2026 PERFORMANCE MEASURE CHEAT SHEET

Overview

This document explains all measures in the 2026 HMS Performance Index. Utilize this document as a supplement to the final 2026 HMS Performance Index to understand the nuances of each measure and its scoring methodology. The 2026 HMS Performance Index is broken down in to 8 site-specific measures, 1 collaborative wide measure, and 3 optional bonus points measures:

Measure	Measure Name	Measure Type	Quarters Included
1	Timeliness, Completeness, and Accuracy of HMS Data (5 metrics included)	Participation, Site-Specific	Metric-Specific
2	Collaborative Wide Meeting Participation - Physician Champion or Delegate	Participation, Site-Specific	Attendance Q4 2025 - Q3 2026
3	Collaborative Wide Meeting Participation - Clinical Data Abstractor or Other QI Staff	Participation, Site-Specific	Attendance Q4 2025 - Q3 2026
4	Increase Use of Appropriate Antibiotic Treatment Duration in Uncomplicated CAP	Performance, Site-Specific	Adjusted Rate Q3 2026
5	ABX Quality Improvement - UTI Guideline Updates	Performance, Site-Specific	Submission by Q3 2026
6	Increase Antibiotics Delivered within 3 Hours of Hospital Arrival for Sepsis Cases with Hypotension	Performance, Site-Specific	Adjusted Rate Q3 2026
7	Increase Discharge/Post-Discharge Care Coordination for Sepsis Cases Discharged to Home-Like Setting	Performance, Site-Specific	Adjusted Rate Q3 2026
8	Increase Use of Balanced Solutions in Patients with Sepsis	Performance, Site-Specific	Adjusted Rate Q3 2026
C	Reduce Use of Antibiotics in Patients with ASB	Performance, Collaborative	Raw Rate Q3 2026
Bonus 1	Participation Bonus Points (4 metrics included)	Participation, Site-Specific	Metric-Specific
Bonus 2	Increase Success of PROs Collection in Patients Eligible for PROs in ABX Cases	Performance, Site-Specific	Adjusted Rate Q3 2026
Bonus 3	Increase Success of PROs Collection in Patients Eligible for PROs in Sepsis Cases	Performance, Site-Specific	Adjusted Rate Q3 2026

Measure 1: Timeliness, Completeness, and Accuracy of HMS Data

This measure is comprised of 5 individual metrics, with 2 points assigned to each measure. The total points possible for this measure is 10.

Metric	Metric Detail	Quarters Included	Cycles Included	Data Pull Date
1	≥ 95% of registry data on time and complete at Mid-Year	Q1 2026	2232 - 2238	4/13/2026
2	≥ 95% of registry data on time and complete at End-of-Year	Q1 - Q3 2026	2232 - 2250	10/5/2026
3	≥ 95% of registry data accurate	Q4 2025 - Q3 2026	2225 - 2250	10/5/2026
4	Audit case corrections completed by due date			
5	Two semi-annual QI activity surveys completed			

Measure 1: Details

Metrics 1 & 2: Timeliness and Completeness of HMS Data

Timeliness of registry data for the ABX and Sepsis initiatives is assessed based upon the number of fully completed cases submitted out of the total number of cases required/expected for that site at the timepoint of assessment. To pass each metric, at least 95% of the number of required/expected cases for the site for the ABX initiative must be fully abstracted (with all required forms and PROs, if eligible, completed) **and** at least 95% of the number of required/expected cases for the site for the Sepsis initiative must be fully abstracted (with all required forms and PROs, if eligible, completed). These numbers are not combined - they are assessed separately and both must be met to receive full points for this portion of the measure.

Required Forms by Initiative

ABX - Pneumonia	ABX - Positive Urine Culture	Sepsis
Baseline	Baseline	Organ Function Calculator
Antibiotics	Culture	Baseline
Discharge	Discharge	Hospital Encounter
Pneumonia	UTI Window	Discharge
Daily Entry	UTI	Daily Entry Days 1-4
All eligible PROs attempts	All eligible PROs attempts	All eligible PROs attempts

Timepoints of Assessment

Timeliness and Completeness of data are assessed twice in the 2026 Performance Year: at the end of Q1 2026 and at the end of Q3 2026. See table above for full detail.

Calculation of Timeliness and Completeness Percentage

ABX Cases

$$\frac{\text{Number of ABX cases fully abstracted with all required forms completed by due date} + \text{Number of ABX Free Cases taken (if eligible)}}{\text{Number of ABX cases expected/required to be abstracted by due date} + \text{Number of ABX Free Cases taken (if eligible)}} = \%\ \text{Timeliness and Completeness of ABX Cases}$$

Sepsis Cases

$$\frac{\text{Number of Sepsis cases fully abstracted with all required forms completed by due date} + \text{Number of Sepsis Free Cases taken (if eligible)}}{\text{Number of Sepsis cases expected/required to be abstracted by due date} + \text{Number of Sepsis Free Cases taken (if eligible)}} = \%\ \text{Timeliness and Completeness of Sepsis Cases}$$

