



Inpatient Quality Reporting Program

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NHSN: Transition to the Rebaseline Guidance for Acute Care Facilities

Presentation Transcript

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Candace Jackson: Hello and welcome to the Hospital Inpatient Quality Reporting Program webinar on *NHSN: Transition to the 2015 ReBaseline Guidance for Acute Care Facilities*. My name is Candace Jackson, and I will be your host for today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation along with the questions and answers will be posted to our inpatient website, www.qualityreportingcenter.com generally within 10 business days. If you registered for this event, a reminder email, as well as the slides, was sent to your email about two hours ago. If you did not receive that email, you can download the slides at our inpatient website, again that's www.qualityreportingcenter.com. And now, I would like to

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introduce our guest speakers for today: Prachi Patel, Rebecca Konnor and Lindsey Weiner. Prachi Patel, MPH, is a Public Health Analyst with NHSN Methods and Analytics team. She provides support to NHSN healthcare facilities on reporting their CMS required data and their NHSN data analysis and interpretation. Rebecca Konnor, MPH is a Public Health Analyst with NHSN's Methods and Analytics team and a trained epidemiologist with experience in conducting disease surveillance to monitor the incidents and the prevalence of disease in our communities. Lindsey Weiner, MPH is an epidemiologist on the NHSN's Methods and Analytics team. She provides training to NHSN users on HAI data analysis and is involved in an analysis and publication of national NHSN data. Again, any questions that are not answered during our question and answer session at the end of the webinar will be posted to the qualityreportingcenter.com website generally within 10 business days. We do ask that, if you submit a question through the chat feature, that you be very specific and, if possible, reference a slide number that you are asking about. Please be aware that not all questions submitted to the chat may not be answered during the presentation. Thank you again to everyone for joining. Prachi, the floor is yours.

Prachi Patel:

Thank you, Candace. Good afternoon and thank you all for attending today's webinar. My name is Prachi Patel and today me and my fellow team members, Rebecca and Lindsey, will be reviewing the *NHSN: Transition to the 2015 ReBaseline Guidance for Acute Care Facilities*.

Today's objectives are: explain the elements of the new HAI risk model, review the use of the SIRs in relation to the Centers for Medicare & Medicaid Services, or CMS, Program; learn how to review NHSN data; preview the new application interface; and also to discuss additional resources and upcoming events.

Before we get into the individual models, I just wanted to go over some important general information regarding the rebaseline. It's coming, there's no stopping it. The new risk adjusted baseline or BS2 will be implemented into the NHSN application on December 10, 2016. Now through December 10, which is the scheduled release of the NHSN

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version 8.6, we are developing new reports and NHSN applications and providing a multitude of education opportunities, such as newsletters, quick reference guides, and rebaseline webinars. Now, with the NHSN version 8.6 release on December 10, NHSN users will be able to run SIRs for 2015 and 2016 under both the old baseline, or BS1, and the new baseline, or BS2. Also, it's important to keep in mind that data for 2017 and forward will be available under the new BS2 only.

For our rebaseline modeling approach, we included the following: we used only in-plan data that was reported into NHSN from January 2015 till December 2015 as reported by May 16, 2016; we included facilities from all states, territories, and DoD installations; the lead analysts applied consistent overarching methods and analytic approach; we had input that was solicited from subject matter experts; decisions were made before regarding which factors should or should not be considered potential risk factors in the model; and finally, data cleaning and outlier detection was performed prior to modeling work.

Now that we have a general understanding of the rebaseline, let us proceed to the CMS model. To start off, I will be going over the rebaseline efforts and modeling detail for device associated events or CLABSI and CAUTI.

For Central Line-Associated Bloodstream Infections, or CLABSIs, data is submitted to CMS that includes in-plan data. Beginning with 2011, it has been required to report all adult, pediatric, and neonatal ICU locations. In the beginning of 2015, additional locations were added: adult and pediatric, adult and pediatric surgical wards, and adult and pediatric medical/surgical wards.

Now, let me go over model changes for CLABSI. A negative binomial regression model used to calculate the number of predicted infections. MBI-LCBIs were excluded and removed from the CLABSI SIR. And finally, we had addition of events and device days from some ICU locations. Now, the reason for this was there were some locations that at the time of Baseline 1 did not have enough data to be included in the SIR calculations. They were still required to be reported, but SIRs were not

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calculated. Now, with the Baseline 2, data from these locations will now be included in the SIR calculations.

Now, let's go onto Catheter Associated Urinary Tract Infections, or CAUTI. CAUTI data is submitted to CMS that includes in-plan data. And, beginning with 2012 data, it has been required to report all adult and pediatric ICU locations. Then, beginning in 2015, additional locations were added: adult and pediatric medical wards, adult and pediatric surgical wards, and adult and pediatric medical/surgical wards.

Now, let me go over some model changes for CAUTI. A negative binomial regression model was used to calculate the number of predicted infections. Urinary catheter days will continue to be used in SIR locations. And, just like CLABSI, there was an addition of events and device days of some ICU locations. And, that was because there were some locations that, at the time of the Baseline 1, did not have enough data to be included in the SIR calculations. Regardless, they were still required to be reported, but we cannot – you couldn't calculate the SIRs. Now, with the Baseline 2, data from these locations will now be included in the SIR calculations.

For rebaseline models of CLASBI and CAUTI, the following factors are included in the final model. For both CLABSI and CAUTI there was a type of CDC location, facility type, medical school affiliation, and facility bed size.

