# MSQC 2025 QII 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 Team meetings**  a. Kickoff meeting by March 31, 2025  b. Two (2) additional multidisciplinary meetings before December 1, 2025 |
| Goal 3. Meet the **process/outcomes measures** |
| Goal 4. Refine the MSQC SUCCESS **urinary care pathway** |
| Goal 5. Perform a **quality review** of the designated cases |
| Goal 6. Submit this 2025 QI Tracking Sheet and SUCCESS Project Summary 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% |

# 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 work within the multidisciplinary team to review data, guide quality improvement and toolkit element implementation plans, and refine 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. (8 points total)

### Goal 2ai. Multidisciplinary Kickoff Meeting

Kickoff meeting by March 31, 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. (4 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 2aii. Two (2) additional Multidisciplinary Meetings

Two (2) additional multidisciplinary team meetings (minimally) before December 1, 2025, which include a review of SUCCESS data and a quality review for cases in Goal 5. (2 points each)

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| Attach relevant documents with the submission or embed them here for Additional Meeting #1. Must include SUCCESS data review and a quality review of eligible cases. Submit minutes, slides, a list of attendees, and their roles. |

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| Attach relevant documents with the submission or embed them here for Additional Meeting #2. Must include SUCCESS data review and a quality review of eligible cases. Submit minutes, slides, a list of attendees, and their roles. |

## Goal 3. Meet the process/outcomes measures

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

**Scoring**: 20 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)* | **Final 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* | *Rate 9 Date* | **Final 2025 Rate** |
| ***Catheter use measures*** | | | | | | | | | | | |
| * 1. a1. Indwelling catheters are not used intraoperatively for > 90% of Category A\* cases (excluding lap appy) AND a2 (both need to meet) |  |  |  |  |  |  |  |  |  |  |  |
| a2. Indwelling catheters are not used intraoperatively for > 50% of Category A\* cases (lap appy only) AND a1 (both need to meet) |  |  |  |  |  |  |  |  |  |  |  |
| b. Indwelling catheters, if used, are removed in OR for > 90% of Category B\* cases |  |  |  |  |  |  |  |  |  |  |  |
| ***Urinary retention diagnosis and management measures*** | | | | | | | | | | | |
| c. Bladder scan volume is documented > 90% of the time before urinary catheterization if used, for cases with POUR |  |  |  |  |  |  |  |  |  |  |  |
| d. No urinary catheter is used for bladder scan volumes < 300 ml for > 90% of cases with POUR |  |  |  |  |  |  |  |  |  |  |  |
| e. ISC was performed as opposed to an indwelling catheter (unless volume > 500) for > 90% of cases with POUR |  |  |  |  |  |  |  |  |  |  |  |

**\*** Category Definitions:

Category A: Avoid Placement: Avoid placing indwelling urinary catheter for these procedures: inappropriate to use a catheter or risks

outweigh 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, continue refining the MSQC SUCCESS urinary care pathway which is your hospital’s utilization of each element of the SUCCESS toolkit. Include a narrative of how any processes, policies, and toolkit elements were modified from 2024, and include in the modified care pathway the process of educating about and using alternatives to catheters and coudé catheters, and how the voiding trial algorithm or similar was incorporated into practice if this was not included in 2024’s care pathway. (4 points)

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| Attach relevant documents, including the final care pathway and a narrative of modifications, with the submission or embed them here. |

## Goal 5. Perform case quality review

**Measurement period:** 1/1/2025 to 12/1/2025 OR dates.

Submit an overall findings summary (including trends identified, action plans implemented) for cases that meet any of the criteria below. You may use the table below or your own document. (10 points):

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|  | **Trends Identified** | **Action Plans Implemented** |
| 1. Patients in Category A who have an indwelling urinary catheter placed in the OR. |  |  |
| 1. 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. |  |  |
| 1. Patients who return to ED with Retention. |  |  |
| 1. Patients who were discharged with an indwelling catheter or need for ISC. |  |  |
| 1. Patients who have Urinary Catheter-Related Trauma assigned. |  |  |

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

## Project Summary/Implementation Points

An additional 0-10 implementation points may be granted based on the detail of the project summary/narrative; to be added to achieve the maximum of 45 project points. A 10-point narrative includes identifying pertinent activities in a tracking log all year, summarizing successes and barriers, providing an analysis/reflection, and identifying the next steps.

|  | **Details** |
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| **Activities Tracking for the year**  Examples (not all-inclusive): pertinent meetings held (include a meeting summary), communications with multidisciplinary team members, description of materials/toolkit items developed/modified, teaching with staff/patients; how are the elements implemented/utilized, data sharing |  |
| **Summary of Successes**  Example questions: What has your hospital improved on? What are you most proud of from participating in this project for 2-3 years? |  |
| **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:  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 with this project?  Is it sustainable even though it is no longer 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)