ABX Example

$$\frac{240\ \text{ABX cases fully abstracted with all required forms completed by due date} + 20\ \text{ABX Free Cases taken}}{250\ \text{ABX cases expected/required to be abstracted by due date} + 20\ \text{ABX Free Cases taken}} = 260 / 270 = 96.3\%$$

Measure 1: Details

Metrics 1 & 2: Timeliness and Completeness of HMS Data

Important Notes Regarding Timeliness and Completeness Assessment

Both ABX and Sepsis need to have 95% or more of their individual required cases abstracted to be considered full points for Metrics 1 and 2. The following are examples of passing and failing scenarios:

ABX Timeliness & Completion Percentage	Sepsis Timeliness & Completeness Percentage	Pass/Fail?
96%	100%	Pass
81%	97%	Fail
98%	78%	Fail
84%	68%	Fail

The number of cases that are expected/required to be abstracted by a site by each due date is determined utilizing the Cycle Data tab reporting for each individual site and the case volume requirements set by the HMS Coordinating Center. The following are the rules around determining the number of cases expected/required:

1. If no information is entered in the Cycle Data tab for a given cycle, that Cycle will be considered to be full volume.
2. Cycle volumes in the Cycle Data tab should reflect the number of available, eligible cases for that cycle - not just the number of cases abstracted.
3. The Coordinating Center is **unable to accept** reports of low volume in any Cycle until ALL potentially eligible cases for the performance year (Q1-Q3 2026) are reported to have been reviewed for eligibility in the Cycle Data tab. For Q1-Q3 2026, cases from Q4 2025 **cannot** be utilized for backfilling low volume cycles.
4. If your site is consistently unable to meet the year-to-date case volume requirement in each cycle because of lack of available, eligible cases, your site is unable to take free cases.

Metric 3: Accuracy of HMS Data

Accuracy of registry data is based on score(s) received for site audits conducted during the performance year. Scores are averaged if multiple audits take place during the year.

HMS Audit: General Overview

Data audits are conducted for educational purposes and to ensure that data is being collected consistently across all participating hospitals. The goal of the audit is to identify any issues with the abstraction process so that they can be appropriately addressed via education and/or changes to the data entry system, as well as reinforce and celebrate appropriate practice.

Cases to be audited are selected randomly and intend to represent a sample of most common scenarios faced by abstractors for each initiative. During the audit, the HMS Auditor(s) will complete an independent review of the medical documentation for each case and comparing it to what was entered into the HMS database.

Audits are performed on the site as a whole - not on an individual abstractor. For Metric 3 in Performance Measure 1, full points will be awarded to the site if they achieve a 95% or greater rate of accuracy. If a site receives a score of less than 95% on an individual audit, every attempt will be made to re-audit that site in the same performance year. If two or more audits are conducted at one site within one Performance Year, the average of the total audit scores will be used for scoring on the final year-end Performance Index.

Important Audit Scoring Note

If an audited case is found to be ineligible, a score of 90% will be assigned for that case in the final audit summary. The total audit score is calculated by calculating the average score of all audited cases.

Measure 1: Details

Metric 3: Accuracy of HMS Data

Audit Scoring Calculation

Scoring by Case

$$\frac{\text{Number of data elements accurately abstracted}}{\text{Number of data elements possibly abstracted}} = \%\ \text{Accuracy of Audited Case}$$

Overall Scoring

$$\frac{\text{Sum of audited case scores}}{\text{Number of cases audited}} = \text{Final Audit Score}$$

Metric 4: Audit Case Corrections Completed by Due Date

Upon receiving the final audit summary from the HMS Coordinating Center (typically 2-4 weeks after the completion of the audit review), the site has three months after the **date of receipt** of the summary to make all updates in the HMS database noted or by the end-of-year deadline (10/5/2026), whichever comes first. If a site has more than 1 audit in the performance year, all audit correction due dates must be met in order to receive full points for this metric.

Failure to complete audit corrections by their due date(s) will result in the site receiving 0 points for Metric 4.

Metric 5: Completion of Both Semi-Annual Quality Improvement Surveys

The HMS Coordinating Center sends two Quality Improvement (QI) surveys per year - in Fall and Spring. Both surveys must be completed by the due dates announced by the Coordinating Center in the email with the survey's link and supplemental information in order to receive full points for this metric. The following are examples of passing and failing scenarios:

Fall QI Survey Completion	Spring QI Survey Completion	Pass/Fail?
Completed by Due Date	Completed by Due Date	Pass
Not Completed by Due Date	Completed by Due Date	Fail
Completed by Due Date	Not Completed by Due Date	Fail
Not Completed by Due Date	Not Completed by Due Date	Fail

Measures 2 and 3: Collaborative Wide Meeting Participation

Measure 2: Collaborative Wide Meeting Participation - Physician Champion or Delegate

HMS hosts 3 Collaborative Wide Meetings each year - March (virtual), July (in-person), and November (in-person). Participation of the Physician Champion or delegate is defined as virtual (March) or in-person (July & November) attendance at each meeting for the required attendee. The Physician Champion or delegate may only represent **one HMS-participating site** per meeting. Each site is able to send more than one Physician Champion or delegate, but at least one per site must be present for each meeting to achieve full points.

