Instructions for Completion of the Patient Safety Annual Facility Survey for LTAC (CDC 57.151)

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2020, a facility would complete a 2019 survey.
Facility Characteristics	
Ownership (check one)	*Required*. Select the appropriate ownership of this facility: • For profit • Not for profit, including church • Government • Veterans Affairs
Affiliation (check one)	*Required.* Select the appropriate affiliation for this facility: • Independent – The facility is a stand-alone facility that does not share a building, staff, or policies (such as infection control) with any other healthcare institution. • Hospital system – The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. Facility may or may not share staff as well as a building with other facilities that are part of that hospital system. • Multi-facility organization (specialty network) – The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure.
Setting/Classification: If classified as "Free-standing", does your LTAC hospital share physical housing with one or more of the following on-site facilities or units? (check all that apply)	*Required.* Select the physical setting of the facility: free-standing or within a hospital. *Conditionally Required.* If facility is classified as free-standing, select one or more of the following facility or unit types that share physical housing with your LTAC: • No (none) • Skilled nursing facility (SNF)/nursing home • Residential facility (assisted living) • Inpatient rehabilitation facility • Neuro-behavioral unit or facility • Other: specify
If classified as "Within a hospital", is your LTAC hospital located:	*Conditionally Required.* If facility is classified as within a hospital, indicate 'Yes' or 'No' if it is: • In a building that does not provide acute care services (e.g., psychiatric hospital) • Near (but not within) an acute care hospital

Facility Characteristics (continued)	
Number of Patient Days	*Required.* Enter the total number of patient days for your hospital during the last full calendar year.
Number of Admissions	*Required.* Enter the total number of inpatient admissions for your hospital during the last full calendar year.
Average daily census	*Required.* Enter the average number of patients housed each day during the last full calendar year. Please round to the nearest whole number.
Numbers of LTAC beds in the following categories (categories should equal total number of beds)	*Required.* Enter the total number of LTAC beds in each on the following categories during the last full calendar year: • Intensive care unit (ICU) or critical care beds • High observation/special care/high acuity beds (not ICU) • General LTAC beds
Total number of LTAC beds (licensed capacity)	*Required.* The total number of LTAC beds in the facility during the last full calendar year will be automatically summed based on the above counts.
Number of single occupancy rooms	*Required.* Enter the total number of single occupancy rooms during the last full calendar year.
Total number of admissions with one of the following conditions identified on admission	*Required.* Enter the total count of patients identified on admission or upon initial assessment and review of patient during admission with the following conditions (Note: these categories are not mutually exclusive). • Ventilator dependence • Hemodialysis For a list of ICD-10 and DRG codes associated with these conditions please review this spreadsheet: http://www.cdc.gov/nhsn/xls/DRGs-ICD-9s-NHSN-LTAC-Survey.xlsx

Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
1. Does your facility have its own on-site laboratory that performs antimicrobial susceptibility testing? If No, where is your facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used, indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.

Facility Microbiology Laboratory Practices (continued)	
2. For the following organisms, please indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism. Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.
3. Has the laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
4. Has the laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
5. Does the laboratory perform a test for the presence of carbapenemase?	*Required.* Select 'Yes' if your laboratory performs a test for carbapenemase production; otherwise, select 'No'.
If Yes, please indicate what is done if carbapenemase production is detected (check one).	*Conditionally Required.* If 'Yes', specify what is done if carbapenemase production is detected.
If Yes, which test is routinely performed to detect carbapenemase (check all that apply)?	*Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase.
If Yes, does the laboratory have a policy to routinely notify any of the following when CP-CRE are detected?	*Conditionally Required.* If 'Yes', specify if laboratory has policy to notify Physician or Infection Control when CP-CRE are detected.

