**MSQC 2025 Preoperative Testing for Low-Risk Surgeries QI Implementation Project**

**Tracking Sheet and Narrative Summary Report**

| **Facility Name:** | **[Insert Facility Name Here]** |
| --- | --- |
| **Report Submitted By:** | **[Enter Name of Report Submitter]** |
| **Facility Prior Year Project:** | [ ]  | **2024 Preoperative Testing Project Site** |  | [ ]  | **2023 Preoperative Testing Project Site** |
|  |

**Collaborative Wide Measure**

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| **Collaborative-Wide Measure (CWM)** | **Goal Description** | **Points** |
| **Preoperative optimization for elective abdominal hernia surgery\*** |
| Reduce rate of persons with body mass index (BMI) ≥ 40 kg/m2 undergoing elective abdominal hernia surgery to ≤ 11.5%, or 10% relative reduction compared to 10/1/2023 – 9/30/2024 hospital rate.  | **Meet both measures: 10 points****Meet one measure: 5 points****No measures met: 0 points** |
| Reduce rate of persons with active tobacco use undergoing elective abdominal hernia surgery to ≤ 14%, or 10% relative reduction compared to 10/1/2023 – 9/30/2024 hospital rate.  |
| **Measurement Period:** 1/1/2025 – 12/31/2025\* |
| **BMI ≥ 40 kg/m2****Measurement Denominator:**[Abdominal Hernia Surgery Cohort Definition](#AbdominalHerniaCohort) | **BMI ≥ 40 kg/m2 Measurement Numerator:**Denominator cases with BMI ≥ 40kg/m2 |
| **Active Tobacco Use Measurement Denominator:**[Abdominal Hernia Surgery Cohort Definition](#AbdominalHerniaCohort)**AND**Disseminated Cancer = No or is null | **Active Tobacco Use Measurement Numerator:**Denominator cases who smoked within the 30 days prior to surgery |
| **Report Monitoring Source:** [Workstation](http://msqc.arbormetrix.com/) Dashboard Collaborative Wide Measure report |
| \*Includes completed cases (including follow up) in the Workstation as of 1/16/2026 when MSQC pulls final data set to calculate P4P performance. |

**Abdominal Hernia Surgery Cohort Definition:**

* [Abdominal hernia procedure CPT code](#AbdHerniaCPT), **AND**
* Case Status = Sampled, **AND**
* Complete Status = Complete including 30-day follow-up, **AND**
* Surgical Priority = Elective, **AND**
* Is the CPT® code the intended primary procedure? = Yes

| **Abdominal Hernia CPT Codes** |
| --- |
| 49591 | 49591: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible |
| 49592 | 49592: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated |
| 49593 | 49593: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible |
| 49594 | 49594: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated |
| 49595 | 49595: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible |
| 49596 | 49596: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated |
| 49613 | 49613: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible |
| 49614 | 49614: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated |
| 49615 | 49615: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible |
| 49616 | 49616: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated |
| 49617 | 49617: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible |
| 49618 | 49618: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated |
| 49621 | 49621: Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible |
| 49622 | 49622: Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated |

**Collaborative-Wide Measure Tracking\***

\*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.

| **Goals:** | **BMI ≥ 40 kg/m**2 **(MSQC Goal: ≤ 11.5%, or 10% reduction)** | **Tobacco (MSQC Goal: ≤ 14%, or 10% reduction)** |
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| **Time Period** | **Date Obtained** | **MSQC Performance** | **Site Performance** | **MSQC Performance** | **Site Performance** |
| **Num** | **Denom** | **Rate %** | **Num** | **Denom** | **Rate %** | **Num** | **Denom** | **Rate %** | **Num** | **Denom** | **Rate %** |
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**Hospital-Wide Measure**

