



## Transition to ICD-10-CM/PCS and CPT Codes

CDC continues to work on updated ICD-10-CM/PCS and CPT mappings to all NHSN operative procedure categories for SSI surveillance. These mappings are anticipated to be available by July 2014.

ICD-10-CM/PCS codes will replace ICD-9-CM codes on October 1, 2014 but NHSN will not have the ability to receive these codes until January 2015.

The NHSN guidance for entry of surgical denominator data for the last quarter of 2014 data is to enter the NHSN Procedure Code (e.g. COLO or HYST) but do not enter any ICD-10-CM/PCS codes associated with the procedure.

At the time of the January 2015 NHSN update will be able to accept the new ICD-10-CM/PCS codes. NHSN users will be able to enter the ICD-10-CM/PCS and CPT codes for January 1, 2015 procedures and SSIs going forward.

### Inside this issue:

Transition to ICD-10-CM/PCS and CPT Codes	<a href="#"><u>1</u></a>
Reminder! Data for CMS Quality Reporting Programs due Soon!	<a href="#"><u>2</u></a>
Updates for Including the Medicare Beneficiary Number (MBN) for Upcoming CMS Reporting	<a href="#"><u>3</u></a>
ASC Enrollment	<a href="#"><u>3</u></a>
Update on NHSN's Migration to SAMS	<a href="#"><u>4</u></a>
Clarifications to 2014 NHSN SSI Protocol	<a href="#"><u>4</u></a>
Is an Infection Device-associated if the Device has been Removed and Reinserted?	<a href="#"><u>5</u></a>
FAQs from the IPs	<a href="#"><u>5</u></a>
New! MDRO & CDI LabID Event Calculator	<a href="#"><u>6</u></a>
Present on Admission (POA)??? Make Sure!!	<a href="#"><u>7</u></a>
An Analysis Update Regarding New and Updated Protocols	<a href="#"><u>8</u></a>
Reminder about CDI Test Type	<a href="#"><u>8</u></a>
Refresher: Counting FacWideIN Patient Days and Admissions for MDRO/CDI Reporting	<a href="#"><u>9</u></a>
New Analysis Guides Available: Troubleshoot your SIR	<a href="#"><u>9</u></a>
NHSN Updates that could affect your facility!	<a href="#"><u>9</u></a>
Analysis Tip: Use Unique Names for Customized Output Options	<a href="#"><u>10</u></a>
Biovigilance Updates	<a href="#"><u>10</u></a>
CDA Corner	<a href="#"><u>11</u></a>
Items of Interest from CDC HAI Outbreak and Response Activity	<a href="#"><u>11</u></a>
NHSN Enrollment Update	<a href="#"><u>11</u></a>

## Reminder! Data for CMS Quality Reporting Programs due Soon!

### **Outpatient Dialysis Facilities that participate in the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP):**

The following data must be entered into NHSN by **April 15, 2014**.

2013 (January 1 – December 31) Dialysis Event data (includes positive blood culture, I.V. antimicrobial start, and signs of vascular access infection)

---

The following data must be entered into NHSN by **May 15, 2014** for facilities that participate in certain CMS quality reporting programs.

### **Acute Care Hospitals that participate in the Hospital Inpatient Quality Reporting (IQR) Program:**

2013 Quarter 4 (October 1 – December 31) CLABSI and CAUTI data (ICU locations only)

2013 Quarter 4 (October 1 – December 31) COLO and HYST SSI data

2013 Quarter 4 (October 1 – December 31) MRSA Bacteremia and *C.difficile* LabID Events (FacWideIN, all HO and CO)

2013 Quarter 4 & 2014 Quarter 1 (October 1 – March 31) Healthcare Personnel Influenza Vaccination Summary data

### **Inpatient Rehabilitation Facilities (IRFs) that participate in the Inpatient Rehabilitation Facility Quality Reporting Program:**

2013 Quarter 4 (October 1 – December 31) CAUTI data (all bedded inpatient locations)

### **Long-Term Acute Care Facilities (LTACs/LTCHs) that participate in the Long-Term Care Hospital Quality Reporting Program:**

2013 Quarter 4 (October 1 – December 31) CLABSI and CAUTI data (all bedded inpatient locations)

**NEW:** 2014 Quarter 1 (January 1 – March 31) CLABSI and CAUTI data (all bedded inpatient locations)

*Note: For this monthly deadline only, both Q4 2013 and Q1 2014 are due on the same date because of updates in the CMS reporting requirements.*

