2026 Hospital Pay-for-Performance Program (for peer groups 1 through 4)

Hospital CQI Performance Index Scorecards

Hospital CQI Pay-for-Performance Program

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

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

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

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

CQI performance index scorecards

In addition, each CQI performance index scorecard will be made available through each coordinating center.

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

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

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

CQI Program Manager Contacts

CQI	CQI Clinical Focus Area	Index Scorecard Section	Coordinating Center Program Manager	Email
ASPIRE	Anesthesiology	3-12	Tory Lacca Kate Buehler	lacca@umich.edu kjbucrek@med.umich.edu
BMC2	Angioplasty & Vascular Surgery	13-18	Mollie Bodin	mbodin@med.umich.edu
HMS	Hospital Medicine	19-27	Elizabeth McLaughlin	emcnair@umich.edu
MAQI2	Anticoagulation	28-33	Brian Haymart	khaymart@umich.edu
MARCQI	Knee/Hip Arthroplasty	34-64	Tae Kim	taekk@med.umich.edu
MBSC	Bariatric Surgery	65-68	Amanda Stricklen Rachel Ross	aoreilly@umich.edu rachacoo@umich.edu
MEDIC	Emergency Department	69-78	Andy Scott	afscott@med.umich.edu
MROQC	Radiation Oncology	79-90	Melissa Mietzel	hillmel@umich.edu
MSQC	General Surgery	91-96	Amanda Stricklen Rachel Ross	aoreilly@umich.edu rachacoo@umich.edu
MSSIC	Spine Surgery	97-113	Jamie Myers	Jmyer8@hfhs.org
MSTCVS	Cardiac Surgery	114-118	Melissa Clark	clarkmel@med.umich.edu
MTQIP	Trauma Surgery	119-122	Judy Mikhail	jmikhail@umich.edu
OBI	Obstetrics	123-129	Helen Costis	hcostis@umich.edu

2026 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohorts 1 - 7** Measurement Period: 10/01/2025 - 09/30/2026			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at meetings. Three total meetings with six opportunities for attendance.**	
		6 / 6 Meetings	10
		5 / 6 Meetings	5
		4 or Less Meetings	0
2	5%	**Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings.**	
		5 - 6 / 6 Meetings	5
		4 or less Meetings	0
3	5%	**ACQR/ASPIRE Quality Champion perform data validation, case validation and submit data by the 3rd Wednesday of each month for January - November and by the 2nd Wednesday of the month for December. Data must be of high quality upon submission, >90% of diagnostics marked as 'Data Accurately Represented.'**	
		10 - 12/12 Months	5
		9 or Less Months	0
4	10%	**Site Based Quality Meetings: Sites to hold an onsite in-person or virtual meeting following the three ASPIRE Collaborative meetings to discuss the data and plans for quality improvement at their site**	
		3 Meetings	10
		2 Meetings	5
		1 or less Meetings	0
5	25%	**Global Warming Footprint (SUS 02): Increase percentage of cases where carbon dioxide equivalents (CO_2 eq) normalized by hour for cases receiving halogenated agents and/or nitrous oxide is less than CO_2 eq of 2% sevoflurane at 2L FGF = 2.83 kg CO_2/hr or the Total CO_2 eq is less than 2.83 kg CO_2 for the maintenance period of anesthesia. (Cumulative score October 1, 2025 through September 30, 2026)**	
		Performance is>=65%, Absolute performance improves by>=20 percentage points or, if performance>=40% and relative performance increases by>=50%	25
		Performance is>=60%, Absolute performance improves by>=15 percentage points or, if performance>=40% and relative performance increases by>=40%	15
		Performance is>=55%, absolute performance improves by>=10 percentage points or, if performance>=40% and relative performance increases by>=30%	10
		Performance is < 55%, absolute performance improves by < 10 percentage points or, if performance>=40% and relative performance increases by < 30%	0

2026 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohorts 1 - 7** Measurement Period: 10/01/2025 - 09/30/2026			
Measure #	Weight	Measure Description	Points
6	20%	**Perioperative Hypothermia (TEMP 03): Reduce percentage of cases requiring general or neuraxial anesthesia for whom a body temperature>=36 degrees Celsius (or 96.8 degrees Fahrenheit) was not recorded within 30 minutes before to 15 minutes after anesthesia end time. (Cumulative score October 1, 2025 through September 30, 2026)**	
		Performance is <= 4.5%, Absolute performance improves by>=4 percentage points or, if relative performance improves by>=30%	20
		Performance is <=5.5%, Absolute performance improves by>=3 percentage points or, if relative performance improves by>=20%	10
		Performance is <= 7%, Absolute performance improves by>=2 percentage points or, if relative performance improves by>=10%	5
		Performance is > 7%, Absolute performance improves by < 2 percentage points or, if relative performance improves by < 10%	0
7	25%	**Site Directed Measure: Site chooses a measure they are performing below threshold for a process measure or above threshold for an outcome measure to improve for the year. (Cumulative score October 1, 2025 through September 30, 2026)**	
		Performance is>=90% for process or <=5% for outcome, or shows>=15% improvement (absolute)	25
		Performance is>=85% for process or <=10% for outcome, or shows>=10% improvement (absolute)	15
		Performance is>=80% for process or <= 20% for outcome, or shows>=5% improvement (absolute)	10
		Performance is < 80% for process or > 20% for outcome, or shows < 5% improvement (absolute)	0
Please note: all measures above are scored using hospital methodology.			

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)
2026 Performance Index Scorecard Measure Explanation: Cohort 1 - 7
Measurement Period: 10/01/2025 - 09/30/2026
CQI P4P Performance Index Scorecard supporting documentation

Measure number and description	Additional narrative describing the measure
Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at meetings. Three total meetings with six opportunities for attendance.	The ASPIRE Quality Champion (or a designated representative who must be an anesthesiologist) and the Anesthesiology Clinical Quality Reviewer (ACQR), combined, must attend ASPIRE Collaborative meetings in 2025-26. There are three total meetings with six opportunities for attendance: 1. MPOG (Multicenter Perioperative Outcomes Group) Retreat: Friday, October 10, 2025 2. MSQC (Michigan Surgical Quality Collaborative) / ASPIRE Meeting: Friday, March 13, 2026 3. ASPIRE Collaborative Meeting: Friday, July 17, 2026
Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings.	There will be six Quality Committee e-meetings in 2025-26. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2025-26 meetings: 1. Monday, November 24, 2025 2. Monday, January 26, 2026 3. Monday, February 23, 2026 4. Monday, May 18, 2026 5. Monday, July 27, 2026 6. Monday, September 28, 2026
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 with >90% of all high priority and required diagnostics marked as 'Data Accurately Represented.'	Maintenance Schedule located on MPOG website in the resources tab of the quality section. Data must be of high quality upon submission, >90% of all 'High Priority' and 'Required' diagnostics marked as 'Data Accurately Represented.'
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.	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.
Global Warming Footprint (SUS 02): Percentage of cases where carbon dioxide equivalents (CO2 eq) normalized by hour for cases receiving halogenated agents and/or nitrous oxide is less than CO2 eq of 2% sevoflurane at 2L FGF = 2.83 kg CO2/hr or the Total CO2 eq is less than 2.83 kg CO2 for the maintenance period of anesthesia. (Cumulative score October 1, 2025 through September 30, 2026)	Sites will be awarded points for compliance with the sustainability measure SUS 02 (cumulative score October 1, 2025 through September 30, 2026). If the performance threshold is not met, Coordinating Center will assess 12-month average score for October 1, 2025 – September 30, 2026 and compare to 12-month average score for October 1, 2024 – September 30, 2025. Coordinating Center will assign points based on either absolute percentage point improvement or relative performance improvement, prioritizing the method that results in the highest number of points to be awarded.

Perioperative Hypothermia (TEMP 03): Percentage of cases requiring general or neuraxial anesthesia for whom a body temperature>=36 degrees Celsius (or 96.8 degrees Fahrenheit) was not recorded within 30 minutes before to 15 minutes after anesthesia end time. (Cumulative score October 1, 2025 through September 30, 2026)	Sites will be awarded points for compliance with the temperature measure TEMP 03 (cumulative score October 1, 2025 through September 30, 2026). If the performance threshold is not met, Coordinating Center will assess 12-month average score for October 1, 2025 – September 30, 2026 and compare to 12-month average score for October 1, 2024 – September 30, 2025. Coordinating Center will assign points based on either absolute percentage point improvement or relative performance improvement, prioritizing the method that results in the highest number of points to be awarded. will be evaluated to allocate points.
Site Directed Measure: Site chooses a measure they are performing below threshold for a process measure or above threshold for an outcome measure to improve for the year. (Cumulative score October 1, 2025 through September 30, 2026)	Sites will choose a measure where performance is above the ASPIRE threshold for inverse (outcome) measures (5 or 10%) or a process measure with performance less than threshold (90%) that needs improvement. Sites must submit their current measure score (August 1, 2024 through July 31, 2025) to the Coordinating Center by Friday, September 12, 2025, for review and approval. Measure selection form is located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section. If the performance threshold is not met, Coordinating Center will assess 12-month average score for October 1, 2025 – September 30, 2026 and compare to 12-month average score for October 1, 2024 – September 30, 2025. Only absolute percentage point improvement will be evaluated to allocate points.

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2026 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohorts 8** Measurement Period: 10/01/2025 - 09/30/2026			
Measure #	Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at collaborative meetings. Three total meetings with six opportunities for attendance**.	
		6 / 6 Meetings	20
		5 / 6 Meetings	10
		4 or Less Meetings	0
2	10%	**Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings.**	
		5 - 6 / 6 Meetings	10
		4 Meetings	5
		3 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 with >90% of all high priority and required diagnostics marked as 'Data Accurately Represented.'**	
		11 / 12 Months	20
		10 / 12 Months	15
		9 / 12 Months	10
		9 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 Meeting	5
		1 Meetings	0
6	10%	**ACQR Attend the Fall ACQR Retreat.**	
		Yes	10
		No	0
7	10%	**Neuromuscular Blockage (NMB 01) Increase percentage of cases with a documented Train of Four (TOF) after last dose of non-depolarizing neuromuscular blocker (Cumulative score October 1, 2025 - September 30, 2026)**	
		Performance is>=90%	10
		Performance is < 90%	0

2026 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohorts 8** Measurement Period: 10/01/2025 - 09/30/2026			
Measure #	Weight	Measure Description	Points
8	10%	**Site Directed Measure: Site chooses a measure they are performing below threshold for a process measure or above threshold for an outcome measure to improve for the year. (Cumulative score October 1, 2025 through September 30, 2026)**	
		Performance is>=90% for process or <=5% for outcome, or shows>=15% improvement (absolute)	10
		Performance is>=80% for process or <=10% for outcome, or shows>=10% improvement (absolute)	5
		Performance is < 80% for process or >10% for outcome	0
Please note: all measures above are scored using hospital methodology.			

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)
2026 Performance Index Scorecard Measure Explanation: Cohort 8
Measurement Period: 10/01/2025 - 09/30/2026
CQI P4P Performance Index Scorecard supporting documentation

Measure number and description	Additional narrative describing the measure
Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at meetings. Three total meetings with six opportunities for attendance.	The ASPIRE Quality Champion (or a designated representative who must be an anesthesiologist) and the Anesthesiology Clinical Quality Reviewer (ACQR), combined, must attend ASPIRE Collaborative meetings in 2025-26. There are three total meetings with six opportunities for attendance: 1. MPOG (Multicenter Perioperative Outcomes Group) Retreat: Friday, October 10, 2025 2. MSQC (Michigan Surgical Quality Collaborative) / ASPIRE Meeting: Friday, March 13, 2026 3. ASPIRE Collaborative Meeting: Friday, July 17, 2026
Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings.	There will be six Quality Committee e-meetings in 2025-26. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2025-26 meetings: 1. Monday, November 24, 2025 2. Monday, January 26, 2026 3. Monday, February 23, 2026 4. Monday, May 18, 2026 5. Monday, July 27, 2026 6. Monday, September 28, 2026
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 with >90% of all high priority and required diagnostics marked as 'Data Accurately Represented.'	Maintenance Schedule located on MPOG website in the resources tab of the quality section. Data must be of high quality upon submission, >90% of all 'High Priority' and 'Required' diagnostics marked as 'Data Accurately Represented.'
ASPIRE Quality Champion and ACQR monthly meetings	ASPIRE Quality Champion and ACQR need to meet monthly to discuss the data and plans for quality improvement. A log of the meeting must be submitted to the ASPIRE Coordinating Center each month. Logs are located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section.
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.	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.
ACQR Attend the Fall ACQR Retreat.	ACQR must attend the fall ACQR Retreat to be held on Friday, September 11, 2026.
Neuromuscular Blockage (NMB 01) Percentage of cases with a documented Train of Four (TOF) after last dose of non-depolarizing neuromuscular blocker (Cumulative score October 1, 2025 - September 30, 2026)	Sites will be awarded points for compliance with the neuromuscular blockade monitoring measure NMB 01 (cumulative score October 1, 2025 through September 30, 2026).

Site Directed Measure: Site chooses a measure they are performing below threshold for a process measure or above threshold for an outcome measure to improve for the year. (Cumulative score October 1, 2025 through September 30, 2026)	Sites will choose a measure where performance is above the ASPIRE threshold for inverse (outcome) measures (5 or 10%) or a process measure with performance less than threshold (90%) that needs improvement. Sites must submit their current measure score (August 1, 2024 through July 31, 2025) to the Coordinating Center by Friday, September 12, 2025, for review and approval. Measure selection form is located on the MPOG website in the P4P sub tab of the Michigan hospitals tab of the quality section. If the performance threshold is not met, Coordinating Center will assess the 12-month average score for October 1, 2025 – September 30, 2026 and compare to 12-month average score for October 1, 2024 – September 30, 2025. Absolute percentage point improvement will be evaluated to allocate points. See P4P Scorecard for point distribution

2026 Anesthesiology Quality Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard **Cohorts 9** Measurement Period: 10/01/2025 - 09/30/2026			
Measure #	Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at collaborative meetings. Three total meetings with six opportunities for attendance**.	
		6 / 6 Meetings	20
		5 / 6 Meetings	10
		4 or Less Meetings	0
2	10%	**Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings.**	
		5 - 6 / 6 Meetings	10
		4 Meetings	5
		3 or Less Meetings	0
3	10%	**Timeliness of Regulatory/Legal documentation: Business Associate Agreement (BAA), Data Use Agreement (DUA), Multicenter Perioperative Outcomes Group (MPOG) Bylaws & IRB**	
		Submitted by February 1, 2026	10
		Submitted by March 1, 2026	5
		Submitted after March 1, 2026	0
4	10%	**Hire an Anesthesiology Clinical Quality Reviewer (ACQR)**	
		ACQR Start Date on or before December 1, 2025	10
		ACQR Start Date on or before January 1, 2026	5
		ACQR Start Date on or after January 1, 2026	0
5	20%	**Timeliness of data submission (with Case by Case Validation and Data Diagnostic Attestations Completed)**	
		Submitted by July 1, 2026	10
		Submitted by September 1, 2026	5
		Submitted after September 1, 2026	0
6	20%	**Performance Metric: Accuracy of data of "High" and "Required" priority data diagnostics marked as "Data Accurately Represented" in Data Diagnostics Tool**	
		>= 90% diagnostics marked as "Data Accurately Represented"	20
		>= 75 - 90% marked as "Data Accurately Represented"	10
		< 75% marked as "Data Accurately Represented"	0
7	10%	**Timeliness of Responses to Coordinating Center Inquiry Requests**	
		Within 2 business days	20
		Within 5 business days	15
		Greater than 5 business days	10

Please note: all measures above are scored using hospital methodology.

Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)
2026 Performance Index Scorecard Measure Explanation: Cohort 9
Measurement Period: 10/01/2025 - 09/30/2026
CQI P4P Performance Index Scorecard supporting documentation

Measure number and description	Additional narrative describing the measure
Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at meetings. Three total meetings with six opportunities for attendance.	The ASPIRE Quality Champion (or a designated representative who must be an anesthesiologist) and the Anesthesiology Clinical Quality Reviewer (ACQR), combined, must attend ASPIRE Collaborative meetings in 2025-26. There are three total meetings with six opportunities for attendance: 1. MPOG (Multicenter Perioperative Outcomes Group) Retreat: Friday, October 10, 2025 2. MSQC (Michigan Surgical Quality Collaborative) / ASPIRE Meeting: Friday, March 13, 2026 3. ASPIRE Collaborative Meeting: Friday, July 17, 2026
Attend ASPIRE Quality Committee e-meetings: ASPIRE Quality Champion or ACQR attendance across six meetings.	There will be six Quality Committee e-meetings in 2025-26. One representative (ASPIRE Quality Champion or ACQR) must attend the following 2025-26 meetings: 1. Monday, November 24, 2025 2. Monday, January 26, 2026 3. Monday, February 23, 2026 4. Monday, May 18, 2026 5. Monday, July 27, 2026 6. Monday, September 28, 2026
Timeliness of Regulatory/Legal documentation: Business Associate Agreement (BAA), Data Use Agreement (DUA), Multicenter Perioperative Outcomes Group (MPOG) Bylaws & IRB	All regulatory documents must be submitted to the Coordinating Center by February 1, 2026.
Hire an Anesthesiology Clinical Quality Reviewer (ACQR)	Must hire Anesthesiology Clinical Quality Reviewer (ACQR) by December 1, 2025. The success of the program is greater when the ACQR is hired early in the process.
Timeliness of data submission (with Case-by-Case Validation and Data Diagnostic Attestations Completed)	The minimum data requirements must be uploaded into the Multicenter Perioperative Outcomes Group (MPOG) central repository by July 1, 2026. The MPOG minimum data requirements can be found on the MPOG website.
Performance Metric: Accuracy of data of "High" and "Required" priority data diagnostics marked as "Data Accurately Represented" in Data Diagnostics Tool	Data must be of high quality before the July 1, 2026 upload. The ASPIRE team will assist in determining if data is approved for uploading to MPOG.
Timeliness of Responses to Coordinating Center Inquiry Requests	Timeliness of responses to the coordinating center requests. The ASPIRE team will evaluate response rates.

2026 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2)
Performance Index Scorecard
PCI & Vascular Surgery Sites
Measurement period identified in each measure

Measure #	Weight	Measure Description	PCI points	VS points
1	10%	**Meeting Participation - Clinician Lead** **Measurement period: 1/1/2026 - 12/31/2026**		
		2 Meetings (attendance at the PCI Spring Collaborative and VS Fall Collaborative meeting earns 1 additional extra credit point)	7.5	7.5
		1 Meeting	3.5	3.5
		Did not participate	0	0
2	10%	**Data Coordinator Expectations** **Measurement period: 1/1/2026 - 12/31/2026**		
		Meets all expectations	7.5	7.5
		Meets most expectations	3.5	3.5
		Does not meet expectations	0	0
3	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement period: 1/1/2026 - 12/31/2026**		
		Submitted reviews for 100% of cases	5	5
		Submitted reviews for <100% of cases	0	0
Sites select two measures for scoring from measures 4, 5, 6 **Measurement Period: 01/01/2026 – 06/30/2026**				
4	16%	**Vascular Surgery Performance Goal - Documentation of EVAR* imaging performed on the 1-year follow up form** **Measurement period: 1/1/2026-6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**		
		>=85%	NA	10
		75% - <85%	NA	5
		<75%	NA	0
5		**Vascular Surgery Performance Goal - Duplex ultrasound completed prior to asymptomatic carotid endarterectomy** **Measurement period: 1/1/2026-6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**		
		>=90%	NA	10
		80% - <90%	NA	5
		<80%	NA	0
6		**Vascular Surgery Performance Goal - Vein mapping completed before elective lower extremity open bypass** **Measurement period: 1/1/2026 - 6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**		
		>=90%	NA	10
		80% - <90%	NA	5
		<80%	NA	0

2026 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI & Vascular Surgery Sites** Measurement period identified in each measure				
Measure #	Weight	Measure Description	PCI points	VS points
7	10%	**Vascular Surgery Performance Goal - Smokers receive smoking cessation treatment prior to discharge** **Measurement period: 1/1/2026 - 6/30/2026** **Baseline period: 1/1/2023 - 3/31/2024**		
		>=65%	NA	10
		55% - <65%	NA	5
		<55%	NA	0
8	10%	**PCI Performance Goal - Use of IVUS/OCT^ for stent optimization** **Measurement period: 1/1/2026 - 6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**		
		>60% in EITHER all cases OR >75% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	10	NA
		>10 percentage points absolute increase in all cases from Q4 YTD 2025	5	NA
		<10 percentage points absolute increase in all cases from Q4 YTD 2025	0	NA
9	24%	**PCI Performance Goal – Composite, inclusive of risk-adjusted mortality, risk-adjusted AKI, risk-adjusted major bleeding, guideline medications prescription at discharge (aspirin, statin, P2Y12), and referral to cardiac rehab.** Each component awarded either 0,3, or 5 points for a total score of between 0 and 25 points. **Measurement period: 1/1/2026-6/30/2026**	0-25	NA
10	10%	**PCI Performance Goal - Cardiac rehabilitation utilization within 90 days after PCI discharge** **Measurement period: 1/1/2025 - 12/31/2025** **Baseline period: 10/01/2022 - 9/30/2023**		
		Site performance>=40% or absolute increase of>=5 points in the measurement period (CY2025) compared with the immediate prior 12 month period (CY2024). Scored in 2026	10	NA
		Site performance>=37% or absolute increase of>=3 points in the measurement period (CY2025) compared with the immediate prior 12 month period (CY2024). Scored in 2026	5	NA
		Site performance <37% and absolute increase of <3 points from baseline site performance. Scored in 2025.	0	NA
11	N/A	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD Measurement period: **1/1/2026 - 12/31/2026**	1-5	1-5
Please note: all measures above are scored using hospital methodology.				

2026 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2)
Performance Index Scorecard
PCI only sites
Measurement period identified in the measure

Measure #	Weight	Measure Description	PCI points
1	10%	**Meeting Participation - Clinician Lead** **Measurement period: 1/1/2026 - 12/31/2026**	
		2 Meetings (attendance at the PCI Spring Collaborative and VS Fall Collaborative meeting earns 1 additional extra credit point)	10
		1 Meeting	5
		Did not participate	0
2	10%	**Data Coordinator Expectations** **Measurement period: 1/1/2026 - 12/31/2026**	
		Meets all expectations	10
		Meets most expectations	5
		Does not meet expectations	0
3	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement period: 1/1/2026 - 12/31/2026**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
8	10%	**PCI Performance Goal - Use of IVUS/OCT for stent optimization** **Measurement period: 1/1/2026 - 6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**	
		≥60% in EITHER all cases OR ≥75% in cases involving the left main coronary artery, in-stent restenosis, or stent thrombosis	10
		≥10 percentage points absolute increase in all cases from Q4 YTD 2024	5
		<10 percentage points absolute increase in all cases from Q4 YTD 2024	0
9	50%	**PCI Performance Goal – Composite, inclusive of risk-adjusted mortality, risk-adjusted AKI, risk-adjusted major bleeding, guideline medications prescription at discharge (aspirin, statin, P2Y12), and referral to cardiac rehab.** Each component awarded either 0,3, or 5 points and multiplied by 2 for a total score of between 0 and 50 points. **Measurement period: 1/1/2026-6/30/2026**	0-50
10	10%	**PCI Performance Goal - Cardiac rehabilitation utilization within 90 days after PCI discharge** **Measurement period: 1/1/2025 - 12/31/2025** **Baseline period: 10/01/2022 - 9/30/2023**	
		Site performance>=40% or absolute increase of>=5 points in the measurement period (CY2025) compared with the immediate prior 12 month period (CY2024). Scored in 2026	10
		Site performance>=37% or absolute increase of>=3 points in the measurement period (CY2025) compared with the immediate prior 12 month period (CY2024). Scored in 2026	5
		Site performance <37% and absolute increase of <3 points from baseline site performance. Scored in 2026.	0

2026 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2) Performance Index Scorecard **PCI only sites** Measurement period identified in the measure			
Measure #	Weight	Measure Description	PCI points
11	N/A	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD Measurement period: **1/1/2026 - 12/31/2026**	
Please note: all measures above are scored using hospital methodology.			

2026 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2)
Performance Index Scorecard
Vascular Surgery only sites
Measurement Period identified in each measure

Measure #	Weight	Measure Description	VS points
1	10%	**Meeting Participation - Clinician Lead** **Measurement period: 1/1/2026 - 12/31/2026**	
		2 Meetings (attendance at the PCI Spring Collaborative and VS Fall Collaborative meeting earns 1 additional extra credit point)	10
		1 Meeting	5
		Did not participate	0
2	10%	**Data Coordinator Expectations** **Measurement period: 1/1/2026 - 12/31/2026**	
		Meets all expectations	10
		Meets most expectations	7.5
		Does not meet expectations	0
3	10%	**Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality** **Measurement period: 1/1/2026 - 12/31/2026**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
Sites select two measures for scoring from measures 4, 5, 6			
4	25%	**Vascular Surgery Performance Goal - Documentation of EVAR* imaging performed on the 1-year follow up form** **Measurement period: 1/1/2026-6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**	
		>=85%	25
		75% - <85%	15
		<75%	0
5	25%	**Vascular Surgery Performance Goal - Duplex ultrasound completed prior to asymptomatic carotid endarterectomy** **Measurement period: 1/1/2026 - 6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**	
		>=90%	25
		80% - <90%	15
		<80%	0
6	25%	**Vascular Surgery Performance Goal - Vein mapping completed before elective lower extremity open bypass** **Measurement period: 1/1/2026 - 6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**	
		>=90%	25
		80% - <90%	15
		<80%	0

2026 Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2)
Performance Index Scorecard
Vascular Surgery only sites
Measurement Period identified in each measure

Measure #	Weight	Measure Description	VS points
7	20%	**Vascular Surgery Performance Goal - Smokers receive smoking cessation treatment prior to discharge** **Measurement period: 1/1/2026 - 6/30/2026** **Baseline period: 1/1/2024 - 12/31/2024**	
		>=65%	20
		55% - <65%	15
		<55%	0
11	0%	Extra credit: 1 point per approved activity (maximum of 5 points) Examples include: Physician attendance at the collaborative-wide meeting, presentation at a meeting, engagement in a work group/task force, referral of an engaged patient advisor, special initiatives, TBD Measurement period: **1/1/2026 - 12/31/2026**	1-5
Note that the total is 125 given there is a 'choose two' measure option **Please note**: all measures above are scored using hospital methodology.			

