Hospital Value-Based Purchasing (VBP) Program

Support Contractor

Healthcare-Associated Infection (HAI) Measures: Reminders and Updates

Presentation Transcript

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Maria Gugliuzza: Hello and welcome today's webinar; Healthcare Associated Infection Measures: Reminders and Updates. My name is Maria Gugliuzza and I am the Provider Education and Outreach Lead at the Hospital Inpatient Value, Incentives and Quality Reporting Outreach and Education Support Contractor. And I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation and the question and answers will be posted to the inpatient website, www.qualityreportingcenter.com, in the upcoming weeks and will also be posted to the *QualityNet* at a later date. If you registered for this event, the reminder email with the slides was sent out to your email about two hours ago. If you did not receive that email, you can download slides at our inpatient website at www.qualityreportingcenter.com. If you have a question as we move through the webinar, please type your question into the chat window with the slide number associated and we will answer as many questions as time allows. Any questions that are not answered during the webinar will be posted to this qualityreportingcenter.com website in the upcoming week.

I would now like to welcome today's speakers. Bethany Wheeler-Bunch will be representing the Hospital Value-Based Purchasing Program from the VIQR Support team. Elizabeth Bainger, Program Lead on the HAC Reduction Program at CMS, will present on the HAC Reduction Program with Maggie Dudeck and Prachi Patel from the NHSN Methods and Analytics Team will present for the CDC.

This event will provide reminders and updates for the Healthcare Associated Infection, HAI Measures, included in the Centers for Medicare and Medicaid services Hospital Quality program.

Participants will be able to perform the following: recall how the HAI measures are used in CMS hospital quality programs, discuss the use of a National Healthcare Safety Network database for the CMS quality reporting programs, identify the steps to improve data entry and submissions, to review the troubleshooting tips and ways to validate the

completeness and submission, describe best practices in HAI data tracking as part of ongoing quality initiative.

This slide provides a list of acronyms that we will use throughout the presentation for your reference.

I would now like to introduce our first speaker for today's event, Bethany Wheeler-Bunch. Bethany, the floor is yours.

Bethany Wheeler-Bunch: Thank you Maria. Before we dive into the updates for the HAI measures, I would first like to show how the HAI measures are currently used in the Hospital Value-Based Purchasing Program.

In the fiscal year 2018 Hospital VBP program, the HAI measures of CLABSI, CAUTI, MRSA, CDI and SSI, are included in the Safety Domain, along with the PSI 90 Composite and the PC-01 Measure. The other domains in the fiscal year 2018 program, includes the Clinical Care Domain, the Efficiency and Cost Reduction Domain and the Patient and Caregiver Centered Experience of Care/Coordination Domain. Each domain in fiscal year 2018 is weighted at 25% of the Total Performance Score. The fiscal year 2018 program results were made available through the Percentage Payment Summary Report on July 27, 2017 through the *QualityNet Secure Portal*. CMS anticipates publicly reporting your results on *Hospital Compare* starting in December 2017. The per claim adjustment to payment for fiscal year 2018, will begin on October 1, 2017 and will continue until September 30, 2018.

In the fiscal year 2019 and fiscal year 2020 Hospital VBP Program years, the HAI measures remain the same with CLABSI, CAUTI, MRSA, CDI and SSI in the Safety Domain. However, the PSI 90 Composite was removed from the Safety Domain. For more information on that removal, I recommend checking out the fiscal year 2018 IPPS Final Rule webinar from August 29 on the qualityreportingcenter.com website. The other change to the fiscal year 2019 and fiscal year 2020 program years that I would like to point out, is the addition of the THA/TKA Complication Measure to the Clinical Care Domain.

As I mentioned a few slides back, CMS released, for fiscal year 2018, Percentage Payment Summary Reports in late July. After the release of those reports, the question listed on this slide: "Why don't my NHSN HAI Measure data in the Hospital VBP Program, match the data reported on *Hospital Compare* or my data in NHSN?" was the most frequently asked question. The answer, in the variance may be due to three reasons. First, CDC expanded the CLABSI and CAUTI measure locations to include select wards in addition to the already reported ICU locations of calendar year 2015. Select ward locations are defined as Adults or Pediatric, Medical, Surgical and Medical/Surgical Wards. The Hospital Value-Based Purchasing Program will not start using those expanded locations until the fiscal year 2019 program year. Second, the standard population, also known as CDC's baseline, used to calculate the predicted number of infections, was updated starting with calendar year 2015 data. Like the first change, this update will not be used in the Hospital VBP Program until fiscal year 2019. The last reason your data may not match NHSN, would occur if someone at your hospital added, removed or modified data in NHSN after the quarterly submission deadline. Once the submission deadline has passed, CDC takes a snapshot of that data and sends to CMS for use in programs such as the Hospital Value-Based Purchasing Program. Any changes made in NHSN after that snapshot, would not then be subsequently sent to CMS, although you can still see those changes in NHSN.

In order to calculate the NHSN measures for use in both the Hospital IQR Program and the Hospital VBP Program, CDC must go through several steps. First, CDC determines each NHSN measure's number of predicted infections. CDC determines the number of predicted infections using both specific patient care location characteristics (for example, the number of days in which a patient in an ICU, has a central line) and infection rates, that occurred among a standard. Finally, for NHSN measure, CDC calculates the Standardized Infection Ratio, also known as the SIR, by comparing the hospitals observed number of HAIs with the number of HAIs predicted for the hospital, adjusting for several risk factors. Beginning in calendar year 2015, CDC collected data in order to update

the standard population data for all of these NHSN measures. Because the Hospital VBP Program calculates the improvement points using comparisons between data collected from hospitals in a baseline period, and data collected in a performance period, the Hospital VBP Program must treat CDC standard population data updates differently than other quality programs. CMS determines that they cannot equally compare CDCs "new standard population" data to the "current standard population" data in order to calculate improvement points. If CMS does not address the CDCs measure updates, they would've been unable to compare the baseline and performance periods for NHSN measures in the fiscal year 2017 and fiscal year 2018 program years. To address the problem, CMS used the "current standard population" data to calculate performance standards and calculate and publicly report measure results until the fiscal year 2019 program year, as depicted in the table on the slide.

