The Federal Office of Rural Health Policy

**Mission**
FORHP collaborates with rural communities and partners to support programs and shape policy that will improve health in rural America.
Community-Based Division

- Rural Health Outreach Program
- Rural Health Network Development Planning Program
- Rural Health Opioid Program
- Small Health Care Provider Quality Improvement Program

Hospital-State Division

- State Offices of Rural Health Program
- Medicare Rural Hospital Flexibility Grant Program
- Small Hospital Improvement Program Grant

Office for the Advancement of Telehealth

- The Telehealth Network Grant Program
- The Telehealth Resource Center Program
- The Telehealth Licensure and Portability Program

Policy and Research Division

- Rural Health Research Center Program
- Rural Training Track Technical Assistance Center
- Rural Assistance Center
- Rural Policy Analysis
- Rapid Response Data Analysis
- Rural Health Value
Medicare Beneficiary Quality Improvement Project (MBQIP)

- A quality improvement activity within the Medicare Rural Hospital Flexibility Grant Program (Flex)
- Reporting common, rural-relevant CMS measures across patient safety/inpatient, patient engagement, care transitions, and outpatient care
- Measuring outcomes and demonstrating improvements
- Sharing best practices
Starting in 2018, Critical Access Hospitals (CAHs) participating in MBQIP will be required to fully implement a Hospital Antibiotic Stewardship Program (AMS) following the CDC’s 7 Core Elements by August 31, 2022.

FORHP encourages CAHs to collaborate with their state Flex Coordinators, state HAI and AR prevention programs, and other partners such as the Quality Improvement Networks – Quality Improvement Organizations (QIN-QIOs) and Hospital Improvement Innovation Networks (HIINs) to share resources and implement an Antibiotic Stewardship program in their facilities.
# MBQIP Measures

## Core/Required Improvement Initiatives

### Patient Safety/Inpatient
- IMM-2: Influenza Immunization for inpatients
- **Antibiotic Stewardship: Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey**

### Inpatient ED Measures:
- ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients
- ED-2: Admit Decision Time to ED Departure Time for Admitted Patients

## Patient Engagement

### Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:
  - Communication with Doctors
  - Communication with Nurses
  - Responsiveness of Hospital Staff
  - Pain Management
  - Communication about Medicines
  - Discharge Information
  - Cleanliness of the Hospital Environment
  - Quietness of the Hospital Environment
  - Transition of Care

The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.

## Care Transitions

### Emergency Department Transfer Communication (EDTC)
- 7 sub-measures; 27 data elements; 1 composite
  - EDTC-1: Administrative Communication (2 data elements)
  - EDTC-2: Patient Information (6 data elements)
  - EDTC-3: Vital Signs (6 data elements)
  - EDTC-4: Medication Information (3 data elements)
  - EDTC-5: Physician or Practitioner Generated Information (2 data elements)
  - EDTC-6: Nurse Generated Information (6 data elements)
  - EDTC-7: Procedures and Tests (2 data elements)
  - All-EDTC: Composite of All 27 data elements

## Outpatient

### Chest Pain/AMI:
- OP-1: Median Time to Fibrinolysis
- OP-2: Fibrinolytic Therapy
- OP-3: Median Time to Transfer to another Facility for Acute Coronary Intervention
- OP-4: Aspirin at Arrival
- OP-5: Median Time to ECG

### ED Throughput
- OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
- OP-22: Patient Left Without Being Seen

### Pain Management
- OP-21: Median Time to Pain Management for Long Bone Fracture
Enroll in CDC National Healthcare Safety Network (NHSN)

Submit **CDC NHSN Annual Facility survey** yearly – starting in 2018 for calendar year 2017

Review **CDC 7 Core Elements**

Contact your state HAI Coordinator for technical assistance
Resources for CAHs

• Information about MBQIP: [https://www.ruralcenter.org/tasc/mbqip](https://www.ruralcenter.org/tasc/mbqip)


• Evidence-Based Programs and Strategies for Reducing Healthcare-Associated Infections (HAI) in CAHs: [http://www.flexmonitoring.org/publications/pb40/](http://www.flexmonitoring.org/publications/pb40/)


MBQIP TA Questions to: tasc@ruralcenter.org
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Twitter: twitter.com/HRSAgov
Facebook: facebook.com/HHS.HRSA
Annual Survey and Location Mapping for Critical Access Hospitals