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| **Collaborative-Wide Measure (CWM)** | **Goal Description** | **Points** |
| **Preoperative optimization for elective abdominal hernia surgery\*** |
| Reduce rate of persons with body mass index (BMI) ≥ 40 kg/m2 undergoing elective abdominal hernia surgery to ≤ 11.5%, or 10% relative reduction compared to 10/1/2023 – 9/30/2024 hospital rate.  | **Meet both measures: 10 points****Meet one measure: 5 points****No measures met: 0 points** |
| Reduce rate of persons with active tobacco use undergoing elective abdominal hernia surgery to ≤ 14%, or 10% relative reduction compared to 10/1/2023 – 9/30/2024 hospital rate.  |
| **Measurement Period:** 1/1/2025 – 12/31/2025\* |
| **BMI ≥ 40 kg/m2****Measurement Denominator:**[Abdominal Hernia Surgery Cohort Definition](#AbdominalHerniaCohort) | **BMI ≥ 40 kg/m2 Measurement Numerator:**Denominator cases with BMI ≥ 40kg/m2 |
| **Active Tobacco Use Measurement Denominator:**[Abdominal Hernia Surgery Cohort Definition](#AbdominalHerniaCohort)**AND**Disseminated Cancer = No or is null | **Active Tobacco Use Measurement Numerator:**Denominator cases who smoked within the 30 days prior to surgery |
| **Report Monitoring Source:** [Workstation](http://msqc.arbormetrix.com/) Dashboard Collaborative Wide Measure report |
| \*Includes completed cases (including follow up) in the Workstation as of 1/16/2026 when MSQC pulls final data set to calculate P4P performance. |

**Hospital-Wide Measure Tracking\***

\*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.

| **Goals:** | **BMI ≥ 40 kg/m**2 **(MSQC Goal: ≤ 11.5%, or 10% reduction)** | **Tobacco (MSQC Goal: ≤ 14%, or 10% reduction)** |
| --- | --- | --- |
| **Time Period** | **Date Obtained** | **MSQC Performance** | **Site Performance** | **MSQC Performance** | **Site Performance** |
| **Num** | **Denom** | **Rate %** | **Num** | **Denom** | **Rate %** | **Num** | **Denom** | **Rate %** | **Num** | **Denom** | **Rate %** |
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**Complete Cancer Variable Documentation Measure (CRC, Breast, Whipple, Thyroid)**

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| **Cancer-Related Variable Documentation** | **Goal Description** | **Points** |
| **Complete documentation of designated cancer variables (CRC, breast, Whipple, thyroid)** **≥ 90%** | **5** |
| **Measurement Period:** 1/1/2025 – 12/31/2025\* |
| **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 |
| **Colorectal Cancer Denominator:**Includes all CRC CPT codes that enable CRC tab | **Colorectal Cancer Numerator:**1. If *Positive Surgical Margin* = Yes, *Which margin was positive?* ≠ “Not specified”

**AND**1. If ICD-10 diagnosis code = C20 **and if** (CPT≠ 45171, 45172 (local excision)), **and if** rectal cancer in middle or lower 1/3 location, then *TME Grade* ≠ “Not Graded”
 |
| **Breast Cancer Denominator:**Includes breast CPT codes and cancer/DCIS ICD-10 codes listed in Program Manual | **Breast Cancer Numerator:**1. *Date of diagnosis known* = “Yes”

**AND**1. *T stage* ≠ “Staging not performed””
 |
| **Whipple Cancer Denominator:**Includes all Whipple CPT codes | **Whipple Cancer Numerator:**1. *How Pancreatic Duct Size was determined* ≠ “Pancreatic duct size not measured”

**AND**1. *Pancreas Texture* ≠ “Not Reported”
 |
| **Thyroid Cancer Denominator:**Includes thyroid CPT codes and ICD-10 diagnosis code C73 | **Thyroid Cancer Numerator:**1. *T stage* ≠ “Staging not performed”

**AND**1. *Size of malignancy/tumor/mass* ≠ “Not Available”

**AND**1. *Postoperative surgical pathology results* ≠ “Complete histology unavailable”
 |
| **Report Monitoring Source**: QI push reports via [Dropbox](https://www.dropbox.com/) |
| \*Includes completed cases (including follow up) in the Workstation as of 1/16/2026 when MSQC pulls final data set to calculate P4P performance. |

[**Additional documentation**](https://msqc.org/wp-content/uploads/2024/11/2025_MSQC_Participation-Engagement_Details_11-25-2024-1.pdf) **located on the** [**2025 Quality Initiatives page of MSQC website**](https://msqc.org/quality-improvement/2025-msqc-quality-initiatives/)

