Inpatient Quality Reporting Program

Successfully Reporting NHSN Data to Satisfy Hospital Quality Reporting Program Requirements

Presentation Transcript

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Matt McDonough: Hello, and welcome to today's webinar.

Before we start today's webinar, I'd like to cover some brief housekeeping tips with you, so that before we turn things over to our speakers you understand how today's web event is going to operate.

As you can see on your screen, audio for this event is available via Internet streaming, and if you're hearing my voice over your computer speakers or your headphones, then you know that. What that means is that no telephone line is required, but that you do need to connect computer speakers or headphones to hear this streaming audio feed.

Now, we do have limited dial-in lines available. If for some reason, your audio feed doesn't work or becomes disrupted or choppy, please send a

chat message if that is needed. And, as a second note, we are recording this event, as well, for future reference.

Now, if you are streaming audio, you'll notice that there are some tips that you can use to troubleshoot audio issues that you encounter. For example, if your audio from your computer speakers begins to break up, or if it suddenly stops, what you could do is click the pause button as displayed on this slide, wait about five seconds, and then click the play button. Your audio feed should resume. Now, if you hear a bad echo on the call, if my voice is echoing badly right now, that usually means that you're connected multiple times to this event and you're hearing my voice on two separate audio feeds. What you'll need to do here is close all but one of the browser tabs that is connected to this event and the echoing issue will clear up.

Now, attendees on today's event are in a listen-only mode, but that doesn't mean that you can't interact with our panelist today. You can submit questions to our panelist at any time via the Chat panel. Simply type your questions into the *Chat with the Presenter* box that's located in the bottom left of your screen, and then click the "Send" button. When you do that, all of our presenters today will see your question and, if time and resources allow, your questions will be answered. All questions are being archived, however, for future reference.

That's going to do it for my introduction. So, without further ado, I'd like to hand it over to our first speaker of the day.

Candace Jackson: Thank you, Matt.

Good afternoon. My name is Candace Jackson and I will be the moderator for this event today. Welcome to the *Successfully Reporting NHSN Data to Satisfy Hospital Quality Reporting Program Requirements* webinar.

I would just like to remind you that this program is being recorded and the transcript of today's presentation, as well as the audio portion of the program, will be posted along with the slides and the transcript of the questions and answers on *QualityNet* at a later date. The presentation will also be posted to the *Quality Reporting Center* Website.

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The purpose of this presentation is to provide an in-depth discussion of the Hospital Quality Reporting Program, National Healthcare Safety Network Reporting (including successful data entry), troubleshooting tips, and data submission validation.

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At the end of today's presentation, the participants will be able to discuss the use of the NHSN database, identify steps to improve data entry and submission to meet the HQR program requirements, identify and utilize troubleshooting tips, and describe best practices in HAI data tracking.

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The next three slides provide a list of acronyms used in this presentation.

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And next slide, please.

And next slide, please.

I would now like to introduce the speakers for today's presentation.

Maggie Dudeck, MPH, CPH, is an epidemiologist for the NHSN Methods and Analytics Team, in the Division of Healthcare Quality Promotion at CDC. Maggie began her career with CDC in 2003, working as a graduate student with the HQP on the NNIS system, and eventually, NHSN. She currently has a central role in NHSN data cleaning and HAI analytic activities. She provides direct user support and documentation with a focus on analysis and interpretation of data and has served as lead author or co-author to several national level HAI annual reports. She provides subject matter expertise in NHSN development and analysis activities and to interagency working groups, and provides training to various groups around the country. Maggie earned her Bachelor of Science degree from

Northern Illinois University and her Masters of Public Health in epidemiology from Emory University.

Joseph Clift is a health insurance specialist for the Centers for Medicare & Medicaid Services in Baltimore, Maryland. He serves as the Measures Lead for the Hospital-Acquired Condition Reduction Program within CMS' Hospital and Patient Quality Reporting Program, and as a support for [the] Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Program. Dr. Clift works alongside measure stewards to assist with measure development and management, supports proposed and final rule development, including responding to public comments for CMS' Inpatient and Outpatient Prospective Payment System rules, and serves as a Contracting Officer's Representative on assigned contracts and Interagency Agreements. Dr. Clift has an EdD degree in health education from Nova Southeastern University in Fort Lauderdale, Florida, as well as an MS degree from the University of Maryland University College in Adelphi, Maryland.

Suzette Gerhart is a California native. She received a B.A. in Liberal Arts from Cal State University Northridge. She moved to Arizona in the fall of 1996, and began working with HSAG in March of 1997. She began working with the Arizona QIO program assisting Arizona hospitals with inpatient reporting in 2003. In August of 2014, she began working with the VIQR support contractor assisting providers nationally with their inpatient reporting.

Maggie, I will turn the presentation over to you.

Maggie Dudeck: Thank you, and thank you everybody for joining this afternoon.

My goal for my portion of a presentation is to help walk you through all the steps needed to complete your reporting for the CMS quality reporting programs, focusing on Acute Care Hospitals, Inpatient Rehab Facilities, and Long Term Acute Care Hospitals.

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So before I get started, I do want to just give you an outline of the Inpatient Rehab Facilities, or IRFs, and how we distinguish between the two kinds of IRFs in NHSN and at CDC.

There are freestanding IRFs, and these are those facilities that enroll into NHSN as a HOSP-REHAB, or a rehab hospital. They are their own entity. But then we also know that there are IRF units within the Acute Care Hospital setting, and these units report as individual locations within the hospital that is reporting to NHSN. So really, our freestanding IRFs are considered physically separate buildings, whereas IRF units, again, are locations within the Acute Care Hospital.

I have included some information here regarding the CMS certification number for you to review after today's presentation. But chances are, if you have an IRF unit and you've been reporting for it, then you are aware of this information already, but it is here for a resource. Of course, if you have any questions regarding your facility type or how to enroll or report for that facility type or location, you can send your questions to the NHSN help desk.

Next slide.

So, I wanted to take a quick moment just to talk about how NHSN is used, not just for CMS reporting but for other types of reporting. NHSN – really, think of it as a vehicle that can be used to fulfill multiple purposes, okay? So, NHSN is a software application with a database behind the scenes to store the data that is reported by your facility. So, NHSN is used for, as we know, to report certain measures and certain data to fulfill reporting requirement for a CMS quality reporting program, or state mandates on top of any CMS quality reporting program requirements, And then some hospitals and facility types also voluntarily report HAI data that is of interest to them. So, they may report ventilator-associated events that are not required by their state. They're not required by CMS, but it is an HAI that they wish to perform some surveillance on and they wish to make some improvements.