2026 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
1	10%	**Timeliness[1], Completeness[2], and Accuracy[3] of HMS Data (5 metrics) Measurement Period: ABX and Sepsis Discharges from 07/31/25 – 07/29/26** 1. >=95% of registry data on time[1] and complete[2] at Mid-Year 2.>=95% of registry data on time[1] and complete[2] at End-of-Year 3.>=95% of registry data accurate[3] 4. Audit case corrections completed by due date[3] 5. Two semi-annual QI activity surveys completed[4]	
		5 of 5 metrics met	10
		4 of 5 metrics met	8
		3 of 5 metrics met	6
		2 of 5 metrics met	4
		1 of 5 metrics met	2
		0 of 5 metrics met	0
2	10%	**Collaborative Wide Meeting Participation[5]– Physician Champion or Delegate[6]** **Measurement Period: 9/13/25 – 9/11/26**	
		3 meetings	10
		2 meetings	5
		1 meeting	3
		No meetings	0
3	10%	**Collaborative Wide Meeting Participation[5]– Clinical Data Abstractor or Other QI Staff[7]** **Measurement Period: 9/13/25 – 9/11/26**	
		3 meetings	10
		2 meetings	5
		1 meeting	3
		No meetings	0
4	15%	**Increase Use of Appropriate Antibiotic Treatment Duration8 (3 – 5 days) in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e., reduce excess durations)[9,10]** **Measurement Period: ABX Discharges from 5/7/26 – 7/29/26**	
		>=75% of uncomplicated CAP cases receive appropriate duration[8] of antibiotics	15
		65-74% of uncomplicated CAP cases receive appropriate duration[8] of antibiotics	8
		<= 64% of uncomplicated CAP cases receive appropriate duration[8] of antibiotics	0

2026 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
5	5%	**Antimicrobial Quality Improvement – Urinary Tract Infection (UTI) Guideline Updates[11] Measurement Period: 9/13/25 – 9/11/26**	
		Submit updated locally developed UTI guidelines with all elements included[11]	5
		Updated UTI guidelines not submitted or all elements not included[11]	0
6	15%	**Increase Antibiotics Delivered within 3 hours of Hospital Arrival for Sepsis Cases with Hypotension[9,10,12] Measurement Period: Sepsis Discharges from 5/7/26 – 7/29/26**	
		>=75% of sepsis cases with hypotension[12] receive antibiotics within 3 hours of hospital arrival	15
		71 – 74% of sepsis cases with hypotension[12] receive antibiotics within 3 hours of hospital arrival	8
		<=70% of sepsis cases with hypotension[12] receive antibiotics within 3 hours of hospital arrival	0
7	15%	**Increase Discharge/Post-Discharge Care Coordination for Sepsis Cases Discharged to Home-like Setting [9,10,13,14,15] Measurement Period: Sepsis Discharges from 5/7/26 – 7/29/26**	
		>= 86% of ALL sepsis cases discharged to home-like setting[13] received at least 1 of 4 discharge/post- discharge coordination of care measures[14] AND >=74% sepsis cases at high risk[15] of readmission received at least 2 of 4 discharge/post-discharge coordination of care measures[14]	15
		>= 86% of ALL sepsis cases discharged to home-like setting[12] received at least 1 of 4 discharge/post- discharge coordination of care measures[14] OR>=74% sepsis cases at high risk[15] of readmission received at least 2 of 4 discharge/post-discharge coordination of care measures[14]	8
		<= 85% of ALL sepsis cases discharged to home-like setting[13] received at least 1 of 4 discharge/post-discharge coordination of care measures[14] AND <= 73% sepsis cases at high risk[15] of readmission received at least 2 of 4 discharge/post-discharge coordination of care measures[14]	0
8	15%	**Increase Use of Balanced Solutions in Patients with Sepsis [9,10,16] Measurement Period: Sepsis Discharges from 5/7/26 – 7/29/26**	
		>= 50% of sepsis cases who have>=75% of their bolus and/or maintenance fluid as balanced solutions in the first 48 hours of hospital arrival[16]	15
		25 – 49% of sepsis cases who have>=75% of their bolus and/or maintenance fluid as balanced solutions in the first 48 hours of hospital arrival[16]	8
		<=24% of sepsis cases who have>=75% of their bolus and/or maintenance fluid as balanced solutions in the first 48 hours of hospital arrival[16]	0
C	5%	**Reduce Use of Antibiotics in Patients with Asymptomatic Bacteriuria (ASB)[17,18] Measurement Period: ABX Discharges from 5/7/26 – 7/29/26**	
		<=10% collaborative-wide average[18] of positive urine culture cases treated with an antibiotic are ASB cases[17]	5
		> 10% collaborative-wide average[18] of positive urine culture cases treated with an antibiotic are ASB cases[17]	0

2026 Michigan Hospital Medicine Safety (HMS) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
Optional Bonus Points*			
Optional	5%	Participation Bonus Points: Each site has the option of earning up to 5 bonus points toward their participation metrics (1-3) during the performance year. Each opportunity for bonus points is highlighted below with their point allowance: Measurement Period: 9/13/25 – 9/11/26 • Emergency Medicine Physician[19] attendance at the 2 in-person Collaborative Wide Meetings convened during the performance year (July & November) – 5 points • Present HMS data or about HMS at a national meeting (with approval)[20] – 3 points • Emergency Medicine Physician[19] attendance at 1 in-person Collaborative Wide Meeting convened during the performance year (July OR November) – 2 points • Present at an HMS meeting, event, or webinar during the performance year[21] – 2 points	5
Optional	2.5%	Performance Bonus: Increase success of Patient Reported Outcomes (PROs – phone, email, or text) collection in patients eligible for PROs completion in Antimicrobial Use Cases[9,22] Measurement Period: ABX Discharges from 5/7/26 – 7/29/26	
		≥ 85% success of Patient Reported Outcomes (PROs) collection in Antimicrobial Use cases[22]	2.5
		80-84% success of Patient Reported Outcomes (PROs) collection in Antimicrobial Use cases[22]	2
		75-79% success of Patient Reported Outcomes (PROs) collection in Antimicrobial Use cases[22]	1.5
Optional	2.5%	Performance Bonus: Increase success of Patient Reported Outcomes (PROs – phone, email, or text) collection in patients eligible for PROs completion in Sepsis Cases[9,22] Measurement Period: Sepsis Discharges from 5/7/26 – 7/29/26	
		≥ 85% success of Patient Reported Outcomes (PROs) collection in Sepsis cases[22]	2.5
		80-84% success of Patient Reported Outcomes (PROs) collection in Sepsis cases[22]	2
		67-79% success of Patient Reported Outcomes (PROs) collection in Sepsis cases[22]	1.5
*Earned bonus points will be added to the scorecard total, with the final score not to exceed 100 points overall. Participation bonus points may only apply to participation-based measures (1-3) and performance bonus points may only apply to performance-based measures (4-8).			

HMS
2026 Performance Index Scorecard Measure Explanation: All Cohorts
CQI P4P Performance Index Scorecard supporting documentation

Measure number and description	Additional narrative describing the measure
Measure #1: Timeliness, Completeness, and Accuracy of HMS Data (5 metrics)	1. Timeliness of registry data for the Antimicrobial and Sepsis initiatives is assessed based upon the number of fully completed cases submitted out of the total number of cases required/expected for that site at the timepoint of assessment. This assessment will occur twice in a performance year – once at mid-year and once at year end. 2. Completeness of registry data is assessed based upon completeness of ALL required forms (including all patient reported outcomes attempts in eligible cases) for each case that is marked as Completed in the registry. This assessment will occur twice in a performance year – once at mid-year and once at year end. 3. Accuracy of registry data is based on score(s) received for site audits conducted during the performance year. Scores are averaged if multiple audits take place during the year. For audits conducted during the performance year, audit case corrections must be completed or discrepancies addressed within 3 months of audit summary receipt (due date for case corrections provided in audit summary) or end of performance year deadline – whichever comes first. 4. Semi-annual Quality Improvement (QI) Activity surveys are sent twice per year – in Spring and Fall. Each survey has two sections: one for Antimicrobial Use and one for Sepsis. All surveys must be completed by due dates announced by Coordinating Center to receive full points for this year.
Measure #2: Collaborative Wide Meeting Participation – Physician Champion or Delegate	5. HMS hosts three Collaborative Wide Meetings per year, scheduled in March (virtual), July (in-person), and November (in-person). Participation is defined as virtual or in-person attendance at each meeting for the required attendees. 6. A Physician Champion or delegate must be a physician as outlined in the HMS Hospital Eligibility and Expectations Document. A delegate for the Physician Champion cannot be a Resident, Fellow, Intern, or Advanced Practice Professional. Physician Champions or delegate may only represent one (1) site per meeting.
Measure #3: Collaborative Wide Meeting Participation – Clinical Data Abstractor or Other QI Staff	5. HMS hosts three Collaborative Wide Meetings per year, scheduled in March (virtual), July (in-person), and November (in-person). Participation is defined as virtual or in-person attendance at each meeting for the required attendees. 7. Each site must send one (1) Clinical Data Abstractor or other Quality Improvement Staff member to each Collaborative Wide Meeting. CDAs or other Quality Improvement Staff members can only represent one (1) site per meeting.
Measure #4: Increase Use of Appropriate Antibiotic Treatment Duration (3 – 5 days) in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e., reduce excess durations)	8. Antibiotic duration for Uncomplicated CAP is considered appropriate if 3 to 5 days of total antibiotic treatment (inpatient and outpatient) is administered. Antibiotic days of treatment are counted as calendar days rather than 24-hour periods; therefore, six (6) days of total antibiotic duration is also considered appropriate for the allowance of a one-day grace period. Cases with total antibiotic durations of 1 or 2 days are excluded from the denominator of this measure. Duration is calculated using effective duration which considers the presence of pathogen susceptibility and resistance. Cases missing critical data to calculate duration are excluded from the measure. 9. This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3) of the Performance Year. 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 average. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative, and reflects the improvement work each hospital is doing over a given performance year.

<table>
<tr><td></td><td>10. If there are no eligible cases for a site to be assessed in this measure from Q4 2025 through Q3 2026, both the numerator and denominator of points for this measure will be removed from the site's final score.</td></tr>
<tr><td>Measure #5: Antimicrobial Quality Improvement – Urinary Tract Infection (UTI) Guideline Updates</td><td>11. HMS will distribute a survey to all abstractors and quality leads to collect the necessary information for this measure. It is the responsibility of the abstractor or quality lead to collaborate with key stakeholders involved in updating and implementing clinical guidelines to ensure compliance with this measure. Updated UTI guidelines must either be fully implemented and in use by the time of submission OR have documented proof that updates have been submitted for local approval.
Locally-developed UTI Guidelines must include ALL the following elements:
Identify symptoms of a urinary tract infection (UTI)
Maintain existing HMS-concordant guidelines
Recommend against sending urine cultures in the absence of urinary symptoms
Recommend against treating a positive urine culture in the absence of urinary symptoms
De-emphasize fluoroquinolones
Complicated UTI classification should include:
Febrile UTI
Bacteremic UTI
Pyelonephritis
CAUTI
Uncomplicated Lower UTI or Cystitis classification should include:
Infections localized to the bladder (in women or men) regardless of comorbidities
Provide antibiotic treatment recommendations for Uncomplicated UTI, including the following:
Transition to oral therapy
Dose
Duration of treatment
Selection of beta-lactam antibiotic is at the discretion of the site; alternative agents may be used in cases of an allergy
<table>
<tr><th>Antibiotic</th><th>Duration</th></tr>
<tr><td colspan="2">Preferred</td></tr>
<tr><td>Nitrofurantoin</td><td>5 days</td></tr>
<tr><td>Trimethoprim-sulfamethoxazole</td><td>3 days</td></tr>
<tr><td>IV beta-lactam to any oral agent</td><td>≤ 5 days</td></tr>
<tr><td colspan="2">Alternative</td></tr>
<tr><td>Fosfomycin</td><td>1 dose</td></tr>
<tr><td>Exclusively oral Beta-Lactam</td><td>≤ 7 days</td></tr>
</table>
</td></tr>
<tr><td>Measure #6: Increase Antibiotics Delivered within 3 hours of Hospital Arrival for Sepsis Cases with Hypotension</td><td>9. This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3) of the Performance Year. 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 average. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative, and reflects the improvement work each hospital is doing over a given performance year.

10. If there are no eligible cases for a site to be assessed in this measure from Q4 2025 through Q3 2026, both the numerator and denominator of points for this measure will be removed from the site's final score.</td></tr>
</table>

<table>
<tr><td></td><td>12. Hypotension is defined as: an intravenous vasopressor initiated OR systolic blood pressure < 90 mmHg OR calculated MAP < 65 within two hours of arrival to the hospital encounter. Patients excluded from review in this measure include those with viral sepsis (COVID and Influenza), < 2 SIRS, normal white blood cell count, no elevated lactate, and no symptoms of infection.</td></tr>
<tr><td>Measure #7: Increase Discharge/Post-Discharge Care Coordination for Sepsis Cases Discharged to Home-like Setting</td><td>9. This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3) of the Performance Year. 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 average. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative, and reflects the improvement work each hospital is doing over a given performance year.

10. If there are no eligible cases for a site to be assessed in this measure from Q4 2025 through Q3 2026, both the numerator and denominator of points for this measure will be removed from the site's final score.

13. A home-like setting includes any of the following locations, with or without home health care services: home, assisted living, custodial nursing, or temporary shelter.

14. Discharge/post-discharge coordination of care measures:
Hospital contact information provided at discharge (in discharge paperwork)
Scheduled for outpatient follow-up within 2 weeks (at time of discharge)
Post-discharge telephone call attempted within 3 calendar days of hospital discharge OR visit with Primary Care Provider or specialist within 3 calendar days of hospital discharge
Patient is discharged to a home-like setting with home health services

15. High risk patients are those who are deemed by a site-specific readmission risk score to be high risk. If a site does not have a readmission risk score in place or it is not used/reported for an individual patient, the patient will be scored using the HMS Readmission Score (see components below). A score of 4 or higher using the HMS Readmission Score is considered high risk. The HMS Sepsis Readmission Score is based upon elements from published literature (i.e., LACE score, Sepsis Transition and Recovery (STAR) program high risk readmission definition, etc.). The scoring methodology is as follows:

<table>
<tr><th>Element</th><th>Score</th></tr>
<tr><td>Length of Stay</td><td>1 – 6 Days – 0 Points
7 – 10 Days – 1 Point
11 – 14 Days – 2 Points
15+ Days – 3 Points</td></tr>
<tr><td>Admitted from SNF/SAR/LTAC</td><td>1 Point</td></tr>
<tr><td>Admitted to the ICU during hospital encounter</td><td>1 Point</td></tr>
<tr><td>Hospitalization in the 90 days prior to hospital encounter</td><td>1 Point</td></tr>
<tr><td>Baseline functional limitation (ADL – any limitation - partially/fully dependent)</td><td>1 Point</td></tr>
<tr><td>Mild, moderate or severe liver disease</td><td>1 Point</td></tr>
<tr><td>Baseline cognitive impairment</td><td>1 Point</td></tr>
<tr><td>Hematologic malignancy (Leukemia/Lymphoma)</td><td>1 Point</td></tr>
<tr><td>Congestive heart failure</td><td>1 Point</td></tr>
</table>
</td></tr>
</table>

	<table><tr><td>Cardiovascular disease</td><td>1 Point</td></tr><tr><td>Peripheral vascular disease</td><td>1 Point</td></tr><tr><td>Moderate or severe kidney disease</td><td>1 Point</td></tr></table>
Measure #8: Increase Use of Balanced Solutions in Patients with Sepsis	9. This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3) of the Performance Year. 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 average. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative, and reflects the improvement work each hospital is doing over a given performance year. 10. If there are no eligible cases for a site to be assessed in this measure from Q4 2025 through Q3 2026, both the numerator and denominator of points for this measure will be removed from the site's final score. 16. Balanced Solutions are defined as Lactated Ringers or Plasma-Lyte (alone or in dextrose). Bicarbonate infusions are excluded from the numerator and denominator of this measure. Sepsis cases eligible for this measure include all patients who received > 1 liter of bolus and/or maintenance fluid within the first 48 hours of hospital arrival.
Measure C: Reduce Use of Antibiotics in Patients with Asymptomatic Bacteriuria (ASB)	17. Antibiotic treatment for ASB is assessed based on treatment on day 2 or later of the entire hospital encounter. This portion of the measure is assessed out of all positive urine culture cases abstracted during the performance year. 18. The Collaborative Wide measure is assessed at year end based on the collaborative-wide average for the final quarter of data entered (Q3) in the performance year.
Optional Bonus #1	19. The Emergency Medicine Physician in attendance at the in-person Collaborative Wide Meeting cannot be a resident, fellow, intern or Advanced Practice Professional. Emergency Medicine Physicians may only represent one (1) site per meeting. The Emergency Medicine Physician may not also be the Physician representing the site for Measure 2 of the Performance Index. 20. Presenters who are interested in sharing HMS data at a national or international meeting must submit intent to present data to the HMS Coordinating Center and receive approval from our Data, Design, and Publications Committee. Guidelines in the most recent HMS Publication Policy must be followed. 21. Bonus points will be awarded to sites who present at an HMS Collaborative Wide Meeting, HMS-sponsored event, HMS Abstractor Conference Call, or HMS webinar during the 2026 Performance Year when requested by the HMS Coordinating Center. Sites may only receive bonus points for 1 presentation per year.
Optional Bonus #2: PROS - ABX	9. This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3) of the Performance Year. 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 average. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative, and reflects the improvement work each hospital is doing over a given performance year. 22. This section will be calculated by assessing the number of cases with successful Patient Reported Outcomes (PROs) out of those eligible for PROs. A successful PROs attempt means that the patient was contact and information was obtained.
Optional Bonus #3: PROS-Sepsis	9. This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3) of the Performance Year. 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 average. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative, and reflects the improvement work each hospital is doing over a given performance year. 22. This section will be calculated by assessing the number of cases with successful Patient Reported Outcomes (PROs) out of those eligible for PROs. A successful PROs attempt means that the patient was contact and information was obtained.

Historically, to assess performance, HMS utilized data submitted during the last quarter of a given year to allow sites to improve over the course of the year without impacting their pay for performance payment. With this method, looking at one quarter of data resulted in unstable and unreliable estimates of a hospital's true performance. To mitigate this issue, the HMS Coordinating Center and the Data, Design, and Publications Committee (DDP) reviewed this approach and discussed potential solutions with other Blue Cross Blue Shield of Michigan (BCBSM) quality collaboratives, statistical/methodologic experts, and reviewed national approaches for performance assessment (i.e., Centers for Medicare & Medicaid Services (CMS)). As an outcome of these discussions, the Coordinating Center developed a new method to assess hospital performance similar to the way in which CMS assesses hospital performance nationally. This method was approved by the HMS DDP subcommittee and BCBSM in 2018.

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 rate, as well as the average rate and improvement rate of each individual hospital are incorporated into the final adjusted rate. Each hospital's adjusted rate reflects both change in performance over time and overall performance relative to the collaborative averages. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative as a whole, and better reflects the improvement work each hospital is doing over a given performance year.

Utilizing the adjusted method, there are several ways for hospitals to improve their performance scores over time. These include:

- Continued high performance for hospitals exceeding current performance thresholds
- Improvements over time
- High performance in a majority of quarters

The following table details the method of assessment used for each measure on the 2025 Performance Index scorecard:

Measure #**	Title	2025 Assessment Period	2025 Method of Assessment
4	Increase Use of 5 Days of Antibiotic Treatment in Uncomplicated Community Acquired Pneumonia (CAP)	ABX Discharge Dates: 07/31/25 – 11/05/25	Adjusted
5	Increase Antibiotics Delivered within 3 hours of Arrival for Septic Cases with Hypotension	Sepsis Discharge Dates: 07/01/25 – 10/06/25	Adjusted
6	Increase Discharge/Post-Discharge Care Coordination for Sepsis Cases Discharged to Home-like Setting	Sepsis Discharge Dates: 07/01/25 – 10/06/25	Adjusted
7	Increase Use of Balanced Solutions over Normal Saline in Patients with Sepsis	Sepsis Discharge Dates: 07/01/25 – 10/06/25	Adjusted
C*	Reduce Use of Antibiotics in Patients with Asymptomatic Bacteriuria (ASB)	ABX Discharge Dates: 07/31/25 – 11/05/25	Raw Collaborative Average

*Measure C is a collaborative wide measure
**Measures 1-3 are participation-based measures and are not adjusted

2026 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Henry Ford St. John and Trinity Ann Arbor** **Measurement period: 01/01/2026 – 12/31/2026**			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative-wide meeting participation -Clinical Champion**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
2	10%	**Collaborative-wide meeting participation -Coordinator/Lead Abstractor**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
3	10%	**Completeness and accuracy of data**	
		Critical data elements are complete/accurate in >=90% of cases	10
		Critical data elements are complete/accurate in 70-89% of cases	5
		Critical data elements are complete/accurate in <70% of cases	0
4	35%	**Increase the amount of alerts resolved associated with DOAC Dashboard utilization** **Baseline period: (01/01/2025) - 08/08/2025)**	
		>=250 known/possible critical alerts addressed in 2026	35
		200-249 known/possible critical alerts addressed in 2026	25
		100-199 known/possible critical alerts addressed in 2026	15
		<100 known/possible critical alerts addressed in 2026	0
5	35%	**Decrease % of patients on inappropriate aspirin that are on DOACs** **Baseline period: (01/01/2025) - (08/08/2025)**	
		<=16% or relative decrease of >=10%	35
		17-19% or relative decrease of 5-9%	25
		20-22% or relative decrease of 1-4%	15
		>22% and no decrease from baseline	0
Please note: all measures above are scored using hospital methodology.			

2026 Michigan Anticoagulation Quality Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **U of M, Henry Ford, Corewell East, Corewell West** **Measurement period: 01/01/2026 – 12/31/2026**			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative-wide meeting participation -Clinical Champion**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
2	10%	**Collaborative-wide meeting participation -Coordinator/Lead Abstractor**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
3	10%	**Completeness and accuracy of data**	
		Critical data elements are complete/accurate in >=90% of cases	10
		Critical data elements are complete/accurate in 70-89% of cases	5
		Critical data elements are complete/accurate in <70% of cases	0
4	10%	**Smoking status assessment and documentation** **Baseline period: (01/01/2025) - (08/8/2025)**	
		>=95% of newly enrolled patients in 2026 will have smoking status assessed and documented and referred to cessation programs	10
		70-94% of newly enrolled patients in 2026 will have smoking status assessed and documented and referred to cessation programs	7
		50-69% of newly enrolled patients in 2026 will have smoking status assessed and documented and referred to cessation programs	4
		<50% of newly enrolled patients in 2026 will have smoking status assessed and documented and referred to cessation programs	0
5	10%	**Decrease inappropriate aspirin use in patients on warfarin** **Baseline period: (01/01/2025) - (08/08/2025)**	
		<=9% or relative decrease of >=15%	10
		16-10% or relative decrease of 10-14%	7
		22-17% or relative decrease of 5-9%	4
		>22% or relative decrease of <5%	0
6	10%	**Extended international normalized ratio (INR) testing interval** **Baseline period: (01/01/2025) - (08/08/2025)**	
		>=84% of eligible patients received extended intervals	10
		70-83% of eligible patients received extended intervals	7
		50-69% of eligible patients received extended intervals	4
		<50% of eligible patients received extended intervals	0

2026 Michigan Anticoagulation Quality Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **U of M, Henry Ford, Corewell East, Corewell West** **Measurement period: 01/01/2026 – 12/31/2026**			
Measure #	Weight	Measure Description	Points
7	10%	**Gastroprotection in patients on warfarin at high-risk for upper GI bleeding (site level)** **Baseline period: (01/01/2025) - (08/08/2025)**	
		>=58% or relative increase of >=10%	10
		40-57% or relative increase of 6-9%	7
		25-39% or relative increase of 2-5%	4
		<25% or relative increase of <2%	0
8	10%	**Gastroprotection in patients on warfarin at high-risk for upper GI bleeding (consortium-level)** **Baseline period:(01/01/2025) –(08/08/2025)**	
		>=65%	10
		50-64%	7
		40-49%	4
		<40%	0
9	10%	**DOAC Dashboard utilization** **Baseline period:(01/01/2025) –(08/08/2025)**	
		>=1000 known/possible critical alerts addressed in 2026	10
		500-999 known/possible critical alerts addressed in 2026	7
		250-499 known/possible critical alerts addressed in 2026	4
		<250 known/possible critical alerts addressed in 2026	0
10	10%	**Inappropriate aspirin in patients on DOACs** **Baseline period: (01/01/2025) –(08/08/2025)**	
		Protocol/process for de-prescribing aspirin (+ all of below)	10
		Protocol/process for contacting providers about aspirin de-prescribing (+ all of below)	7
		Protocol/process to determine appropriateness (+ below)	4
		Process for identifying patients on combination DOAC + aspirin therapy	2
		No process or protocols related to aspirin de-prescribing	0
Please note: Measures 1-7, 9-10 above are scored using hospital methodology. Measure 8 is scored using collaborative methodology.			

2026 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Memorial Healthcare** **Measurement Period: 01/01/2026 – 12/31/2026**			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative-wide meeting participation -Clinical Champion**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
2	10%	**Collaborative-wide meeting participation -Coordinator/Lead Abstractor**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	7
		Attended 1 out of 3 meetings	4
		Did not attend any meetings	0
3	10%	**Completeness and accuracy of data**	
		Critical data elements are complete/accurate in >=90% of cases	10
		Critical data elements are complete/accurate in 70-89% of cases	5
		Critical data elements are complete/accurate in <70% of cases	0
4	15%	**Smoking status assessment and documentation Baseline period: (01/01/2025) - (08/08/2025)**	
		>=95% of newly enrolled patients in 2026 will have smoking status assessed and documented and referred to cessation programs	15
		70-94% of newly enrolled patients in 2026 will have smoking status assessed and documented and referred to cessation programs	10
		50-69% of newly enrolled patients in 2026 will have smoking status assessed and documented and referred to cessation programs	5
		<50% of newly enrolled patients in 2026 will have smoking status assessed and documented and referred to cessation programs	0
5	15	**Decrease inappropriate aspirin use in patients on warfarin Baseline period: (01/01/2025) - (08/08/2025)**	
		<=9% or relative decrease of >=15%	15
		16-10% or relative decrease of 10-14%	10
		22-17% or relative decrease of 5-9%	5
		>22% or relative decrease of <5%	0
6	15%	**Extended international normalized ratio (INR) testing interval Baseline period: (01/01/2025) - (08/08/2025)**	
		>=84% of eligible patients received extended intervals	15
		70-83% of eligible patients received extended intervals	10
		50-69% of eligible patients received extended intervals	5
		<50% of eligible patients received extended intervals	0

2026 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Memorial Healthcare** **Measurement Period: 01/01/2026 – 12/31/2026**			
Measure #	Weight	Measure Description	Points
7	15%	**Gastroprotection in patients on warfarin at high-risk for upper GI bleeding (site level)** **Baseline period:(01/01/2025 – 08/08/2025)**	
		>=58% or relative increase of >=10%	15
		40-57% or relative increase of 6-9%	10
		25-39% or relative increase of 2-5%	5
		<25% or relative increase of <2%	0
8	10%	**Gastroprotection in patients on warfarin at high-risk for upper GI bleeding (consortium- level)** **Baseline period: (01/01/2025) - (08/08/2025)**	
		>=65%	10
		50-64%	7
		40-49%	4
		<40%	0
Please note: Measures 1-6, 8 above are scored using hospital methodology. Measure 7 is scored using collaborative methodology.			

2026 Michigan Anticoagulation Improvement Initiative (MAQI2) Collaborative Quality Initiative Performance Index Scorecard **Bronson/MyMichigan** **Measurement Period: 01/01/2026 – 12/31/2026**			
Measure #	Weight	Measure Description	Points
1	10%	**Collaborative-wide meeting participation -Clinical Champion**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	5
		Attended 1 out of 3 meetings	3
		Did not attend any meetings	0
2	10%	**Collaborative-wide meeting participation -Coordinator/Lead Abstractor**	
		Attended all 3 meetings	10
		Attended 2 out of 3 meetings	5
		Attended 1 out of 3 meetings	3
		Did not attend any meetings	0
3	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 50-69% of cases	3
		Critical data elements are complete/accurate in <50% of cases	0
4	20%	**New enrollee smoking status assessment, documentation and referral to cessation programs** **Baseline period: status as of 8/8/25**	
		Enrollment protocol revised and smoking cessation process fully developed, approved, and in place	20
		Enrollment protocol revised and smoking cessation process fully developed but not yet in place	10
		Enrollment protocol and smoking cessation process partially developed	5
		No progress made on enrollment protocol changes or development of smoking cessation process	0
5	20%	**Extended INR testing interval protocol development** **Baseline period: status as of 8/8/25**	
		Warfarin management protocols fully revised, approved, and in place	20
		Warfarin management protocols fully revised but not in place	10
		Warfarin management protocols partially revised	5
		No progress made on revising warfarin management protocols	0
6	30%	**DOAC dashboard implementation and utilization** **Baseline period: status as of 8/8/25**	
		Dashboard fully implemented and >=250 alerts resolved	30
		Dashboard fully implemented and staffed but <250 alerts resolved	20
		Dashboard partially implemented	10
		No progress made on dashboard implementation	0
Please note: all measures above are scored using hospital methodology.			

