MSTCVS Quality Collaborative

2026 Michigan Perfusion Quality Improvement "U-Pick" Pay-For-Performance (P4P) Project

Using PERForm to Support Quality Improvement Efforts

Background: The 2026 Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative (MSTCVS-QC) PERForm pay-for-performance (P4P) initiative focuses on supporting Michigan sites in using their own PERForm data to monitor and advance a quality improvement initiative of their choosing.

Each Michigan site is encouraged to collaborate within its surgical team to select a PERForm Registry metric to track from January 1, 2026, through September 30, 2026. This metric does not need to be perfusion-specific, but it must be a variable captured in the PERForm registry. Metrics may complement ongoing state-wide initiatives (e.g., reducing intra-operative RBC use) or support site-specific priorities (e.g., increasing post-operative debrief completions).

Sites should identify their metric and submit it to the MSTCVS Coordinating Center (dnieter@med.umich.edu) by the February 18, 2026 virtual PERForm meeting for discussion at that meeting where submissions will be reviewed and discussed.

Useful PERForm tools for this project include Data Tables, Metric Library, and Data Quality Report. Training videos are available through the ARMUS Health Catalyst Support ZenDesk with links posted on the mstcvs.org website.

P4P Deliverables

The Chief Perfusionist or a designated representative with PERForm data extraction access are *encouraged* to submit a progress report summarizing the selected metric prior to the Spring and Summer Quarterly Quality Collaborative meetings (via REDCap) for the purpose of fostering discussion and garnering feedback. Deadlines for these quarterly submissions are:

Q1 submission: May 12, 2026

Q2 submission: August 11, 2026

The “final” *required* report must be submitted by **November 10, 2026,** for the hospital to receive 2026 Perfusion P4P points. This report must include data for the selected metric for Q1, Q2, and Q3 of 2026.

All files should be uploaded to REDCap using the following path:

MSTCVS ➡ PERForm ➡ Michigan ➡ Your Hospital Name ➡ P4P

For assistance, contact:

Don Nieter (dnieter@med.umich.edu) or

Raquel Hazzard (rhazzard@med.umich.edu)

EXAMPLE: Debrief Tracking

Below is an example of tracking post-operative debrief completion using the PERForm Data Tables exported to Excel.

- Q1 2025: 9 cases (4 Yes, 3 No, 1: NULL) ➡ 44.4% with a documented debrief
- Q2 2025: 12 cases (7 Yes, 5 No) ➡ 58.3% with a documented debrief
- Q3 2025: 19 cases (10 Yes, 5 No, 4 NULL) ➡ 52.6% with a documented debrief

	A	B	D	E	G	H
1	Q1: Date Of Surgery	Post Operative Debrief	Q2: Date Of Surgery	Post Operative Debrief	Q3: Date Of Surgery	Post Operative Debrief
2	1/30/2025		6/30/2025	Yes	9/5/2025	
3	3/4/2025	No	4/2/2025	No	7/6/2025	No
4	3/14/2025	No	6/30/2025	No	7/2/2025	Yes
5	2/3/2025	Yes	6/30/2025	Yes	7/17/2025	Yes
6	3/14/2025	No	6/28/2025	Yes	7/2/2025	Yes
7	1/20/2025	Yes	5/17/2025	Yes	7/7/2025	Yes
8	2/7/2025	Yes	4/1/2025	No	7/9/2025	No
9	2/18/2025	Yes	6/5/2025	Yes	7/30/2025	No
10			6/29/2025	No	7/9/2025	Yes
11			6/2/2025	Yes	8/11/2025	No
12			6/26/2025	Yes	8/21/2025	Yes
13					7/1/2025	Yes
14					7/1/2025	No
15					7/5/2025	
16					7/12/2025	Yes
17					7/15/2025	Yes
18					7/9/2025	Yes
19					9/10/2025	

A similar example can be generated using the PERForm Metric Library by selecting specific procedure groups such as CABG, Valve, or CABG + Valve.

