



Blue Cross Blue Shield of Michigan

2012 Pay-for-Performance

Collaborative Quality Initiatives Scoring Index

Updated March 2012



2012 CQI Performance Index Measures

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* Only hospitals not eligible to participate in MSQC receive P4P recognition for their participation in the MHA Keystone: Surgery initiative.

2012 CQI Performance Index Measures

Overview

The BCBSM Hospital Pay-for-Performance Program asks hospitals to participate in all hospital-based CQIs for which they are eligible, up to a maximum of 10 per hospital. A hospital's P4P score for each CQI is determined by its performance on specific measures related to that CQI. These measures are referred to as the hospital's CQI performance index.

The measures and weights in each CQI performance index are developed by the corresponding CQI coordinating center. Some measures are related to the quality of participation, such as meeting attendance and the accuracy and timeliness of the data the hospital submits. Some CQIs also have measures related to quality improvement and outcomes, such as composite morbidity or reductions in surgical complications.

The measures in a CQI index may change each year. Over time, the relative weight given to quality improvement and outcome measures (versus participation measures) will increase.

The measures within each index apply to a hospital only if it is eligible to participate in the corresponding CQI. The weights and measures may be adjusted or waived for newly participating hospitals.

Hospital scores on each CQI performance index are determined by the coordinating center. The coordinating center for each CQI will also submit each hospital's score to BCBSM. If a hospital participates in multiple CQIs BCBSM will combine its scores for each CQI into one overall score. An example of how the combined score is calculated is provided on Page 4.

The measurement period for each CQI index measure is January through December, unless otherwise noted.

Specific questions on the index measures or scoring should be directed to the applicable coordinating center. Other questions about the CQIs can be directed to the BCBSM CQI program administrator, Rozanne Darland, at rdarland@bcbsm.com or 313-448-5573.

2012 CQI Performance Index Measures

CQI Scoring Process

A hospital participating in multiple CQIs will have its index scores combined into one average score. For example, assume the following:

- Hospital A participates in three CQIs
- Its total CQI weight is 12 percent (3 CQIs x 4% = 12%)
- Its performance on CQI #1 is 94%
- Its performance on CQI #2 is 90%
- Its performance on CQI #3 is 85%

Hospital A's overall CQI score is calculated as follows:

	Index Score		Weight		Score
CQI #1	94%	X	4%	=	3.8%
CQI #2	90%	X	4%	=	3.6%
CQI #3	85%	X	4%	=	3.4%
Total CQI Score					10.8%

In this example, Hospital A earned a total CQI score of 10.8 percent out of a possible 12.0 percent.

2012 CQI Performance Index Measures

BCBSM Cardiac Consortium - Vascular Interventions Collaborative (BMC2-VIC)

(formerly named Peripheral Vascular Initiative, BMC2-PVI)

Measure	Weight	Measure Description	Points
#1	14	Timeliness of data	
		On time > 95%	14
		On time 51% - 95%	7
		Did not submit or late with 50%	0
#2	14	Accuracy of data (Tier 1 - based on prior audit year)	
		≤ 0.3 findings per case	14
		> 0.3 – 2 findings per case	7
		> 2 findings per case or did not submit	0
#3	16	Meeting participation – clinician lead	
		Participated in 2 meetings	16
		Participated in 1 meeting	8
		Did not participate	0
#4	14	Meeting participation – data coordinator	
		Participated in most meetings and calls	14
		Participated in more than ½ meetings and calls	7
		Participated in more than 0	3
		Did not participate	0
#5	14	Quality indicator performance goals: Statin at discharge > 75% and ASA (any anti-platelet, unless contraindicated) > 90%	
		Both goals met	14
		1 goal met, one goal not met but higher than last year	7
		1 goal met, 1 goal not met and lower or equal to last year	3
		Neither goal met	0
#6	14	Quality indicator performance goal: Post PVI Transfusion < 7%	
		Met transfusion goal < 7%	14
		Goal not met – rate lower than last year	7
		Goal not met – higher or equal to last year	0
#7	14	Quality indicator performance goal – All BMC2 VIC quarterly, year-to-date, Quality Improvement Reports and Morbidity and Mortality reports distributed to all physician participants and internally within the hospital in a timely manner, within 2 weeks of issuance.	
		Obtain signed attestation from cath lab director > 90% distributed on time	14
		Obtain signed attestation from cath lab director ≤ 90% and > 60% distributed on time	7
		Obtain signed attestation from cath lab director ≤ 60% distributed on time or no attestation from the cath lab director	0

