# MSQC 2025 QII Tracking Sheet and CRC Project Summary

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

## [CRC Project Overview](#_SUCCESS_Project)

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| Goal 1. Capture all CRC **data** in MSQC Workstation for eligible cases |
| Goal 2. Identify Colorectal **Surgeon Lead** |
| Goal 3. **Multidisciplinary Team meetings**  a. Kickoff meeting by March 29, 2025  b. Three (3) additional multidisciplinary meetings before December 31, 2025 |
| Goal 4. Perform a **checklist** **review** of the designated cases |
| Goal 5. Meet the **process improvement** goals |
| Goal 6. Participate in the **Colorectal Cancer Tumor Board Project** |
| Goal 7. Submit this 2025 QI Tracking Sheet and CRC Project Summary Report to MSQC by **January 16, 2025.** Attach relevant documents with the submission or embed them within this document. |

## [Collaborative & Hospital-Wide Measures 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) ≥ 40 kg/m2 undergoing elective surgery to < 11.5% or 10% relative reduction • Reduce rate of persons with active tobacco use undergoing elective surgery to < 14% or 10% relative reduction |
| **Hospital-Wide Measure: Preop Optimization for elective abdominal hernia surgery:** • Reduce rate of persons with body mass index (BMI) ≥ 40 kg/m2 undergoing elective surgery to < 11.5% or 10% relative reduction • Reduce rate of persons with active tobacco use undergoing elective surgery to < 14% or 10% relative reduction |

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

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| **Collaborative Meetings (3 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% of total volume (Cycle 33, 2024 to Cycle 32, 2025) * Case Selection Audit with ≥ 95% agreement * 30 day follow-up rate ≥ 80% for 4 quarters (October 1, 2024 to September 30, 2025) |
| **Complete documentation of designated cancer variables** (CRC, Breast, Whipple, Thyroid) > 90% |

# CRC Project

## Goal 1. Capture all CRC data

Capture all enabled variables in the CRC tab for eligible cases.

## Goal 2. Identify Colorectal Surgeon Lead

Surgeon Name and Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Goal 3. Multidisciplinary Team Meetings

Participants: Participating hospitals will form a multidisciplinary team to review baseline data, guide quality improvement plans, disseminate information at the hospital, and be actively engaged in meeting project goals. The multidisciplinary team must include providers from: General or Colorectal Surgery, Medical Oncology, Pathology, Radiology, and nursing or a cancer patient navigator. Other suggested specialties that may be included are: Radiation Oncology, Gastroenterology, Primary Care, or others as relevant to the particular hospital. (9 points total)

### Goal 3a. Multidisciplinary Kickoff Meeting

Kickoff meeting by March 29, 2025, to review project requirements and preliminary data. This should be a working meeting with the multidisciplinary team members who will be participating in the project, not simply an announcement of the project. (3 points)

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| Attach relevant documents with the submission or embed them here. Submit minutes, slides, a list of attendees, and their roles. |

### Goal 3b. Three (3) additional Multidisciplinary Meetings

At least three (3) additional quarterly multidisciplinary meetings before December 31, 2025, which include a review of colorectal cancer data including the results of colorectal-specific patient-reported outcomes (PROs), progress and plans to reach Process Improvement goals, and multidisciplinary checklist review of all positive flagged margin cases for the prior quarter. (2 points for each meeting)

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| Attach relevant documents with the submission or embed them here for Additional Meeting #1 | Attach relevant documents with the submission or embed them here for Additional Meeting #2 | Attach relevant documents with the submission or embed them here for Additional Meeting #3 |

## Goal 4. Perform Multidisciplinary Checklist Review

Perform an internal quality review of each colorectal cancer case that results in the following flagged cases from 1/1/2025 to 12/1/2025 OR dates.

(10 points).

