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

September 27, 2017
Speakers

Bethany Wheeler-Bunch, MSHA
Project Lead, Hospital Value-Based Purchasing (VBP) Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor (SC)

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Program Lead, Hospital-Acquired Condition Reduction Program (HACRP)
Quality Measurement and Value-Based Incentives Group (QMVIG)
Center for Clinical Standards & Quality (CCSQ), Centers for Medicare & Medicaid Services (CMS)

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Lead, National Healthcare Safety Network (NHSN) Methods and Analytics Team
Division of Healthcare Quality Promotion (DHQP)
National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)
Centers for Disease Control and Prevention (CDC)

Prachi Patel, MPH
Public Health Analyst, NHSN Methods and Analytics Team
DHQP, NCEZID, CDC

Moderator
Maria Gugliuzza, MBA
Project Manager, Hospital VBP Program, VIQR Outreach and Education SC
Purpose

This event will provide reminders and updates for the Healthcare-Associated Infection (HAI) measures included in the Centers for Medicare & Medicaid Services (CMS) hospital quality programs.
Objectives

Participants will be able to perform the following:

- Recall how the HAI measures are used in CMS hospital quality programs
- Discuss the use of the National Healthcare Safety Network (NHSN) database for CMS quality reporting programs
- Identify steps to improve data entry and submissions
- Review trouble-shooting tips and ways to validate data completeness and submission
- Describe best practices in HAI data tracking as part of ongoing quality initiatives
Acronyms

ACA
Affordable Care Act

ACH
acute care hospital

CAUTI
catheter-associated urinary tract infection

CCN
CMS Certification Number

CDC
Centers for Disease Control and Prevention

CDI
Clostridium difficile infection

CLABSI
central line-associated bloodstream infection

CMS
Centers for Medicare & Medicaid Services

COLO
colon surgery

CY
calendar year

ED
emergency department

FY
fiscal year

HAC
hospital-acquired condition

HACRP
Hospital-Acquired Condition Reduction Program

HAI
healthcare-associated infection

HSR
hospital specific report

HYST
abdominal hysterectomy surgery

ICU
intensive care unit

IRF
inpatient rehabilitation facility

IQR
Inpatient Quality Reporting

LabID
laboratory identified

LOS
length of stay

MBI-LCBI
Mucosal Barrier Injury Laboratory-Confirmed Bloodstream Infections

MRP
monthly reporting plan

MRSA
Methicillin-resistant Staphylococcus aureus

NHSN
National Healthcare Safety Network

ONC
oncology

PATOS
present at time of surgery

PPSR
Percentage Payment Summary Report

QRP
Quality Reporting Program

SIR
Standardized Infection Ratio

SSI
surgical site infection

TPS
Total Performance Score

VBP
Value-Based Purchasing
Hospital Value-Based Purchasing (VBP) Program

Bethany Wheeler-Bunch, MSHA
Project Lead, Hospital VBP Program
Hospital Inpatient VIQR Outreach and Education SC
FY 2018
Domains and Measures

SAFETY
1. **PSI 90**: Complication/patient safety for selected indicators (composite)
2. **CDI**: Clostridium difficile Infection
3. **CAUTI**: Catheter-Associated Urinary Tract Infection
4. **CLABSII**: Central Line-Associated Bloodstream Infection
5. **MRSA**: Methicillin-resistant Staphylococcus aureus Bacteremia
6. **SSI**: Surgical Site Infection Colon Surgery and Abdominal Hysterectomy
7. **PC-01**: Elective Delivery Prior to 39 Completed Weeks Gestation

CLINICAL CARE
1. **MORT-30-AMI**: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. **MORT-30-HF**: Heart Failure (HF) 30-Day Mortality Rate
3. **MORT-30-PN**: Pneumonia (PN) 30-Day Mortality Rate

EFFICIENCY AND COST REDUCTION
1. **MSPB**: Medicare Spending per Beneficiary (MSPB)

PATIENT- AND CAREGIVER-CENTERED EXPERIENCE OF CARE/CARE COORDINATION (Experience of Care)

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions:
1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition*
8. Overall Rating of Hospital

* An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program.
FY 2019 and FY 2020
Domains and Measures

SAFETY
1. CDI: Clostridium difficile Infection
2. CAUTI: Catheter-Associated Urinary Tract Infection
3. CLABSI: Central Line-Associated Blood Stream Infection
4. MRSA: Methicillin-Resistant Staphylococcus aureus Bacteremia
5. SSI: Surgical Site Infection Colon Surgery & Abdominal Hysterectomy
6. PC-01: Elective Delivery Prior to 39 Completed Weeks Gestation

EFFICIENCY AND COST REDUCTION
1. MSPB: Medicare Spending per Beneficiary (MSPB)

CLINICAL CARE
1. MORT-30-AMI: Acute Myocardial Infarction (AMI) 30-Day Mortality Rate
2. MORT-30-HF: Heart Failure (HF) 30-Day Mortality Rate
3. MORT-30-PN: Pneumonia (PN) 30-Day Mortality Rate
4. THA/TKA: Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Complication Rate

Person and Community Engagement
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Dimensions:
1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Communication about Medicines
5. Cleanliness and Quietness of Hospital Environment
6. Discharge Information
7. Care Transition
8. Overall Rating of Hospital
Frequently Asked Question

Question:
Why don’t my NHSN HAI measure data in Hospital VBP match the data reported on Hospital Compare or my data in NHSN?

Answer:
There are three possible reasons why your data do not match:

- Central line-associated bloodstream infection (CLABSI)/ Catheter-associated urinary tract infection (CAUTI) expanded locations
  - The Hospital Inpatient Quality Reporting (IQR) Program started reporting expanded locations with calendar year (CY) 2015 data, but the Hospital VBP Program will not start until fiscal year (FY) 2019.

- New standard population (baseline)
  - The CDC updated its standard population with CY 2015 data, but the Hospital VBP Program will not use the update until FY 2019.

- Updates to data made in NHSN after the quarterly submission deadlines will not be reflected in CMS programs.
NHSN Measures
Standard Population Data

Routine Maintenance

• CDC updated the standard population data (a.k.a. national baseline) to ensure the NHSN measures’ number of predicted infections reflect the current state of HAIs in the United States.