So, currently hospitals will not be able to calculate their own 2016 quarter one and quarter two HAI SIRs in any given applications until December. We will go over more information about this later on in the slides. But, keeping this in mind, we will be reviewing some methods to help check your data in NHSN before the December release. Now, let us go over some steps that can help you in checking your numerator and denominator data during the CMS deadline. First, it's important to clear all alerts for whichever quarter you're running your data, then generate your datasets to ensure that you're including the most up to date information in your data table. Then, you would run your CMS CLASBI and CAUTI reports. In

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this screenshot, I have highlighted which section for CLASBI and CAUTI you would run. The following CAUTI elements will match between NHSN and QNET. The number of CAUTIs or numerator and the urinary catheter days. Now, the following CLASBI elements will match both between NHSN and QNET. The number of CLASBIs excluding MBI-LCBIs and your central line days. The other factors from *QualityNet*, such as the SIR, the P-value and the 95 percent confidence interval will match within NHSN. And, further on in the slides, I will go over the steps it takes to calculate those matching elements.

Now, let's go into a little bit more detail on checking your data. For my examples, I'll be using CLASBI. For a numerator check, keep in mind that MBI-LCBIs will be removed from the CLASBI SIR. To correctly count the number of events that will contribute to your CLASBI numerator, you will need to run a CLASBI line risk to identify all MBI-LCBIs. Once you have removed those events from your events count, you will have your contributing numerator. So, from the CLASBI line list you would open your device associated module holder and navigate to the CLASBI folder. Once you've located the all CLASBI events line list, which in the image to your left that box in red, you will modify that line list to run for your desired time period. To your right this an example of the line list data table. As you can see, MBI-LCBIs will be identified with a Y. Those would be the ones that you would need to remove from your numerator count.

Now, onto your denominator check for CLASBI. As I mentioned before, the central line days in QNET will not match what is NHSN. But, as a reminder, they will match your summary data. To correctly enumerate the contributing denominator, you will need to run a line list for all summary data. The summary line list is located in the events folder. After you run your summary line list for your desired quarter, you will then add up all contributing locations to determine your denominator data. So, for example, in the screenshot to the right, I would need to add up all my devices for the three ICU locations to compute my contributing denominator.

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Also please remember to do a quick data quality check. To run a data quality check for your CDC locations, just review your facility CDC locations in NHSN. Also for your facility type, this can be viewed under facility, and then you would go to facility info. And, these are designated during enrollment in NHSN. You can look at your medical school affiliation and facility bed size in your 2015 annual survey. And please, make sure that those are correct, so that you're getting the correct risk adjustment for your HAI measures. So now, I'm going to pass on the presentation to Rebecca to go over SSI models.

Rebecca Konnor: Thanks, Prachi. Hello everyone, and thank you for joining the webinar. By this time, I believe you all have learned about the new rebaseline using the 2015 NHSN data. For detailed information on the rebaseline, the process, the approach, and timeline, please visit our rebaseline website, which will share at the end of the presentation. With that said, I will be speaking specifically about the rebaseline SSI data as it relates to the upcoming CMS deadline. But first, a little background information about the rebaseline SSI data. We used logistic regression models to calculate the risk adjusted number of predicted infections, which is the denominator of your SSI SIR. The main change in the new 2015 adjusted SSI model is the new risk factors that are included in the model. A list of risk factors used in the complex 30-day SSI SIR model, also known as the CMS model, will be discussed in subsequent slides.

The complex 30-day model includes COLO and HYST surgery. The data included in the 30-day model SIR are in-plan, inpatient procedures in adults 18 years and older, it includes SSIs of deep incision primary, or DIP, and organ/space O/S. It also includes SSIs identified within 30 days of the procedure date. The procedure date is used to calculate the SIR because the procedure carries the risk for infection. And, SSIs regardless of how they are detected, are included in the complex 30-day model. And now, under the new 2015 baseline, all the SSI SIR models, including the complex 30-day model, also known as the CMS model, will include either closure method; that is, procedures with primary or other than primary closure methods.

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Now, let's talk about what is excluded from the SSI SIR. This table lists the data exclusions for the SSI SIR. Some of these exclusions are often due to potential data quality issues, others are due to data outliers. As you may notice, this table shows the old list of exclusions in addition to new ones. The SSI SIR excludes data from Ambulatory Surgery Centers, or ASCs, and Long-Term Acute Care Hospitals, or LTACHs. Present At Time of Surgery, or PATOS, equals yes SSIs are excluded from the numerator of the SSIs. And, the procedures they resulted from are excluded from the denominator on the SSI. The SIR also excludes procedures, if any of the following is true: procedures where the age at the time of procedure is greater than 109; if gender is missing or if gender is other, or O; procedures with duration less than five minutes or greater than the IQR5, also called the procedure duration cut off point; if BMI is less than 12 or greater than 60 for adults; if the medical affiliation is missing or medical affiliation is yes, but the med type is missing; if closure technique is missing; if ASA score is missing; if number of beds is missing or any of the risk factors that are included in the SSI SIR risk adjustment is missing; and, if procedures are classified as outpatient and the resulting SSI. These procedures will be excluded from the SSI SIR.

The risk for infection based on the new baseline is determined using the risk factors that are listed here. As you may know, this list is different from the factors used to determine risk for infection under the 2006 to 2008 baseline. Under the new rebaseline the risk factors used to determine risk or infection following a colon surgery includes age, ASA score, BMI, cancer hospital, closure technique, diabetes and gender. Under the new rebaseline the risk factors used to determine risk for infection following a hysterectomy surgery include age, ASA score, BMI, cancer hospital, and diabetes.

Now, let's talk about your SIRs using the new rebaseline. NHSN will submit SIRs to CMS using the new 2015 risk adjusted baseline in upcoming deadlines. We recommend that you review details of the process and approach to the rebaseline and risk adjustment provided in previous webinars. Please visit the link provided here for more

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information. Compared to the current baseline in NHSN, which is from 2006 to 2008 baseline for SSIs, you will notice differences in your numerator and in your denominator under the new rebaseline, once it is available in December. These are due to the new data inclusions and exclusions that I have just talked about in addition to the updated risk factors.