Measures 2 & 3: Details

Measure 2: Collaborative Wide Meeting Participation - Physician Champion or Delegate

A Physician Champion or delegate must meet the following requirements outlined below:

- Interested and active in the care of hospitalized medical patients at the participating site
- Champion the QI efforts at the participating site associated with HMS initiatives
- Be willing to work with the HMS Coordinating Center in developing and implementing continuous quality improvement efforts associated with HMS initiatives
- Delegates for the primary Physician Champion must be a physician and cannot be a Resident, Intern, Fellow or Advanced Practice Professional (Physician Assistant or Nurse Practitioner)

Measure 3: Collaborative Wide Meeting Participation - CDA or Other QI Staff

HMS hosts 3 Collaborative Wide Meetings each year - March (virtual), July (in-person), and November (in-person). Participation of the Clinical Data Abstractor (CDA) or other QI Staff is defined as virtual (March) or in-person (July & November) attendance at each meeting for the required attendee. The CDA or other QI staff may only represent **one HMS-participating site** per meeting. Each site is able to send **more than one** CDA or other QI staff, but **at least one per site** must be present for each meeting to achieve full points.

Measures 4 & 5: Site-Specific Antimicrobial Use Performance

Measure 4: Increase Use of Appropriate Antibiotic Treatment Duration in Uncomplicated Community-Acquired Pneumonia Cases

Antibiotic duration of Uncomplicated Community-Acquired Pneumonia (uCAP) cases is considered appropriate if 3 to 5 days of total, effective antibiotic treatment (inpatient and outpatient) is administered.

Definition of Uncomplicated CAP

Uncomplicated CAP is defined as a patient who meets the radiographic and clinical criteria for pneumonia who do not meet the criteria for Complicated CAP.

HMS Pneumonia Categorization

To meet the clinical criteria for pneumonia, a case must have one of the following radiographic components and two or more clinical findings. Radiographs from 3 days prior through day 4 of the hospital encounter are utilized in this determination. Clinical findings from 2 days prior through day 2 of the hospital encounter are utilized in this determination.

If a Chest CT and Chest X-Ray or Abdominal CT are done within 1 calendar day of each other within this timeframe, the radiographic findings from the Chest CT will be utilized over those from a Chest X-Ray or Abdominal CT when determining pneumonia diagnosis.

Radiographic Component (Need at least 1)	
Air bronchograms	Infection/Cannot rule out infection/Likely infection
Air space density/opacity/disease	Infiltrate
Aspiration	Loculations
Aspiration pneumonia	Mass
Bronchopneumonia	Necrotizing pneumonia
Cannot rule out pneumonia	Nodules/Nodular airspace disease
Cavitation	Pleural effusion
Consolidation	Pneumonia
Ground Glass	Post-obstructive Pneumonia

Measure 4: Details

Measure 4: Increase Use of Appropriate Antibiotic Treatment Duration in uCAP Cases

HMS Pneumonia Categorization (Continued)

Clinical Findings (Need at least 2)	
Cough Increased secretions/sputum production Dyspnea/shortness of breath or Tachypnea Hypoxia/hypoxemia	Fever/rigors or hypothermia Physical exam consistent with pneumonia (rales, crackles, dullness on percussion, bronchial breath sounds, egophony, or rhonchi) WBC > 10,000 or < 4,000

HMS Pneumonia Subcategories

HMS has three subcategories of pneumonia cases: Questionable Pneumonia, Complicated CAP, and Uncomplicated CAP. Questionable pneumonia cases are those who do not meet the radiographic or clinical criteria outlined in the prior section. Uncomplicated CAP cases are those who meet the radiographic or clinical criteria for pneumonia, but do not meet any of the following criteria for Complicated CAP (where support of a 5-day antibiotic duration is limited):

HMS Complicated CAP Criteria	
Criteria	**Definition**
Moderate to severe immune compromise	Congenital or acquired immunodeficiency, asplenia, nephrotic syndrome, kidney transplant, HIV/AIDs, recent chemotherapy (past 30 days for solid tumor) or other cancer treatment (prior 6 months for lymphoma or hematologic malignancy), or recent administration of biologic agents/immunosuppressants/steroids
Structural lung disease	Bronchiectasis, pulmonary fibrosis, interstitial lung disease, or presence of a tracheostomy during the hospital encounter
Lung malignancy	Small cell and non-small cell lung cancer or metastases to the lung
Culture with Staphylococcus aureus or MRSA	MSSA or MRSA on cultures or MRSA nasal swabs collected during the hospital encounter or in the 14 days prior to the hospital encounter
Culture with non-fermenting Gram-negative bacilli	Respiratory, blood, or pleural fluid cultures collected during or in the 14 days prior to the hospital encounter that are positive for any of the following: Acinetobacter, Achromobacter, Burkholderia, Pseudomonas, or Stenotrophomonas
Moderate to severe COPD	Documentation in the medical record of moderate or severe COPD, documentation of COPD with use of home oxygen, or documentation of an FEV1 value of < 80%

Measure 4 Scoring Methodology

This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3 2026) of the Performance Year. The method for obtaining each hospital's adjusted performance score utilizes all available data from the most recent 4 quarters (Q4 2025 - Q3 2026). The following are the elements that contribute to the adjusted performance score:

- Collaborative wide average
- Collaborative wide improvement or decline
- Site's average rate of performance change over time
- Site's overall performance related to the collaborative

The following is the point distribution for this measure:

Full Points (15)	Partial Points (8)	No Points (0)
≥ 75% of uCAP cases receive appropriate duration of antibiotics	65-74% of uCAP cases receive appropriate duration of antibiotics	≤ 64% of uCAP cases receive appropriate duration of antibiotics

uCAP Antibiotic Duration Calculation Rules

- Days of treatment are assessed starting with the first day of effective antibiotic treatment during the hospital encounter.
- Antibiotic duration is calculated using effective duration which considers the presence of pathogen susceptibility and resistance.
- Antibiotic days of treatment are counted as calendar days rather than 24-hour periods; therefore, 6 total days of antibiotic duration is also considered appropriate for the allowance of a 1-day grace period.
- Cases with total antibiotic durations of 1 or 2 days are excluded from the denominator of this measure.
- Missing critical data calculate duration.

Measure 4 & 5: Details

Measure 4: Increase Use of Appropriate Antibiotic Treatment Duration in uCAP Cases

Measure 4 Raw Rate Scoring Calculation

$$\frac{\text{Pneumonia cases classified as uCAP that received 3-5 days (+ 1 day) of antibiotics}}{\text{Pneumonia cases classified as Uncomplicated CAP eligible for 5 days of antibiotics}} = \% \text{ Passing Cases}$$

Measure 5: Urinary Tract Infection (UTI) Guideline Updates

The intention of this measure is to support the adoption and implementation of the updated IDSA Complicated UTI Clinical Guidelines for Treatment and Management. HMS will distribute a survey in Fall 2026 to all HMS ABX abstractors and quality administrative leads to collect the necessary information for this measure. It is the responsibility of the ABX abstractor and/or quality administrative lead to collaborate with key stakeholders involved in updating and implementing clinical guidelines to ensure compliance with this measure.

Updated UTI guidelines (with the following criteria in place) must either by fully implemented and in use by the time of submission OR have documented proof that updates have been submitted for local approval.

Locally-developed UTI guidelines must included ALL of the following elements (and meet the above criteria) to achieve full points on this measure:

- Identify symptoms of a UTI
- Maintain existing HMS-concordant guidelines
  - Recommend against sending urine cultures in the absence of urinary symptoms
  - Recommend against treating a positive urine culture in the absence of urinary symptoms
  - De-emphasize fluoroquinolones
- Complicated UTI classification should include:
  - Febrile UTI
  - Bacteremic UTI
  - Pyelonephritis
  - CAUTI
- Uncomplicated Lower UTI or Cystitis classification should include:
  - Infections localized to the bladder (in women or men) regardless of comorbidities
- Provide antibiotic treatment recommendations for Uncomplicated Lower UTI/Cystitis, including:
  - Transition to oral therapy
  - Dose
  - Duration of treatment
  - Selection of beta-lactam antibiotic is at the discretion of the site; alternative agents may be used in cases of an allergy

Antibiotic	Duration
Preferred	
Nitrofurantoin	5 days
Trimethoprim-sulfamethoxazole	3 days
IV beta-lactam to any oral agent	≤ 5 days
Alternative	
Fosfomycin	1 dose
Exclusively oral beta-lactam	≤ 7 days

Measure 5: Details

Measure 5: Urinary Tract Infection (UTI) Guideline Updates

Measure 5 Point Distribution

The following is the point distribution for this measure:

Full Points (5)	No Points (0)
Submit updated locally-developed UTI guidelines with all elements included	Updated UTI guidelines not submitted or all elements not included

Measures 6-8: Site-Specific Sepsis Performance

Measure 6: Increase Antibiotics Delivered within 3 hours of Hospital Arrival for Sepsis Cases with Hypotension

For this measure, HMS is assessing whether antibiotics were administered within 3 hours of arrival to patients presenting with hypotension within the first 2 hours of hospital arrival. The Surviving Sepsis Campaign Guidelines recommend adult patients presenting with shock and possible or probable sepsis should receive antimicrobials immediately, ideally within 1 hour.

Cases Included in this Measure

Patients presenting with hypotension within 1-2 hours of hospital arrival. Hypotension is defined as any of the following:

- An intravenous vasopressor initiated
- Systolic blood pressure < 90 mmHg
- MAP < 65 mmHg

Cases Excluded from this Measure

Cases excluded from this measure are those that meet at least one of the following criteria:

- Positive COVID or Influenza A/B test within the 3 days prior to or on days 1 or 2 of the hospital encounter
- Less than 2 SIRS criteria within the first 2 hours of hospital arrival:
  - Temperature < 36C or > 38C
  - Heart rate > 90 bpm
  - Respiratory rate > 20
- White blood cell count of 4,000-12,000
- Lactate < 2.0
- No signs/symptoms of infection (see table for details)