### **Cancer Hospitals that participate in the PPS-Exempt Cancer Hospital Quality Reporting Program:**

2013 Quarter 4 (October 1 – December 31) CLABSI and CAUTI data (all bedded inpatient care locations)

Please make sure at least one individual at your facility can access NHSN via an active digital certificate or SAMS and has been assigned appropriate user rights in NHSN so they may enter and view the facility's data. To ensure your data have been correctly entered into NHSN, please make sure to verify that your monthly reporting plans are complete, you've entered appropriate summary and event data, and you've cleared all alerts from your NHSN facility homepage. For additional guidance on ensuring your data are accurately sent to CMS for Quality Reporting purposes, please visit our website and navigate to the appropriate section(s) for your facility type:

<http://www.cdc.gov/nhsn/cms/index.html>.

If you have any questions, please contact the NHSN Helpdesk: [NHSN@cdc.gov](mailto:NHSN@cdc.gov).

## Updates for Including the Medicare Beneficiary Number (MBN) for Upcoming CMS Reporting

Beginning July 1, 2014, acute care facilities participating in the Hospital IQR Program, must enter the MBN on all event records for Medicare patients; MBN is not required to be entered on NHSN procedure records for Medicare patients at this time. Further, we've provided some additional clarification regarding the MBN below:

- A MBN is also known as a Health Insurance Claim Number (HIC or HICN).
- Not all Medicare Health Maintenance Organization (HMO) plans have a "standard" MBN or HIC number.
- Only enter the beneficiary's MBN if it is a "standard" or "valid" MBN.
- Do not enter dashes, spaces or special characters.
- All alpha characters must be upper case.
- Length cannot be less than 7 or more than 12 characters.
- Do not use 999999999999 for unknown numbers.

If the first character is numeric, the first 9 characters must be numeric.

MBN Length	Rule
10	9 numeric + 1 alpha
11	9 numeric + 1 alpha + 1 numeric OR 9 numeric + 2 alpha

If the first character is alpha, there must be 1-3 alpha characters followed by 6 or 9 numbers.

MBN Length	Rule
7	1 alpha + 6 numeric
8	2 alpha + 6 numeric
9	3 alpha + 6 numeric
10	1 alpha + 9 numeric
11	2 alpha + 9 numeric
12	3 alpha + 9 numeric

## ASC Enrollment

Ambulatory surgical centers (ASCs) that participate in CMS's Ambulatory Surgical Center Quality Reporting (ASCQR) Program must report healthcare personnel (HCP) influenza vaccination summary data via NHSN beginning with the 2014-2015 influenza season. CMS and NHSN will provide more detailed guidance and training for ASCs during the coming months, but for now ASCs are encouraged to begin the NHSN enrollment process.

If your ASC is already enrolled in NHSN, e.g., because your state requires your facility to report surgical site infections, you do not need to re-enroll the facility in NHSN to report HCP influenza vaccination summary data. You must have your NHSN Facility Administrator activate the Healthcare Personnel Safety Component by logging into NHSN and navigating to Facility > Facility Info, then checking the box for Healthcare Personnel Safety and clicking the "Update" button at the bottom of the screen.

NHSN enrollment information and resources for ASCs that are not already enrolled in NHSN may be found at <http://www.cdc.gov/nhsn/ambulatory-surgery/enroll.html> and will be updated with additional information as it becomes available. The following tips will also assist ASCs as they enroll in NHSN:

- Each CMS-licensed ASC should enroll in NHSN as a separate facility (i.e., they will have a unique NHSN OrgID) even if they are owned by or affiliated with a healthcare system or acute care hospital. These ASCs will have a separate 10 character alphanumeric CCN with a 'C' in the third position.
- During enrollment the NHSN Facility Administrator should identify the facility as an "AMB-SURG – Outpatient Surgery Facility."
- During enrollment the NHSN Facility Administrator should select the Healthcare Personnel Safety (HPS) Component on the "Facility Enrollment Page."

## Update on NHSN's Migration to SAMS

NHSN started its general migration to the Secure Access Management System, or SAMS, in late 2013. SAMS will soon replace the Secure Data Network (SDN) that is currently used by NHSN for user identity verification. This means that in the future, digital certificates will no longer be required to access NHSN. Unlike digital certificates, SAMS will not require you to install anything on your computer and it will not require an annual renewal. SAMS will allow NHSN users to access NHSN from any computer with a password and your SAMS grid card.