2012 CQI Performance Index Measures

BCBSM Cardiovascular Consortium – Percutaneous Coronary Intervention (BMC2–PCI)

Measure	Weight	Measure Description	Points
#1	14	Timeliness of data	
		On time > 95%	14
		On time 51% - 95%	7
		Did not submit or late with 50%	0
#2	14	Accuracy of data (Tier 1 - based on prior audit year)	
		≤ 0.3 findings per case	14
		> 0.3 – 2 findings per case	7
		> 2 findings per case or did not submit	0
#3	16	Meeting participation – clinician lead	
		Participated in 2 meetings	16
		Participated in 1 meeting	8
		Did not participate	0
#4	14	Meeting participation – data coordinator	
		Participated in most meetings and calls	14
		Participated in more than ½ meetings and calls	7
		Participated in more than 0 meetings and calls	3
		Did not participate	0
#5	14	Quality indicator performance goal - transfusion	
		Met transfusion goal < 5%	14
		Did not meet goal but lower than last year	7
#6	14	Quality indicator performance goal – post procedure creatinine values	
		Obtain post procedure creatinine ≥ 95%	14
		Obtain post procedure creatinine ≥ 80%	7
		Obtain post procedure creatinine < 80%	0
#7	14	Quality indicator performance goal – All BMC2 PCI quarterly, year to date, Procedure Indications Reports, and Quality Improvement Reports and Morbidity and Mortality reports distributed to all physician participants and internally within the hospital in a timely manner, within 2 weeks of issuance.	
		Obtain signed attestation from cath lab director ≥ 90% distributed on time	14
		Obtain signed attestation from cath lab director ≤ 90% and > 60% distributed on time	7
		Obtain signed attestation from cath lab director ≤ 60% distributed on time	0

2012 CQI Performance Index Measures

Michigan Society of Cardiovascular and Thoracic Surgeons Quality Improvement Initiative (MSTCVS)

Measure	Weight	Measure Description*	Points
#1	5	Timeliness of data	
		On time 4 of 4 times	5
		On time 3 of 4 times	2
		On time fewer than 3 of 4 times	0
#2	10	Accuracy of data**	
		4 or 5 Star audit score	10
		3 Star audit score	5
		< 2 Star audit score	0
#3	10	Meeting participation – surgeon lead	
		Participated in 4 out of 4 meetings	10
		Participated in 3 out of 4 meetings	5
		Participated in fewer than 3 meetings	0
#4	10	Meeting participation – data manager	
		Participated in 4 out of 4 meetings	10
		Participated in 3 out of 4 meetings	5
		Participated in fewer than 3 meetings	0
#5	15	Implementation of site specific quality improvement agenda	
		Developed and implemented	15
		Developed but not implemented	10
		Not developed	0
#6	25	Isolated CABG: O/E mortality ratio for rolling 24 month period (October 1, 2010 through September 30, 2012)	
		O/E ratio < 1.0	25
		O/E ratio < 1.5	20
		O/E ratio > 1.5	0
#7	25	Isolated CABG: Appropriate medications at discharge – beta blockers, anti lipids, anti platelets (October 1, 2010 through September 30, 2012)	
		Three out of three on > 95% of CABG population	25
		Three out of three on 90% - 95%	20
		Three out of three on < 90%	0

* Unless otherwise specified, all measures are for the reporting period of January 1, 2012 – December 31, 2012

**MSTCVS data audits will be conducted annually for sites receiving 3 Stars or less and every other year for sites receiving 4 or 5 Stars. Audits may be conducted more frequently at the discretion of the Coordinating Center.

2012 CQI Performance Index Measures

Hospital Medicine Safety (HMS)

Measure	Weight	Measure Description	Points
#1	25	Timeliness of data¹	
		On time ≥ 95%	20
		On time 76% - 94%	15
		On time 50% - 75%	10
		On time < 50%	0
#2	25	Completeness¹ and accuracy² of data	
		≥ 95%	20
		76% - 94%	15
		50% - 75%	10
		< 50%	0
#3	25	Consortium-wide meeting participation³ – clinician lead or designee	
		Participated in all meetings	20
		Participated in more than ½	15
		Participated in more than 0	10
		Participated in no meetings	0
#4	25	Consortium-wide meeting participation³ – data abstractor or QI administrative lead	
		Participated in all meetings	20
		Participated in more than ½	15
		Participated in more than 0	10
		Participated in no meetings	0
#5	20	QI Activity⁴	
		Responded to data with changes in process or achieved HMS Goals	20
		Data shared with VTE Committee	15
		VTE Committee created and actively meeting ⁵	10
		No Activity	0