PERForm				
	Multiple Procedure Types Q1 2025 - Q3 2025			
26. Safety Metrics	**Q1 '25**	**Q2 '25**	**Q3 '25**	**Total**
Post-Operative Debrief	42.5%	42.1%	47.4%	44.0%
N	737	705	844	2286
D	1734	1676	1782	5192

Below is the complete approved 2026 MSTCVS P4P matrix (also available on the mstcvs.org website). Perfusion P4P in yellow.

Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS)
Quality Collaborative
2026 Hospital CQI Performance Index

Measure #	Weight	Measure	Points Earned
#1	10	**Accuracy of data** 5-star audit score 4-star audit score 3-star audit score ≤ 2-star audit score	 10 8 6 0
#2	8	**Quarterly collaborative meeting participation** - Surgeon Attendance **(January 1, 2026–December 31, 2026)** Surgeon attended 4 quarterly meetings **and** an Alternate Surgeon attended ≥1 meeting Surgeon attended 3 quarterly meetings **and** an Alternate Surgeon attended ≥1 meeting Surgeon attended 2 quarterly meetings **and** an Alternate Surgeon attended ≥1 meeting Surgeon attended 1 quarterly meetings **and** an Alternate Surgeon attended ≥1 meeting Surgeon attended 0 quarterly meetings or No Alternate Surgeon attendance **To receive any points, at least one quarterly meeting must be attended by an Alternate Surgeon (a surgeon other than the designated Physician Champion). This requirement applies to any hospital that had an Alternate Surgeon on record at any point during the year.* *Hospitals with no Alternate Surgeon on record for the **entire year** are exempt from the alternate attendance requirement.*	 8 6 4 2 0
#3	4	**Quarterly collaborative meeting participation** - Data Manager Attendance **(January 1, 2026–December 31, 2026)** Data manager attended 4 quarterly meetings Data manager attended 3 quarterly meetings Data manager attended 2 quarterly meetings Data manager attended 1 quarterly meeting Attended 0 quarterly meetings	 4 3 2 1 0
#4	4	**Quarterly data manager educational meeting** - Data Manager **(January 1, 2026–December 31, 2026)** Attended 4 data manager meetings Attended 3 data manager meetings Attended 2 data manager meetings Attended 1 data manager meeting Attended 0 data manager meetings	 4 3 2 1 0
#5	4	**Quarterly PERForm educational meeting + Quality Report Submission** - Perfusionist **(January 1, 2026–December 31, 2026)** Attended 4 PERForm meetings + Quality Report Submission Attended 3 PERForm meetings + Quality Report Submission Attended 2 PERForm meetings + Quality Report Submission Attended 1 PERForm meeting + Quality Report Submission Attended 0 PERForm meetings / No Quality Report Submitted **No points will be awarded if a PERForm Quality Report is not submitted*	 4 3 2 1 0
#6	15	**Collaborative-wide quality initiative 2026:** **Isolated CAB – Reduction in Intra/Postoperative Red Blood Cell Transfusion** **(January 1, 2026–September 30, 2026)** Intra/Postoperative Red Blood Cell Transfusion: **January-September 2026** collaborative mean rate of ≤ 25% Intra/Postoperative Red Blood Cell Transfusion: **January-September 2026** collaborative mean rate of > 25%	 15 0
#7	15	**Site specific quality initiative** **(January 1, 2026–September 30, 2026)** Met improvement goal Improved but did not meet goal Implemented plan but did not improve Improved but unable to implement plan or did not submit plan/progress report	 15 10 5 0
#8	20	**Isolated CAB: O/E Mortality for 12 months** **(October 1, 2025–September 30, 2026)** O/E ≤ 1.0 O/E ≤ 1.5 O/E > 1.5	 20 10 0
#9	20	**Isolated Valve +/- CAB Mortality and Major Morbidity OE for 36 months** **(October 1, 2023–September 30, 2026)** O/E ≤ 1.0 O/E ≤ 1.5 O/E > 1.5	 20 10 0
#10	1	**Extra Credit Opportunities: Maximum of 5 Extra Credit Points Available** 1 point awarded toward participation measures for each approved activity completed by surgeons 5 points awarded toward performance measures if all three cardiac surgery VBR measures are achieved	