As of March 17, 2014, 730 NHSN users (approximately 3% of all users) completed their migration to SAMS and an additional 1,435 NHSN users (approximately 7% of all users) have been invited to begin the process. We are now inviting 500 existing NHSN users with expiring digital certificates to SAMS per week and all new users will be invited to SAMS without ever needing a digital certificate. At this rate, NHSN will complete its migration from SDN to SAMS sooner than we originally planned!

So far feedback about the process has been positive and there has been widespread agreement that SAMS is a welcome change from the use of digital certificates to access the NHSN application. However, we would like to remind our users of the following:

- When you complete the SAMS process you will receive an e-mail letting you know that you may access the SAMS Partner Portal. However, you must receive your SAMS grid card, which will be delivered to your home address via U.S. mail, before you may access NHSN through SAMS. Access to NHSN requires both an individual's password and information from their SAMS grid card.
- By using NHSN you have access to non-public information and U.S. law **requires** the identity of potential users to be verified. You will be expected to submit two forms of identification during the process. This step is critical to protect private data and to help prevent information misuse. Please be assured that every effort has been made to keep this necessary process as simple and non-intrusive as possible. Also be assured that your identity information will be only used to help determine your suitability for access to NHSN and that this data will not be shared.
- Each individual NHSN user has to be SAMified. As with digital certificates, SAMS accounts or profiles may not be shared. Remember, these systems allow for verification of the identity of each individual who accesses NHSN, which is important to protect the security of the system and the information it contains.
- Periodically check the users in your NHSN facility and deactivate the profiles of any users who no longer need access. This will prevent us from attempting to migrate them to SAMS.

For more information about SAMS and NHSN's migration to SAMS, please visit <http://www.cdc.gov/nhsn/sams/about-sams.html>. We will continue to keep you informed through our quarterly newsletters, our e-mails and updates, and our website, and please don't hesitate to contact [nhsn@cdc.gov](mailto:nhsn@cdc.gov) if you have questions or need assistance.

## Clarifications to 2014 NHSN SSI Protocol

- The definition for "Non-primary Closure" in the Key Terms and in the Table of Instructions for SSI "Denominator for Procedure" form was the 2013 definition when the January 2014 protocol was released this has been corrected and the current 2014 definition has been inserted in both places.
- "Not incidental to another procedure" should be deleted for APPY in Table 1 on page 3 of the SSI protocol.
- NOTE: The PJI definition in the HAI chapter on page 17-10 is correct (see below). There has been some confusion regarding criterion 3a. It has been confirmed that it is correct as written in the protocol.

### **PJI – Periprosthetic Joint Infection (following HPRO and KPRO only)**

Joint or bursa infections must meet at least 1 of the following criteria:

1. Two positive periprosthetic (*tissue or fluid*) cultures with identical organisms
2. A sinus tract communicating with the joint
3. Having three of the following minor criteria:
  - a. Elevated serum C-reactive protein (CRP; >100 mg/L) AND erythrocyte sedimentation rate (ESR; >30 mm/hr).
  - b. Elevated synovial fluid white blood cell (WBC; >10,000 cells/ $\mu$ L) count OR ++ (*or greater*) change on leukocyte esterase test strip of synovial fluid.
  - c. Elevated synovial fluid polymorphonuclear neutrophil percentage (PMN% >90%).
  - d. Positive histological analysis of periprosthetic tissue (>5 neutrophils (PMNs) per high power field).
  - e. A single positive periprosthetic (*tissue or fluid*) culture.

## Is an Infection Device-associated if the Device has been Removed and Reinserted?

**Q:** What if your patient has a Foley catheter or central line in place for several days, and then has it removed for a short period of time before another is reinserted? Is an infection that develops shortly after reinsertion and meeting NHSN criterion actually a device-associated infection (i.e. a CLABSI or CAUTI)?

**A:** Here is how to determine device-association in such a circumstance: If the patient is without the device for at least 1 full calendar day (NOT to be read as 24 hours), then the device day count will start anew. If instead, a device is reinserted before a full calendar day has passed, the device day count will continue. Please see the examples below for determining the number of Foley days. The same principles apply for determining the number of central line days with removal and replacement of a central line.