General Symptoms	Cognitive Symptoms	Urinary Symptoms	Respiratory Symptoms
Abdominal pain/ nausea/vomiting/diarrhea	Altered mental status	CVA pain or tenderness/ suprapubic tenderness/flank pain	Accessory muscle use/retractions/increased work of breathing/tachypnea
Autonomic dysreflexia/increased spasticity	Confusion/disorientation	Dysuria/frequency/polyuria	Cough/chest congestion/ sputum production
Chills/rigors or Fever > 37.2C	Delirium/encephalopathy/not acting like themselves	Urinary urgency	Crackles/rales
Fatigue/malaise/myalgias/ headache/weakness	Lethargy/somnolence		Dyspnea/shortness of breath/ hypoxia/new or worsening FiO2 requirement
Fever (Subjective)	Obtundation/coma		Rhonchi

Measures 6 & 7: Details

Measure 6: Increase Antibiotics Delivered within 3 hours of Hospital Arrival for Sepsis Cases with Hypotension

Measure 6 Scoring Methodology

This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3 2026) of the Performance Year. The method for obtaining each hospital's adjusted performance score utilizes all available data from the most recent 4 quarters (Q4 2025 - Q3 2026). The following are the elements that contribute to the adjusted performance score:

- Collaborative wide average
- Collaborative wide improvement or decline
- Site's average rate of performance change over time
- Site's overall performance related to the collaborative

The following is the point distribution for this measure:

Full Points (15)	Partial Points (8)	No Points (0)
≥ 75% of sepsis cases with hypotension receive antibiotics within 3 hours of hospital arrival	71-74% of sepsis cases with hypotension receive antibiotics within 3 hours of hospital arrival	≤ 70% of sepsis cases with hypotension receive antibiotics within 3 hours of hospital arrival

Measure 6 Raw Rate Scoring Calculation

$$\frac{\text{Sepsis cases with hypotension that receive antibiotics within 3 hours of hospital arrival}}{\text{All sepsis cases with hypotension and no exclusion criteria}} = \%\ \text{Passing Cases}$$

Measure 7: Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to a Home-Like Setting

For this measure, HMS is assessing if patients discharged to a home-like setting are receiving at least one discharge/post-discharge coordination of care measures and if patients who are at high risk of readmission are receiving at least two discharge/post-discharge coordination of care measures.

Home-Like Setting Definition

Patients are considered to be discharged to a home-like setting if they are discharged from the hospital encounter to any of the following locations (with or without home health services):

- Home
- Assisted living
- Custodial nursing
- Temporary shelter

High Risk Definition

Patients are considered to be high risk for readmission through one of the following two methods:

- Patients deemed by your site-specific readmission risk score to be high risk
- If no site-specific readmission risk score is available, the **HMS Sepsis Readmission Score** will be utilized

Measure 7: Details

Measure 7: Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to a Home-Like Setting

Discharge/Post-Discharge Care Coordination Measures

The following are the 4 discharge/post-discharge care coordination measures that are considered for this performance measure:

Measure	Requirements
Hospital contact information provided at discharge (in discharge paper work)	1. Phone number must be prominently displayed in discharge paperwork with instructions to call the number if the patient has any questions, concerns, or complications post-discharge 2. Phone line must be manned 24/7 3. Number must connect patient to a provider within 1 hour 4. You may include a PCP or specialist number if that provider meets **both** of the following requirements: the PCP/specialist saw the patient during their hospitalization AND assumed the patients care upon discharge
Scheduled for outpatient follow-up within 2 weeks (at time of discharge)	1. Follow-up visit with a PCP or specialist (MD or APP) must be scheduled **prior to patient discharge** 2. Appointment details must be placed in the patient's discharge paperwork
Post-discharge telephone call attempted within 3 calendar days of hospital discharge **OR** visit with Primary Care Provider or specialist within 3 calendar days	**Requirements for phone call:** 1. Caller must be a clinician (Physician, Nurse, Pharmacist, APP, Case Manager, or Social Worker) 2. Caller had access to the patient's hospitalization records in the EMR 3. Caller placed a record of the call in the EMR 4. Robocalls will only count toward this measure if the patient is connected with a clinician at the end of the call
Patient is discharged to a home-like setting with home health services	1. Patient is ordered to receive home nursing services or palliative care services at time of discharge 2. Excludes physical therapy, occupational therapy, or infusion services

Measure 7: Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to a Home-Like Setting

HMS Sepsis Readmission Score Definition

The HMS Sepsis Readmission Score is based upon elements from published literature such as the LACE Score and Sepsis Transition and Recovery (STAR) program high-risk readmission definition. The following table explains the scoring structure:

Element	Score
Length of Stay	1-6 Days: 0 points 7-10 Days: 1 point 11-14 Days: 2 points 15+ Days: 3 points
Admitted from SNF/SAR/LTAC	1 point
Admitted to the ICU during the hospital encounter	1 point
Hospitalization in the 90 days prior to the hospital encounter	1 point
Baseline functional limitation (partially/fully dependent)	1 point
Mild, moderate, or severe liver disease	1 point
Hematologic malignancy (leukemia/lymphoma)	1 point
Congestive heart failure	1 point
Cardiovascular disease	1 point
Peripheral vascular disease	1 point
Moderate or severe kidney disease	1 point
High Risk for Readmission = ≥ 4 points	