As you all know, we submit quarterly SIRs to CMS for every CCN. We submit the following data elements to CMS in aggregate form. These include: the numerator, also known as the number of observed SSIs; the denominator, also called the number of predicted SSIs; the number of procedures; the SIR itself; the P-value; and the 95 percent confidence intervals for the SIR.

The SIRs for the upcoming CMS deadline will use the 2015 risk adjusted baseline. The CMS reporting deadline for 2016 quarter two is November 15, 2016. However, the new baseline and updated risk adjusted model will not be implemented in NHSN until December 10, 2016. So, you will not be able to generate the 2015 baseline SIR for 2016 quarter two in the application until after the deadline has passed. You will, however, be able to preview SIR on *QualityNet*. The SIR the number of procedures, number of observed SSIs, the number of predicted SSIs will be different from what you generate in NHSN during this time. I'm talking about the stuff you would see on *QualityNet*. I also would like to mention that, if you do notice that the number of procedures is incorrect on *QualityNet* when you preview it, please let us know.

So, the question now is, how do you know what is included in your data because you will not be able to run your SIRs in NHSN using the new baseline? Well, we encourage you to continue to follow the steps in place already for checking your data for CMS submission. Be sure to include HYST and COLO on your monthly reporting plans for the quarter. Address all outstanding alerts related to procedures and SSIs. Generate a dataset. And then, run the complex 30-day SSI data report that is found in the CMS report under analysis. Review your table of incomplete and custom procedures not included in the SIR, if applicable. In addition,

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review the new data inclusions and exclusions and the new risk factors that we have just talked about. Make sure that you save a copy of all of this information and compare to the reports that on the preview site.

To check your denominator, specifically the number of procedures that will be included in the denominator, which is the number of predicted SSIs, run a line list of procedures limiting to COLO and HYST and the time period in question. In this case, it would be quarter two for 2016. You can find a quick reference guide on how to run a line list at the link below. After that, review the procedure line list for the inclusion and exclusion criteria. As I have mentioned before, procedures included in the new SIRs are those that are in-plan, inpatient procedures in adults 18 years and older, and procedures with either primary or other than primary closure techniques.

Procedures excluded from the new SIR include: procedures with gender equals other, or O; procedures in patients with BMI less than 12 or greater than 60; procedures with SSIs that are present at time of surgery equals Yes; procedures with duration of less than five minutes or greater than the IQR5, and in this case for COLO, the new duration cutoff point is 697 minutes, and for HYST it's 547 minutes; procedures missing any of the required risk factors are also excluded from the denominator; and also, age at time of procedure great than 109 years are excluded from the denominator.

To check your numerator, or the number of observed SSIs, run a line list of SSI events as shown in the screenshot below. Limit the line list report to COLO and HYST and the time period in question, which would be 2016 quarter two. Please note that, if a procedure is excluded from the denominator, the resulting SSI is excluded from the numerator.

Review the SSI event line list for inclusion and exclusion criteria. Under the new rebaseline, the SSI events included in the new SIR are: SSIs of deep incision primaries and organ/space; SSIs that are identified within 30 days of the procedure date; and SSIs regardless of detection method; and finally, SSI events excluded from the new SSI SIR are SSI events that are

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PATOS = YES. And, that concludes my portion for the SSI SIR. I will pass it now over to Lindsey to talk to us about MRSA and *C.difficile* LabID events.

Lindsey Weiner: Thanks, Rebecca. Good afternoon everyone, we're going to switch gears now to talk about MRSA bacteremia and *C. difficile* LabID events and some of the changes you can expect to see in your LabID event SIR because of the rebaseline. And, we will also talk about how you can verify your 2016 quarter two LabID event data before the November 15 reporting deadline.

So, a quick reminder on what data elements we send to CMS. For LabID events, it's a quarterly facility wide inpatient, or FacWideIN, SIR. So, that's one SIR for entire facility, each quarter, based on the CCN, or CMS certification number. So, if your hospital shares a CCN with another hospital, the data from both hospitals will be combined into a single SIR before they are sent to CMS. In addition to the actual SIRs we also send: the numerator, which is the number of unique hospital onset events; the denominators, which is the number of predicted hospital onset events; the total patient days; as well as the P-value; and 95 percent confidence interval for the SIR.

Okay, so, the question we've been receiving a lot is what is changing because of the rebaseline? We will continue to send CMS the exact same data elements that we have in the past. Those are the ones listed here on the slide. However, we are now using an updated formula to calculate the number of predicted events. So, this means that the denominator of the SIR is changing because of the new risk adjustment.

The number of predicted LabID events will now be calculated based on the national experience from 2015 instead of the original baseline of 2010 to 2011. The number of predicted events will also account for a new set of risk factors based on the variables that we found were significant predictors of LabID events, according to the 2015 national experience.

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So, here's a table showing the new risk adjustment variables. I'll start on the left with MRSA bacteremia. The first variable is the facility type. So, this means that cancer facilities will now be receiving a different risk adjustment from non-cancer facilities. We also have medical school affiliation, or teaching status. This is something that is recorded on your annual facility survey, and it looks at whether your hospital is a major teaching, graduate teaching or has an undergraduate teaching status. MRSA bacteremia also includes the number of ICU beds in the risk adjustment, which is also taken from the annual survey, as well as the average length of stay for patients in your hospital. The average length of stay is calculated by dividing the total number of annual patient days by the total number of annual admissions for your facility, and those are based on the two values reported on the annual survey for overall patient days and overall admissions. For MRSA bacteremia, we also include the inpatient community onset prevalence rate, and new for the 2015 baseline, the outpatient community onset prevalence rate in emergency departments, or a 24 hour observation location. Moving over now to *C. difficile*, you can see that the first three variables are exactly the same as MRSA bacteremia: the facility type, medical school affiliation, and number of ICU beds. In addition, for *C. difficile*, the SIR's risk adjusted for the total number of facility beds, the inpatient community onset *C. difficile* prevalence rate and whether or not the facility has an ED or 24 hour observation location. And, of course, the *C. difficile* SIR is risk adjusted for the laboratory test method used to detect CDI.