Also beginning in calendar year of 2015, CMS started using data from Adult or Pediatric Medical, Surgical and Medical/Surgical Wards for the CLABSI and CAUTI measures. Prior to calendar year 2015, CMS only used data from the select ICU locations listed on that slide. For the same reason that we discussed regarding the standard population data, CMS chose not to use the expanded locations until fiscal year 2019. Because the Hospital VBP Program calculates improvement points using comparisons between data collected from hospitals in a baseline period and data collected in a performance period, CMS determined that they cannot equally compare the ICU only locations to the expanded set of ward locations in order to calculate improvement points. If CMS did not address that CDC measure update, they would have been unable to compare the baseline and performance periods from the CLABSI and CAUTI Measures in fiscal year 2017 and fiscal year 2018 because of the use of calendar year 2013 and 2014 as baseline periods which was prior to the change in location reporting that we saw in calendar year 2015. To address the problems, CMS used the ICU only locations to calculate performance standards and to calculate and publicly report measure scores including the performance period, until the fiscal year of 2019 program year, as depicted in the table on this slide.

Going back to our frequently asked question, the third reason a hospital's data in the Hospital VBP program may not match what is reported in NHSN, is if the hospital modifies their data in NHSN after the quarterly submission deadline. So I would like to use the next two slides to review which data can be reviewed and when it is appropriate to review that data. Hospitals may review their data using CMS programs in two different stages. The first stage is considered a patient-level data review stage, in which hospitals ensure their underlying data or claims are accurate, either prior to the submission deadline, the claims pull date, or during the HCAHPS review and correction period, depending on the measure. The second page of the review is the scoring and eligibility review. During the second stage, hospitals can ensure that the data reviewed during stage one is properly displaying on the reports such as scoring, (such as improvement points, measure scores or domain scores) were calculated correctly based on the already finalized measure results or that your hospital's eligibility is correctly applied. Corrections or modifications to the underlying data is not allowed during stage two review. Example of stage two reviews includes the Hospital IQR Program Preview Report, the Hospital Value-Based Purchasing Program review and correction period and the Claims-based Measure review and correction period. Specifically, for CDC NHSN measures, the stage one review allows hospitals to use the approximate four and a half months after the quarterly reporting period ends to submit and review their data in NHSN. Corrections or modifications to the data after the quarterly submission deadline will not be reflected in CMS reports or programs, although the data can still be entered and viewed in NHSN.

The stage two review of the NHSN measures occurs during the review and correction period for the Percentage Payment Summary Reports released on or around August 1st annually. After the release of the report, hospitals will have 30 days to review and request correction of the calculation of scores for each measure, domain and the Total Performance Score. Requests for correction of the underlying data, such as the reported numbers of HAIs, your hospital's SIR value or reported central line days, urinary catheter days, surgical procedures performed, or patient days is not

allowed during this period and should have been addressed during the stage one review, which is prior to the quarterly submission deadline.

This slide contains resources available to your hospital regarding the Hospital Value-Based Purchasing Program. I would like to point out the resource in the middle of the slide regarding the ListServes and discussion. If you've not signed up for the program ListServes yet, I would like to emphasize the importance of doing so. We release almost all of our communications regarding report releases, performance standards, technical updates and upcoming webinars through the Hospital VBP Program ListServe. So please go out and sign up for the ListServ if you would like to receive those types of communications.

I would now like to hand the webinar over to Elizabeth Bainger to present on the HAC Reduction Program. Elizabeth, the floor is yours.

Elizabeth Bainger: Thanks very much Bethany. I guess let me get a shout out to the other co-presenters. I'm hearing some feedback, so if you're not speaking, please make sure that your phone is on mute. And that's a shout out to all the other co-presenters.

So hi everyone, I'm Elizabeth Bainger and I want to thank you for joining us today. I'm very pleased to have this opportunity to talk with you about the Hospital-Acquired Condition, or HAC Reduction Program. Slide 20.

Hospital-Acquired Conditions, or HACs, include both Healthcare-Associated Infections, which are the focus of today's discussion, and Safety Events. The measures included in the HAC Reduction Program includes preventable conditions like Surgical Site Infections, which take a significant toll on patients and families and costs billions of dollars each year. So let me take a step back for a moment and tell you how the program came to be. The HAC Reduction Program was established under the Affordable Care Act. It is a Medicare pay-for-performance program. That means it links payment to quality of care. Part of the ACA, and beginning with October 1, 2014 discharges, the Secretary of Health and Human Services is required to adjust payments to hospitals that rank in the

worst performing 25% of all subsection (d) hospitals. With respect to the HAC Reduction Program quality measures, CMS may reduce these hospitals' payments by 1% of what would have otherwise been paid for all discharges. Maryland hospitals are exempt from payment adjustments under the HAC Reduction Program because they currently operate under a waiver agreement. Just as a look-ahead, I want to share with you, that next month we will be presenting a webinar that focuses on payment so I'm not going to go into those details now, but please be on the lookout for information about that upcoming webinar. Slide 21.

This slide shows the measures included in the HAC Reduction Program. Remember that I said HAC included Safety Events. Hospital performance with regard to safety, is captured by the PSI 90 Measure. As you can see, for the first three years of the program we used the recalibrated version of the PSI 90. For fiscal years 2018 and 2019, we're using the modified recalibrated Patient Safety and Adverse Events Composite, but this presentation focuses on Healthcare-Associated Infection. And the HAC Reduction Program has grown through the years to include five HAI Measures, CLABSI, CAUTI, Surgical Site Infections, MRSA and Cdiff. Slide 22.

The total HAC Score is based on the six quality measures I just discussed and they've been separated into two domains. Domain 1 focuses on safety and it counts towards 15% of the total HAC Score. Domain 2 includes the five HAI measures. Doman 2 counts toward 85% of the total HAC Score. If a hospital has only one domain score, CMS applies a weight of 100% to that domain. This slide also shows the performance periods for measures included in the HAC Reduction Program. Generally speaking, the HAC Reduction Program uses a two-year performance period, however you can see that when we transition to the modified recalibrated Patient Safety and Adverse Events Composite, the performance period for Domain 1 was shortened. Though not shown for the fiscal year 2020 program, we are returning to a two-year performance period for all measures. Slide 23.

For fiscal year 2018, we implemented a number of changes. The HAC Reduction Program updated risk adjustments in all models and we're also

using calendar year 2015 as the new baseline for all CDC NHSN measures. And I want to mention that this does differ from HVBP, as Bethany just went through. The fiscal year 2018 Hospital Value-Based Purchasing Program does not use the CY 2015 baseline for CDC NHSN measures. We also changed the Cdiff unity onset prevalence rate, which determines outliers to above 2.6 for hospitals and all quarters during the performance period. So in that scenario where the community onset prevalence rate for all quarters is above 2.6 during the performance period, in that scenario, we will not calculate a Standardized Infection Ratio or SIR for Cdiff. for a hospital. We also removed the outlier designation for MRSA. The HAC Reduction Program CLABSI and CAUTI measures expanded beyond Intensive Care Units to include data for Medical, Surgical and Medical/Surgical Wards. Again, I want to point out that this differs from HVBP. The FY 2018 Hospital Value-Based Purchasing Program does not use the expanded CLABSI and CAUTI measures that include ward data. But because of the ward expansion, the HAC Reduction Program removed the No Facilities Waiver for CLABSI and CAUTI measures. Slide 24.