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So, you probably all know NHSN, not only as an application, but as an actual surveillance program, uses standard surveillance protocols, and these protocols and definitions are in place so that any events that are identified in the denominator data that are collected are done so in a standardized fashion. And this allows for appropriate comparison and tracking across the country. It also allows for these data to be entered and analyzed by the hospital. So, every healthcare facility that reports data to NHSN can get those data back out of NHSN using the various analysis tools; and we will talk about those towards the end of my presentation today. Also, there are groups in NHSN, and so those may be like quality improvement organizations or state health departments that have access to your data. And you would know if they have access to your hospital's data because you would give them rights, and actually allow them to have access to those data. And some of those groups may analyze your hospital's data for validation purposes to come up with its own metrics or to help your healthcare facility comply with some of the CMS reporting requirements.

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I do have just some recommendations and some requirements to review with you when using NHSN. And, one of the big recommendations I have is for your organization to develop a routine schedule for not only entering the data into NHSN, but also analyzing the data that are in NHSN. This routine may depend on multiple factors, you know, including, of course, CMS quality reporting program deadlines. But, in addition to that, your hospital may have some internal reporting needs and dashboards and things like that. So, consider those items, develop a routine for entering those data, for analyzing those data, and also be sure to leave yourself plenty of time to do a thorough review of the data that are obtained from the report, so that you can ensure that those data are accurate and reflect your hospital in an accurate way. I recommend that a checklist [be] used when entering and analyzing data, as these can help. A checklist can really help to ensure that your data are complete for each measure required; and,

we will be going through a checklist today. But, I do also want to review with you some requirements when reporting data to NHSN.

So first of all, all of the data that are collected and reported to NHSN must be reported according to the NHSN surveillance protocols, surveillance methodologies, and definitions. Okay, so all of those have to be according to the standard set forth by CDC and NHSN. In addition, we have something called "In-Plan" data, and I'll explain what that means in a few slides. But, I'm bringing it up now just so you remember, as we go through today's presentation, that only "In-Plan" data that are complete are eligible to be shared with CMS, meaning CDC does not hold the authority to share "Off-Plan" data with CMS. We can only share those data that are "In-Plan" and prescribed for the quality reporting programs.

Next slide.

I am excited to share with all of you that in the coming days, we will have a new NHSN resource available to everybody on the NHSN website. It is setup to be a monthly checklist. Okay, so, we did have a checklist of sorts on the website, but there was one checklist for every single type of event in the Quality Reporting Program. What we've done is, we have condensed them into one document where the first page is a quick snapshot. So, if you are someone at a healthcare facility who is very comfortable and has been reporting these data for a while and you just need a really quick snapshot [to] look at all the things you need to make sure are complete, this first page will be for you. The pages that follow will be more detailed and will have more detailed information on reporting for each individual event type and measure required. Okay, so this will be available soon on the NHSN website, so, please stay tuned for more about that.

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So, I figured what would help for today's presentation is to pretty much walk through that checklist but in more general terms. I think the best way to think about completing your reporting for CMS is to go through each

item in order that the data are considered when we compile the data for your hospital and preparing it to send to CMS. So, the first item is to confirm and update the CCN that is in NHSN.

Next slide.

So, the CCN, or CMS Certification Number, is something that is entered when your facility enrolled in NHSN and it is available on a Facility Information frame within the NHSN application. I have a screenshot here showing this information. The CCN can only be entered or modified by a user at your hospital who has administrative rights. And so, if you go into NHSN, and you see the option on the left-hand side that says "Facility," then you know you have administrative rights. If you do not see that option, you do not have those rights. There is at least one person in every healthcare facility joined to NHSN who has these rights. We refer to that as the Facility Administrator. So, at a minimum, we know at least one person can update this information.

What I want to point out is that the CCN applies to all of the reporting for this main facility type, and I'll describe to you in a minute why, you know, there is a bit of a distinction. But, let's say it's – this is an Acute Care Hospital and I have the CMS certification number here on my Facility Information screen, that CCN would apply to all of the reporting for the Hospital Inpatient Quality Reporting Program and no other program, okay? So, all the data for that program would be submitted according to the CCN that is listed on the screen. If this CCN is not correct, your data will not be submitted to CMS correctly because we use that as the primary identifier. So, please be sure to double and triple check the number.

Next slide.

This slide is just a screenshot to show you that if you have – if you are an Acute Care Hospital that has an IRF unit reporting as a location under your hospital's NHSN log in, then the CCN for that IRF unit is to be entered on the location screen. So, you know, again, you can update this

information if it's incorrect, and, it is available through the Facility and then Locations option in NHSN.

Next slide.

We do have some instructions on the NHSN website to update your facility's or your IRF unit['s] CCN and NHSN. I have provided a long URL here or web address here. However, know that we have a main CMS reporting page on the NHSN website and this information is also on that page. So please, have that handy as you're reviewing your CCN.

Next slide.

So, now that we've completed that first step and let's say we know our CCN is correct, we can move on to the next step in the process in our monthly checklist; and that is, we should review the Monthly Reporting Plans and update them if necessary.

Next slide.

The Monthly Reporting Plan allows us at CDC to know which modules your facility is following during that given month, and, this is what we refer to as "In-Plan" data. Now, when you indicate something in your plan – so let's say for example you have CLABSI and CAUTI for your ICU and you put that in a Monthly Reporting Plan, then that drives a lot of the other requirements when you go to enter and report your data, okay? So, again this is why I'm going through this in order.

If you have something that is not "In-Plan," then those – those rules are a little more relaxed and your data would not be eligible to be submitted to CMS. Every healthcare facility has to enter a plan for every month of the year. If you don't enter a plan, we don't allow you to enter any kind of data whatsoever. So, you would definitely know if you did not have a plan in place. But, once you enter a plan, please make sure that you've included all of the required elements for your hospital and for the Quality Reporting Program in which you are participating. If you notice that there's an error

in your Monthly Reporting Plan, you can go back and change it and you can modify it by adding units, or HAIs, or removing rows from that plan.

Next slide.

Just to reiterate, I know I've said this a couple of times already and you'll hear it from me again, NHSN are only going to submit data for those complete months in which those data are indicated in the Monthly Reporting Plan. So, if you forget to include, let's say, CLABSI and CAUTI for your ICU in your Monthly Reporting Plan, but you report them, it doesn't matter. If it's not in your plan, they will not go forward to CMS for that Quality Reporting Program. So, it is incredibly important to make sure your plans are accurate and up-to-date and include all of the elements required for that reporting program. And, during my portion today of the presentation, I'll show you there's a couple of spots where you can tell if you're entering data and something is not there, and you'll know it's not "In-Plan."

Next slide.

So, I wanted to provide you with just a very quick snapshot of the requirements for 2015 so you have just a bit available for you, just to review. We know that hospitals are required, for the Hospital Inpatient Quality Reporting Program, to report CLABSI data from all of their ICUs in addition to their NICUs, and then, beginning with this year, they must report for all medical, surgical, and medical surgical wards. Now, that ward – those ward types – it would include adult and pediatric wards, and they are at the general medical, surgical, and combined medical surgical according to the CDC definitions of those location types. For CAUTIs, the reporting is very similar, although there is no reporting of CAUTI from NICUs. Then for LabID reporting, the requirement is for department and observation units, if applicable. So, if your hospital has a standing ED or separate observation units, you must always include those data. And then, of course, for SSI, you're required to report inpatient COLO and abdominal hysterectomy procedure data.

