2023 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 08/03/2023-11/08/2023 (PICC Insertions/Hospital Discharges)- **Hospitals Enrolled Prior to 2020**			
Measure	Weight	Measure Description	Points
1	5	**Timeliness of HMS Data at Mid-Year and End of Year[1]**	
		On time ≥ 95% at Mid-Year AND End of Year	5
		On time ≥ 95% at Mid-Year OR End of Year	3
		On time < 95% at Mid-Year AND End of Year	0
2	5	**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	5
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed OR audit case corrections not completed by due date	0
3	10	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings	10
		2 meetings	5
		1 meeting	0
		No meetings	0
4	10	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings	10
		2 meetings	5
		1 meeting	0
		No meetings	0
5	15	**Increase Use of 5 Days of Antibiotic Treatment[7] in Uncomplicated CAP (Community Acquired Pneumonia) Cases (i.e., reduce excess durations)[5,6]**	
		≥ 65% uncomplicated CAP cases receive 5 days[7] of antibiotics **OR** ≥ 65% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[8]	15
		50-64% uncomplicated CAP cases receive 5 days[7] of antibiotics **OR** 45-64% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[8]	10
		< 50% uncomplicated CAP cases receive 5 days[7] of antibiotics **AND** < 45% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[8]	0
6	15	**Reduce Use of Inappropriate Empiric Broad-Spectrum Antibiotics[11] for Patients with Uncomplicated CAP (Community Acquired Pneumonia)[5,6]**	
		≤ 15% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	15
		16-20% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	10
		> 20% of uncomplicated CAP cases receive an inappropriate broad-spectrum antibiotic empirically	0
7	15	**Reduce Use of Antibiotics[9] in Patients with ASB (Asymptomatic Bacteriuria) [5,6,10]**	
		≤ 10% of positive urine culture cases treated with an antibiotic are ASB cases **OR** ≥ 45% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[8]	15
		11-19% of positive urine culture cases treated with an antibiotic are ASB cases **OR** 30-44% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[8]	10
		> 19% of positive urine culture cases treated with an antibiotic are ASB cases **AND** < 30% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[8]	0

8/9	15	**Reduce Triple Lumen PICCs in Special Populations – Oncology or Critical Care**	
		Oncology	
		≤ 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **AND** participation in special population workgroup[13,14,15]	15
		≤ 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **OR** participation in special population workgroup[13,14,15]	10
		> 25% of PICCs placed in oncology patients[17] are triple lumens and in for ≤5 Days **AND** No participation in special population workgroup[13,14,15]	0
		OR	
		Critical Care (ICU)	
		≤ 30% of PICCs placed in critical care patients[16] are triple lumens **AND** Participation in special population workgroup[13,14,15]	15
		≤ 30% of PICCs placed in critical care patients[16] are triple lumens **OR** Participation in special population workgroup[13,14,15]	10
		> 30% of PICCs placed in critical care patients[16] are triple lumens **AND** No Participation in special population workgroup[13,14,15]	0
C	10	**PICC and Midline Documentation- Catheter-to-Vein Ratio and Lumens[12]**	
		≥ 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio **AND** ≥ 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	10
		≥ 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio **OR** ≥ 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	5
		< 90% **collaborative-wide average** of PICC/Midlines with documentation of Catheter-to-Vein Ratio **AND** < 98% **collaborative-wide average** of PICC/Midlines with documentation of Lumens	0
Optional Bonus			
Optional	5	Specialist[15] attendance at 3 of the special population workgroup meetings[13,14] during the calendar year in the hospital's pre-determined workgroup area **OR** Specialist[15] attendance at 1 or more of the special population workgroup meetings[14] that is not the hospital's pre-determined workgroup area 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] Assessed at year end based on final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2023. To determine the final score, an adjusted statistical model will be utilized. The method for obtaining each hospital's adjusted performance measurement utilizes all available data from the most recent 4 quarters. The collaborative wide average and collaborative wide improvement or decline, as well as the average rate change over time of each individual hospital are incorporated into the final adjusted rate. Each hospital's adjusted rate reflects both change in performance over time and overall performance relative to the collaborative averages. The adjusted performance is a more stable and reliable estimate of each hospital's current performance, their performance relative to collaborative as a whole, and reflects the improvement work each hospital is doing over a given performance year.

[6] The adjusted model for this measure includes all cohorts except Cohort 2022.

[7] Considered appropriate if 6 or fewer days of antibiotic treatment are administered

[8] Rate of change is based on the adjusted method and may not reflect raw rates from quarter to quarter

[9] Assessed based on treatment on day 2 or later of the entire hospital encounter.

[10] Out of all positive urine culture cases.

[11] Assessed based on treatment on day 2 of the hospital encounter.

[12] Assessed at year end based on the collaborative-wide average for the final quarter of data entered (per the data collection calendar) in the data registry during the calendar year 2023. This is different than the other performance measures in the index, which are applied to each individual hospital. New hospitals joining HMS in 2022 will not be used to calculate the collaborative average.

[13] Participation in Special Population Workgroup

- At least 3 individuals representing the following roles must attend 3 of the 3 tri-annual initiative specific work group meetings
    - 1 Quality Professional
    - 1 Physician (the physician in attendance for at least 1 of the 3 meetings per year must be a specialist in the special population area)
    - 1 Vascular Access Team Member or Interventional Radiologist Representative

[14] 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.

[15] 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.

[16] PICC placements where the patient was in the ICU at the time of PICC insertion.

[17] PICC placements where one of the following is true:

- Chemotherapy was delivered through the PICC
- Documented placement indication was for chemotherapy
- If the medical record reflects a cancer diagnosis **AND** the PICC was placed for a cancer-related admission