was the second most common primary indication (2020 OBI Workstation).
Balance Measure	No increase in severe maternal morbidity or mortality or fetal morbidity or mortality.

Background for Management of Category II Fetal Heart Tracings (FHTs):

2020 OBI workstation data shows that abnormal or indeterminate fetal heart rate tracings was the second most common indication for cesarean delivery. Since this represents such a large portion of primary cesarean births in Michigan, quality improvement efforts will need to focus on effectively managing this common clinical finding. This project will focus on the implementation of standardized, evidence-based guidance for the management of category II fetal heart tracings through the use of a checklist or algorithm that guides clinical decision making. Published evidence supports that team huddles improve communication and help create highly reliable teams (Lawrence et al., AJOG, 2012 and Provost et al., Health Care Manage Rev., 2015). Additionally, regular interdisciplinary team huddles for review of fetal heart rate monitoring has been shown to enhance multidisciplinary communication, reduces variation in FHR monitor analysis, improve health outcomes for term newborns and assists with labor management decision making (Thompson et al., AWHONN, 2018).

QI Implementation Requirements for Management of Category II Fetal Heart Tracings (FHTs):

For NTSV patients with category II fetal heart rate tracings that proceed to cesarean delivery, this project will focus on the implementation of standardized, evidence-based guidance for the management of category II fetal heart tracings through the use of a checklist or algorithm which includes patient centered huddles. Through provider documentation and OBI clinical data abstraction, hospitals will track the use of an evidence- based algorithm for the management of category II FHTs. OBI will provide the algorithm and sample smartphrase for providers to use if desired. Points for implementation of the QI Implementation Goals will be awarded on a prorated basis upon actual performance.

Quality Improvement Implementation: Implementation of an Intermittent Auscultation (IA) Bundle	
Time Period	1/1/2022 - 12/31/2022
Target Population	**Inclusion criteria:** Labor Status at admission = Spontaneous onset of labor, membranes intact or spontaneous onset of labor, membranes ruptured, or prior Induction, presenting in labor, membranes intact or ruptured **Exclusion criteria:** ● Labor status at admission = Induction, membranes intact or induction membranes ruptured ● Provider documentation that CEFM ordered at admission due to one or more of the following: ○ Pre-pregnancy diabetes ○ Gestational diabetes ○ Pre-pregnancy HTN ○ Gestational hypertension ○ Non reassuring fetal status ○ Abnormal vaginal bleeding ○ Meconium-stained fluid ○ Chorioamnionitis ○ Patient prefers CEFM **Numerator:** Intermittent Auscultation ordered by provider at admission (may include conditional orders to move to continuous EFM if needed). **Denominator:** NTSV spontaneous labor admissions meeting the above inclusion and exclusion criteria.
Goal	Sites will order an intermittent auscultation bundle for eligible patients to increase the use of intermittent auscultation.
2020 OBI Baseline Data	Of the 10,821 patients admitted in spontaneous labor (1,814 did not meet project inclusion/exclusion criteria), 24.2% of women had either IA or a combination of IA and EFM ordered at admission. Of the eligible patients in active labor with IA or a combination of IA and EFM ordered at admission (530 met inclusion/exclusion criteria listed below and were without epidural or oxytocin use), 57.6% had either IA or a combination of IA and EFM.
Balance Measure	No increase in severe maternal morbidity or mortality or fetal morbidity or mortality.

Background for Implementation of an Intermittent Auscultation (IA) Bundle: Despite evidence that continuous electronic fetal monitoring (CEFM) in low risk patients increases the use of cesarean birth (CB) and operative vaginal delivery without improvement in the incidence of perinatal death or cerebral palsy, it is still one of the most widely used obstetric interventions performed today (1,2,3,4). A recent systematic review concluded that when compared to other types of fetal monitoring, intermittent auscultation (IA) reduces emergency cesarean deliveries without increasing adverse maternal or neonatal outcomes (5). Additionally, IA allows patients freedom of movement promoting shorter labors, fewer second stage abnormal fetal heart rate patterns, and decreased cesarean birth rates (6). OBI workstation 2020 data shows that abnormal fetal heart rate tracings is the second leading primary indication for cesarean delivery among NTSV patients admitted in spontaneous labor, presenting an area of opportunity for improvement for OBI hospitals.

QI Implementation Requirements for Implementation of an Intermittent Auscultation (IA) Bundle:

For NTSV patients meeting the listed inclusion/exclusion criteria, each site will implement an intermittent auscultation bundle. To measure fidelity in using this bundle, through clinical data abstraction, hospitals will track the ordering of IA at admission for eligible patients. For patients deemed not eligible, it will be required that the provider document the rationale for not ordering IA. Points for implementation of the QI Implementation Goals will be awarded on a prorated basis upon actual performance.

QI Implementation Goals for Implementation of an Intermittent Auscultation (IA) Bundle:

	Process Measure	How It Will Be Measured	Timeframe	Points Available
A	Intermittent Auscultation (IA) will be ordered at admission for at least 60% of eligible NTSV patients.	The proportion of eligible NTSV patients with IA ordered at admissionusing clinically abstracted data. SeeAppendix B.	March 1, 2022 - October 31, 2022 delivery dates* *End date subject to change depending on OBI case lock scheduleand P4P score submission to BCBSM.	≥60%: 40 pts 59-40%: 30pts 39-25%: 20 pts <25%: 0 pts
B	Conduct quarterly multidisciplinary team meetings to discuss project progress and review data. Two of these quarterly meetings must involve disseminating relevant OBI data and implementation progress with the full maternity care team (i.e. usinga 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 agendas and rosters for a total of 4 meetings to OBI Coordinating Center by January 6, 2023.	January 1, 2022 – December 31, 2022	4 mtgs: 30 Pts 3 mtgs: 20 pts 2 mtgs: 10 pts
C	Submit quarterly program implementation progress reports.	OBI Workstation Program Progress Reports submitted by quarterly deadlines.	Due Dates: • March 31, 2022 • June 30, 2022 • September 30, 2022 • January 6, 2023	4 reports: 30pts 3 reports: 20 pts 2 reports: 10 pts
			Total	**100 points**