Next slide.

For the Long Term Care Hospital Quality Reporting for 2015, or I'll refer to this also as LTCH, that's the CDC language we use, LTCH, CLABSI and CAUTI are continued to be reported from all inpatient units. And now, for 2015, MRSA blood and CDI LabID data are required at the FacWideIN level. But of course, this would not include any ED or observation unit, as those units would be applicable to LTCH facilities.

Next slide.

So, now we're [going] to get into some distinguishing factors for the IRF quality reporting. If you are a free standing IRF, then you are required to report CAUTI from all of your IRF units and MRSA, blood, and CDI LabID at the FacWideIN level. So that means FacWideIN would be in your Monthly Reporting Plan, and it would be how you report your denominator data.

Next slide.

However, if the IRF is a unit or a location within an Acute Care Hospital, the reporting is a little different. So, the Acute Care Hospital that's in NHSN would have to include the CMS IRF unit in their monthly reporting plan for CAUTI. And, for MRSA blood and CDI LabID, they would have to indicate each IRF unit individually in the Monthly Reporting Plan, as well as in the denominator data. So, the distinguishing factor here is that FacWideIN at the Acute Care Hospital does not cover the LabID reporting for the IRF unit, okay? The IRF unit has to be called out and reported for separately.

Next slide.

So, this just reiterates what I said. So, if your Acute Care Hospital has a CMS IRF unit or location, you must list that location as a separate row in your Plan for each of these event types.

Next slide.

So, now that we reviewed the steps for the Monthly Reporting Plan, we can talk about the actual entry of the event into NHSN.

Next slide.

So, for the event, these are really considered the numerator for the measures that we submit to CMS on behalf of your hospital. So, of course, your facility should be performing the surveillance for these events according the NHSN protocol and the definitions and follow along with the surveillance methodology. If you identify any event, you would answer those events, and this can be done by using the "Event Add" option in NHSN on the navigation bar when you're in the application.

What I want to point out here is that if you have to report surgical site infection data, when you report that SSI, you must link to a procedure record that's already in the system, okay? If you enter an SSI and it does not prompt you to link it to a procedure and allows you [to] save it, then it's likely that that procedure is not "In-Plan," okay? So, that would be kind of a hint for you. But, if it is "In-Plan," you would get a prompt and say, "You have to link this to a procedure record." And keep in mind that the patient ID is the primary identifier, so the patient ID must match exactly between the SSI and the procedure in order to pull out that record and to perform the link. So, if you have a patient ID with leading zeros on one record, it has to have leading zeros on the other record. So you've dashes in one record, you have the hyphens or dashes in the other.

Next slide.

So, now that we've talked about the numerator data or the event level data, I'm going to go ahead and move on to denominator data. We're going to spend a little bit more time on this. And so, the denominator has to be entered for each month and for the event type under surveillance. That's because if we don't have this denominator data, we can't calculate the standardized infection ratios or the rate for some programs in order to be able to submit those data to CMS.

Next slide.

So, we're going to go through this looking at each of the event type separately. For CLABSI and CAUTI data, the denominator data have to be entered for each required location for each month in the quarter, all right? This can be done by going to the summary data add option in NHSN. And for the reporting of the ICU in the ward level data, the Summary Data Type that you want to select is the Device-Associated-Intensive Care Unit/Other Location. If you are reporting for NICUs or neonatal intensive care units, then you would select the Device Associated-NICU option.

Next slide.

This is a snapshot of a data entry screen for entering the CLABSI and CAUTI denominator data. So again, you would have been collecting these data according to the NHSN protocols and definitions, and then you would enter in the monthly number of case days and each of the device date types for what's required for your hospital. So, I have central line days and urinary catheter days.

Next slide.

Here's a really big tip for everybody. So, the red asterisks that appear on the screen are a really big clue to tell you what data are required in part of your reporting plan. So, in this example, I have red asterisks next to Total Patient Days and Central Line Days. But notice, next to Urinary Catheter Days, I don't have that red asterisk. So, that means that CAUTI is not in my Monthly Reporting Plan for this location in month because the application is not requiring me to enter those denominator data, okay? So I would be able to save this record with no denominator, and I would not receive any alerts for reporting my events, and any data reported would – for CAUTI, would not be sent to CMS. So, please make sure that when you're entering this data, you see that red star and that will confirm with you that the data are "In-Plan" for that unit in month.

Next slide.

Now, if your hospital – if you know when you enter this denominator data, you know that your hospital identified zero events. Then you can go ahead

and check the Report No Event box on the denominator screen when you save the record. So, in this example, I've checked the box for CLABSI under Report No Events because I know that my hospital did not identify any CLABSIs in this unit in – for this month. Now, if I don't check this box and I don't enter CLABSI, I will be given an alert, and we'll show you what those alerts looks like. But, if you know from the get go that you had zero identified, you can check that box here and save the record, and then that will resolve the alert. The reason this is required is that CDC wants each hospital to confirm that if there are no events entered, that you truly identified zero events, meaning a zero is really a zero. It is a verification that you didn't just forget or mistakenly not enter an event; that you really are saying, "No, we've identified zero according to the NHSN protocols." And only then will we include that zero rate or that zero numerator for your hospital when we submit data.

Next slide.

So, the denominator data for SSI operate a little differently, okay? And, that is a procedure record has to be entered or imported for every inpatient COLO and HYST procedure that is performed in your hospital. So, there is no one summarized metric as showing, "Okay, we just had X number of procedures." We actually need an individual procedure record reported because this is where the risk information is held for each of those procedures. Procedures can be entered by using the Procedure Add option on the navigation bar or they can be imported. And, the data can be imported using a CSV file or through clinical document architecture or CDA. And CDA is an option for those that have a vendor system that sets up that import format.

Next slide.

All right, I'm going to stay in CDI LabID data. I just want to take a moment to talk about some changes that we had in 2015 that you likely noticed. So, this screen shot is showing FacWideIN or overall Inpatient Facility-Wide reporting. So, you know, of course, I want to point out the red asterisks next to many of these data entry fields. There are now three

levels, or tiers, of denominator data. So, at the top here, next to settings, I have Inpatient Total Facility Patient Days and Total Facility Admissions. This number is required and includes all inpatient units, so every single inpatient unit that is physically within the bounds and the walls of your facility. The next level is MDRO Patient Days and MDRO Admissions. So, this number would be the total reported at the top minus the counts that are from those units or locations that have a CCN – a unique CCN; so, that would be like your IRF unit, or if you had inpatient psych facility units. So, you would subtract those out of the total and then you would have a new set of Patient Days. So, this second level of MDRO Patient Days and MDRO Admissions, these will [be] the denominators to use for your MRSA LabID reporting, for the hospital, for FacWideIN. The third tier is for CDI. So, you would basically take the MDRO Patient Days and the admissions and subtract out any counts from the NICUs and theWell-Baby units, okay, because those units are not eligible for CDI surveillance.