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 1** Participation Measurement Period:01/01/2026 - 11/15/2026 QI Measurement Period: 01/01/2026 - 06/30/2026*			
Measure #	Weight	Measure Description	Points
1	20	**Collaborative Meeting Participation*-Clinical Champions (01.01.2026-11.15.2026)** ***Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<2 meetings attended	0
2	20	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2026-11.15.2026)** ***Attendance at both the CDA Breakout and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<2 meetings attended	0
3	5	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive New site kickoff meeting time on Wednesday, January 21, 2026 for: 1. Clinical Champion 2. Quality Administrator 3. Clinical Data Abstractor (if identified)	5
4	5	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive New site kickoff meeting time on Wednesday, January 21, 2026 for: 1. Site IT Support	5
5	20	**Accuracy and Completeness of Data Submission (01.01.2026 - 06.30.2026) - 5 metrics** 1. Complete data entry >= 97% - 100% of the time; Educational review complete with no concerns (e.g., greater than 97% accuracy) 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) >= 97% - 100% of the time 3. First 10 cases abstracted by 05.31.2026 4. All cases performed or before 05.04.2026 abstracted by 10.01.2026 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2026	
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 1** Participation Measurement Period:01/01/2026 - 11/15/2026 QI Measurement Period: 01/01/2026 - 06/30/2026*			
Measure #	Weight	Measure Description	Points
6	15	**Access to Surgeon's Office Records (90 day events): (Surgery dates 01.01.2026-08.31.2026)**	
		90% + patient data captured	15
		75% - 89% patient data captured	7.5
		Less than 75% data captured	0
7	15	**Site based Quality Meetings:(02.07.2026-11.15.2026)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	15
Participation Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.07.2026-11.15.2026)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 0.5 extra credit points per site towards participation measures**	0.5
Participation Extra Credit	0	**MODB Data submission:** Provide site's written planned process for site's submission of all MARCQI eligible cases data to Michigan Health and Hospital Association's Michigan Outpatient Database (MODB) by August 31, 2026 ***Maximum total of 0.5 extra credit points per site towards performance measures**	0.5
Participation Extra Credit	0	**PROs Collection:** For surgeries performed on 01.01.2026-06.30.2026, **SITE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric. ***Maximum total of 1 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 90%+	1
		75 - 89%	0.5
		60 - 74%	0.25
		The site is not awarded points if collection is less than 60%	0
Participation Extra Credit	0	**PROs Collection:** Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2026) at a SITE are 70% or greater for both primary hip and knee procedures combined When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 1** Participation Measurement Period:01/01/2026 - 11/15/2026 QI Measurement Period: 01/01/2026 - 06/30/2026*			
Measure #	Weight	Measure Description	Points
		***Maximum total of 1 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	1
		60-69%	0.5
		The site is not awarded extra credit if collection is less than 60%	0
Please note: all measures above are scored using hospital methodology.			

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
1	20	**Collaborative Meeting Participation*-Clinical Champions (01.01.2026-11.15.2026)** *Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<2 meetings attended	0
Participation Extra Credit	0	**Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team, Patient education, Optimization & Appropriateness, etc.)** *Maximum total 1 point extra credit per site towards participation measures	1
2	15	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2025-11.15.2025)** *Attendance at both the CDA Breakout and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time	
		3 out of 3 meetings attended	15
		2 out of 3 meetings attended	7.5
		<2 meetings attended	0
Participation Extra Credit	0	**CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.)** *Maximum total 0.5 point extra credit per site towards participation measures	0.5
Participation Extra Credit	0	**Site's with CDAs in their role for 9 months or greater as of March 31, 2026 who have at least one CDA attend the in-person CDA refresher training course on June 24, 2026.** *Maximum total 0.5 point extra credit per site	0.5
3	20	**Accuracy and Completeness of Data Submission (audits 07.01.2025 - 06.30.2026) - 5 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) >= 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) >= 97% - 100% of the time 3. All cases performed on or before 12.31.2025 abstracted completely by 05.31.2026 4. All cases performed or before 05.04.2026 abstracted by 10.01.2026 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2026	
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
4	5	**Site level:** Access to 90-day post-operative clinical office notes for every participating MARCQI surgeon at the site is demonstrated to be 99% or above for cases completed (07.01.2025 - 06.30.2026). If a MARCQI surgeon's rate for access to clinical office notes has been lower than 99% over the last few years, an attestation for the changes made and implemented will be required, and a demonstration may be requested.	5
5	20	**Site based Quality Meetings:**(02.07.2026-11.15.2026) The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	20
Participation Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.07.2026-11.15.2026)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. *Maximum total of 3 extra credit points per site towards participation measures	3
6	2	**90-Day Hip fracture**: Reduce or maintain **COLLABORATIVE** level rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) at 0.80%	2
7	2	**90-Day Hip dislocation**: Reduce or maintain **COLLABORATIVE** level rate of 90-Day Hip dislocation for all primary HIP procedures (excluding conversions) at <= 1.0%	2
8	5	**30-Day Emergency Department (ED) visit:** Reduce **SITE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **HIP** procedures as seen on a site's April 2025 MARCQI Quarterly Report.	
		When April 2025 baseline is: **>3.60%**, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure <=**3.60%**, the site maintain a 30-day ED visit rate of <= 3.6% following primary HIP procedures with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report	5
		When April 2025 baseline is: **>3.60%**, the site meets a site-level reduction of>=5% but <10% site-level rate of 30-Day ED visits following primary HIP procedure	3

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
		<=3.60%, the site sees a site-level increase of <= 2% site-level rate of 30-Day ED visits following primary HIP procedure	
		When April 2025 baseline is: **>3.60%**, the site attains a site-level reduction is <5% the site-level rate of 30-Day ED visits following primary HIP procedure <=**3.60%**, the site sees a site-level increase of >2% but <= 4% of site-level rate of 30-Day ED visits following primary HIP procedure	1
		When April 2025 baseline is: **>3.60%**, the site maintains or does not reduce the site-level rate of 30-Day ED visits following primary HIP procedure <=**3.60%**, the site increases by >4% in the rate of the site-level 30-Day ED visits following primary HIP procedure	0
Performance Extra Credit (Affiliate hospital & HOPD)	0	**30-Day Emergency Department (ED) visit: If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal when April 2025 baseline is:** >3.60%, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary HIP procedure OR <=3.60%, the site maintain a 30-day ED visit rate of <= 3.60% following primary HIP procedures with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report but the affiliate site/s or HOPD did meet the goal when April 2024 baseline is: >3.60%, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure OR <= 3.60%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary HIP procedure Then the flagship hospital's P4P scorecard will receive 1 extra credit point. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Performance Extra Credit	0	**30-Day Emergency Department (ED) visit:** On January 2027 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **HIP** procedures increased from baseline in April 2025. The site will perform a deep dive into all 30-Day Emergency Department (ED) visits for all primary HIP procedures during the measurement period, and submit the deep dive details and 1 page report of the findings by 11:59PM ET February 12, 2027. ***Maximum total of 2 extra credit points per site towards performance measures**	2
9	5	**30-Day Emergency Department (ED) visit:** Reduce **SITE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **KNEE** procedures as seen on a site's April 2025 MARCQI Quarterly Report.	

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
		When April 2025 baseline is: **>4.20%**, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure <=**4.20%**, the site maintain a 30-day ED visit rate of <= 4.20% following primary KNEE procedures with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report	5
		When April 2025 baseline is: **>4.20%**, the site meets a site-level reduction of>=5% but <10% site-level rate of 30-Day ED visits following primary KNEE procedure <=**4.20%**, the site sees a site-level increase of ≤ 2% site-level rate of 30-Day ED visits following primary KNEE procedure	3
		When April 2025 baseline is: **>4.20%**, the site attains a site-level reduction is <5% the site-level rate of 30-Day ED visits following primary KNEE procedure <=**4.20%**, the site sees a site-level increase of >2% but <=4% of site-level rate of 30-Day ED visits following primary KNEE procedure	1
		When April 2025 baseline is: **>4.20%**, the site maintains or does not reduce the site-level rate of 30-Day ED visits following primary KNEE procedure <=**4.20%**, the site increases by >4% in the rate of the site-level 30-Day ED visits following primary KNEE procedure	0
Performance Extra Credit	0	**30-Day Emergency Department (ED) visit:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal when April 2025 baseline is: >4.20%, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure OR <=4.20%, the site maintain a 30-day ED visit rate of <= 4.20% following primary KNEE procedures with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report but the affiliate site/s or HOPD did meet the goal when April 2024 baseline is: >4.20%, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure OR <= 4.20%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary KNEE procedure Then the flagship hospital's P4P scorecard will receive 1 extra credit point. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** ****If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met**	1

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
Performance Extra Credit (Affiliate hospital & HOPD)	0	30-Day Emergency Department (ED) visit: On January 2027 MARCQI Quarterly Report, SITE level rate of 30-Day Emergency Department (ED) visit for all primary KNEE procedures increased from baseline in April 2025. The site will perform a deep dive into all 30-Day Emergency Department (ED) visits for all primary KNEE procedures during the measurement period, and submit the deep dive details and 1 page report of the findings by 11:59PM ET February 12, 2027. *Maximum total of 2 extra credit points per site towards performance measures	2
10	5	**PROs Collection:** For surgeries performed on 07.01.2025-06.30.2026, **SITE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		The site is awarded full points for collection rates of 90%+	5
		75 - 89%	3
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0
11	1	**PROs Collection:** For surgeries performed on 07.01.2025-06.30.2026, **COLLABORATIVE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		Awarded full points for collection rates of 90%+	1
		75 - 89%	0.5
		60 - 74%	0.25
		The site is not awarded points if collection is less than 60%	0
Performance Extra Credit (Affiliate hospital & HOPD)	0	**PROs Collection:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal to collect 90% or more PRE-OPERATIVE HOOS-JR or KOOS JR + PROMIS10 for surgeries performed on 07.01.2025-06.30.2026, but the affiliate site/s or HOPD did meet the goal on the January 2027 Quarterly Reports, extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Performance Extra Credit	0	**PROs Collection:** Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries performed between 07.01.2025 - 06.30.2026) at a **SITE** are 70% or greater for both primary hip and knee procedures combined *When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.* ***Maximum total of 2 extra credit points per site towards**	

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 2** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
		performance measures	
		The site is awarded full points for collection rates of 70%+	2
		60 - 69%	1.5
		50 - 59%	1
		The site is not awarded extra credit if collection is less than 50%	0
Performance Extra Credit (Affiliate hospital & HOPD)	0	**PROs Collection:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal to collect 50% or more PRE-OPERATIVE HOOS-JR or KOOS JR + PROMIS10 for surgeries performed on 06.01.2024-11.04.2025, but the affiliate site/s or HOPD did meet the goal on the January 2027 Quarterly Reports, extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Please note: Measures 1-5, 8-10 above are scored using hospital methodology. Measures 6-7, 11 are scored using collaborative methodology.			

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Weight	Measure Description	Points
1	10	**Collaborative Meeting Participation*-Clinical Champions (01.01.2026-11.15.2026)** *Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time	
		3 out of 3 meetings attended	10
		2 out of 3 meetings attended	5
		<2 meetings attended	0
Participation Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team, Patient education, Optimization & Appropriateness, etc.) *Maximum total 1 point extra credit per site towards participation measures	1
2	4	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2026-11.15.2026)** *Attendance at both the CDA Breakout and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time	
		3 out of 3 meetings attended	4
		2 out of 3 meetings attended	2
		<2 meetings attended	0
Participation Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site towards participation measures**	0.5
Participation Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of March 31, 2026 who have at least one CDA attend the in-person CDA refresher training course on June 24, 2026. ***Maximum total 0.5 point extra credit per site**	0.5
3	8	**Accuracy and Completeness of Data Submission (audits 07.01.2025 - 06.30.2026) - 5 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) >= 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) >= 97% - 100% of the time 3. All cases performed on or before 12.31.2025 abstracted completely by 05.31.2026 4. All cases performed or before 05.04.2026 abstracted by 10.01.2026 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2026	
		5 of 5 metrics met	8
		4 of 5 metrics met	6
		3 of 5 metrics met	4
		2 of 5 metrics met	2
		1 of 5 metrics met	1
		0 of 5 metrics met	0

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Weight	Measure Description	Points
4	3	**Site level**: Access to 90-day post-operative clinical office notes for every participating MARCQI surgeon at the site is demonstrated to be 99% or above for cases completed (07.01.2025 - 06.30.2026). If a MARCQI surgeon's rate for access to clinical office notes has been lower than 99% over the last few years, an attestation for the changes made and implemented will be required, and a demonstration may be requested.	3
5	5	**Site based Quality Meetings:(02.07.2026-11.15.2026)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting**.**	5
Participation Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.07.2026-11.15.2026)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. *Maximum total of 3 extra credit points per site towards participation measures	3
6	2.5	**90-Day Hip fracture:** Reduce or maintain **COLLABORATIVE** level rate of 90-Day Hip fracture for all primary HIP procedures (excluding conversions) at ≤ 0.80%	2.5
7	2.5	**90-Day Hip dislocation:** Reduce or maintain **COLLABORATIVE** level rate of 90-Day Hip dislocation for all primary HIP procedures (excluding conversions) at ≤ 1.0%	2.5
8	10	**30-Day Emergency Department (ED) visit: Reduce SITE level rate of 30-Day Emergency Department (ED) visit by 10% for all primary HIP procedures as seen on a site's April 2025 MARCQI Quarterly Report.**	
		When April 2025 baseline is: **>3.60%**, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure **≤3.60%**, the site maintain a 30-day ED visit rate of ≤ 3.6% following primary HIP procedures with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report	10
		When April 2025 baseline is: **>3.60%**, the site meets a site-level reduction of ≥ 5% but <10%	6

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Weight	Measure Description	Points
		site-level rate of 30-Day ED visits following primary HIP procedure **≤3.60%**, the site sees a site-level increase of ≤ 2% site-level rate of 30-Day ED visits following primary HIP procedure	
		When April 2025 baseline is: **>3.60%**, the site attains a site-level reduction is <5% the site-level rate of 30-Day ED visits following primary HIP procedure **≤3.60%**, the site sees a site-level increase of >2% but ≤ 4% of site-level rate of 30-Day ED visits following primary HIP procedure	2
		When April 2025 baseline is: **>3.60%**, the site maintains or does not reduce the site-level rate of 30-Day ED visits following primary HIP procedure **≤3.60%**, the site increases by >4% in the rate of the site-level 30-Day ED visits following primary HIP procedure	0
Performance Extra Credit (Affiliate hospital & HOPD)	0	**30-Day Emergency Department (ED) visit:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal (e.g., full credit) when April 2025 baseline is: >3.60%, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure OR <3.60%, the site maintain a 30-day ED visit rate of < 3.6% following primary HIP procedures with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report but the affiliate site/s or HOPD did meet the goal when April 2025 baseline is: >3.60%, the site meets a site-level reduction of 10% or meets the 3.60% rate of 30-Day ED visits following primary HIP procedure OR <3.60%, the site maintain a 30-day ED visit rate of < 3.6% with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report Then the flagship hospital's P4P scorecard will receive 1 extra credit point. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Performance Extra Credit	0	**30-Day Emergency Department (ED) visit:** On January 2027 MARCQI Quarterly Report, **SITE** level rate of 30-Day Emergency Department (ED) visit for all primary **HIP** procedures increased from baseline in April 2025. The site will perform a deep dive into all 30-Day Emergency Department (ED) visits for all primary HIP procedures during the measurement period, and submit the deep dive details and 1 page report of the findings by 11:59PM ET February 12, 2027. ***Maximum total of 2 extra credit points per site towards performance measures**	2

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Weight	Measure Description	Points
9	10	**30-Day Emergency Department (ED) visit:** Reduce **SITE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **KNEE** procedures as seen on a site's April 2025 MARCQI Quarterly Report.	
		When April 2025 baseline is: **>4.20%**, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure **<=4.20%**, the site maintain a 30-day ED visit rate of ≤ 4.20% following primary KNEE procedures with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report	10
		When April 2025 baseline is: **>4.20%**, the site meets a site-level reduction of ≥ 5% but <10% site-level rate of 30-Day ED visits following primary KNEE procedure **<=4.20%**, the site sees a site-level increase of ≤ 2% site-level rate of 30-Day ED visits following primary KNEE procedure	6
		When April 2025 baseline is: **>4.20%**, the site attains a site-level reduction is <5% the site-level rate of 30-Day ED visits following primary KNEE procedure **<=4.20%**, the site sees a site-level increase of >2% but ≤ 4% of site-level rate of 30-Day ED visits following primary KNEE procedure	2
		When April 2025 baseline is: **>4.20%**, the site maintains or does not reduce the site-level rate of 30-Day ED visits following primary KNEE procedure **<=4.20%**, the site increases by >4% in the rate of the site-level 30-Day ED visits following primary KNEE procedure	0
Performance Extra Credit (Affiliate hospital & HOPD)	0	30-Day Emergency Department (ED) visit: If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal when April 2025 baseline is: >4.20%, the site meets a site-level reduction of 10% or meets the 4.20% rate of 30-Day ED visits following primary KNEE procedure OR <=4.20%, the site maintain a 30-day ED visit rate of < 4.20% following primary KNEE procedures with no concern in their statistical process control chart on the January 2027 MARCQI Quarterly Report but the affiliate site/s or HOPD did meet the goal when April 2024 baseline is: >4.20%, the site meets a site-level reduction of 10% or meets the <=4.20% rate of 30-Day ED visits following primary KNEE procedure OR =<4.20%, the site maintains baseline outcome or reduces rate of 30-Day ED visits following primary KNEE procedure Then the flagship hospital's P4P scorecard will receive 1 extra credit point. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures**	1

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Weight	Measure Description	Points
		**If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	
Performance Extra Credit	0	**30-Day Emergency Department (ED) visit:** On January 2027 MARCQI Quarterly Report, SITE level rate of 30-Day Emergency Department (ED) visit for all primary **KNEE** procedures increased from baseline in April 2025. The site will perform a deep dive into all 30-Day Emergency Department (ED) visits for all primary KNEE procedures during the measurement period, and submit the deep dive details and 1 page report of the findings by 11:59PM ET February 12, 2027. ***Maximum total of 2 extra credit points per site towards performance measures**	2
10	5	**30-Day Emergency Department (ED) visit:** Reduce **COLLABORATIVE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **HIP** procedures from 5.37% to 4.83%.	
		30-Day ED visit COLLABORATIVE rate for all primary **HIP** procedures in <= 4.83%	5
		30-Day ED visit COLLABORATIVE rate for all primary **HIP** procedures is > 4.83% but <= 5.00%	3
		30-Day ED visit COLLABORATIVE rate for all primary **HIP** procedures is > 5.00% but <=5.37%	1
		No reduction in 30-Day ED visit COLLABORATIVE rate for all primary **HIP** procedures is seen	0
11	5	**30-Day Emergency Department (ED) visit:** Reduce **COLLABORATIVE** level rate of 30-Day Emergency Department (ED) visit by 10% for all primary **KNEE** procedures from 6.7% to 6.03%.	
		30-Day ED visit COLLABORATIVE rate for all primary **KNEE** procedures in <= 6.03%	5
		30-Day ED visit COLLABORATIVE rate for all primary **KNEE** procedures is > 6.03% but <= 6.37%	3
		30-Day ED visit COLLABORATIVE rate for all primary **KNEE** procedures is > 6.37% but <6.70%	1
		No reduction in 30-Day ED visit COLLABORATIVE rate for all primary **KNEE** procedures is seen	0
12	6	**PROs Collection:** For surgeries performed on 07.01.2025-06.30.2026, **SITE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		The site is awarded full points for collection rates of 90%+	6
		75 - 89%	3
		60 - 74%	1
13	3	**PROs Collection:** For surgeries performed on 07.01.2025-06.30.2026, **COLLABORATIVE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and*	

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Weight	Measure Description	Points
		completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		Awarded full points for collection rates of 90%+	3
		75 - 89%	2
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0
Performance Extra Credit (Affiliate hospital & HOPD)	0	**PROs Collection:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal to collect 90% or more PRE-OPERATIVE HOOS-JR or KOOS JR + PROMIS10 for surgeries performed on 07.01.2025-06.30.2026, but the affiliate site/s or HOPD did meet the goal on the January 2027 Quarterly Reports, extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Performance Extra Credit	0	**PROs Collection:** Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries performed between 07.01.2025 - 06.30.2026) at a **SITE** are 70% or greater for both primary hip and knee procedures combined *When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.* ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	2
		60 - 69%	1.5
		50 - 59%	1
		The site is not awarded extra credit if collection is less than 50%	0
14	6	**PROs Collection:** For surgeries performed on 06.01.2024 to 11.04.2025, **SITE** level primary PRE-OPERATIVE & 1 YEAR POST-OPERATIVE (300-425 days) HOOS -JR or KOOS-JR + PROMIS10 completion rate of 50% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		The site is awarded full points for collection rates of 50%+	6
		40 - 49%	3
		30 - 39%	1
		The site is not awarded points if collection is less than 30%	0
Performance Extra Credit (Affiliate hospital & HOPD)	0	**PROs Collection:** If the combined data of the flagship hospital, affiliate hospital, and/or HOPD did not meet the goal to collect 50% or more PRE-OPERATIVE HOOS-JR or KOOS JR + PROMIS10 for surgeries performed on 06.01.2024-11.04.2025, but the affiliate site/s or HOPD did meet the goal on the January 2027 Quarterly Reports, extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all	1

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Weight	Measure Description	Points
		affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	
15	20	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If red on scorecard of April, 2025, you must strongly consider choosing this as the project. If you have worked on this metric previously or have difficultly developing a goal, a yellow target area may be chosen with the Program Manager's approval. If you would like to continue with your FY2025 site based QI project topic, please discuss with the Program Manager. If no red, you will choose a 'yellow'. All projects must come from the April 2025 MARCQI Quarterly Report --Project goals must seek a ≥ 20% improvement unless otherwise approved by the Program Manager --Mid-Year Progress Report is due in May 29, 2026 & Final Progress report is due February 12, 2027 --Clinical Champion must have a role in the Quality Improvement project plan --All sites are expected to complete a proposal, mid-year report, final report, A3, and presentation of their project by the clinical champion when asked. ***A clinical champion and Clinical Data Abstractor not presenting on a project when asked will yield -20 points on the FY2027 P4P scorecard --Final results are based on quarterly reports of January 2027	
		• Plan submitted and approved, reporting requirements & timelines met, A3 submitted, and goal met* *Clinical Champion and Clinical Data Abstractor must be available to present and address questions about the project at June 2027 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2027 P4P scorecard*	20
		• Plan submitted and approved • Reporting requirements are met & timelines, but the target identified is not met • Site performs a deep dive on all cases impacting the missed quality improvement goal at the site and/or flagships with its combined partners (affiliates and HOPD) and submits the deep dive findings with the final report submission on February 12, 2027 • A3 submitted with final report and presentation by clinical champion given at June 2027 MARCQI Collaborative-wide sessions* *Clinical Champion and Clinical Data Abstractor must be available to present and address questions about the project at June 2027 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2027 P4P scorecard*	15
		• Plan submitted and approved • Reporting requirements are met & timelines, but the target identified is not met • Site does not perform a deep dive on all cases impacting the missed quality improvement goal at the site and/or flagships with its combined partners (affiliates and HOPD) • A3 submitted with final report and presentation by clinical champion given at June 2027 MARCQI Collaborative-wide sessions* *Clinical Champion and Clinical Data Abstractor must be available to present and address questions about the project at	10

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Index Scorecard **HOSPITAL - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Weight	Measure Description	Points
		June 2027 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2027 P4P scorecard*	
		• Plan submitted and approved • All reporting requirements are NOT met within the communicated timelines • Goal is not met *Clinical Champion and Clinical Data Abstractor must be available to present and address questions about the project at June 2027 Collaborative-wide session if asked **Not presenting if asked will yield -20 points on the FY2027 P4P scorecard*	5
		Plan is not developed, reports not done.	0
Performance Extra Credit (Flagship hospital)	0	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If combined data of flagship, affiliate hospital, and/or HOPD do not meet full metric for full points, but the FLAGSHIP hospital met all metrics and site level goal, then extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Performance Extra Credit (Affiliate hospital & HOPD)	0	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If combined data of flagship, affiliate hospital, and/or HOPD do not meet full metric for full points, but the AFFILATE hospital/HOPD met all metrics and site level goal, then extra credit is awarded. ***Maximum total of 1 extra credit points per FLAGSHIP site towards performance measures** **If a flagship site has more than one affiliate or HOPD, then all affiliate and HOPD site data will be aggregated to determine if the extra credit measure is met	1
Performance Extra Credit	0	**Reverse Site-Visits:** If a site is **RED or YELLOW** in a quality improvement area on their VISUAL Scorecard and they complete a SITE VISIT to a site that is **GREEN** on their VISUAL Scorecard and vis-versa, the RED/YELLOW site and GREEN sites are both eligible for extra credit if: **--**Both sites must visit each other for the same quality improvement area (e.g., sites must observe what is going well and what may not be going as well) between 07.01.2025 - 09.30.2026 --Both sites submit a report regarding the lessons learned for the site visits by 12.04.2026 --Both sites must be willing to have their clinical champion share their findings with the collaborative if asked or results in -5 points on the FY2027 P4P Scorecard --Both sites must have their clinical champions and Clinical Data Abstractors at both site visits --Sites are not part of the same health system or have an affiliate site/HOPD relationship --MARCQI Coordinating Center is alerted to the site visits and has the opportunity to join if requested ***Maximum total of 5 extra credit points per site towards performance measures**	5

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI)
Performance Index Scorecard
HOSPITAL - Year 3+
Participation Measurement Period: 01/01/2026 - 11/15/2026 QI
Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted

Measure #	Weight	Measure Description	Points
Please note: Measures 1-5, 8-9, 12, 14, 15 above are scored using hospital methodology. Measures 6-7, 10-11, 13 are scored using collaborative methodology.			

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Center (ASC) - Year 1** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 01/01/2026 - 06/30/2026			
Measure #	Max. Weight	Measure Description	Points
1	20	**Collaborative Meeting Participation*-Clinical Champions (01.01.2026-11.15.2026)** *Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<2 meetings attended	0
2	15	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2026-11.15.2026)** ***Attendance at both the CDA Breakout and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	15
		2 out of 3 meetings attended	7.5
		<2 meetings attended	0
3	5	**Collaborative Meeting Participation*-Quality Administrator (01.01.2026-11.15.2026)** This person cannot be the same person filling the Clinical Data Abstractor (CDA) role at the site as a CDA or Quality Director CDA ***Attendance at both the CDA Breakout and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	5
		2 out of 3 meetings attended	2
		<3 meetings attended	0
4	5	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive New site kickoff meeting time on Wednesday, January 21, 2026 for: 1. Clinical Champion 2. Quality Administrator 3. Clinical Data Abstractor (if identified)	5
5	5	**New site kickoff:** Completion of all necessary pre-meeting modules prior to attendance at 80% of the live/interactive New site kickoff meeting time on Wednesday, January 21, 2026 for: 1. Site IT Support	5

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Center (ASC) - Year 1** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 01/01/2026 - 06/30/2026			
Measure #	Max. Weight	Measure Description	Points
6	20	**Accuracy and Completeness of Data Submission (01.01.2026 - 06.30.2026) - 5 metrics** 1. Complete data entry ≥ 97% - 100% of the time; Educational review complete with no concerns (e.g., greater than 97% accuracy) 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) ≥ 97% - 100% of the time 3. First 10 cases abstracted by 05.31.2026 4. All cases performed or before 05.04.2026 abstracted by 10.01.2026 5. Documentation of utilization of all MARCQI FTEs awarded towards MARCQI activities or documentation of request to lower MARCQI FTE award to site submitted to MARCQI coordinating center by 11.30.2026	
		5 of 5 metrics met	20
		4 of 5 metrics met	16
		3 of 5 metrics met	12
		2 of 5 metrics met	8
		1 of 5 metrics met	4
		0 of 5 metrics met	0
7	15	**Access to Surgeon's Office Records (90 day events): (Surgery dates 01.01.2026-08.31.2026)**	
		90% + patient data captured	15
		75% - 89% patient data captured	7.5
		Less than 75% data captured	0
8	15	**Site based Quality Meetings:(02.07.2026-11.15.2026)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	15
Participation Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.07.2026-11.15.2026)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 0.5 extra credit points per site towards participation measures**	0.5
Participation Extra Credit	0	**MODB Data submission:** Provide site's written planned process for site's submission of all MARCQI eligible cases data to Michigan Health and Hospital Association's Michigan Outpatient Database (MODB) by August 31, 2026 ***Maximum total of 0.5 extra credit points per site towards performance measures**	0.5

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **For Ambulatory Surgery Center (ASC) - Year 1** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 01/01/2026 - 06/30/2026			
Measure #	Max. Weight	Measure Description	Points
Participation Extra Credit	0	**PROs Collection:** For surgeries performed on 01.01.2026-06.30.2026, **SITE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.* ***Maximum total of 1 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 90%+	1
		75 - 89%	0.5
		60 - 74%	0.25
		The site is not awarded points if collection is less than 60%	0
Participation Extra Credit	0	**PROs Collection:** Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries on or before 06.30.2026) at a **SITE** are 70% or greater for both primary hip and knee procedures combined *When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.* ***Maximum total of 1 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	1
		60%	0.5
		The site is not awarded extra credit if collection is less than 60%	0
Please note: all measures above are scored using ASC methodology.			