  ▪ CAUTI standard population data are CY 2009.
  ▪ CLABSI and SSI standard population data are CY 2006–2008.
  ▪ CDI and MRSA standard population data are CY 2010–2011.

• Beginning with CY 2015, CDC collected data in order to update the standard population for all measures listed above.

<table>
<thead>
<tr>
<th>Data Period</th>
<th>FY 2017 Program Year</th>
<th>FY 2018 Program Year</th>
<th>FY 2019 Program Year</th>
<th>FY 2020 Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSN Measures Baseline Period</td>
<td>Current standard population data</td>
<td>Current standard population data</td>
<td>New standard population data</td>
<td>New standard population data</td>
</tr>
<tr>
<td>NHSN Measures Performance Period</td>
<td>Current standard population data</td>
<td>Current standard population data</td>
<td>New standard population data</td>
<td>New standard population data</td>
</tr>
</tbody>
</table>
## CLABSI and CAUTI Locations

<table>
<thead>
<tr>
<th>Data Period</th>
<th>FY 2017 Program Year</th>
<th>FY 2018 Program Year</th>
<th>FY 2019 Program Year</th>
<th>FY 2020 Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital VBP Program Baseline Period</td>
<td><strong>CLABSI</strong>: Adult, Pediatric, and Neonatal intensive care unit (ICU) locations <strong>CAUTI</strong>: Adult and Pediatric ICU locations</td>
<td><strong>CLABSI</strong>: Adult, Pediatric, and Neonatal ICU locations <strong>CAUTI</strong>: Adult and Pediatric ICU locations</td>
<td><strong>CLABSI</strong>: Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards <strong>CAUTI</strong>: Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards</td>
<td><strong>CLABSI</strong>: Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards <strong>CAUTI</strong>: Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards</td>
</tr>
<tr>
<td>Hospital VBP Program Performance Period</td>
<td><strong>CLABSI</strong>: Adult, Pediatric, and Neonatal ICU locations <strong>CAUTI</strong>: Adult and Pediatric ICU locations</td>
<td><strong>CLABSI</strong>: Adult, Pediatric, and Neonatal ICU locations <strong>CAUTI</strong>: Adult and Pediatric ICU locations</td>
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</tr>
</tbody>
</table>
Reviewing Your Data: CDC NHSN Measures

Stage One: Patient-Level Data Review

- Hospitals have approximately 4.5 months after the quarterly reporting period ends to submit their data.
- Hospitals should use this time to ensure accuracy of the data and make any necessary corrections.
- Corrections to the data cannot be made after the submission deadline.
- HAI data that have been changed in NHSN after the submission deadline will not be reflected in any of the CMS programs, CMS reports, or on Hospital Compare.
Reviewing Your Data: Hospital VBP Program

Stage Two: Scoring/Eligibility Review

• Hospitals have approximately 30 days to request a review and correction following the release of the percentage payment summary report (PPSR).
  ▪ Hospitals may review and request recalculation of scores on each condition, domain, and Total Performance Score (TPS).
  ▪ Requests for submission of new or corrected data, including claims to the underlying measure data, are not allowed.
  ▪ Specific to the HAI measures, the Review and Corrections period does not allow hospitals to correct the following:
    o Reported number of HAIs
    o Standardized Infection Ratios (SIRs)
    o Reported central-line days, urinary catheter days, surgical procedures performed, or patient days

• Hospitals may appeal the calculation of their performance assessment within 30 calendar days of receipt of the CMS review and correction decision.

• For more information, visit QualityNet: https://www.qualitynet.org/dcs/ContentServer?c=Page&p=QnetPublic%2FPage%2FQnetTier3&cid=1228772479558
Hospital VBP Program Resources

Technical questions or issues related to accessing reports
• Email the QualityNet Help Desk at qnetsupport@HCQIS.org
• Call the QualityNet Help Desk at (866) 288-8912

Ask questions or access Frequently Asked Questions (FAQs) related to Hospital VBP
• Submit questions or access the FAQs via the Hospital-Inpatient Questions and Answers tool at https://cms-ip.custhelp.com
• Call the Hospital Inpatient program at (844) 472-4477

Hospital VBP Program general information
• https://www.qualitynet.org/dcs/ContentServer?c=Page&papename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937

Hospital VBP Program ListServes and discussions
• Register at https://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/Register

Hospital VBP Program monthly webinars
• Find archived webinars and future webinar schedule and registration at http://www.qualityreportingcenter.com

Hospital VBP Program data and scoring on Hospital Compare
• View data up to FY 2017 at http://www.medicare.gov/hospitalcompare/data/hospital-vbp.html
Hospital-Acquired Condition Reduction Program (HACRP)

Elizabeth Bainger, DNP, RN, CPHQ
Program Lead, HACRP
QMVIG, CCSQ, CMS
The HAC Reduction Program (HACRP) was established to incentivize hospitals to reduce the number of HACs. HACs include patient safety events (e.g., falls) and HAIs (e.g., surgical site infections). HACRP was mandated by section 3008 of the 2010 Affordable Care Act (ACA). CMS started applying payment adjustments with FY 2015 discharges (beginning October 1, 2014). In FY 2018, hospitals that rank in the worst-performing 25 percent of all subsection (d) hospitals will receive a one percent payment adjustment of what could have been otherwise paid.
## Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>FY 2018</th>
<th>FY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recalibrated PSI 90 Composite: Patient Safety for Selected Indicators</td>
<td>√</td>
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<td>Blank</td>
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<tr>
<td>Modified Recalibrated PSI 90 Composite: Patient Safety and Adverse Events Composite</td>
<td>Blank</td>
<td>Blank</td>
<td>Blank</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Central Line-Associated Bloodstream Infection (CLABSI)</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Catheter-Associated Urinary Tract Infection (CAUTI)</td>
<td>√</td>
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<tr>
<td>Surgical Site Infection (SSI) (Abdominal Hysterectomy and Colon Procedures)</td>
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</tr>
<tr>
<td>Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia</td>
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<td>Blank</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Clostridium difficile Infection (CDI)</td>
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</tr>
</tbody>
</table>
## Performance Periods and Domain Weights