Okay, so, because we know that the denominator of the SIR is changing to account for those new variables, that means that the actual SIR will be different, as well as the P-value and the 95 percent confidence interval. You can interpret the SIR as a comparison between the number of observed events in your hospital to the number that are predicted for your hospital based on the 2015 national experience.

Okay, the next few points are something that was mentioned earlier in the webinar by my colleague, but these points about NHSN and *QualityNet* are very important, so we want to make sure that everyone hears and

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understands them. The updated risk models will be incorporated into the NHSN application in December 2016. Now, for the 2016 quarter two data, which is submitted to CMS on November 15, which is before those risk models are incorporated into NHSN, the SIR reports that you generate in NHSN will use the original baseline – the original risk adjustment. However, the data submitted to *QualityNet* and CMS for the 2016 quarter two deadline will use the updated 2015 baseline. For LabID events in particular, this means that your SIR reports from *QualityNet* versus the SIR reports in NHSN will not match for some data elements, and those are the ones listed in orange on the slide. It's the number of predicted events, the SIR, the P-value, and the confidence interval. However, the two data elements that will match between NHSN and *QualityNet* is the numerator of the SIR, which is the number of unique hospital onset events, as well as the total patient days.

I'm now going to walk you through some steps you can take to check your LabID event data for quarter two. So, the first step is to follow your usual procedures for ensuring that your data are complete and ready for submission. This involves checking your monthly reporting plans to make sure that FacWideIN is listed for all three months of the quarter for both MRSA and *C. diff*, and to ensure that there are no outstanding alerts on your NHSN home screen. I have a link on the slide that will take you to a CMS checklist, which will walk you through some additional steps you can use to make sure your data are ready for the CMS deadline. Step two, you can still run your CMS LabID SIR in NHSN to preview the numerator, the number of hospital onset events, as well as the total patient days, as these numbers will reflect the numbers that will be sent to CMS for the quarter two deadline. And, I have the screenshot here showing you where to find the CMS SIR report for MRSA bacteremia and *C. difficile*.

Here is an example SIR report for quarter two for MRSA bacteremia where I have the numerator of the SIR and the number of patient days highlighted. You'll want to follow your regular data quality assessment steps to confirm that these two values are accurate. So, that means running a MRSA or a CDI event line list to review which events are being

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encountered in the SIR. And, you can run a summary data line list or manually review your monthly denominators to ensure that the total number of patient days is accurate for the quarter. There are more detailed steps on how you can check these two fields at the troubleshooting tips document with – the link is located at the bottom of the slide.

Step three, in order to do a data quality check of the number of predicted events, you'll want to review the new risk adjustment variables for your hospital to be sure that they are entered correctly in NHSN. So, we will start with MRSA bacteremia. The first variable is facility type. This is something that you indicate when you first enroll in NHSN, and it tells us the type of facility that you're enrolling. In order to check this, right now you can click facility on the NHSN left navigation bar, and then with the dropdown menu, click facility info. You'll then see the fields for facility type, and the majority of hospitals are enrolled as a HOSP-GEN, G – E – N, which stands for general acute care hospital. However, we do have facilities enrolled as HOSP-CAH, C – A – H, which stands for critical access hospital. And, I do just want to point out here that the HOSP-CAH facility type is reserved for those facilities with the CMS designation as a critical access hospital. So, if you do not have that CMS certification as a critical access hospital, you should not be enrolled as one in NHSN, and that will affect your risk adjustment. You also want to be sure to review your 2015 annual survey and check the medical school affiliation and the number of ICU beds to be sure that those are entered accurately. You can pull up your 2015 survey in NHSN by clicking surveys and then Find.

And, in addition, while you're looking at your 2015 survey, you should also review your annual patient days and your annual admission. These counts should reflect the total value for all inpatient locations, including CMS certified units. The next variable for the MRSA risk adjustment is the inpatient community onset prevalence rate. This is the same prevalence rate that's currently being used in the original risk adjustment. You can run your MRSA rate tables and look for the table in the report called inpatient MRSA BSI admission prevalence rate. When you run this rate for quarter two, you want to make sure that three months are being

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included in the rate, and check the numerator, which is the number of community onset events and the denominator, which is the number of admissions to ensure that they are accurate for the entire quarter.

Okay, and the last variable for MRSA bacteremia is the outpatient community onset prevalence rate. This is a new variable that was not originally being used in the previous risk adjustment, but you can find this by running your MRSA rate tables and looking for the table called outpatient MRSA BSI prevalence rate. The MRSA bacteremia SIR is risk adjusted for the prevalence rate in emergency departments and 24-hour observation locations. It does not account for the prevalence rate in any other type of outpatient location. When you review this rate, you just want to make sure that the numerator and the number of encounters is correct for the entire quarter. If your hospital does not have an emergency department or 24-hour observation location, that's perfectly fine, you will still receive an appropriate risk adjustment for your SIR.