Now, if you are an IRF – free-standing IRF – or if you are an LTAC, then you would likely, in a large majority of cases – all of these numbers would be the same. So all three Patient Day counts would be the same and all three Admission counts would be the same. But, the Acute Care Hospitals are those that would have a high likelihood of having some sort of difference that would have to subtract out. I've also outlined on the screen that – let's look at this first column on left for MRSA. I have LabID event lab specimens. It's a little hard to see. But what I want to point out is that there are two check boxes and both of them are checked. That first one that falls under MRSA is greyed-out and notice that it has a red star, so that means that I've indicated in my Plan that for FacWideIN for this month, I've checked the box for MRSA LabID. If you have to check that box on your own, there's not going to be a star and also means your data are not "In-Plan," okay? So, if that is automatically checked for you, you know it's "In-Plan." And then, of course, you have the opportunity at this time to check Report No Events if you know your Hospital has not identified any events.

Next slide.

Just a reminder, for Acute Care Hospitals, that in addition to entering a FacWideIN denominator record, you also have to enter separate denominator records for each ED and each observation unit, if applicable; as well as each CMS IRF unit, if you have that within your hospital. So, each of those are separate locations and separate denominator records that are entered.

Next slide.

So, the next thing we need to talk about is really a hot topic, and it is the Alert. Now, I'm not going to go through all Alerts. I think we have something like seven different Alerts in NHSN, but I'm going to touch on the four main Alerts.

Next slide.

I would like to take an opportunity to remind everybody that Alerts are generated for "In-Plan" data only. So again, I talked a lot about "In-Plan." If an event is not "In-Plan" for a month, you will not get an Alert, okay? We are only going to alert you for those data that are "In-Plan," and that's partially because we didn't want to bother hospitals who are choosing to enter data voluntarily, and we don't know what to expect from them. But, when you put something in your plan, we know exactly what is expected for data entry, and we want to make sure Alerts are resolved. So I'll go through each of these four Alerts.

Next slide.

The first Alert is called Missing Event. So, a Missing Event Alert means that your hospital did not record a CLABSI, CAUTI, or LabID event for a month and location, okay? When you see this Alert, you need to first verify that your hospital truly identified zero events of that type for that location and month, okay? So, make sure that your hospital actually had zero. If your hospital did not identify an event, then you can check the Report No Events box on the Alert tab that you'll see, or you could do it through the denominator data record, which I just showed you. And of

course, if your hospitals did identify an event, then we would want you to enter that into NHSN.

Next slide.

This is a snapshot of the Alert screen. I have the Missing Event tab access, so I'm pointing that out at the top tab. These are always available to you. So, actually, when you login to NHSN, the first screen that you'll see are – is a screen that shows you the alerts that you have. So, if your hospital has anything that requires attention, we will put that on the front page. Then, you can actually access them by using the alert option on the left hand navigation bar. So, this is the missing events alert. I just want to point out, in this case, we have one row for each of these ICU types. You noticed that there is a month and year. We give you the Alert saying "Summary but no events." And, if you click on the link that says, under Summary Data Form Type, you can select the DACA; that would take you to the denominator form. Or, you could just check the box that says "report no events" on the screen and then click "Save." Just be sure to click "Save." If you don't click "Save," it doesn't save your alert verification.

Next slide.

The next option is Missing Summary Data. So, the Missing Summary Data alert will appear if your hospital did not report a denominator data record for an event month and/or location. So, previously, this alert had only appeared if your hospital also reported an event. However, beginning with 2015, and some of you may have already noticed this, this alert will appear regardless of whether events of that type have been entered, okay? So, essentially, if you have not reported your CLABSI denominator data yet and you have not entered any CLABSI events, you will still get this alert to tell you, "Hey, you've not answered this data yet."

Next slide.

So, this is just showing you the Missing Summary Data alert tab. Since there are multiple fields or data requirements for denominator data, we can't allow you to resolve this by using the Alert screen. Instead, you need

to click on the link on your Alert Type that says "Add Summary," and upon doing that, you will be taken to the denominator form and then you can enter in the data for that location and month.

Next slide.

The next alert and the fourth, last alert I will be talking about is the Missing Procedures alert, okay? So this will appear – actually, this is the next to last, I apologize. This will appear if your hospital did not report at least one procedure record for that month's procedure category and setting, all right? So, again, if you see this alert, you need to verify if your hospital truly performed zero procedures of that type; and we know that to be true for some of the smaller hospitals where you may not have very many procedures reported or performed that are of the required categories. So, if your hospital did not perform any procedures in that category, you can check the Report No Procedures box on the alert tab. That alert screen is the only place where you have the opportunity to enter no – or to verify no procedures, okay? There is no denominator form for this; no summarize denominator form, so you have to check the box on the alert screen. If your hospital did perform procedures, then, of course, you would enter them, and enter them in the manners that we talked about, either entering each record individually or importing them through one of the two methods available.

Next slide.

So, very similar to what we were seeing before, this is the Missing Procedures alert tab. Again, you can check the box under No Procedures Performed. What I want to point out here is that we provide a row for each month, procedure, and setting. So, if your hospital indicated that you are following both inpatient and outpatient procedures of a certain category, we have the alert separated by inpatient versus outpatient, okay? So, this is telling me that my hospital has not entered any inpatient COLO or inpatient hysterectomy procedures for March 2015. Of course, if I check that No Procedure Performed box, I need to click the "Save" button.

Next slide.

Once I've resolved data for missing procedures or if I've entered my procedures, another alert that could appear is Procedure-Associated Event or essentially SSI. So, again, as we said before, if this appears, this means that your hospital did not report at least one SSI event for the month and procedure category. But the caveat here is that the alert is going to be related to the date of procedure, not the date of event, so you would verify if your hospital truly identified zero events of that type. If you did not identify an event, check the Report No Event box, and if you did, you would enter in the event.

Next slide.

Again, this is a tab very similar to what you've seen. Now, I think this is a good time for me to mention that, if you check the Report No Event box and then you notice, "Oh my gosh," a week later you've identified an event you need to report, go ahead and report it. It will undo that No Event behind the scenes, and so that way the event can be counted, okay? So, just know that it's not a big deal. Just enter if it's identified and it will be accounted for.

Next slide.