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Measures Included</th>
<th>Performance Period</th>
<th>Domain Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2018</td>
<td><strong>Domain 1</strong>: Modified Recalibrated PSI 90 Composite</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Domain 2</strong>: CDC NHSN Measures (CLABSI, CAUTI, SSI, MRSA, CDI)</td>
<td>Domain 1: 7/1/2014–9/30/2015*&lt;br&gt;Domain 2: 1/1/2015–12/31/2016</td>
<td>Domain 1: 15%&lt;br&gt;Domain 2: 85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Shortened period</td>
<td></td>
</tr>
<tr>
<td>FY 2019</td>
<td><strong>Domain 1</strong>: Modified Recalibrated PSI 90 Composite</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Domain 2</strong>: CDC NHSN Measures (CLABSI, CAUTI, SSI, MRSA, CDI)</td>
<td>Domain 1: 10/1/2015–6/30/17&lt;br&gt;Domain 2: 1/1/2016–12/31/2017</td>
<td>Domain 1: 15%&lt;br&gt;Domain 2: 85%</td>
</tr>
</tbody>
</table>
Updates to HAI Measures in FY 2018

- Used CY 2015 as the new baseline for all CDC NHSN measures and updated risk adjustment in all models
- Changed the CDI community-onset prevalence rate, which determines hospital outliers for all quarters in the performance period, to greater than 2.6
- Removed the outlier designation for MRSA under the updated risk-adjustment model
- Expanded CLABSI and CAUTI measures beyond ICUs to include data from medical, surgical, and medical-surgical wards
- Removed the No Facilities waiver for CLABSI and CAUTI measures because of the ward expansion
Healthcare-Associated Infection (HAI) Data Flow

End of the reporting quarter

4.5 months from the end of the reporting quarter to submit, review, and correct data in NHSN*

CDC creates snapshot immediately at close of submission deadline

CMS calculates score

30-Day Review and Corrections Period**

Data publicly reported on Hospital Compare (December)

*Eligible hospitals have until May 15th of each year to submit an HAI exception form for CLABSI, CAUTI, and SSI only

**The Review and Corrections period does not allow hospitals to correct: (1) reported number of HAIs; (2) Standardized Infection Ratios (SIRs); and (3) reported central-line days, urinary catheter days, surgical procedures performed, or patient days.
Review and Corrections Period

• CMS distributes HACRP Hospital-Specific Reports (HSRs) via the QualityNet Secure Portal.

• CMS gives hospitals 30 days to review their HACRP data, submit questions about the calculation of their results, and request corrections of calculation errors.
CDC NHSN Measures

• CMS calculates the CLABSI, CAUTI, SSI, MRSA, and CDI HAI measures using chart-abstracted data submitted by hospitals via the NHSN.

• The HACRP Review and Corrections period does not allow hospitals to correct the following:
  - Reported number of HAIs
  - SIRs
  - Reported central-line days, urinary catheter days, surgical procedures performed, or patient days
CDC NHSN Measures

• Under the Hospital IQR Program, hospitals can submit, review, and correct the CDC NHSN HAI data for 4.5 months after the end of the reporting quarter.

• 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.

• Hospitals are strongly encouraged to review and correct their data prior to the HAI submission deadline.
Resources

- HACRP general information on QualityNet: [www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166](www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166)

- HACRP information on CMS: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html)


- HACRP data on Hospital Compare: [https://www.medicare.gov/hospitalcompare/HAC-reduction-program.html](https://www.medicare.gov/hospitalcompare/HAC-reduction-program.html)

- HACRP payment penalty file: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html).

- HACRP Review and Corrections overview: [https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774298670](https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228774298670)

- Stakeholder questions can be directed to hacrp@lantanagroup.com.
Measure Exception Form

Bethany Wheeler-Bunch, MSHA
Project Lead, Hospital VBP Program
Hospital Inpatient VIQR Outreach and Education SC
Measure Exception Form

• Provides a mechanism for 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

• May be used by the following programs:
  ▪ Hospital IQR
  ▪ HAC Reduction
Measure Exception Form

• May be used for the following measures:
  ▪ Perinatal Care (PC-01) starting with 3Q 2015
  ▪ Emergency Department (ED-1 and ED-2) starting with 3Q 2015
  ▪ HAI Measures
    o SSI
    o CAUTI
    o CLABSI

• Must be renewed at least annually
SSI Exception

Specified Colon and Abdominal Hysterectomy Surgical Procedures

• Only hospitals that performed nine or fewer of any of the specified colon and abdominal hysterectomy combined in the calendar year prior to the reporting year are eligible for the SSI measure exception.
CLABSI and CAUTI Exception

- Hospitals are required to report CAUTI and CLABSI data from all patient care locations that are mapped by the NHSN as:
  - Adult and Pediatric Medical, Surgical, and Medical/Surgical wards.
  - ICUs.
- The ward locations will be limited to those locations that are mapped or defined as:

<table>
<thead>
<tr>
<th>CDC Location Label</th>
<th>CDC Location Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Ward</td>
<td>IN:ACUTE:WARD:M</td>
</tr>
<tr>
<td>Medical/Surgical Ward</td>
<td>IN:ACUTE:WARD:MS</td>
</tr>
<tr>
<td>Surgical Ward</td>
<td>IN:ACUTE:WARD:S</td>
</tr>
<tr>
<td>Pediatric Medical Ward</td>
<td>IN:ACUTE:WARD:M_PED</td>
</tr>
<tr>
<td>Pediatric Medical/Surgical Ward</td>
<td>IN:ACUTE:WARD:MS_PED</td>
</tr>
<tr>
<td>Pediatric Surgical Ward</td>
<td>IN:ACUTE:WARD:S_PED</td>
</tr>
</tbody>
</table>
CLABSI and CAUTI Exception

Hospitals that have no ICU locations or Adult or Pediatric Medical, Surgical, or Medical/Surgical wards are eligible for the measure exception.
Submission Instructions

• Locate the Measure Exception Form at:

• Complete and Submit form by:
  ▪ Email: QRSupport@hcqis.org
  ▪ Secure Fax: 877.789.4443
  ▪ QualityNet Secure Portal, Secure File Transfer: “WAIVER EXCEPTION WITHHOLDING” group

• Submit form for:
  ▪ Quarterly submissions by the CMS submission deadlines
  ▪ Calendar Year 2018 by August 15, 2018*
  *These are recommended dates.
Successfully Reporting NHSN Data to Satisfy Hospital Quality Reporting Program Requirements

**Maggie Dudeck, MPH**  
Lead, NHSN Methods and Analytics Team  
DHQP, NCEZID, CDC

**Prachi Patel, MPH**  
Public Health Analyst, NHSN Methods and Analytics Team  
DHQP, NCEZID, CDC
Using NHSN: CMS

NHSN is used as the vehicle to:

• Report select measures which fulfill mandated HAI reporting requirements for CMS and the individual states.