And now, moving on to the risk adjustment for *C. difficile*, we already talked about the first three variables: facility type, medical school affiliation, and number of ICU beds. You'll also want to review the total number of beds on your 2015 annual survey and confirm that you are reporting from an emergency room or 24-hour observation location correctly. So the *C. difficile* SIR uses the ED and 24-hour observation data a little bit differently. Instead of looking at the actual prevalence rate, you just want to make sure that, if you have one of these locations in your hospital, that they are mapped correctly in NHSN and included on your monthly reporting plans for *C. difficile*. You also want to be sure to check your CDI test type. This is something that you enter on the FacWideIN denominator record for the last month of the quarter. So, since we're talking about quarter two, that would be June. And then, you'll want to review the inpatient community onset CDI prevalence rate, which can be found in the *C. difficile* rate table.

I do want to go into a little more detail on the CDI test type. This is a screenshot from a June FacWideIN summary record and I've highlighted the location where you will select your CDI test type. I encourage

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everyone to review their June denominator record for the LabID events, and ensure that you've entered the correct CDI test type. If your facility is using PCR as a test method, be sure you have selected NAAT, or N – A – A – T, which stands for Nucleic Acid Amplification Test. This is a more general term that refers to PCR. If you do try to use the free text entry for this field and type in PCR, the system will not recognize that as a PCR test, and you will not receive the accurate risk adjustment. Okay. So, if you're using PCR, just make sure you've selected NAAT as your test type.

Okay, here's a screenshot showing you where you can find your *C. difficile* prevalence rate. It's in the *C. difficile* LabID event folder, and you'll scroll down to the rate table. You can modify that rate table output to only show you 2016 quarter two. Again, you'll want to find the rate table in that output called community onset admission prevalence rate and confirm that all of the fields in that rate table are accurate for the entire quarter.

Okay, I'm now going to talk more about *Hospital Compare* and how SIRs under the new baseline will begin to show up on their website.

So, the December 2016 update to *Hospital Compare* will be the first time that SIRs calculated under the new baseline will be available on *Hospital Compare*. This type will show an SIR for the calendar year of 2015, will have quarter one through quarter four under the new baseline. And, these data will be used for other programs, such as the HAC program and the hospital value based purchasing program. The preview period for this data began on October 8, so right now you are able to go into *QualityNet* and preview your SIRs for 2015 calculated under the new baseline. And, just remember, that they will not match the SIR report that you generate in NHSN right now, however once NHSN is updated that first week in December, you then will be able to see SIRs calculated under the new baseline in NHSN. There is more information about how you can review your preview report in our latest NHSN newsletter, which is available at [this link](#).

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All future releases of *Hospital Compare* starting with this year December 2016 will show SIRs calculated under the new baseline. And, after December, *Hospital Compare* will go back to the rolling four quarters that it typically does. So, the next refresh will be in April of 2017, and that refresh will contain an SIR from 2015 quarter three through 2016 quarter two. The language and the materials on the *Hospital Compare* website will also be updated to reflect the new baseline and the new risk adjustment variable. I'm now going to turn it back over to Prachi to provide more information about *QualityNet*.

Prachi Patel:

Thank you, Lindsey. Like as has been mentioned before multiple times, let us take a little bit more detailed look at the data in QNET versus NHSN.

As we stated earlier, six quarters of data will be sent to CMS using the new rebaseline, specifically quarter one and quarter two will be submitted to CMS before the hospitals have an opportunity to view it. So, you may be asking yourself, why will 2014 Q1 and Q2 SIRs be submitted to CMS before hospitals have the opportunity to view them? We know and understand how important your data is to you. Beginning with Central Line-Associated Bloodstream Infections, in the first quarter of 2011 CDC submitted HAI SIRs on behalf of hospitals to CMS. In that time CDC also always enabled hospitals to reproduce the SIR calculations in the NHSN application. This year CDC is developing a new risk model for each HAI, which is part of CDC's work to establish a new baseline for each HAI SIR calculation and plans to use the new risk models in the 2016 Q1, Q2 HAI SIRs reported on behalf of hospitals to CMS. These new risk models also will be incorporated into the new – next release of the NHSN application. As a result, hospitals will not be able to calculate their own 2016 Q1, Q2 SIRs in the NHSN application until December. The remaining months of 2016 will be used to ensure that the new risk models and new output options have been accurately applied in NHSN.

Beginning on October 8, 2016, like Lindsey said before, hospitals will be able to view their 2016 preview report via the *QualityNet Secure Portal*, which will contain HAI data from 2015 Q1 through Q4. The SIRs

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contained in this preview report will be calculated using the updated risk models from the new 2015 national baseline. You will notice a difference between your data showed in these preview reports and the data in NHSN. Analysis reports run in NHSN prior to the next NHSN update in December 2016 will still use the original baseline, data, and risk models.

So, in summary, CDC re-sent 2015 Q1 through Q4 data under the new 2015 baseline for the following measures: the hospital IQR, CLABSI, CAUTI, SSI-COLO, SSI-HYST, MRSA LabID, and CDI LabID. The new baseline will continue to be used for the rolling four quarter public reporting file. CDC is also sending 2016 Q1 onwards data to CMS under the new 2015 baseline for all quality reporting HAI measures in each quarterly deadline. SIRs calculated under the new 2015 baseline will be available within the NHSN application in December, 2016. So, our bottom line, stating it again, the 2015 data shown in the *Hospital Compare* preview report for the December *Hospital Compare* release will be different than the data currently in NHSN.

So, here are some additional resources that we have on our NHSN or will be up in the upcoming future.