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
1	20	**Collaborative Meeting Participation*-Clinical Champions (01.01.2026-11.15.2026)** ***Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	20
		2 out of 3 meetings attended	10
		<2 meetings attended	0
Participation Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team, Patient education, Optimization & Appropriateness, etc.) ***Maximum total 1 point extra credit per site towards participation measures**	1
2	15	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2026-11.15.2026)** ***Attendance at both the CDA Breakout and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	15
		2 out of 3 meetings attended	7.5
		<2 meetings attended	0
Participation Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site towards participation measures**	0.5
Participation Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of March 31, 2026 who have at least one CDA attend the in-person CDA refresher training course on June 24, 2026. ***Maximum total 0.5 point extra credit per site**	0.5
Participation Extra Credit	0	**Collaborative Meeting Participation*- Site Administrator** (01.01.2026-11.15.2026) *Attendance at 3 of 3 Collaborative-wide meeting in February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time • Individual must be identified and confirmed to fill this role by 1st 2026 MARCQI Collaborative-wide meeting • This person cannot be the same person filling the Clinical Data Abstractor (CDA) role at the site as a CDA or Quality Director CDA ***Maximum total 0.5 point extra credit per site**	0.5

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard **ASC - Year 2** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
3	20	**Accuracy and Completeness of Data Submission (audits 07.01.2025 - 06.30.2026) - 6 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All cases performed on or before 12.31.2025 abstracted completely by 05.31.2026 4. All cases performed or before 05.04.2026 abstracted by 10.01.2026 5. Demonstration of successful submission of MARCQI eligible cases to the Michigan Outpatient Database with the Michigan Health and Hospital Association by 08.31.2026 6. Attestation of BCBSM ASF CQI participation funding utilization to support dedicated data abstraction support for effective and complete MARCQI data abstraction and quality improvement work to the MARCQI Coordinating Center by 11.30.2026	
		6 of 6 metrics met	20
		5 of 6 metrics met	16
		4 of 6 metrics met	12
		3 of 6 metrics met	8
		2 of 6 metrics met	4
		1 of 6 metrics met	1
		0 of 6 metrics met	0
4	5	**Site level**: Access to 90-day post-operative clinical office notes for every participating MARCQI surgeon at the site is demonstrated to be 99% or above for cases completed (07.01.2025 - 06.30.2026). If a MARCQI surgeon's rate for access to clinical office notes has been lower than 99% over the last few years, an attestation for the changes made and implemented will be required, and a demonstration may be requested.	5
5	20	**Site based Quality Meetings:(02.07.2026-11.15.2026)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	20
Participation Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.07.2026-11.15.2026)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site-based QI meetings. ***Maximum total of 3 extra credit points per site towards participation measures**	3

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI)
Performance Incentive Scorecard
ASC - Year 2
Participation Measurement Period: 01/01/2026 - 11/15/2026 QI
Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted

Measure #	Max. Weight	Measure Description	Points
6	5	**PROs Collection:** For surgeries performed on 07.01.2025-06.30.2026, **SITE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	
		The site is awarded full points for collection rates of 90%+	5
		75 - 89%	2.5
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0
Performance Extra Credit	0	**PROs Collection:** Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries performed between 07.01.2025 - 06.30.2026) at a **SITE** are 70% or greater for both primary hip and knee procedures combined *When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.* ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	2
		60 - 69%	1.5
		50 - 59%	1
		The site is not awarded extra credit if collection is less than 50%	0
Performance Extra Credit	0	**PROs Collection:** For surgeries performed on 06.01.2024 to 11.04.2025, **SITE** level primary PRE-OPERATIVE & 1 YEAR POST-OPERATIVE (300-425 days) HOOS -JR or KOOS-JR + PROMIS10 completion rate of 50% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.* ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 50%+	2
		40 - 49%	1.5
		30 - 39%	1
		The site is not awarded points if collection is less than 30%	0
7	5	**% of Opioid naive THA patients at the SITE meet the MARCQI Pain control pathway guidelines (<=240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	5
		60-84% of THA patients prescribed **<240 OME**	2.5
		Less than 60% of patients meet the prescribing criteria	0
8	5	**% of Opioid naive TKA patients at the SITE meet the MARCQI Pain control pathway guidelines (<=320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	5
		70-89% of TKA patients prescribed **<320 OME**	2.5
		Less than 70% of patients meet the prescribing criteria	0

2025 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI)
Performance Incentive Scorecard
ASC - Year 2
Participation Measurement Period: 01/01/2026 - 11/15/2026 QI
Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted

Measure #	Max. Weight	Measure Description	Points
9	2.5	**% of Opioid naive THA patients at the COLLABORTIVE meet the MARCQI Pain control pathway guidelines (<=240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	2.5
		60-84% of THA patients prescribed **<240 OME**	1
		Less than 60% of patients meet the prescribing criteria	0
10	2.5	**% of Opioid naive TKA patients at the COLLABORATIVE meet the MARCQI Pain control pathway guidelines (≤320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	2.5
		70-89% of TKA patients prescribed **<320 OME**	1
		Less than 70% of patients meet the prescribing criteria	0

Please note: Measures 1-8 above are scored using ASC methodology. Measures 9-10 are scored using collaborative methodology.

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
1	10%	**Collaborative Meeting Participation*-Clinical Champions (01.01.2026-11.15.2026)** ***Attendance at both the Medical Advisory Committee and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	10
		2 out of 3 meetings attended	5
		<2 meetings attended	0
Participation Extra Credit	0	Clinical Champion active engagement and participation in Quality Improvement working groups (e.g., PROS, ASC, Infection, Hip Fractures, Pain control, Device committee, Outlier work group, Quality Metrics work group, Executive Committee, Academic Quality Team, Patient education, Optimization & Appropriateness, etc.) ***Maximum total 1 point extra credit per site towards participation measures**	1
2	4%	**Collaborative Meeting Participation*-Clinical Data Abstractors (01.01.2026-11.15.2026)** ***Attendance at both the CDA Breakout and Collaborative-wide meeting on February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time**	
		3 out of 3 meetings attended	4
		2 out of 3 meetings attended	2
		<2 meetings attended	0
Participation Extra Credit	0	CDA active engagement and participation in CDA Committees or working groups (e.g., CDA Committee, Specifications Manual work group, PROS, ASC, Infection, Patient education, etc.) ***Maximum total 0.5 point extra credit per site towards participation measures**	0.5
Participation Extra Credit	0	Site's with CDAs in their role for 9 months or greater as of March 31, 2026 who have at least one CDA attend the in-person CDA refresher training course on June 24, 2026. ***Maximum total 0.5 point extra credit per site**	0.5
Participation Extra Credit	0	**Collaborative Meeting Participation*- Site Administrator** (01.01.2026-11.15.2026) *Attendance at 3 of 3 Collaborative-wide meeting in February 6, 2026 (Virtual); May 15, 2026 (In-person); and October 2, 2026 (In-person) for 80% of the meeting time • Individual must be identified and confirmed to fill this role by 1st 2026 MARCQI Collaborative-wide meeting • This person cannot be the same person filling the Clinical Data Abstractor (CDA) role at the site as a CDA or Quality Director CDA ***Maximum total 0.5 point extra credit per site**	0.5
3	10	**Accuracy and Completeness of Data Submission (audits 07.01.2025 - 06.30.2026) - 6 metrics** 1. Complete data entry (e.g. Data quality assurance and inclusion review scores) > 97% - 100% of the time 2. On-time data entry (e.g. Data abstraction completed 91-150 days post-op) > 97% - 100% of the time 3. All cases performed on or before 12.31.2025 abstracted	

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
		completely by 05.31.2026 4. All cases performed or before 05.04.2026 abstracted by 10.01.2026 5. Demonstration of successful submission of MARCQI eligible cases to the Michigan Outpatient Database with the Michigan Health and Hospital Association by 08.31.2026 6. Attestation of BCBSM ASF CQI participation funding utilization to support dedicated data abstraction support for effective and complete MARCQI data abstraction and quality improvement work to the MARCQI Coordinating Center by 11.30.2026	
		6 of 6 metrics met	10
		5 of 6 metrics met	8
		4 of 6 metrics met	6
		3 of 6 metrics met	4
		2 of 6 metrics met	2
		1 of 6 metrics met	1
		0 of 6 metrics met	0
4	2	**Site leve**l: Access to 90-day post-operative clinical office notes for every participating MARCQI surgeon at the site is demonstrated to be 99% or above for cases completed (07.01.2025 - 06.30.2026). If a MARCQI surgeon's rate for access to clinical office notes has been lower than 99% over the last few years, an attestation for the changes made and implemented will be required, and a demonstration may be requested.	2
5	4	**Site based Quality Meetings:(02.07.2026-11.15.2026)** The site is awarded points for holding 3 meetings or more a year (following the MARCQI Collaborative meetings) to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. The minimum requirement is 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The Clinical Champion must be present to lead the discussion for the meeting to qualify as a site-based QI meeting following a collaborative-wide meeting. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	4
Participation Extra Credit	0	87.5% of MARCQI surgeons at the site attend 3 of 3 site-based QI meetings (02.07.2026-11.15.2026)--meaning the MARCQI surgeons must attend 1 site based QI meeting after each MARCQI collaborative-wide meeting for a minimum total of 3 site based QI meetings. ***Maximum total of 3 extra credit points per site towards participation measures**	3
6	15	**PROs Collection:** For surgeries performed on 07.01.2025-06.30.2026, **SITE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.*	

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
		The site is awarded full points for collection rates of 90%+	15
		75 - 89%	10
		60 - 74%	5
		The site is not awarded points if collection is less than 60%	0
7	5	**PROs Collection**: For surgeries performed on 07.01.2025-06.30.2026, **COLLABORATIVE** level primary PRE-OPERATIVE HOOS -JR or KOOS-JR + PROMIS10 completion rate of 90% or more. When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.	
		Awarded full points for collection rates of 90%+	5
		75 - 89%	3
		60 - 74%	1
		The site is not awarded points if collection is less than 60%	0
Performance Extra Credit	0	**PROs Collection**: Completed primary Pre-op and 2-16 week post-op HOOS -JR or KOOS-JR + PROMIS10 (Overall average as of surgeries performed between 07.01.2025 - 06.30.2026) at a **SITE** are 70% or greater for both primary hip and knee procedures combined When the difference between the PROS submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric. ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 70%+	2
		60 - 69%	1.5
		50 - 59%	1
		The site is not awarded extra credit if collection is less than 50%	0
Performance Extra Credit	0	**PROs Collection:** For surgeries performed on 06.01.2024 to 11.04.2025, **SITE** level primary PRE-OPERATIVE & 1 YEAR POST-OPERATIVE (300-425 days) HOOS -JR or KOOS-JR + PROMIS10 completion rate of 50% or more. *When the difference between the PROs submission and completion rate at the site is >5%, the PROS completion rate will be used for this metric.* ***Maximum total of 2 extra credit points per site towards performance measures**	
		The site is awarded full points for collection rates of 50%+	2
		40 - 49%	1.5
		30 - 39%	1
		The site is not awarded points if collection is less than 30%	0

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI)
Performance Incentive Scorecard for **ASC - Year 3+**
Participation Measurement Period: 01/01/2026 - 11/15/2026
QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted

Measure #	Max. Weight	Measure Description	Points
8	10	**% of Opioid naive THA patients at the SITE meet the MARCQI Pain control pathway guidelines (<=240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	10
		60-84% of THA patients prescribed **<240 OME**	5
		Less than 60% of patients meet the prescribing criteria	0
9	10	**% of Opioid naive TKA patients at the SITE meet the MARCQI Pain control pathway guidelines (≤320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	10
		70-89% of TKA patients prescribed **<320 OME**	5
		Less than 70% of patients meet the prescribing criteria	0
10	5	**% of Opioid naive THA patients at the COLLABORTIVE meet the MARCQI Pain control pathway guidelines (<=240 OME)**	
		85% or greater of THA patients meet the guidelines of **240 OME** or less	5
		60-84% of THA patients prescribed **<240 OME**	2.5
		Less than 60% of patients meet the prescribing criteria	0
11	5	**% of Opioid naive TKA patients at the COLLABORATIVE meet the MARCQI Pain control pathway guidelines (<=320 OME)**	
		90% or greater of TKA patients meet the guidelines of **320 OME** or less	5
		70-89% of TKA patients prescribed **<320 OME**	2.5
		Less than 70% of patients meet the prescribing criteria	0
12	20	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative).** If red on scorecard of April, 2025, you must strongly consider choosing this as the project. If you have worked on this metric previously or have difficultly developing a goal, a yellow target area may be chosen with the Program Manager's approval. If you would like to continue with your FY2025 site based QI project topic, please discuss with the Program Manager. If no red, you will choose a 'yellow'. All projects must come from the April 2025 MARCQI Quarterly Report --Project goals must seek a ≥ 20% improvement unless otherwise approved by the Program Manager --Mid-Year Progress Report is due in May 29, 2026 & Final Progress report is due February 12, 2027 --Clinical Champion must have a role in the Quality Improvement project plan --All sites are expected to complete a proposal, mid-year report, final report, A3, and presentation of their project by the clinical champion when asked. ***A clinical champion and Clinical Data Abstractor not presenting on a project when asked will yield -20 points on the FY2027 P4P scorecard --Final results are based on quarterly reports of January 2027	
		• Plan submitted and approved, reporting requirements & timelines met, A3 submitted, and goal met* *Clinical Champion and Clinical Data Abstractor must be available to present and address questions about the project at June 2027 Collaborative-wide session if asked	20

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
		Not presenting if asked will yield -20 points on the FY2027 P4P scorecard	
		• Plan submitted and approved • Reporting requirements are met & timelines, but the target identified is not met • Site performs a deep dive on all cases impacting the missed quality improvement goal at the site and/or flagships with its combined partners (affiliates and HOPD) and submits the deep dive findings with summary report with the FY2026 Site based QI project final report submission on February 12, 2027 • A3 submitted with final report and presentation by clinical champion given at June 2027 MARCQI Collaborative-wide sessions* *Clinical Champion and Clinical Data Abstractor must be available to present and address questions about the project at June 2027 Collaborative-wide session if asked *Not presenting if asked will yield -20 points on the FY2027 P4P scorecard*	15
		• Plan submitted and approved • Reporting requirements are met & timelines, but the target identified is not met • Site does not perform a deep dive on all cases impacting the missed quality improvement goal at the site and/or flagships with its combined partners (affiliates and HOPD) • A3 submitted with final report and presentation by clinical champion given at June 2027 MARCQI Collaborative-wide sessions* *Clinical Champion and Clinical Data Abstractor must be available to present and address questions about the project at June 2027 Collaborative-wide session if asked *Not presenting if asked will yield -20 points on the FY2027 P4P scorecard*	10
		• Plan submitted and approved • All reporting requirements are NOT met within the communicated timelines • Goal is not met *Clinical Champion and Clinical Data Abstractor must be available to present and address questions about the project at June 2027 Collaborative-wide session if asked *Not presenting if asked will yield -20 points on the FY2027 P4P scorecard*	5
		Plan is not developed, reports not done.	0
Performance Extra Credit	0	**Reverse Site-Visits:** If a site is **RED or YELLOW** in a quality improvement area on their VISUAL Scorecard and they complete a SITE VISIT to a site that is **GREEN** on their VISUAL Scorecard and vis-versa, the RED/YELLOW site and GREEN sites are both eligible for extra credit if: **--**Both sites must visit each other for the same quality improvement area (e.g., sites must observe what is going well and what may not be going as well) between 07.01.2025 - 09.30.2026 --Both sites submit a report regarding the lessons learned for the site visits by December 4, 2026 --Both sites must be willing to have their clinical champion share their findings with the collaborative if asked or results in -5 points	5

2026 Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI) Performance Incentive Scorecard for **ASC - Year 3+** Participation Measurement Period: 01/01/2026 - 11/15/2026 QI Measurement Period: 07/01/2025 - 06/30/2026, unless otherwise noted			
Measure #	Max. Weight	Measure Description	Points
		on the FY2027 P4P Scorecard --Both sites must have their clinical champions and Clinical Data Abstractors at both site visits --Sites are not part of the same health system or have an affiliate site/HOPD relationship --MARCQI Coordinating Center is alerted to the site visits and has the opportunity to join if requested ***Maximum total of 5 extra credit points per site towards performance measures**	
Please note: Measures 1-6, 8-9, 12 above are scored using ASC methodology. Measures 7,10-11 are scored using collaborative methodology.			

2026 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
1	10%	**Improvement/Excellence In Grade 1 Complication Rate:** Reduce grade 1 complications to 4%, will be measured on a per site basis. If the site does not meet the 4% goal, a z-sore will be calculated to determine relative improvement. Improvement *(z-score)* will be measured using trended data from OR dates of 10/1/2023 to 9/30/2026 and rounded to the nearest whole number. Excellence *(adjusted rate)* will be measured using OR dates of 10/1/2025 to 9/30/2026 and rounded to the nearest whole number. The better of the two scores will be used. **Measurement periods:** Improvement - OR dates 10/1/2023 to 9/30/2026 Excellence - OR dates 10/1/2025 to 9/30/2026	
		Major improvement (z-score less than -1 or Grade 1 complication rate <= 4%)	10
		Moderate improvement/maintained complication rate (z-score between 0 and -1)	5
		No improvement/rates of grade 1 complications increased (z-score>=0)	0
2	10%	**Improvement/Excellence in Serious Complication Rate:** Reduce grade 2 and 3 complications (serious complications) to 2%, will be measured on a per site basis. If the site does not meet the 2% goal, a z-sore will be calculated to determine relative improvement. Improvement (z-score) will be measured using trended data from OR dates of 10/1/2023 to 9/30/2026 and rounded to the nearest whole number. Excellence *(adjusted rate)* will be measured using OR dates of 10/1/2025 to 9/30/2026 and rounded to one decimal point. The better of the two scores will be used. **Measurement periods:** Improvement - OR dates 10/1/2023 to 9/30/2026 Excellence - OR Dates 10/1/2025 to 9/30/2026	
		Major improvement (z-score less than -1 or serious complication rate <= 2.0%)	10
		Moderate improvement/maintained complication rate (z-score between 0 and -1)	5
		No improvement/rates of serious complications increased (z-score>=0)	0
3	10%	**Non-Medical Drivers of Health (NMDH) Screening, Data Abstraction and Entry into the MBSC website (percentage rounded to the nearest whole number)**	
		>= 65% to 100% NMDH screening and findings entered into the MBSC website with OR dates>=6/1/2026	10
		30% to 64% NMDH screening and findings entered into the MBSC website with OR dates>=6/1/2026	5
		0% to 29% NMDH screening and findings entered into the MBSC website with OR dates>=6/1/2026	0

2026 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
4	5%	**Compliance with VTE Prophylaxis - Pre-Operatively and Post-Operatively:** must meet 95% compliance for both pre-op **AND** post-op to receive the points **Unadjusted; Rounded to nearest whole number** Measurement period: OR dates 1/1/2026 to 9/30/2026	
		>= 95% compliance with guidelines	5
		0 to 94% compliance with guidelines	0
5	5%	**Compliance with VTE Prophylaxis - Post Discharge:** based on the post-discharge risk stratification recommendations for 1-month prophylaxis per the **updated MBSC - Weigh The Odds** VTE risk calculator **Unadjusted; Rounded to nearest whole number** Measurement Period: OR dates 10/1/2025 to 9/30/2026 Baseline Period: 10/1/2024 to 4/30/2025	
		>= 70% compliance with guidelines or a > 2.5% relative improvement from the previous year (1/1/2025 to 12/31/2025)	5
		0 to 69% compliance with guidelines	0
6	10%	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs)** **Reduce Post-Op Opioid Use after Bariatric Surgery** **Unadjusted; Rounded to nearest whole number** Measurement Period: OR dates 10/1/2025 to 9/30/2026 Baseline period: 4/1/2024 to 3/31/2025 Baseline rate to determine relative reduction = **28.1 MME**	
		<= 28 MME or>=10% relative reduction in opioid use	10
		5-9% relative reduction in opioid use	5
		< 5% relative reduction	0
7	10%	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs)** **Reduce Post-Op Opioid Use after Bariatric Surgery** **Unadjusted; Rounded to the nearest whole number** Measurement period: OR dates 10/1/2025 to 9/30/2026 Baseline period: 4/1/2024 to 3/31/2025 Baseline rate to determine relative reduction = **28.1 MME** ******No points will be awarded if your hospital is>=70MME	
		<= 28 MME or>=10% relative reduction in opioid use	10
		5-9% relative reduction in opioid use	5
		< 5% relative reduction	0
8	5%	**Reduce avoidable ED Visits (not resulting in a readmission, "avoidable")** **Unadjusted and rounded to the nearest whole number** Measurement period: OR dates 10/1/2025 to 9/30/2026	
		<= 6% Avoidable ED visits	5
		> 6% Avoidable ED visits	0
9	5%	**Reduce readmissions or reoperations for gallbladder disease within 1 year of bariatric surgery** **Patient Reported Outcome Measure - Gallstone Prevention** Patients who have a gallbladder following bariatric surgery will not experience a readmission or reoperation due to gallbladder disease within 1-year of their bariatric surgery (as reported on 1-year follow-up survey) To prevent this, surgeons are encouraged to discharge all patients	

2026 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
		with a gallbladder with a prescription for a gallstone dissolution agent - Ursodiol (Actigall, Reltone, Urso 250, Urso Forte) 300 mg BID for 6-months) following their bariatric surgery (RN abstracted) ****Patients reporting a readmission/reoperation for gallstone disease who received recommended prophylaxis will be excluded. Measurement period: OR dates 2/1/2026 - 1/31/2027 Survey completion dates: 2/1/2025 - 1/31/2026 Baseline period: 5/1/2023 - 4/30/2024 Baseline rate = **1.91%**	
		<= 2% of patients will report a hospital admission or operation for gallstone disease within 1-year of their bariatric surgery on their first year annual follow-up survey	5
		Between 2-2.5% of patients will report a hospital admission or operation for gallstone disease within 1-year of their bariatric surgery on their first year annual follow-up survey	3
		>= 2.5% of patients will report a hospital admission or operation for gallstone disease within 1-year of their bariatric surgery on their first year annual follow-up survey	0
10	5%	**Meeting Attendance - Surgeon:** **In order for a surgeon to earn meeting attendance credit for a hospital, they must complete 10 bariatric surgery cases at that hospital for the dates of 1/1/2026 to 9/30/2026 Measurement period: OR Dates 1/1/2026 to 9/30/2026	
		Attended 2 out of 2 meetings	5
		Attended fewer than 2 meetings	0
11	5%	**Meeting Attendance - Abstractor/Coordinator:** Measurement period: OR Dates 1/1/2026 to 9/30/2026	
		Attended 2 out of 2 meetings	5
		Attended fewer than 2 meetings	0
12	5%	**Timely Monthly Data Submissions (30-day information & registry paperwork):** (Submitted to coordinating center by the last business day of each month - Please refer to 2026 Data Entry Deadlines Spreadsheet) **In order to be eligible for this measure, you must achieve > 90% on the 2026 yearly audit when applicable. If the hospital does not reach > 90% for the yearly audit, they will receive 0 points for this measure. Measurement period: OR Dates 1/1/2026 to 9/30/2026	
		On time 11-12 months	5
		On time 10 months	3
		On time 9 months or less	0
13	5%	**Consent Rate:** **Unadjusted; Rounded to nearest whole number** Measurement period: OR Dates 10/1/2025 to 9/30/2026	
		>= 90% consented patients	5
		80-89% consented patients	3
		<80% consented patients	0
14	10%	**Physician Engagement:**	10

2026 Michigan Bariatric Surgery Collaborative Quality Initiative (MBSC) Performance Index Scorecard Measurement period identified in each measure			
Measure #	Weight	Measure Description	Points
		** 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 1/1/2026 to 9/30/2026 Measurement period: OR Dates 1/1/2026 to 9/30/2026	
		Following items count as 1 activity point:	
		Committee participation	
		MBSC survey response	
		Participate in a qualitative interview	
		Coauthor a paper	
		Participate in quality improvement initiatives (FUTURE/MSHIELD/etc.)	
		Attend or present at a pre-meeting session (IH committee/surgeon skill/etc.) on the day of the MBSC tri-annual meeting	
		Present MBSC data at a MBSC Tri-annual meeting	
		Attend quality site visit as a guest surgeon	
		Hospital follow up rate of>=68% for the OR dates of 1/1/2025 to 9/30/2025	
		Following items count as 2 activity points:	
		Host quality site visit	
		Present MBSC data at a national meeting	
		Lead author on an MBSC publication	
		No participation	0
Please note: Measures 1-2, 4-5, 7-8, 10-14 above are scored using hospital methodology. Measures 3,6, 9 are scored using collaborative methodology.			

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 1 Sites**			
Measure #	Weight	Measure Description	Points
1	10%	**Data Delivery: Timeliness** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All 10 months of data transfers on time	10
		9 months of data transfers on time	8
		7-8 months of data transfers on time	4
		< 7 months of data transfers on time	0
2	10%	**Data Delivery: Adherence and Accuracy** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All 10 months of data transfers adhere to MEDIC data dictionary and are accurate	10
		9 months of data transfers adhere to MEDIC data dictionary and are accurate	8
		7-8 months of data transfers adhere to MEDIC data dictionary and are accurate	4
		< 7 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	6%	**Electronic Data Dictionary Update** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		Successful submission by deadline	6
		Successful submission within 1 month of deadline	3
		Submission more than 1 month after deadline	0
4	13%	**Abstraction: Timeliness** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All cases abstracted by quarterly deadline	13
		1 deadline missed	8
		2+ deadlines missed	0
5	12%	**Meeting Attendance: Clinical Champion** Measurement Period: 11/1/2025 - 8/31/2025 Baseline Period: NA	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0
6	12%	**Meeting Attendance: Data Abstractor** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		Attend All Meetings	12
		Miss 1 Meeting	6
		Miss >1 Meeting	0

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 1 Sites**			
Measure #	Weight	Measure Description	Points
7	14%	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		>= 90% of case cohort decisions are correct	14
		>= 75% of case cohort decisions are correct	8
		< 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
8	14%	**Time from Agreement being signed to successful submission of electronic production data** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		<90 days	14
		91-120 days	8
		>120 days	0
9	9%	**Intervention Planning for Year 2 (Intervention Templates, etc.)** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All Year 2 materials complete and submitted on time	9
		Year 2 materials incomplete and/or submitted late	0
Please note: All above are scored using hospital methodology.			