Scott Decker MPH, CHES
Methods and Analytics Team
Division of Healthcare Quality Improvement

2/7/2018
Patient Safety Annual Survey
Objectives

- Review data from recent CAH Annual Survey Data
- Identify important dates, details, and updates to the 2017 annual survey
- Understand how to run analysis of survey level data and modify those reports, including the core elements of antibiotic stewardship line list
- Highlight the impact of survey level data on the facility generated standardized infection ratio
- Review best practices for location mapping in NHSN
- Review common location mapping scenario’s specific to CAH’s
Patient Safety Hospital Annual Survey

- Annual survey released in NHSN that gathers facility level data from previous calendar year
- This mandatory survey is completed by all enrolled facilities in NHSN to provide updated information on hospital characteristics and practices
- Survey broken up into different sections: facility characteristics, lab practices, infection control practices, antibiotic stewardship practices, and water management and monitoring program*
- Blank versions of the 2017 survey and instructions are available to help complete the survey

*New
New Questions Added

- New section of questions dedicated to water management within healthcare facilities will be added to all Patient Safety surveys.
- 3 questions added to assist CDC with collecting information on Legionnaires Disease (LD).
  - Outbreaks of LD are often associated with large water systems, such as hospitals.
- Survey instructions provide some assistance towards answering these new questions.
  - Similar to other sections in the annual survey, consultation with appropriate healthcare personnel may be necessary to complete responses.
Water Management and Monitoring Questions

- Users who complete the annual survey please identify facility personnel that can help assist with these questions.
## CAH at-a-Glance

*Data from completed surveys in NHSN as of January 1, 2018*

<table>
<thead>
<tr>
<th>Ownership</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td># of CAH’s</td>
<td>915</td>
<td>966</td>
</tr>
<tr>
<td>Government</td>
<td>111 (12.13%)</td>
<td>111 (11.49%)</td>
</tr>
<tr>
<td>Non-profit</td>
<td>720 (78.69%)</td>
<td>773 (80.02%)</td>
</tr>
<tr>
<td>For Profit</td>
<td>83 (9.07%)</td>
<td>81 (8.39%)</td>
</tr>
<tr>
<td>Physician Owned</td>
<td>1 (0.11%)</td>
<td>0</td>
</tr>
</tbody>
</table>
# CAH at-a-Glance

<table>
<thead>
<tr>
<th>Facility Characteristics*</th>
<th>2015</th>
<th>2016</th>
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</thead>
<tbody>
<tr>
<td>Avg. Number of beds</td>
<td>26.08</td>
<td>22.2</td>
</tr>
<tr>
<td>Avg. Number of ICU Beds</td>
<td>5.56</td>
<td>1.15</td>
</tr>
<tr>
<td>Avg. Number of Patient Days</td>
<td>2793.23</td>
<td>2723.32</td>
</tr>
<tr>
<td>Average Number of Admissions</td>
<td>732.94</td>
<td>736.30</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>3.81**</td>
<td>3.69</td>
</tr>
</tbody>
</table>

*Data from completed surveys in NHSN as of January 1, 2018

* Hospice Beds and patient days are included in these calculations
CAH at-a-Glance

*Data from completed surveys in NHSN as of January 1, 2018

<table>
<thead>
<tr>
<th>Medical School Affiliation*</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>62 (6.77%)</td>
<td>125 (12.85%)</td>
</tr>
<tr>
<td>No</td>
<td>853 (93.23%)</td>
<td>841 (87.10%)</td>
</tr>
<tr>
<td>(Type) Undergraduate</td>
<td>20 (32.26%)</td>
<td>56 (44.80%)</td>
</tr>
<tr>
<td>(Type) Graduate</td>
<td>33 (53.23%)</td>
<td>48 (38.80%)</td>
</tr>
<tr>
<td>(Type) Major</td>
<td>9 (14.52%)</td>
<td>21 (16.80%)</td>
</tr>
</tbody>
</table>
Medical School Affiliation

The three different levels of medical school affiliation are:

- **Major Teaching** – Facility trains medical students, nursing students, and post-graduate residents. Note that there is no minimum number of students that must be present in your facility to meet this designation, and it is not necessary for your facility to be attached/affiliated with a medical school.
- **Graduate Teaching** – Facility trains post-graduate residents/fellows
- **Undergraduate Teaching** – Facility trains current (undergraduate) medical students and/or nursing students

❖ Select the highest level that your facility meets on the annual survey
Annual Surveys and Risk Adjustment for CAH

- Some factors for the SIR risk adjustment calculations come from the annual survey
- Changes in your data from one survey year to the next may impact your facilities SIR for certain HAI measures
- To identify which factors impact CAH across all HAI’s, please visit the newly published Guide to SIR
Annual Surveys and Risk Adjustment for CAH (cont.)