• Voluntarily report HAI data that are of interest to hospitals and/or special study groups or initiatives.
The NHSN application:

- Uses standard surveillance protocols to report events and eligible denominators.
- Allows data to be entered and analyzed by the hospital and groups using standardized protocols and risk-adjusted measures.
Using NHSN: Recommendations and Requirements for CMS Quality Reporting Programs

• Recommendations include:
  ▪ Developing a routine schedule as to when your hospital will enter and analyze data in NHSN.
  ▪ Using a checklist to ensure data are complete for each measure required.
  ▪ Having back-up personnel who can use the NHSN system.

• Requirements include:
  ▪ Collect and report data according to NHSN protocols.
    o Only share “In Plan” and complete data with CMS.
Using NHSN: Resources

• NHSN’s CMS Reporting webpage: https://www.cdc.gov/nhsn/cms/index.html
  ▪ Operational Guidance documents describe NHSN reporting requirements to comply with CMS Quality Reporting Programs (QRPs).
  ▪ CMS Reporting resources provide information on how to use CMS reports within NHSN and monthly reporting checklists.
Using NHSN: Resources

National Healthcare Safety Network (NHSN)

CMS Requirements

CMS Resources for NHSN Users

- Operational Guidance for Acute Care Hospitals
- Operational Guidance for Ambulatory Surgery Centers
- Operational Guidance for PPS-Exempt Cancer Hospitals
- Operational Guidance for Long term Acute Care Facilities
- Operational Guidance for Inpatient Psychiatric Facilities
- Operational Guidance for Inpatient Rehabilitation Facilities
- Outpatient Dialysis Facilities

CMS Reporting

- Importance of NHSN Reporting
- CLABSI (Acute Care Hospitals)
- CRBSI (PPS-Exempt Cancer Hospitals)

Resources

- Healthcare Facility HAIs Reporting Requirements to CMS via NHSN Current and Proposed Requirements September 2015 [PDF - 102K]
- Reporting Requirements and Deadlines in NHSN per CMS Current Rules 2015 [PDF - 157K]
- Hospital Inpatient Quality Reporting Program
- CMS Hospital Compare tool
- CMS Inpatient Prospective Payment System (IPPS) Rule
- Changing a CCN within NHSN (updated July 2015) [PDF - 290K]
Sharing NHSN Data with CMS

• CDC sends NHSN data to CMS, on behalf of participating hospitals.

• CMS prescribes the quarterly deadline date/time.
  ▪ CDC takes a snapshot of the NHSN database at the prescribed time.
  ▪ CDC compiles SIRs based on the snapshot and sends to CMS on the first business day after the deadline.
Sharing NHSN Data with CMS

• Data for a given quarter are considered **frozen** at the time of each quarterly deadline and are never updated with a new snapshot of the NHSN database.

• NHSN data for CMS programs that reflect multiple quarters of data use data that were frozen at each quarterly deadline.

• It’s important to make sure your hospital’s data are accurate and complete in time for the deadline!
# NHSN Resource

## Monthly Checklist


### NHSN Monthly Checklist for Reporting to CMS Hospital IQR

- **CCN:** __________________
- **Month/Year:** __________

<table>
<thead>
<tr>
<th></th>
<th>CAUTI</th>
<th>CLABSI</th>
<th>FACWIDEIN LabID Event</th>
<th>SSI</th>
<th>HCP Influenza Vaccination (seasonal)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Plan</strong></td>
<td>ICUs</td>
<td>ICUs</td>
<td>CDI</td>
<td>COLO</td>
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<td></td>
<td>Wards*</td>
<td>Wards*</td>
<td>MRSA</td>
<td>HYST</td>
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<tr>
<td><strong>Seasonal Influenza Vaccination Summary Data</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monthly Denominator Data</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ICUs</td>
<td>ICUs</td>
<td>FACWIDEIN</td>
<td>COLO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wards*</td>
<td>Wards*</td>
<td>ED</td>
<td>HYST</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Observation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9/27/2017
Monthly CHECKLIST

Use a monthly checklist to ensure data are complete by the deadline and will be submitted to CMS:

- Confirm (and update if necessary) CCN in NHSN.
- Review Monthly Reporting Plans (MRPs) and update if necessary.
- Identify and enter all required events into NHSN.
- Enter denominator data for each month under surveillance.
- Resolve “Alerts,” if applicable.
- Use NHSN Analysis Reports to verify accuracy and completion of data entry prior to CMS deadline.
Confirm CCN in NHSN

- A hospital’s CCN applies to **ALL** CMS-related reporting in NHSN for the ACH.
- It is important to double- and triple-check this number.
- Edits to the CCN must be completed by an administrative user (e.g., facility administrator).
Update CCN in NHSN

Instructions for updating your hospital’s CCN in NHSN can be found at:

Monthly CHECKLIST

✓ Confirm (and update if necessary) CCN in NHSN.

☐ Review Monthly Reporting Plans (MRPs) and update if necessary.

☐ Identify and enter all required events into NHSN.

☐ Enter denominator data for each month under surveillance.

☐ Resolve “Alerts,” if applicable.

☐ Use NHSN Analysis Reports to verify accuracy and completion of data entry prior to CMS deadline.
Review the Monthly Reporting Plan

• The Monthly Reporting Plan (MRP) informs CDC as to:
  ▪ Which modules a facility is following during a given month.
    ◦ Referred to as “In-Plan” data
  ▪ Which data can be used for aggregate analyses.
  ▪ Which data can be shared with CMS, per the scope of the CMS program.

