

Tennessee State Healthcare-Associated Infections (HAI) Plan Webinar Q & A

Presented by Dr. Marion Kainer, Tennessee Department of Health

Hosted by the Tennessee Center for Patient Safety, Tennessee Hospital Association

- 1) My hospital has 4 inpt behavioral health units. Are those pts included in the denominators for MRSA, etc?

Yes, there are no exclusion criteria per CDC guidelines.

- 2) Very impressive plan but the missing piece is where the local support is to come from to collect the local data? We have been told that TNCare will decrease to us by 7 million dollars next year and that there will be no additional hours for IC in the new budget year. What is the answer??

This is a critical issue for which there is no easy answer. A combination of initiatives at the national level are calling for increased transparency related to HAIs, payment incentives through CMS, national plans to publish facility-specific rates on HHS's Hospital Compare, and the HHS National Action Plan. The initiatives will have a significant effect on a facility's financial bottom line if HAI rates are high, making it in the best interest of the facility to invest the resources necessary to support HAI surveillance and prevention. The recent APIC presentation by Denise Murphy provides a starting point for IP's to begin discussions with the hospital administrators to gain needed resources for infection prevention and control programs. It is not likely to happen overnight, but in the context of the national climate, hospitals will have to invest in infection control to stay competitive. Please contact Q-source for a copy of the presentation/webinar from Denise Murphy..

- 3) On page 11 and 12 of our copy of the state report it says Implementation depends on enrolling facilities of LESS than 25 ADC? Is this correct?

For the new reporting requirements from TDH, if you are an LTAC, reporting is required July 1, 2010 regardless of daily census. If you are not an LTAC, and your ADC is 25 or greater, you are required to report beginning July 1, 2010. TDH plans to get input from the Multidisciplinary Advisory Group (MDAG) regarding a tiered approach for facilities with ADC <25. TDH is going to propose that facilities with an ADC <25 (and who are not LTACs) begin reporting in January 2011.

- 4) In reporting CLABSI from general units, NHSN does not ask for separating temp vs perm cent lines for ICU's--why do this for general units??

For general units, central lines are not broken down into temporary versus permanent. This is done only in Specialty Care Areas.

- 5) There is controversy as to at what age C diff toxin is reliable. Is there an age cutoff for reporting C diff test results??

In C. diff surveillance, for both patient days and admissions, NICU and Well-Baby Nurseries are not included in the denominator.

- 6) It is a very comprehensive plan--very impressive. But the missing piece is where the local support will come from?

Please see Question 2).

- 7) We admit patients from other acute hospitals and at times the patient is diagnosed with CDI after 48 hours of admission but had the symptoms of CDI on admission and had antibiotics at the acute hospital. Will we be required to report the CDI or should the acute facility that the patient was transferred from report the event?

You would be required to report the CDI as a LabID Event. For the LabID Event, which is what is being required by TDH, these patients would be reported if they had no prior positive for C. diff at your facility within the last 14 days. For C. diff infection surveillance, the criteria are different (see below).

Your facility is welcome to do infection-based surveillance in addition to the LabID Event, but it is not required by TDH. If you choose to also include infection-based surveillance, the NHSN definition includes all nosocomial infections where C. diff is the associated pathogen. Cases of CDI that are not present or incubating at the time of admissions should be reported as GI-GE or GI-GIT infections, whichever is appropriate. The definition can be found on page 20 of the NHSN MDRO protocol.

http://www.cdc.gov/nhsn/PDFs/MDRO_CDADprotocolv41Dec08final.pdf

- 8) We are an acute inpatient rehabilitation hospital (not an LTAC) and currently not an NHSN hospital. Our ADC is >25. Will we be required to report through NHSN?

Please see question 3).

- 9) We contract for dialysis services for our inpatients. Would this qualify for reporting as required for inpatient dialysis?

If your dialysis patients are located in a unit where 80% of patients receive dialysis, regardless of who is providing it, then you would report this as a specialty care area – inpatient dialysis. If your dialysis patients are scattered throughout the facility and there is no unit where 80% or more of the patients are on inpatient dialysis, then you would not have a reporting location of SCA-inpatient dialysis.

- 10) For MRSA: what went in the specimen body site/system?

