



Inside this Issue:

Patient Safety Component

Non-compliant Patients and Surveillance Protocols	2
Surgical Site Infection: Important Key Concepts and Reporting Instructions from 2018 Annual Training	2
Device Day Count for Determination of Device- associated Infections in 2018: Notes for Determining Catheter-association for UTI and Counting Denominator Days for CLABSI Surveillance	3
Acceptable Conditions for Marking “Central Line” Data Field “No” When Central Line is Present in 2018 and Beyond	7
Use of the PNEU Definition for Secondary BSI Assignment	9
Handling Temporarily Closed Outpatient Locations for MDRO/CDI Surveillance	10
Procedure Duration and Your Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)	11
HPRO and KPRO Guidance	12
AUR Updates	13
Reminder! Data for CMS Quality Reporting Programs due Soon!	15

Long Term Care Facility (LTCF) Component

2018 Long-term Care Facility Annual Training	16
--	--------------------

Healthcare Personnel Safety Component

Submission of Healthcare Personnel (HCP) Influenza Vaccination Summary Data in NHSN	16
---	--------------------

Dialysis Component

No updates at this time	—
-------------------------	---

Biovigilance Component

Hemovigilance Module Updates	18
------------------------------	--------------------

General NHSN Information

NHSN Training Updates	19
CDA Corner	20
NHSN Helpdesk: Activity Update	21
Enrollment Update	21

Patient Safety Component

Non-compliant Patients and Surveillance Protocols

From time to time NHSN has been asked if patients who are non-compliant with their health care can be excluded from healthcare-associated infection (HAI) surveillance. For instance, can a patient who does not care for a postoperative wound as directed, be excluded from surgical site infection surveillance? Can patients who are observed or suspected of contaminating medical devices, such as picking at, licking, biting, or smearing dirt or feces on intravascular lines be excluded from CLABSI surveillance?

In short, the answer is no, with a few exceptions, which we identify shortly. Encouraging and enabling good patient hygiene, and participation in one's care is a part of high-quality healthcare. Patient deviations from these are opportunities for improvement in patient care for the facility. Challenging patient scenarios do arise, and can sometimes require creative problem-solving to address and may also require increased attention to otherwise routine practices such as "scrub the hub" when accessing intravascular lines.

For Central-line Associated Bloodstream Infection (CLABSI) surveillance, NHSN has allowed the exclusion of specific behaviors such as observed or suspected injection into a vascular line by a patient or, in the case of Munchausen Syndrome by Proxy, their care-giver, when no instruction has been given to do so. In such cases, there must be clearly documented evidence that the vasculature has been, or is suspected of being directly accessed by such an individual.

Surgical Site Infection: Important Key Concepts and Reporting Instructions from 2018 Annual Training

1. SSI Surveillance Period: The surveillance period for an NHSN operative procedure is either 30 or 90 days depending on the NHSN operative procedure category and tissue level of SSI. Please note that the procedure date = day 1 of the surveillance period.

2. Deep incisional SSI Criterion B:

Deep Incisional SSI Criterion B must meet the following criteria:

The date of event for infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in [Table 2](#) of Chapter 9 SSI protocol

AND

involves deep soft tissues of the incision (for example, fascial and muscle layers)

AND

must meet the following:

b. a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee

AND

organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed)

AND

patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.

Surgical Site Infection continued on page 3

Surgical Site Infection: Important Key Concepts and Reporting Instructions from 2018 Annual Training (continued)

** The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician or physician's designee (nurse practitioner or physician's assistant).

NOTE: If a culture or non-culture based test from the deep tissue level has a negative finding Deep Incisional SSI Criterion B will not be met.

3. SSI Denominator Reporting Instruction (24-hour rule)

If a patient goes to the operating room more than once during the same admission and another procedure is performed through the same incision and if the start time of the second procedure is within 24 hours of the finish time of the original operative incision, report only one *Denominator for Procedure* form for the original procedure, combining the durations for both procedures based on the procedure start times and finish times for both procedures. For example, a patient has a CBGB lasting 4 hours. He returns to the OR six hours later for another NHSN operative procedure via the same incision (for example, CARD). The second operation has duration of 1.5 hours. Record the operative procedure as one CBGB and the duration of operation as 5 hour 30 minutes. If the wound class has changed, report the higher wound class. If the ASA class has changed, report the higher ASA class. Do not report the CARD procedure in your denominator data.

NOTE: When the patient returns to the OR within 24 hours of the end of the first procedure assign the surgical wound closure technique that applies when the patient leaves the OR from the first operative procedure.

4. SSI Frequently Asked Questions can be found here: <https://www.cdc.gov/nhsn/faqs/faq-ssi.html>

Device Day Count for Determination of Device-associated Infections in 2018: Notes for Determining Catheter-association for UTI and Counting Denominator Days for CLABSI Surveillance

Counting Device Days To Determine Catheter-association for UTI Surveillance

As of 2018, when a patient is admitted with a device in place, device day count **for determination of device-associated infections** begins with the admission date to the first inpatient location, regardless of how many days the device was in place prior to admission. (Please note that because central lines such as ports, can be in place on admission but not be accessed during the admission, or for several days/weeks after admission, central lines present on admission must also be accessed in the inpatient location before they are eligible for central-line associated bloodstream infections [CLABSI]).

From CAUTI surveillance perspective, in order to determine if the UTI is a CAUTI, this change has implications as it relates to use of fever in a patient > 65 years of age. In patients that are > 65 years of age, fever may not be used as an element until the Foley has been in place for greater than 2 days **as an inpatient** on the date of event. You will not need to know how long the Foley had been in place before admission. A reminder of this was placed in the SUTI 1a criterion in 2018 in addition to the reference of use of fever found in [SUTI 1b criterion](#). Additionally, please refer to [UTI FAQ # 8](#).

Device Day Count for Determination of Device- associated Infections in 2018: Notes for Determining Catheter-association for UTI and Counting Denominator Days for CLABSI Surveillance (continued)

Example 1: Patient > 65 years of age

2/1 and 2/2 fevers are not eligible in a patient > 65 years of age because the Foley was not in place > 2 days on the date of event in an inpatient location

Admit date: 2/1/2018

Hospital Day/Date	First Diagnostic Test	Infection Window Period (*)
1/31/2018		<input type="checkbox"/> Foley prior to admission
1. - 2/1/2018 - Admit Date		<input type="checkbox"/> Foley day #1 F ever
2. - 2/2/2018		<input type="checkbox"/> Foley day #2 F ever
3. - 2/3/2018	✓ DOE	<input checked="" type="checkbox"/> + urine culture F ever
4. - 2/4/2018	Meets SUTI 1a: CAUTI,	<input type="checkbox"/>
5. - 2/5/2018	DOE 2/3 HAI	<input type="checkbox"/>
6. - 2/6/2018		<input type="checkbox"/>

In example 1, the 2/3 urine culture sets the IWP: 1/31 – 2/6.