• A facility must enter a Plan for every month of the year.

• Plans can be modified retrospectively
Review Monthly Reporting Plans

IMPORTANT!

• NHSN will only submit data to CMS for those complete months in which applicable data are indicated on the MRP.

• If data required by QRP are not included in the MRPs, those data will not be submitted to CMS!
Review Monthly Reporting Plan

Current MRP requirements for Hospital IQR:

- **CLABSI**: All ICUs and NICUs, and all adult and pediatric medical, surgical, and medical/surgical wards
- **CAUTI**: All ICUs and all adult and pediatric medical, surgical, and medical/surgical wards
- **MRSA blood LabID** and **CDI LabID**: FacWideIN plus all ED and Observation units, if applicable
- **SSI**: Inpatient COLO and HYST
Example Plan for CLABSI and CAUTI:

Using this example:
- **CARDCRIT**: ICU location – CLABSI and CAUTI are in-plan. Complete data would be shared with CMS. VAE data are in-plan, but are **not** shared.

<table>
<thead>
<tr>
<th>Device-Associated Module</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Locations</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>CARDCRIT - MED CARD CRIT</td>
</tr>
<tr>
<td>MD WARD - MED WARD</td>
</tr>
<tr>
<td>AMAU - ADULT MIXED ACUTIY UNIT</td>
</tr>
</tbody>
</table>

Mandatory fields marked with *

Facility ID *: DHQP MEMORIAL HOSPITAL (ID 10018)
- Month *: April
- Year *: 2017
- No NHSN Patient Safety Modules Followed this Month
Review Monthly Reporting Plan

Example Plan for CLABSI and CAUTI:

Using this example:

- **MD WARD**: Medical ward—CAUTI is in-plan. Complete CAUTI data would be shared with CMS.
  - If CLABSI data are entered, they would *not* be shared with CMS as they are not in-plan for this location and month.
### Example Plan for CLABSI and CAUTI:

Using this example:

- **AMAU**: Mixed Acuity Unit – CLABSI and CAUTI are in-plan, but data would not be shared with CMS, as this location type is not in scope for HIQR program.

#### Device-Associated Module

<table>
<thead>
<tr>
<th>Locations</th>
<th>CLABSI</th>
<th>VAE</th>
<th>CAUTI</th>
<th>CLIP</th>
<th>PedVAP (&lt;18 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARDCRIT - MED CARD CRIT</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD WARD - MED WARD</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMAU - ADULT MIXED ACUITY UNIT</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mandatory fields marked with *

Facility ID *: DHQP MEMORIAL HOSPITAL (ID 10018)

- Month *: April
- Year *: 2017

- No NHSN Patient Safety Modules Followed this Month
Monthly CHECKLIST

- Confirm (and update if necessary) CCN in NHSN.
- Review Monthly Reporting Plans (MRPs) and update if necessary.

- Identify and enter all required events into NHSN.
- Enter denominator data for each month under surveillance.
- Resolve “Alerts,” if applicable.
- Use NHSN Analysis Reports to verify accuracy and completion of data entry prior to CMS deadline.
Enter Events

• Perform surveillance according to NHSN protocols and definitions.
• Enter events that meet the NHSN surveillance definition of that event type.
• Add events by using the Event > Add option in NHSN.
• Link each SSI to a procedure record in NHSN.
  ▪ This link is required.
  ▪ Patient ID is the primary identifier.
Monthly CHECKLIST

- Confirm (and update if necessary) CCN in NHSN.
- Review Monthly Reporting Plans (MRPs) and update if necessary.
- Identify and enter all required events into NHSN.

- Enter denominator data for each month under surveillance.
- Resolve “Alerts,” if applicable.
- Use NHSN Analysis Reports to verify accuracy and completion of data entry prior to CMS deadline.
Enter Denominator Data: CLABSI and CAUTI

- Denominator data must be entered for each required location, each month.
- Go to Summary Data > Add.
- Select the “Device Associated…” summary option application to the location.

Add Patient Safety Summary Data
Enter Denominator Data: CLABSI and CAUTI

Enter patient days and device days, per the NHSN surveillance protocols.
Enter Denominator Data: CLABSI and CAUTI

**TIP! Pay attention to the red asterisks!**

These indicate required fields and are driven off of the plans.

In this example, we know that CAUTI is not in-plan for this location/month – there is no red asterisk!

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Days*</td>
<td></td>
</tr>
<tr>
<td>Central Line Days*</td>
<td></td>
</tr>
<tr>
<td>Urinary Catheter Days*</td>
<td></td>
</tr>
<tr>
<td>Ventilator Days</td>
<td></td>
</tr>
<tr>
<td>APRV Days</td>
<td></td>
</tr>
<tr>
<td>Episides of Mechanical Ventilation</td>
<td></td>
</tr>
<tr>
<td>CLABSI</td>
<td></td>
</tr>
<tr>
<td>CAUTI</td>
<td></td>
</tr>
<tr>
<td>VAE</td>
<td></td>
</tr>
<tr>
<td>PedVAP</td>
<td></td>
</tr>
</tbody>
</table>
Enter Denominator Data: CLABSI and CAUTI

**Mandatory fields marked with **

- **Facility ID**: 10000 (DHQP Memorial Hospital)
- **Location Code**: CMICU_N - CARDIAC ICU
- **Month**: May
- **Year**: 2015

**Report No Events**

- **Total Patient Days**: 1000
- **Central Line Days**: 439
- **Urinary Catheter Days**: 365
- **Ventilator Days**: 

**CLABSI**: ✔

**CAUTI**: 

**REQUIRED**: If your hospital identified 0 events of a particular type for this month and location, check “Report No Events” for the event type.

Data are **not** complete unless an event of that type is reported or you have checked “Report No Events” to verify 0 events identified.
Locations Required for CLABSI and CAUTI

• Reporting requirements are based on how a unit is defined using the CDC definitions and instructions for mapping locations.

• Locations must be mapped and set-up in NHSN according to the “Instructions for Mapping Patient Care Locations in NHSN” on page 2 of the CDC Locations and Descriptions chapter.