Quality Improvement Implementation: TeamBirth

2022 TeamBirth Cohort (Implementation)	
Project Time Period	1/1/2022 - 12/31/2022
Target Population	**Inclusion criteria:** NTSV patients included in workstation data set with planned mode of delivery at time of admission = planned labor for vaginal delivery **Exclusion criteria:** NTSV patients included in workstation data set with planned mode of delivery at time of admission = planned for cesarean delivery **Numerator:** Patients who meet inclusion criteria and have at least one patient-centered huddle during admission for planned labor. **Denominator:** NTSV patients with planned labor for vaginal delivery at TeamBirth hospitals.
Goal	Implementing the TeamBirth core components will provide structure, support and accountability for shared decision making and respectful care. Through patient-centered huddles and a shared labor & delivery planning tool, sites will improve team communication by providing a consistent platform for shared decision-making during assessment of labor progress, and maternal and fetal well-being. Multidisciplinary hospital site implementation teams will adhere to the TeamBirth quality improvement process.
2021 OBI Baseline Data	Per the Q2 2021 Program Progress and Monitoring report submissions, 62 OBI hospitals reported that they are in the process of implementing, or have implemented, a shared decision making tool or tools. 25 OBI hospitals are in the process of implementing, or have implemented a shared decision making board in patient rooms. Workstation data indicates an increase in documentation of shared decision making. In 2019 42.7% of NTSV cases did not have any shared decision making documented, in 2020 35.78%, and of the available cases for 2021, only 24.7% have reported shared decision making not documented. Of the births with a shared decision making document scanned, the proportion in which a nurse also documented birth preferences increased from 28.1% in 2019, to 36.9% in 2020, and 42.9% in 2021.
Balance Measure	No increase in severe maternal morbidity or mortality or fetal morbidity or mortality.

Background for 2022 TeamBirth Cohort (Implementation):

The Institute for Healthcare Improvement Framework for Safe, Reliable and Effective Care recognizes engagement of patients and families as a core component of all quality improvement work. OBI is committed to aligning with the IHI Triple Aim, while safely reducing the NTSV cesarean delivery rate. Shared decision making improves the patient experience of care, supports the "Equitable'' domain of the Institute of Medicine (IOM)'s 6 domains of healthcare quality, and is associated with lower NTSV cesarean delivery rates (Sakala, et al, 2020 and Attanasio, et al, 2018). The TeamBirth model provides hospital teams with a structured implementation pathway for patient-centered huddles and a shared planning board to ensure that shared decision making occurs for all patients through labor and delivery (Aggarwal, A., 2021).

QI Implementation Requirements for 2022 TeamBirth Cohort (Implementation):

Sites that choose to implement TeamBirth as part of the 2022 Cohort will be expected to designate an TeamBirth project manager and multidisciplinary implementation team. OBI intends to host an in-person TeamBirth 2022 project kickoff event on March 11, 2022, (COVID permitting). At least one member of the TeamBirth implementation team and a clinical champion from each site must attend the kickoff event. In the event that OBI is unable to host an in-person event, arrangements will be made for an alternative kick-off event. 2021 and 2022 TeamBirth cohorts will participate in the event in place of the 1st video workgroup for 2022. Designated TeamBirth project managers and implementation teams will be expected to meet quarterly, and submit agendas to OBI by January 6, 2023. All sites are expected to submit quarterly progress reports, sites that select this option must complete the TeamBirth section to receive the allotted points for this measure. Sites will track implementation progress by measuring staff training percentages and through clinical data abstraction. Staff training records will be due to OBI by June 30, 2022. Measurement of the proportion of NTSV patients admitted for planned labor with documentation that a patient-centered huddle fromtime of admission to time of delivery will be based on July 1, 2022 - October 31, 2022 delivery dates.

QI Goals for 2022 TeamBirth Cohort (Implementation):				
	PROCESS MEASURE	**HOW IT WILL BE MEASURED**	**TIME FRAME**	**POINTS AVAILABLE**
A	Staff trained on TeamBirth core components	Proportion of total staff trained on TeamBirth core components	April 2022 - June 30, 2022	≥80%: 20 pts 60-80%: 15 pts 40-60%: 10 pts <40%: 0 pts
B	Patient-centered huddle between time of admission and time of delivery.	Proportion of NTSV patients that have a patient-centered huddle documented between time of admission and time of delivery. See Appendix B.	July 1, 2022 - October 31, 2022 delivery dates	>30%: 20 pts 20-29%: 15 pts 10-19%: 10 pts <10%: 0 pts
C	Conduct quarterly multidisciplinary team meetings to discuss project progress and review data. 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 agendas and rosters for a total of 4 meetings to OBI Coordinating Center by January 6, 2023.	March 1, 2022 - October 31, 2022 delivery dates	4 mtgs: 30 Pts 3 mtgs: 20 pts 2 mtgs: 10 pts
D	Submit quarterly program implementation progress reports	OBI Workstation Program Progress Reports submitted by quarterly deadlines.	Due Dates: • March 31, 2022 • June 30, 2022 • September 30, 2022 January 6, 2023	4 reports: 30pts 3 reports: 20 pts 2 reports: 10 pts
			POINTS	100