# MSQC 2024 QI Tracking Sheet and SUCCESS Project Summary

| **Hospital Name:** | [Insert Facility Name Here] |
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| **Summary Submitted By:** | [Enter Name of Report Submitter] |

## [SUCCESS Project Overview](#_SUCCESS_Project)

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| Goal 1. Capture all SUCCESS **data** in MSQC Workstation for eligible cases |
| Goal 2. **Multidisciplinary** Teama. Kickoff meeting by March 29, 2024b. Two (2) additional multidisciplinary meetings before December 1, 2024, including SUCCESS data and case review  |
| Goal 3. New sites only: Implement the elements of the SUCCESS **toolkit**Continuing sites only: Meet the **process/outcomes measures**  |
| Goal 4. Develop (new sites) or refine (continuing sites) the MSQC SUCCESS **urinary care pathway template** |
| Goal 5. Perform a **quality review** of the designated cases |
| Goal 6. Submit this 2024 QI Tracking Sheet and SUCCESS Project Summary to MSQC by **January 15, 2025.** Attach relevant documents with the submission or embed them within this document. |

## [Collaborative Wide Measure Overview](#_Collaborative_Wide_Measure)

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| **Collaborative Wide Measure\*: Preop Optimization for elective abdominal hernia surgery:**• Reduce rate of persons with body mass index (BMI) ≥ 40kg/m2 undergoing elective surgery to < 12.5% • Reduce rate of persons with active tobacco use undergoing elective surgery to < 15.5%.  |

## [Additional P4P Requirements Overview](#_Additional_QI_Project)

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| **Collaborative Meetings (4 offered) – Surgical Clinical Quality Reviewer (SCQR)** |
| **Collaborative Meetings (3 offered) – Surgeon Champion (SC)** |
| **Conference Calls (3 offered) – SCQR** |
| **SCQR Participation/Engagement** (Participate in at least one MSQC activity listed in the supplement document) |
| **SC Participation/Engagement** (Participate in at least one MSQC activity listed in the supplement document) |
| **Completeness of Data*** Sampled and incomplete cases ≤ 0.5% total volume (Cycle 33, 2023 to Cycle 32, 2024)
* Case Selection Audit with ≥ 95% agreement
* 30 day follow-up rate ≥ 80% for 4 quarters (October 1, 2023 to September 30, 2024)
 |
| **Complete documentation of designated cancer variables** (CRC, Breast, Whipple, Thyroid) > 90% |
| **Submit project report** detailing local processes and structures and outcomes for improving adherence to Collaborative Wide Measure |

# SUCCESS Project

## Goal 1. Capture all SUCCESS data

Capture all enabled variables in the SUCCESS tab for eligible cases (3 points)

## Goal 2. Multidisciplinary Team Meetings

Participating hospitals will establish a multidisciplinary team to review data, guide quality improvement and toolkit element implementation plans, and implement the MSQC SUCCESS urinary care pathway. Suggested participants include surgeon leadership/surgeon champion, surgeons/residents (general &

urology), executive leadership, anesthesiology, nursing supervisors for ER, Perioperative, PACU, and surgical units, quality department manager, patient safety, nursing education, and patient experience officer.

### Goal 2a. Multidisciplinary Kickoff Meeting

Kickoff meeting by March 29, 2024, to review project requirements and preliminary data. The SUCCESS Value Proposition/Leadership Engagement Briefing should be utilized during this meeting. New sites will complete the Readiness Assessment: Urinary Catheter Care Guide to Patient Safety (GPS) with the team (2 points).

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| Attach relevant documents with the submission or embed them here. Must include attendees with roles and minutes. Should include an agenda and/or slides.  |

### Goal 2b. Two (2) additional Multidisciplinary Meetings

Held before December 1, 2024, include a review of SUCCESS data and a quality review for cases for Goal 5 (2 points each meeting).

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| Attach relevant documents with the submission or embed them here for Meeting #1. Must include attendees with roles and minutes showing SUCCESS data was reviewed and a quality review of eligible cases. Should include agenda and/or slides. |

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| Attach relevant documents with the submission or embed them here for Meeting #2. Must include attendees with roles and minutes showing SUCCESS data was reviewed and a quality review of eligible cases. Should include agenda and/or slides. |

## Goal 3.Implement the elements of the SUCCESS toolkit (new sites only)

Submit a narrative of how the following toolkit elements were implemented/utilized. The narrative includes describing the current practice, activities tracking, summarizing success and barriers, providing an analysis/reflection, and identifying the next steps (15 points).