The 2/1 and 2/2 fevers cannot be used because the Foley was not in place > 2 days in the inpatient location on the date of event. The 2/3 fever is eligible to meet SUTI date of event 2/3 which is HAI. The Foley was in place > 2 days in an inpatient location on the DOE therefore this meets SUTI 1a: CAUTI.

Example 2: Patient > 65 years of age

In example 2, the 2/1 urine culture sets the IWP: 1/30 – 2/4.

The 2/2 and 2/3 fevers are not eligible because the Foley was not in place > 2 days in the inpatient location on the date of event. There are no other UTI signs/symptoms nor matching blood organism that can be used to meet ABUTI. Therefore there is no UTI event.

In rare situations such as these, please look for other UTI eligible signs/symptoms such as suprapubic tenderness or costovertebral angle pain or tenderness or matching blood organism to meet a UTI event.

2/2 and 2/3 fevers are not eligible in a patient > 65 years of age because the Foley was not in place > 2 days on the date of event in an inpatient location

Admit date: 2/1/2018

Hospital Day/Date	First Diagnostic Test	Infection Window Period (*)
1/30/2018		<input type="checkbox"/> Foley prior to admission
1/31/2018		<input type="checkbox"/> Foley prior to admission
1. - 2/1/2018 - Admit Date	✓	<input checked="" type="checkbox"/> + urine culture F oley day #1
2. - 2/2/2018		<input type="checkbox"/> F ever F oley day #2
3. - 2/3/2018	No UTI event	<input type="checkbox"/> F ever F oley day #3
4. - 2/4/2018		<input type="checkbox"/>

Device Day Count continued on page 5

Device Day Count for Determination of Device- associated Infections in 2018: Notes for Determining Catheter-association for UTI and Counting Denominator Days for CLABSI Surveillance (continued)

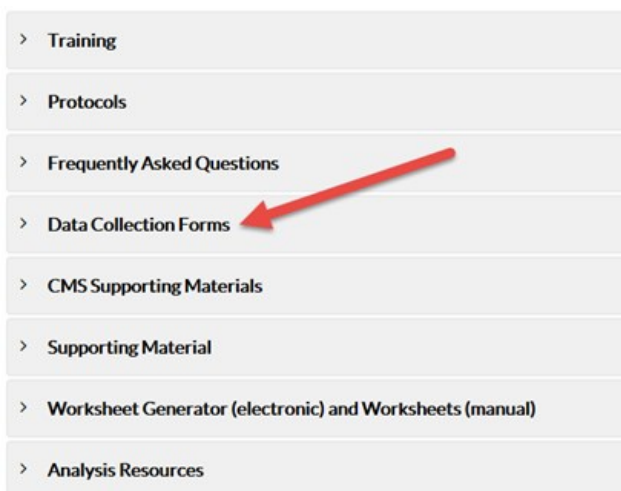
Counting Denominator Days for CLABSI Surveillance

In 2017, central lines that were present on admission were counted differently for denominator counts than central lines (CL) placed after admission. Specifically, pre-existing central lines were not to be included in central-line **denominator counts** (the number of central line days in a location for the month) until the day the line was first accessed during the admission. The rationale for this was that facilities should not be attributed a central-line associated bloodstream infection (CLABSI) for preexisting lines they had not accessed. If no CLABSIs could be attributed to these lines, then the lines should not be included in the denominator counts.

However, user feedback suggested that those doing manual counts (often support staff) may not know the access-status of a line and therefore may have included lines in denominator counts regardless of access. In an effort to simplify the data collection process and to be consistent with other device-associated events (UTI and VAE), the method for counting device days for denominator summary data has been changed for 2018. All central lines (of any type: permanent, including implanted ports, temporary and umbilical) are counted in the same way. Include the line in the CL denominator summary data beginning the first day it is present in an inpatient location. **In other words, if a central line, of any type (permanent-including implanted ports, temporary or umbilical) is present at the time of the denominator count, it is included regardless of access.**

Refer to the *Table of Instructions for Denominators* (for each area, NICU, SCA/Oncology, ICU & other than SCA and NICU) which includes instructions for counting device days for reporting denominator summary data. : <https://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html>

Table of Instructions for Denominators Forms tab found on the BSI landing page:



All Data Collection Forms are Print-only

- [57.108 Primary Bloodstream Infection \(BSI\) form January 2018](#) [PDF - 107K]
 - [Customizable form](#) [DOCX - 39K]
 - [Table of Instructions for BSI form 57.108](#) [PDF - 169K]
- [57.116 Denominators for Neonatal Intensive Care Unit \(NICU\) form January 2018](#) [PDF - 72K]
 - [Customizable form](#) [DOCX - 33K]
 - [Table of Instructions for Denominators for NICU form 57.116](#) [PDF - 131K]
- [57.117 Denominators for Specialty Care Area \(SCA\) form January 2018](#) [PDF - 42K]
 - [Customizable form](#) [DOCX - 29K]
 - [Table of Instructions for Denominators for SCA form 57.117](#) [PDF - 188K]
- [57.118 Denominators for Intensive Care Unit \(ICU\)/Other locations \(not NICU or SCA\) form January 2018](#) [PDF - 40K]
 - [Customizable form](#) [DOCX - 29K]
 - [Table of Instructions for Denominators for ICU form 57.118](#) [PDF - 191K]
- [57.103 Patient Safety Component—Annual Facility Survey form January 2018](#) [PDF - 92K]
 - [Table of Instructions for Patient Safety Component - Annual Hospital Survey 57.103](#) [PDF - 412K]

Device Day Count for Determination of Device- associated Infections in 2018: Notes for Determining Catheter-association for UTI and Counting Denominator Days for CLABSI Surveillance (continued)

TOI for NICU Denominators:

Number of patients with at least 1 central line (CL)	<p>Conditionally required. Complete if you have chosen central line-associated bloodstream infection (CLABSI) as an event to follow in your Plan for this month for this unit. All patients with at least 1 central line in place at the time of the count are included in the denominator regardless of the number of days the central line has been in place</p> <p>For each day of the month, at the same time each day, record the number of patients in each birthweight category on the selected unit who have at least 1 central line. At the end of the month, total the daily counts and record the sums by birthweight category for the month, in the NHSN system for Central Line Days under the option to Add Summary Data.</p>
--	---

TOI for SCA/Oncology Denominators:

Number of patients with at least 1 central line	<p>Conditionally required. Complete if you have chosen central line-associated bloodstream infection (CLABSI) as an event to follow in your Plan for this month. All patients with at least 1 central line in place at the time of the count are included in the denominator regardless of the number of days the central line has been in place.</p>
Temporary	<p>For each day of the month, at the same time each day, record the number of patients on the selected unit who have at least 1 non-tunneled or non-implanted central line. At the end of the month, total the daily counts and record the sum for the month in the NHSN system for Temporary Central Line Days under the option to Add Summary Data.</p>
Permanent	<p>For each day of the month, at the same time each day, record the number of patients on the selected unit who have at least 1 tunneled or implanted central line. At the end of the month, total the daily counts and record the sum for the month in the NHSN system for Permanent Central Line Days under the option to Add Summary Data.</p>

TOI for ICU & other areas (not NICU or SCA) Denominators:

Number of patients with at least 1 central line	<p>Conditionally required. Complete if you have chosen central line-associated bloodstream infection (CLABSI) as an event to follow in your Plan for this month. All patients with at least 1 central line in place at the time of the count are included in the denominator regardless of the number of days the central line has been in place.</p>
---	--

The instructions for counting central line days **for associating a bloodstream infection to a central line** (making CLABSI determination) has not changed in 2018.

Chapter 4 *Device-Associated Module-BSI* page 4-4 provides guidance for such events:

Notes:

1. If a patient is admitted to a *an inpatient* location with a central line (CL) already in place, and it is the patient's only CL, **the day of first access in an inpatient location begins the device day count as CL Day 1 for making device-associated determinations.** Note: simply "de-accessing" a central line (for example, removal of port needle but port remains in body) does not result in the patient's removal from CLABSI surveillance nor from including the central line in central line day counts.

Device Day Count for Determination of Device- associated Infections in 2018: Notes for Determining Catheter-association for UTI and Counting Denominator Days for CLABSI Surveillance (continued)

Eligible Central Line: A CL that has been in place for **more than two consecutive calendar days** (on or after CL day 3), following the *first access* of the central line, in an inpatient location, during the **current admission**. Such lines are **eligible for CLABSI events** and remain eligible for CLABSI events until the day after removal from the body or patient discharge, whichever comes first. See [Table 3](#) for examples

Stated again, counting central line days for making CLABSI determinations begins on the first day of access in an inpatient location. Access, is defined as insertion (during the current admission) or, if present on admission, the first day the line is used as an inpatient for infusion, blood draws or hemodynamic monitoring.

Example:

Date	Admit	HD 2	HD 3	HD 4	HD 5	HD 6	HD 7
CL Status Any type	CL in	CL in	CL in	CL in	CL in	CL in	CL in
Accessed	No	No	Yes	Yes	No De-accessed	No	No
Eligible for CLABSI event	No	No	No	No	Yes-eligible CL	Yes-eligible CL	Yes-eligible CL
CL day			CL day 1	CL day 2	CL day 3	CL day 4	CL day 5
Device day	D day 1	D day 2	D day 3	D day 4	D day 5	D day 6	D day 7

HD = Hospital day

CL day = central line day count for making device-associated determinations (CLABSI event)

D day = central line count for reporting device days as denominators in summary data

Acceptable Conditions for Marking “Central Line” Data Field “No” When Central Line is Present in 2018 and Beyond

NHSN added two new fields to the 2018 bloodstream infection (BSI) event form in the NHSN application, extracorporeal membrane oxygenation (ECMO) and ventricular assist device (VAD). Any application change that results in a need to change the infection control software used by facilities to transmit data to NHSN requires a phase-in process for implementation. Therefore, use of the ECMO and VAD fields is optional for 2018 but will be required in 2019.

Neither device is considered a central line (CL) for central line associated bloodstream infection (CLABSI) reporting purposes. However, there is an increased risk of acquiring a BSI in patients who have ECMO and VAD that may be independent of the presence of a central line. Therefore, when LCBI criteria are met in the presence of ECMO or VAD, the BSI will not be considered central line associated (not a CLABSI) **regardless of the presence of a central line**.

Acceptable Conditions for Marking “Central Line” Data Field “No” When Central Line is Present in 2018 and Beyond (continued)

Use of these two exclusions for (CLABSI) reporting requires positive blood specimen(s) meeting LCBI criteria accompanied by the presence of:

- Extracorporeal life support device, (ECLS or ECMO)

OR

- Ventricular assist device (VAD)

that has been in place for more than 2 days on the BSI date of event (DOE), and is still in place on the BSI DOE or the day before. To report these optional events, mark the “Central Line” risk factor field “No” and the appropriate device field, ECMO or VAD, “Yes”. See below:

BSI Event Form:

Risk Factors	
*If ICU/Other locations, Central line: Yes No	Any hemodialysis catheter present: Yes No
*If Specialty Care Area/Oncology, Permanent central line: Yes No	Extracorporeal life support present (e.g. ECMO): Yes No
Temporary central line: Yes No	Ventricular assist device (VAD) present: Yes No

Additional criteria allowing CLABSI exclusion will be phased-in using the following timeline:

CLABSI exclusions*	2018	2019	2020
Extracorporeal membrane oxygenation (ECMO)	Optional	Required	Required
Ventricular assist device (VAD)	Optional	Required	Required
Epidermolysis Bullosa (EB)	[†] Protocol only	Optional	Required
Munchausen’s syndrome by proxy (MSBP)	[†] Protocol only	Optional	Required
Patient self-injection	[†] Protocol only	Optional	Required
Group B Streptococcus BSI- 1st 6 days of life	[†] Protocol only	Optional	Required
Pus at vascular site	[†] Protocol only	Optional	Required

*Refer to Ch. 4 Device-Associated Module, BSI for complete reporting requirements.

[†] Exclusions are available for use in Ch. 4 BSI protocol but are not yet in the NHSN application.

