2017 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard			
Measure	Weight	Measure Description	Points
1	5	**Timeliness of HMS Data [1]**	
		On time ≥ 95%	5
		On time < 95%	0
2	5	**Completeness [1] and Accuracy [2] of HMS Data**	
		≥ 95%	5
		< 95%	0
3	10	**Consortium-wide Meeting Participation[3] – clinician lead or designee**	
		3 meetings	10
		2 meetings	7
		1 meeting	5
		No meetings	0
4	10	**Consortium-wide Meeting Participation [3] – data abstractor, QI staff, or other**	
		3 meetings	10
		2 meetings	7
		1 meeting	5
		No meetings	0
5	5	**VTE Risk Assessment Completed (on admission) [4]** ↑	
		90-100% of patients assessed for risk on admission	5
		< 90% of patients assessed for risk on admission	0
6	10	**Appropriate Prophylaxis Given (on admission) [4, 5, 6]** ↑	
		85-100% of patients at high risk for VTE	10
		75-84% of patients at high risk for VTE	5
		< 75% of patients at high risk for VTE	0
7	5	**VTE Pharmacologic Prophylaxis Given in Low Risk (on admission) [4, 6]** ↓	
		0-35% (Caprini 0-2) or 0-65% (Padua < 4) of patients at low risk for VTE	5
		> 35% (Caprini 0-2) and > 65% (Padua < 4) of patients at low risk for VTE	0
8	15	**PICCs in for ≤ 5 Days [6] (excluding deaths)** ↓	
		≤ 20% of cases with PICC in for ≤ 5 Days	15
		> 20% of cases with PICC in for ≤ 5 Days	0
9	15	**PICCs in Patients with eGFR < 45 (without Nephrology approval) [6]** ↓	
		≤ 10% of cases with PICC have eGFR < 45	15
		11-15% of cases with PICC have eGFR < 45	8
		> 15% of cases with PICC have eGFR < 45	0
10	15	**Use of Single Lumen PICCs [6]** ↑	
		≥ 25% of cases with PICC have a single lumen	15
		< 25% of cases with PICC have a single lumen	0
11	5	**QI Activity [7]**	
		Have a hospital committee that reviews data related to vascular access devices including PICCs which meets at least quarterly AND develop a plan for how the HMS data from the Antimicrobial Use Initiative will be reviewed & used for quality improvement work	5
		No vascular access review committee AND/OR plan submitted for use of the Antimicrobial Use Initiative data	0

2017 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index – Supporting Documentation

[1]Assessed at year end based on data submitted during calendar year 2017. All required cases must be completed by year end. Final due date will be announced by Coordinating Center.

[2] Assessed at site audit

[3] Based on all meetings scheduled during calendar year 2017. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[4] Assessed at year end based on final quarter of data submitted during calendar year 2017.

[5] This measure includes pharmacologic prophylaxis given on admission for at risk patients with no contraindications and mechanical prophylaxis ordered on admission for at risk patients with contraindications.

[6] Assessed at year end based on final quarter of data submitted during the calendar year 2017. If the final quarter of data does not include at least 30 cases that can be reviewed for this measure (as the denominator), cases from prior quarters during calendar year 2017 will be used as well to have at least 30 total cases to review for this measure. If a hospital does not have 30 cases that can be reviewed for this measure, the measure will not apply to the hospital given too low a volume of relevant cases.

[7] Both parts must be completed to get the points for this measure. Based on semi-annual survey responses. Minutes from the committee that reviews data related to vascular access devices will need to be sent with the semi-annual survey & the minutes will need to outline the quality improvement work being done at the hospital related to the PICC Initiative. The plan for using the Antimicrobial Use Initiative will need to be submitted in the semi-annual survey submitted in the fall of 2017.