6. Does the laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram-negative bacilli? If Yes, indicate methods (check all that apply).	*Required.* Select 'Yes' if your laboratory performs colistin or polymyxin B susceptibility testing for drug-resistant gram-negative bacilli; otherwise, select 'No'. *Conditionally Required.* If 'Yes', select the method(s) used from the choices provided. If 'Other' is selected, please specify.
7. Which of the following methods are used for yeast identification at your facility's laboratory or at the outside laboratory serving your facility? (check all that apply)	*Required.* Select from the choices listed one or more the method(s) used for yeast identification at your facility's laboratory the outside laboratory serving your facility. If 'Other' is selected, please specify.
8. *Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)	*Required.* Select from the choices listed, one or more body sites from which *Candida* is routinely identified to the species level without a specific request from a clinician. If 'Other' is selected, please specify.
9. What method is used for antifungal susceptibility testing (AFST) at your facility's laboratory or the outside laboratory serving your facility? (check all that apply)	*Required.* Select from the choices listed, one or more method (s) used for antifungal susceptibility testing at your facility's laboratory the outside laboratory serving your facility. If 'Other' is selected, please specify.
10. AFST is performed on fungal isolates in which of the following situations:	*Required.* For each of the *Candida* species listed (*Candida albicans*, *Candida glabrata*, and all other *Candida species*), select the most appropriate response for when antifungals susceptibility testing is performed. Chose "Always" if susceptibility testing is routinely performed without a clinician order on at least the first isolate of that species from the patient, regardless of the source of clinical specimen. Chose "Only when isolated from a sterile site" if susceptibility testing is performed routinely without a clinician order. Chose "only when ordered by a clinician" if susceptibility testing is only performed after a clinician specifically orders antifungal susceptibility testing. On that particular species of *Candida* when isolated from a sterile site. If 'Other' is selected, please specify.

11. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)	*Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, please specify. **Note**: "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.
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
12. Number or fraction of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
a. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
b. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.
13. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility	*Required.* Enter the number or fraction of individuals (full-time employees) who perform the functions of a hospital epidemiologist in the facility. An official title of "hospital epidemiologist" is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).	
14. Is it a policy in your facility that patients infected or colonized with MRSA are routinely placed in contact precautions while these patients are in your facility? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with MRSA on Contact Precautions at your facility. If your facility never admits patients with MRSA, select 'Not applicable'.
15. Is it a policy in your facility that patients infected or colonized with VRE are	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary

routinely placed in contact precautions while these patients are in your facility? (check one)	indication for placing admitted patients with VRE on Contact Precautions at your facility. If your facility never admits patients with VRE, select 'Not applicable'.
16. Is it a policy in your facility that patients infected or colonized with CRE (regardless of confirmatory testing for carbapenemase production) are routinely placed in contact precautions while these patients are in your facility? (check one)	*Required*. Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with CRE on Contact Precautions at your facility. If your facility never admits patients with CRE, select 'Not applicable'.
17. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae are routinely placed in contact precautions while these patients are in your facility? (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae, select 'Not applicable'.
18. Does the facility routinely perform screening testing (culture or non-culture) for CRE? If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)	*Required.* Select 'Yes' if your facility **routinely** (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for CRE; select no if either testing is not routinely performed or not performed at all. *Conditionally required*. If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, please specify the situation(s) in which CRE screening is performed. **Note**: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
19. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to non-NICU settings?	*Required.* Select 'Yes' if the facility **routinely** (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA in non-NICU settings; select no if either testing is not routinely performed or not performed at all.