In each quarterly multidisciplinary meeting (required participants described above in meetings, Goal 3), any flagged case during the prior quarter must be reviewed and the checklist must be filled out in RedCap. An example of the checklist for flagged cases is included at the end of the [CRC QII Summary](https://www.msqc.org/_files/ugd/f7f0b1_b37e36c055534de6b9369f5fd70d456c.pdf) document. The multidisciplinary team should identify any underlying trends among cases, and apply that knowledge toward process improvement efforts. The checklist filled out by the multidisciplinary team should be reviewed with the operating surgeon (if they are not part of the initial review).

Submit the Checklist in RedCap for each case. The number of checklists will be confirmed against the number of flagged cases collected at the participating hospital.

Submit an overall findings summary (including trends identified, action plans implemented for process improvement) for cases that meet any of the criteria below. You may use the table below or your own document.

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|  | **Trends Identified** | **Action Plans Implemented** |
| a) positive margins |  |  |
| b) inadequate lymph node examination (< 12 lymph nodes) |  |  |
| c) mismatch repair (MMR) protein or microsatellite instability (MSI) status not performed |  |  |
| d) rectal cancer not discussed in a Tumor Board |  |  |

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| If the table above is not used, attach relevant documents with the submission or embed them here. |

## Goal 5. Meet the process/outcomes measures

**Measurement period:** 4/1/2025 - 12/31/2025 OR dates

**Scoring**: 16 points total, 4 points each measure

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| * 1. **Performance Tracking Grid**   2. *(for your own use; you are not required to track your data here)* | **2024 Rate** | *Rate 1 Date* | *Rate 2 Date* | *Rate 3 Date* | *Rate 4 Date* | *Rate 5 Date* | *Rate 6 Date* | *Rate 7 Date* | *Rate 8 Date* | **Final 2025 Rate** |
| * 1. a. Preoperative imaging within 90 days before surgery for cancer staging for > 80% of elective colorectal cancer surgical patients |  |  |  |  |  |  |  |  |  |  |
| a1. For elective colon resections, this includes (1) CT of the Chest with or without IV contrast and (2) CT with IV contrast of the Abdomen and Pelvis or MRI of the abdomen and pelvis with or without IV contrast. |  |  |  |  |  |  |  |  |  |  |
| a2. For elective rectal resections, this includes (1) CT of the Chest with or without contrast and (2) CT with IV contrast of the Abdomen and Pelvis or MRI of the abdomen with or without IV contrast, and (3) MRI of the pelvis or endorectal ultrasound. |  |  |  |  |  |  |  |  |  |  |
| b. Examination of ≥ 12 lymph nodes on the surgical specimen for ≥ 95% elective colon cancer patients. Excludes rectal cancer cases with CPT codes 0184T, 45171, 45172. |  |  |  |  |  |  |  |  |  |  |
| c. MMR or MSI testing performed on the colon or rectal specimen either before (on biopsy) or after (on surgical specimen) surgery for ≥ 95% of all colorectal cancer surgical patients. |  |  |  |  |  |  |  |  |  |  |
| d. Increase or maintain the rate of PRO responses to the colorectal-specific questions from Q1 2025 compared to Q2 & Q3 2025 of all colorectal cancer surgical patients. |  |  |  |  |  |  |  |  |  |  |

## Goal 6. Participate in the Colorectal Cancer Tumor Board Project

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

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| Attach relevant documents with the submission or embed them here for Tumor Board Session #1 | Attach relevant documents with the submission or embed them here for Tumor Board Session #2 | Attach relevant documents with the submission or embed them here for Tumor Board Session #3 |

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| Attach relevant documents with the submission or embed them here for the Focus Group, including providers who attended. |

