2022 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 08/04/2022-11/09/2022 (PICC Insertions/Hospital Discharges)- **Hospitals Enrolled Prior to 2021**			
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	10	**Increase Use of 5 Days of Antibiotic Treatment[6] in Uncomplicated CAP (Community Acquired Pneumonia) Cases[5] (i.e. reduce excess durations)**	
		≥ 60% uncomplicated CAP cases receive 5 days[6] of antibiotics **OR** ≥ 50% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[7]	10
		45-59% uncomplicated CAP cases receive 5 days[6] of antibiotics **OR** 25-49% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[7]	5
		< 45% uncomplicated CAP cases receive 5 days[6] of antibiotics **AND** < 25% relative increase in the number of uncomplicated CAP cases that receive 5 days of antibiotics during the current performance year[7]	0
6	10	**Reduce Fluoroquinolone Use in Patients with a Positive Urine Culture[8] and Uncomplicated CAP (Community Acquired Pneumonia)[5]**	
		≤ 10% of positive urine culture cases receive non-preferred Fluoroquinolone **AND** ≤ 10% of uncomplicated CAP cases receive non-preferred Fluoroquinolone	10
		≤ 10% of positive urine culture cases receive non-preferred Fluoroquinolone **OR** ≤ 10% of uncomplicated CAP cases receive non-preferred Fluoroquinolone	5
		> 10% of positive urine culture cases receive non-preferred Fluoroquinolone **AND** > 10% of uncomplicated CAP cases receive non-preferred Fluoroquinolone	0
7	10	**Reduce Use of Antibiotics[9] in Patients with ASB (Asymptomatic Bacteriuria) [5,10]**	
		≤ 12% of positive urine culture cases treated with an antibiotic are ASB cases **OR** ≥ 33% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[7][7]	10
		13-22% of positive urine culture cases treated with an antibiotic are ASB cases OR 20- 32% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[7]	5
		> 22% of positive urine culture cases treated with an antibiotic are ASB cases **AND** < 20% relative decrease in the number of positive urine culture cases treated with an antibiotic that are ASB cases during the current performance year[7]	0
8	15	**Reduce PICCs (Peripherally-Inserted Central Catheters) in for ≤ 5 Days (excluding deaths)[5]**	
		≤ 10% of PICC cases in for ≤ 5 Days	15
		11-15% of PICC cases in for ≤ 5 Days	10

		> 15% of PICC cases in for ≤ 5 Days	0
9	15	**Increase Use of Single Lumen PICCs in Non-ICU (Intensive Care Unit) Cases[5]**	
		≥ 80% of non-ICU PICC cases have a single lumen	15
		75-79% of non-ICU PICC cases have a single lumen	10
		< 75% of non-ICU PICC cases have a single lumen	0
10	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
		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] Assessed at year end based on final quarter of data entered (per the data collection calendar) in the data registry during the performance year 2022. 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 hospitals 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] Considered appropriate if 6 or few days of antibiotic treatment

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

[8]Non preferred Fluoroquinolone use is either due to treatment of Asymptomatic Bacteriuria (ASB) or treatment of UTI when there is a safer oral antibiotic alternative

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

[10] Out of all positive urine culture cases

[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 2022. This is different than the other performance measures in the index, which are applied to each individual hospital. New hospitals joining HMS in 2021 and 2022 will not be used to calculate the collaborative average.