If yes, in which situation does the facility routinely perform screening testing for MRSA for non-NICU settings? (check all that apply)	*Conditionally required.* If 'Yes', select **all** the situations for which screening testing is done **routinely** for non-NICU settings. If 'Other' is selected, please specify the situation(s) in which MRSA screening is performed.
20. Does the facility routinely use chlorhexidine bathing on any patients to prevent infection or transmission of MDROs at your facility? (Note: this does not include the use of such bathing in pre-operative patients to prevent surgical site infections (SSIs))	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the infection or transmission of any MDRO; otherwise, select 'No'. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent SSIs. Select 'No' if this agent is not used routinely or is not used at all or if it is only used to prevent surgical site infections in pre-operative patients.
21. Does the facility routinely use a combination of topical chlorhexidine and intranasal mupirocin (or equivalent agent) on any patients to prevent infection or transmission of MRSA at your facility? (Note: this does not include the use of these agents in pre-operative surgical patients or dialysis patients)	*Required.* Select 'Yes' if the combination of topical chlorhexidine and intranasal mupirocin is used **routinely** (i.e., it is standard practice to use these agents when the targeted patient group is present) on patients in the facility specifically to prevent transmission of MRSA. Please do not include the use of these agents in dialysis patients or patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if these combined agents are not used routinely or are not used at all or if they are only used to prevent surgical site infections in pre-operative patients or to prevent infection in dialysis patients.
Antibiotic Stewardship Practices. *Completion of this section should involve leaders of this work, such as pharmacy staff and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (https://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements.html). For additional implementation guidance for small and critical access hospitals, see https://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements-small-critical.html.* *Questions should be answered based on the practices and policies that were in place for the majority of the past full calendar year.*	
22. Our facility has a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board).	*Required.* Select 'Yes' if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select 'No'.

23. Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by: (Check all that apply.)	*Required.* Select 'communicating to staff about stewardship activities, via email, newsletters, events, or other avenues' if there is evidence of broad-reaching communication from senior-level management to hospital staff about antibiotic stewardship efforts (e.g., written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes, updates on the facility's stewardship efforts). Select 'providing opportunities for staff training and development on antibiotic stewardship' if facility leadership and/or management has provided staff antibiotic stewardship education in-house (e.g., workshops, lectures) or access to antibiotic stewardship trainings (e.g., by approving time and/or providing funds to attend stewardship conferences, webinars) within the past year. Select 'allocating information technology resources to support antibiotic stewardship efforts' if your facility has prioritized information technology (IT)-related antibiotic stewardship efforts within the most recent budgeted year (e.g., by providing clinical decision support software, IT staff). If none of these statements apply to your facility, select 'None of the above.'
24. Our facility has a committee responsible for antibiotic stewardship. If Yes, membership in our facility's antibiotic stewardship committee includes: (Check all that apply.)	*Required.* Select 'Yes' if your facility has convened a formalized antibiotic stewardship committee or if your facility has expanded the roles and responsibilities of an existing committee to assess and improve antibiotic use and stewardship; otherwise, select 'No.' *Conditionally Required.* If 'Yes' to question 24, specify the qualification or job title of the committee members. If none of the response options provided apply to your facility, select 'None of the above.'
25. Our facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes. 25a. If Yes, what is the position of this leader? (Check one.)	*Required.* Select 'Yes' if at least one individual has been identified to lead antibiotic stewardship activities, as evidenced by responsibility for improving antibiotic use in their job description or performance review, authority to coordinate activities of staff from multiple departments (e.g., laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on antibiotic stewardship planning and outcomes; otherwise, select 'No.' *Conditionally Required.* If 'Yes' to question 25, specify the qualification or job title of the leader(s). If 'Other' is selected, please specify the position.
25b. If Physician or Co-led is selected, which of the following describes your antibiotic stewardship physician leader? (Check all that apply.)	*Conditionally Required.* If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected in question 25a, specify qualities of your facility's physician leader from the choices listed. Select 'Has antibiotic stewardship responsibilities in their contract or job description' if the **physician** stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the physician stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review.