To start off, we have the rebaseline website. The rebaseline website is located on the NHSN website, and below I have the link directly for the rebaseline website. Next, is updates to existing documents on the NHSN website. Since many aspects of NHSN are changing with the December release, we will be updating all related documents on the website to incorporate different changes. Next, we have the rebaseline compendium, which is currently in progress. This will include high level information regarding the elements that are included in the model. Then, we will be creating NHSN's Standardized Infection Ratio user's guide. This will be a guide that will help all users in understanding the changes to the SIR of different HAI type and how to run the data table in NHSN. Next, we're introducing SURs, or Standardized Utilization Ratios, in NHSN. And, for this new measure, we'll be creating a user's guide that will help users with understanding how the SUR works and how to run the data table in NHSN. And finally, our NHSN quarterly newsletters, the newsletters

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contain a wealth of information. Through our newsletters we send out important information regarding NHSN, we provide training updates, any changes and, of course, rebaseline information.

We also have many upcoming trainings and webinars. In November, which will probably be in early November, we are going to be having a LTCHQR and IRFQR webinar, which is similar to this webinar. On November 30, it will be our *Rebaseline Webinar Part II: Running the New SIRs in NHSN*. I hope you were all able to attend our October 5, which was the *Rebaseline Webinar Part I*, and this will be the part two on November 30. And then, March 2017, we will be having our NHSN annual training, and in this training we'll be going over a detailed review of each new SIR by HAI type.

So, for our November 30 *Rebaseline Webinar Part II: Running the New SIRs in NHSN*, we will be previewing the new application interface of NHSN. As you can see in this screenshot to the right and right below, NHSN will be changing, and we'll be going over the different screen views that you will now have. So, we highly recommend that you attend this webinar. We'll be going over new reports, how we'll be putting rebaseline into practice, going over annual surveys. And also, the registration link is right there, so you can go ahead and go to that link and register.

So, sometimes it's helpful to see the same information presented in another way. Below are links to additional rebaseline resources. Each of these concentrate on one or more of the topics that we've presented today. The first link is to update the national risk adjustment of HAI data. It serves as the introduction to CDC's plans for updating the risk adjustment and describe in length the changes that have occurred in NHSN through the implementation of the original baseline. We also have the June APIC 2016 slides link in here. Beginning on slide 56 of this presentation, we touch on the new models and the implementation of the rebaseline into NHSN. The June newsletter details the rebaseline timeline. It provides more information about the use of NHSN HAI data for Hospital Value-Based Purchasing, where to go to find a description of CMS' VBP

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Program performance period, and a direct link to the final rule regarding the use of the new NHSN baseline. The March newsletter includes a section that highlights the different changes that will affect how CLASBI and SSI is reported present at time of surgery at surgery are calculated under the new 2015 baseline. And, that's it for us today. So, now we will take any questions. And, back to you.

Bethany: Thank you, Prachi. That was an excellent presentation from you, Rebecca, and Lindsey. I think on behalf of all of the participants on today's call, we thank you for that wealth of information that you provided. Before we jump into the Q&A session I just wanted to give a couple of reminders. If you have any questions and – which I've seen people have quite a few questions so far, please submit them into the chat window on your screen. We will try to answer as many questions as we can today; but, any that we do not get to, we will answer – we will try to answer them within about 10 business days. So, check back out on our website qualityreportingcenter.com for the Q&A transcript at a later date. Also, I've seen some requests for the slides come in through the chat window. These are available out on our website, again that's qualityreportingcenter.com. So now, jumping into the Q&As, I'm going to try to ask these as they were asked in the presentation. So, we're going to start off with some CLASBI and CAUTI questions. The first question: if you have a mixed acuity unit only will you have to report?

Prachi Patel: Hi, thanks, Bethany, this is Prachi. And, the answer to that is: it is not a CMS required reportable location, like it was listed in the CLASBI and CAUTI slides, but you will receive an SIR for it, so we do recommend that you put in your information for a mixed acuity wards.

Bethany: Perfect, thank you. I think that actually answered my next two questions regarding mixed acuity units. So, going onto the next question, are telemetry units being included, or is it still just med/surge and ICU units in a SIR?

Prachi Patel: Again this is Prachi, and I'm going to answer this question. Telemetry units are not required by CMS to be reported, but you still will now with

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the 2015 rebaseline be able to get an SIR for them. So, we would recommend you put in your data for a telemetry unit.

Bethany: Thank you. The next question: do we still have to report MBIs since they will not be counted?

Prachi Patel: We are now coming out with different MBI measures like rate tables and foreseeably in the future SIR tables. So, they are not required by CMS to be reported, but you will start to get SIR and rate tables for that. But, they are required for NHSN in our rules.

Bethany: Great, thank you for that clarification. The next question that we received is in regards to slide 15, so I'm going to pull up that slide. The question is: it sounded like Prachi said it will not match NHSN and *QualityNet* and yet the screenshot indicated it will match. Can you clarify that statement?

Prachi Patel: So, this is a little bit of a detailed question, so this might be something that would be better answered in the transcript. But, what I was trying to say with the next slides after this is, if you run those different reports, you'll be able to get the matching information in NHSN and QNET.

Bethany: Great, thank you. The next question: to confirm, did I hear that quarter one and quarter two of 2016 SIR for CLASBI and CAUTI will not be available until December.

Prachi Patel: That is within NHSN. They won't be available until December.

Bethany: Okay, thank you. And, the last question before we go onto the next topic: if a location designation has changed, should that location be inactivated and a new unit activated with a new designation?

Prachi Patel: So, the answer to that is yes, you would have to inactivate that location and create a new location, and go ahead and report in the new location.

Bethany: Great, thank you. Moving on to some of your SSI questions, the first question is in regards to slide 21, so I will jump to that slide. Okay, the question is: what does [inaudible] 5IQR mean?