¹ Assessed at year end based on data submitted during calendar year

² Assessed at site audits (average 1-2 per year)

³ Based on all meetings scheduled during calendar year

⁴ Based on semi-annual survey response

⁵ Minutes from most recent meeting will need to be sent with the semi-annual survey. The VTE Committee is expected to regularly maintain minutes for all meetings. For new sites that join HMS after July 2011, full credit (20 points) will be achieved by having an active VTE Committee by year end.

2012 CQI Performance Index Measures

Michigan Bariatric Surgery Collaborative (MBSC)

Step 1: All hospitals participating in MBSC will be scored on the measures listed in the following table.

Category	Domain	Measures	Weight
Excellence (50%)	Safety (20%)	Serious complication rate	20
	Effectiveness (15%)	Average excess body weight loss	5
		Quality of life scores significantly above collaborative average	5
		Percentage of patients very satisfied	5
	Cost (15%)	Rate of ED visits	7.5
		Readmission rates	7.5
Improvement (50%)	Process (25%)	At least one bariatric surgeon and coordinator attend every meeting*	7.5
		Timely and accurate data submissions	7.5
		Compliance with VTE prophylaxis	10
	Outcomes (25%)	Improvement in rate of serious complications over time	15
		Improvement in rate of ED visits over time	5
		Improvement of rate of readmissions over time	5

*The evaluation period for this measure is January 2011 through December 2012. The evaluation period for all other measures is calendar year 2012.

Step 2: For each measure in the table, hospitals will earn a Z score based on how many standard deviations its performance is from the collaborative mean.

- All performance scores are risk and/or reliability adjusted as appropriate.
- The average collaborative score will be normalized to zero so that hospitals whose performance is better than the mean will earn a positive Z score for that measure and hospitals whose performance is worse than the mean will earn a negative Z score.

Step 3: For each measure in the table, the hospital's Z score will be multiplied by the measure's weight to determine the total points the hospital earns for each measure.

MBSC index scoring description – continued on next page

2012 CQI Performance Index Measures

Michigan Bariatric Surgery Collaborative (MBSC)

(continued)

Step 4: Each hospital's points for all measures will be summed and the hospital scored as follows:

Points earned by the participating site compared to the collaborative mean	CQI Index Score
Site points equal to or more than one standard deviation above the mean	100%
Site points equal to the mean or less than one standard deviation above the mean	75%
Site points less than one standard deviation below the mean	50%
Site points equal to or more than one standard deviation below the mean	25%

2012 CQI Performance Index Measures

Michigan Surgery Quality Collaborative (MSQC)

NOTE: The MSQC measurement period is July 2011 through June 2012

Measure	Weight	Measure Description	Points
#1	10	Accuracy of data	
		Submitted data 95% accurate	10
		Submitted data < 95% accurate	0
#2	15	Meeting participation – clinician lead	
		Attended all meetings	15
		Attended more than half	10
		Attended more than zero	5
#3	15	Meeting participation – surgical clinical reviewer	
		Attended all meetings	15
		Attended more than half	10
		Attended more than zero	5
#4	20	Implementation of MSQC QI agenda	
		Developed and implemented	20
		Developed but not implemented	10
#5	25	Volume of cases	
		Appropriate number of cases entered for the site	25
#6	15	Special project participation	
		Participates in all projects	15
		Participates in at least 1 project	10
		No participation	0

2012 CQI Performance Index Measures

Michigan Surgery Quality Collaborative - Perioperative Interventions (MSQC-POI)