	March 31 (Hospital day 3)	April 1	April 2	April 3	April 4	April 5	April 6
<b>Example A</b>	Foley Day 3	Foley Day 4	Foley removed (Foley Day 5)	Foley replaced (Foley Day 6)	Foley Day 7	Foley Day 8	Foley Day 9
<b>Example B</b>	Foley Day 3	Foley Day 4	Foley removed (Foley Day 5)	No Foley	Foley replaced (Foley Day 1)	Foley Day 2	Foley Day 3

Rationale: NHSN surveillance for infection is not aimed at a specific device. Instead surveillance is aimed at identifying risk to the patient that is the result of device use in general. For the examples above, the patient in Example A is eligible for a CAUTI beginning on March 31, through April 6, and until the Foley is removed for at least a full calendar day.

The patient in Example B is eligible for a CAUTI on March 31 (Foley Day 3) through April 3 because a CAUTI may be identified the day after a device (which had been in place for more than 2 days) is removed. An additional CAUTI for this patient cannot be reported until April 6 (Foley Day 3) since the Foley day count starts over on April 4.

## FAQs from the NHSN IPs

**Q:** How can I determine which LabID Events are being counted in the numerator of my MRSA or *C. difficile* LabID Event SIR?

**A:** MRSA: All MRSA blood specimen hospital-onset (HO) events in which the patient did not have a previous positive MRSA bacteremia LabID event (hospital-onset or community-onset) in the prior 14 days in the facility. Run a line list sorted by "patient ID" and "specimenDate"; if the same patient had 2 MRSA LabID events (from two separate locations) within 14 days, the second "duplicate" event will be excluded from the SIR. Only those events where the "onset" variable = HO will be counted in the SIR. The variable = CO will be used in risk adjustment.

*C. difficile*: All *C. difficile* incident hospital-onset (HO) events. When looking at a *C. difficile* line list, the events that will be counted in the SIR have the "cdiAssay" variable = Incident, and the "onset" variable = HO. The variable = CO will be used in risk adjustment and the same 14 day duplicate exclusion applies as described above.

**Q:** With the new definition of an NHSN operative procedure, should NHSN procedures that did not have a primary closure be included in SSI surveillance?

**A:** As of 2014, incisional closure is NO LONGER a part of the NHSN operative procedure definition; all otherwise eligible procedures are included, regardless of closure type. In the denominator for procedure you will note the closure method as either "Primary Closure" or "Other than Primary."

**Q:** If a patient undergoes an NHSN operative procedure with non-primary closure and subsequently develops an infection that meets criteria for an SSI, must we include this case as an SSI in the numerator?

**A:** Yes, if the surgical procedure type is included in your monthly reporting plan and the patient meets criteria for an SSI it must be reported. It will be attributed and linked to the open procedure that is in your denominator data. Although these open procedures and subsequent SSIs are required to be reported, they are not being sent to CMS at this time. At this time, the SIRs will only be calculated for procedures with a primary closure method.

## FAQs from the NHSN IPs (continued)

**Q:** For ventilated patients with potential lower respiratory infections in adult patient care locations, how do I determine if a positive blood culture should be reported as secondary BSI or if it should be reported as a primary bloodstream infection / CLABSI?

**A:** We understand this is an area of confusion. Please note, first and foremost, for purposes of NHSN, for a bloodstream infection to be determined to be secondary to a primary infection site (i.e. related to an infection at another site, such that primary site of infection may have seeded the bloodstream secondarily) the patient must first meet one of the NHSN site specific definitions. For example, for a secondary bloodstream infection to be deemed secondary to PNEU, one of the NHSN PNEU definitions must be met first. You cannot call a bloodstream infection secondary to PNEU based on a physician's diagnosis of pneumonia, for example, or just by virtue of having a sputum and blood culture with matching pathogens.

To figure out whether a positive blood culture can be called a secondary bloodstream infection (BSI) related to a lower respiratory tract event, consider the following steps:

1). Does the patient meet any of the VAE definitions?

a). If the Possible or Probable VAP definition is met, then you may attribute the blood culture to the VAE (as a secondary BSI) if the blood culture meets the various requirements as outlined in the VAE protocol—the organism isolated from blood must match an organism isolated from the respiratory tract culture used in meeting the Possible or Probable VAP definition AND the blood culture must be collected during the 14-day VAE event period.

b). If only the VAC or IVAC definition is met, then the positive blood culture CANNOT be secondary to the VAE (because according to the VAE surveillance protocol, BSIs cannot be deemed secondary to VAC or to IVAC).