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- Rebecca Konnor:** Hi, that is the procedure cut off point. So, we have a list of times that we provide for each procedure codes that, if the procedure performed has a duration that's longer than the IQR5, it's excluded from the SIR. We will provide a list of all the updated IQR5 for the different NHSN operative procedures, but in a couple of slides after this one, I notate what the procedure duration cut off points are for COLO and HYST. So, for COLO, it's 697 minutes, which means if the procedure is longer or has a duration of longer than 697 minutes, it's excluded from the SIR. And, if it's 500 and – if it's longer than 547 minutes, it's excluded from the SIR for HYST.
- Bethany:** Great, thank you. And, I found here you referenced that for the participants. It's on slide 28, which is now displayed.
- Rebecca Konnor:** Thank you.
- Bethany:** Thank you. The next question is also in regards to slide 21, so I will jump back to that slide. The question is: can you please clarify the exclusion criteria for SSI SIR with regard to medical affiliation is Y?
- Rebecca Konnor:** Sure. So, when we were analyzing the data, we did find that some hospitals had not completed that information on their annual survey, which is something that is done retrospectively. And, we do ask on that annual survey whether you have an affiliation to a medical school. So, it's either you do have it, which will be yes, and that's what the Y stands for, or if you don't, it will be no. And, if you have an affiliation with a medical school and you select yes, you will then be asked what type of medical school is it, if it's a graduate school or an undergraduate school.
- Bethany:** The next question that we received is in regards to slide 22. The question is: this slide did not list wound class. Is that no longer part of the model? If so, will NHSN stop locking the uploaded cases missing wound class?
- Rebecca Konnor:** Thank you so much for that question. Wound class was never included in the risk adjusted model for the complex 30-day SSI model. So, based on the 2006 to 2008 baseline, which is currently in the application, we only use ASA score and age in the risk adjustment for the SIR for the complex

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30-day SSI SIR model. Now it's not included in the 2015 risk adjustment for the complex 30-day SSI SIR. But, you still have to report the wound class for every procedure that you report to NHSN.

Bethany: Thank you for that clarification. The next question is: we are only reporting SSI following abdominal hysterectomy, correct? We are not including vaginal.

Rebecca Konnor: That's correct. We are only – for the complex 30-day SSI SIR, it is only abdominal hysterectomy.

Bethany: Great, thank you. The next question is in regards to slide 27 – moving over to that slide. The question is what does in-plan mean?

Rebecca Konnor: Thank you for that question. In-plan means that you have included surveillance for a specific HAI measure on your monthly reporting plan, which means that you would have to follow the NHSN protocols for that specific measure. That's what in-plan means.

Bethany: Thank you. The next question is in regards to slide 30. What is PATOS = YES? And then, a follow up question to that, is PATOS = YES excluded from the 2015 baseline calculations?

Rebecca Konnor: Thank you for that question. PATOS is Present At time Of Surgery, SSIs basically. And, if you have a Present At Time Of Surgery case, you select PATOS = YES on your procedure record in NHSN. And, if you import your procedures in an import file, there is a column called PATOS where you would put yes or no, depending on the procedure – I mean the SSI that you are importing. And yes, we have excluded PATOS = YES SSIs from the numerator, and then the procedures from which they result are also excluded from the denominator under the 2015 baseline.

Bethany: Thank you for that response. I just have a couple more questions for SSI and then we'll move on. For the SSI events included in the new SIR on slide 30, the SSIs identified within 30 days of the procedure date. Does this mean the superficial SSIs are included?

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- Rebecca Konnor:** No, they are not included in the complex 30-day SSI SIR model. They are, however, included in the all SSI SIR model.
- Bethany:** Thank you. And, just one last question on SSIs before we move on. All SSI SIRs will now include other than primary closure, including the complex 30-day model SIR that goes to CMS. Is that statement correct?
- Rebecca Konnor:** That statement is correct.
- Bethany:** Moving on [inaudible] some CDI questions. Slide 35 is the reference [inaudible]. And, the question is: what are the bed number cut offs for risk adjustment for *C. diff*?
- Lindsey Weiner:** Thank you for that question. For the *C. difficile* model, the variable for total number of beds is a continuous variable meaning there aren't cut offs, but whatever value of bed size you put on your annual survey is the value that will go into the risk adjustment model. And, we will be publishing new documentation on the NHSN website that will explain the cut off and how each of these variables are categorized, and we will put out communications once those are available.
- Bethany:** Thank you. The next question is in reference to slide 44. Is the bed and [inaudible] – excuse me. Is the total number of beds the number of staffed beds or licensed beds?
- Lindsey Weiner:** It's the total number of beds that are set up and staffed in the facility, which is not necessarily the total number licensed.
- Bethany:** Thank you. The next question is in reference to slide 45. What if a facility changes the test type in the middle of a quarter (and they are referencing the CDI test type), should we use what was used for the majority of the time? For example, our organization changed testing from NAAT to toxin two months [inaudible].
- Lindsey Weiner:** So, we recommend that facilities select the CDI test type that was used for the majority of the quarter.