|   | What is your Current Practice?Examples include existing policies, procedures, and unwritten practices before implementation. This requires meeting with or rounding with the multidisciplinary team to discover what is happening. Or what is available. | Activities Tracking/Implementation Steps with dates:Examples (not all-inclusive): pertinent meetings held (include a meeting summary), communications with multidisciplinary team members, materials developed/modified, teaching with staff/patients; how are the elements implemented/utilized, data sharing |
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| Urinary Catheter GPS (Guide to Patient Safety) Tool | *(include a brief summary of the site GPS, describing potential barriers or challenges revealed here)* |  |
| Catheter Injury Prevention Tools1. Safe insertion booklet2. catheter insertion training videos 3. post-difficult catheter insertion patient card4. catheter alternatives |   |   |
| Urinary Retention Management Tools1. Algorithm for urinary retention and safe catheter insertion2. Voiding Trial Algorithm |   |   |
| Appropriate Catheter Use Tools1. MAP poster 2. Nurse Catheter Supply Checklist 3. Alternatives to Indwelling Catheters 4. BladderSafe phone app 5. Catheters (straight, coude) |   |   |
| Other Tools1. Training/Education process for physicians, residents, students, nurses, patients (packet, materials, poster, class, electronic tool, video, etc)2. Bladder scanners3. Urology consults4. Headlamps/lighting |   |   |

## Goal 3. Implement the elements of the SUCCESS toolkit (new sites only)

| **Category** | **Details** |
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| **Summary of Successes of Toolkit Implementation**Example questions:What has your hospital improved on?What are you most proud of? |  |
| **Summary of Barriers/Challenges to Toolkit Implementation**Example questions:What prevented you from improving more?What would you like to see changed?What resources do you need to make the implementation a success? |  |
| **Analyze/Reflect on the Implementation** Example questions:What was the process of ensuring toolkit elements were utilized after implementation?Are there other opportunities for improvement? How can you maintain this change? |  |
| **Next Steps** Example questions:What is the next step in your quality improvement efforts?What are your hospital’s plans going forward with these changes? |  |

## Goal 3. Meet the process/outcomes measures (continuing sites only)

**Measurement period:** 1/1/2024-12/31/2024 OR dates

**Scoring**: 15 points total, 3 points each measure

### Catheter use measures

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| 1. Avoid indwelling catheters intraoperatively in Category A\*: < 10% of cases have an indwelling catheter
 |  | 1. Catheter is removed in OR for > 75% of Category B\* cases
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| **Performance Tracking Grid** *(for your own use; you are not required to track your data here)* | **Baseline Rate:***<enter value here>* |
| **Tracking Time Period** | **Numerator** | **Denominator** | **Rate (%)** | **Cumulative Rate (%)** |
| *Example: Jan 2024* | *20* | *100* | *20%* | *20%* |
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| **Performance Tracking Grid** *(for your own use; you are not required to track your data here)* | **Baseline Rate:***<enter value here>* |
| **Tracking Time Period** | **Numerator** | **Denominator** | **Rate (%)** | **Cumulative Rate (%)** |
| *Example: Jan 2024* | *20* | *100* | *20%* | *20%* |
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### Urinary retention diagnosis and management measures

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| 1. Bladder scan volume is documented > 90% of the time if urinary catheterization for retention was performed
 |  | d. No urinary catheter is used for bladder scan volumes < 300 ml for > 90% of cases  |
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| **Performance Tracking Grid** *(for your own use; you are not required to track your data here)* | **Baseline Rate:***<enter value here>* |
| **Tracking Time Period** | **Numerator** | **Denominator** | **Rate (%)** | **Cumulative Rate (%)** |
| *Example: Jan 2024* | *20* | *100* | *20%* | *20%* |
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| **Performance Tracking Grid** *(for your own use; you are not required to track your data here)* | **Baseline Rate:***<enter value here>* |
| **Tracking Time Period** | **Numerator** | **Denominator** | **Rate (%)** | **Cumulative Rate (%)** |
| *Example: Jan 2024* | *20* | *100* | *20%* | *20%* |
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| 1. ISC was performed as opposed to an indwelling catheter

(unless volume > 500) for > 90% of cases |  |
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| **Performance Tracking Grid** *(for your own use; you are not required to track your data here)* | **Baseline Rate:***<enter value here>* |
| **Tracking Time Period** | **Numerator** | **Denominator** | **Rate (%)** | **Cumulative Rate (%)** |
| *Example: Jan 2024* | *20* | *100* | *20%* | *20%* |
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 | **\*** Category Definitions:Category A: Avoid Placement: Avoid placing indwelling urinary catheter for these procedures: inappropriate to use a catheter or risksoutweigh benefits (includes lap chole <2 hrs, lap/open appy <2 hrs, open groin hernia repair)Category B: Remove in OR: Consider removing indwelling urinary catheter before leaving the operating room (includes lap chole > 2 hrs, lap/open appy > 2 hrs, MIS groin hernia repair, open/MIS abdominal hernia repair < 3 hrs) |

## Goal 4. SUCCESS Urinary Care Pathway

With the multidisciplinary team, develop (new sites) or refine (continuing sites) the MSQC SUCCESS urinary care pathway template for your hospital’s practices. This will be implemented and utilized by the care team to ensure the use of each element of the SUCCESS toolkit. The care pathway should demonstrate what the processes are after the implementation of the toolkit components and how the toolkit elements are utilized at your hospital (8 points).

What is the Revised/Final Practice? Include specific details such as naming the toolkit element (what specifically is in the “toolkit”), where the element is implemented (the unit(s)/setting(s), is it the same for all units?), how the element is used, how people know about it. Include details like where bladder scanners are found, when they are used, any order sets or materials or policies developed or revised, what education is provided about the tools and when (during OR orientation or annual skills day?),patient education availability, etc.