NOTES:

1. All events listed above will set a BSI RIT and any associated device days should be included in the central line count for denominator summary data.
2. If a facility is reporting CLABSIs electronically to NHSN via Clinical Document Architecture (CDA), no CLABSI event is reported in these situations because they are not considered central line associated. Device days should NOT be included in central line counts for denominator summary data.

Use of the PNEU Definition for Secondary BSI Assignment

The PNEU event **can be used** as a site-specific infection for secondary BSI assignment when conducting BSI/CLABSI surveillance for **all patients**. This is true for:

.....patients in adult locations

.....patients in the NICU locations

.....patients in pediatric locations

.....patients in adult locations where VAE surveillance is being performed (regardless of an identification of a VAE)

.....patients who are ventilated or patients who are not ventilated

While it is true **PNEU** (Chapter 6) is only available as in-plan surveillance for PedVAP surveillance (pediatric locations only) and not available for in-plan PNEU/VAP surveillance for patients in adult or neonatal locations, the PNEU definition is still available for assigning secondary BSI attribution along with **UTI** (Chapter 7), **SSI** (Chapter 9) and **Definitions for Specific Types of Infections** (Chapter 17).

For purposes of BSI surveillance, in order to assign a Laboratory Confirmed Bloodstream Infection (LCBI) as secondary to a primary site of infection, one of the NHSN site-specific infection definitions must be fully met. After meeting a site-specific infection definition, one of the two scenarios outlined in the Secondary BSI Guide must also apply (Appendix B of the **BSI** protocol Chapter 4).

Scenario 1: An organism identified from the site-specific infection is used as an element to meet the site-specific infection criterion, AND the blood specimen contains at least one matching organism to that site-specific specimen. The positive blood specimen must be collected during the site-specific infection's secondary BSI attribution period.

OR

Scenario 2: An organism identified from a blood specimen is an element used to meet the site-specific infection criterion, and is collected during the site-specific infection window period.

Additionally note that, for ventilated patients in adult locations only, an LCBI may also be determined to be secondary to VAE as per the specific guidance provided in the **VAE** surveillance protocol. Secondary BSIs cannot be attributed to a VAC or IVAC. Secondary BSI may only be reported for PVAP when at least one eligible organism from the blood specimen that has a collection date in the 14-day event period matches an eligible organism from a respiratory tract specimen used to meet the PVAP definition.

Handling Temporarily Closed Outpatient Locations for MDRO/CDI Surveillance

Is your Emergency Department (ED) or 24-hour observation location temporarily closed for one or more months? The risk adjustment calculations for the FacWideIN MRSA and CDI SIRs take into account whether your facility is reporting LabID event data from EDs and 24-hour observation locations. To ensure your SIRs are accurately calculated when these outpatient locations are *closed*, please follow the guidance below:

Facilities that perform FacWideIN MRSA or *C. difficile* LabID Event surveillance that do not receive patients in a FacWideIN required outpatient location (specifically, Emergency Department and 24-hour Observation) for at least one month should not enter zero encounters on their outpatient MDRO and CDI denominator form for those months.

General	
Setting: Inpatient Total Patient Days :	<input type="text"/>
Total Admissions :	<input type="text"/>
Setting: Outpatient Total Encounters :	<input type="text" value="0"/>

Temporarily closed ED/24-hour observation locations should instead be set to **inactive** and removed from the MDRO section of the applicable Monthly Reporting Plans:

1. Set location to “Inactive” in Location’s Manager (Instructions on page 6 of June 2017 NHSN newsletter: <https://www.cdc.gov/nhsn/pdfs/newsletters/nhsn-nl-jun-2017.pdf>)
2. Go to applicable Monthly Reporting Plan
3. Click “Edit” at bottom of the form
4. Under the “Multi-Drug Resistant Organism Module”, locate the inactive location (will read “[INACTIVE]”)
5. Click the trash icon for this location for CDI and MRSA
6. Click “Save”

Multi-Drug Resistant Organism Module

Locations	Specific Organism Type														
<input type="checkbox"/> FACWIDEIN - Facility-wide Inpatient (FacWIDEIn) ▼	CDIF - C. difficile ▼														
Process and Outcome Measures <table border="1"> <thead> <tr> <th>Infection Surveillance</th> <th>AST-Timing</th> <th>AST-Eligible</th> <th>Incidence</th> <th>Prevalence</th> <th>Lab ID Event All Specimens</th> <th>Lab ID Event Blood Specimens O</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td>▼</td> <td>▼</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Infection Surveillance	AST-Timing	AST-Eligible	Incidence	Prevalence	Lab ID Event All Specimens	Lab ID Event Blood Specimens O	<input type="checkbox"/>	▼	▼	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Infection Surveillance	AST-Timing	AST-Eligible	Incidence	Prevalence	Lab ID Event All Specimens	Lab ID Event Blood Specimens O									
<input type="checkbox"/>	▼	▼	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>									
<input checked="" type="checkbox"/> [INACTIVE] 2WEST - OBSERVATION UNIT ▼	CDIF - C. difficile ▼														
Process and Outcome Measures <table border="1"> <thead> <tr> <th>Infection Surveillance</th> <th>AST-Timing</th> <th>AST-Eligible</th> <th>Incidence</th> <th>Prevalence</th> <th>Lab ID Event All Specimens</th> <th>Lab ID Event Blood Specimens O</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td>▼</td> <td>▼</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input checked="" type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Infection Surveillance	AST-Timing	AST-Eligible	Incidence	Prevalence	Lab ID Event All Specimens	Lab ID Event Blood Specimens O	<input type="checkbox"/>	▼	▼	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Infection Surveillance	AST-Timing	AST-Eligible	Incidence	Prevalence	Lab ID Event All Specimens	Lab ID Event Blood Specimens O									
<input type="checkbox"/>	▼	▼	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>									

Once the outpatient location has re-opened, please place this location back in “Active” status and confirm it is listed on the appropriate Monthly Reporting Plans.

Procedure Duration and Your Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)

The SSI SIR is impacted by the duration of the procedure. One of the universal exclusion criteria that is used to guide the SSI SIR is the exclusion of procedures with durations of less than 5 minutes or greater than the interquartile 5 (IQR5) procedure duration. The IQR5, also called the procedure duration cutoff point, is used as an indicator of an extreme outlier for procedure durations when calculating the SSI SIRs. The IQR5 is calculated as five times the interquartile range (Q1-Q3) above the 75th percentile, as represented in the 2015 National data. For example, if the interquartile range is 30 minutes, and the 75th percentile is 100 minutes, the IQR5 would be calculated as: $100 + (30 \times 5) = 250$ minutes. Procedures with a duration greater than the IQR5 were excluded from the baseline data and will be excluded from all SSI SIR calculations for your facility. Below is the list of the IQR5 values under the 2015 baseline.