**Complete Cancer Variable Documentation Measure Tracking\* (Goal: ≥ 90% for Overall Measure Rate)**

\*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** | **Breast Cancer** | **Whipple Cancer** | **Thyroid Cancer** | **Overall Measureⱡ** |
| --- | --- | --- | --- | --- | --- | --- |
| **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)

**Preoperative Testing for Low-Risk Surgeries QI Project**

**Project Description and supporting 2025 QI project and P4P documents/resources available on** **[2025 Quality Initiatives page of MSQC website](https://msqc.org/quality-improvement/2025-msqc-quality-initiatives/).** Be sure to reference the Final Preoperative Testing for Low-Risk Surgeries QII Summary description document, as it contains additional detail about the project.

**Cohort**: Eligible low-risk surgery cases will meet the procedure inclusion criteria:

* Minor hernia, laparoscopic cholecystectomy, and breast lumpectomy ([see CPT listing](#CohortList)) AND
* ASA Classes 1 and 2, AND
* Surgical Priority = Elective, AND
* Surgical Procedure Tab: Is the CPT code the intended primary procedure= Yes, AND
* Complete Status = Complete including 30-day follow-up (Case Admin.case\_completed = 1 – case abstraction complete including 30 day follow up)

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| **Abdominal Hernias less than 3 cm; all Inguinal and Femoral Hernias (“Minor Hernias”)** |
| 49505 | 49505: Repair initial inguinal hernia, age 5 years or older; reducible. |
| 49507 | 49507: Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated. |
| 49520 | 49520: Repair recurrent inguinal hernia, any age; reducible. |
| 49521 | 49521: Repair recurrent inguinal hernia, any age; incarcerated or strangulated. |
| 49525 | 49525: Repair inguinal hernia, sliding, any age. |
| 49550 | 49550: Repair initial femoral hernia, any age; reducible. |
| 49553 | 49553: Repair initial femoral hernia, any age; incarcerated or strangulated. |
| 49555 | 49555: Repair recurrent femoral hernia; reducible. |
| 49557 | 49557: Repair recurrent femoral hernia; incarcerated or strangulated. |
| 49591 | 49591: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible |
| 49592 | 49592: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated |
| 49613 | 49613: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible |
| 49614 | 49614: Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated |
| 49650 | 49650: Laparoscopy, surgical; repair initial inguinal hernia |
| 49651 | 49651: Laparoscopy, surgical; repair recurrent inguinal hernia |
| 49659 | 49659: Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy. |
| **Laparoscopic Cholecystectomy** |
| 47562 | 47562: Laparoscopy, surgical; cholecystectomy |
| 47563 | 47563: Laparoscopy, surgical; cholecystectomy with cholangiography |
| 47564 | 47564: Laparoscopy, surgical; cholecystectomy with exploration of common duct |
| **Breast Lumpectomy/Partial Mastectomy** |
| 19301 | 19301: Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy) |

**Project Point Distribution Overview**

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| **Goal** | **Goal Description** | **2025 Project Points** |
| **1** | **Data collection of 100% of preoperative testing use** | **3** |
| **2** | **In-depth QI analysis of existing protocol and CDS tool implementation from prior year(s) to identify action plan for current project year** | **15** |
| **3** | **Reduce the rate of unnecessary preoperative testing (20 points total)** |  |
| 3a | Reduce rate of preoperative testing by 20% as compared to baseline | **10** |
| 3b | Preoperative testing performed on the day of surgery must have supporting clinical documentation to justify the need for testing (Goal ≥ 90%) | **10** |
| **4** | **Conduct a minimum of two multidisciplinary meetings with key stakeholders (4 points total)** |  |
| 4a | Host a project kickoff meeting held no later than March 31, 2025 | **2** |
| 4b | Host at least one follow-up multidisciplinary meeting between July and December 2025 | **2** |
| **5** | **Performance Data Monitoring** | **3** |
|  | **Total** | **45** |
|  | Optional Implementation Points (based on detail of project narrative, tracking log and analysis) | **0-10** |