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| Attach relevant documents with the submission or embed them here. |

Continuing sites only: Include a narrative of how any processes and toolkit elements were modified from 2023. Also include in the modified care pathway the process of coudé catheter training and comfort of use by nurses, and how patients at higher risk for urinary catheter trauma are identified.

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| Attach relevant documents with the submission or embed them here. |

## Goal 5. Perform case quality review

**Measurement period:** new sites from 4/1/2024 to 12/1/2024 OR dates, continuing sites from 1/1/2024 to 12/1/2024 OR dates.

An overall findings summary (trends identified, action plans implemented) for cases that meet any of the criteria below should be submitted (8 points):

1. Patients in Category A who have an indwelling urinary catheter placed in the OR.
2. Retention is assigned for patients who had a urinary catheter (ISC or indwelling) placed when < 300 ml is documented via a bladder scanner or the catheter use.
3. Patients who return to ED with Retention.
4. Patients who were discharged with an indwelling catheter or need for ISC.
5. Patients who have Urinary Catheter-Related Trauma assigned.

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| Attach relevant documents with the submission or embed them here. |

# Collaborative Wide Measure Tracking

Preop Optimization for elective abdominal hernia surgery

* Included CPT codes: Abdominal Hernia CPT codes (same CPT codes that enable hernia tab)
	+ Is CPT code the primary procedure = Yes
* Surgical Priority = Elective
* Disseminated Cancer = No or null

**Measurement Period**: 1/1/2024 - 12/31/2024 (cases in Workstation marked Complete (incl. follow-up) as of 1/15/2025 when the final data is pulled)

**Scoring**: points awarded depends on collaborative-wide performance (not individual hospital performance)

Meet both measures 20 points

Meet one measure 10 points

No measures met 0 points

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| Reduce rate of persons with body mass index (BMI) ≥ 40kg/m2 undergoing elective surgery to < 12.5%.Numerator: BMI value ≥ 40kg/m2 [Preop tab: Height/Weight entered] | Reduce rate of persons with active tobacco use undergoing elective surgery to < 15.5%.Numerator: Tobacco Use within 1 month – Cigarette=Yes |
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| **Performance Tracking Grid** *(for your own use; you are not required to track your data here)* |
| **Tracking Time Period** | **Your Hospital Rate (%)** | **MSQC Rate (%)** | **MSQC Cumulative Rate (%)** |
| *Example: Jan 2024* | *10%* | *20%* | *15%* |
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| **Performance Tracking Grid** *(for your own use; you are not required to track your data here)* |
| **Tracking Time Period** | **Your Hospital Rate (%)** | **MSQC Rate (%)** | **MSQC Cumulative Rate (%)** |
| *Example: Jan 2024* | *10%* | *20%* | *15%* |
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### Submit project report

Detail your hospital’s processes and structures for improving adherence to Collaborative Wide Measure (5 points).

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| Attach relevant documents with the submission or embed them here. |

# Additional P4P Requirements

### Meeting Attendance SCQR Call Attendance

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|  | Surgeon Champion (who attended?) | SCQR(who attended?) |  |  | SCQR (who attended?) |
| April 12 |  |  |  | February 8 |  |
| June 21 |  |  |  | August 8 |  |
| September 13  |  |  |  | November 7  |  |
| December 13 |  |  |  |  |  |

### Complete documentation of designated cancer variables

**Measurement period:** 4/1/2024 - 12/31/2024 (cases in Workstation marked Complete (incl. follow-up) as of 1/15/2025 when the final data is pulled)

**Scoring:** > 90% Overall Measure Rate = 5 points, < 90% = 0 points

[**Additional documentation**](https://msqc.org/wp-content/uploads/2024/01/2024-P4P-Cancer-variable-documentation.docx) islocated on the 2024 Quality Initiatives page of MSQC website

\*Use of this section is optional. You can track your progress using any method you prefer, and do not need to submit these numbers to MSQC at the end of the year. MSQC already has this data.

| **Time Period** | **Date Obtained** | **Colorectal Cancer (CRC)** | **Breast Cancer** | **Whipple Cancer** | **Thyroid Cancer** | **Overall Measureⱡ** |
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| Num | Denom | Rate % | Num | Denom | Rate % | Num | Denom | Rate % | Num | Denom | Rate % | **Num** | **Denom** | **Rate %** |
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ⱡOverall Measure Calculation:(CRC Num + Breast Num + Whipple Num + Thyroid Num) / (CRC Denom + Breast Denom + Whipple Denom + Thyroid Denom)

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| **Overall Measure Denominator: sum of all eligible:**Colorectal cancer cases + Whipple cancer cases + Breast cancer cases + Thyroid cancer cases | **Overall Measure Numerator:**Sum of all eligible denominator cases that have every designated cancer-specific variable present and documented in the patient’s medical record |

### SCQR Participation/Engagement Activity

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| Activity Description: Attach relevant documents with the submission or embed them here. |

### Surgeon Champion Participation/Engagement Activity

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| Activity Description:Attach relevant documents with the submission or embed them here. |