2). If the Possible VAP or Probable VAP definition is met, a positive blood culture can either be secondary to the VAE (if it meets the VAE secondary BSI criteria outlined in the protocol and summarized in 1a, above), or secondary to one of the other major HAI sites (e.g., if another Chapter 17 definition is met, including PNEU or LRI), or it may be a primary BSI/CLABSI.

3). If only the VAC or IVAC definition is met, or if no VAE definition is met, then the positive blood culture can be evaluated to see if it is secondary to any of the major sites as defined in Chapter 17—including PNEU or LRI. If the patient does not meet one of these other definitions, the BSI may need to be reported as a primary BSI/CLABSI.

---

The NHSN FAQ documents (updated January 2014) are now posted to the NHSN Website. Applicable FAQ documents are located on each surveillance event type page. These documents include answers to the most frequently asked questions concerning individual NHSN protocols, analyses, CDA, and the Annual Survey. Users are encouraged to review the FAQs before submitting a question to the NHSN mailbox.

## New! MDRO & CDI LabID Event Calculator

CDC has developed a brand new MDRO & CDI LabID Event Calculator. Version 1.0 operates based upon the currently posted (January 2014) LabID Event protocols in the NHSN Multidrug-Resistant Organism (MDRO) & *Clostridium difficile* Infection (CDI) Module. The calculator is a web-based tool that is designed to help users learn how to accurately apply the MDRO & CDI LabID Event algorithms and assist users in making the correct MDRO & CDI LabID Event determinations. Please note that the MDRO & CDI LabID Event Calculator does not ask users to enter any patient identifiers (other than dates of specimen collection, which can be changed as needed). The MDRO & CDI LabID Event Calculator does not save, store, or report any data that is entered. Likewise, LabID Event determination data are NOT reported to the NHSN application, and users will not be able to export data entered into the Calculator. Therefore, events that are determined by the Calculator to be LabID Events will need to be entered into the NHSN application either manually or via CDA. If you have questions or suggestions about the Calculator, please feel free to send them to the NHSN mailbox: [nhsn@cdc.gov](mailto:nhsn@cdc.gov).

NHSN MDRO & CDI LabID Event Calendar link: <http://www.cdc.gov/nhsn/labid-calculator/index.html>

## Present on Admission (POA)??? Make Sure!!

Some NHSN users are under the impression that a patient admitted with a clinical diagnosis of an infection is considered to have an infection present on admission (POA) for NHSN reporting. In this case, subsequent infections that meet infection criteria may be considered extensions of the original infection and not reported as a healthcare-associated infection. BE CAREFUL, THIS MAY NOT BE TRUE!

The NHSN manual states that an infection that is POA must have all of the required infection criteria during the POA time-period. The POA time period includes the 2 days before admission, the day of admission, and the day after admission [i.e. patient reported signs and symptoms must not be used to meet POA] (see table below).

Illustration of present on admission (POA) time frame			
2 calendar days before admission	1 calendar day before admission	Day 1 (Day of admission to inpatient location)	Day 2 (Day after admission to inpatient location)
March 30	March 31	April 1	April 2

Don't be fooled. If a patient does not fully meet criteria in the POA time period, any subsequent infections are eligible to be reported as healthcare-associated. Let's consider an example:

April 1: Patient admitted from home with diagnosis of UTI and multiple sclerosis. Foley catheter present on admission. Urinalysis performed on spun urine, positive for >10 WBC per high power field and leukocyte and nitrite positive. Urine culture collected. No provider documentation of elements of the UTI criteria on April 1 or 2 or the 2 days prior to admission. Blood cultures are collected on admission. Antimicrobial therapy started for presumed UTI.

April 2: Asymptomatic, Foley present. Urine culture results reported as positive for >100,000CFU/ml *E.coli*.

April 3: Asymptomatic, Foley present. Final blood culture results from April 1 show no growth.

April 4: Asymptomatic, Foley present.

April 5: Patient spikes fever to 101.0°C. Foley present.

April 6: Foley present, Tmax 101.2°C. Urine culture collected, positive for >100,000 CFU/ml of *E. coli*.