This graphic depicts the flow of HAI data from when it's generated through the public reporting. And while we look at this graphic, I'm going to talk about the information found on the next three slides but for now I want to stay on this slide so that you can see the data flow. First, the HAI data is generated by events during a patient's hospitalization. Under the Hospital Inpatient Quality Reporting Program, hospitals can submit, review and correct their HAI data in NHSN for four and a half months following the end of the reporting quarter. I want to take this opportunity, as Bethany just did, to strongly encourage you to review and correct your hospital's data prior to the HAI submission deadline. This is your opportunity to correct the underlying data that will be used to calculate your measures scores. Next along the graphic, you can see that immediately following the submission deadline, the CDC effectively creates a snapshot of the data and sends this to CMS. CMS does not receive or use data entered into NHSN after the submission deadline. Moving along, you can see that CMS uses the data you've submitted

through NHSN in accordance with the applicable deadline. We use that data to calculate the CLABSI, CAUTI, SSI, MRSA and Cdiff Measure scores. These scores are included in Hospital's Specific Reports or HSRs. The HSRs are distributed via the *QualityNet Secure Portal*. So here's another reminder, I want to strongly encourage you to keep your *QualityNet* account up-to-date so that you're able to access your hospital's HSR as soon as it becomes available. Moving along the graphic, after the scores are calculated and the HSRs are distributed, you have 30 days to review and request recalculation of your hospital's HAI Measure scores. And although we're focusing on HAI data in this graphic, I do want to note that this is also your opportunity to review your modified, recalibrated, Patient Safety and Adverse Events Composite results and your total HAC Score. We call this 30-day period the Review and Correction period. But I want you to the note the focus of this Review and Corrections period. It's to allow you an opportunity to submit questions about the calculation of your hospital's results and request corrections of calculation errors. The Review and Corrections period does not allow hospitals to submit additional corrections related to underlying data. So you cannot use this 30-day period to correct your hospital's reported number of HAIs, Standardized Infection Ratios or the reported central line days, urinary catheter days, surgical procedures performed or patient days. I think you just heard that from Bethany, so we're sounding like a broken record, but we really want to emphasize this. I'd like for you to think of this is as a two-staged approach. First, you have a chance to review and correct your hospital's underlying data during the four and a half-month period following the reporting quarter. Second, you'll have the 30-day Review and Corrections period which allows you the opportunity to review and correct your hospital's measure calculations based on that underlying data. And finally, the graphic concludes with the hospital data being publicly reported on *Hospital Compare*. This usually happens in December. Next slide.

Now Slides 25, 26 and 27 present the same information that I just shared with you but in text format.

This brings us to Slide 28, and here we've provided links to additional resources related to program methodology and general information, public reporting, payment and the review and corrections period. You can copy and paste these links into your browser or if you download the slide, you'll find the links are clickable. Thank you very much for your time and attention and now I'd like to pass the presentation back to Bethany Wheeler-Bunch to present the Measure Exception form.

Bethany Wheeler-Bunch: Thank you Elizabeth. I would now like to provide some information on the Measure Exception form.

The Measure Exception form is available to hospitals to notify CMS when they do not have any measure specific locations and/or treat patients related to the specific hospital reporting program measures. The Measure Exception form may be used by the Hospital IQR Program when determining the hospital's eligibility for the Annual Payment Updates, also known as the APU, and for the HAC Reduction Program Measure score.

The Measure Exception form is currently available for the PC-01, ED-1, ED-2, SSI, CAUTI and CLABSI measures. The form must be renewed at minimum, on an annual basis.

In order to be eligible for an SSI exception, the hospital must have performed nine or fewer combined specified colon and abdominal hysterectomies in the calendar year prior to the reporting year.

Hospitals are required to report CAUTI and CLABSI data from all patient care locations that are mapped by NHSN as ICUs or adults and pediatric medical, surgical, and medical/surgical wards. The CDC's location wards that will be used in CMS reporting are listed on this slide.

In order to be eligible for the CLABSI and CAUTI waiver, a hospital must not have any ICU locations for Adults or Pediatric Medical, Surgical or Medical/Surgical Wards.

To submit a Measure Exception form, please use the link on this slide to access the form. Complete and submit the form through either the email address, secure fax or through the *QualityNet Secure Portal* secure file transfer "Waiver Exception Withholding Group." If submitting the form on a quarterly basis, the form would need to be submitted by each of the quarterly submission deadlines. If submitting annually, we ask that the calendar year of 2018 forms be submitted by August 15, 2018.

I now would like to hand the webinar over to Maggie Dudeck and Prachi Patel from the NHSN Methods and Analytics team at CDC. The floor is now yours.

Maggie Dudeck: Thank you Bethany and thank you everybody. This is Maggie Dudeck and Prachi Patel. If we can move on to the next slide.

So today we'll be covering the use of NHSN data for the purposes of fulfilling CMS Quality Reporting Programs and subsequent programs that use those data. NHSN, as you know, is used as a vehicle to report HAI data, in this case, more focused on CLABSI, CAUTI, SSIs and LabID events which fulfill the mandated reporting requirements for CMS as well as some of you who have requirements for your individual state. In addition, hospitals can use NHSN to voluntarily report HAI data that are of interest to their own organization, maybe their corporate entity or any special study groups that they're involved in. Next slide.

In order to report data through NHSN, we of course have an application. It is an online tool that uses standard surveillance protocols to report the events and the denominators that are eligible and related to that event type. It also allows data to be entered and analyzed by the hospital and data can also be analyzed by group organizations using our standardized protocols and risk adjusted measures. Next slide.