For MRSA, the Specimen Body Site/System will always be CARD and the Specimen Source will be BLDSP (since surveillance is positive blood cultures only).

A full listing of the codes can be found at:

http://www.cdc.gov/nhsn/PDFs/pscManual/LabID_Event_Specimen_Source_Codes_Final_010110.pdf

- 11) Will we need to modify our plan for NHSN to include C-diff, SSI for hip prosthesis, etc prior to entering this data.

Yes. In order to enable NHSN's underlying data validation rules, your reporting plan must be modified to include new locations and conditions. For its aggregate national reports, CDC only uses data from facilities that are "in-plan". We also want to make sure that national data includes data submitted from Tennessee.

- 12) Once we start reporting MRSA and CDiff LabId events in July, will we be able to stop reporting (redundant) to TCPS?

TDH will work closely with TCPS to develop a solution that minimizes reporting burden on IPs. Please stay tuned for future developments in this area.

- 13) What will be the definition for determination of a resistant MDR -Klebsiella and MDR-Acinetobacter

Though MDR-Klebsiella and MDR Acinetobacter are not required by TDH, facilities are welcome to use the NHSN MDRO module to monitor these. The definitions are located on page 4 of the NHSN MDRO/CDAD Module Protocol. The full protocol can be found at:

http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

Currently, MDR-Klebsiella is defined as: Klebsiella spp. Testing non-susceptible (i.e. resistant or intermediate) to ceftazidime or ceftriaxone.

MDR-Acinetobacter is defined as: Acinetobacter spp. Testing resistant to all agents (for which testing was done) in at least 3 antimicrobial classes, including β -lactams, aminoglycosides, carbapenems, and fluoroquinolones. A table is included in the protocol listing included drugs from each of the classes.

- 14) Will we be able to get a copy of the slides?

The slides from the webinar are available now on the THA website at

http://www.tnpatientsafety.com/Portals/0/Home%20Page/March16_Webinar_final.pdf

- 15) When will the next TN HAI Report on CLABSIs be published?

A TDH report will be released in April 2010 that includes an update on CLABSI data with the addition of NICU data. This report will be facility specific.

A TDH report is to be released in the latter half of 2010. It will include an update on CLABSI surveillance (facility specific) and SSI data (in aggregate, not facility specific).

- 16) None of what you are requiring will reduce the reporting/data collection burden on the IP. It increases the burden.

Also see Question 2). As collection of surveillance data assists with identify problem areas and appropriate prevention strategies are applied, incidence will decrease. As incidence decreases, so will reporting burden. However, it is not possible to identify problem areas and determine effectiveness of prevention efforts without collection of sound surveillance data.

- 17) The contract Dr Kainer keeps mentioning, who is the vendor? Will all hospitals be forced to buy this product?

TDH has not chosen a vendor assist with implementation of electronic reporting for NHSN (initial LabID Event for CDI and MRSA) and state reportable conditions. The RFP has not yet been released. Whatever vendor is chosen, hospitals will not be forced to purchase or implement any particular solution, but can leverage existing resources or a product of their own choosing.

- 18) What is the purpose of the Infection Control Risk Assessment?

We did not cover the infection control risk assessment in this webinar. However, if you would like more information, please contact Dr. Marion Kainer at marion.kainer@tn.gov.

- 19) For MDRO is it strictly ED only. What about other outpatient and clinic areas?

To meet TDH reporting requirements for MDRO, the ED is the only outpatient setting required to minimize reporting burden. Facilities are more than welcome to utilize NHSN to monitor other outpatient and clinic areas.

- 20) How can a fair SIR be calculated if we have to send in Burn and Trauma CLABSI?

If burn and trauma ICU data are include in CLABSI surveillance, the SIR is adjusted based on the patient population within the respective ICUs. The national mean used in the calculation will include burn and trauma ICUs

- 21) I manually create an excel spreadsheet for one of the hospitals that electronically uploads SSI data to NHSN. It takes 4-5 hours every week to accomplish this.

TDH is establishing a focus group related to SSI surveillance. Within the focus group, best practices for extraction of denominator data from surgical software and upload into NHSN will be identified. We will be recruiting for participation in this group. Facilities that have already developed methods are encouraged to participate. The goal is to develop effective and efficient methods for doing this that can be shared with the rest of the state.