So, now we've gone through all of the data entry requirements, right? We've checked everything that we need to check. Everything is In-Plan. We checked our Alert. The last step is to use the NHSN Analysis Output option so that we can check on the accuracy and the completion of our data entry prior to a CMS deadline. These data should be checked regularly, and they should be checked as closely as possible to the final time right before a deadline. And the reason this is important is because once a CMS deadline has passed, no updates are ever submitted to CMS. So, while you are at your facility, you have the ability to change data in NHSN after the fact that you have your reports updated. So, the updates are never sent to CMS. Once that deadline has occurred, the data are frozen on that end, okay? So it's incredibly important that this process and

this step is performed prior to the deadline so that you know that your hospital can be represented accurately on *Hospital Compare* and through all of the subsequent programs that used those data.

Next slide.

So, I'll be taking the next few moments to highlight something that we have in NHSN, and we have CMS Report or Analysis Output Options. These Output Options were created in order to pretty much mirror the data that would be submitted to CMS on behalf of your facilities for that upcoming quarter, alright? So, it really is the true picture of what is going to be sent forward. So, if something is wrong in the report you run in NHSN, it will be wrong when it gets submitted to CMS.

Now, I know there is probably many of you that are not familiar or could – maybe don't regularly run analysis reports in NHSN, so we do have a number of training resources and guides available on the website. Because – for the sake of time today, I will not be able to go through all of the "how tos" for that. So please, refer to that if you are newer to using this function.

Next slide.

This is a snapshot of the Analysis Output Option screen within NHSN, and what I have just highlighted is [the] Output Options folder that says CMS reports. We have organized the reports first by the quality reporting program, and then within each of those we have one report for each measure that is required.

Next slide.

When you run the reports, I just want to point out to remind everybody to please read the footnotes that appear at the bottom of each report. These footnotes can provide valuable information regarding the data that are on each table or regarding the data that are not in the table. So please, be sure to take a look at them. In addition, those footnotes will include the date that you last generated data sets, so we know exactly the date and time that

is reflected and to which data were current when running that report. Again, the data on this table should be used to confirm the accuracy of the data and to check the quality of your hospital data, prior to the deadlines for that upcoming quarter.

Next slide.

Just a quick, brief reminder, I know we got a lot of questions about rates. The majority of the data that are submitted do use something called the Standardize Infection Ratio or SIR. The SIR looks at the number of identified or observed infections divided by the number of expected or predicted. And that expected number takes into account the data that your hospital has reported in addition to some national historic baseline risk adjustment information.

Next slide.

So again, when you run your report, the data that appear will be current as of the last time you generated the data sets, and that date and time will be in the footnotes to all of your reports. So, I do want to mention, as well, that at CDC we do send monthly preliminary files to CMS. As a deadline nears, we send those data more frequently so that hospitals have an opportunity to review their data in *QualityNet*. But the exceptions to that is something I've already stated, that quarterly data are frozen as of the final submission date for a quarter. So, all this to say that when you run these reports from within NHSN – and the reports I'm talking about are the analysis reports, the SIRs and the rates themselves, okay, when you run those reports, please save a copy so that if you are asked to review those data for *Hospital Compare* Preview or for any other program, then you already have that snapshot saved because any changes made in NHSN after that will change your data on the CDC NHSN site and not on the CMS site.

Next slide.

I'm just showing this as an example for you. This is a snapshot of an SSI SIR that would be submitted for the Acute Care Hospitals for CMS. What

I want to point out here is that I have the CCN at the top of my table. So, even looking at this report, I can tell if my CCN is correct. The data are generated by Calendar Year quarter. So, this is 2015 Q1 data. So, if my data were to be submitted today, this is exactly what would be submitted for my hospital. It takes into account all of the rules that we talked about [for] In-plan data. Have I checked if no SSIs are identified for each month? Have I reported the right number of procedures? Is all of that complete? There are also lots of footnotes here. And, we can see on this report at the very bottom of my screenshot there is something that says, "Data contained in this report were last generated on May 26, 2015 at 12:43 PM," so I know at that day and time, this is exactly what was submitted or what was entered for my hospital.

Also a reminder: if you have the number of expected infections less than one, which is the case in this HYST row here, that means that a SIR is not calculated, but those data are still submitted to CMS. So, I'm still showing it's having data reported for that quarter. It's just that there aren't enough data with which to calculate the SIR.

Next slide.

We do have guidance documents for each of the CMS-related reports. This website is the direct link to the CMS reporting page on the NHSN website, so please have this website handy. We have all of the operational guidance and documents regarding the SIR that I pointed out here. They're using the SIR CLABSI data for CMS IPPS Output Option.

Next slide.

So, I'm not going to spend a lot of time on this, but this is just a reminder that although there are multiple organizations that may be using your facility's data, at the end of the day, they are your data, they are your facility's data. So really, you know, if you haven't already begun to take ownership of the data that are in NHSN, then take some ownership in ensuring the accuracy and then using those data for any sort of internal processes and measurement that are of interest to your hospital.

Next slide.

I also want to remind everybody that the SIR are incredibly important, that they should be reviewed. They can help you track your data for accuracy and that they should be saved for each quarter so you know what was submitted to CMS. However, there are many other reports that can help you ensure the accuracy of your data. So, please be sure to use this, especially [the] line list and frequency tables can be incredibly helpful in ensuring the accuracy of your quarterly data.

Next slide.

When checking your data or doing data quality checks, remember or keep in mind what is being measured, how it's being measured, and for which time period, because this can really save you a lot of time in the end, and it can direct your data analysis effort. Also, understand what is required for completion. So, we know that for today, we're talking about what's completed or what's required for CMS quality reporting programs so you know, "Okay, I have to include things in my plan. I have to report denominator data, but also understand what risk factors contribute to the measure and what elements contribute to that measure." And you know, I – actually, I love seeing questions from hospitals who are saying, "You know what, I reported five SSIs [and] for some reason, only three are showing up in my SIR report. Why is that?" And so, we can help them through that. And, sometimes it's just the matter of – there's certain inclusion or exclusion criteria. But it's so great to know that so many of you are paying that close attention to your data that you're going now to each number and making sure that they're all accurate.

Next slide, please.

Also, to reiterate, know your numbers. I'm sure many of you have a general idea of the number of patient days you see in your hospital or in certain units. You have a general idea of the number of procedures performed, so you should know if something may have been entered incorrectly, it would certainly jump out at you.

Next slide.

I also just wanted to take a second to show you and review with you just a few of the things that can potentially impact your resulting rates or SIR. Some of these are more obvious than others. So obviously, if you enter another event that could impact your rate but there are other things that could impact the resulting numbers, as well. So, for example, for LabID reporting, the assignment of what healthcare onset versus community onset could be based on other events for that patient, as well as admission date or discharge date, so that information is changed; that could change the resulting numbers.

Next slide.

All right, to change gears here for just a second, I do want to take a moment to touch on Healthcare Personnel Influenza Vaccination. The Healthcare Personnel Influenza Vaccination is reported once per flu season. We know it's already been reported for the 2014 and 15 season and that is complete. But, I just wanted to remind everybody that this data are reported as a single summary form per facility.