Locations Required for CLABSI and CAUTI

- In addition to reporting CLABSI and CAUTI data from all adult, pediatric, and neonatal ICUs, CMS IPPS hospitals will also be required to report CLABSI and CAUTI data from adult and pediatric medical, surgical, and medical/surgical wards.

<table>
<thead>
<tr>
<th>CDC Location Label</th>
<th>CDC Location Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Ward</td>
<td>IN:ACUTE:WARD:M</td>
</tr>
<tr>
<td>Medical/Surgical Ward</td>
<td>IN:ACUTE:WARD:MS</td>
</tr>
<tr>
<td>Surgical Ward</td>
<td>IN:ACUTE:WARD:S</td>
</tr>
<tr>
<td>Pediatric Medical Ward</td>
<td>IN:ACUTE:WARD:M_PED</td>
</tr>
<tr>
<td>Pediatric Medical/Surgical Ward</td>
<td>IN:ACUTE:WARD:MS_PED</td>
</tr>
<tr>
<td>Pediatric Surgical Ward</td>
<td>IN:ACUTE:WARD:S_PED</td>
</tr>
</tbody>
</table>
Locations Required for CLABSI and CAUTI

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 (e.g., mapped as orthopedic ward, telemetry ward, step-down unit) would not be required to report CLABSI and CAUTI data for the CMS Hospital IQR Program in 2015; any CLABSI or CAUTI data reported from non-required units in NHSN will not be submitted to CMS.
Enter Denominator Data: COLO and HYST Procedures

- A procedure record must be entered for each inpatient COLO and HYST procedure performed in your hospital.
- Procedures can be entered by:
  - Procedure > Add
  - Import, via .csv file or CDA
Enter Denominator Data: MRSA Blood and CDI LabID

• On the summary data entry screen, select FacWideIN as the location for which you are entering the summary data. After selecting the FacWideIN location, month, and year, six summary data fields will become required.

• Details about how to complete these data can be found at this direct URL: https://www.cdc.gov/nhsn/pdfs/cms/acute-care-mrsa-cdi-labiddenominator-reporting.pdf
Enter Denominator Data: MRSA Blood and CDI LabID

Used for the MRSA bacteremia SIR/rate calculations. Subtract counts from IRF and IPF units with unique CCN.

<table>
<thead>
<tr>
<th>Location Code</th>
<th>FACWIDEIN - Facility-wide Inpatient (FacW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>January</td>
</tr>
<tr>
<td>Year</td>
<td>2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting: Inpatient</th>
<th>Total Facility Patient Days</th>
<th>Total Facility Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1200</td>
<td>427</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting: Outpatient</th>
<th>Total Facility Encounters</th>
<th>MDRO Patient Days</th>
<th>MDRO Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1089</td>
<td>354</td>
</tr>
</tbody>
</table>

If monitoring **MDRO** in a FACWIDE location, then subtract all counts from patient care units with unique CCNs (IRF and IPF) from Totals:

<table>
<thead>
<tr>
<th>MDRO Patient Days</th>
<th>MDRO Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1089</td>
<td>354</td>
</tr>
</tbody>
</table>

If monitoring **C. difficile** in a FACWIDE location, then subtract all counts from patient care units as well as NICU and Well Baby counts from Totals:

<table>
<thead>
<tr>
<th>CDI Patient Days</th>
<th>CDI Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1080</td>
<td>310</td>
</tr>
</tbody>
</table>

Used for the **C. difficile** SIR/rate calculations. Subtract counts from IRF and IPF units with unique CCN, and subtract counts from NICUs and well-baby units.
Enter Denominator Data: MRSA blood and CDI LabID

In addition to a FacWideIN record, acute care hospitals also need to report denominators for each of the following, if applicable:

• Emergency Department (ED)
• Observation unit
NHSN Alerts and Analysis
Monthly CHECKLIST

- Confirm (and update if necessary) CCN in NHSN.
- Review Monthly Reporting Plans (MRPs) and update if necessary.
- Identify and enter all required events into NHSN.
- Enter denominator data for each month under surveillance.

☐ Resolve “Alerts,” if applicable.

☐ Use NHSN Analysis Reports to verify accuracy and completion of data entry prior to CMS deadline.
Resolve Alerts

• Alerts are generated for “In-Plan” data only.
• If the following alerts are not resolved, the data for that month are not complete and will not be submitted to CMS:
  ▪ Missing events
  ▪ Missing summary data
  ▪ Missing procedures
  ▪ Missing procedure-associated events
Resolve Alerts

NHSN - National Healthcare Safety Network

NHSN Patient Safety Component Home Page

- TAP Strategy Dashboard
- Action Items

COMPLETE THESE ITEMS

Not Accepted

ALERTS

9 Incomplete Events
82 Missing Events
23 Incomplete Summary Items
314 Missing Summary Items
43 Incomplete Procedures
64 Missing Procedures
51 Missing Procedure-Associated Events

9/27/2017
Resolve Alerts: Missing Events

- A “Missing Events” alert will appear if your hospital did not report a CLABSI, CAUTI, or LabID event for a month/location.
- Verify that your hospital truly identified zero events of that type.
- If your hospital did not identify an event:
  - Check “Report No Events” on the Alert tab, or on the Denominator Data Record.
- If your hospital did identify an event:
  - Enter the event in NHSN.
Resolve Alerts: Missing Events

This is an example of the “Missing Events” Alert.

Note: After checking “Report No Events,” remember to click “Save.”
Resolve Alerts:
Missing Summary Data

• “Missing Summary Data” appears if your hospital did not report a denominator 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/location.
Resolve Alerts: Missing Summary Data

Summary data (i.e., denominator data) can be entered by clicking the “Add Summary” link on the Alert screen.
Resolve Alerts: Missing Procedures

- The “Missing Procedures” alert will appear if your hospital did not report at least one procedure record for that month/procedure category/setting.
- Verify that your hospital truly performed zero procedures of that type.
- If your hospital did not perform any procedures in that category:
  - Check “Report No Procedures” on the Alert tab.
- If your hospital did perform procedures:
  - Enter the procedures into NHSN.
## Resolve Alerts: Missing Procedures

This is an example of the “Missing Procedures” Alert.