Table 1. 2015 Baseline IQR5 Values for NHSN Operative Procedures, Adult and Pediatric Patients

NHSN Operative Procedure	IQR5 (in minutes)	IQR5 (in hours and minutes)	
	Minutes	Hours	Minutes
AAA	1116	18	36
AMP	300	5	0
APPY	210	3	30
AVSD	471.5	7	51.5
BILI	1295	21	35
BRST	777	12	57
CARD	1001	16	41
CBGB	847	14	7
CBGC	847	14	7
CEA	376	6	16
CHOL	346	5	46
COLO	697	11	37
CRAN	904	15	4
CSEC	170	2	50
FUSN	874	14	34
FX	532	8	52
GAST	489	8	9
HER	521	8	41
HPRO	349	5	49
HTP	1355	22	35
HYST	547	9	7
KPRO	316	5	16
KTP	670	11	10
LAM	687	11	27
LTP	1243	20	43
NECK	1796	29	56
NEPH	774	12	54
OVRV	594	9	56
PACE	311	5	11
PRST	737	12	17
PVBY	850	14	10
REC	1136	18	56
RFUSN	1129	18	49
SB	856	14	16
SPLE	1073	17	53
THOR	721	12	1
THYR	506	8	26
VHYS	506	8	26
VSHN	378	6	18
XLAP	724	12	4

Procedure Duration and Your Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) (continued)

Knowledge Check: How to apply the procedure duration exclusions to the SSI SIR reports.

QUESTION: Which of the procedures in the following scenarios will be excluded from the SSI SIR reports?

- a) A heart transplant procedure performed on a 45 year old female that lasted 1277 minutes
- b) A small bowel procedure performed on a 52 year old male that lasted 856 minutes
- c) An open reduction of fracture performed on a 17 year old male that lasted 533 minutes
- d) A breast procedure performed on a 25 year old female that lasted 4 minutes
- e) A thoracic surgery performed on a 38 year old male that lasted 712 minutes
- f) C and D

ANSWER: F

Rationale: The procedure in response option A is greater than 5 minutes but less than the IQR5 value so it will be included in the SSI SIR reports. The procedure in response option B is greater than 5 minutes and exactly at the IQR5 value, and therefore will be included in the SSI SIR reports. Procedure C is one minute above the IQR5 value and procedure D is less than 5 minutes so **both C and D** will be excluded from all SSI SIR Reports. Procedure E will be included in the SSI SIR reports because the duration is greater than 5 minutes but less than the IQR5 value.

HPRO and KPRO Guidance

Several of you have made us aware that there were codes missing from the “*Guidance for HPRO & KPRO Procedure Details*” which is posted at. This document has been updated.

The following HPRO codes have been added to the guidance document:

OSR9069	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
OSR906A	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
OSR906Z	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
OSRB069	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
OSRB06A	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
OSRB06Z	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
OSWA0JZ	Revision of Synthetic Substitute in Right Hip Joint, Acetabular Surface, Open Approach
OSWE0JZ	Revision of Synthetic Substitute in Left Hip Joint, Acetabular Surface, Open Approach
OSWR0JZ	Revision of Synthetic Substitute in Right Hip Joint, Femoral Surface, Open Approach
OSWS0JZ	Revision of Synthetic Substitute in Left Hip Joint, Femoral Surface, Open Approach

HPRO and KPRO Guidance continued on page 13

HPRO and KPRO Guidance (continued)

The following KPRO codes have been added to the guidance document:

OSWC0JC	Revision of Synthetic Substitute from Right Knee Joint, Patellar Surface, Open Approach
OSRC069	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
OSRC06A	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
OSRC06Z	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
OSRC0L9	Replacement of Right Knee Joint with Unicondylar Synthetic Substitute, Cemented, Open Approach
OSRC0LA	Replacement of Right Knee Joint with Unicondylar Synthetic Substitute, Uncemented, Open Approach
OSRC0LZ	Replacement of Right Knee Joint with Unicondylar Synthetic Substitute, Open Approach
OSRD069	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
OSRD06A	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
OSRD06Z	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
OSRD0L9	Replacement of Left Knee Joint with Unicondylar Synthetic Substitute, Cemented, Open Approach
OSRD0LA	Replacement of Left Knee Joint with Unicondylar Synthetic Substitute, Uncemented, Open Approach
OSRD0LZ	Replacement of Left Knee Joint with Unicondylar Synthetic Substitute, Open Approach
OSUD09C	Supplement Left Knee Joint with Liner, Patellar Surface, Open Approach
OSWC0JZ	Revision of Synthetic Substitute from Right Knee Joint, Open Approach
OSWD0JC	Revision of Synthetic Substitute from Left Knee Joint, Patellar Surface, Open Approach
OSWD0JZ	Revision of Synthetic Substitute from Left Knee Joint, Open Approach
OSWT0JZ	Revision of Synthetic Substitute from Right Knee Joint, Femoral Surface, Open Approach
OSWU0JZ	Revision of Synthetic Substitute from Left Knee Joint, Femoral Surface, Open Approach
OSWV0JZ	Revision of Synthetic Substitute from Right Knee Joint, Tibial Surface, Open Approach
OSWW0JZ	Revision of Synthetic Substitute from Left Knee Joint, Tibial Surface, Open Approach

AUR Updates

Reporting 2017 AU Data & Validation Outreach

As a reminder, please submit all outstanding 2017 AU data as soon as possible. The NHSN AU Team will be reviewing 2017 AU Option data in early 2018 to begin exploring the possibility of updating the current SAAR models and developing new models with additional location types. To ensure the most reliable and accurate models, NHSN tentatively anticipates excluding all locations with 1 or more months of missing and/or invalid 2017 data from the modeling process. Therefore, to maximize the number and types of locations assessed, we highly encourage facilities to ensure reporting is complete for the year 2017.

Additionally, in order to maintain SAAR accuracy and reliability when creating new models, data quality is of the utmost importance and we encourage continued data validation. Many facilities have received emails regarding potential AU antimicrobial days and days present validation issues. We encourage facilities receiving these emails to review the location(s)/month(s) identified by the NHSN AU Team and work to correct and re-upload the data (if necessary) no later than April 30. Data not fixed/uploaded prior to April 30 will not be included in the SAAR modeling update.