Next slide.

For those Acute Care Hospitals that have an IRF unit, a reminder that you would report a summary record for the Acute-Care Hospital, and then a separate summary record for each IRF unit. So, this is very similar to how the LabID data are reported and how CAUTI data are reported. So, the data for the IRF unit have to be reported on a separate record than the Acute-Care Hospital.

Next slide.

We do, of course, have training and many resources for the Healthcare Personnel Influenza Vaccination. This can be found on the NHSN website. And, of course, we have information through the CMS Reporting page. So, if you are not familiar, if you're new to doing this type of reporting for your hospital, you know that plenty of resources are available.

Next slide.

All right, so these are some of the key NHSN website resources that I wanted to provide to you all. Please have these handy and they can be incredibly helpful as you analyze the data and also ensure that the reporting is complete for your hospital.

And we go on to the next slide.

Just a reminder that if you have questions specific to your reporting to NHSN or using the NHSN report, you can email us directly at nhsn@cdc.gov.

So with that, I thank you for your attention. I'm going to go ahead and pass this along to Joseph.

Joseph Clift:	Hi. Great. Thank you, Maggie for that. And thank you everybody for taking time out of your day to attend this presentation. I'm just watching the clock, so I'll kind of go a little quicker than I probably would have because I want to make sure that we have time to get through everything in the time that we have left today. So, I'm going to start with the – talking about the CMS programs that use the CDC NHSN measures. And I'm going to start by talking about the IRFs and the Long – LTCHs.

Next slide, please.

So, the IRF and LTCH quality reporting programs, they were both enacted by Section 3004 of the Affordable Care Act and both provider types began reporting quality data to CMS on October 1, 2012. While IRFs and LTCHs both use assessment instruments to report quality data to us, and when I say us, I mean CMS, IRFs used the IRF PAI (Patients Assessment Instrument) and LTCHs use the LTCH Care Data Set. Both IRFs and LTCHs are also required to report specific quality data via the NHSN.

So, before either provider type can begin reporting data to NHSN, they are first required to enroll in NHSN and complete training modules specific to the quality measures required for their quality reporting programs, and all

of these are outlined in CMS regulations and also on our website. So, once IRFs and LTCHs have completed these training modules, then they will need to apply for NHSN reporting permissions. So, listed below on this slide are some specific links for enrollments related to each providers type.

Next slide, please.

So, currently for Calendar Year 2015, which is affecting the Fiscal Year 2017 annual payment update, LTCHs are required to report data on size in NHSN quality measures. CDC data is required to be submitted on a quarterly basis. However, compliance is based on four quarters of reporting. LTCHs have a quarterly deadline, which currently fall approximately 45 days after the end of each quarter. So, you'll see on this slide here, on the right hand side, tells you the quarterly data submission deadlines for each quarter. So, for example; quarter one is due by May 15.

On this slide, we ask that you please note the date in the parentheses in the left-hand column. While LTCHs currently have 45 days beyond the end of each quarter in which to submit their quality data, CMS has proposed, in this year's Fiscal Year 2016 IPPS LTCH PPS Proposed Rule, to extend the current 45-day timeframe to 135 days. Our proposal is based on the needs to allow LTCHs an appropriate amount of time to review and correct their quality data prior to CMS publicly displaying that data. If CMS finalizes this Proposed Rule – Final Rule, which will be publish at the end of this month, LTCHs would have 135 days beyond the end of each calendar year quarter to submit their quality data to CMS. So, this change, if finalized, will begin with quarter four of this year, 2015, and LTCHs would then have until May 15, 2016 to submit their quarter four 2015 data. The one exception to this proposed policy is data submitted on the Influenza Vaccination Coverage Among Healthcare Personnel measure. Data for this measure, as I explained earlier, is only selected between October 1 and March 31, what we call the Influenza Vaccination Season. The deadline for this measure will remain 45 days beyond the end of the reporting period. LTCHs are only required to submit data to inform this quality measure once, and that data must be submitted to CMS via the NHSN by May 15 of each year.

We ask that you continue to check the CMS LTCHs quarterly on the quality reporting website for updates and information related to the data submission deadlines, as well as information related to publication of the Fiscal Year 2016 ITPS LTCHs PPS Final Rule.

Next slide, please.

Currently for calendar year 2015 affecting the FY 2017 APU determination, IRFs are required to report on four NHSN quality measures. CDC data is required to be submitted on a quarterly basis. However, compliance again is based on four quarters of reporting. IRFs have a quarterly deadline related to the submission of quality data, which is 135 days after the end of the Calendar Year quarter. So, quarter one 2015 data has to be submitted via the NHSN to CMS no later than August 15, 2015. The one exception, similar to LTCHs for this policy, is that the Influenza Vaccination Coverage Among Healthcare Personnel workers is due by May 15 of each year for the preceding flu season.

Next slide.

The majority of IRFs and LTCHs that do not meet CMS compliance standards and find themselves at risk of a two percent reduction to their applicable FY Annual Payment Update are missing one of the two elements listed here. It is imperative that your facility or hospitals know how to verify that each of these elements has been submitted for each required NHSN quality measure, for each of the 12 months within the Calendar Year.

Next slide, please.

So now, we'll move into the Inpatient Quality Reporting Program, IQR, and the Hospital Value-Based Purchasing Program, HVBP.

Next slide.

So to meet IQR requirements for Fiscal Year 17, hospitals must submit the CLABSI, CAUTI, the colon and abdominal hysterectomy, SSI, MRSA, *C.*

Diff, and influenza vaccination measures by the appropriate quarterly submission deadline. For CLABSI and CAUTI, hospitals will report data from adult and pediatric Medical Surgical, Med-Surg, in addition to all adult, pediatric, and neonatal ICUs.

For the surgical Site Infection for abdominal hysterectomy and colon surgeries, enter data for each procedure performed and, if events have been identified, the event must be linked to the procedure record. This is just to reiterate what Maggie said before, that the SSI has to be linked to a procedure record.

Next slide.

Starting with January first of this year, in addition to reporting MRSA and *C.Diff* facility-wide, you must also report any Emergency Department and 24-hour Observation Units that you may have at your facility.

Next slide.

And to clarify, the Healthcare Personnel Influenza Vaccination data from fourth quarter of 2014 through the first quarter of 2015 (that was submitted on May – by May 15 of this year), that's going to be used for the Fiscal Year 2017 determinations. For Fiscal Year 18, data for the upcoming influenza season (which will be the fourth quarter of 2015 through first quarter next year of 2016) will be used. The submission deadline for the FY 18 data will be May 15, 2016.

Next slide.

So, this slide here just summarizes the submission deadlines for IQR for FY 17. Please note that the submission deadline to submit first quarter 2015 data is August 15th, which is right around the corner.

Next slide please.