**Note:** After checking “Report No Procedures,” remember to click “Save.”

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Procedures</th>
<th>Setting</th>
<th>No Procedures Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/2015</td>
<td>COLO - Colon surgery</td>
<td>OUT - Outpatient</td>
<td>☐</td>
</tr>
<tr>
<td>09/2015</td>
<td>COLO - Colon surgery</td>
<td>IN - Inpatient</td>
<td>☐</td>
</tr>
<tr>
<td>10/2015</td>
<td>COLO - Colon surgery</td>
<td>IN - Inpatient</td>
<td>☐</td>
</tr>
<tr>
<td>04/2016</td>
<td>HPRO - Hip prosthesis</td>
<td>IN - Inpatient</td>
<td>☐</td>
</tr>
<tr>
<td>04/2016</td>
<td>HPRO - Hip prosthesis</td>
<td>OUT - Outpatient</td>
<td>☐</td>
</tr>
<tr>
<td>06/2016</td>
<td>CHOL - Gallbladder surgery</td>
<td>IN - Inpatient</td>
<td>☐</td>
</tr>
<tr>
<td>06/2016</td>
<td>CHOL - Gallbladder surgery</td>
<td>OUT - Outpatient</td>
<td>☐</td>
</tr>
<tr>
<td>07/2016</td>
<td>CHOL - Gallbladder surgery</td>
<td>IN - Inpatient</td>
<td>☐</td>
</tr>
<tr>
<td>07/2016</td>
<td>CHOL - Gallbladder surgery</td>
<td>OUT - Outpatient</td>
<td>☐</td>
</tr>
<tr>
<td>08/2016</td>
<td>CARD - Cardiac surgery</td>
<td>IN - Inpatient</td>
<td>☐</td>
</tr>
</tbody>
</table>
Resolve Alerts: Missing Procedure-Associated Events

- The “Missing Procedure-associated Events” alert appears if your hospital did not report at least one SSI event for a month/procedure category.
  
  **Note:** This Alert is based on the date of procedure, not the date of event.

- Verify that your hospital truly identified zero events of that type.

- If your hospital did not identify an event:
  - Check “Report No Events” on the Alert tab.

- If your hospital did identify an event:
  - Enter the event in NHSN.
Resolve Alerts: Missing Procedure-Associated Events

This is an example of the “Missing Procedure-associated Events” Alert.

**Note:** After checking “Report No Events,” remember to click “Save.”
Monthly CHECKLIST

- Confirm (and update if necessary) CCN in NHSN.
- Review Monthly Reporting Plans (MRPs) and update if necessary.
- Identify and enter all required events into NHSN.
- Enter denominator data for each month under surveillance.
- Resolve “Alerts,” if applicable.

- Use NHSN Analysis Reports to verify accuracy and completion of data entry prior to CMS deadline.
Analysis output options were created in order to allow facilities to review those data that would be submitted to CMS on their behalf.

If you’re not familiar with the NHSN analysis functionality, please refer to the Analysis Resources and Trainings at: [http://www.cdc.gov/nhsn/PS-Analysis-resources/index.html](http://www.cdc.gov/nhsn/PS-Analysis-resources/index.html).
CMS-related reports are available for each CMS quality reporting program by navigating to: Analysis > Reports> CMS Reports.

![Analysis Reports Diagram]
NHSN Analysis Reports

- Be sure to read the footnotes!
  - Footnotes provide valuable information regarding the data in each table.
- Data in the tables should be used to confirm accuracy and to check the quality of data prior to the CMS deadline for that quarter.
- Always print out a copy of your data tables before a CMS deadline.
  - This will be helpful when verifying Hospital Compare Preview, HVBP, and HACRP data.
NHSN Analysis Reports

• The SIR is a measure that compares the number of HAIs reported to NHSN to the number of infections that would be predicted based on national baseline data:

\[
\text{SIR} = \frac{\text{Observed} \# \text{ HAIs}}{\text{Predicted} \# \text{ HAIs}}
\]

• SIR interpretation:
  - 1 = same number of infections reported as would be predicted given the US baseline data
  - Greater than 1 = more infections reported than what would be predicted given the US baseline data
  - Less than 1 = fewer infections reported than what would be predicted given the US baseline data
Interpreting the SIR Report

1. This report includes non-MBI CLABSI data from acute care hospitals for 2015 and forward.
2. The SIR is only calculated if the number predicted (numPred) is >= 1. Lower bound of 95% Confidence Interval only calculated when number of observed events > 0.
3. The number of predicted events is calculated based on national aggregate NHSN data from 2015. It is risk adjusted for CDC location, hospital beds, medical school affiliation type and facility Type.
4. If the risk factor data are missing, the record will be excluded from the SIR.

Source of aggregate data: 2015 NHSN CLABSI Data
Data contained in this report were last generated on February 23, 2017 at 12:20 PM.
More about CMS Reports in NHSN

- Data appearing within analysis reports in NHSN will be current as of the last time you generated datasets.
- Data changes made in NHSN will be reflected in the next monthly submission to CMS.
  - **EXCEPTION:** Quarterly data are frozen as of the final submission date for a quarter.
  - If you make changes to a quarter’s data *after* the deadline, you will be able to see the changes reflected in the NHSN report.
    - **Note:** Changes made after a quarter’s deadline **will not be** reflected on the CMS side.
- **TIP:** Develop a way to keep track of any changes made to your data after a CMS (or other) deadline!
The SIR is a summary measure used to track HAIs at a national, state, or local level over time.

- SIR compares the observed number of HAIs reported to what would be predicted, given the standard population.
NHSN Analysis Reports

- Guidance documents have been created for each CMS-related report
- Visit: https://www.cdc.gov/nhsn/cms/index.html
Why 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 use of reports.
• Facilitate sharing of data entered into NHSN by CDC, CMS, your state health department, your corporation, special study groups, etc.

At the end of the day, these are YOUR data – you should know your data better than anyone else.
Don’t limit yourself! A number of different types of reports are helpful in analyzing your data…

• Line lists
• Frequency tables
• Charts/graphical reports
• Rate tables
• SIRs
• Descriptive statistics (e.g., mean, median, mode, distribution, outliers, etc.)
Changes to Data

What changes can potentially impact my rates and SIRs?