Measure	Weight	Measure Description	Points
#1	15	Timeliness of Data submission	
		On time 75% of the time	15
		On time 50% of the time	8
		On time < 50% of the time	0
#2	15	Completeness and Accuracy of data	
		> 75%	15
		50% - 75%	8
		< 50%	0
#3	15	Quarterly meeting participation – peri-operative lead	
		> 75%	15
		50% - 75%	8
		< 50%	0
#4	15	Participation in clinical seminar meetings	
		> 75%	15
		50% - 75%	8
		< 50%	0
#5	15	Tech meeting participation – IT specialist	
		> 75%	15
		50% - 75%	8
		< 50%	0
#6	10	Timeliness of inquiry responses	
		Within 2 business days	10
		Within 5 business days	5
		Consistently requires 3 or more contacts from the coordinating center	0
#7a	15	IRB and data use agreement signed on time* (2012 cohort only)	
		Within the deadline	15
		Within 2 weeks of the deadline	10
		Outside 2 weeks of the deadline	0
#7b	15	Implementation of POI/Hospital QI agenda (2011 cohort only)	
		Developed and implemented	15
		Developed but not implemented	8
		Not developed	0

* Timeframes negotiated with hospitals

2012 CQI Performance Index Measures

Michigan Breast Oncology Quality Initiative (MIBOQI)

Measure	Weight	Measure Description	Points
#1 All Sites	5	Eligibility reporting	
		≤ 4 month lag (reporting patient numbers from Aug 2012 or later)	5
		≤ 6 month lag (reporting patient numbers from Jun 2012-Jul 2012)	4
		Not reporting	0
#2 All Sites	5	Data Abstraction	
		≤ 6 month lag (abstracting charts from June 2012 or later)	5
		≤ 8 month lag (abstracting charts from April 2012-May 2012)	4
		Not abstracting	0
#3 All Sites	5	Follow-up Data	
		≥ 90% complete (cumulative through December 2012)	5
		≥ 80% complete (cumulative through December 2012)	4
		Not following up	0
#4 Phases I-II Phases I-V Phase VI All All	5	Accuracy of data - Audit	
		Earned online monitoring status with 3 successful Annual Audits	5
		Above Average rating or better on 2012 Annual Audit	5
		Successful Educational Audit in 2012	5
		Satisfactory rating on 2012 Audit	4
		Unable to audit	0
#5 Phases I-V Distant Sites* Phase VI All All	15	Project Director	
		Attended all Collaborative Meetings in 2012 (self or representative)	15
		Attended all Collaborative Meetings in 2012 (at least 1 in-person; self or rep)	15
		Attended Kick-Off, Site Visit & Grand Rounds in 2012 (self or rep)	15
		Attended > 50% of meetings/calls/events in 2012 (self or rep)	10
		Did not attend any meetings/calls/events in 2012 (and no substitute)	0

MiBOQI performance index continued on next page

2012 CQI Performance Index Measures

Michigan Breast Oncology Quality Initiative (MIBOQI) - continued

Measure	Weight	Measure Description	Points
#6	15	Administrative Lead	
Phases I-V		Attended > 50% of Collaborative Meetings in 2012 (self or rep)	15
Distant Sites*		Attended > 50% of meetings/calls/events in 2012 (self or rep)	15
Phase VI		Attended Kick-Off, Site Visit & Grand Rounds in 2012 (self or rep)	15
All		Attended ≥ 30% of meetings/calls/events in 2012 (self or rep)	10
All		Did not attend any meetings/calls/events in 2012 (and no substitute)	0
#7	15	Clinical Research Associate	
Phases I-V		Attended > 50% of Collaborative Meetings in 2012 (self or rep)	15
Distant Sites*		Attended > 50% of meetings/calls/events in 2012 (self or rep)	15
Phase VI		Attended Grand Rounds, Eligibility Training, & Database Training in 2012	15
All		Attended ≥ 30% of meetings/calls/events in 2012 (self or rep)	10
All		Did not attend any meetings/calls/events in 2012 (and no substitute)	0
#8	10	Breast Cancer Advisory Committee (BCAC)	
Phases I-III		Met regularly in 2012, reviewed and used MIBOQI data	10
Phases IV-V		Met regularly in 2012, submitted agendas & attendee lists	10
Phase VI		BCAC members identified & contacted; 1st meeting held/scheduled in 2012	10
Phases I-III		Met regularly in 2012, submitted agendas & attendee lists	9
Phases I-V		Met regularly in 2012	8
All		No BCAC	0
#9	25	Quality Improvement Agenda - Reduce Surgical Biopsy Rate	
Phases I-II (Beaumont RO, Genesys, Munson, Spectrum, St. Joseph, U of M)		Rates for 2011 at or below 15% recommendation	25
		Rates for 2011 reduced from 2010 rates	20
		Actively worked to reduce rates in 2012	15
		Rates for 2011 statistically significantly higher than rates from previous years combined (p > .05)	0