So today we're going to be talking about some steps to really help you use NHSN to ensure your reporting. This includes some recommendations, as well as some requirements, on how to use NHSN. Our recommendations for our hospitals is to develop a routine schedule as to when your hospital

is going to actually enter, as well as analyze data within NHSN. We also recommend that you use a checklist to make sure that your data are complete for each measure that you are required to report, as well as any measure that you voluntarily report that you need to obtain standardized measurements. And of course, we recommend having a backup person at your hospital who can have access and use the NHSN system, who understands the system and can report data and provide reports as needed if you're unable to use the system if you're out of the office. One of the requirements we have, of course, is a very big one, and that is to collect and report data according to the NHSN protocols. All of our protocols are listed on our website at cdc.gov/nhsn. And from there we have information about not only our surveillance definitions and criteria, but also how to report things like denominator data and how to interpret reports. One of the main points that we want to point out right now, as well as a few points throughout the presentation, is that only in-plan and complete data are shared with CMS. So the purpose of today's portion that Prachi and I will be talking about will cover what in-plan means and what complete means. Next slide.

CDC's NHSN does have a CMS reporting requirements webpage that's listed on this slide. There are a number of resources on there for all of the programs that use NHSN data. One is a category called Operational Guidance Documents, which essentially translates and describes the reporting requirements in accordance with the final rule posted for requiring those data. And then we have resources that provide information on how to use the reports within NHSN, as well as monthly reporting checklists. The Operational Guidance Documents are sorted by facility type. So let's move on to the next slide.

This is a screenshot of the CMS Resources page. In the center of the page, those are the Operational Guidance Documents. Acute care hospitals are at the top. There's one per HAI. Then below that, there's a section for CMS reporting and that's where you'll find monthly checklists and information on how to use the reports within NHSN. And then on the right-hand side, we have additional resources which includes the reporting

requirements, timelines, links to CMS websites and additional information about how to change your CMS certification number or CCN in NHSN. Next slide.

So in order for CMS to use the NHSN data, CDC is actually responsible for sending the NHSN data to CMS on behalf of the participating hospitals, hospitals have to be participating in NHSN, of course, to report the data but we also are only sending data forward for those hospitals that participate in the related CMS program. CMS prescribes the quarterly deadline date and time so on those prescribed deadlines, CDC takes a snapshot of the database as what's already been discussed today, and then we compile the data into Standardized Infection Ratios or SIRs, based on that snapshot of the data, and send to CMS on the first business day after the deadline. So when the deadline falls on the 15th of a month, we then send the data on the next business day following that deadline. Next slide.

Data for the given quarterly deadline, as I mentioned, is a snapshot and they are considered frozen, as we've already discussed today. We never update that snapshot with a new snapshot or updated data from the database. It always remains at that point in time prescribed by our colleagues at CMS. The NHSN data for CMS programs reflect multiple quarters worth of data such as the rolling four quarters on *Hospital Compare*, or the eight quarters worth of data for the HAC Reduction Program, uses data from each quarter that were frozen at each quarter's deadline. So we do not update a quarter's data for the final quarter of that program submission. It's for each individual quarter at each deadline. So it's really important to make sure your hospital's data are accurate and complete in time for that initial quality reporting deadline for that quarter. So that way it can be accurate and complete for subsequent programs. Next slide.

This is an example of a monthly checklist, and what we're going to do now is walk you through each step of the checklist that you can use to ensure your data are complete. Next slide.

The first step is to confirm and if necessary, update your CCN in NHSN. Next slide.

So this is a screenshot of the NHSN application and off to the right, I have a star next to CMS Certification Number. The CCN has to be correct in NHSN for the given quarter, and everything after, in order to ensure your data will be shared with CMS as we operate that based on your CCN. That's how your hospital is identified and it does apply to all CMS related reporting in NHSN for that hospital. So please double and triple check this number. If it needs to be edited, it can be done so by somebody with administrative rights to the facility like the facility administrator. Next slide.

This slide is just a direct link to the instructions on the NHSN website for updating the CCN. This is also found from the CMS reporting page referenced earlier. Next slide.

So the next step in the process is to review your monthly reporting plans and update as necessary. Next slide.

So the monthly reporting plan is a crucial, the next crucial piece of your reporting, as it tells us at CDC and NHSN what modules and protocols your facility is following during a given month. This is what we refer to as in-plan data. So when your hospital selects, let's say, CLABSI reporting for your ICU in the monthly reporting plan, you are telling CDC that those data will be collected and reported according to the NHSN surveillance protocols for CLABSI and that all entered data will be complete and in accordance with those protocols. In-plan data also tells us which data we can use for aggregate analysis at CDC when we provide and produce national aggregate or state aggregate data. And the key here is that it also tells us what data we can share with CMS per the scope of that CMS program. So if your hospital enters CLABSI ICU data, and they are not in your plan, we at CDC do actually not have the authority to send those data to CMS, even if you've entered them. So it's really important to ensure your plans include all data that are required for that CMS program and we'll talk about some examples of what that may look like.

A plan has to be entered for every month of the year. You can copy plans from one month to the next to make that burden less for you and your hospital. And you can also modify your plans retrospectively. So if today I realized I forgot to add something to my April monthly reporting plan, I still have time to update it and have the data complete in time for the upcoming deadline. Next slide.

Again, as I mentioned, we will only submit data to CMS for complete months that are also in-plan. We are not allowed to submit data that are not in-plan. Next slide.

So this is just a high-level summary. We've already talked a little bit about this during today's call, but of the requirements for your monthly reporting plan for the hospital IQR and subsequent programs that use those data. Okay.so I call this the monthly reporting plan requirements but it's really what you should have in your plan to be compliant with the requirements for your CMS program. So let's take a look at some examples. Next slide.

So here is an example monthly reporting plan for a fictitious hospital and we've got three different units on this particular screenshot. So in the first row, we have our Medical, Cardiac, Critical Care, I called it CARDCRIC, in this hospital, it is an ICU location and if you look across the row, I have the boxes checked for CLABSI, VAE, which is Ventilator-Associated Events, and CAUTI. So for this ICU location, CLABSI and CAUTI data are in-plan. So if I completed my numerator and denominator data, those data would be shared with CMS. VAE data are also in-plan but those are not shared with CMS as these are not in scope for that Quality Reporting Program. So those data would be used only for my hospital or any other group that has access to those data. Next slide.

When we move on to the second location, I actually have a Medical Ward. Here, the only box that is checked on that row is for CAUTI. That means CAUTI data are in-plan and all of my complete CAUTI data for that location would be shared with CMS. If my hospital were to enter CLABSI data for my medical ward, those CLABSI data would not be

shared with CMS because it's not in-plan for this location and month. Next slide.

The final location in our example plan is an Adult Mixed Acuity Unit. Now I realize you don't see all the CDC codes, location codes here but I'm wanting to make sure you know that I've mapped this as a Mixed Acuity Unit. CLABSI and CAUTI are both checked for this row, they're in-plan. But again, data from this unit would not be shared with CMS as this location, Mixed Acuity Unit type, is not in scope for that Quality Reporting Program so they are not required data. So, while I may enter data, they are not shared with CMS. Next slide.