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| **Goal#** | **Goal Description** | **Points** |
| **1** | **Data collection (abstraction) completed for** **100% of eligible cases for preoperative testing project** | **3** |
| **Measurement Period:** 1/1/2025 – 12/31/2025\* |
| **Measure Denominator:** [Cohort definition](#Cohort)\*Includes completed cases (including follow up) in the Workstation as of 1/16/2026 when MSQC pulls final data set to calculate P4P performance. | **Measure Numerator:**Case documentation includes all of the following abstracted on all 9 diagnostic tests:1. Presence/absence of diagnostic test in EMR

**AND, if test was performed:**1. Date diagnostic test was performed

**AND, if 1 or more test dates = OR date:**1. “*Is clinical documentation present to support need for preop testing on DOS?*” is not null

**AND, if “*Is clinical documentation present to support need for preop testing on DOS?*” = Yes,** 1. “*What is the reason for testing on DOS?*” is not null

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| **Report Monitoring Source**: QI push reports via [Dropbox](https://www.dropbox.com/) |

**Data Collection Completeness Measure Tracking\* (Goal: 100%)**

\*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** | **Numerator** | **Denominator** | **Rate %** |
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| **Goal#** | **Goal Description** | **Points** |
| **2** | **In-depth QI analysis of existing protocol and CDS tool implementation from prior year(s) to identify action plan for current project year** | **15** |
| **Deliverable**: Submit a copy of the QI analysis on your hospital’s prior year(s) existing protocol and CDS tool implementation with your 2025 final project summary. |

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| **Goal#** | **Goal Description** | **Points** |
| **3** | **Reduce the rate of unnecessary preoperative testing (10 points each; 20 points total)** |  |
| **3a. Reduce rate of preoperative testing by 20% as compared to baseline** | **10** |
| **Baseline Period (2023 sites):** 4/1/2023 – 12/31/2023 |
| **Baseline Period (2024 sites):** 4/1/2024 – 12/31/2024 (lock date 4/30/2024) |
| **Measurement Period (all sites):** 4/1/2025 – 12/31/2025\* |
| Preop Days 1-30 Testing Measurement Denominator:[Cohort definition](#Cohort)**AND**Preop Testing variables are completely abstracted (e.g., is eligible for numerator in Goal #1) | Preop Days 1-30 Testing Measurement Numerator:Cases in the denominator with presence of at least one of the following preoperative diagnostic tests performed between Preop Day #1 and Preop Day #30 (excluding the day of surgery): A blue and black card with black text  Description automatically generated with medium confidence |
|  |
| **3b. Preoperative testing performed on the day of surgery has supporting clinical documentation to justify the need for testing (Goal ≥ 90%)** | **10** |
| **Baseline Period:** 1/1/2025 – 3/31/2025 |
| **Measurement Period:** 4/1/2025 – 12/31/2025\* |
| Day of Surgery Testing Measurement Denominator:[Cohort definition](#Cohort)**AND**Preop Testing variables are completely abstracted (e.g., is eligible for numerator in Goal #1)**AND**Cases with presence of at least one of the preoperative diagnostic tests is performed **on the day of surgery** (prior to In Room Time) | Day of Surgery Testing Measurement Numerator:Cases in the denominator where “*Is clinical documentation present to support need for preop testing on DOS?*” = YesA blue and black card with black text  Description automatically generated with medium confidence |
| **Report Monitoring Source:** QI push reports via [Dropbox](https://www.dropbox.com/) |
| \*Includes completed cases (including follow up) in the Workstation as of 1/16/2026 when MSQC pulls final data set to calculate P4P performance. |

**3a. Preoperative Testing Days 1-30 Measure Tracking\***

\*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.

| **Baseline Period (2023 sites): 4/1/2023 – 12/31/2023** |
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| **Baseline Period (2024 sites): 4/1/2024 – 12/31/2024ⱡ (lock date 4/30/2025)** |
| **Measurement Period (all sites): 4/1/2025 – 12/31/2025** |
| **Baseline: <enter final baseline rate>** |
| **20% Reduction Goal: <enter final reduction goal>** |
| **Time Period** | **Date Obtained** | **Numerator** | **Denominator** | **Rate %** | **% Reduction** |
| Baseline |  |  |  |  |  |
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**ⱡ**Baseline rate and reduction goal will continue to fluctuate until all cases are locked

