| 2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard<br>**Cohort 2022 (Sites Starting in 2022)** | | | |
|---|---|---|---|
| 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<br>• Decrease antibiotic treatment for patients with uncomplicated CAP to 5 days<br>• Decrease unnecessary treatment of ASB<br>• Decreasing broad-spectrum use in patients with uncomplicated CAP | 5 |
| | | Description of interventions not submitted | 0 |
| **Optional Bonus** | | | |
| Optional | 5 | Specialist[7] attendance at 1 or more of the special population workgroup[8] meetings during the calendar year | 5 |
| | | **Total (Max points = 100)** | |

[1] Registry data for all initiatives (Antimicrobial, PICC/Midline and Sepsis) assessed during mid-year performance evaluation review and at year end based on data submitted during calendar year 2023. 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.

[2] Assessed based on scores received for site audits conducted during calendar year 2023. Scores are averaged if multiple audits take place during the year. Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[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 2023. 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 2023/January 2024, HMS will distribute a survey to all abstractors/quality leads to obtain the information required for this measure. It is the abstractor/quality lead's 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.

[7] Specialist is considered Critical Care, Oncology or Hematology Physician

- Oncology workgroup area = Oncology or Hematology Physician
- Critical Care (ICU) workgroup area = Critical Care Physician

If hospital does not have a specialist either employed at the hospital or contracted by the hospital, the HMS Physician Champion is acceptable, however, must be approved by the Coordinating Center.

[8] Initiative specific workgroup will take place at each of the 3 HMS Collaborative Wide Meetings during calendar year 2023 (March 15, July 12, November 1). A virtual option will be made available and will be allowed for participation purposes.