Once you've confirmed that your monthly reporting plans are in accordance with what's required, the next step is to identify and enter all required events into NHSN. Next slide.

So your event-level data are what we refer to as your numerators for your SIRs. These are things like your CLABSI events, your CAUTI events, and Surgical Site Infections. So of course, the requirement is that hospitals perform surveillance according to our protocols and definitions, and if you identify an event that meets that definition, it must be entered into NHSN. Events can be added by using the option "Event Add" within NHSN. One important thing to note is that for Surgical Site Infections, you have to link that SSI to an existing procedure record in NHSN. So if I've identified a Surgical Site Infection following an abdominal hysterectomy procedure, when I enter my SSI, there's an option for me to link to a procedure. And when I do that, that creates the connection and has the risk factor information on the procedure record, and then the event-level information on the SSI record. But remember that patient ID is the primary identifier so hospitals should use the same patient ID type for their patients to ensure that if you do have an SSI to report, that it is the same patient ID that exists on the procedure record. And the same would hold true for any other event type to ensure the rules are applied appropriately. Next slide.

So of course, if we need numerators, we need denominators. So the denominator data for each month under surveillance, has to be entered. Let's move on to the next slide.

So denominator data are also referred to as summary data. What we mean by denominator data for CLABSI and CAUTI is that for each location and month, you enter the patient days, the central line days and the urinary catheter days. These data can be entered by going to "Summary Data>Add" within NHSN. And then you select the device associated, summary data type that is applicable to that location. So if we are entering data for an ICU or a ward, we would select, Intensive Care Unit/Other Location. Next slide.

So this is an example of a device associated denominator data record. What we have here is a cardiac ICU location and we have the required fields for total patient days, central line days and urinary catheter days. There's also an option to check, "Report No Events." I'm not going to go into a lot of detail of that now. We'll touch on it in a minute, and Prachi will also spend some time talking about reporting "No Events" and addressing alerts. Next slide.

One of the pieces of advice that I have for hospitals is to always pay attention to the red asterisks when you're entering data. That red asterisk will indicate the data that are required according to your monthly reporting plans. So in this example, notice that patient days and central line days have a red asterisk, so those are required. I cannot save this denominator record without entering data into those fields. But for urinary catheter days, there's no red asterisk so that means if I don't enter any data, I can save the record without urinary catheter days. It also means that CAUTI is not in my monthly reporting plan for this location and month. So that is another way to check to make sure your plans are correct. If I see this, I know that, okay, not only do I need to enter these data but I have to make sure it's in my plan and go back and update my plan. Next slide.

This is just an example showing where you can select, "Report No Events" if you have not identified any device associated events of that

type. I'm not going to spend time on this because Prachi will be talking about it a little bit more in detail when we talk about alerts, but just note that we require hospitals to verify with us if they've identified zero events so that we know a zero is true zero. And so this is one way to indicate and verify that. Next slide.

For locations that are required for CLABSI and CAUTI, the reporting requirements are based on how that unit is defined using our CDC definitions and instructions for mapping that unit, okay. So we do have instructions and definitions that are listed on this slide. This document is also listed under, Supporting Materials on all of our protocol driven and event-level driven pages on the NHSN website. And there's a specific algorithm to follow in order to determine what sort of CDC location that unit meets. So if you have not done so already, I certainly suggest you at least take a look at that. Hopefully you all mapped your locations already according to those definitions. If at any point you have questions about what definition most closely aligns with your unit, please reach out to us at NHSN. We do understand that there's some unique circumstances and while our location definitions cover a large majority, I would say probably 99% of what people have, we know there are some unique scenarios in hospitals and so we can help you interpret our descriptions and guide you towards the most appropriate location. Next slide.

Again, we're going to talk a little bit more about the wards. I'm sure you've probably guessed by now that this is an incredibly important piece of the CLABSI and CAUTI requirement. So again, the locations required are based on the CDC location code that is mapped. That location code should match the definition and how you define that unit in your hospital based on our CDC definitions. So for CLABSI and CAUTI, we know that all Adult and Pediatric ICUs must be reported. For CLABSI, Neo-Natal ICUs have to reported. And then beginning in 2015, so a couple of years ago, CLABSI and CAUTI data also had to be reported from Adult and Pediatric Medical, Surgical and Medical/Surgical Wards. I've listed those six locations here. Again, if you have a ward unit that does not meet this,- one of these definitions, if you only have a single ward, and let's say it

meets the definition of a neurology ward, I'm just making that up, you would not map it as one of these six. You would map it as a neurology ward and as such, you would not be required to report data for that location. Next slide.

Again, I'm not going to go through this but it's just additional text to drive home the point that the location has to meet the CDC definition for that location type. Next slide.

So we do need to talk a little bit about the other two events in the denominator data. First of all, for colon surgeries and abdominal hysterectomies, a procedure record has to be entered for each inpatient COLO and HYST that are performed in your hospital per the requirements. You can manually add procedures by using the "Procedure Add" function or the data can be imported. We do have a CSV file import option as well as Clinical Document Architecture or CDA. CDA is increasingly being used by hospitals and it is a way to import data in a standardized machine-readable format. If you have a data mining tool at your hospital, infection control software, that sort of system may be able to produce a CDA file or a CSV file for you and that will certainly help you in your data collection and reporting. Next slide.

Okay finally, before we move on to alerts and analysis, let's talk about the denominator data for MRSA blood and CDI LabID. So for this particular event type, on your summary data entry screen, you would select FacWideIN as the location for what you're entering your inpatient summary data. After selecting FacWideIN, the location and the FacWideIN month and year, six summary data fields will be required. We do have specific guidance about how to complete these data at this URL listed on this slide. But also note that you will have to enter emergency department and observation unit data on separate denominator records, if you have those units in your hospital. Next slide.