**3b. Preoperative Testing Day of Surgery Measure Tracking\***

\*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.

| **Baseline Period: 1/1/2025 – 3/31/2025** |
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| **Measurement Period: 4/1/2025 – 12/31/2025** |
| **Goal: ≥ 90%** |
| **Time Period** | **Date Obtained** | **Numerator** | **Denominator** | **Rate %** |
| Baseline |  |  |  |  |
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| **Goal#** | **Goal Description** | **Points** |
| **4** | **Conduct a minimum of two multidisciplinary meetings with key stakeholders (4 points total)** |
| **4a: Host a project kickoff meeting held no later than March 31, 2025** | **2** |
| **Deliverable:** Submit presentation materials, meeting minutes, and an attendee list with each attendee’s department affiliation documented with your 2025 final project summary |
| **4b: Host at least one follow-up multidisciplinary meeting between July and December 2025** | **2** |
| **Deliverable:** Submit presentation materials, meeting minutes, and an attendee list with each attendee’s department affiliation documented with your 2025 final project summary. |
| **Multidisciplinary meeting requirements**1. For this project, attendees **must** include a general surgeon, anesthesiologist, and MSQC/QI department representation. Other stakeholders (e.g., family medicine, IM, preop clinic staff) may also attend. If the full complement of required attendees is not present at the meeting, no points will be awarded.
2. Meetings must be synchronous, and can be in person, virtual, or hybrid formats. Project information shared over email, or multiple one-on-one meetings do not count toward this requirement and will not be eligible to earn points.
3. Multidisciplinary meetings must meet the intent and spirit of a multidisciplinary meeting. This meeting is to be a **working meeting** with interactive discussion between team members about the QI project, current state, future state, project rollout, barriers, successes, and other pertinent issues.
4. Meetings where the project content is presented to attendees without meaningful project discussion are not acceptable. For example, presenting an overview of the MSQC P4P requirements/QI project at a monthly surgical dept/hospital quality committee as a single item in an otherwise busy agenda will not be eligible to earn points for this goal.
5. At a minimum, presentation materials, meeting minutes reflecting discussion and work about the project, and a listing of each attendee with their credentials and department affiliation are required in order to earn points for this goal. If an attendee list or the meeting minutes are not submitted, no points will be awarded. Presentation materials alone are not a substitute for either the meeting minutes or the attendee list.
6. The project summary must clearly state the date of the multidisciplinary meeting, and the documentation attached must be clearly labeled as being specifically for the multidisciplinary meeting in order to earn points for this goal. Multiple submissions of meeting documentation from unrelated meetings will not be reviewed by MSQC to determine if any of them meet multidisciplinary meeting requirements. For example, do not submit minutes from 12 monthly surgery department meetings as your multidisciplinary meeting and indicate “see attached files”. It is your responsibility to clearly indicate the exact date of the multidisciplinary meeting and attach the related required documentation for that meeting. Only those documents will be reviewed for goal eligibility.
 |

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| --- | --- | --- |
| **Goal#** | **Goal Description** | **Points** |
| **5** | **Performance Data Monitoring: utilize the MSQC and MVC data reports to monitor your site’s progress and identify when program adjustments are necessary. (3 points total)** |  |
| **5a: Access regularly distributed MSQC QI push reports from your site’s** [**Dropbox**](https://www.dropbox.com/login) **account, monitor performance, and share results with the project team at multi-disciplinary meetings**.  | **1** |
| **Deliverable:** Include documentation in meeting minutes (to be submitted with your 2025 final project summary) that addresses your data findings and interpretations. (1 point) |
| **5b. Access and download your site’s interactive preoperative testing reports from the MVC data registry application and discuss the report findings with your team during the multi-disciplinary meetings.** Meeting minutes should reflect discussion of the data findings.  | **2** |
| **Deliverable:** At a minimum, download the reports prior to each required multi-disciplinary meeting, and include a copy of each downloaded report as attachments to the meeting minutes. (1 point for each required meeting occurrence (prior to 3/31/2025, and again for July – December 2025)). Note: MVC will be offering data registry training in early 2025. MSQC will notify sites of training availability. |