Measures 7 & 8: Details

Measure 7: Increase Discharge/Post-Discharge Care Coordination for Sepsis Patients Discharged to a Home-Like Setting

Measure 7 Scoring Methodology

This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3 2026) of the Performance Year. The method for obtaining each hospital's adjusted performance score utilizes all available data from the most recent 4 quarters (Q4 2025 - Q3 2026). The following are the elements that contribute to the adjusted performance score:

- Collaborative wide average
- Collaborative wide improvement or decline
- Site's average rate of performance change over time
- Site's overall performance related to the collaborative

The following is the point distribution for this measure:

Full Points (15)	Partial Points (8)	No Points (0)
≥ 86% of all sepsis cases discharged to a home-like setting received at least 1 of 4 discharge/post-discharge coordination of care measures **AND** ≥ 74% sepsis cases at high risk of readmission received at least 2 of 4 discharge/ post-discharge coordination of care measures	≥ 86% of all sepsis cases discharged to a home-like setting received at least 1 of 4 discharge/post-discharge coordination of care measures **OR** ≥ 74% sepsis cases at high risk of readmission received at least 2 of 4 discharge/ post-discharge coordination of care measures	≤ 85% of all sepsis cases discharged to a home-like setting received at least 1 of 4 discharge/post-discharge coordination of care measures **AND** ≤ 73% sepsis cases at high risk of readmission received at least 2 of 4 discharge/post-discharge coordination of care measures

Measure 7 Raw Rate Scoring Calculations

Part One: All Sepsis Cases

$$\frac{\text{Sepsis cases receive at least 1 discharge/post-discharge care coordination measures}}{\text{All sepsis cases discharged to a home-like setting}} = \%\ \text{Passing Cases}$$

Part Two: High-Risk Sepsis Cases

$$\frac{\text{Sepsis cases at high risk of readmission receive at least 2 discharge/post-discharge care coordination measures}}{\text{All sepsis cases discharged to a home-like setting}} = \%\ \text{Passing Cases}$$

Measure 8: Increase Use of Balanced Solutions over Normal Saline in Patients with Sepsis

For this measure, HMS is assessing the ratio of receipt of balanced solutions vs. normal saline in patients with sepsis who receive more than 1 liter of bolus and/or maintenance fluids in the first 48 hours of the hospital encounter. The Surviving Sepsis Campaign Guidelines suggest that adults with sepsis or septic shock receive balanced crystalloids instead of normal saline for resuscitation.

Measure 8: Details

Measure 8: Increase Use of Balanced Solutions over Normal Saline in Patients with Sepsis

Fluid Inclusion Definitions

- Balanced solutions are defined as Lactated Ringers, Plasma-Lyte, Dextrose in Lactated Ringer's, Dextrose in Plasma-Lyte, and Normosol
- Bicarbonate infusions are excluded from the numerator and denominator of this measure

Measure 8 Scoring Methodology

This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3 2026) of the Performance Year. The method for obtaining each hospital's adjusted performance score utilizes all available data from the most recent 4 quarters (Q4 2025 - Q3 2026). The following are the elements that contribute to the adjusted performance score:

- Collaborative wide average
- Collaborative wide improvement or decline
- Site's average rate of performance change over time
- Site's overall performance related to the collaborative

The following is the point distribution for this measure:

Full Points (15)	Partial Points (8)	No Points (0)
≥ 50% of sepsis cases who have ≥ 75% of their bolus and/or maintenance fluids as balanced solutions in the first 48 hours of the hospital encounter	25-49% of sepsis cases who have ≥ 75% of their bolus and/or maintenance fluids as balanced solutions in the first 48 hours of the hospital encounter	≤ 24% of sepsis cases who have ≥ 75% of their bolus and/or maintenance fluids as balanced solutions in the first 48 hours of the hospital encounter

Measure 8 Calculations

Part One: Determining Balanced Solutions Ratio by Case

$$\frac{\text{Volume of bolus/maintenance fluid administered as balanced solutions in first 48 hours of hospital encounter}}{\text{Total bolus/maintenance fluid volume received in first 48 hours of hospital encounter}} = \%\ \text{Balanced Fluids Administered}$$

Part Two: Raw Rate Scoring Calculation

$$\frac{\text{Sepsis cases receiving} \geq 75\% \text{ of their bolus/maintenance fluid as balanced solutions in the first 48 hours of the hospital encounter}}{\text{All sepsis cases receiving} \geq 1 \text{ liter of bolus/maintenance fluid in the first 48 hours of the hospital encounter}} = \%\ \text{Passing Cases}$$

Measure C: Collaborative Wide Antimicrobial Use Measure

Measure C: Reduce Use of Antibiotics in Patients with Asymptomatic Bacteriuria

For this measure, HMS is assessing (at a collaborative wide level) if patients with asymptomatic bacteriuria (ASB) are receiving antibiotics on day 2 or later of the hospital encounter. National guidelines strongly recommend against routine antibiotic treatment for ASB in most adults.

