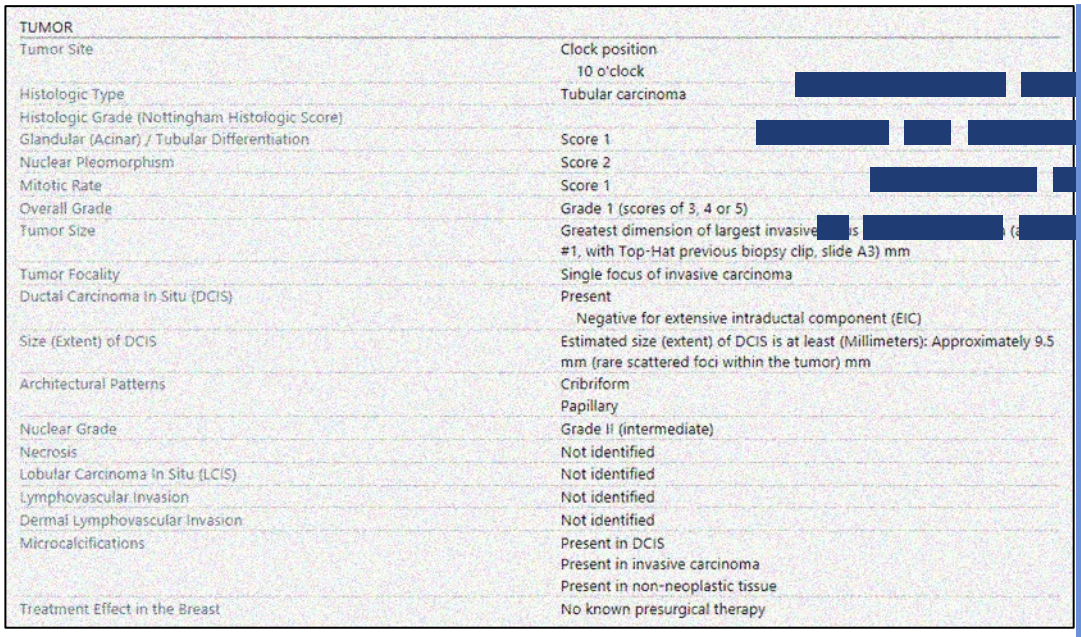
IN CASE YOU MISSED IT

SCQR NEWSLETTER | FEBRUARY 2023 | ISSUE FOUR

MSQC
MICHIGAN SURGICAL QUALITY COLLABORATIVE



TUMOR	
Tumor Site	Clock position 10 o'clock
Histologic Type	Tubular carcinoma
Histologic Grade (Nottingham Histologic Score)	
Glandular (Acinar) / Tubular Differentiation	Score 1
Nuclear Pleomorphism	Score 2
Mitotic Rate	Score 1
Overall Grade	Grade 1 (scores of 3, 4 or 5)
Tumor Size	Greatest dimension of largest invasive [redacted] (a #1, with Top-Hat previous biopsy clip, slide A3) mm
Tumor Focality	Single focus of invasive carcinoma
Ductal Carcinoma In Situ (DCIS)	Present Negative for extensive intraductal component (EIC)
Size (Extent) of DCIS	Estimated size (extent) of DCIS is at least (Millimeters): Approximately 9.5 mm (rare scattered foci within the tumor) mm
Architectural Patterns	Cribriform Papillary
Nuclear Grade	Grade II (intermediate)
Necrosis	Not identified
Lobular Carcinoma In Situ (LCIS)	Not identified
Lymphovascular Invasion	Not identified
Dermal Lymphovascular Invasion	Not identified
Microcalcifications	Present in DCIS Present in invasive carcinoma Present in non-neoplastic tissue
Treatment Effect in the Breast	No known presurgical therapy

DEFINITIONS FAQS

Fistula Case Inclusion?

Is this case included, and if so, what is the CPT code? See answer on bottom right, next page.