## Project Summary/Implementation Points/Oversampling

* An additional 0-5 implementation points may be granted based on the detail of the project summary/narrative; to be added to achieve the maximum of 45 CRC project points.
  + A 5-point narrative includes identifying pertinent activities in a tracking log all year (e.g., completing the table below), summarizing successes and barriers, providing an analysis/reflection, and identifying the next steps.
* An additional 5 points may be granted if all colorectal cancer cases are abstracted which includes oversampling of all eligible cases (including those that were Not Sampled), to be added to achieve the maximum of 45 project points. Oversampled cases will be included in the Process Improvement Goals.
  + **Did you oversample and abstract ALL eligible cases ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  | **Details** |
| --- | --- |
| **Activities Tracking for the year**  Examples (not all-inclusive): pertinent meetings held (include a meeting summary), communications with multidisciplinary team members, description of materials items developed/modified, teaching with staff/patients, data sharing |  |
| **Summary of Successes**  Example questions: What has your hospital improved on? What are you most proud of from participating in this project? |  |
| **Summary of Barriers/Challenges**  Example questions: What prevented you from improving more? What would you like to see changed? What resources do you need to make the implementation of this project a success? |  |
| **Analyze/Reflection**  Example questions:  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 with this project? Is it sustainable if you don’t participate again as an “official” MSQC project? |  |

# Collaborative & Hospital-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**: 1/1/2025 - 12/31/2025 (cases in Workstation marked Complete (incl. follow-up) as of 1/17/2026 when the final data is pulled)

**Scoring**: points awarded depends on collaborative-wide performance and hospital performance

A screenshot of a computer screen

Description automatically generated

|  |  |
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| Reduce rate of persons with body mass index (BMI) ≥ 40kg/m2 undergoing elective surgery to < 11.5% or 10% relative reduction.  Numerator: BMI value ≥ 40kg/m2 [Preop tab: Height/Weight entered] | Reduce rate of persons with active tobacco use undergoing elective surgery to < 14% or 10% relative reduction.  Numerator: Tobacco Use within 1 month – Cigarette=Yes |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Performance Tracking** *(for your own use; you are not required to track your data here)* | | | | | | **Tracking Time Period** | **Your Hospital Rate (%)** | **Your Hospital Cumulative Rate (%)** | **MSQC Rate (%)** | **MSQC Cumulative Rate (%)** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Performance Tracking**  *(for your own use; you are not required to track your data here)* | | | | | | **Tracking Time Period** | **Your Hospital Rate (%)** | **Your Hospital Cumulative Rate (%)** | **MSQC Rate (%)** | **MSQC Cumulative Rate (%)** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |

# Additional P4P Requirements

### MSQC Meeting Attendance SCQR Conference Call Attendance

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|  | **Surgeon Champion**  (who attended?) | **SCQR**  (who attended?) |  |  | **SCQR**  (who attended?) |
| April 11 |  |  |  | February 6 |  |
| September 12 |  |  |  | August 7 |  |
| December 12 |  |  |  | November 6 |  |

### Complete documentation of designated cancer variables

**Measurement period:** 1/1/2025 - 12/31/2025 (cases in Workstation marked Complete (incl. follow-up) as of 1/17/2026 when the final data is pulled)

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

[Additional documentation](https://www.msqc.org/_files/ugd/f7f0b1_9f98ccef11e9438f9ade59d56bb575b5.pdf) islocated on the 2025 Quality Initiatives page of the MSQC website. Your hospital report is available monthly in Dropbox.

Use of the tracking table below is optional, you do not need to submit these numbers to MSQC.

| **Tracking Time Period** | **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: **add all Numerators** (CRC + Breast + Whipple + Thyroid ) **÷ add all Denominators** (CRC + Breast + Whipple + Thyroid)

### SCQR Participation/Engagement Activity

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| Attach relevant documents with the submission or embed them here. Activity Description (does not include attending MSQC Collaborative meetings or SCQR conference calls): |

See this document for qualifying activities and requirements: [MSQC Participation/Engagement Supplemental Documentation](https://www.msqc.org/_files/ugd/d5fc0a_afdfdecaddd24f4eada12de70910cd00.pdf)

### Surgeon Champion Participation/Engagement Activity

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| Attach relevant documents with the submission or embed them here. Activity Description (does not include attending MSQC Collaborative meetings): |

See this document for qualifying activities and requirements: [MSQC Participation/Engagement Supplemental Documentation](https://www.msqc.org/_files/ugd/d5fc0a_afdfdecaddd24f4eada12de70910cd00.pdf)