MiBOQI performance index continued on next page

2012 CQI Performance Index Measures

Michigan Breast Oncology Quality Initiative (MIBOQI) - continued

Measure	Weight	Measure Description	Points
#10 Phase I-II (Ingham, McLaren, Saint Mary's, St. Johns)	25	Quality Improvement Agenda - Improve Concordance on NCCN Guideline	
		System/procedure changes in place & used to improve concordance in 2012	25
		Used 2010 reasons for non-concordance to make specific QI plans	20
		Determined reasons for non-concordance using 2010 data	15
		No QI Agenda	0
#11 Phase I-II (Oakwood)	25	Quality Improvement Agenda - Improve Concordance on ASCO/NCCN QM	
		Concordance for combined 2010 & 2011 data at or above 80% target	25
		Concordance increased (from 65%) for 2010/2011 data	20
		Actively worked to increase concordance in 2012	15
		No QI Agenda	0
#12 Phase I-II (Henry Ford, Providence)	25	Quality Improvement Agenda - Shorten Time Between Events for Patients	
		Goals for length of time outlined in QI Agenda achieved/exceeded in 2011/12	25
		Target length of time reduced in 2011/2012 from previous years	20
		Actively worked to reduce targeted length of time in 2012	15
		No QI Agenda	0
#13 Phase III	25	Quality Improvement Agenda	
		Actively working on QI plan in 2012	25
		Created a plan of action for QI in 2012	20
		Areas of opportunity chosen in 2012	15
		No QI Agenda by the end of 2012	0

MiBOQI performance index continued on next page

2012 CQI Performance Index Measures

Michigan Breast Oncology Quality Initiative (MIBOQI) - continued

Measure	Weight	Measure Description	Points
#14 Phase IV-V	25	Quality Improvement	
		Used info from collaborative to improve systems/procedures in 2012	25
		Looked at systems/procedures of other successful MiBOQI groups in 2012	20
		Discussed current systems/procedures among team in 2012	15
		No effort to look at own systems/procedures by the end of 2012	0
#15 Phase VI	5	IRB	
		IRB approved in 2012	5
		IRB application in progress by the end of 2012	3
		No IRB approval in 2012	0
#16 Phase VI	5	Staffing	
		CRA hired by the end of 2012	5
		In the process of identifying CRA	3
		No CRA candidate by the end of 2012	0
#17 Phase VI	5	Grand Rounds/Site Visit	
		Grand Rounds and Site Visit complete or scheduled by end of 2012	5
		In the process of scheduling Grand Rounds and Site Visit	3
		No Grand Rounds or Site Visit scheduled by the end of 2012	0
#18 Phase VI	5	Working with private practice doctors	
		Private practice doctors contacted and on board by the end of 2012	5
		Worked w/ private practice doctors to bring them on board in 2012	4
		Not working with private practice doctors by the end of 2012	0
#19 Phase VI	5	Response to Coordinating Center requests	
		Responded within a week (throughout 2012)	5
		Responded, but took over a week (throughout 2012)	4
		Did not respond (throughout 2012)	0

* Distant sites include Marquette

2012 CQI Performance Index Measures

Michigan Trauma Quality Improvement Project (MTQIP)

Measure	Weight	Measure Description	Points
#1	20	Timeliness of data	
		On time 3 of 3 times	20
		On time 2 of 3 times	10
		On time < 2 of 3 times	0
#2	15	Site visit/audit	
		Completed	15
		Not completed	0
#3	15	Selection of performance improvement project	
		Yes	15
		No	0
#4	25	Meeting participation - clinician lead	
		All meetings	25
		2 of 3 meetings	10
		1 of 3 meetings	5
		Did not participate	0
#5	25	Meeting participation - program manager and registrar (average)	
		All meetings	25
		2 of 3 meetings	10
		1 of 3 meetings	5
		Did not participate	0

2012 CQI Performance Index Measures

Michigan Radiation Oncology Quality Consortium (MROQC)