	Select 'Is physically on-site in your facility (either part-time or full-time)' if the **physician** stewardship leader works onsite at the facility, whether full-time or part-time, versus solely engaging in your facility's stewardship activities remotely. Select 'Completed an ID fellowship' if the **physician** stewardship leader completed an ID fellowship, i.e., a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program or other coursework' if the **physician** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or continuing education credit(s). If none of these statements apply to your facility's antibiotic stewardship **physician** leader, select 'None of the above.'
25c. If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (Check all that apply.)	*Conditionally Required.* If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was selected in question 25a, specify from the choices listed qualities of your facility's **pharmacist** leader. Select 'Has antibiotic stewardship responsibilities in their contract or job description' if the **pharmacist** stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the pharmacist stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review. Select 'Is physically on-site in your facility (either part-time or full-time)' if the **pharmacist** stewardship leader works onsite at the facility, whether full-time or part-time, versus solely engaging in your facility's stewardship activities remotely. Select 'Completed a PGY2 ID residency and/or ID fellowship' if the **pharmacist** stewardship leader completed a PGY2 ID residency and/or ID fellowship, i.e., a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program or other coursework' if the **pharmacist** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or continuing education credit(s). If none of these statements apply to your facility's antibiotic stewardship **pharmacist** leader, select 'None of the above

Antibiotic Stewardship Practices (continued)	
25d. If Physician or Other is selected, is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Conditionally Required*. If 'Physician' or 'Other' was selected in question 25a, select 'Yes' if your facility has at least one pharmacist who dedicates time **distinct from general pharmacy duties** to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.
26. Our facility has a policy or formal procedure for: (Check all that apply.)	*Required*. Specify the policies or formal procedures that your facility has in place from the choices listed. Antibiotic time-out refers to a standardized process or protocol for clinicians on the treating team to reassess the continuing need and choice of antibiotics between 48 and 72 hours after the initial order (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration). Prospective audit with feedback refers to the stewardship team (or physicians or pharmacists knowledgeable in antibiotic use and who are overseen by the stewardship team and are not part of the treating team) conducting a prospective review of the appropriateness of antibiotic use and then providing feedback in real-time to the front-line clinicians with recommendations based on the culture results, clinical status of the patient and other important factors. Prior authorization refers to if your facility has at least one antibiotic agent that requires the stewardship team, or a physician or pharmacist overseen by the stewardship team, to review and approve administration of the drug (on the formulary) due to its spectrum of activity, cost, or associated toxicities before the agent can be dispensed. It is assumed that non-formulary drugs already require prior authorization. If your facility does not have any of the listed policies or formal procedures, select 'None of the above.'
26a. Our stewardship team audits antibiotic orders to review appropriateness of indications	*Conditionally Required.* If 'required documentation of indication for antibiotic orders' was selected in question 26, select 'Yes' if antibiotic orders have been audited to confirm documentation of indication; otherwise, select 'No'.
26b. For which categories of antimicrobials? (Check all that apply.)	*Conditionally Required.* If 'prospective audit with feedback' was selected for question 26, specify for which categories of antimicrobials the stewardship team reviews courses of therapy for specified agents and provides feedback and recommendations to the treating team (i.e., prospective audit and feedback). If none of the listed categories of antimicrobials apply, select 'None of the above.'
26c. For which categories of antimicrobials? (Check all that apply.)	*Conditionally Required.* If 'prior authorization' was selected for question 26, specify for which categories of antimicrobials the stewardship team reviews and approves administration prior to dispensing. If none of the listed categories of antimicrobials apply, select 'None of the above.'

Antibiotic Stewardship Practices (continued)	
27. Providers have access to facility-or region-specific treatment guidelines or recommendations for commonly encountered infections. If Yes: Our stewardship team monitors adherence to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections.	*Required.* Select 'Yes' if your facility has, or accesses, and uses facility- or region-specific guidelines or recommendations for antibiotic treatment selection based on national guidelines and local susceptibility reports for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'. *Conditionally Required*. If 'Yes' to question 27, select 'Yes' if charts have been audited to confirm adherence to facility- or region-specific treatment guidelines or recommendations for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select 'No'.
28. Our facility targets select diagnoses for active interventions to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response).	*Required*. Select 'Yes' if your facility targets any diagnoses for active interventions specifically to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response); otherwise, select 'No.'
29. Our stewardship team monitors: (Check all that apply.)	*Required*. Select, from the choices listed, the measures that your facility's stewardship team monitors. Monitoring antibiotic resistance patterns can include antibiograms, either in the facility or at the regional level (e.g., receiving local data from a neighboring hospital). Monitoring *Clostridiodes difficile* includes infection rates or events in your facility. If monitoring antibiotic use in a way other than DOT, DDD, or expenditures at least quarterly at the unit-, service-, and/or facility-wide level, select 'antibiotic use in some other way' and specify the metric. If your facility does not monitor any of the items listed, select 'None of the above.'