AUR Updates continued on page 14

AUR Updates (continued)

Important Update for AU Users with Custom NHSN User Rights

Users with customized rights will need their rights updated to see the community-onset (CO) Standardized Antimicrobial Administration Ratio (SAAR) on the SAAR analysis reports. Be sure to check at least the View box next to Patient Safety Annual Facility Survey on the custom user rights screen when assigning or updating a user's customized rights, as shown in the screenshot below.

Plan	View	Add,Edit	All Rights
Patient Safety Monthly Reporting Plan	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Annual Survey	View	Add,Edit	All Rights
Patient Safety Annual Facility Survey	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Analysis			
Patient Safety Data Analysis	<input checked="" type="checkbox"/>		

Access to the survey data is required in order to generate the CO SAARs due to the CO SAAR model including a survey variable. Our previously posted "User Rights in NHSN- AU Option" guidance document previously did not include survey access; this guidance has since been updated: <https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-au-user-rights.pdf>.

New AUR Module Resources Posted

- **New AU Option Annual Data Validation Guidance**

- The newly posted "AU Option Annual Data Validation Protocol" should be used on an annual basis or in the event of extreme high or low SAAR values. The questions were developed to focus validation efforts on key AU Option protocol definitions and common data errors. Check it out today! <https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/aur/annual-au-data-validation-508.pdf>

- **New Bar Chart Quick Reference Guide**

- The "Antimicrobial Use Bar Chart - Selected Drugs Quick Reference Guide" is located on our webpage under Analysis Resources: <https://www.cdc.gov/nhsn/acute-care-hospital/aur/index.html>. This Quick Reference Guide shows how to run the Bar Chart - All Data- Selected Agent Distribution by Month. The bar chart shows selected agent distribution by location and month so facilities are able to generate a graphical representation of antimicrobial use. This new bar chart is especially helpful for determining which antimicrobials are being used the most within a specific SAAR category.

- **New AU Option and AR Option FAQs**

- FAQs for both Antimicrobial Use and Antimicrobial Resistance Options have been posted on our webpage under Frequently Asked Questions: <https://www.cdc.gov/nhsn/acute-care-hospital/aur/index.html>. These FAQs reflect common questions that we receive from users including general reporting, troubleshooting CDA file upload errors, interpreting analysis reports and more!

Reminder! Data for CMS Quality Reporting Programs due Soon!

The following data must be entered into NHSN by **May 15, 2018** for facilities that participate in certain CMS quality reporting programs.

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

2017 Quarter 4 (October 1 – December 30) CLABSI and CAUTI data

- All ICU locations
- Adult and pediatric medical, surgical, and medical/surgical wards

2017 Quarter 4 (October 1 – December 30) Inpatient COLO and HYST SSI data

2017 Quarter 4 (October 1 – December 30) MRSA Bacteremia and *C. difficile* LabID Events (all healthcare-onset and community-onset)

- FacWideIN
- ED and 24-hour observation locations

2017 Quarter 4 & 2018 Quarter 1 (October 1 – March 31) Healthcare Personnel Influenza Vaccination Summary data

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

2017 Quarter 4 (October 1 – December 30) CLABSI and CAUTI data (all bedded inpatient care locations)

2017 Quarter 4 (October 1 – December 30) Inpatient COLO and HYST SSI data

2017 Quarter 4 (October 1 – December 30) MRSA Bacteremia and *C. difficile* LabID Events (all healthcare-onset and community-onset)

2017 Quarter 4 & 2018 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:

2017 Quarter 4 (October 1 – December 30) CAUTI data (all bedded inpatient locations)

2017 Quarter 4 (October 1 – December 30) MRSA Bacteremia and *C. difficile* LabID Events (all healthcare-onset and community-onset)

- Freestanding IRFs: Reporting by FacWideIN
- IRF units within acute care or critical access hospitals: Reporting by each CMS IRF unit

2017 Quarter 4 & 2018 Quarter 1 (October 1 – March 31) Healthcare Personnel Influenza Vaccination Summary data

- IRF units within acute care or critical access hospitals must submit a separate summary record specifically for the IRF unit: <http://www.cdc.gov/nhsn/pdfs/training/vaccination/hcp-flu-vaccination-summary-reporting-irf-training-slides.pdf>.

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

2017 Quarter 4 (October 1 – December 30) CLABSI and CAUTI data (all bedded inpatient locations)

2017 Quarter 4 (October 1 – December 30) MRSA Bacteremia and *C. difficile* LabID Events (FacWideIN, all healthcare-onset and community-onset)

2017 Quarter 4 (October 1 – December 30) VAE data (all bedded inpatient locations)

2017 Quarter 4 & 2018 Quarter 1 (October 1 – March 31) Healthcare Personnel Influenza Vaccination Summary data

Inpatient Psychiatric Facilities (IPFs) that participate in the Inpatient Psychiatric Facility Quality Reporting Program:

2017 Quarter 4 & 2018 Quarter 1 (October 1 – March 31) Healthcare Personnel Influenza Vaccination Summary data

- IPF units within acute care or critical access hospitals must submit a separate summary record specifically for the IPF unit: <http://www.cdc.gov/nhsn/pdfs/training/vaccination/hcp-flu-vax-summary-reporting-ipf-training.pdf>

Reminder! Data for CMS Quality Reporting Programs due Soon! (continued)

Ambulatory Surgical Centers (ASCs) that participate in the Ambulatory Surgical Center Quality Reporting Program:
2017 Quarter 4 & 2018 Quarter 1 (October 1 – March 31) Healthcare Personnel Influenza Vaccination Summary data

Dialysis Facilities that participate in the CMS End Stage Renal Disease (ESRD) Quality Incentive Program (QIP):
2017 Quarter 4 & 2018 Quarter 1 (October 1 – March 31) Healthcare Personnel Influenza Vaccination Summary data

Please make sure at least one individual at your facility can access NHSN via 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: 1) your monthly reporting plans are complete, 2) you've entered appropriate summary and event data or checked the appropriate no events boxes, and 3) 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: <https://www.cdc.gov/nhsn/cms/index.html>

Long-term Care Facility Component

2018 Long-term Care Facility Annual Training

The National Healthcare Safety Network's (NHSN) 2018 Long-term Care Facility Annual Training is scheduled to take place July 16 - 18, 2018 in Atlanta at the CDC. All three days will be dedicated to Infection Prevention and Surveillance in the Long-term Care Facility setting. Speakers will discuss a variety of topics including antibiotic stewardship, prevention and surveillance for UTI, C. difficile, multi-drug resistant organisms, antibiotic stewardship, and more. Users will also have the opportunity to participate in hands-on NHSN navigation and analysis training. Stay tuned for more information later this year.