Measure C: Details

Measure C: Reduce Use of Antibiotics in Patients with ASB

Defining ASB

ASB is defined as the clinical scenario in which the first urine culture collected during the hospital encounter is positive (per the site's laboratory criteria), but the patient does not have any signs/symptoms of a UTI on the 3 days before, day of, or 3 days after collection of the first positive urine culture (referred to as the UTI Window).

Signs/Symptoms of UTI	
Urgency Frequency Dysuria Fever (> 38C in age 18-64, >37.8C in age 65+) Rigors Costovertebral pain/tenderness Flank pain/tenderness	Suprapubic pain/tenderness Acute hematuria Increased spasticity or autonomic dysreflexia in patients with spinal cord injury Acute mental status change (with leukocytosis > 10,000, hypotension (<90 mmHg systolic), or > 2 SIRS criteria within 1 calendar day of AMS)

Additional Details for ASB Measure

- ASB treatment is assessed based upon antibiotic treatment administered to the patient on day 2 or later of the hospital encounter (including at discharge from the hospital encounter).
- Cases meeting criteria for severe sepsis with organ dysfunction on the day before, day of, or day after the collection of the first positive urine culture are **not** classified as ASB.
- Cases where increased seizure activity is documented are not included in this measure. Clinical judgement is advised for these patients.
- Cases where antibiotics were given only on day 1 of the hospital encounter and have a frequency of q48h or where antibiotics are given outside of the UTI Window are not included in this measure.

Measure C Scoring Methodology

This measure is assessed utilizing the **collaborative wide average** for the final quarter of data (Q3 2026) for the 2026 Performance Year. This collaborative wide score will be utilized on the final 2026 Performance Measure scorecard for all HMS participating sites, regardless of the site's individual score.

The following is the point distribution for this measure:

Full Points (5)	No Points (0)
≤ 10% of the collaborative average of positive urine culture cases are ASB cases treated with an antibiotic on day 2 or later of the hospital encounter	≥ 10% of the collaborative average of positive urine culture cases are ASB cases treated with an antibiotic on day 2 or later of the hospital encounter

Measure C Raw Rate Scoring Calculation

$$\frac{\text{Collaborative wide number of positive urine culture cases classified as ASB that received antibiotics on day 2 of the hospital encounter}}{\text{Collaborative wide number of all positive urine culture cases eligible for this measure}} = \text{Collaborative Wide Average}$$

Optional Bonus Point Measures

Bonus Points General Overview

Bonus points are **optional** incentives provided to each site to assist with increasing the overall score on the Performance Index. The overall score on the Performance Index is **100 points** - bonus points may be added to the scorecard total, in their respective categories, up to the 100 point total. The final score will not exceed 100 points overall. Participation bonus points may only apply to participation-based measures (1-3) and performance bonus points may only apply to performance based measures (4-8 + C).

Optional Bonus Point Measures

Participation Bonus Points

Each participating hospital has the option of earning **up to 5** bonus points toward their participation metrics (measures 1-3) during the 2026 Performance Year. The following is the breakdown of the bonus point opportunities and their scoring periods:

Opportunity	Opportunity Detail	Quarters Included	Points Available
Emergency Medicine physician attendance at 2 in-person CWMs	To receive full points, the EM physician must attend both the November 2025 and July 2026 CWMs. See additional criteria for EM physician below.	Q4 2025 - Q3 2026	5 points
Present HMS data or about HMS at a national meeting (with Coordinating Center approval)	Presenters who are interested in sharing HMS data at a national or international meeting must submit intent to present data to the HMS Coordinating Center and receive approval from the HMS DDP committee. Guidelines in the most recent HMS Publication Policy must be followed.	Q1 - Q3 2026	3 points
Emergency Medicine physician attendance at 1 of 2 in-person CWMs	To receive full points, the EM physician must attend either the November 2025 or July 2026 CWM. See additional criteria for EM physician below.	Q4 2025 - Q3 2026	2 points
Site member presents at an HMS meeting, event, or webinar	Items included in this measure include HMS CWMs, HMS-sponsored events/webinars, or HMS Abstractor Conference Calls. Sites may only receive these points for one single presentation in the eligible timeframe.	Q1 - Q3 2026	2 points

Emergency Medicine Provider Definitions

The following are the requirements needed to be met by the Emergency Medicine physician to count for participation bonus points:

- The EM physician cannot be a resident, fellow, intern, or Advanced Practice Professional
- EM physicians can only represent 1 site per meeting
- The EM physician may not also be the Physician representing the site in order to meet Measure 2 of the Performance Index (CWM meeting participation - Physician Champion or delegate)

Performance Bonus Points Measure 1: Increase Success of Patient Reported Outcomes Collection in Patients Eligible for PROs Completion in ABX Cases

The intention of this bonus points measure is to encourage and incentivize the success of Patient Reported Outcomes (PROs) attempts in ABX patients who are eligible for PROs (phone, email, or text). A successful PROs attempt means that the patient (or their caregiver) was contacted and information was obtained.