- Every year a new survey is entered into NHSN to reflect data from the prior calendar year
- SIRS will use the most recent annual survey on file for the current SIRs
  - Right now, facilities are either using 2016 or the 2017 survey
  - Those values will be used to calculate 2016 and 2017 SIRs
- Under the new baseline, SIRS will be risk adjusted using the corresponding annual survey from that year
- If the annual survey from that year hasn’t been completed, SIRs will be risk adjusted using the most recent available survey
Risk Adjustment Example: CAUTI

- Medical school affiliation is a risk factor for CAUTI surveillance within CAH.
- Facility’s that select “Undergraduate” as their status have found to have a higher risk for CAUTI infection compared to facilities who have Major/Graduate/ Non-teaching status.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Parameter Estimate</th>
<th>Standard Error</th>
<th>P-value</th>
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</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>-7.3337</td>
<td>0.0970</td>
<td>&lt;0.0001</td>
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<tr>
<td>Medical school affiliation*:Undergraduate</td>
<td>1.3191</td>
<td>0.4744</td>
<td>0.0054</td>
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<tr>
<td>Medical school affiliation*:Major/Graduate/Non-teaching</td>
<td>REFERENT</td>
<td>-</td>
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Risk Adjustment Example: CAUTI (cont.)

Summary Data for Q1 2016 and Q1 2017

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<th>summaryYM</th>
<th>summarytype</th>
<th>location</th>
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<th>numPatDays</th>
<th>numDays</th>
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<td>2016M01</td>
<td>ICU</td>
<td>INMEDCC</td>
<td>CC</td>
<td>IN ACUTE:CC:M</td>
<td>CAU</td>
<td>400</td>
<td>250</td>
<td>N</td>
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<tr>
<td>10376</td>
<td>N/A</td>
<td>2016M02</td>
<td>ICU</td>
<td>INMEDCC</td>
<td>CC</td>
<td>IN ACUTE:CC:M</td>
<td>CAU</td>
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<td>255</td>
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<tr>
<td>10376</td>
<td>N/A</td>
<td>2016M03</td>
<td>ICU</td>
<td>INMEDCC</td>
<td>CC</td>
<td>IN ACUTE:CC:M</td>
<td>CAU</td>
<td>350</td>
<td>255</td>
<td>N</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>orgId</th>
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<th>numPatDays</th>
<th>numDays</th>
<th>reEvents</th>
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</thead>
<tbody>
<tr>
<td>10376</td>
<td>N/A</td>
<td>2017M01</td>
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<td>CAU</td>
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<td>CAU</td>
<td>375</td>
<td>255</td>
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<tr>
<td>10376</td>
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<td>2017M03</td>
<td>ICU</td>
<td>INMEDCC</td>
<td>CC</td>
<td>IN ACUTE:CC:M</td>
<td>CAU</td>
<td>350</td>
<td>255</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

CAUTI Events for Q1 2016 (n=3), and Q1 2017 (n=3)
Risk Adjustment Example: CAUTI (cont.)

National Healthcare Safety Network
SIR for CAUTI Data for Critical Access Hospital IQR (2015 Baseline) - By OrgId/Location
As of: February 6, 2010 at 1:25 PM
Data Range: B52, CAU_RATE:CAH_CMS summaryYQ 2016Q1 to 2017Q1
if (ltdPlan = "Y") AND (locationType IN ("CC", "CC_ONC")) OR (ltdPlan = "Y") AND (locCDC IN ("IN:ACUTE:WARD:1", "IN:ACUTE:WARD:2")

<table>
<thead>
<tr>
<th>orgId</th>
<th>ccn</th>
<th>location</th>
<th>summaryYQ</th>
<th>month</th>
<th>infcount</th>
<th>numPred</th>
<th>numcathdays</th>
<th>SIR</th>
<th>SIR_pval</th>
<th>SIR95CI</th>
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<tbody>
<tr>
<td>10376</td>
<td>N/A</td>
<td>INMEDCC</td>
<td>2016Q1</td>
<td>3</td>
<td>3</td>
<td>1.859</td>
<td>761</td>
<td>1.614</td>
<td>0.4036</td>
<td>0.410, 4.392</td>
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</tbody>
</table>