This patient has a catheter-associated urinary tract by NHSN definitions on April 6. The patient was asymptomatic in the first 2 days of admission, and did not have a matching positive blood culture to the urine culture. Therefore there was no POA symptomatic urinary tract infection (SUTI) nor POA asymptomatic bacteremic urinary tract infection (ABUTI). Because criteria for SUTI were met on day 6 of admission, this is a SUTI for this facility.

Rationale: The definition for POA infection has been very concrete since January 2013. It does not include physician diagnosis, unless physician diagnosis is a part of the NHSN infection definition. Physician diagnosis is not an element of the NHSN UTI definition. Therefore, clinical diagnosis and treatment of UTI alone cannot be used to determine that a UTI is present on admission. Since there was no NHSN UTI on admission, when the case-definition for UTI was met on April 6, it was reportable for CAUTI surveillance. Facilities should strive to ensure that full physical assessments are performed and results are documented to fully capture infections that are POA.

Be very careful when identifying POA infections.

## An Analysis Update Regarding New and Updated Protocols

Due to recent protocol changes in NHSN, we have been asked by many NHSN users about the availability of new benchmarks and/or risk adjustment. Below is information regarding some recent protocol updates and their impact on existing analytic reports.

**Height, Weight, Diabetes, and Procedure Closure Technique for SSIs:** Since these data were not reported prior to 2014 for risk adjustment purposes, these data will not be factored into the SIRs at this time, under the current 2006-2008 baseline. With regard to closure technique, the current SSI SIRs will exclude those procedures reported to NHSN with a closure technique that is “other than primary.” As data are reported, we will assess the potential for these variables to be used as risk factors in future SSI risk models.

**VAE:** After careful consideration, some changes were made to the protocols for this event type in 2014. Once we have at least a full year of VAE data reported, we can determine if the volume is sufficient with which to produce aggregate reports. Therefore, we do not yet have SIRs or national pooled means for this event type. Until national aggregate data are provided for VAE, hospitals may wish to perform internal comparisons of their VAE rates by using the NHSN Statistics Calculator. More information regarding the statistics calculator can be found here: <http://www.cdc.gov/nhsn/PS-Analysis-resources/PDF/StatsCalc.pdf>.

**MBI LCBIs:** The identification of CLABSIs as MBI-LCBI first became required in 2014. As with VAE, we will need at least one full year of data reported before we can make any final determinations as to how these MBIs should be handled analytically at a national level. Therefore, MBI-LCBIs that are central-line associated are currently included in all CLABSI rates and SIRs provided by NHSN.

## Reminder about CDI Test Type

As mentioned in the February 2014 NHSN release notes, data collection for the type of test used to identify CDI has been added to the MDRO/CDI Module’s summary data screen. This will allow CDC to provide more timely risk adjustment when calculating CDI LabID SIRs. When the summary data form is completed for the last month of each quarter (March, June, September, and December), users will be asked to report the primary type of test that was used to identify CDI in the hospital for that quarter.

The CDI test type choices appearing on the denominator form will be consistent with those that appear on the Annual Survey. As a reminder, “Other” should not be used to name specific laboratories, reference laboratories, or the brand names of *C. difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report. Because these data are used for determining risk adjustment for current and future national aggregate data, as well as for public reporting of data on Hospital Compare, these data should be reported as accurately as possible. If “Other” is selected when a more appropriate response is available, your facility’s data will not be risk-adjusted to the most appropriate level.

CDI LabID SIRs for 2014 and forward will be risk adjusted at the quarterly level using the test type submitted on the MDRO/CDI module’s summary data screen for the corresponding quarter (e.g., the CDI test type reported on the March 2014 denominator form will be applied to the 2014Q1 CDI LabID SIR). CDI LabID SIRs for 2012-2013 will continue to use the CDI Test Type as reported on the Annual Hospital Survey.



## Refresher: Counting FacWideIN Patient Days and Admissions for MDRO/CDI Reporting

We currently have over 3000 facilities reporting MDRO/CDI data into NHSN and many new facilities will begin collecting and entering these data for upcoming CMS quality reporting programs. If your facility is already reporting these data or if you're gearing up to report in the coming months, here are a few things to keep in mind about counting Patient Days and Admissions for your facility-wide inpatient counts.