Patients Ineligible for PROs

The following are the criteria that would make a case ineligible for a PROs attempt in the ABX initiative:

- The patient was transferred to the ICU or another acute care hospital at the end of abstraction
- The patient was discharged to inpatient or home hospice, or hospice provided in another healthcare facility
- At the 30th day post-discharge, the patient was found via medical documentation to be:
  - Deceased
  - In a correctional facility
  - In an Extended Care Facility
  - In the hospital
- Patient had a status change after 30 days post-discharge prohibiting the abstractor from contacting the patient or their caregiver
- Cases where no contact information (phone/email) is available for the patient or caregiver
- Patient or caregiver refuses to answer questions

Optional Bonus Point Measures

Performance Bonus Points Measure 1: Increase Success of Patient Reported Outcomes Collection in Patients Eligible for PROs Completion in ABX Cases

Defining PROs Success

There are three methods available in the HMS Registry for obtaining PROs: phone, email, text, or Institution-Based PROs. The following are the definitions of "success" in each method:

Phone	Email	Text	Institution-Based PROs
"Yes" is noted in the registry as the response to the question "Indicate whether you were able to obtain information from the patient or their caregiver via phone"	An email sent to the patient through the HMS ePROs process	A text is sent to the patient through the HMS ePROs process	"Yes" is noted in the registry as the response to the question "Indicate whether you were successful in gathering follow-up information for the patient utilizing your Institution-Based PROs process"

Performance Bonus Point Measure 1 Scoring Methodology

This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3 2026) of the Performance Year. The method for obtaining each hospital's adjusted performance score utilizes all available data from the most recent 4 quarters (Q4 2025 - Q3 2026). The following are the elements that contribute to the adjusted performance score:

- Collaborative wide average
- Collaborative wide improvement or decline
- Site's average rate of performance change over time
- Site's overall performance related to the collaborative

The following is the bonus point distribution for this measure:

2.5 Bonus Points	2 Bonus Points	1.5 Bonus Points
≥ 85% success of PROs collection in ABX cases	80-84% success of PROs collection in ABX cases	75-79% success of PROs collection in ABX cases

Performance Bonus Point Measure 1 Raw Rate Scoring Calculation

$$\frac{\text{Number of ABX cases with a successful phone call/Institution-Based PROs attempt OR an ePROs response was received}}{\text{Number of ABX cases eligible for PROs data collection}} = \%\ \text{ABX PROs Success Rate}$$

Performance Bonus Points Measure 2: Increase Success of Patient Reported Outcomes Collection in Patients Eligible for PROs Completion in Sepsis Cases

The intention of this bonus points measure is to encourage and incentivize the success of Patient Reported Outcomes (PROs) attempts in Sepsis patients who are eligible for PROs (phone, email, or text). A successful PROs attempt means that the patient (or their caregiver) was contacted and information was obtained.

Optional Bonus Point Measures

Performance Bonus Points Measure 2: Increase Success of Patient Reported Outcomes Collection in Patients Eligible for PROs Completion in Sepsis Cases

Patients Ineligible for PROs

The following are the criteria that would make a case ineligible for a PROs attempt in the Sepsis initiative:

- The patient was transferred to the ICU or another acute care hospital at the end of abstraction
- The patient was discharged to inpatient or home hospice, or hospice provided in another healthcare facility
- At the 30th day post-discharge, the patient was found via medical documentation to be:
  - Deceased
  - In a correctional facility
  - In an Extended Care Facility
  - In the hospital
- Patient had a status change after 30 days post-discharge prohibiting the abstractor from contacting the patient or their caregiver
- Cases where no contact information (phone/email) is available for the patient or caregiver
- Patient or caregiver refuses to answer questions

Defining PROs Success

There are three methods available in the HMS Registry for obtaining PROs: phone, email, text, or Institution-Based PROs. The following are the definitions of "success" in each method:

Phone	Email	Text	Institution-Based PROs
"Yes" is noted in the registry as the response to the question "Indicate whether you were able to obtain information from the patient or their caregiver via phone"	An email sent to the patient through the HMS ePROs process	A text is sent to the patient through the HMS ePROs process	"Yes" is noted in the registry as the response to the question "Indicate whether you were successful in gathering follow-up information for the patient utilizing your Institution-Based PROs process"

Performance Bonus Point Measure 2 Scoring Methodology

This measure is assessed utilizing an adjusted statistical model in the final quarter (Q3 2026) of the Performance Year. The method for obtaining each hospital's adjusted performance score utilizes all available data from the most recent 4 quarters (Q4 2025 - Q3 2026). The following are the elements that contribute to the adjusted performance score:

- Collaborative wide average
- Collaborative wide improvement or decline
- Site's average rate of performance change over time
- Site's overall performance related to the collaborative

The following is the bonus point distribution for this measure:

2.5 Bonus Points	2 Bonus Points	1.5 Bonus Points
≥ 85% success of PROs collection in Sepsis cases	80-84% success of PROs collection in Sepsis cases	67-79% success of PROs collection in Sepsis cases

Performance Bonus Point Measure 2 Raw Rate Scoring Calculation

$$\frac{\text{Number of Sepsis cases with a successful phone call/Institution-Based PROs attempt OR an ePROs response was received}}{\text{Number of Sepsis cases eligible for PROs data collection}} = \%\ \text{Sepsis PROs Success Rate}$$