The following is the application required by hospitals in the state of Michigan who would like to be considered for the Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE). Michigan hospitals are eligible to receive funding from Blue Cross Blue Shield Michigan (BCBSM) to participate in MPOG. For more information, [visit our website](https://mpog.org/join/funding-michigan/).

In addition to completing the required information, the bottom of the form requires a signature from the Anesthesiology Department Chair / Practice Lead (Sponsor), ASPIRE Quality Champion and the hospital IT Lead, ensuring that the hospital will support the effort by providing the resources needed to submit data into the MPOG registry.

Submit completed forms to: Tory Lacca ([lacca@med.umich.edu](mailto:lacca@med.umich.edu)).

# Hospital Information

## Hospital Name

|  |  |
| --- | --- |
| Hospital: |  |
| Address: |  |
| Name of anesthesia information system (i.e. Epic, Cerner), dates in use and version: |  |

## Hospital Pay-for-Performance (P4P) Administrator

If your hospital participates with any other BCBSM Collaborative Quality Initiative (CQI), then your hospital should have a P4P Administrator who manages the program. If you do not know the hospital P4P Administrator, please contact Tory Lacca ([lacca@med.umich.edu](mailto:lacca@med.umich.edu)) for assistance.

|  |  |
| --- | --- |
| Name: |  |
| E-mail: |  |

## IT Manager or Lead Developer:

Individual from the hospital who will allocate the technical resources for MPOG implementation.

|  |  |
| --- | --- |
| IT Support Name: |  |
| IT Support’s E-mail: |  |

# Practice Information

## Anesthesiology Practice Group (if applicable)

|  |  |
| --- | --- |
| Name of Practice Group: |  |
| Administrative Contact: |  |
| E-mail: |  |

## Department Chair

|  |  |
| --- | --- |
| Name: |  |
| E-mail: |  |

## Practice Lead (if different than department :

|  |  |
| --- | --- |
| Name: |  |
| E-mail: |  |

## Additional Information:

1. Do the anesthesiology providers practice at other hospitals? If so, where?
2. Are there multiple groups at the same hospital? If so, please list all anesthesia practices.
   1. ~~How many Tax Identification NumbersS?~~
   2. Does your practice employ CRNAs?
3. How many cases per month are performed at the hospital?
4. Who is your billing vendor(s)?

# MPOG Roles

## Anesthesiology Quality Champion:\*

An anesthesiologist who will serve as the quality champion. They will serve on the Quality Committee to debate items of interest, including quality measure criteria, meeting agendas, best practices, data validation, etc.

|  |  |
| --- | --- |
| QI Champion Name: |  |
| QI Champion E-mail: |  |

## Anesthesiology IT Champion:\*

An anesthesiologist who will assist with the technical efforts of MPOG. The IT Champion will work the developers at their institution and MPOG to assist with the IT infrastructure.

|  |  |
| --- | --- |
| IT Champion Name: |  |
| IT Champion E-mail: |  |

## Anesthesiology Principal Investigator (PI):\*

An anesthesiologist who will serve as the research champion. The PI will lead the research efforts and serve on the research publications committee that determines the scientific validity of proposals.

|  |  |
| --- | --- |
| PI’s Name: |  |
| PI’s E-mail: |  |

\*The PI, Quality Champion and IT Champion can be the same individual or assigned to different individuals. We defer to the institution to determine who will be best suited for the role. Please note, all of these roles must be identified.

## Signatures:

This application is not binding, but signatures are required to ensure that all necessary parties are aware of the level of commitment that is required to join MPOG.

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**Department Chair**  Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anesthesiology Quality Champion Signature** Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital IT Lead**  Date:

Submit completed forms to: Tory Lacca ([lacca@med.umich.edu](mailto:lacca@med.umich.edu)).