SIR report using the 2016 Annual Survey

National Healthcare Safety Network
SIR for CAUTI Data for Critical Access Hospital IQR (2015 Baseline) - By OrgId
As of: February 6, 2010 at 1:25 PM
Data Range: B52, CAU_RATE:CAH_CMS summaryYQ 2016Q1 to 2017Q1
if (ltdPlan = "Y") AND (locationType IN ("CC", "CC_ONC")) OR (ltdPlan = "Y") AND (locCDC IN ("IN:ACUTE:WARD:1", "IN:

<table>
<thead>
<tr>
<th>orgId</th>
<th>ccn</th>
<th>summaryYQ</th>
<th>infcount</th>
<th>numPred</th>
<th>numcathdays</th>
<th>SIR</th>
<th>SIR_pval</th>
<th>SIR95CI</th>
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<tbody>
<tr>
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<td>2017Q1</td>
<td>3</td>
<td>0.497</td>
<td>761</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Analyzing the Annual Survey

- Analysis of the annual survey in NHSN datasets are a good tool for routine data quality checks.
- Survey responses found on these reports can be easily compared across multiple survey years.
- The report can be accessed within NHSN Reports > Advanced Folder > Facility Level Data.
Analyzing the Annual Survey (cont.)

- Select “Modify” if you’d like to edit the survey line list
- Select “Modify” to select specific survey questions/variables to be displayed
- Please view the resource guide “How to Modify a Line List” for more instruction on how to save and export your reports
Analyzing the Annual Survey (cont.)

- Output will be ordered by survey year and will included all completed surveys
- Information found on the report can help explain potential data quality issues found in other analysis (e.g. Medical School Affiliation Change)

Surveys can always be edited and saved in NHSN if a correction needs to be made
Core Elements Line List Output Option

- Line list that maps responses Antibiotic Stewardship Practices section of the annual survey to the CDC’s 7 Core Elements of Antibiotic Stewardship (questions 23-33)
- Option is found in the Advanced Folder > Facility Level Data and be simply run without any or much modifications
- The core elements that a facility has met will be summed in the “coreElementsMet” column
Core Elements Question Mapping

- Please view the resource guide on How to Run the Core Elements Line list to identify which survey questions and variables map to each specific element

**Table of Core Elements Mapping to Hospital Annual Survey**

<table>
<thead>
<tr>
<th>Core Element</th>
<th>Questions from PS Annual Survey-Hospital</th>
<th>Variable name(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>Q23: Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)?</td>
<td>facS supp</td>
</tr>
<tr>
<td></td>
<td>Q26: Does your facility provide any salary support for dedicated time for antibiotic stewardship leadership activities?</td>
<td>abxStewardSalary</td>
</tr>
<tr>
<td>Accountability</td>
<td>Q24: Is there a leader responsible for stewardship activities at your facility? If Yes, what is the position of this leader?</td>
<td>abxSteward</td>
</tr>
<tr>
<td>Drug Expertise</td>
<td>Q25: Is there at least one pharmacist responsible for improving</td>
<td>abxPharm</td>
</tr>
</tbody>
</table>
Location Mapping
Importance of NHSN Location Mapping

- NHSN locations are created and updated in order to identify similar populations across different facility types.
- Similar populations are believed to have similar risks for healthcare-associated infections (HAIs):
  - Similar medical devices
  - Similar invasive procedures
  - Similar host factors affecting susceptibility
- Several HAI surveillance modules utilize location type as a risk factor:
  - MBI-LCBI
  - Device associated- CLABSI, CAUTI, VAE
  - CDI and MRSA
Information from this presentation can be found in chapter 15 of the NHSN Protocol found here: [https://www.cdc.gov/nhsn/pdfs/pscmanual/15locationsdescriptions_current.pdf](https://www.cdc.gov/nhsn/pdfs/pscmanual/15locationsdescriptions_current.pdf)

Document provides definitions for each CDC location used for surveillance for all facility types.