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 2 Sites**			
Measure #	Weight	Measure Description	Points
1	12%	**Data Delivery: Timeliness** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All 10 months of data transfers on time	12
		9 months of data transfers on time	9
		7-8 months of data transfers on time	6
		< 7 months of data transfers on time	0
2	12%	**Data Delivery: Adherence and Accuracy** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All 10 months of data transfers adhere to MEDIC data dictionary and are accurate	12
		9 months of data transfers adhere to MEDIC data dictionary and are accurate	9
		7-8 months of data transfers adhere to MEDIC data dictionary and are accurate	6
		< 7 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	6%	**Electronic Data Dictionary Update** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		Successful submission by deadline	6
		Successful submission within 1 month of deadline	3
		Submission more than 1 month after deadline	0
4	10%	**Abstraction: Timeliness** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All cases abstracted by quarterly deadline	10
		1 deadline missed	5
		2+ deadlines missed	0
5	10%	**Meeting Attendance: Clinical Champion** Measurement Period: 11/1/2025 - 8/31/2025 Baseline Period: NA	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
6	10%	**Meeting Attendance: Data Abstractor** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		Attend All Meetings	10
		Miss 1 Meeting	5
		Miss >1 Meeting	0
7	10%	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		>= 90% of case cohort decisions are correct	4
		>= 75% of case cohort decisions are correct	2
		< 75% of case cohort decisions are correct	0

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 2 Sites**			
Measure #	Weight	Measure Description	Points
		>= 97% of abstracted registry data accurate	6
		95%-97% of abstracted registry data accurate	3
		<95% of abstracted registry data accurate	0
8- Choose 1 of 4	10%	**Site Specific - Quality Improvement Initiative: Adult Head Injury CT Appropriateness –Increase the percent of appropriate head CTs performed on adult patients with minor head injuries as defined by the Canadian CT Head Rule with a target of>=70% (choose 1/4 initiatives in measure 8)** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		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	4
		QI Project not developed or implemented	0
	10%	**Site Specific - Quality Improvement Initiative: Pediatric Intermediate Risk Head Injury CT Utilization - Decrease the percentage off CT head scans for pediatric intermediate risk minor head injury with a target of <= 15% (choose 1/4 initiatives in measure 8)** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		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	4
		QI Project not developed or implemented	0
	10%	**Site Specific Quality Improvement Measure: Peds Chest Xray Utilization - Decrease the percentage of children with asthma, bronchitis, and croup that receive a chest x-ray with a target of <=24% (choose 1/4 initiatives in measure 8)** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		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	4
		QI Project not developed or implemented	0
	10%	**Site Specific Quality Improvement Initiative: Naloxone Distribution for Opioid Use Harm Reduction - Increase the number of naloxone kits distributed to patients at risk for harm from opioid overdoes with a target of>=50% (choose 1/4 initiatives in measure 8)** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		QI Project developed and implemented and site met or exceeded	10

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 2 Sites**			
Measure #	Weight	Measure Description	Points
		target	
		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	4
		QI Project not developed or implemented	0
9		Not applicable for Year 2 sites	
10	5%	**Collaborative-Wide Measure: Adult Suspected PE CT Diagnostic Yield - Increase Collaborative Wide performance for increasing the number of CT for PE scans that are positive with a target of >=8.0%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2026	
		Met Diagnostic Yield Target	5
		Did meet target	0
11	10%	**Collaborative Wide Measure - Adult Low Risk Chest Pain Safe Discharge Initiative - Increase the percent of safe discharge of adult low risk chest pain cases with a target of >=95%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		Met Discharge Rate Target	10
		Did meet target	0
12	5%	**Collaborative Wide Measure - Increase the percent of asthma Bundle Compliance for Pediatric Asthma Patients with a target of >=18%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		Met Bundle Compliance Target	15
		Did meet target	0
Please note: Measures 1-9 above are scored using hospital methodology. Measures 10-12 are scored using collaborative methodology.			

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
1	4%	**Data Delivery: Timeliness** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All 10 months of data transfers on time	4
		9 months of data transfers on time	3
		7-8 months of data transfers on time	2
		< 7 months of data transfers on time	0
2	4%	**Data Delivery: Adherence and Accuracy** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All 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	3
		7-8 months of data transfers adhere to MEDIC data dictionary and are accurate	2
		< 7 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	2%	**Electronic Data Dictionary Update** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		Successful submission by deadline	2
		Successful submission within 1 month of deadline	1
		Submission more than 1 month after deadline	0
4	5%	**Abstraction: Timeliness** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All cases abstracted by quarterly deadline	5
		1 deadline missed	3
		2+ deadlines missed	0
5	5%	**Meeting Attendance: Clinical Champion** Measurement Period: 11/1/2025 - 8/31/2025 Baseline Period: NA	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
6	5%	**Meeting Attendance: Data Abstractor** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
7	5%	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		>= 90% of case cohort decisions are correct	2
		>= 75% of case cohort decisions are correct	1
		< 75% of case cohort decisions are correct	0

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
		>= 97% of abstracted registry data accurate	3
		95%-97% of abstracted registry data accurate	2
		<95% of abstracted registry data accurate	0
8 (Choose 2 of 4)	20%	**Site Specific - Quality Improvement Initiative: Adult Head Injury CT Appropriateness --Increase the percent of appropriate head CTs performed on adult patients with minor head injuries as defined by the Canadian CT Head Rule with a target of>=70% (choose 2/4 initiatives in measure 8)** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	8
		QI Project not developed or implemented	0
	20%	**Site Specific - Quality Improvement Initiative: Pediatric Intermediate Risk Head Injury CT Utilization --Decrease the percentage of CT head scans for pediatric intermediate risk minor head injury with a target of <= 15% (choose 2/4 initiatives in measure 8) of peds patients** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	8
		QI Project not developed or implemented	0
	20%	**Site Specific Quality Improvement Measure: Peds Chest Xray Utilization - Decrease the percentage of children with asthma, bronchitis, and croup that receive a chest xray with a target of <=24% (choose 2/4 initiatives in measure 8)** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	8
		QI Project not developed or implemented	0
	20%	**Site Specific Quality Improvement Initiative: Naloxone Distribution for Opioid Use Harm Reduction - Increase the number of naloxone kits distributed to patients at risk for harm from opioid overdoes with a target of>=50% (choose 2/4 initiatives in measure 8)** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		QI Project developed and implemented and site met or exceeded target	20

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 3+ Sites**			
Measure #	Weight	Measure Description	Points
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	8
		QI Project not developed or implemented	0
9	20%	**Site Specific Quality Improvement Initiative: Pediatric Readiness - Must choose this measure once out of every 3 years. Improve a site's pediatric readiness as measured by the NPRP Pediatric Readiness Survey. When working on pediatric readiness, hospital must choose 1/4 measure 8 initiatives** Measurement Period: 11/1/2024 - 8/31/2026 Baseline Period: 4/1/2024 - 6/1/2025	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	8
		QI Project not developed or implemented	0
10	5%	**Collaborative-Wide Measure: Adult Suspected PE CT Diagnostic Yield - Increase the percentage of CTs for suspected pulmonary embolism that diagnosed positive with a target of>=8.0%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2026	
		Met Diagnostic Yield Target	5
		Did meet target	0
11	10%	**Collaborative Wide Measure - Adult Low Risk Chest Pain Safe Discharge Initiative - Increase the percent of safe discharge for adult low risk chest pain patients with a target of>=95%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		Met Discharge Rate Target	10
		Did meet target	0
12	15%	**Collaborative Wide Measure - Increase the percentage of pediatric asthma patients who receive steroids and bronchodilators within 60 minutes of arrival to the emergency department and who receive serial asthma scores with a target of>=18%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		Met Bundle Compliance Target	15
		Did meet target	0
Please note: Measures 1-9 above are scored using hospital methodology. Measures 10-12 are scored using collaborative methodology.			

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 3+ Peds**			
Measure #	Weight	Measure Description	Points
1	4%	**Data Delivery: Timeliness** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All 10 months of data transfers on time	4
		9 months of data transfers on time	3
		7-8 months of data transfers on time	2
		< 7 months of data transfers on time	0
2	4%	**Data Delivery: Adherence and Accuracy** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All 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	3
		7-8 months of data transfers adhere to MEDIC data dictionary and are accurate	2
		< 7 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	2%	**Electronic Data Dictionary Update** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		Successful submission by deadline	2
		Successful submission within 1 month of deadline	1
		Submission more than 1 month after deadline	0
4	5%	**Abstraction: Timeliness** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		All cases abstracted by quarterly deadline	5
		1 deadline missed	3
		2+ deadlines missed	0
5	5%	**Meeting Attendance: Clinical Champion** Measurement Period: 11/1/2025 - 8/31/2025 Baseline Period: NA	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
6	5%	**Meeting Attendance: Data Abstractor** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		Attend All Meetings	5
		Miss 1 Meeting	3
		Miss >1 Meeting	0
7	5%	**Annual Abstraction Audit: SNAP (Sharing Knowledge And Perspectives) Review** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: NA	
		>= 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
8a		8a is not applicable to pediatric sites	

2026 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Measurement Period: 11/1/2025 – 8/31/2026 **Year 3+ Peds**			
Measure #	Weight	Measure Description	Points
8b	20%	**Site Specific - Quality Improvement Initiative: Pediatric Intermediate Risk Head Injury CT Utilization - Decrease the percent of CT utilization for pediatric intermediate risk minor heard injury with a target of <= 15%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	8
		QI Project not developed or implemented	0
8c	20%	**Site Specific Quality Improvement Measure: Peds Chest Xray Utilization - Reduce the utilization of chest x-rays for pediatric patients with asthma, bronchiolitis, and croup with a target of <= 24%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	8
		QI Project not developed or implemented	0
8d		8d is not applicable to pediatric sites	
9	20%	**Site Specific Quality Improvement Initiative: Pediatric Readiness - Must choose this measure once out of every 3 years. When working on pediatric readiness, hospital must choose 1/2 measure 8 initiatives** Measurement Period: 11/1/2024 - 8/31/2026 Baseline Period: 4/1/2024 - 6/1/2025	
		QI Project developed and implemented and site met or exceeded target	20
		QI Project developed and implemented and site made improvement toward, but did not meet, the target	12
		QI Project developed and implemented but there was no improvement to the target	8
		QI Project not developed or implemented	0
12	30%	**Collaborative Wide Measure - Increase the percentage of pediatric asthma patients who receive steroids and bronchodilators within 60 minutes of arrival to the emergency department and who receive serial asthma scores with a target of >=18%** Measurement Period: 11/1/2025 - 8/31/2026 Baseline Period: 4/1/2024 - 3/31/2025	
		Met Bundle Compliance Target	30
		Did meet target	0
Please note: Measures 1-9 above are scored using hospital methodology. Measure 12 is scored using collaborative methodology.			

2026 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
1	6%	**Clinical audit, CDA team meeting participation, and submission of clinical data[1]** Measurement period: 01/01/2026-09/30/2026 Baseline period: Not Applicable	
		All metrics met	6
		Some metrics met	1-5
		No metrics met	0
2	6%	**Timely submission of high-quality physics & dosimetry data** Measurement period: 01/01/2026-09/30/2026 Baseline period: Not Applicable	
		Three metrics met	6
		Two metrics met	4
		One metric met	2
		No metrics met	0
3	10%	**Increase the collaborative-wide utilization of prone positioning for breast cancer radiation treatment** Measurement period: 01/01/2026-09/30/2026 Baseline period: 01/01/2025-06/30/2025	
		>= 40% of breast cancer patients were treated in the prone position across MROQC	10
		30-39% of breast cancer patients were treated in the prone position across MROQC	5
		<30% of breast cancer patients were treated in the prone position across MROQC	0
4	10%	**Increase the baseline and post-radiation treatment (RT) completion rate of standard of care arm measurements for lymphedema assessment in node positive breast cancer patients treated to regional fields.** A.>=50% of breast patients treated to regional fields with a baseline measurement (B7 or B9) in 2025 must have a follow-up measurement (B10 or B14) completed and reported in cm within Q1-Q3 of 2026. B.>=50% of breast patients treated to regional fields with a RT start date within Q1-Q3 of 2026 must have a baseline measurement (B7 or B9) reported in cm and complete nodal irradiation data (dose to irradiated nodal groups is reported and nodal contours are named according to TG263 guidelines)**.** Measurement period: 01/01/2026-09/30/2026 Baseline period: Metric A:01/01/2025-06/30/2025; Metric B:01/01/2025-06/30/2025	
		A and B were met	10
		Either A or B was met	7
		Neither A or B was met	0
5	10%	**For treatment of lung cancer with hypofractionation (6-20 fractions), MROQC Consensus Quality Guidelines are achieved for at least 75% of patients collaborative-wide.** Measurement Period: 01/01/2026-09/30/2026	

2026 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
		Baseline Period: 05/01/2024-05/01/2025	
		>=75% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase 1 guideline fractionation & dosimetric goals	10
		60-74% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase 1 guideline fractionation & dosimetric goals	5
		<60% of patients treated with hypofractionation (6-20 fx) for lung cancer across MROQC achieved the phase 1 guideline fractionation & dosimetric goals	0
6	10%	**Increase the utilization rate of bone mets treatments consisting of 5 fractions or fewer.** Measurement period: 01/01/2026-09/30/2026 Baseline period: 01/01/2025-06/30/2025	
		>=75% rate achieved	10
		60-74% rate achieved	7
		<60% rate achieved	0
7	10%	**Increase the rate of physics consultation for bone metastases reirradiation.*** ***For cases where there is concern for toxicity due to cumulative dose (Type 1 or Type 2 reirradiation), the physics consult must occur prior to physician approval. For Type 1 reirradiation cases with no concern for toxicity, the consult must occur prior to the start of treatment.*** Measurement period: 01/01/2026-09/30/2026 Baseline period: 01/01/2025-06/30/2025	
		>=50% of bone mets reirradiation cases received a physics consult	10
		<50% of bone mets reirradiation cases received a physics consult	0
8	10%	**Improve the percentage of patients with intact, localized, high-risk prostate cancer receiving definitive radiotherapy that are recommended to receive long-term androgen deprivation therapy (ADT).** Measurement period: 01/01/2026-09/30/2026 Baseline period: 01/01/2025-06/30/2025	
		>=65% of prostate cancer patients recommended to receive long-term ADT	10
		55-64% of prostate cancer patients recommended to receive long-term ADT	7
		<55% of prostate cancer patients recommended to receive long-term ADT	0
9	10%	**Increase MRI utilization for intact prostate cancer patients receiving definitive radiotherapy** Measurement period: 01/01/2026-09/30/2026 Baseline period: 01/01/2025-06/30/2025	
		>=70% of prostate cancer patients received an MRI	10
		60-69% of prostate cancer patients received an MRI	7
		<60% of prostate cancer patients received an MRI	0

2026 Michigan Radiation Oncology Quality Consortium (MROQC) Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
10	6%	**Collaborative Meeting Participation – Clinical Champion** ***(Per MROQC CC Attendance Policy)*** Measurement period: 01/01/2026-11/01/2026 Baseline period: Not Applicable	
		All meetings or two meetings with one meeting attended by an acceptable designee	6
		Two Meetings	4
		One Meeting or None Attended	0
11	6%	**Collaborative Meeting Participation – Physics Lead (or designee)** Measurement period: 01/01/2026-11/01/2026 Baseline period: Not Applicable	
		All Meetings	6
		Two Meetings	4
		One Meeting or None Attended	0
12	6%	**Collaborative Meeting Participation – Clinical Data Abstractor (CDA or designee)** Measurement period: 01/01/2026-11/01/2026 Baseline period: Not Applicable	
		All Meetings	6
		Two Meetings	4
		One Meeting or None Attended	0
Bonus	10%	**MROQC Physician Engagement (not to exceed 100 points on total scorecard)**	
		• Lead author on an MROQC publication (Counts as 2 items) • Lead a skills workshop (Counts as 2 items) • Present at an MROQC collaborative-wide meeting (Non-leadership role only) • Present on MROQC at a national meeting (Cannot be a resident) • Attend 5 working group meetings in 2026 (Total across practice physicians; 1 physician counts per meeting (i.e., no double points if 2 attend the same meeting)) • Coauthor on an MROQC publication • Participate in 3 case review sessions • Propose a new quality measure: provide reasoning to implement the measure, work with the MROQC data team to review supporting data and present the measure to the working group.	
		5 or more items achieved	10
		3-4 items achieved	5
		1-2 items achieved	1
Please note: Measures 1-2, 4, 6-12, and bonus above are scored using hospital methodology. Measures 3 and 5 are scored using collaborative methodology.			

MROQC
2026 Performance Index Scorecard Measure Explanation
(Start Date: 01/01/2026)
CQI P4P Performance Index Scorecard supporting documentation

Measure number and description	Additional narrative describing the measure
Measure #1: Clinical Audit, CDA Team Meeting Participation, and Submission of Clinical Data	**1. Clinical Audit – 2 points** **a. Increase the overall data accuracy rate, target is >=95% as determined by a clinical audit of breast, lung, bone mets, and prostate data.** i. Metric score – 1 point. ii. Audit cases are patients with an RT end date within the 2025 calendar year (1/1/2025 - 12/31/2025). Patients with an RT end date in 2026 can be utilized for facilities with an insufficient number of cases. **b. Sufficient audit preparation and follow-up** i. Metric score – 1 point. ii. Audit materials available for review at the time of audit. iii. An appropriate staff member (CDA) attends the audit. iv. Corrections identified during the clinical audit are completed within 2 weeks of receiving them. **<u>Audit Exemption Criteria for High-Performing Facilities:</u>** • **Eligibility**: Facilities that achieved a clinical audit score of 98% or higher in 2025. • **Exemption:** These facilities will be exempt from the clinical audit for the subsequent year, 2026. • **Score Carry-Over:** During the exempt year, the score achieved in the preceding year, 2025, will be carried over. This means that high-performing facilities will automatically get 2 points for the clinical audit metric. • Facilities that achieve a clinical audit score below 98% in 2025 will continue with their annual 2026 clinical audit without exemption. • **Facilities that were granted an audit exemption in 2025 will be audited in 2026.** **2. CDA Team Meeting Attendance – 1 point** **a.** Metric Score – 1 point **b.** CDAs must attend at least 3 CDA team meetings in 2026. **c.** Credit awarded based on Zoom attendance list. **d.** Only one person is required to attend and receive credit for facilities with multiple CDAs. **e.** If fewer than 3 meetings are held in 2026, the requirement will change to reflect the actual number of meetings held. **3. Increase in Submission of Clinical Forms – 3 points**

	a. Target: >= 90% of baseline, on-treatment, and end-of-treatment forms submitted by the data entry deadline. i. Metric Score - 1 point. ii. Relevant Forms: Breast (B1, B3, B5, B6, B7, *B9), Lung (L1, L2, **EOT** L3, L4, L5, L6, L7, *L8), Bone Mets (M1, M3, M4, M6) and Prostate (P1 /P2, P3, P4, P7). *Only the end of treatment date is needed on the B9 and L8 forms for lung SBRT /breast ultra-hypofractionation cases. iii. Metric calculation: $\frac{\textit{Patients who are missing at least 1 form}}{\textit{All eligible Patients}}$ iv. Eligible patients are defined as having an RT start date of 1/1/2026- 7/31/2026. v. Data entry deadline: Form data must be submitted by 11/15/2026. vi. Follow-up forms are excluded from this measure. vii. If an SE2 form is submitted, all the required forms listed on the SE2 must be entered to receive credit. **b. Target: >= 60% Completion rate of 36-Month prostate P6 follow-up form** i. Metric Score – 1 point. ii. Relevant Form: CDA -month follow-up form (P6) iii. Metric Calculation: $\frac{\textit{Submission of the 36-month P6 form due during 1/1/2026-7/31/2026}}{\textit{All 36-month P6 Forms due during 1/1/2026 -7/31/2026}}$ iv. The RT end date will be used to identify patients who are eligible for 36-month follow-up during the 1/1/2026-7/31/2026 measurement period. v. The 36-month P6 follow-up form is expected to be completed 30 to 40 months after the RT end date. c. **Target: >=75% Completion rate of annual lung follow-up form** i. Metric Score -1 point. ii. Relevant Form: CDA 1 year follow-up form (L11) iii. Metric Calculation: $\frac{\textit{Submission of the 1-year L11 form due during 1/1/2026-7/31/2026}}{\textit{All 1-year L11 Forms due during 1/1/2026 -7/31/2026}}$

iv. The RT end date on the L8 form will be used to identify patients who are eligible for the first-year follow-up during the 1/1/2026-7/31/2026 measurement period.

v. The 1-year L11 follow-up form is expected to be completed 9 to 15 months after the RT end date.

vi. Patients who completed RT between 1/1/2025 and 7/31/2025 but are terminated earlier than 12 months after their RT end date *(the 1st year follow-up),* will not be excluded from this measure. In this case, L11 forms should be filled out at the same time an SE2 *(early termination form)* is completed.

P4P Scoring:

Clinical Audit, CDA Team Meeting Participation, and Submission of Clinical Data Score Breakdown	
6 Total Points:	
1 point	Clinical Audit data accuracy
1 point	Sufficient audit preparation and follow-up
1 point	CDA Team meeting attendance
1 point	Submission of baseline, on-treatment, and end-of-treatment clinical forms
1 point	Submission of P6, 36-month form
1 point	Submission of L11, 1 year form
• All metrics met: 6 points. • Some metrics met: Partial points given based on the breakdown above.	

Measure #2: Timely Submission of High-Quality Physics & Dosimetry Data

A. Physics & dosimetry information is submitted within 6 weeks of end of treatment for >=85% of breast, lung, bone mets, and prostate patients from the 2026 performance year.

a. "Physics & dosimetry information" refers to the patient-specific Radiotherapy Technical Details form and full DICOM data set where required.* Credit is received if the patient's information is submitted within 6 weeks of the patient's RT end date.
**Note that DICOM data upload is not required for bone mets patients treated with a 2D or 3D technique.*

Population: Patients with RT start date of 01/01/2026-09/30/2026 and whose physics data are due by the November 2026 data entry deadline.

B. Physics & dosimetry information is error-free according to database-specific Physics-Data Checker reports for >=95% of 2026 patients.

a. Any errors on the Physics-Data Checker reports for 2026 patients must be resolved by the November 2026 deadline for a case to be counted as "error-free."

Population: Patients with RT start date of 01/01/2026-09/30/2026.

	C. Physics data audit score achieved is >=97% and the facility demonstrates sufficient audit preparation and follow-up. a. Overall data accuracy is >=97% as determined by an audit of breast, lung, bone mets, and prostate cases. Audit cases are patients with an RT end date within the 2025 calendar year (1/1/2025-12/31/2025). b. Sufficient audit preparation and follow-up, which includes: i. Audit materials available for review at the time of audit. ii. Appropriate staff member (physicist or dosimetrist) attends the audit. iii. Corrections identified during the audit are completed within 2 weeks of receiving them. **Audit Exemption for High-Performing Facilities:** • Facilities that achieved a physics audit score of 99% or higher in 2025 will be exempt from the physics data audit in 2026. • During the exempt year, the score achieved in the previous year will be carried over. This means that high-performing facilities will automatically meet physics data audit Metric C. • Facilities with a physics audit score below 99% in 2025 will continue with their annual 2026 physics audit without exemption. • **Facilities that were granted an audit exemption in 2025 will be audited in 2026.** **P4P Scoring:** • Three Metrics Met 6 points • Two Metrics Met 4 points • One Metric Met 2 points • No Metrics Met 0 points
Measure #3: **Increase the collaborative-wide utilization of prone positioning for breast cancer radiation treatment**	**Population:** Breast cancer patients enrolled in MROQC during Q1-Q3 2026. **Numerator:** Breast cancer patients who receive whole or partial breast radiation only in the prone position. **Denominator:** Breast cancer patients who do not have any of the following exclusions for prone positioning during the measurement period: -Lack prone treatment equipment -Cannot tolerate prone positioning -Refuses prone positioning after being informed of its potential benefits -Is receiving regional (nodal) irradiation -Have small breasts, defined as a cup size A or a breast PTV_eval volume ≤ 1000cc. **

	Small breasted patients will be excluded from the denominator for purposes of this measure. These patients may, however, be treated in the prone position if the patient and the oncologist choose to do so but if they are excluded, it will not affect the facility's calculation of the measure. • Data from the BRTD will be used for this measure as well as the B7, which will capture any contraindications for treatment with prone by the physician. • The MROQC collaborative will use breast data from node negative patients with an RT start date of 01/01/2026-9/30/2026 for this measure. The score reported will be the **collaborative performance at the end of Q3 2026. This will allow for measurement/improvement, and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in late 2026.

Measure #4:
Increase the baseline and post-radiation treatment (RT) completion rate of standard of care arm measurements for lymphedema assessment in node positive breast cancer patients treated to regional fields.
 	
A. >=50% of breast patients treated to regional fields with a baseline measurement (B7 or B9) in 2025 must have a follow-up measurement (B10 or B14) completed and reported in cm within Q1-Q3 of 2026.*
 	
B. >=50% of breast patients treated to regional fields with a RT start date within Q1-Q3 of 2026 must have a baseline measurement (B7 or B9) reported in cm and complete nodal irradiation data (dose to irradiated nodal groups is reported and nodal contours are named according to TG263 guidelines).
	Population: Node positive breast cancer patients with RT start dates of 01/01/26-09/30/26.
	
	Numerator: Number of node positive breast cancer patients who receive the standard of care arm measurements for lymphedema assessment at baseline (pre-RT) and in follow-up (post-RT).
	
	Denominator: Total number of node positive breast cancer patients who were treated with regional fields *(excluding IMN only)*
	
	• The following patients will be excluded from the measure:
	  ○ Patients who decline the measurements.
	  ○ Patients who have a virtual visit.
	  ○ Patients who did not complete RT
	
	• Documentation of this measure will come from the B7 or B9 forms (Baseline) and/or B10 or B14 (Follow-Up) as well as the BRTD (to determine if the patient is node positive).
	
	• MROQC will use facility data from node positive breast patients with baseline measurements in 2025 who will be due for a follow-up in Q1-Q3 2026 as well as cases with an RT start date of 01/01/2026-09/30/2026 to capture baseline measurements for this measure. The score reported will be the facility performance rate as of the end of Q3 2026 (using Q1-Q3 2026 overall rate). This will allow for measurement/improvement, and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in late 2026.

Measure #5: **For treatment of lung cancer with hypofractionation (6-20 fractions), MROQC Consensus Quality Guidelines are achieved.**	**Population**: Lung cases treated with hypofractionation with RT start dates of 01/01/26-09/30/26. **Numerator:** All lung cases treated with hypofractionation meeting the MROQC Consensus Quality Guidelines.