Additional updates can be found in the LTCF newsletter, available here: <https://www.cdc.gov/nhsn/ltc/newsletters/index.html>

Healthcare Personnel Safety Component

Submission of Healthcare Personnel (HCP) Influenza Vaccination Summary Data in NHSN

Submission of Healthcare Personnel (HCP) Influenza Vaccination Summary Data in NHSN

Several facilities have contacted NHSN to request assistance with verifying their facility's HCP influenza vaccination summary data. While data verification is important for all facilities, those required to submit data to CMS should be particularly mindful: <https://www.cdc.gov/nhsn/pdfs/cms/cms-reporting-requirements.pdf>.

As we approach the May 15 submission deadline for the 2017-2018 influenza season, we have outlined some guidance to help facilities check their HCP vaccination data.

Submission of Healthcare Personnel (HCP) Influenza Vaccination Summary Data in NHSN (continued)

Data Verification in NHSN

NHSN does not provide a confirmation e-mail to facilities once they have submitted their data. CDC assists with routinely verifying HCP influenza vaccination summary data during the first year of data reporting for a CMS program as a courtesy to facilities. After the first year, facilities should follow the steps below to verify data. Facilities should also maintain printed copies or screenshots of their data entry for their records.

1. Ensure that your facility is enrolled in NHSN as the correct facility type. You can view this information on the Facility Information page for your facility in NHSN. For example, if your facility is an ambulatory surgery center, it should only be enrolled in NHSN as “AMB-SURG – Outpatient Surgery Facility.” If you have questions about your NHSN facility type, please contact NHSN@cdc.gov for assistance.
2. Ensure that the correct facility CMS Certification Number (CCN) and CCN effective date have been entered into the “Facility Information” page of NHSN. Specific guidance on adding/Updating the facility CCN and CCN effective date within NHSN can be found here: www.cdc.gov/nhsn/pdfs/cms/changing-ccn-within-nhsn.pdf.
3. Run a CMS Line Listing Report to ensure that data have been correctly entered into NHSN. Directions on how to run these reports are located by facility type under the “CMS Reporting” heading at this link: www.cdc.gov/nhsn/cms/index.html. This line listing shows what data for your facility will be shared with CMS.
4. In addition to the three steps above, ambulatory surgery centers can use the NHSN Status Listing Tool at: www.qualityreportingcenter.com/asc/nhsn-listing/ to determine whether their data have been entered into NHSN and included in the data files shared with CMS. By entering the facility CCN, facilities can verify that their data were entered successfully for the current reporting period. Please note that this tool is only updated periodically, and a “date last updated” is indicated on the website. If your data were entered into NHSN close to or after this date, it may not be reflected on the website. Therefore, you would need to wait until the next time the tool is updated to confirm your data.

As long as your facility is enrolled as the correct facility type, your CCN and CCN effective date are correct, and your data appear in the CMS Line Listing for the current reporting period, no further action is required on your part. Your data will be shared with CMS following the reporting deadline established by CMS for your facility type.

Also, please note that some facilities are required to report HCP influenza vaccination summary data not only to NHSN to meet CMS reporting requirements, but to other entities, such as their state or city. For non-CMS reporting requirements, facilities will need to determine if reporting through NHSN is sufficient to meet these requirements, or if data must be transmitted via another mechanism. For your reference, more information about reporting requirements, along with a data submission checklist can be found here: <https://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/verification-hcp-flu-data.pdf>

Submission of Healthcare Personnel (HCP) Influenza Vaccination Summary Data in NHSN (continued)

Data Verification in Quality Net

Acute care facilities, ambulatory surgery centers, inpatient psychiatric facilities, and PPS-exempt cancer hospitals may also check Quality Net to verify that their data have been received by CMS. Please note that the Quality Net reports are only updated periodically. Therefore, we kindly ask that you refrain from contacting the NHSN Helpdesk until after you have verified that you entered your HCP influenza vaccination summary data prior to the date listed on the Quality Net report. If you confirmed your data within NHSN using the steps listed above, but your data are not appearing on Quality Net, then you will need to take the following action:

1. Run a Quality Net Report for the first quarter of the reporting year. Since the HCP influenza vaccination summary reporting crosses two quarters, we classify the data as part of quarter one in the second year of the influenza season. For example, if you are reporting data for the 2017-2018 influenza season, you will need to run a Quality Net report for Q1 2018.
2. Check the Quality Net website to determine if there are any known issues in the Quality Net system that may be preventing your data from appearing as completed. To do so, click on the following link: www.qualitynet.org and then click on your facility type under “Known Issues – Hospital Reporting” box on the left-hand side of the webpage.
3. *If you are still unable to confirm submission of data using the Quality Net reports after completing these two steps, please reach out to Quality Net about this as CDC does not oversee these particular reports.*

We greatly appreciate your help with data verification, since responding to these requests delays our ability to rapidly resolve issues for facilities that are encountering difficulties collecting or entering their data.

If you have any questions, please contact: nhsn@cdc.gov and specify “HPS Flu Summary” along with your facility type in the subject line of the e-mail.

Biovigilance Component

Hemovigilance Module Updates

Complete Annual Facility Survey

Each year, facilities should complete the Annual Facility Form during January. If you have not yet completed the form, please do so as soon as possible. This report provides CDC with facility and transfusion services characteristics. CDC uses these descriptive data to provide context for aggregated analyses. To assist with data entry for question 17 (total number of transfused units annually), refer to the Annual Facility Survey Question 17 Quick Reference Guide.

Upcoming Webinar

Do you have a question about the Hemovigilance Module? Send the Hemovigilance Team your questions about data reporting requirements, the Analysis feature, or any additional items. We will share the answers during a live presentation on **Wednesday, March 28, 2018 from 1-2 pm EST**. You can email your questions to Misha Baker, xwt1@cdc.gov. Registration details will be sent out in a forthcoming email to all HV users.

Hemovigilance Module Updates (continued)

Website Updates

Several new trainings have been posted on the NHSN Hemovigilance website. The Hemovigilance Module: Introduction to Analysis is a new self-paced online training that guides users through the basics of using the NHSN Hemovigilance Analysis feature and can be completed for Continuing Education credits.