Includes the decision tree to assist in determining the correct CDC location descriptions to map to your facility.
NHSN 80% Rule

- Each patient care area in a facility that is monitored in NHSN is “mapped” to one or more CDC locations.
- The specific CDC location code is determined by the type of patients cared for in that area, over the last full year, according to this rule.
- If ≥ 80% of patients are of a certain type, then that area is designated as that type of location.
Step 1: Define Acuity Level

- **Is this patient care area comprised of at least 80% of patients that are of the same acuity level?**
- **Examples of acuity levels:**
  - Critical Care Units (CC)
  - Inpatient Specialty Care Areas (SCA)
  - Inpatient Wards
  - Step Down Units
- **If YES, proceed to Step 2** and map to a location type of that acuity level using the NHSN 80% Rule for that specific type

* Based on patient mix over last full year
Step 1. Define Acuity Level

If NO:

- Can this patient care area be split into 2 or more locations in NHSN for the purposes of surveillance, also referred to as “virtual locations”?
  
  If YES: Proceed to Step 2 and create locations in NHSN for each of the acuity levels, using the NHSN 80% Rule
  
  If NO: Map to a CDC Mixed Acuity location
Best Practices for determining a patient acuity level

- Review the patient mix for any unit for the last full calendar year
  - Acuity billing data is the most reliable method, but admission diagnosis is also an acceptable choice
- If one year of data is not available, a shorter period of time is acceptable
  - NHSN guidance has been at least 3 month
- Consult with clinical leadership
  - Not the best option, but may be the only possible method if opening a new facility/unit.
- Continue to monitor patient breakdowns on a routine basis
Step 2: Define the Type of Service

Is this patient care area a general medical, surgical, or medical/surgical unit? Or is it comprised of patients from a specific service type (e.g., burn, cardiac)?

- If GENERAL: Are more than 60% of patients either medical or surgical?
  
  If YES: Create a location in NHSN that is mapped to the majority type (medical or surgical)
  
  If NO: Create a location in NHSN that is mapped to a combined medical/surgical CDC location

  The mix of patients should then be a 50/50 to 60/40 mix of medical and surgical patients
Step 2 for Specific Service Type Location

- If SPECIFIC: Does this unit meet the NHSN 80% Rule for locations?

  If YES: Create a location in NHSN that is mapped to that location type

  If NO: Can this single unit be split into 2 or more units in NHSN for the purposes of surveillance, also referred to as “virtual locations”?
Step 2 for General Medical/Surgical Locations

Can this single unit be split into 2 or more units in NHSN for the purposes of surveillance, also referred to as “virtual locations”?

If YES: Create locations in NHSN for each of these specific service virtual locations

If NO: Is the mix of patients in this unit approximately a 50/50 to 60/40 mix of combined medical and surgical?
Step 2 for Units that Cannot be Split

Is the mix of patients in this unit approximately a 50/50 to 60/40 mix of combined medical and surgical?

   If YES: Create a location in NHSN that is mapped to a combined medical/surgical unit

   If NO: Create a location in NHSN that is mapped to the location of the majority type (greater than 60%), either medical or surgical
Virtual Locations

- Created in NHSN when a facility is unable to meet the 80% rule for location designation in a single physical unit, but would like to report their NHSN surveillance data for each of the major specific patient types in that unit.
Virtual Locations

- While it is recommended that virtual locations be used when a location can be geographically split, this is not a required to map two virtual locations.
- To use virtual locations, unit staff will need to be able to identify the specific beds that are used for all patients types found in that area.
  - This is done in order to assign them to the correctly mapped CDC description code(s).
  - This is easier when there is some kind of physical delineation in a unit that separates two or more differing patient populations.
Mixed Acuity Units (MAU’s)

- Collection of patients of differing acuity levels (critical care, wards, step-down, etc.)
- Not able to separate out which type of patients are housed in this unit when this location is used
  - MAU are not included in any ICU/Ward-specific reporting requirements
- Contact your Quality Improvement Organization or HAI coordinator to learn how the use of this location may impact compliance for certain reporting requirements
- Benchmarking for MAU are now available in NHSN after the rebaseline
CAH Mapping Scenario

- A critical access hospital has one unit comprising of 42% adult critical care (Beds 1-10) and 58% adult ward (Beds 11-25) as determined by a year’s worth of admission diagnoses.