- 22) The data for the completion of the MDRO form is NOT available in the lab database. The IP will have to fill out these forms one at a time from multiple data bases.

In many facilities, the information required will be contained in the Lab's information system (LIMS) and the admissions, discharge, and transfer system (ADT). Some facilities complete this by getting a listing of patients with positive specimens from the

lab then gathering other needed information from the ADT system for those patients. The RFP that Dr. Kainer mentioned to enable electronic reporting will assist with getting these data into NHSN in an automated fashion and reducing reporting burden.

- 23) How do we connect our lab to NHSN for this upload. We have been trying for years and are unable to get our (very sophisticated) lab to upload anything.

As HAI data are becoming more important at the national level and begin to affect hospitals' bottom line, executive support of these types of projects should increase. Through automation of these processes via electronic reporting (the RFP mentioned in question 22) above), support will be in place to assist facilities with upload of data.

- 24) We are one of the hospitals that uploads SSI data. We still have to manually query the data to correct error prior to upload. Each procedure upload takes about 1-2 hours to correct error and ready the file for upload to NHSN.

See question 21) above.

- 25) What is the purpose of adding BICU and Trauma to CLABSI data?

Even though rates are higher in burn and trauma than in other ICUs, there are still opportunities to reduce the incidence of CLABSIs in these populations. Even though it is unlikely to get to 0 in these areas, collection of sound surveillance data is essential to establishing a baseline and determining which prevention activities are effective in these populations..

- 26) How can you electronically upload CLIP data? Will we have to manually enter these data?

At this time, the data are entered manually. NHSN is working on the ability to allow CLIP data to be imported via Clinical Document Architecture (CDA). At this time, they do not have an estimated date of implementation.

- 27) What is the purpose of collecting ED data for C diff and MDRO/MRSA?

See also question 56), which deals with C. diff specifically. For blood cultures for MRSA, about 75% are collected in the ED; if we do not collect the data for the ED, we will grossly underestimate the overall MRSA BSI burden. This is an indicator of community-onset MRSA. Most community-onset MRSA BSIs are however healthcare associated. If we are able to decrease transmission of MRSA within healthcare settings, we should also see a decrease in community-onset MRSA. In addition, the more MRSA comes into a facility, the greater the chances of another patient within that facility acquiring MRSA..

- 28) This state plan enormously increases the burden of ICP reporting for all hospitals. We are not getting any additional resources. How can we spend time preventing infections when we will be spending much more time collecting and reporting these data?

See question 2) and question 16). The focus of the webinar on 3/16 was the surveillance portion. There is also a prevention portion which will be covered on another call.

- 29) Who answers the question Has the patient been discharged from your facility in last 3 months?

This information is usually captured in the ADT (admission, discharge, transfer) system.

- 30) What can we do...we use different location codes with NHSN versus lab location codes?
How can we upload from our lab?

The answer is different depending on the nature of the difference: 1) the location codes in your ADT system are different from the location codes in your lab system or 2) the location codes used by your facility are different from the standard location codes within NHSN. Without knowing if 1 and 2 apply to you or just 2, it is difficult to provide suggestions. However, please contact Dr. Kainer (marion.kainer@tn.gov) and we will work with you to find a solution.

In general, facilities have their own location codes which are different from the NHSN codes. When locations are added within NHSN, you can call them whatever you want, but you map each code to a standard code within NHSN. If the codes in your ADT are different than your lab, an additional mapping may need to be created that is kept locally to facilitate electronic reporting.

- 31) Will additional reports be produced for all required reporting events? CLABSI is the only document produced thus far and no CBGB data has been seen.

A TDH report will be released in April 2010 that includes an update on CLABSI data with the addition of NICU data. This report will be facility specific.

A TDH report is to be released in the latter half of 2010. It will include an update on CLABSI surveillance (facility specific) and SSI data (in aggregate, not facility specific).

Other conditions will be incorporated into reports and release based on the following factors: as data become available, based upon the national context, and recommendations of Tennessee's Multidisciplinary Advisory Group (MDAG).

- 32) Would DOA patients be included in total ER visits?

No. DOAs should not be counted in the encounter denominator.

- 33) How can we get copies of the slides? They will be helpful in letting our c-suite know of our added duties.