So here, I wanted to take a moment to really talk you through this data entry piece for the MDRO, I'm sorry, MRSA blood and CDI LabID. Now I mention that there are three different, or I'm sorry, there's six summary

data fields, three different tiers of data. So I would like to point out that right under where it says, General, we have Setting Inpatient and we have fields for Total Facility Patient Days and Total Facility Admissions. What those are referring to are actually, out of every inpatient unit in your hospital, how many patient days and admissions you had during the month. That's pretty self-explanatory and I think people understand what we're looking for in those two fields. But what we really need to clarify are with the following two fields. The first, or I'm sorry, the next tier of data that I've got outlined here is, if monitoring MDRO in a FacWide location, and we're doing FacWideIN, we are looking for a subset of your total patient days and admissions. But what we're looking for are, if you take the total facility patient days and admissions and subtract the days and admissions from a CMS certified Inpatient Rehab Facility and Inpatient Psychiatric Facility, those are the patient days and admissions we're looking for. So this is labeled as MDRO Patient Days and MDRO Admissions. What we are not looking for is the number of patient days for those patients that had an MDRO. We really are looking for your facility as a whole, minus those two types of CMS certified units. Okay, so the number should be fairly close to what you had on the top line. These data are used for the MRSA blood SIR and rate calculations so it's really important that those data are correct. Now, the last box that we've outlined are for Cdiff. So again, we want another subset. So what we need to do is we need to take from the total patient days and admissions, subtract patient days and admissions from our CMS certified IRF and IPF units as well as the patient days and admissions from Neo-Natal ICUs and Well-Baby units. The reason is because NICUs and Well-Baby Units are not applicable for surveillance of C. difficile. So again, we are not looking for the number of days in which patients with CDI were in the hospital, we really are looking for how many patient days did you have in your hospital as a whole, minus the days and admissions from those specific units we've listed. And of course, these data are used for calculation of your SIRs and rates. Next slide.

I already mentioned that additional denominator would be entered if you have Emergency Department and Observation Units, in which case, we

would be asking for numbers of encounters. So let's move on to the next slide and I will turn it over to my colleague, Prachi Patel to talk about alerts and analysis in NHSN.

Prachi Patel: Thank you Maggie. Like Maggie said, I will be going over the last two bullet points in the checklist and also some FAQs. Next slide.

Let's look into the alerts. Next slide.

Like we mentioned, it is very important to remember that alerts are generated for in-plan data only. If you're following data off-plan, then you will not receive alerts for incomplete data. For in-plan data, if the following alerts are not resolved that month, then the data is not complete and it will not be submitted to CMS. This includes missing events, missing summary data, missing procedures and missing procedures associated events. Next slide.

So this is a screenshot of the initial page that is loaded after you log in to NHSN. The alerts will be the first thing that appear on the home screen. You can resolve the alerts by just clicking on the tab you wish to address. Next slide.

A missing event alert will appear if your hospital does not report a CLABSI, CAUTI or LabID event for month or location. You would verify that your hospital truly identified zero events for that type. If your hospital did not identify an event, check the Report No Events on the Alert tab or on the Denominator Data Record. If your hospital did identify an event, enter the event into NHSN. Next slide.

So this is an example of the missing events alert tab. Again, this alert will list months in which events from certain modules were included in the monthly reporting plan and summary data have been reported to NHSN but no events have been entered. If you truly have no events, you would just check the "Report No Events" box and also don't forget to save that record. Next slide.

Now on to resolving missing summary data alerts which appears if your hospital did not report a denominated data record for an event, month and/or location. This alert appears regardless of whether events of that type have been entered for that month or location. Next slide.

Here is an example of the missing summary data alert page. The summary data or denominator data can be entered by clicking the "Add Summary" link that is on the Alert screen. As you can see in this screenshot, that "Add Summary" link is boxed in red. Once you add that summary, also don't forget to save. Next slide.

The Missing Procedures Alert appears if your facility does not report at least one procedure for that month, procedure category or setting. You would need to verify that your hospital truly did not perform any procedures of that type. If your facility did not perform any procedures in that category, you would need to check the "Report No Procedures" on that Alert Tab. If your facility did perform procedures in that category, then you would enter the procedure into NHSN. Next slide.

This is an example of the Missing Procedures Alert. After you check the "Report No Procedures," which is boxed in red in this screenshot, the procedure will be listed by category and setting. When finished, don't forget to remember to save. Next slide.

The Missing Procedure-Associated Event Alert appears if your facility did not report at least one SSI event for a month or procedure category. Remember, this alert is based on the date of the procedure, not the date of the event. It is very important to verify that your facility truly identified zero events of that type. Once you verify that your facility did not identify an event, then check the "Report No Events" on the Alert Tab. However, if your hospital did identify an event of that type, then enter an event into NHSN. Next slide.

This screenshot is an example of the Missing Procedure-Associated Events Tab. Like I mentioned before, if your facility did not have any

events for that procedure type, you would check the “Report No Events” box and once checked, save the change. Next slide.

Now we can move on to using the announced reports located in NHSN, to verify that accuracy and the completion of data entry before the CMS deadline. This would be your last step after you verify everything in this monthly checklist. Next slide.

The Analysis Reports were created to allow facilities to review the data that would be submitted to CMS on their behalf. If you’re not aware or familiar with NHSN analysis functionality, please refer to this link on this presentation. This is a great resource of all the report types in NHSN. Next slide.

Before running the CMS reports, I just want to mention, it is very important to generate your Data Sets. This will ensure that any data that has been recently added or any alerts that have been resolved will be incorporated into your report. And to navigate to your CMS report, you would navigate to the CMS Reports Tab in the Analysis Report Tree. In this screenshot in the slide, the CMS Report Tab, I’ve starred. This folder includes CMS reports for all facilities types that are participating in a different CMS programs. Next slide.

Important items to remember when checking your data in the CMS reports is that it’s imperative that attention is paid to the footnotes. The footnotes provide valuable information regarding the data in each table. It is also important to run the reports and check the accuracy of the data before each CMS deadline. After running the reports, always print out a copy of your tables before the deadline. This comes in great help when verifying your *Hospital Compare* previews, HVBP and HARC or P month [HACRP], data months down the line. Next slide.

The SIR is a measure that is used to track HAIs. It is the ratio of the number of observed infections to the number of predicted infections at the level of aggregation, whether that’s national, state, facility or any other type. An SIR 1 indicates that the number of observed infections reported

to NHSN is equal to the number of predicted infections, given the baseline data to which your HAI data is being compared. While an SIR that is greater than one indicates that the group has more observed infections than predicted, an SIR less than one indicates that a group has fewer infections than predicted. An SIR accounts for differences in incident and exposure across available factors known to be associated with a given HAI. Next slide.

Before we go into interpreting your SIR report, I just want to point out the different elements of the report. Starting at the top is the title of the SIR report and what this specific table will include. For this table, it is the SIR data for the 2015 baseline by OrgID. Below the title is a section showing the OrgID, CCN and Med Type or Medical Type of that facility. So for any reports that you would run for your facility, would have your facility information in this area. Below that is the SIR data and footnotes. And lastly, the red box at the bottom of the report highlights the source of the aggregate data for the report. For this it is the 2015 CLABSI data. And also, it shows when the data sets were last generated. Next slide.