Antibiotic Stewardship Practices (continued)	
29a. If antibiotic use in DOT, DDD, or some other way is selected: Our stewardship team provides individual-, unit-, or service-specific reports on antibiotic use to prescribers, at least annually. 29b. If Yes is selected: Our stewardship team uses individual-, unit-, or service-specific antibiotic use reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually.	*Conditionally Required*. If 'DOT,' 'DDD,' or 'Other' antibiotic use measure is selected for question 29, select 'Yes' if individual-, unit-, or service-specific reports are developed and provided to prescribers, at least annually, on their antibiotic use; otherwise, select 'No.' *Conditionally Required*. If 'Yes' to question 29a, select 'Yes' if your facility's stewardship team provides data-driven, targeted feedback to any prescribers about how they can improve their antibiotic prescribing (e.g., academic detailing, prescriber-specific feedback and recommendations), at least annually; otherwise, select 'No.'
30. Our stewardship team provides the following updates or reports, at least annually: (Check all that apply.)	*Required.* Select, from the choices listed, the ways in which your stewardship team reports out your facility's antibiotic stewardship activities. Select 'updates to facility leadership on antibiotic use and stewardship efforts' if your facility's stewardship team shares updates with facility-level leadership (e.g., executive leadership, or other leadership committees or entities that are responsible for the facility) on antibiotic use and stewardship efforts or outcomes, at least annually. Select 'outcomes for antibiotic stewardship interventions to staff' if your facility's antibiotic stewardship team communicates outcomes of antibiotic stewardship interventions (e.g., antibiotic use or patient outcome measures) with hospital staff, at least annually. If your facility does not provide the updates or reports included in this question, *at least annually, select 'None of the above.'*
31. Which of the following groups receive education on appropriate antibiotic use at least annually? (Check all that apply.)	*Required*. Select, from the choices listed, the groups in your facility that receive education specifically about appropriate antibiotic use (e.g., Grand Rounds, in-service training, and direct instruction) at least annually. 'Prescribers' includes both prescribers employed by the facility and licensed independent practitioners. If none of the listed groups at your facility receive education on appropriate antibiotic use at least annually, select 'None of the above.'

Optional Antibiotic Stewardship Practices Questions **Responses to the following questions are not required to complete the annual survey.** **Please provide additional information about your facility's antibiotic stewardship activities and leadership.**	
32. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives.	*Optional*. Select 'Yes' if your facility's antibiotic stewardship activities are developed or implemented in conjunction with quality improvement and/or patient safety initiatives in the facility (e.g., the stewardship team works with the quality improvement or patient safety team to implement stewardship interventions, the stewardship team participates in quality improvement meetings regarding sepsis core measures); otherwise, select 'No.'
33. Our facility accesses targeted remote stewardship expertise (e.g., tele-stewardship) to obtain facility-specific support for our antibiotic stewardship efforts.	*Optional*. Select 'Yes' if, over the past calendar year, your facility ever accessed remote stewardship expertise that was specifically targeted for your facility's antibiotic stewardship efforts. This does *not* include generic stewardship resources (e.g., webinars). Otherwise, select 'No.'
34. Our stewardship team works with the microbiology laboratory to inform cascade and/or selective reporting protocols for isolate susceptibilities.	*Optional*. Select 'Yes' if your facility uses cascade and/or selective reporting, and stewardship representation participates in the development of cascade and/or selective reporting protocols. Select 'No' if your facility uses cascade and/or selective reporting, but protocols are developed <u>without</u> input from stewardship representation. Select 'Not applicable' if your facility does not use cascade and/or selective reporting.
35. Our stewardship team monitors compliance with appropriate surgical prophylaxis.	*Optional*. Select 'Yes' if your facility's stewardship team monitors compliance with appropriate surgical antibiotic prophylaxis guidelines intended to optimize antibiotic selection and duration; otherwise, select 'No.'
36. If you selected 'Yes' to question 25 (your facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes): Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply.)	*Conditional to Q25; optional*. If 'Yes' to question 25, specify the group(s) that provide(s) oversight of your facility's antibiotic stewardship efforts and to whom the antibiotic stewardship leader is accountable. If 'Other' is selected, please specify the committee or job title. Select 'None' if no further oversight is provided to the antibiotic stewardship leader(s).