Additionally, four new Quick Reference Guides are now available on the website. These cover how to:

- [Correctly report incidents \(some quick tips!\)](#)
- [Use the Analysis feature to complete parts of the Annual Facility Survey](#)
- [Interpret the new auto-designation feature on the Adverse Reaction form](#)
- [Correctly report DSTR reactions which do not meet NHSN timeframe criteria](#)

Closing Out Data

CDC would like to remind facilities to address any missing data for 2017. Check the alerts on the Biovigilance Component Home Screen to see which data are missing. Please send questions and feedback to nhsn@cdc.gov and include 'Hemovigilance' in the subject line for the fastest response.

General NHSN Information

NHSN Training Updates

We want to thank everyone for their participation in NHSN Annual Training, "Accurately Reporting Healthcare-Associated Infections to NHSN in 2018" in Atlanta on February 26 – March 2, 2018. Three hundred individuals accepted invitations to travel to Atlanta to attend, and live webstreaming was available for those unable to attend training in-person. Live webstream attendance was as high as 10,000 individuals on any single day of the training.

The training included presentations on the general changes for 2018 NHSN reporting and described new analysis tools. Speakers discussed how to identify and report Ventilator-associated Events, Catheter-associated Urinary Tract Infections (CAUTI), Central Line-associated Blood Stream Infections (CLABSI), Secondary Bloodstream Infection (BSI) and Site-Specific Infections, Surgical Site Infections (SSI), and MRSA Bacteremia and *C. difficile* LabID events. Validation of healthcare-associated infection data and antibiotic stewardship surveillance practices and the NHSN Antibiotic Use and Resistance Module were also reviewed.

The archived webstream video of each session and all presentation slides will be posted to the NHSN website in the coming months, and NHSN will provide a notification when these are available. We want to thank everyone for the successful turnout and your participation. If you have questions about the training, please contact us at NHSNTrain@cdc.gov

Continuing Education

Continuing Education (CE) credits will be available later in the spring for those who watched the NHSN Training via web stream. NHSN will send an announcement with instructions on how to obtain CE credits once online training and CE credits are available. CEs that will be available include CME, CNE, CPH, and CEU. Please contact NHSNTrain@cdc.gov with any questions regarding continuing education for NHSN training activities.

CDA Corner

There are no CDA version changes for the 8.9 NHSN April 2018 deployment.

Change Requests Implemented in NHSN v8.9 Release that affect CDA Reporting

Refer to the v8.9 vendor IDM for details.

- SSI event: Specific Event HEP no longer available for SSI for a LTP procedure
- ICD-10 and/or CPT corrections have been entered on the 2017 and 2018 Procedure Code tabs in the v8.9 Vendor IDM. After the v8.9 deployment in April, the codes will be effective for all of 2017 and 2018, respectively.

AUR Module Updates

Check the [AUR Updates](#) section of the Newsletter for a list changes made in the AUR Module within NHSN 8.8.

CDA Version Guide Always Available!

The Guide to CDA versions on the NHSN CDA Submission Support Portal is always available to verify you are submitting CDAs based on the correct Implementation Guide: <http://www.cdc.gov/nhsn/cdaportal/toolkits/guidetocdaversions.html>.

NHSN CDA Submission Support Portal (CSSP)

Guide to CDA Versions

For creating CDA files, please see the specific Implementation Guide (IG) and its associated reference materials. The table below describes the specific Implementation Guide (IG) to be used for each component based on the event/insertion/procedure/specimen collection dates (as applicable) for each year.

Events or Denominators	2018	2017	2016	2015
CDA Toolkit Release	8.8	8.6	8.5	8.4 & 8.3
DIALYSIS				
Dialysis Event	R3-D1.1	R3-D1	R2-D2.1	R2-D1.1
Dialysis Denominator	R3-D1	R3-D1	R7	R7
EVENTS				
Primary Bloodstream Infection (BSI)	R9	R9	R9	R9
Central Line Insertion Practices Adherence (CLIP) Monitoring	R2-D2.1	R2-D2.1	R2-D2.1	R9
Urinary Tract Infection	R2-D1.1	R2-D1.1	R2-D1.1	R2-D1.1

Upcoming CDA Vendor Webinar

The next CDA vendor webinar will be held on April 13, 2018. This webinar will provide highlights on CDA related changes for upcoming 8.9 and 9.2 NHSN releases.

As an Important Reminder...

Not all NHSN changes are documented in the IDM so be sure to reference the updated protocols. Other helpful links are the following:

- Archived Newsletters: <https://www.cdc.gov/nhsn/newsletters/index.html>
- Archived NHSN email communication: <https://www.cdc.gov/nhsn/commup/>

CDA and CSV Import Metrics Update:

Percentage of data per specific event or summary that is imported via CDA and CSV as a percentage of all submitted data to NHSN for the following date ranges:

Query Date Range	April 1, 2016 - March 31, 2017	July 1, 2016 - June 30, 2017	Oct. 1, 2016 - Sept. 30, 2017
Blood Stream Infection	36%	37%	40%
Urinary Tract Infection	34%	36%	38%
Surgical Site Infection	27%	27%	29%
Laboratory Identified Event	49%	52%	54%
Dialysis Event	50%	56%	66%
Antimicrobial Resistance Event	100%	100%	100%
Surgical Procedure - via CDA	36%	35%	35%
Surgical Procedure - via CSV	37%	43%	38%
ICU /Other Summary	20%	21%	22%
SCA/ONC Summary	22%	23%	24%
NICU Summary	20%	21%	21%
MDRO Summary	6%	6%	6%
Dialysis Summary	38%	43%	52%
Antimicrobial Use	100%	100%	100%
Antimicrobial Resistance Summary	100%	100%	100%
Hemovigilance Summary	0%	0%	0%

NHSN Help Desk Activity Update

Quarter 1, 2018

(Averages)

1,055 Email Inquiries per Week

27 Facilities Enrolled per Week

NHSN Enrollment Update

NHSN Enrollment Update (as of March 23, 2018):

7,015 Hospitals (this includes 531 Long-term Acute Care Hospitals and 351 Free-standing Inpatient Rehabilitation Facilities)

7,219 Outpatient Hemodialysis Facilities

5,058 Ambulatory Surgery Centers (ASCs)

3,269 Long-term Care Facilities

22,561 Total Healthcare Facilities Enrolled

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; CDC's NHSN Website: www.cdc.gov/nhsn