So data that is appearing within the Analysis Reports in NHSN will be current as the last time that you generated your Data Sets. Data changes made in NHSN will be reflected in the next month the submission to CMS. Again, there's an exception. Quarterly data are frozen as the final submission date for a quarter. If you make changes to a quarter's data after the deadline, you will not be able to see those changes reflected in a NHSN report. So it is important to develop a way to track any changes made to your data after a CMS deadline. Next slide.

Here's an example of the CLABSI SIR Report. The ratio of the observed number of HAIs reported to which would be the predicted, given the standard population is the SIR. In this example, the SIR is .999. Next slide.

We also have a bunch of different guidance documents that we have created for each CMS related report. Please visit this link in this slide and

you will able to look at all the different HAI types according to your facility type. Next slide.

So why is it important to analyze data in NHSN? Analysis of data in NHSN helps to provide feedback to internal stakeholders, facilitate internal HAI data validation activities, inform prioritization and success of prevention activities through the use of reports and facilitate sharing of data entered into NHSN by CDC, CMS, your state health department, your corporation or any special study groups. At the end of the day, this is your data. You should know your data better than anyone else. Next slide.

Also, don't limit yourself. There are a number of different types of reports that are helpful in analyzing your data such as line list, frequency tables, charts and graphical reports, rate tables, also the SIR tables, and there's also descriptive statistics that you can look at such as mean, median or mode. Next slide.

So what changes can potentially impact your rates in SIRs? It could be anything from entry to edit or deletion of events, changes to numbers of patient days, device days or admissions, removal or addition to your monthly reporting plan, change in admission date, previous discharge date on LabID events, or changes to relevant factors in the annual survey, such as medical school affiliation or facility bed size. And lastly, the resolution of "Report No Events" alerts. Next slide.

It's also important to do data quality checks. So for data quality checks, you can look at your monthly reporting plan. Is your monthly reporting plan complete? Are all active locations applicable to NHSN surveillance listed? Are all appropriate procedures selected? Are all the appropriate lab specimens selected to collect for LabID data? Then you can look at your annual survey. Are the number of beds updated for in the previous survey year? And has the hospital's medical school affiliation changed in the past year? Also your alerts. Have the alerts been resolved for the required analysis month? And also, using your NHSN analysis, have you generated new data sets? And did you add any information after your last analysis run? Next slide.

Some general tips for data quality is to know your numbers. Know the number of patient days, admissions in your hospital each month. Remember your device use for locations under surveillance and average length of stay in each unit. And also know what goes into an NHSN risk adjustment. We would also recommend that you would look at the SIR guide which goes into detailed information regarding the risk, the 2015 rebaseline. And also, be aware to changes in your hospitals electronic data system. Next slide.

Before we get into some FAQs, I just wanted to highlight some changes that were made in the 2015 rebaseline. For CLABSI, MBI, LCBI events, are now excluded from the CLABSI numerator. And for SSIs, events classified as PATOS are now excluded from the SSI numerator. For more additional information on the different changes, you can visit our NHSN rebaseline page which is listed below. Next slide.

So let's look at some FAQs. So NHSN, while running my CLABSI and CAUTI IQR reports, I'm unable to see my location, 5West. I do not have any alerts and I know my data's complete. Why is this happening? And an answer to that is, the IQR reports for CLABSI and CAUTI only include data from CMS reportable locations, like we've said over and over again in this call. As you can see, this unit is mapped as a telemetry unit which is not required to be reported for the CMS IQR program. And just as a small note, with the 2015 rebaseline, we were able to conduct analysis on all location types which means that you will be able to run SIRs for previously excluded locations such as telemetry units and mixed acuity units, however these units are not required by CMS to be reported for the quality reporting programs or pay-for-performance. These units will not appear in the CMS reports, however, you can run the non-CMS SIR reports and see these units in the SIR data tables. Next slide.

If your hospital does not have a unit that meets the CDC definition for ICU and NICU or one of the six ward types, your hospital may be eligible for a CLABSI/CAUTI exception. This is something that we've gone over previously in this webinar and details can be found on *QualityNet*. Next slide.

Let's look at a FAQ for your monthly reporting plan. NHSN, while running my CAUTI IQR report for Quarter 3, I'm unable to see the July's data from my med/surg unit. I do not have any alerts. And the answer to that is, the reason why this unit is not included in the CAUTI CMS IQR Report is because it's not included in the July monthly reporting plan. If units are not included in the monthly reporting plan, they will not be included in the CMS reports or be sent to CMS. Data that officially does not want to be reported can still be entered and analyzed in NHSN by simply keeping it off-plan. However, like I mentioned before, alerts will not be generated for off-plan data. It would be the user's responsibility to ensure that all data and events are complete. Next slide.

Lastly, a survey data and an SIRs question. NHSN, I'm reviewing my OP hospital's data and the number of predicted infections and the SIRs changed. I did not add or edit any data. Why is it different? And the answer to that is it's likely that changes are due to the changes or addition of your hospital's annual survey. Next slide.

So NHSN will use the survey data for the year that matches the year of the HAI data, unless the survey does not yet exist, in which the most recent survey is used. Every year a new survey is entered into NHSN to reflect data from the prior calendar year. SIRs will use the most recent annual or survey on file for that current SIR. Under the new rebaseline, SIRs will be risk adjusted using the corresponding annual survey year from that year. If the annual survey from that year has not been completed, SIRs will be risk adjusted using the most recent available survey. Next slide.

And with that, that concludes our portion of this webinar. Here's some additional resources that can be very helpful with your data entry and checking of your data before the CMS deadline. And we would highly recommend that you visit all these links. Next slide.

And now I will turn it over to Maria.

Maria Gugliuzza: Thank you. I'd just like to take a quick second to thank everybody for their participation in today's webinar. We did receive some questions.

And I'd also would like to thank the presenters for their excellent job today. Let's get to the first question.

Maggie, Prachi, this is for you. Are the NHSN CMS reports different from the TAP reports? How?

Maggie Dudeck: So thank you for that question. The CMS reports are different from the TAP reports. To put this into context, TAP stands for Targeted Assessment for Prevention. The TAP reports and the TAP dashboard are limited only to CLABSI, CAUTI and CDI LabID data at this time. And are a way to measure the number of excess in sections or in other words, how many infections would need to be prevented in order to reach a stated goal.