For FY 17, for the HVBP, a total five NHSN measures are included. These are CLABSI, CAUTI, SSI, MRSA and *C. Diff*. The five measures in the

AHRQ PSI-90 composite make up the Safety Domain, which is 20 percent of the HVBP Program Total Performance Score for the FY 2017 program.

Next slide.

CMS uses an improvement and achievement scoring methodology when calculating the measure scores for the five NHSN measures in the HVBP program. Hospitals can only earn one measure score in each of those five measures, but it can be the greater of either the Improvement or the Achievement score calculated by CMS. Achievement score is awarded by comparing a hospital standardized infection ratio, or SIR, to all other hospitals' SIRs, whereas Improvement Points are awarded by comparing a hospital SIR to that same hospital's SIR of an earlier period.

Next slide.

And now, we'll move into the last program that I'm going to talk about today. So this is the Hospital Acquired Condition, HAC Reduction Program.

Next slide.

The measures used in the program through Fiscal Year 2017 were finalized in the Fiscal Year 2014 IPPS LTACH PPS rule. Measures for the HAC Reduction Program used two years of data. Beginning with the program in 2015, there were two CDC NHSN measures in the program, and since then, we have added Surgical Site Infection for colon and abdominal hysterectomy, and for FY 17 MRSA and *C. Diff*. As was discussed earlier, the reporting is quarterly to the NHSN. The hospitals on the call today have already received their Hospital Specific Reports, or HSRs, for Fiscal Year 2016, which included CLABSI, CAUTI, and SSI.

Next slide.

As we stated before, there are five CDC measures in the HAC program. For FY 17 we propose to increase the Domain 2 weight to 85 percent, which is up from the 75 percent rating [in] FY 16. All CDC measures and

HAC Reduction Program are calculated using the hospital surveillance data submitted to NHSN. For Fiscal Year 17, data reported are for infections occurring from January 1, 2014 through December 31of this year.

Next slide.

So, the purpose of this slide is just to show a visual of how the total HAC score is calculated. Domain 1, as many of you are aware, is the AHRQ PSI-90, which is claims-based. Domain 2 includes the CDC measures. There are 64 possible combinations of how the total HAC score can be calculated. Some hospitals may have one or more CDC measures; some may have no CDC measure data that can be calculated, and their total HAC score will just be based on the AHRQ PSI-90 results. Since we focus this presentation on Fiscal Year 2017, since that's the data you're reporting now, we included the Domain 2 weight of 85 percent on this slide, since that's what proposed. The actual Domain 1 and 2 weighting will be available for the public when the Final Rule is published.

Since we are on the topic of total HAC score and the hospitals recently received their HSRs for FY 2016, we want to state and remind hospitals that the Review and Correction Period is not the opportunity to correct underlying data used to calculate the total HAC score. So, if you recall when Maggie was talking about slide 49, about making sure data is entered before the submission deadline, that's incredibly important because you cannot change the data and you cannot change the underlying data for the total HAC score. And we wind up – we do get a lot of questions about this and the response is the same; [it] is that the Review and Corrections Period is not the opportunity to change the underlying data used to calculate the total HAC score.

Next slide.

So, this next slide just has some additional resources. Many of the resources available to inform you of all things HAC are on the *QualityNet* website. If you select the **[Hospital-Inpatient]** tab, and then select HAC

Reduction Program, you'll be able to see a lot of resources about the HAC Reduction Program.

And now, Suzette will discuss some lessons learned and reporting tips. Suzette?

Suzette Gerhart: Thank you, Joe, and good afternoon everyone.

Next slide, please.

First, I would like to review how to verify that your HAI data has been received by running CMS reports on *QualityNet*. The two reports you can run to verify your data are the Provider Participation Report and the Facility, State and National report. The Provider Participation Report is located in the My Report section on *QualityNet* under the Annual Payment Update reports category. This report shows whether HAI data has been submitted and the date of the last NHSN file update to CMS. If both are "Yes," then your data has been received into the clinical warehouse. If it shows "No," then the data has not been received.

Next slide, please.

The Facility, State and National report is located under the Feedback Report category. This report shows the numerator, dominator, SIR, locations, procedures, device days, patient days and procedures, and the last NHSN file update to CMS. If data has been received in the clinical warehouse, the fields will be populated, and if no data has been received, the fields will be blank. Please note, State and National columns will remain blank until approximately 30 days after a data submission deadline.

Next slide, please.

We've been getting a lot of questions regarding the 2015 location mapping changes for CLABSI and CAUTI. Acute Care Hospitals must now report CLABSI and CAUTI from all adult and pediatric medical, surgical, or combined medical surgical wards, in addition to ongoing reporting from

all adult, pediatric, and neonatal ICUs. Any unit that meets the CDC definition for and is mapped as a specific type that is not an ICU, NICU or one of the six wards listed below, (example: mapped as an Orthopedic ward, Telemetry ward or Step-down unit) would not be required to report CLABSI or CAUTI data for the CMS Hospital Inpatient Program in 2015.

Next slide, please.

The new reporting requirements are based on how [a] unit is defined using the CDC definitions and instructions from mapping locations. If you have questions about how to map a particular unit, please send an email to NHSN help desk at nhsn@cdc.gov. The updated HAI Measure Exception Form reflecting these changes will not be available until January of 2016. We therefore ask that hospitals use the current HAI Measure Exception form located on the Healthcare Associated Infection page on *QualityNet*. And, please, disregard the language under CAUTI stating hospital has no adult or pediatric Intensive Care Units, as well as the language under CLABSI, stating hospital has no adult, pediatric, or neonatal Intensive Care Unit locations. Please note the criteria for the SSI exemption has not changed. Please use the guidance referenced on this slide to submit your Exemption Form.

Next slide, please.

This is a draft of the 2016 HAI Measure Exception Form. It will be finalized and posted on *QualityNet* in January 2016 and will reflect the 2015 location changes.

Next slide, please.

And next slide, please.

Next, I want to share with you some of the lessons learned and most common questions we have received from providers during the last APU reconsideration process. The first lesson is, "I have entered all my HAI data but I am still on the CMS Outstanding list." Always recheck every data field and review the monthly reporting checklist because the CDC

will not share your information at CMS if required data fields are missing. It is advisable to do this well in advance of the data submission deadline.

Next slide, please.

Another lesson is, "I have submitted all my data and can see it in NHSN but my CMS reports are showing the data is still incomplete." Data entered into NHSN moved from the CDC to CMS and each step has a period of time associated with it. You can verify your data directly in NHSN by generating a data set, running CMS reports, and saving a copy. Each report will have a date and time stamp on it, so you can verify data submission.

Next slide, please.

A third lesson is, "My NHSN Administrator has left and I haven't received my SAMS card yet for access to NHSN to enter my data." Please make sure that you have two administrators at your facility, a primary and a backup. The proofing process for a new administrator can take at least 30 to 45 days. You will need to apply for SAMS well in advance of the data submission deadline.