**Option 1:**
Map as a CDC mixed acuity location

**Option 2**
Split the unit into two virtual units; 1 Adult Critical Care Unit and 1 Adult Ward
Observation Units/Overflow

- The 24 hour observation unit location in NHSN (OUT:ACUTE:WARD) is considered an outpatient unit
  - Appropriate to map if at least 80% of patients are in this location for < 24 hours and 50% of the patient population does not get transferred to an inpatient location within the hospital
- It’s not appropriate to use this location as an inpatient overflow location.
  - A Mixed Acuity Unit may be more appropriate for this scenario.
How to Map Inpatient Rehabilitation/Psychiatric Facility (IRF/IPF) Units

Scenario 1: Your IRF/IPF is within the four (4) walls of an Acute Care Hospital (ACH) or Critical Access Hospital (CAH)

Does this unit have a separate CCN (i.e. has a R,T,M, or S in place of the third digit of the facility CCN)?

- **Yes**
  - Map as
    - IN:ACUTE:WARD:REHAB
    - IN:ACUTE:WARD:BHV
    - IN:ACUTE:WARD:BHV_ADOL
  - Designate your location as a CMS IRF/IPF Location

- **No**
  - Map as
    - IN:ACUTE:WARD:REHAB
    - IN:ACUTE:WARD:BHV
    - IN:ACUTE:WARD:BHV_ADOL
  - No further action required
Designate to CMS IRF/IPF Unit

1. Go to the facility manager to add a location
2. Enter the “Your Code” and “Your Label” values to help identify the unit
3. Using the dropdown for CDC Location Description select the appropriate location for your IRF/IPF Unit
4. If you wish to designate this as a CMS IRF/IPF unit, select “Yes” on the dropdown
5. Enter the unique CCN and the effective date for this unit that will include a R,T,M, or S in place of the third digit.
6. Click “Add” to make this unit active in your facility
Other reminders for mapping CMS IRF/IPF Units

- The unique CCN must match the CCN for the Acute Care Hospital or Critical Access Hospital with only the third digit replaced by an R,T,M, or S
  - All IRF’s with the final four digits between 3025-3099 should be enrolled into NHSN as a separate rehabilitation facility
  - All IPF’s with the final four digits between 4000-4999 should be enrolled into NHSN as a separate psychiatric facility
- LabID events reporting from these units will be excluded from the acute care data sent to CMS for the Hospital Inpatient Quality Reporting Program
How to Map Inpatient Rehabilitation/Psychiatric Facility (IRF/IPF) Units

Scenario 2: Your IRF/IPF is not physically located within your Acute Care Hospital (ACH) or Critical Access Hospital (CAH)

- IRF’s and IPF’s that are psychically separate from their main facility will need to enroll a separate facility for these two location types
- Users will need to go to their SAMS activities to see if they have the enrollment option (contact the helpdesk at nhsn@cdc.gov if option is not available)
How to Map Inpatient Rehabilitation/Psychiatric Facility (IRF/IPF) Units

- Upon enrollment if the IRF unit is the only location that is in this facility, then select facility type as HOSP-REHAB; if there are other non-IRF units then select HOSP-GEN
  - For IPF units select HOSP-PYSCH; if there are other non-IRF units then select HOSP-GEN

- When enrolling, use the CMS IRF/IPF CCN for the entire facility

- Once the new facility is enrolled, proceed to the locations manager to add the new IRF/IPF unit (you will not need to indicate that this location is a CMS unit within a hospital)
Final check

✓ Review data from recent CAH Annual Survey Data
✓ Identify important dates, details, and updates to the 2017 annual survey
✓ Understand how to run analysis of survey level data and modify those reports, including the core elements of antibiotic stewardship line list
✓ Highlight the impact of survey level data on the facility generated standardized infection ratio
✓ Review best practices for location mapping in NHSN
✓ Review common location mapping scenario’s specific to CAH’s
Resources

- Blank Copy of the Patient Safety Annual Survey for Hospitals: https://www.cdc.gov/nhsn/forms/57.103_pshospsurv_blank.pdf
- How to modify a report: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/howtomodifyreport.pdf
- How to modify a line list: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/linelists.pdf
- How to run a Core Elements Line List: https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/core-elements-linelist.pdf
- Patient Safety Survey FAQ’s: https://www.cdc.gov/nhsn/faqs/faq-annual-survey.html
Questions

For specific location and survey questions, please send them to nhsn@cdc.gov

Kindly submit your 2017 Annual Survey no later than March 1, 2018! The earlier the better!
For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.