So those reports are part of a first step of an entire strategy to look at where prevention efforts are needed to get the most infections prevented to drive the SIRs down. And it's really part of more of collaborations. The CMS reports are limited strictly to those data required for CMS and of course, are generated for SSI data and MRSA as well. If you're interested in more information on the TAP reports and the strategy, please send an email to nhsn@cdc.gov. I will be more than happy to direct you to a large number of resources that we have about that strategy.

Maria Gugliuzza: Thank you. So next question. Maggie, Prachi again. Why are SIRs only calculated for Cdiff and MRSA on a quarterly basis?

Prachi Patel: So the reason why CDI data is only calculated at the quarterly basis is because of the CDI test type. That information is collected at the end of each quarter and that information goes into the risk adjustments for that information. It also calculates the quarterly prevalence rate for that corresponding quarter.

Maria Gugliuzza: Thank you. We have time for a few more questions. The next question, looks like it's for our NHSN. Does the NHSN have a listing of the infection codes specifically looked for in regard to the SSI charts?

Maggie Dudeck: That is an excellent question and I'm afraid I don't have an answer for you today but I'm sure our SSI subject matter experts here at NHSN would be able to help direct people to that resource if we have it. I'm not quite sure if we have that exact resource. So please email us at nhsn@cdc.gov and our SSI SMEs will be happy to help.

Maria Gugliuzza: Wonderful. Next question, do retrospective plans need to be completed in quarterly time frames or can one be completed outside of the most recent quarter? Maggie, Prachi, I think this one's for you.

Maggie Dudeck: Yes, so the plans, we recommend that the plans are completed as early as you can, really. So we encourage people to complete their plans for the entire year at one point so that way you can ensure, going forward, that everything that should be required is in there. The plans, you know, should be reviewed, a final check before your quarterly reporting deadline so that you can make sure that everything is really in there that should be in there. So with that being said, they don't have to be entered quarterly, they really are a monthly record that could be completed up to a year in advance if needed and reviewed whenever it needs to be reviewed. If they are updated retrospectively, just keep in mind that if the CMS deadline has already passed, it doesn't matter how you update your plan, it wouldn't affect what has already been sent or not sent to CMS.

Maria Gugliuzza: Thank you. Another question here, let's see. Referring to slide 65. If we have less than five per year, do we still enter our facility cases? Slide 65.

Maggie Dudeck: Slide 65. Okay, so I'm sure maybe, this is Maggie. CDC and our CMS colleagues can step in as well. You can always enter data into NHSN whether or not it's required. I would refer to our colleagues at CMS around the process if a hospital has a low volume of procedures and whether or not those data would be required to be reported.

Bethany Wheeler-Bunch: Thanks for that question. In terms of the Measure Exception form which is the other option if you have low case counts for the SSI measures, as we covered on the Measure Exception slide, I'm going to move to that slide now. Here it is. Only hospitals that perform nine or fewer of any of the specified colon and abdominal hysterectomy surgeries combined in the

previous calendar year would be eligible to submit the Measure Exception form for SSI which would waive your requirement to submit it. And you would not be penalized under the Hospital IQR Program or HAC Reduction Program for not having data in that calendar year that follows that as long as you have submitted this Measure Exception form. So it's nine or fewer combined in the previous calendar year.

Maria Gugliuzza: Thanks Bethany. Slide 48 is our next question. We have two facilities under one CCN. Data is entered into two separate accounts or by facility into NHSN. How is that data combined? Does NHSN, the CDC or CMS complete this process?

Maggie Dudeck: Hi, this is Maggie at CDC. Great question. We know that's one of our frequently asked questions here at NHSN. What we do at CDC, is we calculate the number of predicted at the most granular level first. So to make it an easy example, let's use CDI LabID. We calculate the number predicted for the FacWideIN measure. We also calculate the total number of healthcare onset incident events. And if there are more than one NHSN facilities that share a single CCN, we then total up the number of predicted for that CCN across those various org IDs and the same for the number of events. And then we calculate the SIR. So the important point there is that the risk adjustment is able to be applied at the most granular level possible and then rolled up to the CCN. It's one of the benefits of the Standardized Infection Ratio. As an individual hospital, you can get a single SIR for a unit and roll it up to your whole facility level. Very similar when we roll it up by the CCN level and it's only the CNN level data that are shared with CMS. And I think that should answer that question.

Maria Gugliuzza: Thank you. It looks like we have time for one more question. Let's see. I'm sorry, Maggie, Prachi, another question for you. What if you downsize a unit reducing the number of beds? Do we reflect that number anywhere in NHSN?

Maggie Dudeck: Yes, we do. That's a good question. We do have a field on our location manager and it's called "Bed Size." So, you know, we certainly do

encourage hospitals to go ahead and update that number. I will say, however, that we don't have any rules in place that cross-check that information, although we are running some checks here at CDC just to ensure that we're able to identify if hospitals are maybe entering more patient days then we would anticipate. So again, we encourage folks to check that number. If you need instructions on how to do that, you can email us and we'll provide you. It's a fairly easy process, just a few steps, that we can send you to do that. That number on the number of beds for a unit, is not used in the risk adjustment itself. It's merely something that can help us manage and understand how large the locations are that facilities are reporting.

Maria Gugliuzza: All right, one last question. Just to verify, the hospital can be impacted for PSIs and HAIs in two programs, VBP and HAC Reduction?

Bethany Wheeler-Bunch: Hi, I can take that one.

Maria Gugliuzza: Thanks Bethany.

Bethany Wheeler-Bunch: Yes, the PSI 90 Composite and the Healthcare-Associated Infection Measures with CLABSI, CAUTI, MRSA, CDI and SSI are included or where included both in the HAC Reduction Program and the Hospital Value-Based Purchasing Program in FY 2018. Moving forward in FY 2019, the Hospital Value-Based Purchasing Program, the AHRQ PSI 90 Composite. And just for reference, VBP was using the old version of that measure in the fiscal year 2018 program. We're removing that in FY 2019 and CMS finalized their proposal to reinclude the new version of that measure in VBP in FY 2023. But yes, both the HAC Reduction Program and the Hospital Value-Based Purchasing Program use these measures, although both programs use different methodology and different types of payment adjustments.

Maria Gugliuzza: Thanks Bethany. That's all the time we have today. I just want to take a quick second again, to thank everyone for their wonderful questions and any questions that we did not get to today will be answered. Please take the time to review the continuing education slides and if you need any

assistance, the contact information is on the slides. Again, I'd just like to thank everybody.