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- Bethany:** Thank you. The next question is: does the system identify GDH plus EIA for toxin followed by NAAT for discrepant results as PCR, or do we only select NAAT?
- Lindsey Weiner:** Yes, the option that you mentioned with GDH following with NAAT will be counted as part of the risk adjustment for PCR or NAAT.
- Bethany:** Great, thank you. And just to clarify that was the GDH plus EIA for toxin followed by the NAAT. The next question that we received is in regards to slide 46. Please comment on CO versus CO HCFA using the new updated CDI risk adjustment.
- Lindsey Weiner:** Sure. So, one of the variables in the CDI risk adjustment is the inpatient community onset prevalence rate. This prevalence rate will only include the events classified as CO, or community onset. It will not include the CO HCFA events, or community onset healthcare facility associated.
- Bethany:** Thank you for that clarification. And, a MRSA question: do we include 24-hour observation units in MRSA LabID reporting?
- Lindsey Weiner:** Yes. So, part of the NHSN protocol for FacWideIN or facility wide inpatient does require the reporting of data from emergency departments and 24-hour observation units, if you have those locations in your facility.
- Bethany:** Thank you. Now I'm going to move on into some more general questions. The first one is: do any of these changes apply to ASCs?
- Prachi Patel:** No, this webinar is specifically for acute care facilities. Not all of these will apply to LTACs or ASCs.
- Bethany:** Thank you. The next question is: will the SIR be combined if two hospitals share one CCN number? We have a 100 percent pediatric hospital sharing with an adult hospital. Will the SIR not be separated? Both hospitals have an NHSN ID to separate all other data.
- Prachi Patel:** Yes, thanks for that question. The SIR is risk adjusted separately for those two hospitals and calculated separately. However if both hospitals are participating in the CMS Inpatient Quality Reporting Program, after risk

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adjustment the data will be combined and a single SIR will be submitted for both hospitals.

Rebecca Konnor: And, for SSIs, we do not report COLO or HYST for anyone under 18 years old.

Bethany: Great, that's an excellent clarification point. The next question is: are step down units/intermediate care units counted as ICU beds?

Prachi Patel: No, they are not counted as ICU beds.

Bethany: Thank you. The next question is: after December 10 will we be able to go back and run a SIR on the new criteria for second quarter or, excuse me, for 2016?

Prachi Patel: Yes, they will. Users will have the opportunity to go back and run their SIRs for 2016, once the rebaseline has been incorporated into the application in December.

Bethany: Thank you. The next question is: will the summary SIR reports be available to pediatric hospitals that are participating but not included in the CMS Program?

Prachi Patel: Yes, they will be available for all hospital types.

Bethany: Thank you. The next question is: to clarify, those hospitals that have sub provider units, such as psych and rehab, those patient days in bed should not be included in the annual survey, correct?

Lindsey Weiner: Actually counts from those units should be included on the annual survey. So, any patient days, admissions and the total number of beds on the annual survey should include any inpatient unit in the facility, even if those have a separate CMS certification number such as a rehab or a psych unit.

Bethany: Thank you. The next question: can you please define CMS certified units?

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Lindsey Weiner: Sure. So, what we mean by that: there are sometimes units in a hospital that are designated separately by CMS and they have a separate CMS certification number or CCN separate from the rest of the hospital. So, those are the particular nits that we're talking about.

Bethany: Great, thank you for that answer. I'm just going to look through to see if we received any more questions that we can answer at this point. One of the questions here: is there a manual that explains how to generate datasets and also how to run reports?

Prachi Patel: Yes, our NHSN website has a lot of different reference guides and informational templates that you can use to help you navigate NHSN, and how to run your reports, and what your output tables are saying to you.

Bethany: Thank you. And, one last question: how is the quarterly data aggregated into [inaudible] by CMS. Do you sum the numerators and denominators to calculate the new SIR rate for the 12 months, or do you average the quarterly SIR rates as they were submitted by NHSN?

Lindsey Weiner: So, you would sum the numerator, and sum the denominator, and then divide those two summed values to arrive annual SIR. It's not an average of the monthly or quarterly SIRs.

Bethany: Thank you for that. And, I want to thank all three of you again for agreeing to present and presenting this great information that we've all been looking forward to.

I will now turn it over to Deb Price to present on the continuing education credits that you can receive. However, before I do that, I just want to remind everyone that the slides are available at qualityreportingcenter.com. Thank you. Deb, the floor is yours.

Deb Price: Well thank you so much speakers, and thank you Bethany for the time. Hello everyone, today's webinar has been approved for 1.5 continuing education credits by the boards listed on this slide. We are now a nationally accredited nursing provider, and, as such, all nurses report their

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own credits to the boards using the national provider number shown on the last bullet, provider number 16578.

We now have an online CE certificate process where you can receive your certificate two separate times. First time is, if you registered through this webinar in ReadyTalk®, at the end of my slides, a survey will pop up, and then, that survey will take you through the steps to get your certificate. However, if you can't wait to do the survey, or if you have another appointment in a couple of minutes, whatever, we will be sending out another survey within 48 hours, and you'll be able to get your certificate that way. We'll send the survey to you, and, if there's anyone else in the room with you, you know just sitting there, that has not registered but has listened to our event, please forward that survey to them, so they can also get a certificate.

If you do not immediately receive an email to address that you registered with, after the survey, that means that there is a firewall up. You need to go back and register a personal email address, and the next few slides will show you how to do that.

This is what the survey will look like immediately after my last slide. The bottom right hand corner you see a Done button. When you click the Done button ...

... this is what page pops up. You see that there are two links on this page. First one is the new user link. And, that is what you're going to use if you've never received a certificate from us before or if you've received certificates but you've had problems getting them lately. And, that's usually because hospitals and nursing facilities have firewalls that pop up, and it's usually easier if you can just register your personal email.

This is what the new user page looks like. You put your first name, last name. We're asking you to please use a personal email, like Yahoo or Gmail or ATT, one that will not possibly get a firewall up. And, of course a phone number, if you could give us your personal phone number that can be linked to that personal email we would appreciate it.

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This is what the existing user page, or link, takes you to. Your user name is your complete email address, including what's after the @ sign. And, your password is the password you created. If you forget it, just put your browser – you know, put your cursor into the password space, and you can put in a new password. It will allow you to put in a new password. And now, we'd like to thank everyone for spending the last almost hour and a half with us. We hope that you learned something, and I hope – we hope that you come back for the next event that we have. Please enjoy the rest of your day...

END