- Observation patients housed in an inpatient location must be included in FacWideIN LabID Event reporting (include in both numerator and denominator). Observation patients housed in an outpatient observation location must be excluded from FacWideIN reporting.
  - Keep in mind that many billing systems do not include observation patients in the inpatient admission or patient day counts. If you receive monthly admission and patient day counts from your finance department, make sure observation patients are being included/excluded as appropriate depending on the units where they are being housed.
- For the FacWideIN admission count, include any new patients that are assigned to a bed in any inpatient location within the facility. Qualification as a new patient means that the patient was not present on the previous calendar day. The daily admission counts are summed at the end of the calendar month for a monthly facility-wide inpatient admission count.
  - Keep in mind that you should not be summing the admission counts from all inpatient locations for the monthly count. If a patient is admitted into multiple inpatient locations throughout their stay in the acute care facility they should still only count as 1 admission to the facility for the monthly FacWideIN admission count.

## New Analysis Guides Available: Troubleshoot your SIR

We have recently created analysis guides to help you troubleshoot your standardized infection ratios (SIRs) for each applicable HAI type. These guides present the most common problems users experience when trying to generate and interpret their SIRs, and provide additional explanations on how to solve and further investigate potential issues. Troubleshooting guides can be found on each of the HAI event type webpages, as well as on the [Analysis Quick Reference Guide](#) webpage.

General Tips for NHSN Analysis: <http://www.cdc.gov/nhsn/PS-Analysis-resources/PDF/General-Tips-NHSN-Analysis.pdf>

Troubleshooting CLABSI & CAUTI SIR: [http://www.cdc.gov/nhsn/PS-Analysis-resources/PDF/CLABSI CAUTI\\_Tips.pdf](http://www.cdc.gov/nhsn/PS-Analysis-resources/PDF/CLABSI CAUTI_Tips.pdf)

Troubleshooting SSI SIR: [http://www.cdc.gov/nhsn/PS-Analysis-resources/PDF/SSI-SIR\\_Tips.pdf](http://www.cdc.gov/nhsn/PS-Analysis-resources/PDF/SSI-SIR_Tips.pdf)

Troubleshooting MRSA and CDI SIR: [http://www.cdc.gov/nhsn/PS-Analysis-resources/PDF/MRSACDI\\_Tips.pdf](http://www.cdc.gov/nhsn/PS-Analysis-resources/PDF/MRSACDI_Tips.pdf)

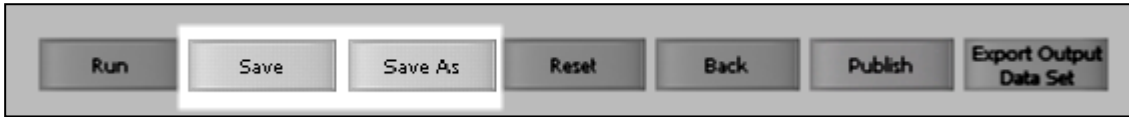
## NHSN Updates that could affect your facility!

In the next major release of NHSN, coming in July 2014, two reporting options will be removed from the system: the **Patient** Vaccination Module within the Patient Safety Component and the location type of "All Inpatient Beds Combined." Please take a minute to review whether either of these options have been used within your NHSN facility. The NHSN Team will be following up individually with all affected facilities prior to the July NHSN release.

## Analysis Tip: Use Unique Names for Customized Output Options

We are happy to see so many users creating and saving customized output options within NHSN!

When updating an existing Custom Output Option, users have the option to “Save” the changes, or “Save As”:



Clicking “Save” will save the changes within that same output option, similar to saving changes to a document.

Clicking “Save As” will save the changes as a brand new custom output option.

We noticed that some users have chosen to keep the same Output Name when using the “Save As” button. Remember that, when saving a custom output option, it’s highly recommended to use a unique Output Name.

**Modify Attributes of the Output:**

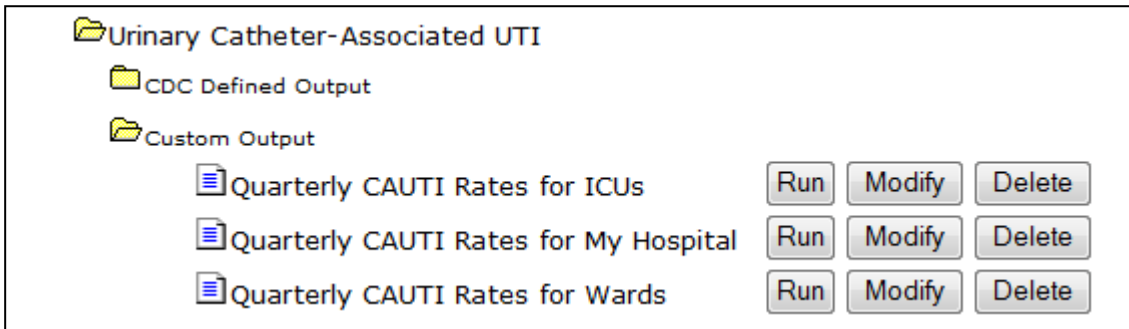
Last Modified On: **03/03/2014**

Output Type: **Rate Table**

Output Name:

Output Title:

Doing this will make it easier for you to find the option you need, when you need it!



For more tips on using the Analysis features in NHSN, please see our library of Quick Reference Guides, available at: <http://www.cdc.gov/nhsn/PS-Analysis-resources/reference-guides.html>.

## Biovigilance Component Updates

### 2013 Hemovigilance Module Annual Facility Survey

Facilities should begin working on their 2013 Annual Facility Survey. We recommend that facilities complete the form on paper before entering into NHSN. The paper version of the form can be found on our website (<http://www.cdc.gov/nhsn/acute-care-hospital/bio-hemo/index.html>). We are aware of an issue related to the ‘Print PDF Form’ link and survey question 8 and are working toward resolving the issue. However, the data entered on survey question 8 is saved correctly and the errors on the PDF are not included in the database.

## CDA Corner

- The CDA files for CLABSI, CLIP, Dialysis, and SSI events as well as surgical procedure denominators have changed significantly for 2014 data. If you try to import an older version of these CDAs for 2014 events or procedures, you will receive the error message: "The R2 or R5 format is not valid for these data." Please contact your vendor and ask them about their plans for rolling out the new "R9" version of these events for 2014 data.
- You may see a new option under "Facility" in the NHSN navigation bar for "CDA Automation." This is a new method of sending CDAs to NHSN that is currently being developed and tested. Unless you are explicitly told to do so by your CDA vendor, please do NOT enter any information in this screen. The only information that you need to provide before being able to manually import zip files of CDAs is your facility's object identifier, or OID, on the Facility Information screen.

## Items of Interest from CDC HAI Outbreak and Response Activity

### Emerging Infectious Diseases -- Carbapenem Resistance

In March 2014, CDC became aware of two *Pseudomonas aeruginosa* isolates from epidemiologically unrelated patients that tested as resistant to carbapenems but susceptible to aztreonam. Testing of these isolates identified that they possessed the gene for the Verona Integron-Encoded Metallo- $\beta$ -lactamase (VIM). If NHSN facilities are aware of *Pseudomonas aeruginosa* isolates meeting this phenotype (susceptible to aztreonam but resistant to carbapenems) they can be forwarded to CDC for testing for metallo- $\beta$ -lactamases via your state health department.

### Outbreaks of Infections Associated With Cosmetic Surgery Procedures

On March 7, CDC reported an outbreak of nontuberculous Mycobacterium (NTM) wound infections among medical tourists undergoing cosmetic surgeries in the Dominican Republic. (Full report found here: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6309a5.htm>.) Outbreaks and clusters of NTM and other types of infections have also been described in connection with U.S. cosmetic surgery clinics. NHSN facilities that become aware of these types of infections (in the course of evaluating a newly admitted patient with NTM infection, for example) should consider reporting potential cases to their state or local health department.

## NHSN Enrollment Update

### NHSN Enrollment Update (as of March 4, 2014):

5,684	Hospitals (this includes 558 Long-term Acute Care Hospitals and 291 Free-standing Inpatient Rehabilitation Facilities)
6,401	Outpatient Hemodialysis Facilities
340	Ambulatory Surgery Centers (ASCs)
218	Long-term Care Facilities
<b>12,643</b>	<b>Total Healthcare Facilities Enrolled</b>

The National Healthcare Safety Network (NHSN) is a voluntary, secure, Internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC.

During 2008, enrollment in NHSN was opened to all types of healthcare facilities in the United States, including acute care hospitals, long-term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities.



The Centers for Disease Control and Prevention (CDC)  
MS-A24, 1600 Clifton Road, Atlanta, GA 30333  
E-mail: [nhsn@cdc.gov](mailto:nhsn@cdc.gov); CDC's NHSN Website: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)