	Denominator: All lung cases treated with hypofractionation. • The lung radiotherapy technical details (LRTD) form will be used to determine fractionation and the lung DICOM will be used to identify if organs at risk (OARs) are contoured per the MROQC Consensus Quality Guidelines. • The MROQC collaborative will use lung data from patients treated with hypofractionation with an RT start date of 01/01/2026-9/30/2026 for this measure. The score reported will be the collaborative performance at the end of Q3 2026. This will allow for measurement/improvement, and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in late 2026.
Measure #7: **Increase the utilization rate of bone mets treatments consisting of 5 fractions or fewer.**	**Population:** All bone mets cases who start treatment in Q1-Q3 2026 **Numerator:** Bone mets cases receiving 5 or fewer fractions **Denominator:** All bone mets cases except for those being treated for cord compression • Data from the baseline clinical data form (M1), physician baseline (M4), and the bone mets physics survey (MRTD) for bone mets cases with a radiotherapy (RT) start date of 1/1/2026 through an RT start date of 9/30/2026 will be used to assess this measure. The physics survey (MRTD) will be used to determine the number of fractions delivered. • The score reported will be the facility's performance as of the end of Q3 2026 (using Q1-Q3 2026 overall rate). This will allow for measurement/improvement and allow for time to finalize data collection and determination of a facility's final rate.
Measure #8: **Increase the rate of physics consultation for bone metastases reirradiation.*** ***For cases where there is concern for toxicity due to cumulative dose (Type 1 or Type 2 reirradiation), the physics consult must occur prior to physician approval. For Type1 reirradiation cases with no concern for toxicity, the consult must occur prior to the start of treatment.***	**Population:** Patients undergoing reirradiation treatments within the participating radiation oncology departments. **Numerator**: The number of reirradiation cases with documented medical physics consultations. **Denominator**: The total number of reirradiation cases. • For bone mets reirradiation cases, the bone mets physics survey (MRTD) will be the source for documentation of a physics consult prior to final physician approval of a treatment plan. • For Type 1 reirradiation where there is overlap of irradiation volumes but no concern for toxicity from cumulative doses, physics must be consulted prior to treatment. • MROQC will use facility data for bone mets reirradiation cases with an RT start date of 01/01/2026-09/30/2026 for this measure. The score reported will be the facility performance as of the end of Q3 2026 (using Q1-Q3 2026 overall rate). This will allow for

	measurement/improvement, and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in late 2026.
Measure #9: **Improve the percentage of patients with intact, localized, high-risk prostate cancer patients receiving definitive radiotherapy that are recommended to receive long-term androgen deprivation therapy (ADT).**	**Population:** Patients with Intact, High-risk prostate cancer per NCCN guidelines with RT start dates of 01/01/2026-09/30/2026. **Numerator:** Number of high-risk patients recommended to receive an intended ADT duration in accordance with ASTRO/AUA guidelines (18-36 months). **Denominator:** Number of patients with intact, high-risk prostate cancer per NCCN guidelines. • The P3 will capture the intended duration, clinical trial participation, and patient refusal (*possible exclusions*). Risk grouping will come from either the MUSIC baseline data (matching facilities) or the P7 (facilities without a MUSIC partner). • MROQC will use facility prostate case data with an RT start date of 01/01/2026-09/30/2026 for this measure. The score reported will be the facility performance as of the end of Q3 2026 (using Q1-Q3 2026 overall rate). This will allow for measurement/improvement and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in late 2026.

Measure #10: Increase MRI utilization for intact prostate cancer patients receiving definitive radiotherapy	**Population:** Patients with intact prostate cancer with RT start dates of 01/01/2026-09/30/2026 undergoing treatment type external beam radiation therapy with or without brachytherapy.
	
	Numerator: All prostate patients with an MRI in the last 12 months report on the P3 form.
	
	Denominator: All intact patients, with treatment type = “EBRT alone” or “Combination therapy of EBRT and brachytherapy’
	
	• Patients unable to undergo MRI will be excluded. Examples:
	  ○ Patients declined due to medical reasons, personal preference or cost
	  ○ Implanted medical device
	  ○ Lack of insurance coverage
	• The prostate physics survey (PRTD) will be used to collect data on the number of intact prostate cancer patients receiving EBRT. The physician androgen deprivation form (P3 form) will be used to identify patients who underwent MRI in the last 12 months.
	• MROQC will use facility prostate case data with an RT start date of 01/01/2026-09/30/2026 for this measure. The score reported will be the facility performance as of the end of Q3 2026 (using Q1-Q3 2026 overall rate). This will allow for measurement/improvement and also allow for time to finalize data collection, determination of final rate, and scoring before scores are due to BCBSM in early 2026.

Measure #11: Collaborative-Wide Meeting Participation – Clinical Champion (per MROQC CC Attendance Policy)	All Clinical Champions are expected to attend the three (3) Collaborative Meetings held each year. Full Pay for Performance (P4P) points are awarded for attendance at the 3 meetings. When the Clinical Champion cannot attend a substitute may be allowed to represent the facility. A substitute is allowed once a year; the Clinical Champion must attend at least two of the meetings and can send a substitute for the third and still receive full P4P points. If two substitutes attend in a calendar year, only partial points will be given. Ideally, the substitute is another Radiation Oncologist from that facility that treats MROQC patients. Other Radiation Oncologists are acceptable. • In certain cases (example: a small facility with only 1-2 Radiation Oncologists), another physician is acceptable such as the Chief Medical Officer (CMO), the Chief of Quality, or a physician involved in Radiation Oncology cases. • Residents, Physician Assistants (PA), Nurse Practitioners or non-physicians are not acceptable substitutes. 1. Friday, February 13th, 2026 (virtual) 2. Friday, May 15th, 2026 3. Friday, October 9th, 2026
Measure #12: Collaborative-Wide Meeting Participation – Physics Lead (or designee)	The facility's Physics Lead (or designee-i.e., another physicist or a dosimetrist who works on MROQC) is expected to attend all of the MROQC Collaborative Meetings for 2026. 1. Friday, February 13th, 2026 (virtual) 2. Friday, May 15th, 2026 3. Friday, October 9th, 2026
Measure #13: Collaborative-Wide Meeting Participation – Clinical Data Abstractor (or designee)	MROQC CDAs (or designee-i.e., another CDA or someone who works on MROQC not covering another role at a meeting) are expected to attend all of the MROQC Collaborative Meetings for 2026. 1. Friday, February 13th, 2026 (virtual) 2. Friday, May 15th, 2026 3. Friday, October 9th, 2026
Bonus Measure: **MROQC Physician Engagement**	MROQC Physician Engagement (10 Bonus Points) *Not to exceed 100 points total on the P4P scorecard* • Lead author on an MROQC publication *(Counts as 2 items)* • Lead a skills workshop *(Counts as 2 items)* • Present at an MROQC collaborative-wide meeting *(non-leadership role only)* • Present on MROQC at a national meeting *(Cannot be a resident)* • Attend 5 working group meetings in 2026 *(Total across practice physicians; 1 physician counts per meeting i.e., no double points if 2 attend the same meeting)* • Coauthor on an MROQC publication • Attend 3 case review sessions

	• Propose a new quality measure: provide reasoning to implement the measure, work with the MROQC data team to review supporting data and present the measure to the relevant working group Metrics of Success: 5 or more items achieved 10 points 3-4 items achieved 5 points 1-2 items achieved 1 point Qualifications: 1. Must be a Clinical Champion or Participating Physician 2. Cannot be a resident

2026 Michigan Surgical Quality Collaborative (MSQC) Performance Index			
Measure #	Weight	Measure Description	Points
1	6%	**Collaborative Meetings (4 offered) – Surgical Clinical Quality Reviewer (SCQR)**	
		4 or more meetings	6
		3 meetings	5
		2 meetings	3
		1 meeting	1
2	6%	**Collaborative Meetings (3 offered) – Surgeon Champion (SC)**	
		3 or more meetings	6
		2 meetings	4
		1 meeting	2
3	4%	**Conference Calls (3 offered) – SCQR**	
		2 or more calls	4
		1 call	2
		0 calls	0
4	4%	**SCQR Participation/Engagement**	
		Participated in at least one MSQC activity listed in the supplement document.	4
		No Contribution: Did not participate in any activities listed in the supplement document.	0
5	4%	**SC Participation/Engagement**	
		Participated in at least one MSQC activity listed in the supplement document.	4
		No Contribution: Did not participate in any activities listed in the supplement document.	0
6	6%	**Completeness of Data (maximum 6 pts available)**	
		Sampled and incomplete cases <= 0.5% total volume	1
		Case Abstraction Audit with >=95% agreement	1
		30 day follow-up rate>=80% for 4th quarter 2025 (October – December cases)	1
		30 day follow-up rate>=80% for 1st quarter 2026 (Jan – March cases)	1
		30 day follow-up rate>=80% for 2nd quarter 2026 (April – June cases)	1
		30 day follow-up rate>=80% for 3rd quarter 2026 (July – September cases)	1
Bonus		Sites may earn additional points if the Surgeon Champion completes at least one activity listed below during the time period of 1/1/2026 to 12/31/2026. SC must have completed one other engagement activity to earn bonus points. - Complete an additional surgeon engagement activity - Bring an additional surgeon to a procedure-specific track at an MSQC meeting - Submit another hernia video by a surgeon different from other video submission(s)	5
		Participation Category Subtotal (not to exceed 30 points)	**30**

2026 Michigan Surgical Quality Collaborative (MSQC) Performance Index			
Measure #	Weight	Measure Description	Points
7	10%	**Collaborative Wide Measure: Preop Optimization: Reduce rate of persons with active tobacco use undergoing all elective non-cancer surgery <= 13% or>=10% relative reduction compared to 4/1/2024 to 3/31/2025 collaborative rate of 12.66%**	
		<=13% rate of tobacco use at the time of elective non-cancer surgery or>=10% relative reduction	10
		Moderate improvement (relative reduction of 5-9%)	5
		No significant improvement (relative reduction 0-4% or active tobacco use percentage increased)	0
8	10%	**Hospital Wide Measure: Preop Optimization: Reduce rate of persons with active tobacco use undergoing all elective non-cancer surgery to <= 13% or>=10% relative reduction compared to 4/1/2024 to 3/31/2025 hospital rate**	
		<= 13% rate of tobacco use at the time of elective non-cancer surgery or>=10% relative reduction	10
		Moderate improvement (relative reduction of 5-9%)	5
		No significant improvement (relative reduction 0-4% or active tobacco use percentage increased)	0
9	10%	**Hospital wide measure: Intraop multi-modal pain management for all patients except for those who experience intraop death** Increase rate of persons with intraop multi-modal pain management administration to >=85% or>=10% relative improvment compared to 4/1/2024 to 3/31/2025 hospital rate	
		>= 85 - 100% or>=10% relative improvement	10
		< 85%	0
10	40%	**Quality Improvement Initiative (QII) - choose from one of the following:** Option A: SUCCESS Option B: Frailty Option C: Breast Surgery Option D: Preoperative Testing (by invitation only) Option E: Colorectal Option F: Hernia	40
		Quality Improvement Category Subtotal (not to exceed 70 points)	70
Please note: Measures 1-6, 8-10 above are scored using hospital methodology. Measure 7 is scored using collaborative methodology.			

2026 Michigan Surgical Quality Collaborative
Performance Index Scorecard
Project Time Period: 1/1/2026 – 12/31/2026

Measure 4 and 5: SCQR & SC Participation/Engagement Supplemental Documentation*

In order to achieve their respective participation points, both the Surgeon Champion and the SCQR must <u>each</u> complete at least one activity listed below for the time period of 1/1/2026 to 12/31/2026.

***MSQC will make a final determination whether activities submitted for engagement points meet requirements for points to be awarded.**

Participation/ Engagement Activity	2026 Surgeon Champion (SC)/SCQR Engagement Activity Requirements

Executive Committee	• Committee members can only be the primary or alternate Surgeon Champion, and the primary SCQR.
	• Members must attend all in-person and virtual Executive Committee Meetings held in 2026.
	  ○ *Scheduled on the mornings of our Collaborative Meetings: 3/13, 10/2, and 12/11.
	  ○ *Only the assigned committee members will earn points for attendance. Delegate (alternate) attendees will not count toward engagement activity requirement.
	  ○ You must sign the Executive Committee attendance sheet and also check in at the MSQC conference registration table in order to earn P4P points.
	• Additional ad hoc meetings or surveys may be required throughout the year.
	• Limited number of membership appointments are available for 2026, which will be determined by lottery. Send your membership request to MSQCCustomerSupport@med.umich.edu by January 31, 2026. New members will be notified no later than February 9, 2026.

SUCCESS Stakeholder Committee	• Committee members can only be the primary/alternate Surgeon Champion or primary SCQR.
	• Must attend all in-person and virtual SUCCESS Stakeholder Committee Meetings held in 2026.
	  ○ *Scheduled on the days of our Collaborative Meetings: 3/13, 10/2, and 12/11.
	  ○ *Only the assigned committee members will earn points for attendance. Delegate (alternate) attendees will not count toward engagement activity requirement.
	  ○ You must sign the SUCCESS Stakeholder Committee attendance sheet and also check in at the MSQC conference registration table in order to earn P4P points.
	• Additional ad hoc meetings or surveys may be required throughout the year.
	• Limited number of membership appointments are available for 2025, which will be determined by lottery. Send your membership request to MSQC-Info@med.umich.edu by January 31, 2026. New members will be notified no later than February 9, 2026.

Breast Care Committee	• Committee members can only be the primary/alternate Surgeon Champion or primary SCQR.
	• Must attend all in-person and virtual Breast Care Committee Meetings held in 2026.
	  ○ *Scheduled on the days of our Collaborative Meetings: 3/13, 10/2, and 12/11.
	  ○ *Only the assigned committee members will earn points for attendance. Delegate (alternate) attendees will not count toward engagement activity requirement.
	  ○ You must sign the Breast Care Committee attendance sheet and also check in at the MSQC conference registration table in order to earn P4P points.
	• Additional ad hoc meetings or surveys may be required throughout the year.
	• Limited number of membership appointments are available for 2025, which will be determined by lottery. Send your membership request to MSQC-Info@med.umich.edu

Participation/ Engagement Activity	2026 Surgeon Champion (SC)/SCQR Engagement Activity Requirements
Present QI findings or serve as a content expert at a MSQC Collaborative Meeting (speaker or panel discussion)	• Present QI findings as a speaker or serve as a panelist at one of the MSQC Collaborative Meetings (if invited by MSQC). • Complete the participation obligation at the MSQC meeting. • Submit your presentation materials (if applicable) to MSQC prior to the MSQC Collaborative meeting.
Site-to-site collaboration efforts to disseminate best practices (facilitated by MSQC)	• Collaborate to share your MSQC-approved best practice(s) with another hospital site(s) that is (are) experiencing challenges with the same area of focus. * • MSQC will facilitate an in-person or virtual meeting to share best practices between the sites. This may or may not include another site coming to visit your hospital to see your process in action. • All sites will complete a post-collaboration survey distributed by MSQC. The survey must be completed within the MSQC-designated deadline. • All sites involved in the collaboration activity will receive P4P points. The SC and/or SCQR must be present during the activity in order to earn points. *Facilitated by MSQC, who will pair best practice site with a recipient site.
Serve in the role of mentor or mentee with another SCQR (**SCQR activity only**)	• SCQRs can volunteer to be a mentor if they are an abstractor with a minimum of 2 years' data abstraction experience. • SCQRs can request to be a mentee by providing information on their needs. SCQRs with less than 6 months' experience will receive priority. • MSQC-approved mentors will be partnered with a mentee to serve as a resource for 2026. • The mentor and mentee will communicate a minimum of once a month during the term of the mentorship. • The length of the mentorship will be a minimum of 6 months during the year for which P4P points are awarded. • MSQC will distribute surveys to both the mentor and mentee at intervals during the period of the mentorship to serve as a check-in. Both the mentor and mentee must complete these surveys within the designated survey response deadline. • Mentor or mentee volunteers that are not paired by MSQC with a site during the project year will not earn engagement points. • Ongoing participation points for extension of the mentor-mentee relationship into the subsequent QI project year will be determined on a case-by-case basis.

Local, state, or national conference presentation, using MSQC data to promote QI method and results	• Complete a presentation at a local, state, or national conference using MSQC data as the focus of the presentation.
	• MSQC must approve of conference sponsor.
	• MSQC must vet and approve the presentation content for P4P eligibility. After receiving acceptance by the conference sponsor, the final presentation material must be submitted to MSQC.
	• Submit conference sponsor-prepared documentation (agenda, brochure, bio, etc.) that contains the following elements to the MSQC Coordinating Center with annual QI project submission:
	  ○ Conference title
	  ○ Conference sponsor
	  ○ Conference date(s)
	  ○ Your presentation date (if multi-day conference)
	  ○ Session title
	  ○ Session description and/or goals
	  ○ Presenter name
	  ○ Presenter bio (if available)
	• Final presentation materials must be submitted to MSQC with the annual QI project submission.

Publish a peer-reviewed paper using MSQC data	• Listed as author on a paper using MSQC data in the analysis that is either published or accepted for publication in a peer-reviewed journal during the project year.

Participation/ Engagement Activity	2026 Surgeon Champion (SC)/SCQR Engagement Activity Requirements
	• Paper must reference that MSQC data was used. The BCBSM-approved disclaimer statement must be included in the article content or acknowledgements. • The SC and SCQR can earn P4P points on the same paper if they are both listed as authors. • Submit the formally published paper in the journal's format, the journal's name, volume, issue, Digital Object Identifier (DOI), and citation, to the MSQC Coordinating Center with the annual QI project submission. • Submit journal publisher's communication of acceptance for publication, along with the pre-publication version for papers that are accepted for publication during the project year, to the MSQC Coordinating Center with the annual QI project submission. Acceptance for publication communication must include journal name, date of communication, article name, author name(s), and intended date of publication. • A single paper can only be used one time to earn engagement points. Papers accepted for publication and awarded P4P engagement points in a calendar year cannot earn P4P engagement points for publication in a subsequent project year.
Complete MSQC-related qualitative interviews	• Opportunities may arise during the project year to participate in a qualitative interview to benefit research activities. • MSQC will indicate when a particular survey is eligible to earn engagement P4P points. • If a survey has a facility-centric focus, MSQC will determine if SC, or SCQR, or both, are eligible to earn engagement P4P points, in alignment with the goals of the survey. • MSQC must have evidence that the survey was **completed and returned** to the survey coordinating team **within the defined survey deadline** before points can be awarded.
Host an MSQC QI site visit (virtual or in-person)	• Plan and facilitate an MSQC site visit (virtual or in-person). • Engagement P4P points will only be awarded to the SC and/or SCQR that actively participates and is present at the event. • The number of opportunities will be based on MSQC team resources and content expert availability. Therefore, interested sites should contact MSQC Coordinating Center early in 2026 with their topic of interest and desired time of year. • Please note that it typically takes 2-3 months to plan a successful in-person site visit.
Create materials to be shared collaborative-wide (teaching, video, patient handouts)	• Submit your exceptional clinical resources, patient education materials or staff education resources on any of the MSQC related procedures/ interests to the MSQC Coordinating Center. • Submit the material via the MSQC survey process, which will include questions on how this content was developed, who were the stakeholders in the process, how the material was received/utilized at your facility, and the impact on your QI efforts. • MSQC will review your submissions and determine if it can be shared as a collaborative-wide resource. • To allow time for review, materials will not be accepted at the MSQC Coordinating Center any later than July 14, 2026. • Items that are selected and shared are eligible to earn P4P engagement points. • Points are awarded to both the SC and the SCQR if both participated in the development of the content. • Items that have not been significantly updated or altered, or shared with MSQC in the past, are not eligible for submission again.
Present MSQC data or updates at hospital meeting (**Surgeon Champion activity only**)	• Present **and discuss** MSQC data or updates at a Dept. of Surgery or other leadership-level hospital meeting (distribution of information via electronic or written meeting packets without any substantive discussion during the meeting does not meet the requirement). • Submit meeting agenda, minutes reflecting the discussion, and attendance roster (names, job title or dept. represented) to the MSQC Coordinating Center with the annual QI project submission. If necessary, you may redact other non-pertinent portions of the meeting minutes.
Additional opportunities that arise during the year	• Additional participation and engagement activities may arise during the year – pilot projects, research opportunities, beta testing of MSQC registry changes, etc.

Participation/ Engagement Activity	2026 Surgeon Champion (SC)/SCQR Engagement Activity Requirements
	• When these opportunities develop, MSQC will indicate if they are eligible for engagement P4P points, any requirements associated with them, and how to indicate your willingness to participate.

2026 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital - Year 1**			
Measure #	Weight	Measure Description	Points
Participation Measurement Period 1/1/26 - 12/31/26 (Except for measures 7 & 8 below)			
1	15%	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	15
		Attended 2 out of 3 meetings	10
		Attended 1 out of 3 meetings	5
		No Attendance	0
2	10%	**Meetings – Clinical Data Abstractor**	
		Attended all 3	10
		Attended 2 out of 3	6
		Attended 1 out of 3	3
		Attend 0	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 (9 calls/year)**	
		Participate on 9 calls	10
		Participate on 8 calls	6
		Participate on 7 calls	3
		Participate on less than 7 calls	0
5	10%	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one in person triannual MSSIC meeting	10
		No Attendance	0
6	10%	**Annual Audit Review – Data Review: Accuracy of data**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
7	15%	**All official documents signed: IRB and Business Associate Agreement** Measurement period: 10/1/25 - 7/31/26	

2026 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital - Year 1**			
Measure #	Weight	Measure Description	Points
		Within 2 months of Coordinating Center approval date to proceed	15
		Within 3 months of Coordinating Center approval date to proceed	12
		Within 4 months of Coordinating Center approval date to proceed	8
		Within 5 months of Coordinating Center approval date to proceed	4
		6 or more months of Coordinating Center approval date to proceed	0
8	15%	**Hire Data Abstractor in a timely manner** **Measurement period: 10/1/25 - 7/31/26**	
		Within 2 months of Coordinating Center approval date to proceed	15
		Within 3 months of Coordinating Center approval date to proceed	12
		Within 4 months of Coordinating Center approval date to proceed	8
		Within 5 months of Coordinating Center approval date to proceed	4
		6 or more months of Coordinating Center approval date to proceed	0
Please note: Measures 1-8 above are scored using hospital methodology.			

Michigan Spine Surgery Improvement Collaborative (MSSIC)
2026 Performance Index Scorecard Measure Explanation: Hospital, Year 1

CQI P4P Performance Index Scorecard supporting document

Measure number and description	Additional narrative describing the measure
Meetings, calls, and audits are based on calendar year (1/1/26 - 12/31/26).	
#1 - Meeting participation - Surgeon Champion: (Three meetings per calendar year.)	Please refer to the 2026 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. The surgeon champion(s) will attend all collaborative meetings and conference calls. If there is more than one surgeon champion at a site, each one is required to attend at least one in-person collaborative meeting and one call every year. If the surgeon champion is unable to attend, he or she will send a delegate surgeon to attend the meeting or call to fulfill the Performance Index. CMEs are awarded for attending meetings.
#2 - Meeting participation – Clinical Data Abstractor. It is required that the MSSIC Abstractor be present at all MSSIC meetings. If there are two abstractors, attendance by both is strongly encouraged, but at least one must attend to meet the measure. (Three meetings per calendar year.)	Please refer to the 2026 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. *MSSIC requires at least one MSSIC abstractor per site attend all Collaborative-wide meetings, and conference calls. If there is more than one abstractor at a site, each one is required to attend at least one in-person collaborative meeting and attend at least four calls. If an abstractor is unable to attend a collaborative meeting or be on a call, he or she will notify the coordinating center and will send a delegate abstractor to attend the meeting or call.
#3 - Conference Calls Surgeon Champion (Three calls per year.)	Please refer to the 2026 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements. *Please see description in measure #1 for more details.
#4 - Conference Calls - Clinical Data Abstractor. It is required that the MSSIC Abstractor be present on all calls. If there are two abstractors, attendance by both is strongly encouraged, but at least one must attend to meet the measure. (Nine calls per year.)	Please refer to the 2026 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements. *Please see description in measure #2 for more details.
#5 - Meeting participation - Administrative Lead (no designee), at least one in person meeting per year.	Please refer to the 2026 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. Meeting attendance must be in person. Only attending the virtual meeting does not meet the requirement.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
Measurement period for #7 & #8: 10/1/25-7/31/26	
#7 - All official documents signed: IRB and Business Associate Agreement	All required documents signed and returned to the MSSIC Program Manager. The timeframe associated with points earned begins with the email date from the MSSIC Program Manager notifying the site of approval to proceed with documents & hire.
#8 - Hire Data Abstractor in a timely manner	It is the site’s responsibility to notify the MSSIC Program Manager, in writing, when the data abstractor is hired. A start date for the abstractor must also be communicated. The timeframe associated with points earned begins with the email

	date from the MSSIC Program Manager notifying the site of approval to proceed with documents & hire.

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

2026 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 2**			
Measure #	Weight	Measure Description	Points
Participation Measurement Period (1/1/26 - 12/31/26) Performance Measurement Period (10/1/25 - 7/31/26) Baseline Measurement period (n/a, new process)			
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%	**Meetings – Clinical Data Abstractor**	
		Attended all 3	15
		Attended 2 out of 3	10
		Attended 1 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 (9 calls/year)**	
		Participate on 9 calls	10
		Participate on 8 calls	6
		Participate on 7 calls	3
		Participate on less than 7 calls	0
5	15%	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one in person triannual MSSIC meeting	15
		No Attendance	0
6	10%	**Annual Audit Review – Data Review: Accuracy of data -**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
Enhanced Recovery After Surgery (ERAS), Phase 1 Performance Measures - (20 points below) Measurement period: 10/1/25 - 7/31/26			
7	5%	**Demonstration of multidisciplinary team engagement through the submission of quarterly meeting attendance sheet and minutes supporting discussion and establishment of ERAS. (See supporting doc for details)**	
		3/3 meeting submissions	5
		2/3 meeting submissions	3
		0-1 meeting submissions	0

2026 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 2**			
Measure #	Weight	Measure Description	Points
8	15%	**No later than 7/31/26, each site will have submitted and obtained approval by the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program.** Measurement period: 10/1/25 - 7/31/26 Baseline period: n/a, new process	
		1.) ERAS protocol document outlining how each of the 6 required components will be implemented. Template provided by the Coordinating Center. 2.) Submission of ERAS supporting documents that support all 6 required components, including but not limited to: pre-surgical patient education, order sets, protocols, applicable screen shots from EMR, discharge instructions, and risk-assessment tools implemented in support of the ERAS program. See ERAS protocol document for the full list of supporting documents.	15
		One of the 6 required ERAS elements was not submitted and approved as demonstrated by the above documents.	7
		More than one of the 6 required ERAS elements was not submitted and approved as demonstrated by the above documents.	0
9	Bonus	Optional Bonus Participation Points: Bonus points are awarded to sites with above and beyond participation efforts as demonstrated by one of below activities. 1.) Surgeon Champion sits on a MSSIC Committee and demonstrates full engagement and participation as outlined in the support document. 2.) Abstractor sits on a MSSIC Committee and demonstrates full engagement and participation as outlined in the support document. 3.) By Coordinating Center invitation or approval, the site: • Contributes an article to the MSSIC Newsletter • Presents at a collaborative-wide meeting • Presents on an abstractor call • Contributes toward the Patient Advisory Group (input, patients, support a meeting). (*Sites will not exceed 100%. The bonus participation measure will only assist where points were lost on other participation measures.)	5
Please note: Measures 1-9 above are scored using hospital/ASF methodology.			

Michigan Spine Surgery Improvement Collaborative (MSSIC)
2026 Performance Index Scorecard Measure Explanation: Hospital & ASF, Year 2

CQI P4P Performance Index Scorecard supporting document.

