2022 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard **Cohort 2021 (Sites Starting in 2021)**			
Measure	Weight	Measure Description	Points
1	15	**Timeliness of HMS Data at Mid-Year and End of Year[1]**	
		On time ≥ 95% at Mid-Year AND End of Year	15
		On time ≥ 95% at Mid-Year OR End of Year	8
		On time < 95% at Mid-Year AND End of Year	0
2	15	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, AND audit case corrections completed by due date	15
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed OR audit case corrections not completed by due date	0
3	20	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
4	20	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	20
		2 meetings	10
		1 meeting	0
		No meetings	0
5	10	**PICC Quality Improvement[6]**	
		Convene a vascular access committee at least quarterly to review PICC use and outcomes **AND** use MAGIC or a related decision-tool to determine PICC appropriateness	10
		Convene a vascular access committee at least quarterly to review PICC use and outcomes **OR** use MAGIC or a related decision-tool to determine PICC appropriateness	5
		No vascular access committee meetings convened AND no use of MAGIC or a related decision-tool to determine PICC appropriateness	0
6	5	**PICC/Midline Documentation[6]**	
		Submit PICC AND midline (if hospital inserts midlines) insertion template including documentation of catheter-to-vein ratio and number of lumens	5
		Local PICC AND midline (if hospital inserts midlines) insertion template including documentation of catheter-to-vein ratio and number of lumens not submitted	0
7	10	**Antimicrobial Quality Improvement- Guidelines[6]**	
		Submit UTI and CAP guidelines developed locally (aligned with HMS recommendations)[5]	10
		Local UTI and CAP guidelines not submitted or not aligned with HMS recommendations	0
8	5	**Antimicrobial Quality Improvement- Intervention Description[6]**	
		Submit a description of one intervention you have done, are doing or plan on doing for each • Decrease antibiotic treatment for patients with uncomplicated CAP to 5 days • Decrease unnecessary treatment of ASB • Decreasing inappropriate Fluoroquinolone (FQ) use for patients with UTI/ASB and CAP	5
		Description of interventions not submitted	0
		Total (Max points = 100)	

[1] Registry data assessed during mid-year performance evaluation review and at year end based on data submitted during calendar year 2022. All required cases must be completed by the mid-year performance evaluation review AND by year end. Mid-year due date and final due date will be announced by Coordinating Center. Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[2] Assessed based on scores received for site audits conducted during calendar year 2022. Scores are averaged if multiple audits take place during the year.

[3] For audits conducted during the calendar year, audit case corrections must be completed or discrepancies addressed within 3 months of audit summary receipt (due date for case corrections provided in audit summary).

[4] Based on all meetings scheduled during calendar year 2022. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] CAP Institutional guidelines should:

- Recommend 5-day antibiotic treatment duration for uncomplicated CAP
- Review the risk factors for multi-drug resistant organisms (MDRO) (i.e. provide guidance on when anti-pseudomonal and anti MRSA coverage is needed)
- Provide recommendations for transition to oral therapy
- De-emphasize fluoroquinolones

UTI Institutional guidelines should:

- Recommend against sending urine cultures in the absence of urinary symptoms
- Recommend against treating a positive urine culture in the absence of urinary symptoms
- Provide recommendations for transition to oral therapy
- De-emphasize fluoroquinolones

[6] In December 2022/January 2023, HMS will distribute a survey to all abstractors/quality leads to obtain the information required for this measure. It is the abstractor/quality leads responsibility to work with key stakeholders who are involved with and lead the quality improvement work at each hospital related to the area of assessment.