- Entry, edit, or deletion of events
- Changes to numbers of patient days, device days, admissions
- Removal or addition to MRPs
- Change in admission date, previous discharge date on LabID events
- Changes to relevant factors in the annual survey (e.g., medical school affiliation, facility bedsize)
- Resolution of “Report No Events” alerts
Data Quality Checks

• Monthly reporting plans
  ▪ Are the monthly reporting plans complete?
  ▪ Are “Active” locations applicable to NHSN surveillance listed?
  ▪ Are all appropriate procedures selected?
  ▪ Are the appropriate lab specimens selected to collect for LabID data?

• Annual survey
  ▪ Are the number of beds updated from the previous survey year?
  ▪ Has the hospital’s medical school affiliation changed?

• Alerts
  ▪ Have the alerts been resolved for the required analysis months?

• Using NHSN Analysis
  ▪ Are new datasets generated?
  ▪ Were new events entered after I ran my analysis?
General Tips for Data Quality

• Know your numbers.
  ▪ Number of patient days
  ▪ Number of admissions in your hospital each month
  ▪ Device use for locations under surveillance
  ▪ Average LOS in each unit

• Know what goes into the NHSN risk adjustment.

• Be aware of changes to your hospital’s electronic data system(s).
Changes for the 2015 Rebaseline

• CLABSI
  ▪ Mucosal Barrier Injury Laboratory-Confirmed Bloodstream Infections (MBI-LCBI) events are now excluded from the CLABSI numerator.

• SSIs
  ▪ Events classified as present at time of surgery (PATOS) are now excluded from the SSI numerator.

For additional information, please visit the NHSN Rebaseline page: https://www.cdc.gov/nhsn/2015rebaseline/index.html
FAQs: Location Mapping

Question:
NHSN, While running my CLABSI and CAUTI IQR reports, I am unable to see my location 5WEST. I do not have any alerts and I know my data are complete. Why is this happening?

Answer:
IQR reports for CLABSI and CAUTI only include data from CMS reportable locations. As you can see, this unit is mapped at a telemetry unit, which is not required to be reported for CMS IQR program.
FAQs Location Mapping

• If your hospital does not have a unit that meets the CDC definition for an ICU, NICU, or one of the six ward types, your hospital may be eligible for a CLABSI/CAUTI exception.

• Details can be found on QualityNet: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021
FAQs: Monthly Reporting Plan

Question:
NHSN, While running my CAUTI IQR report Q3, I am unable to see July’s data for my medical/surgical unit. I do not have any alerts.

Answer:
This unit is not included in the CAUTI CMS IQR report because it is not included in the July MRP. If units are not included in the MRP, then they will not be included in the IQR reports or be sent to CMS.
FAQs: Survey Data and SIRs

Question:
NHSN, I’m reviewing my hospital’s data and the number of predicted infections and the SIR changed, but I did not add or edit any data. Why is it different?

Answer:
It’s likely that the changes are due to the changes or addition of your hospital’s annual survey.
FAQs: Survey Data and SIRs

NHSN will use the survey data for the year that matches the year of the HAI data, unless that survey does not yet exist in which the most recent survey is used.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Survey used at deadline</th>
<th>Survey used currently in NHSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 Q3</td>
<td>2015</td>
<td>2015</td>
</tr>
<tr>
<td>2015 Q4</td>
<td>2015</td>
<td>2015</td>
</tr>
<tr>
<td>2016 Q1</td>
<td>2015</td>
<td>2016, if entered (2015 if not entered yet)</td>
</tr>
<tr>
<td>2016 Q2</td>
<td>2015</td>
<td>2016, if entered (2015 if not entered yet)</td>
</tr>
<tr>
<td>2016 Q3</td>
<td>2016, if entered at time of deadline</td>
<td>2016, if entered</td>
</tr>
</tbody>
</table>
Additional Resources

- NHSN surveillance protocols for acute care hospitals
- Data entry and analysis training
  http://www.cdc.gov/nhsn/training/analysis/index.html
- NHSN SIR Guide
- 2015 rebaseline page
  https://www.cdc.gov/nhsn/2015rebaseline/index.html
- How to View Create & Modify Dates within NHSN
- How to Modify a Report
  https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/howtomodifyreport.pdf
- Reporting requirements and deadlines:
Questions or Need Help?

Email user support at nhsn@cdc.gov
Healthcare-Associated Infection (HAI) Measures: Reminders & Updates

Question & Answer Session
Continuing Education Approval

This program has been approved for 1.5 continuing education (CE) units for the following professional boards:

- **National**
  - Board of Registered Nursing (Provider #16578)

- **Florida**
  - Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
  - Board of Nursing Home Administrators
  - Board of Dietetics and Nutrition Practice Council
  - Board of Pharmacy

**Please Note:** To verify CE approval for any other state, license or certification, please check with your licensing or certification board.
CE Credit Process

• Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.

• After completion of the survey, click “Done” at the bottom of the screen.

• Another page will open that asks you to register in the HSAG Learning Management Center.
  
  o This is a separate registration from ReadyTalk®.
  o Please use your personal email to receive your certificate.
  o Healthcare facilities have firewalls up that block our certificates.
CE Certificate Problems

• If you do not **immediately** receive a response to the email that you signed up with in the Learning Management Center, you have a firewall up that is blocking the link that was sent.

• Please go back to the **New User** link and register your personal email account.
  - Personal emails do not have firewalls.
CE Credit Process: Survey

10. What is your overall level of satisfaction with this presentation?
- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
- Very dissatisfied

If you answered "very dissatisfied", please explain:

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

Powered by SurveyMonkey
Check out our sample surveys and create your own now!
Thank you for completing our survey!
Please click on one of the links below to obtain your certificate for your state licensure.
You must be registered with the learning management site.

New User Link:
https://lmc.hshapps.com/register/default.aspx?ID=da0a12bc-db39-4b8f-b429-d6f6b9ccbf1ae

Existing User Link:
https://lmc.hshapps.com/test/adduser.aspx?ID=da0a12bc-db39-4b8f-b429-d6f6b9ccbf1ae

Note: If you click the 'Done' button below, you will not have the opportunity to receive your certificate without participating in a longer survey.

Done
CE Credit Process: New User
CE Credit Process: Existing User
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