Measure number and description	Additional narrative describing the measure
Participation measures are based on calendar year meetings, calls, and audit (1/1/26 - 12/31/26).	
#1 - Meeting participation - Surgeon Champion: Three meetings per calendar year	Please refer to the 2026 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. The surgeon champion(s) will attend all collaborative meetings and conference calls. If there is more than one surgeon champion at a site, each one is required to attend at least one in-person collaborative meeting and one call every year. If the surgeon champion is unable to attend, he or she will send a delegate surgeon to attend the meeting or call to fulfill the Performance Index. CMEs are awarded for attending meetings.
#2 - Meeting participation – Clinical Data Abstractor. It is required that the MSSIC Abstractor be present at all MSSIC meetings. If there are two abstractors, attendance by both is strongly encouraged, but at least one must attend to meet the measure. (Three meetings per calendar year.)	Please refer to the 2026 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. *MSSIC requires at least one MSSIC abstractor per site attend all Collaborative-wide meetings, and conference calls. If there is more than one abstractor at a site, each one is required to attend at least one in-person collaborative meeting and attend at least four calls. If an abstractor is unable to attend a collaborative meeting or be on a call, he or she will notify the coordinating center and will send a delegate abstractor to attend the meeting or call.
#3 - Conference Calls Surgeon Champion (Three calls per year.)	Please refer to the 2026 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements. *Please see description in measure #1 for more details.
#4 - Conference Calls - Clinical Data Abstractor. It is required that the MSSIC Abstractor be present on all calls. If there are two abstractors, attendance by both is strongly encouraged, but at least one must attend to meet the measure. (Nine calls per year.)	Please refer to the 2026 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements. *Please see description in measure #2 for more details.
#5 - Meeting participation - Administrative Lead (no designee), at least one in person meeting per year.	Please refer to the 2026 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. Meeting attendance must be in person. Only attending the virtual meeting does not meet the requirement.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
Enhanced Recovery After Surgery (ERAS) Performance Measures	
#7 - Demonstration of multidisciplinary team engagement through the submission of meeting attendance and minutes supporting discussion and establishment of ERAS. Measurement period: 10/1/25 - 7/31/26	Year-2 sites will demonstrate site engagement through the submission of meeting attendance and minutes which support the development and implementation of ERAS. The Coordinating Center will supply a “MSSIC 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 **three deliverables** are as follows:

	• Meeting between October 1 – December 31, 2025. **Submit form by January 5, 2026.** • Meeting between January 1 – March 31, 2026. **Submit form by April 5, 2026.** • Meeting between April 1 – June 30, 2026. **Submit form by July 5, 2026.**
#8 - No later than 7/31/26, each site will have submitted and obtained approval by the Coordinating Center, the following deliverables as evidence of a fully developed and implemented ERAS program. Measurement period: 10/1/25 - 7/31/26	It is important to note that all ERAS deliverables must be approved and finalized no later than 7/31/26. Simply submitting the deliverables by 7/31/26 does not meet the measure. This work is meant to be ongoing with deliverables being submitted throughout the performance period. The MSSIC QI team will coach sites if deliverables seem off-pace. • MSSIC ERAS Protocol Document (template provided by the Coordinating Center) outlining the process of how each of the 6 required components will be implemented at the site. The content should be high-level, and the template will provide fields for specific information that is requested. • Submission of applicable ERAS supporting documents: ○ Order sets, protocols, pre-surgical patient education (booklets, class PowerPoints, online education links, etc.), applicable screenshots from the EMR, comprehensive discharge instructions, and risk-assessment tools implemented in support of the ERAS program. These supporting documents will also be listed in each section of the ERAS Protocol Document to assist you.

#9 - **Optional, Bonus Participation Points:** Bonus points are awarded to sites with above and beyond participation efforts as demonstrated by one of described activities.	Five bonus points are available, and it is all or nothing.
	Surgeon Champion sits on a MSSIC Committee and demonstrates full engagement and participation as defined by the Committee upon which they will sit. Participates constructively, collaboratively, and cordially.
	  • For the Executive Committee this is defined as: Attend 2 out of the 3 Executive Committee meetings that follow the Collaborative-wide meetings. Respond in timely matter to email request for review of Coordinating Center proposals, questions and/or concerns. Attend at least 75% of ad hoc conference calls and/or virtual meetings.
	  • For the Publication Committee this is defined as meeting criteria outlined in the Committee Expectations document provided to Publication Committee members.
	  • For any other Surgeon Committees or Work Groups – Participation in at least 75% of meetings and meeting any other criteria outlined in documentation for the relevant work group.
	2.) Abstractor sits on a MSSIC Committee and demonstrates full engagement and participation as defined by the Committee upon which they will sit.
	  • For Abstractor Committee this is defined as: Attendance at 75% of committee meetings and timely email response to 75% of committee requests.
	3.) By Coordinating Center invitation or approval, the site:
	  • Contributes an article to the MSSIC Newsletter
	  • Presents at a collaborative-wide meeting
	  • Present on an abstractor call
	  • Contributes toward the Patient Advisory Group (input, patients, support a meeting).

***Sites will not exceed 100%. The bonus participation measure will only assist where points were lost on other attendance participation measures for calls and meetings. Bonus participation points will not count towards lost points on the audit score.**

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

2026 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older**			
Measure #	Weight	Measure Description	Points
Participation Measurement Period (1/1/26 - 12/31/26) Performance Measurement Period (10/1/25 - 7/31/26) Baseline Measurement period (8/1/24-1/31/25, unless otherwise stated			
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%	**Meetings – Clinical Data Abstractor**	
		Attended all 3	3
		Attended 2 out of 3	2
		Attended 1 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 (9 calls/year)**	
		Participate on 9 calls	3
		Participate on 8 calls	2
		Participate on 7 calls	1
		Participate on less than 7 calls	0
5	4%	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one in person 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	15%	**Hospital or ASF: Improve Dual collection rate of both a baseline and 90-day questionnaire (rounded to the nearest whole number) Measurement period: 10/1/25 - 7/31/26 Baseline period: 8/24/24 - 1/1/25**	
		Collection rate of 66% or more	15
		Collection rate of 51% - 65%	7
		Collection rate of less than 50%	0
8	20%	**Hospital or ASF: Improve compliance of presurgical Smoking Risk Assessment and Optimization before surgery (rounded to the nearest whole number). Measurement period: 10/1/25 - 7/31/26 Baseline period: 8/1/24 - 1/31/25**	
		>= 85% OR>= 20 percentage points of absolute improvement in the site's baseline collection rate	20
		61%-84% OR 11-19 percentage points of absolute improvement in the site's baseline collection rate	10

2026 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older**			
Measure #	Weight	Measure Description	Points
		<= 60% OR <= 10 percentage points of absolute improvement in the site's baseline collection rate	0
Site Specific: Each MSSIC site will do either 9a or 9b, depending on site's baseline data. The choice must be approved by the Coordinating Center and may be assigned. *See Support Document for additional details.*			
9a	15%	**Site Specific: Reduce the site ED Occurrence rate within 0-30 days after surgery Measurement period: 10/1/25 - 7/31/26 *Baseline period: 8/1/24 - 1/31/25**	
		ED occurrence within 0-30 days baseline rate <= 5.0% or a 3% reduction in the *baseline rate	15
		ED occurrence within 0-30 days 1.0%-2.99% reduction in the *baseline rate	8
		ED occurrence within 0-30 days < 1% reduction in the *baseline rate	0
9b	15%	**Site Specific: Reduce the site Readmission Occurrence rate within 0-30 days after surgery Measurement period: 10/1/25 - 7/31/26 Baseline period: 8/1/24 - 1/31/25**	
		Readmission occurrence within 0-30 days baseline rate <= 4.0% or a 3% reduction in the *baseline rate	15
		Readmission occurrence within 0-30 days 1.0%-2.99% reduction in the *baseline rate	8
		Readmission occurrence within 0-30 days < 1% reduction in the *baseline rate	0
10	20%	**Hospital or ASF: Improve the rate of patients that receive all required Presurgical Risk Assessments & Optimization (rounded to the nearest whole number).** Measurement period: 10/1/25 - 7/31/26 Baseline period: 8/1/24 - 1/31/25	
		>= 80% or greater, **OR**>=20 percentage points of absolute improvement in the *baseline rate	20
		60%-70%, **OR** 11-19 percentage points of absolute improvement from *baseline rate	14
		31%-59% **OR** 1-10 percentage points of absolute improvement from *baseline rate	7
		<= 30%, **OR** < 1% improvement from *baseline rate	0
11	**Bonus**	**Hospital or ASF: Optional Bonus Performance Points:** Bonus points are awarded to sites with above and beyond QI efforts as demonstrated by participating in at least one MSSIC pilot: Centralized Pain or Bone Health Optimization. Please see the Support Document for details. **(*Sites will not exceed 100%. The bonus performance measure will only assist where points were lost on other performance measures.)**	10

2026 Michigan Spine Surgery Improvement Collaborative (MSSIC) Quality Initiative Performance Index Scorecard **Hospital & ASF - Year 3 & Older**			
Measure #	Weight	Measure Description	Points
12	**Bonus**	**<u>Optional Bonus Participation Points</u>**: Bonus points are awarded to sites with above and beyond participation efforts as demonstrated by one of below activities. 1.) Surgeon Champion sits on a MSSIC Committee and demonstrates full engagement and participation as outlined in the support document. 2.) Abstractor sits on a MSSIC Committee and demonstrates full engagement and participation as outlined in the support document. 3.) By Coordinating Center invitation or approval, the site: • Contributes an article to the MSSIC Newsletter • Presents at a collaborative-wide meeting • Presents on an abstractor call • Contributes toward the Patient Advisory Group (input, patients, support a meeting). **(*Sites will not exceed 100%. The bonus participation measure will only assist where points were lost on other participation measures.)**	2
Please note: Measures 1-12 above are scored using hospital/ASF methodology.			

Michigan Spine Surgery Improvement Collaborative (MSSIC)
2026 Performance Index Scorecard Measure Explanation:
Hospital & ASF, Year 3 & Older

CQI P4P Performance Index Scorecard supporting document.

Measure number and description	Additional narrative describing the measure
Participation measures are based on calendar year meetings, calls, and audit (1/1/26 - 12/31/26).	
#1 - Meeting participation - Surgeon Champion: (Three meetings per calendar year)	Please refer to the 2026 MSSIC Surgeon Champion Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. The surgeon champion(s) will attend all collaborative meetings and conference calls. If there is more than one surgeon champion at a site, each one is required to attend at least one in-person collaborative meeting and one call every year. If the surgeon champion is unable to attend, he or she will send a delegate surgeon to attend the meeting or call to fulfill the Performance Index. CMEs are awarded for attending meetings.
#2 - Meeting participation – Clinical Data Abstractor. It is required that the MSSIC Abstractor be present at all MSSIC meetings. If there are two abstractors, attendance by both is strongly encouraged, but at least one must attend to meet the measure. (Three meetings per calendar year.)	Please refer to the 2026 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. *MSSIC requires at least one MSSIC abstractor per site attend all Collaborative-wide meetings, and conference calls. If there is more than one abstractor at a site, each one is required to attend at least one in-person collaborative meeting and attend at least four calls. If an abstractor is unable to attend a collaborative meeting or be on a call, he or she will notify the coordinating center and will send a delegate abstractor to attend the meeting or call.
#3 - Conference Calls Surgeon Champion (Three calls per year.)	Please refer to the 2026 MSSIC Surgeon Champion Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements. *Please see description in measure #1 for more details.
#4 - Conference Calls - Clinical Data Abstractor. It is required that the MSSIC Abstractor be present on all calls. If there are two abstractors, attendance by both is strongly encouraged, but at least one must attend to meet the measure. (Nine calls per year.)	Please refer to the 2026 MSSIC Data Abstractor Schedule for mandatory calls and to the MSSIC Eligibility and Expectations Document for participation requirements. *Please see description in measure #2 for more details.
#5 - Meeting participation - Administrative Lead (no designee), at least one in person meeting per year.	Please refer to the 2026 MSSIC Data Abstractor Schedule for details and location of mandatory meetings and to the MSSIC Eligibility and Expectations Document for participation requirements. Meeting attendance must be in person. Only attending the virtual meeting does not meet the requirement.
#6 - Annual Audit Review – Data Review: Accuracy of data	The abstractor(s) will participate in MSSIC Coordinating Center-led audits of charts of patients entered in the MSSIC registry to assure complete, quality data collection. Please see the MSSIC Manual of Operations, Section 2, “Abstractor Education and Training” for more details.
#7. Improve Dual collection rate of both a baseline and 90-day questionnaire (rounded to the nearest whole number) Measurement period: Questionnaires with due dates: 10/1/25 - 7/31/26 (This equates to surgery dates: 8/2/25-3/22/26) Baseline period: 8/24/24 - 1/1/25	MSSIC has modified its patient survey collection performance metric to help improve patient-reported outcomes data collection and quality. To measure change in patients and see if they improved in pain or physical function - both a baseline survey and a post-operative survey must be collected. For this metric a complete status for surveys will include surveys that have a scoreable PROMIS Physical Function form, a scoreable PHQ-2 form, and a scoreable pain scale for either cervical or lumbar surgery. For a site to meet dual collection they must

	have scoreable outcomes data on all three tools for both baseline and post-operative surveys. Sites will maintain responsibility for collecting post-op surveys for all sampled patients (including those without a baseline) at all time periods, however the performance metric will target patients with pre and post surveys. Collection of post-operative surveys, even when the baseline is missing, is still critical for MSSIC data as it shares information on items like satisfaction, opioid usage, and return to work.
#8 - Improve compliance of presurgical Smoking Risk Assessment and Optimization before surgery. Measurement period: 10/1/25 - 7/31/26 Baseline period: 8/1/24 - 1/31/25	Although the cardiovascular and respiratory complications related to smoking are well documented, an emerging body of literature suggests that tobacco addiction predisposes users to an increased incidence of postoperative complications in most surgical disciplines. Of particular interest to the practicing spine surgeon are the increased risks of nonunion, postoperative wound complications, and diminishment of both objective and subjective postoperative outcomes. Multiple investigators have reported cigarette use as a major independent risk factor for the development of a lumbar pseudarthrosis, as well as an association between smoking and worse clinical outcome measures and return to work rates in individuals undergoing lumbar spine procedures. The overall health benefits related to smoking cessation are well documented and include decreased risks of multiple types of primary malignancies, coronary and peripheral arterial disease, respiratory infection, cerebral vascular accident, and chronic pulmonary disease. Similarly, multiple investigators have reported significant benefits associated with tobacco cessation in patients undergoing spine surgery. Glassman et al noted significant improvements in fusion rates, satisfaction scores, and return to work rates in patients who refrained from smoking postoperatively, with results tending to be better in individuals who quit for more than 6 months after surgery. **Smoking Risk Assessment & Optimization Requirement** Spine surgery patients are to be assessed for smoking status and if they are a smoker, standardized interventions are to be implemented and evidence of this must be documented in the EMR. This can be documented in a standardized tool, or in a narrative note or smart phrase. Required: • Counseling a patient to quit and set a quit date • Provide resources for smoking cessation assistance If needed, depending on patient needs: • Prescribe, or refer to PCP to prescribe, medication assistance (Bupropion or Varenicline). • Possible delay of surgery until the patient quits If a site needs to revise their protocol and process to assure that their smoking cessation risk assessment and optimization protocol meets the minimum requirement, they are expected to do so and submit it for approval to the MSSIC QI team. *Jackson KL 2nd, Devine JG. The Effects of Smoking and Smoking Cessation on Spine Surgery: A Systematic Review of the Literature. Global Spine J. 2016 Nov;6(7):695-701. doi: 10.1055/s-0036-1571285. Epub 2016 Jan 15. PMID: 27781190; PMCID: PMC5077710.*

	Khurana VG. Adverse impact of smoking on the spine and spinal surgery. Surg Neurol Int 2021;12:118
Site Specific: Each MSSIC site will do either 9a or 9b, depending on site's baseline data. The choice must be submitted on the template provided and must be approved by the Coordinating Center (CC) by 9/5/25 or it may be assigned by the CC. • **If assigned, the CC will email the site no later than 7/25/25.** • **No QI Report template submissions, but use of the template is highly recommended to support your project. However,** ***A QI Poster presentation is required at the Nov. 2026 MSSIC meeting. The Coordinating Center will provide a template and guidelines for submission.***	
#9a - Site Specific: Reduce the site ED Occurrence rate within 0-30 days after surgery. Measurement period: 10/1/25 - 7/31/26 Baseline period: 8/1/24 - 1/31/25	Emergency department (ED) visits after spine surgery are a common, costly, and often unrecognized source of post-discharge hospital reutilization. Even when not associated with readmission, a return to the ED following spine surgery can be indicative of adverse postsurgical events. It is MSSIC's intention to identify methods to reduce this adverse event and improve the value of care for these patients. Our goal is to safely reduce or redirect ED visits to a more appropriate level of care after spine surgery where possible. Importantly, ED visits are associated with long wait times, high cost, low patient satisfaction, and generate almost half of all hospital readmissions. Therefore, ED visits after elective surgery constitute an important determinant of quality and cost of care. Although not yet targeted by large scale initiatives like the CMS Hospital Readmission Reduction Program, ED visits will matter in future bundled payment models. Emergency department (ED) visits cost ~$328.1 billion per year to the health care system, of which 19.6%, or $64.4 billion is potentially avoidable. (Galarraga JE, Pines JM. Costs of ED episodes of care in the United States. Am J Emerg Med. 2016; 34:357–365.) The average cost for an ED visit after elective, lumbar spine surgery was $1,455 (Jain, Nikhil MD*; Brock, John L. BA†; Phillips, Frank M. MD‡; Weaver, Tristan MD*; Khan, Safdar N. MD* 30-Day Emergency Department Visits After Primary Lumbar Fusion, Clinical Spine Surgery: April 2019 - Volume 32 - Issue 3 - p 113-119 doi: 10.1097/BSD.0000000000000766).
#9b - Site Specific: Reduce the site Readmission Occurrence rate within 0-30 days after surgery. Measurement period: 10/1/25 - 7/31/26 Baseline period: 8/1/24 - 1/31/25	Hospital readmission is a high-priority outcome metric in a variety of clinical areas and is used by CMS as a measure of hospital quality of care. A hospital readmission generally means the presence of a serious, potentially avoidable complication. Aside from the potential for some long-term health deficit due to the complication, a readmission involves much cost (to both payor and patient), time away from work or other preferred activity, and burden on the family members or other caregivers who help the patient with aspects of hospitalization. Readmissions often involve a blend of revision surgeries, treatment of SSIs, and other adverse events that are very expensive and traumatic for the patient. MSSIC has investigated the cost of an episode of readmissions. In addition, we have partnered with MVC on this cost study. At this time, we feel confident that a readmission can conservatively cost $17,977 per event.
#10 – Improve the rate of patients that receive all required Presurgical Risk Assessments & Optimization.	One of the six, required components of MSSIC Enhanced Recovery After Spine Surgery is standardized risk assessment and optimization. Given the physiologic and physical strain that

Measurement period: 10/1/25 - 7/31/26 Baseline period: 8/1/24 - 1/31/25	can be associated with spine surgery, it is important to optimize patients pre-operatively to improve outcomes and reduce the risk of post-operative complications (*Wang TY, Price M, Mehta VA, Bergin SM, Sankey EW, Foster N, Erickson M, Gupta DK, Gottfried ON, Karikari IO, Than KD, Goodwin CR, Shaffrey CI, Abd-El-Barr MM. Preoperative optimization for patients undergoing elective spine surgery. Clin Neurol Neurosurg. 2021 Mar;202:106445. doi: 10.1016/j.clineuro.2020.106445. Epub 2021 Jan 14. PMID: 33454498*.) MSSIC requires at least the following standardized risk assessments with optimization interventions: Blood sugar, Smoking, Opioids, and then a choice of either Nutrition or Anemia (however, both are encouraged). Risk assessments and optimization interventions must include a standardized assessment, defined thresholds that trigger or indicate optimization is needed, and standardized optimization interventions. They must be evidence based and supported in peer-reviewed literature. Risk assessment and optimization protocols must be submitted to the Coordinating Center and approved prior to capture in the registry. The cases that fall in the numerator for this measure are those where "yes" was captured for the variable: "*Were all ERAS risk assessments administered as agreed upon by your site*?" (Patients that are admitted emergently, as defined in the Master Variable List, are excluded from the denominator.) Answering "yes" to this variable is attestation that <u>all</u> required risk assessments as detailed above were <u>fully</u> implemented for that patient. If even one risk assessment was not fully implemented, you must answer, "no."
#11- **Optional, Bonus Performance Points**: Bonus points are awarded to sites with above and beyond QI efforts as demonstrated by participating in at least one MSSIC pilot: Centralized Pain or Bone Health Optimization.	Ten bonus points are available, and it is all or nothing. Bonus points are awarded to sites with above and beyond QI efforts as demonstrated by participating in at least one MSSIC pilot: Centralized Pain or Bone Health Optimization. Please contact the MSSIC QI team expressing your intent to participate no later than 9/1/25. Implementation must include all spine surgeons. Tool collection must begin no later than OR date 10/1/25 and the site must obtain an average compliance of at least 50% for the measurement period to qualify.
***Sites will not exceed 100% on the Performance Index. The bonus performance measure will only add ten points where points were lost on other performance measures. It will not assist where points were lost on participation measures.**	
#12 - **Optional, Bonus Participation Points:** Bonus points are awarded to sites with above and beyond participation efforts as demonstrated by one of described activities.	Two bonus points are available, and it is all or nothing. Surgeon Champion sits on a MSSIC Committee and demonstrates full engagement and participation as defined by the Committee upon which they will sit. Participates constructively, collaboratively, and cordially. • For the <u>Executive Committee</u> this is defined as: Attend 2 out of the 3 Executive Committee meetings that follow the Collaborative-wide meetings. Respond in timely matter to email request for review of Coordinating Center proposals, questions and/or concerns. Attend at least 75% of ad hoc conference calls and/or virtual meetings. • For the <u>Publication Committee</u> this is defined as meeting criteria outlined in the Committee Expectations document provided to Publication Committee members.

	• For any other Surgeon Committees or Work Groups – Participation in at least 75% of meetings and meeting any other criteria outlined in documentation for the relevant work group. 4.) Abstractor sits on a MSSIC Committee and demonstrates full engagement and participation as defined by the Committee upon which they will sit. • For Abstractor Committee this is defined as: Attendance at 75% of committee meetings and timely email response to 75% of committee requests. 5.) By Coordinating Center invitation or approval, the site: • Contributes an article to the MSSIC Newsletter • Presents at a collaborative-wide meeting • Present on an abstractor call • Contributes toward the Patient Advisory Group (input, patients, support a meeting).
***Sites will not exceed 100%. The bonus participation measure will only assist where points were lost on other attendance participation measures for calls and meetings. Bonus participation points will not count towards lost points on the audit score.**	

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

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

2026 Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
1	10%	**Accuracy of Data (January 1, 2026-December 31, 2026)**	
		5-star audit score	10
		4-star audit score	8
		3-star audit score	6
		<= 2-star audit score	0
2	8%	**Quarterly collaborative meeting participation – Surgeon Attendance (January 1, 2026–December 31, 2026)**	
		Surgeon attended 4 quarterly meetings and an Alternate Surgeon attended >=1 meeting	8
		Surgeon attended 3 quarterly meetings and an Alternate Surgeon attended >=1 meeting	6
		Surgeon attended 2 quarterly meetings and an Alternate Surgeon attended >=1 meeting	4
		Surgeon attended 1 quarterly meeting and an Alternate Surgeon attended >=1 meeting	2
		Surgeon attended 0 quarterly meetings or No Alternate Surgeon attendance	0
		To receive any points, at least one quarterly meeting must be attended by an Alternate Surgeon (a surgeon other than the designated Physician Champion).	
3	8%	**Quarterly collaborative meeting participation – Data Manager (January 1, 2026–December 31, 2026)**	
		Data Manager attended 4 quarterly meetings	4
		Data Manager attended 3 quarterly meetings	3
		Data Manager attended 2 quarterly meetings	2
		Data Manager attended 1 quarterly meeting	1
		Data Manager attended 0 quarterly meetings	0
4	4%	**Quarterly data manager educational meeting - Data Manager (January 1, 2026–December 31, 2026)**	
		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, 2026–December 31, 2026)**	
		Attended 4 PERForm meetings + Quality Report Submission	4
		Attended 3 PERForm meetings + Quality Report Submission	3
		Attended 2 PERForm meetings + Quality Report Submission	2
		Attended 1 PERForm meetings + Quality Report Submission	1
		Attended 0 PERForm meetings	0
		No points will be awarded unless a PERForm Quality Report is submitted	
6	15%	**Collaborative-wide quality initiative 2026: Isolated CAB - Reduction in intra/postoperative red blood cell transfusion (January 1, 2026–September 30, 2026)**	

2026 Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
		Collaborative mean intra/postoperative RBC transfusion rate 25% or less	15
		Collaborative mean intra/postoperative RBC transfusion rate greater than 25%	0
7	15%	**Site specific quality initiative (January 1,2026-September 30, 2026)**	
		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 (October 1, 2025–September 30, 2026)**	
		O/E <= 1.0	20
		O/E 1.1-1.5	10
		O/E > 1.5	0
9	20%	**Isolated Valve +/- CAB Mortality and Major Morbidity OE for 36 months (October 1, 2023–September 30, 2026)**	
		O/E <= 1.0	20
		O/E 1.1-1.5	10
		O/E > 1.5	0
10	5%	**Extra Credit Opportunities (Maximum of 5 Points; Index cannot exceed 100 points):**	
		1 point per approved participation activity for surgeons	
		5 points if target achieved at the hospital level in all 3 Cardiac Surgery VBR Measures	
Please note: Measures 1-5, 7-10 above are scored using hospital methodology. Measure 6 is scored using collaborative methodology.			

2026 MSTCVS Quality Collaborative
Performance Index – Supporting Documentation

Accuracy of data: Accuracy of Capturing all Critical Data Elements

Each site receives an audit score based on the number of deductions per case represented on a rating system from 1 star (>40.1 deductions/case) to 5 stars (<8.0 deductions per case.)

5-star audit score	10 pts
4-star audit score	8 pts
3-star audit score	6 pts
≤ 2-star audit score	0 pts

Quarterly Collaborative Meeting Participation - Surgeon Attendance
(January 1, 2026 - December 31, 2026)

The MSTCVS QC Physician Champion must attend all four 2026 MSTCVS Quality Collaborative meetings to receive full P4P points. If the Physician Champion is unable to attend, credit may be earned if another surgeon who performs cardiac surgery at the site attends in their place.

To receive any points, at least one quarterly meeting must be attended by an Alternate Surgeon (a surgeon other than the designated Physician Champion). This requirement applies to hospitals that had an Alternate Surgeon on record at any point during the year. Hospitals with no Alternate Surgeon on record for the entire year are exempt from the alternate attendance requirement.

Surgeon attended 4 quarterly meetings **and** an Alternate Surgeon attended ≥1 meeting	8 pts
Surgeon attended 3 quarterly meetings **and** an Alternate Surgeon attended ≥1 meeting	6 pts
Surgeon attended 2 quarterly meetings **and** an Alternate Surgeon attended ≥1 meeting	4 pts
Surgeon attended 1 quarterly meeting **and** an Alternate Surgeon attended ≥1 meeting	2 pts
Surgeon attended 0 quarterly meetings or No Alternate Surgeon attendance	0 pts

Quarterly Collaborative Meeting Participation – Data Manager Attendance
(January 1, 2026 - December 31, 2026)

The MSTCVS QC data manager must attend all four 2026 MSTCVS Quality Collaborative meetings to receive full P4P points.

Attended 4 quarterly meetings	4 pts
Attended 3 quarterly meetings	3 pts
Attended 2 quarterly meetings	2 pts
Attended 1 quarterly meeting	1 pts
Attended 0 quarterly meetings	0 pts

Quarterly Data Manager Educational Meeting - Data Manager
(January 1, 2026 - December 31, 2026)

The MSTCVS QC data manager must attend all four 2026 MSTCVS Quality Collaborative data manager educational meetings to receive full P4P points.

Attended 4 data manager educational meetings	4 pts
Attended 3 data manager educational meetings	3 pts
Attended 2 data manager educational meetings	2 pts
Attended 1 data manager educational meeting	1 pts
Attended 0 data manager educational meetings	0 pts

Quarterly PERForm Registry Meeting + Quality Report Submission - Perfusionist
(January 1, 2026 - December 31, 2026)

A perfusionist who works at the site must attend all four 2026 MSTCVS Quality Collaborative PERForm Registry meetings **and** submit a PERForm Quality Report to receive full P4P points. No points will be awarded if a Quality Report is not submitted. Attendance does not need to be by the same perfusionist at each meeting. A perfusionist may represent a maximum of two sites if they routinely practice at both.

Attended 4 PERForm Registry meetings + Quality Report Submission	4 pts
Attended 3 PERForm Registry meetings + Quality Report Submission	3 pts
Attended 2 PERForm Registry meetings + Quality Report Submission	2 pts
Attended 1 PERForm Registry meeting + Quality Report Submission	1 pts
Attended 0 PERForm Registry meetings / No Quality Report Submitted	0 pts

**No points will be awarded unless a PERForm Quality Report is submitted*

2026 MSTCVS Quality Collaborative
Performance Index – Supporting Documentation

Collaborative-Wide Quality Initiative (QI):

Isolated CAB – Reduction in Intra/Postoperative Red Blood Cell Transfusion
(January 1, 2026 – September 30, 2026)

Reduction of intraoperative and postoperative red blood cell transfusions in isolated CAB patients was chosen as the 2026 Collaborative-Wide quality initiative by the Quality Committee.