Optional Antibiotic Stewardship Practices Questions (continued)	
37. If you selected 'Physician' or 'Co-led…' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Physician): On average, what percent time does the **physician** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)	*Conditional to Q25; optional*. If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected for question 25, specify the best estimate for the percentage of time the **physician** stewardship leader dedicates to antibiotic stewardship activities in your facility. This should reflect an estimate of the actual percentage of time dedicated to antibiotic stewardship, on average, in your facility.
38. If you selected 'Pharmacist' or 'Co-led…' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Pharmacist): On average, what percent time does the **pharmacist** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)	*Conditional to Q25; optional.* If 'Pharmacist or 'Co-led by both Pharmacist and Physician' was selected for question 25 specify the best estimate for the percentage of time the **pharmacist** stewardship leader dedicates to antibiotic stewardship efforts in your facility. This should reflect an estimate of the actual percentage of time dedicated to antibiotic stewardship activities, on average, in your facility.
39. If you selected that the physician (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **physician** (co) leader's contract or job description? (Check one.)	*Conditional to Q25; optional*. If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for question 25b, specify the percent time (or equivalent) stipulated in the **physician** stewardship leader's contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select 'Not specified.' This percent time should reflect the stated expectation for stewardship efforts, not necessarily actual time worked. This may be the same, more, or less than the time specified in question 37.
40. If you selected that the pharmacist (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's contract or job description? (Check one.)	*Conditional to Q25; optional*. If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for question 25c, specify the percent time (or equivalent) stipulated in the **pharmacist** stewardship leader's contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select "Not specified." This percent time should reflect the stated expectation for stewardship efforts, not necessarily actual time worked. This may be the same, more, or less than the time specified in question 38.

Water Management Program (prevent legionella) *(Optional section. Responses to the following questions are not required to complete the annual survey. Completed with input from facility water management team.)*	
41. Have you ever conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens? (e.g. *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomona,* and nontuberculous mycobacteria and fungi) could grow and spread in the facility water system (e.g., piping infrastructure)? If Yes, when was the most recent assessment conducted? *(Check one)*	*Optional*. Select 'Yes' if your facility has conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens (for example, *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (for example, piping infrastructure); Otherwise, select 'No' *Conditionally Required*. If 'Yes', specify the time period in which the most recent assessment was conducted. If 'Other' is selected, please specify the time period.
42. Does your facility have a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens? If Yes, who is represented on the team? *(Check all that apply)*	*Optional.* Select 'Yes' if your has a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens; Otherwise, select 'No' *Conditionally Required*. If 'Yes', specify the roles of the team members represented on the water management program team. If 'Other' is selected, please specify the role of the team member.
43. Do you regularly monitor the following parameters in your building's water system? *(Check all that apply)* If Yes, do you have a plan for corrective actions when specific parameters are not within acceptable limits as determined by your water management program?	*Optional.* Select 'Yes' if your facility regularly monitors the following parameters in your building's water system; Otherwise, select 'No' • Disinfectant (such as residual chlorine) • Temperature • Heterotrophic plate counts • Specific tests for *Legionella* *Conditionally Required*. For each parameter, if 'Yes', specify if your facility has a plan for corrective actions when the specific parameter is not within acceptable limits as determined by your water management program?