Measure	Weight	Measure Description	Points
#1	10	Inclusion enrollment	
		At least 95% of all eligible patients are enrolled	10
		50-94% of all eligible patients are enrolled	5
		< 50% all eligible patients are enrolled	0
#2	8	Timeliness of physics data submission	
		> 95% of data submitted within 2 weeks of treatment completion	8
		> 95% of data submitted within three weeks	5
		> 95% of data submitted within four weeks	3
		> 95% of data submitted after eight weeks	1
		< 95% of data submitted after eight weeks	0
#3	12	Quality (completeness and accuracy) of clinical data	
		> 90% score on audit	12
		81% - 90% score on audit	10
		60%- 80% score on audit	6
		< 60% score on audit	0
#4	12	Quality (completeness and accuracy) of technical data	
		> 90% score on audit	12
		81% - 90% score on audit	10
		60%- 80% score on audit	6
		< 60% score on audit	0
#5	8	Quality (completeness and accuracy) of survey data	
		> 90% score on audit	8
		81%-90% score on audit	5
		60% - 80% score on audit	3
		< 60% score on audit	0

MROQC performance index continued on next page

2012 CQI Performance Index Measures

Michigan Radiation Oncology Quality Consortium (MROQC) (continued)

Measure	Weight	Measure Description	Points
#6	4	Consent for digital imaging	
		> 85% of all breast cancer patients consented for digital images	4
		76-85% of all breast cancer patients consented for digital images	3
		60%-75% of all breast cancer patients consented for digital images	2
		< 60% of all breast cancer patients consented for digital images	0
#7	4	Upload of digital imaging	
		> 95% of all expected digital images uploaded	4
		80%-95%	3
		50%-79%	2
		< 50%	0
#8	12	Meeting participation – clinical champion	
		All meeting	12
		Two meetings	8
		One meeting	3
		None	0
#9	12	Meeting participation – physics lead	
		All meeting	12
		Two meetings	8
		One meeting	3
		None	0
#10	12	Meeting participation – data coordinator	
		All meetings	12
		Two meetings	8
		One meeting	3
		None	0
#11	6	Meeting participation – clinical champion	
		All meeting	6
		Two meetings	4
		One meeting	2
		None	0

2012 CQI Performance Index Measures

Michigan Arthroplasty Registry Collaborative Quality Initiative (MARCQI)

Measure	Weight	Measure Description	Points
#1	20	Quarterly meetings participation -clinical champion (CC)	
		3 out of 4	20
		2 out of 4	10
		< 2	0
#2	20	Quarterly meeting participation – clinical data abstractor (CDA)	
		3 out of 4	20
		2 out of 4	10
		< 2	0
#3	10	Tech quarterly meeting participation – IT specialist	
		3 out of 4	10
		2 out of 4	5
		< 2	0
#4	15	Timeliness of data submission	
		On time ≥75-100% of the time	15
		On time < 75% of the time	10
		On time ≤ 60% of the time	0
#5	15	Completeness and accuracy of data	
		On completeness/accuracy ≥ 75-100% of the time	15
		On completeness/accuracy < 75% of the time	10
		On completeness/accuracy ≤ 60% of the time	0
#6	10	Timeliness of response to the coordinating center inquiry requests	
		Within 2 business days	10
		Within 5 business days	5
		Consistently requires 3 or more coordinating center contacts for response	0
#7	10	IRB, Data Use Agreement and Business Associate Agreement signed on time* (2012 cohort only)	
		Within the 3 months deadline	10
		Within 6 months of the deadline	5
		Outside of the 6 month deadline	0

* Timeframes negotiated with hospitals

2012 CQI Performance Index Measures

MHA Keystone: Hospital Associated Infections

Measure	Weight	Measure Description	Points
#1	30	Data Collection	
		90% of data returned	30
		50% - 89%	15
		Less than 50%	0
#2	30	Participation in conference calls	
		At least six conference calls	30
		Less than six conference calls	15
		No conference calls	0
#3	40	CAUTI Bundle Intervention implementation	
		Fully implemented	40
		Partially implemented	25
		Not begun	0

Frequency of Reporting:

- Initial phase (baseline to post intervention 1) - weekly
- Post intervention phase – quarterly

MHA Keystone: Surgery

Measure	Weight	Measure Description	Points
#1	30	Data Collection*	
		90% or more of data returned	30
		50% - 89%	15
		Less than 50%	0
#2	30	Participation in conference calls	
		At least one meeting and six conference calls	30
		At least one meeting and less than six conference calls	15
		No meetings and less than six conference calls	0
#3	40	Intervention implementation	
		Fully implemented	40
		Partially implemented	25
		Not begun	0

*Data collection activities include monthly briefing, debriefing, and mislabeled specimens.