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| **Goal#** | **Goal Description** |
| **6** | **2025 final project summary** |
| **Deliverable:** Submit the 2025 final project summary to the MSQC Coordinating Center no later than January 16, 2026. |
| The QII project summary will be submitted using the template available on the [MSQC 2025 QI web page](https://msqc.org/quality-improvement/2025-msqc-quality-initiatives/) of the MSQC website. The document will contain a narrative describing the adoption, implementation, and monitoring of a preoperative testing protocol for low-risk surgeries, along with successes, barriers, plans for moving forward with the project. Project/P4P deliverables are to be submitted with the final project summary (as indicated in the project and P4P goals)You must adhere to the [project submission requirements](#SubmissionReqs) outlined in this document |

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| **Optional****Implementation****Points** | **Description** | **Points\*** |
| **MSQC Optional Implementation Points** | **0-10 points added****per MSQC discretion** |
| MSQC has the option of awarding up to 10 additional implementation points. These “bonus” points are completely at MSQC’s discretion, available for instances when a site does not earn points on a QI measure, but their submitted project narrative clearly describes the significant QI implementation efforts put forth throughout the year. The details provided in the project narrative, tracking log and analysis are used to determine eligibility for the implementation points, should QI measure performance not meet the established threshold to earn points.\*Not to exceed 45 points total for final project score |

**Important Project Dates**

|  |  |
| --- | --- |
| **Date** | **Activity/Deliverable** |
| **4/1/2023 – 12/31/2023** | * Baseline period for Goal #3a (for 2023 sites): Reduce use of preoperative testing by at least 20% from baseline
 |
| **4/1/2024 – 12/31/2024** | * Baseline period for Goal #3a (for 2024 sites): Reduce the use of preoperative testing by at least 20% from baseline
 |
| **1/1/2025** | * Measurement period begins for Goal #1: Complete data collection on all 9 tests and date of surgery testing documentation
* Baseline period begins for Goal #3b: Preoperative testing performed on the day of surgery has supporting clinical documentation to justify the need for testing
 |
| **First week of every month** | * QI Push Reports distributed by MSQC Coordinating Center to site’s Dropbox account (tentatively scheduled to begin in March 2025)
 |
| **3/31/2025** | * Project kick-off multidisciplinary meeting deadline
* Baseline period ends for Goal #3b: Preoperative testing performed on the day of surgery has supporting clinical documentation to justify the need for testing
 |
| **4/1/2025** | * Measurement period begins for Goal #3a: Reduce use of preoperative testing by at least 20% from baseline (all sites)
 |
| **12/31/2025** | * Deadline for hosting second multidisciplinary meeting
* Measurement period ends (all measures)
 |
| **1/16/2026** | * 2025 QI Project with Tracking Sheets due to MSQC Coordinating Center
 |
| **1/16/2026** | * Measurement period data analyzed by MSQC\*

\*all eligible 2025 completed cases in Workstation as of this date |

**Complete the Preoperative Testing for Low-Risk Surgeries Summary Report**

**Due to the MSQC Coordinating Center by January 16, 2026. Attach relevant documents with report submission.**

**See** [**important project submission information**](#SubmissionReqs) **below\***

| **Preoperative Testing QI Project** | **Preoperative Testing QI Project Activity/Category Details** |
| --- | --- |
| **Activities**Examples (not all-inclusive):Dates; meetings; materials developed; education materials; clinical decision support tools created; communications with multidisciplinary team members; any teaching done with staff | **Enter information here** |
| **Successes**Example questions:What has your hospital improved on?What are you most proud of? | **Enter information here** |
| **Barriers/challenges**Example questions:What prevented you from improving more?What would you like to see changed? | **Enter information here** |
| **Analysis/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? | **Enter information here** |
| **Goal #2 Deliverable**Submit a copy of your site’s In-depth QI analysis of existing protocol and CDS tool implementation from prior year(s) to identify action plan for current project year | **Enter information/embed files here** |
| **Goal #4a Deliverable**Multidisciplinary Project Kickoff Meeting held by March 31, 2025. Submit presentation materials, meeting minutes, and an attendee list with each attendee’s department affiliation | **Enter information/embed files here** |
| **Goal #4b Deliverable**2nd multidisciplinary project meeting held between July and December 2025.Submit presentation materials, meeting minutes, and an attendee list with each attendee’s department affiliation | **Enter information/embed files here** |
| **Goal #5a Deliverable**Access regularly distributed MSQC QI push reports from your site’s Dropbox account, monitor performance, and share results with the project team at multi-disciplinary meetings. Include documentation in meeting minutes that addresses your data findings and interpretations.. | **Enter information/embed files here** |
| **Goal 5b Deliverable**Access and download interactive preoperative testing reports from the MVC data registry application and discuss the report findings with your team during the multi-disciplinary meetings. Meeting minutes should reflect discussion of the data findings. Include a copy of each downloaded report as attachments to the meeting minutes. | **Enter information/embed files here** |