Preop/Postop Dx: Colovesical Fistula
Procedure: Sigmoid resection & ostomy creation
Procedure Description: …The sigmoid colon was identified and found to be densely adhered to the bladder. The sigmoid colon was then carefully disarticulated from its connection to the bladder and no obvious connection was found. There was no visible perforation or otherwise defect in the bladder identified. Sigmoid transected and proximal rectum transected, and specimen passed off the field. End colostomy created.
Path: Diverticulitis. No sigmoid defect.

Did you notice the clarifications about fistulas on p. 27 of the 2023 Program Manual? If you have read this and are still not sure about case inclusion, send your op report and path report to MSQC-Info@med.umich.edu for assistance.

Breast Cases FAQs

As more breast case abstraction is being done, we have compiled an FAQ document. This will be updated as we get questions, so check back frequently.

Testing Dates?

For ALL MSQC variables, the date the diagnostic test was obtained is the one you should report or use as criteria. Do not use the result date.

This includes, for examples, screening QI tests, date of diagnosis (breast biopsy) sepsis criteria (WBC, lactic, etc.), radiology study (for pneumonia), and urine culture (for UTI).

SCQR CONFERENCE CALL – RECAP

Review the minutes and recording from the 2/9 call **here**

UPCOMING EVENTS

April 21 MSQC-ASPIRE Meeting
Michigan Union | Ann Arbor

June 16 SCQR Training Day
Soaring Eagle Casino & Resort | Mt. Pleasant

MSQC UPDATES

The "?" in the MSQC Workstation can now be used to send all MSQC-related questions to the clinical team (variables and definitions questions, reporting Workstation issues, etc.) ("?" is no longer only for Workstation issues). You can continue to email **MSQC-Info@med.umich.edu** if you prefer.

Final P4P Scorecards were sent to all sites on 2/27. Check your email inbox and junk box, and reach out if you have not received it.

2023 Abstraction

- Please review the 2023 Manual during abstraction! Many updates were made, and many questions received could have been answered with the Manual.
- Opioid tab: answer "Patient did not respond" to *Do you know how many opioid pills taken* if pt not given a script, unknown if pt ever received a script, pt not d/c to home, or pt in hospital >30 days.
- For the new hernia variable – *Skin Closure Type*, if both suture and glue are used to close the skin, report "suture".

New Supervisor?

Please let us know if you have a new Supervisor! If you haven't already notified us, use the link in the "02 Update contact information" below.

You can also share these resources with them so they can learn more about MSQC:

- **Supervisor Video**
- **FTE and VBR Models**

Do you follow Twitter?

Follow MSQCs active Twitter account here @MSQCPSO

Recent Publications

We recently re-published an ROI paper with MVC. Click here to read how we helped hospitals save $2.5 million in colectomy post-discharge spending.

MSQC QUICK LINKS

01 Unlock case request

02 Update contact/ hospital information

03 Add Surgeon to Workstation

04 Register for SCQR Training-Report Vacancy

05 MSQC Toolkits

06 MSQC Changelog

Quality Improvement Corner

New Toolkit

A Smoking Cessation Toolkit which includes resources for smokers and health care professionals is now available **here.**

2023 Kickoff Webinars

Recordings and slides are posted **here**. These webinars contain a wealth of information about your projects! Please be sure to review these if you have questions about the project, available tools, or requirements.

Coming soon…

More resources for the Preop Screening project including updated documents and preop testing workgroups (Save the Date: 3/15) with MVC to share and discuss implementation ideas. See **QI webpage**.

Answer to Mini Case study: there was no active communication between colon and bladder (only adherence), no leaking urine, no bladder repair was needed. CPT code 44661 includes "The connection of the fistula to the bladder is resected and the bladder is closed with sutures." The latter part was not done so we cannot call this a colovesical fistula takedown. Therefore, this case is not considered a colovesical fistula repair and it can be included with 44143.