2026 Collaborative mean rate for intra/postoperative red blood cell transfusion of 25% or less……..	15 pts
2026 Collaborative mean rate for intra/postoperative red blood cell transfusion of greater than 25% ……	0 pts

Site Specific Quality Initiative (QI):

Determined by Site by November 2025 (January 1, 2026 – September 30, 2026)

Each MSTCVS Quality Collaborative site must select and implement a quality initiative for the 2026 calendar year. Initiatives must include baseline data from January-September 2025 and target goal(s) will be measured over January-September 2026. Full points will be awarded if stated improvement goal is achieved.

All initiatives will be reviewed and approved by the MSTCVS Quality Committee in November 2026. The MSTCVS Quality Committee will evaluate each site's improvement, using submitted progress reports and data, to determine eligibility for points.

Met improvement goal ……	15 pts
Improved but did not meet goal ……	10 pts
Implemented plan but did not improve ……	5 pts
No evidence that plan was implemented or no plan/report(s) submitted ……	0 pts

Met improvement goal	Improved but did not meet goal	Implemented plan but did not improve	No evidence that plan was implemented or no plan/report(s) submitted
Reports include a written QI plan with defined goals, initiatives, success/barriers, and documentation of successful implementation. January-September 2026 data demonstrate that the stated goal was achieved.	Reports include a written QI plan with defined goals, initiatives, successes/barriers, and documentation of successful implementation. January–September 2026 data demonstrate improvement but the target goal was not met.	Report includes a written QI plan with defined goals, initiatives, successes/barriers, and documentation of successful implementation. January–September 2026 data show no improvement compared with 2025 baseline data.	A QI plan was not implemented or Progress/Final reports were not submitted. Points will not be awarded without documentation of plan implementation and report submission.

Isolated CABG: O/E Mortality for 12 Months

(October 1, 2025 – September 30, 2026)

The National Society of Thoracic Surgeons (STS) provides an observed-to-expected (O/E) ratio for mortality that accounts for each patient's individualized preoperative risk and the expected mortality based on similar patients in the STS national database.

Participating sites must achieve an isolated CABG mortality O/E ratio of less than 1.0 to receive full points.

Individual hospital O/E isolated CAB mortality ≤ 1.0 ……	20 pts
Individual hospital O/E isolated CAB mortality 1.1-1.5 ……	10 pts
Individual hospital O/E isolated CAB mortality > 1.5 ……	0 pts

Isolated Valve +/- CAB Mortality and Major Morbidity O/E for 36 months

(October 1, 2023 – September 30, 2026)

The National Society of Thoracic Surgeons (STS) provides an observed-to-expected (O/E) ratio for mortality and major morbidity that accounts for each patient's individualized preoperative risk and the expected mortality or major morbidity based on similar patients in the STS national database.

Participating sites must have an isolated valve +/- CABG mortality and major morbidity O/E ratio of less than 1.0 to receive full points. Procedures include AVR, AVR + CAB, MVR, MVR + CAB, MV repair, and MV repair + CAB.

Individual hospital O/E isolated valve mortality ≤ 1.0 ……	20 pts
Individual hospital O/E isolated valve mortality 1.1-1.5 ……	10 pts
Individual hospital O/E isolated valve mortality > 1.5 ……	0 pts

2026 MSTCVS Quality Collaborative
Performance Index – Supporting Documentation

Extra Credit Opportunities: 1 point per approved activity for surgeons – (maximum 5 extra credit points)
Extra credit points may be awarded to supplement final scores. Maximum Performance Index score per site is 100. • Surgeons may be awarded **1 extra credit** point toward participation measures (#1-5) for approved activities. Examples include, but are not limited to, site visits, active participation in workgroups active participation (including Funded Projects Workgroup 2 of 4 meeting attendance), and presentations at quarterly MSTCVS-QC or MISHC meetings. • Five extra credit points may be awarded toward performance measures (#6-9) if all three VBR measures are achieved.

2026 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
1	10%	**Data Submission** Measurement period: (01/01/2026) - (12/31/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		On time and complete 3 of 3 times	10
		On time and complete 2 of 3 times	5
		On time and complete 1 of 3 times	0
2	10%	**Meeting Participation** Measurement period: (01/01/2026) - (12/31/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		Surgeon, and Manager (TPM) or Abstractor (MCR) attend 3 of 3 mtgs	9
		Surgeon, and Manager (TPM) or Abstractor (MCR) attend 2 of 3 mtgs	6
		Surgeon, and Manager (TPM) or Abstractor (MCR) attend 0-1 of 3 mtgs	0
		Registrar or Abstractor (MCR) attend June data abstractor mtg	1
3	10%	**Data Validation Error Rate** Measurement period: (01/01/2026) - (12/31/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		0.0-3.0%	10
		3.1-4.0%	8
		4.1-5.0%	5
		> 5.0%	0
4a	8	**Increase percentage of trauma patients that receive timely administration of Low Molecular Weight Heparin (LMWH) for Venous Thromboembolism Prophylaxis** Measurement period: (01/01/2025) - (06/30/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		>= 52.5% of patients (<= 48 hr)	8
		>= 50.0% of patients (<= 48 hr)	6
		>= 45.0% of patients (<=48 hr)	3
		< 45.0% of patients (<= 48 hr)	0
4b	7	**Increase the percentage of patients compliant with center's weight Based LMWH Venous Thromboembolism Prophylaxis protocol** Measurement period: (07/01/2025) - (06/30/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		>= 30% of patients with high BMI/weight (<=48 hours)	7
		>= 25% of patients with high BMI/weight (<=48 hours)	5
		>= 20% of patients with high BMI/weight (<=48 hours)	3
		< 20% of patients with high BMI/weight (<=48 hours)	0
		No protocol submitted	0
4c	5	**Venous Thromboembolism Prophylaxis Protocol Submission at discharge** Measurement period: (07/01/2025) - (06/30/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		Protocol submitted	5
		No protocol submitted	0
5	10	**Increase timely Surgical Repair (Age>=65) of Isolated Hip Fractures** Measurement period: (07/01/2025) - (06/30/2026) 12 months Baseline period: (01/01/2024) - (12/31/2024)	

2026 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
		>= 92.0% of patients (<= 42 hr)	10
		>= 87.0% of patients (<= 42 hr)	8
		>= 85.0% of patients (<= 42 hr)	5
		< 85.0% of patients (<= 42 hr)	0
6	10	**Improve the Massive Transfusion Red Blood Cell (RBC) to Plasma Ratio Weighted Mean for all trauma patients** Measurement period: (01/01/2025) - (06/30/2026) 18 months Baseline period: (01/01/2024) - (12/31/2024)	0-10
		<= 1.5 RBC to plasma ratio	10
		1.6-2.0 RBC plasma ratio	10
		2.1-2.5 RBC to plasma ratio	5
		> 2.5 RBC to plasma ratio	0
7	10	**Decrease Serious Complication rate** Measurement period: (07/01/2023) - (06/30/2026) 3 years Baseline period: (07/01/2022) - (12/31/2024)	
		< -1 (major improvement)	10
		-1 to 1 or serious complications low-outlier (average or better rate)	7
		> 1 (rates of serious complications increased)	5
8	10	**Decrease Mortality rate** Measurement period: (07/01/2023) - (06/30/2026) 3 years Baseline period: (07/01/2022) - (12/31/2024)	
		< -1 (major improvement)	10
		-1 to 1 or mortality low-outlier (average or better)	7
		> 1 (rates of mortality increased)	5
9	10	**Increase percentage of trauma patients receiving Timely Antibiotics for Open Femur/Tibia Fractures** Measurement period: (07/01/2025) - (06/30/2026) 12 months Baseline period: (01/01/2024) - (12/31/2024)	
		>= 85% of patients (<= 90 minutes)	10
		< 85% of patients (<= 90 minutes)	0
Bonus	2	**Optional Bonus for Death Performance Improvement Case Submission and Presentation** Measurement period: (7/1/25-6/30/26) 12 months Presentations at MTQIP meetings: (Oct 2025, Feb 2026, May 2026) Baseline period: (01/01/2024) - (12/31/2024)	
		Case submission and 15-minute presentation provided upon request	1.5
		Case submission and no meeting presentation provided upon request	0
		No case submission	0
Bonus	10	**Optional Bonus for MACS Participants**	0-10
Please note: MTQIP measures 1-8 and bonus measures above are scored using hospital methodology. Measure 9 is scored using collaborative methodology.			

2026 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
Optional 1	1	**MACS Data Submission** Measurement period: (01/01/2026) - (12/31/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		On time and complete 3 of 3 times	1
		On time and complete 2 of 3 times	0.5
		On time and complete 1 of 3 times	0
Optional 2	1	**MACS Meeting Participation** Measurement period: (01/01/2026) - (12/31/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		Surgeon, and Quality Administrator/Manager/Data Abstractor attends 3 of 3 mtgs	1
		Surgeon, and Quality Administrator/Manager/Data Abstractor attends 2 of 3 mtgs	0.5
		Surgeon, and Quality Administrator/Manager/Data Abstractor attends 0-1 of 3 mtgs	0
Optional 3	1	**MACS Data Validation Error Rate** Measurement period: (01/01/2026) - (12/31/2026) Baseline period: (01/01/2024) - (12/31/2024)	
		0.0-3.0%	1
		3.1-4.0%	0.8
		4.1-5.0%	0.5
		> 5.0%	0
Optional 4	1	**Increase MACS Evidence-Based Opioid Prescribing in patients receiving Appendectomy** Measurement period: (08/01/2025) - (07/31/2026) 12 months Baseline period: (01/01/2022) - (02/28/2025)	
		>= 80% patients (<= 60 discharge OME, oxycodone 5 mg = 8 pills)	1.5
		>= 70% patients (<= 60 discharge OME)	0.7
		< 70% patients (<= 60 discharge OME)	0
Optional 5	1.5	**Increase MACS Evidence-Based Opioid Prescribing in Cholecystectomy (Laparoscopic or Robotic)** Measurement period: (08/01/2025) - (07/31/2026) 12 months Baseline period: (01/01/2024) - (12/31/2024)	
		>= 80% patients (<= 60 discharge OME, oxycodone 5 mg = 8 pills)	1.5
		>= 70% patients (<= 60 discharge OME)	0.7
		< 70% patients (<= 60 discharge OME)	0
Optional 6	1	**Increase the percentage of patients with Appendectomies performed in Uncomplicated Appendicitis with Appendicolith on Computed Tomography** Measurement period: (08/01/2025) - (07/31/2026) 12 months Baseline period: (01/01/2024) - (12/31/2024)	
		>= 95% eligible patients	1
		>= 90% eligible patients	0.5
		< 90% eligible patients	0
Optional 7	1.5	**Readmission Z-Score Trend in Appendicitis** Measurement period: (08/01/2023) - (07/31/2026) 3 years Baseline period: (01/01/2024) - (12/31/2024)	
		< -1 (major improvement)	1.5
		-1 to 1 or serious complications low outlier (average or better rate)	0.7
		> 1 (rates of serious complications increased)	0.5
Optional 8	1.5	**MACS Meeting Presentation on Performance Index Metric Improvement Work or Cystic Duct Leak Management** Measurement period: (07/01/25-6/30/26) 12 months MACS Meeting Presentations (Sept 2025, Dec 2025, Apr 2026)	

2026 Michigan Trauma Quality Improvement Program (MTQIP) Collaborative Quality Initiative Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
		Baseline period: (05/01/24-4/30/25)	
		30 min presentation provided	1.5
		No presentation provided	0

2026 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard—**Year 1** Measurement Period 01/01/2026-12/31/2026			
Measure #	Weight	Measure Description	Points
1	18%	**OBI Semiannual Meeting Attendance**	
		OBI Physician Champion AND Midwife or Nurse Champion AND Clinical Data Abstractor (CDA) combined attendance	
		Spring Semiannual meeting	9
		Fall Semiannual meeting	9
2	15%	**Quality Initiative Engagement** **Measurement period: (01/01/2026 - 12/31/2026**	
		Submits Progress Review and Improvement Mapping for Execution (PRIME) Reports 5 times	
		Per submission	3
3	22%	**Data Accuracy and Completeness of Abstracted Data** **Measurement period: (01/01/2026) - (12/31/2026)**	
		1) Accuracy of Abstracted Data	`
		Data Quality Review score>=90%	10
		Data Quality Review score between 80.0 - 89.0%	5
		2) Timeliness of Abstracted Data	
		>= 95% of cases submitted within 90 days of delivery	5
		Between 80 - 94% of cases submitted within 90 days of delivery	3
		3) Primacy CDA successfully completes OBI training program and 1:1 follow up meeting with an OBI coordinator	5
		4) Primary CDA attends 2 CDA meetings in the measurement period	2
4	20%	**NTSV Cesarean Quality Improvement Planning** **Measurement period: (01/01/2026) - (12/31/2026)** **Baseline period: N/A new site, no baseline**	
		Entire site-specific Champion Team attends both NTSV Cesarean Optimization Group meetings	5
		2 QI Progress Calls, each with all 3 OBI Champions and hospital leader	15
5	5%	**Severe Obstetric Complications PC-07 eCQM** **Measurement period: (01/01/2026) - (12/31/2026)** **Baseline period: N/A new site, no baseline**	
		Submit eCQM Severe Maternal Complications (SMM) data to OBI for all 2025 births by 3/31/2026	5
6	15%	**Induction of Labor** **Measurement period: (01/01/2026) - (12/31/2026)** **Baseline period: N/A new site, no baseline**	
		>= 80% of frontline clinicians attend the virtual IOL Training Webinar or watch the recording by 06/30/2026	5
		Documentation rate for evidence-based IOL variables for relevant births with a delivery date between July - September 2026	
		>= 65% IOL variables	10
		between 55 - 64% IOL variables	5
7	5%	**Patient Reported Data** **Measurement period: (01/01/2026) - (12/31/2026)** **Baseline period: N/A new site, no baseline**	
		Establish a process to collect the Patient Voices Survey in patient setting by the end of the measurement period	5

2026 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard—**Year 1**			
Measure #	Weight	Measure Description	Points
Optional Bonus Points Sites can earn up to 5 bonus points total for the measurement period. Sites cannot exceed 100 points total.			
Optional		**Participation Based Bonus Points**	1
		Author an OBI publication	
		Present OBI data at a national meeting	
		Present (or identify a patient who presents) at an OBI Semiannual meeting	
		Actively participate on an OBI Committee	
		Keep the same Champion Team for the entire measurement period	
		Completely abstract the first page (Patient detail) of a case in the database within 15 days of infant date of birth for >=95% cases in the defined measurement period	2
Please note: Measures 1-7 above are scored using hospital methodology.			

2026 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard—**Year 2+**			
Measure #	Weight	Measure Description	Points
1	16%	**OBI Semiannual Meeting Attendance** **Measurement period: (01/01/2026) - (12/31/2026)**	
		OBI Physician Champion AND Midwife or Nurse Champion AND Clinical Data Abstractor (CDA) combined attendance	
		Spring Semiannual meeting	8
		Fall Semiannual meeting	8
2	5%	**Quality Initiative Engagement** **Measurement period: (01/01/2026 - 12/31/2026)**	
		Submits Progress Review and Improvement Mapping for Execution (PRIME) Reports 5 times	
		Per submission	1
3	9%	**Data Accuracy and Completeness of Abstracted Data** **Measurement period: (01/01/2026) - (12/31/2026)**	
		1) Data Quality Review Score>=97% 2)>=95% of cases from 01/01/2026 - 09/30/2026 completed and submitted prior to 90 days postpartum 3) Primary CDA attendance at OBI's in-person CDA training AND 2 CDA meetings in the measurement period	
		3 of 3 metrics met	9
		2 of 3 metrics met	5
4	35%	**NTSV Cesarean Quality Improvement Planning** Measurement period: (01/01/2026) - (12/31/2026) Baseline period: (01/01/2025) - (09/30/2025)	
		Group 2:	
		Optimization Group Meeting Attendance	35
		Group 1:	
		Optimization Group Meeting Attendance	3
		Dystocia Compliance>=80%	8
		Dystocia Compliance between 70 - 79%	5
		Case Review Completion	8
		Participation in 4 QI Progress Calls (4 points/ Call)	16
		Group 1 Augmented:	
		Optimization Group Meeting Attendance	2
		Dystocia Compliance>=80%	4
		Dystocia Compliance between 70 - 79%	2
		Case Review Completion	5
		Participation in 12 QI Progress Calls (1 point/ Call)	12
		Host 2 Site Visits (6 points/ Visit)	12
5	5%	**Severe Obstetric Complications PC-07 eCQM** **Measurement period: (01/01/2026) - (12/31/2026)** **Baseline period: (01/01/2025) - (12/31/2025)**	
		Successfully submit PC-07 Severe Obstetric Complications eCQM data to OBI for all 2025 births by 03/31/2026	5

2026 Obstetrics Initiative (OBI) Collaborative Quality Initiative Performance Index Scorecard—**Year 2+**			
Measure #	Weight	Measure Description	Points
6	20%	**Induction of Labor** **Measurement period: (01/01/2026) - (12/31/2026)** **Baseline period: N/A new measure**	
		>= 80% of each bedside clinician group attend the virtual IOL Training Webinar or watch the recording by 06/30/2026	8
		Documentation rate for evidence-based IOL variables for relevant births with a delivery date between July - September 2026	
		>= 75% IOL variables	12
		between 65 - 74% IOL variables	9
		between 55 - 64% IOL variables	6
7	10%	**Increase Patient Reported Data** **Measurement period: (04/01/2026) - (12/31/2026)** **Baseline period: (10/01/2025) - (12/31/2025)**	
		Site-specific, inpatient response rate of>=30% for deliveries in the measurement period cumulatively OR>=45% of deliveries for at least 3 consecutive months in the last 6 months of the measurement period	10
Optional	**Optional Bonus Points Sites can earn up to 5 bonus points total for the measurement period. Sites cannot exceed 100 points total. Participation bonus points may only be applied to Participation-based measures and may not exceed the Participation-based points total of 30. Performance bonus points may only be applied to Performance-based measures and may not exceed the Performance-based points total of 70.**		
	Participation-based Bonus Points		
		Author an OBI publication	1
		Present OBI data at a national meeting	
		Present (or identify a patient who presents) at an OBI Semiannual meeting	
		Actively participate on an OBI Committee	
		Keep the same Champion Team for the entire measurement period	
		Completely abstract the first page (Patient detail) of a case in the database within 15 days of infant date of birth for >=95% cases in the defined measurement period	2
	Performance-based Bonus Points		
		Implement the data integration process and utilize it as a method of abstraction by 12/31/26 (only sites not currently utilizing this process are eligible)	2
		Submit sepsis case count (denominator) and whether or not appropriate antibiotic treatment was administered (numerator) to MiAIM	
		Collaborative-wide NTSV Cesarean rate is <= 25.3%, achieved by 9/30/2026, without a rise in collaborative wide SNM/ SMM (based on the national average)	5
Please note: Measures 1-7 above are scored using hospital methodology.			

Obstetrics Initiative (OBI)
2026 Performance Index Scorecard Measure Explanation

Measure #1: OBI Semiannual Meeting Attendance	Champion engagement at each site is essential for learning and improvement to occur. The OBI Physician Champion (or a designated representative who must be an obstetrician or family physician actively practicing inpatient maternity care), Midwife or Nurse Champion (or a designated representative who must be actively providing inpatient maternity care) and Clinical Data Abstractor (CDA; or a designated representative), combined, must attend BOTH OBI Collaborative Meetings. All 3 individuals must attend to obtain the 8 points allocated to each meeting. OBI member hospitals must declare and provide contact information for their 2026 OBI Champions on the OBI Designation Form (submitted by 01/09/2026). During each Semiannual meeting registration period, sites will be able to identify designated representatives to replace declared Champions' attendance, if needed. Small-volume hospitals wishing for one individual to fulfill Semiannual attendance requirements for both the Nurse Champion and the CDA, or for both the Midwife Champion and the Physician Champion, can seek approval from the OBI Coordinating Center during the Semiannual meeting registration period. A clinical champion (physician, midwife, nurse) cannot represent two hospitals at a Semiannual meeting; points earned for attendance will go entirely to one hospital. Conversely, CDAs abstracting data for multiple sites can obtain attendance credit for multiple sites, with permission from the Coordinating Center.
Measure #2: Quality Initiative Engagement	OBI recognizes that progress for quality improvement work happens on a daily basis at the site level. The site will be awarded 5 points when the OBI Champions submit 5 Progress Review and Improvement Mapping for Execution (PRIME) Reports in the measurement period.
Measure #3: Data Accuracy and Completeness of Abstracted Data	OBI's quality initiatives depend on superb data integrity, relying on accurate and thorough case abstraction. With annual changes to the data manual and scorecard, interpretations of the data elements and quality initiatives may become varied. Therefore, education is paramount to the database's success. A site will be awarded the full 9 points for completing all 3 elements of the measure, and partial points may be attained for completing 2 elements. 1) Site Data Quality Reviews will ensure that abstracted data is consistent with the Data Collection Manual. The Site Data Quality Reviews will review cases from the previous measurement period. Compliance will be met if the final score is>=97%. Reviews must be completed by 10/31/2026. 2) Completeness and Timeliness will be measured for cases with delivery dates between 1/1/2026 and 9/30/2026. Compliance will be met if 95% of cases in the reporting period are completed and submitted prior to 90 days postpartum. 3) The primary CDA must attend the annual in-person CDA training. If a CDA is the primary abstractor at multiple sites, credit for attendance will be allocated to each site AND the primary CDA must attend>=2 CDA meetings (e.g. CDA calls, in-person CDA meeting at the Semiannual) in the measurement period. Credit will be awarded for virtual meetings if the CDA joins via the Zoom desktop or mobile app instead of dialing in by phone. This allows for full participation with interactive features like chat, screen sharing, and reactions, helping foster a more connected and engaging experience for all. If a CDA is the primary abstractor at multiple sites, credit for attendance will be allocated to each site.
Measure #4: NTSV Cesarean Measures	**NTSV Cesarean**: OBI offers a variety of activities to support member sites in their local quality improvement efforts. For the 2026 Scorecard, the OBI Coordinating Center will continue to assign each site to a Group for targeted quality improvement support. Sites will be notified of their assigned group no later than November 2025. Sites will be awarded points for this measure by completing the activities designated for their assigned group.
	Optimization Group Attendance: Each site-based Champion Team (i.e., the three individuals defined in Measure 1) must attend the 2/ 2 NTSV Cesarean Optimization Group meetings throughout the measurement period.
	Labor Dystocia Compliance: This measure element will track the proportion of NTSV patients undergoing unplanned cesarean for a primary indication of dystocia (including latent phase arrest, active phase arrest, arrest of descent, and failed induction) who meet the national criteria for dystocia as defined by ACOG/SMFM. All cases with latent phase arrest as the primary indication for dystocia will be considered non-compliant. This metric helps to determine the appropriateness of the decision for surgery. Sites will be awarded points if >=80% of all NTSV Cesareans performed for dystocia meet the national criteria. If the overall rate is between 70 – 79%, sites in Group 1 will be awarded 5 points; and sites in Group 1 Augmented will be awarded 2 points. Extremely small sites will have their dystocia cases reviewed at the end of the measurement period to determine compliance.
	Case Review: This measure element is a critical process that supports clinicians in lifelong learning

	and fosters continuous organizational improvement. High-volume sites (sites that max out at 100 cases) are required to conduct 32 reviews annually. Lower volume sites (sites that never max out at 100 cases) are required to conduct 20 reviews annually. Extremely small volume sites may be allowed to review fewer cases, with permission of the OBI Coordinating Center. Sites will be awarded points for conducting the required number of Case Reviews annually (the number is dependent on the hospital's case volume) and completing OBI's Case Review Submission Form. Quarterly submissions are encouraged. Documentation for successful Case Reviews may be found on the OBI Website.

	NTSV Cesarean Quality Improvement Planning: These measure elements will provide focused OBI Coordinating Center resources to the partnering site's specific needs. Meetings/ calls may include discussion of meaningful improvement goals, response to NTSV case review findings, identification of barriers to improvement, site-specific improvement strategies, or clinician education. Sites with fewer resources (e.g. little or no quality improvement support) may request more QI Progress calls.
	• QI Progress Calls: The entire site-based Champion Team and at least 1 hospital leader (e.g. a C-suite member, Executive leadership, Quality Director) will have virtual meetings with an OBI Quality and Outreach Coordinator in the measurement period. The hospital leader will be required to attend>=2 meetings. The required number of QI Progress calls will be dependent on the site's Group designation.
	  ○ *Group 2 sites*: If the NTSV Cesarean rate is stably low, or falls safely, no Progress Calls are required. If the NTSV Cesarean rate rises, or the rate falls with concerns about safety, that site will move up to fulfilling all of Group 1 requirements with 16 points awarded for Participation in 4 QI Progress Calls (4 points/ Call).
	  ○ *Group 1 and Group 1 Augmented Sites*: Participation in 4 (Group 1) and 12 (Group 1 Augmented) Progress Calls are required for full points; if the NTSV Cesarean rate is safely falling, the OBI Coordinating Center may determine that fewer calls are required to obtain full points.
	• Site Visits: High-volume sites (sites that max out at 100 cases) are required to have 70 staff/ faculty present at EACH site visit. Lower volume sites (sites that never max out at 100 cases) are required to have 32 staff/ faculty present at EACH site visit. Of the numerical threshold, 30% of each attending group (e.g., employed physician group, each private physician group, midwifery group if present at site, family medicine group if present at site) and 30% of the resident group (for sites with ObGyn and/or Family Medicine residencies) are required to be in attendance at EACH site visit.

Measure #5: Severe Obstetric Complications	**Severe Obstetric Complications** are often preventable. Reducing maternal morbidity and inequities in maternal morbidity burden across the population are key national and statewide priorities. Sites will be awarded 5 points for successfully submitting Severe Obstetric Complications PC-07 eCQM data for the 4 quarters of 2025, as specified by the Centers for Medicare and Medicaid Services (CMS), to the OBI Coordinating Center by 03/31/2026.
Measure #6: Induction of Labor Measures	**Induction of Labor Training Webinar:** Offering evidence-based techniques to manage induction of labor procedures is a new OBI initiative, and the evidence base may also be new to frontline clinicians. Sites will be awarded 8 points if 80% of their Physicians (resident and attending physicians), 80% of their Certified Nurse Midwives, and 80% of their nurses view OBI's Induction of Labor Training Webinar live or watch the recording by 06/30/2026. A signed attestation declaring compliance is due to the Coordinating Center by 06/30/2026. Sites will be randomly audited to assess compliance.
	Evidence-Based Induction of Labor Variables: The metric seeks to improve the quality of induction of labor data in the OBI registry, thereby enabling meaningful goal-setting to improve induction management and outcomes. The site will be awarded points for reducing the missingness (i.e. "Not Documented") of the evidence-based induction of labor database variables. The full 12 points will be awarded to the site if their documentation rate is>=75%. A site will earn 9 points if their documentation rate is between 65 – 74%, or 6 points if their documentation rate is between 55 - 64%. Missingness is calculated at the level of the evidence-based behavior (i.e. if any variable needed to assess compliance with a behavior is missing, that behavior is considered "missing") and aggregated to the hospital level. The measurement timeframe is 07/01/2026 - 09/30/2026.

Obstetrics Initiative (OBI)
2026 Performance Index Scorecard Measure Explanation

Measure #7: Patient Reported Data	**Patient Reported Data**: Collecting patient reported data allows OBI to incorporate patient feedback directly into performance measurement and quality improvement activities. Sites will be awarded 10 points for an inpatient-collected response rate that is>=3**0**% for deliveries during 04/01/26 - 12/31/26 OR>=45% of deliveries for at least 3 consecutive months in the last 6 months of the measurement period.