**SCQR and Surgeon Champion Participation/Engagement Activities**

Additional detail regarding this P4P Scorecard requirement is available in the following document posted on the [2025 QI page of the MSQC website:](https://msqc.org/quality-improvement/2025-msqc-quality-initiatives/)

[SCQR & SC Participation/Engagement Supplemental Documentation](https://msqc.org/wp-content/uploads/2024/11/2025_MSQC_Participation-Engagement_Details_11-25-2024-1.pdf)

Indicate the engagement activities completed by the SCQR and Surgeon Champion at your site.

|  | **SCQR Engagement Activity** | **Surgeon Champion Engagement Activity** |
| --- | --- | --- |
|  |  |  |
| **Engagement Activity** | **Activity Completed by SCQR** | **Documents Attached Below (if required)** | **Documents Submitted at Earlier Date to MSQC (enter date)** | **Activity Completed by SC** | **Documents Attached Below (if required)** | **Documents Submitted at Earlier Date to MSQC (enter date)** |
| Executive Committee | [ ]  |  |  | [ ]  |  |  |
| SUCCESS Stakeholder Committee | [ ]  |  |  | [ ]  |  |  |
| Breast QI Committee | [ ]  |  |  | [ ]  |  |  |
| MVC Preoperative Testing Workgroup (3 of 4 events) | [ ]  |  | [ ]  |  |
| Present QI findings or serve as a content expert at a MSQC Collaborative Meeting (speaker or panel discussion) | [ ]  | [ ]  | **<enter date submitted>** | [ ]  | [ ]  | **<enter date submitted>** |
| Site‐to‐site collaboration efforts to disseminate best practices (facilitated by MSQC) | [ ]  | [ ]  | **<enter date submitted>** | [ ]  | [ ]  | **<enter date submitted>** |
| Serve in the role of mentor or mentee with another SCQR (**SCQR activity only**) | [ ]  | [ ]  | **<enter date submitted>** |  |
| Local, state, or national conference presentation, using MSQC data to promote QI method and results | [ ]  | [ ]  | **<enter date submitted>** | [ ]  | [ ]  | **<enter date submitted>** |
| Publish a peer‐reviewed paper using MSQC data | [ ]  | [ ]  | **<enter date submitted>** | [ ]  | [ ]  | **<enter date submitted>** |
| Complete MSQC-related qualitative interviews | [ ]  | [ ]  | **<enter date submitted>** | [ ]  | [ ]  | **<enter date submitted>** |
| Present a poster using MSQC data at the September 2024 MSQC Collaborative Meeting | [ ]  | [ ]  | **<enter date submitted>** | [ ]  | [ ]  | **<enter date submitted>** |
| Host an MSQC QI site visit (virtual or in-person) | [ ]  |  |  | [ ]  |  |  |
| Create materials to be shared collaborative-wide (teaching, video, patient handouts) | [ ]  | [ ]  | **<enter date submitted>** | [ ]  | [ ]  | **<enter date submitted>** |
| Present MSQC data or updates at hospital meeting (**Surgeon Champion activity only**) |  | [ ]  | [ ]  | **<enter date submitted>** |
| Additional opportunities that arise during the year**<enter name of activity here>** | [ ]  | [ ]  | **<enter date submitted>** | [ ]  | [ ]  | **<enter date submitted>** |
| **Attach/embed required documents here 🡪** | **Enter information/embed files here** | **Enter information/embed files here** |