Next slide, please.

A fourth lesson is, "I did not receive the 30-, 15- and seven-day data submission reminder emails." Submission reminder emails are sent via our ListServe to make sure that you receive all the latest reminders. Please review this slide for directions.

Next slide, please.

Finally, the last major lesson is, "Who at our facility receives a phone call regarding our outstanding data?" Five days before the deadline calls are made to the hospital IQR, quality management, and for HAI, calls go to the Infection Preventionist we have on file. At three days before the deadline, calls are made directly to the CEOs. Please review these slides for direction on how to update your contact list.

Back to you, Deb.

Deb Price: Thank you. And I'd like to take a moment to talk about the continuing education.

Today's webinar has been approved for one continuing education credit by the Boards listed on the slide. We are now a nationally accredited nursing provider, and as such, all nurses report their own credit to their Board using our national provider number 16578. We now have [an]online CE certificate process. You can receive your CE certificate two ways: if you registered through ReadyTalk®, a survey will automatically pop up when the webinar closes. The second way is in – within 48 hours, we will be sending around another survey link. That survey link can be distributed to other people in your room.

When you're taking the survey, here's what the bottom half of the survey looks like. You see in the bottom right-hand corner is a little gray button. You click "Done" and then this page will pop up. This page is – has links as an "Existing User" or is a "New User." If you have never received the certificate from us, you will be a "New User."

Please take and register your personal email account where you see "Email" right there. A good one is Yahoo or Gmail. If you use your hospital account, typically they have firewalls up and those firewalls can block our certificate from going in.

If you have already received certificate, this is what an "Existing User Secure Log in" looks like. Your username is your complete email address and then, of course, your password.

Okay, now, I would like to pass the ball back to Candace to go over some questions. Candace?

Candace Jackson: Thank you, Deb. We do have a lot of questions, although we are running late on time, so we will not be able to get through all of those questions. But we will try to provide a response to some of the most frequently asked questions.

	And one of the frequently asked questions that we did see today is, "Is the Critical Access Hospital included in NHSN reporting, and if not, is there an anticipation as to when they will be required to report NHSN data?" And I would direct that question to CMS.
Cindy Tourison:	This is Cindy Tourison. We do encourage hospitals to voluntarily report through our inpatient quality reporting program. However, at this time, the Critical Access Hospitals are not required under Subsection (c) to submit data. And, I could not wager a guess as to whether if they would be required in the future.
Candace Jackson:	Okay, thank you, Cindy. We do have a question about VBP. "When will the VBP safety domain include non-ICU locations be in effect?" And I would address that back to CMS.
Cindy Tourison:	Candace, so we actually have a proposal out there for it to be included, I believe, in 2019. I cannot comment what it's going to look like in the final Rule, as the Final Rule is due out in the next week or so.
Candace Jackson:	Thank you, Cindy.
Cindy Tourison:	However, I would encourage attendees to sign up for our webinar that we'll give on the Final Rule, and those invitations will be going out in the next couple of weeks.
Candace Jackson:	Thank you. A question for Joseph, "Does the HAC reduction program include all inpatient locations or just ICU locations?"
Joseph Clift:	Hi. For which was there – can you say that question again? I'm sorry.
Candace Jackson:	Yes. "Does the HAC reduction program include all inpatient locations or just ICU locations?" And, they did not specify for which Fiscal Year.
Joseph Clift:	Yes, it's just the ICU location. But if – I'm not sure what future year the question is –what they're asking for. The CDC changed their – the criteria and the location starting January 1, 2015 of this year for data reported now.

Candace Jackson: Yes, I'm sorry. I misheard that question. But – so, the requirement from CMS is for CLABSI CAUTI and the addition of the ward units? But then, we did at CDC change the surveillance requirements for our LabID to include ED and Observation Units. Does that answer your question?

Female: I believe so.

Candace Jackson: Okay.

Female: Thank you.

Candace Jackson: Next question, and I would direct this to Maggie and/or Suzette. Does an Exception Form still need to be filed, if we submit an annual survey through NHSN?

Maggie Dudeck: So, this is Maggie. I'll start to answer that and I will let Suzette fill in the information I've missed. But, especially an annual survey that is completed within NHSN is to be used for CDC NHSN purposes only, and some of that information is used in risk adjustment. It is in no way related to an exception form that is used by CMS.

Suzette Gerhart: And I'll answer the second part. So, if your facility does not have an adult or pediatric ICU and they do not have any medical, surgical or med surge wards, per the NHSN definitions, then you would qualify for a waiver. And, if you look at the slide, you will have the instructions on how to submit that waiver.

Candace Jackson: Thank you, Maggie and Suzette. We received a lot of questions in regards to, "Are there ED Units and the Observation Units included NHSN reporting? Maggie could you address – reiterate and readdress that?

Maggie Dudeck: Sure. So beginning with 2015 data, the NHSN surveillance protocol for the FacWideIN LabID surveillance does require that hospitals include ED and observation units in their surveillance efforts. So, when a hospital adds FacWideIN to their monthly reporting plans, the application will actually automatically add any ED and observation units that the hospital has already set up in NHSN, and so that can drive the alert. So, the hospitals

would then be required to enter a separate denominator record for each of the ED and observation unit entering the number of encounters for each of those units, and then they must enter all of the positive specimens that are identified or collected from those units for the selected organism. And, the reason this is the case is that because it allows NHSN to have a better picture of the community onset LabID events that are coming into a hospital so that any subsequent positive specimens collected and reported do not have to be considered healthcare onset, that they would be considered a continuation, in some cases of the community onset case that came into the hospital. And this all – you know, at the end of the day, it ends up in a more accurate picture and better risk adjustments of the hospital's data.

Candace Jackson: Thank you, Maggie. And we do have time, I believe, for one or maybe two more questions. The next question that we saw frequently was, "Beginning October 2015, our coding department will begin coding surgical procedures using ICD-10 procedure code. When can we expect an updated procedure-associated module for SSIs, which will include ICD-10 codes?" Maggie, are you able to address that question?

Maggie Dudeck: I am. So my colleagues here at CDC have been working tirelessly on mapping all of the ICD-10, as well as some CPT codes, for all of the NHSN procedure categories. Those lists of those codes will be available soon. Now, with that being said, hospitals are going to be expected to use those categorizations and those codes for identifying the procedures that need to be recorded. However, if a hospital wishes to report that ICD-10 code and that is an optional field in NHSN reporting. That will not be available until January of 2016 in the application, but those codes and that categorization should still be used beginning in October. Once the lists become available, we will send a communication out to all hospitals that are reporting to NHSN.

Candace Jackson: Thank you, Maggie. And we are at the end of our time for this presentation. We'd like to thank you all for joining the presentation today. I hope that you found the information presented by all of our speakers

very useful and helpful to you, and we hope that you have a good rest of the afternoon. Thank you.

END