The slides from the webinar are available now on the THA website at http://www.tnpatientsafety.com/Portals/0/Home%20Page/March16_Webinar_final.pdf

- 34) When is the first C. Diff data due to be reported?

See question 3).

- 35) Just acquired Infection Control - we have not been reporting to the State because our census was not enough but now it is - not sure when it changed do I need to go back and add those months in that meet the census of 25?

There is no need to go back. Report going forward. If you did collect denominator and numerator data in the past, you are welcome to enter these data.

- 36) We have electronic lab data but are unable to upload this data to NHSN. So do we have to manually enter all this data for facility wide C. Diff and MRSA blood in ICU?

At this time, numerator and denominator data for MSRA and CDI must be entered manually. See question 22) regarding the electronic reporting initiatives designed to decrease reporting burden.

37) We are expending valuable resources in gathering data in our plan, where is the plan for prevention of HAI?

The TDH state HAI plan contains prevention activities, as well. See question 28).

38) WHAT ABOUT OUTPATIENTS & NON-PATIENTS? SHOULD THEY BE INCLUDED IN ENCOUNTER #'?

Only encounters in the ED are required by TDH. Facilities can monitor other outpatient areas in NHSN but it is not required. See question 19) also.

39) WILL THIS INCLUDE FACILITIES THAT DO NOT HAVE ADC OF 25?

See question 3).

40) Is there a timeline for ASC roll out? When will info be available? At the start, in the ASC's, will it focus on specific procedures?

Surveillance in Ambulatory Surgery Centers (ASC) will be addressed later this year in the national HAI action plan. Whatever is included in that plan will be used to inform TDH requirements for ASC. There are many challenges with SSI surveillance implementation in ASCs which will need to be addressed.

41) For the facilities who haven't had to report on NHSN, due to ADC being less than 25, is there a website that lists the NHSN training dates?

See question 76). The NHSN website also contains training information, but the TN training dates will cover information specific to TDH's reporting requirements.

<http://www.cdc.gov/nhsn/training.html>

42) Will facilities have to both enter data into the NHSN software and complete a PH-1600 for the MRSA bloodstream infections?

Yes. It is expected that these will be reported in parallel for approximately 1.5 years. During that time, implementation of electronic reporting is expected to occur in some facilities. At that time, TDH will review the data and determine if parallel reporting will continue.

43) Are you saying that we must report every blood culture positive for MRSA processed in our Lab, every C. diff + stool, whether hospital acquired or not?

Yes. For the LabID Event, the only criteria for inclusion/exclusion is whether or not that patient had a positive specimen in your facility within the last 14 days. Using business rules, the NHSN application applies criteria for hospital- versus community- onset based on admission date and date of specimen collection..

44) When and how will the additional NHSN training for these reporting requirements be conducted?

See question 76).

45) We are also currently collecting CLABSI's on our med/surg areas. That seems to be a big opportunity. Why are we moving so slow to get to that point of measuring any CLABSI?

TDH has tiered implementation of new reporting requirements to minimize burden to be consistent with the national plan. Facilities who would like to enter surveillance data into NHSN for additional areas are encouraged to do so.

- 46) With a major focus on preventable HAI's, why do we not focus on number of patients harmed? Realize that rates have meaning related to external benchmarking. Rates can be deceiving.

Rates were chosen to allow comparisons across facilities and locations and to be consistent with the national HAI plan. TDH has no objection to a facility using number of patients harmed. If the MDAG wishes to include this metric, TDH will consider adding it to the public report..

- 47) c-diff and MRSA form...Is this only for Hosp. acquired or for all that test positive? and for entire hosp or icu?

For MRSA, LabID Event includes all positive blood cultures facility wide plus ED. For CDI, LabID Event includes all positive stool specimens facility wide plus ED, excluding NICU and well baby nursery.

- 48) Is that rule in the powerpoint?

The TDH communicable disease reporting rule has been included in the powerpoint.

- 49) Will you be making recommendations on the testing methods for c dif?

TDH will make no TN-specific recommendations, but will follow the CDC recommendations.

- 50) Will CDC be prepared to download MDRO data?

More clarification is needed to understand what the participant is asking. Please email marion.kainer@tn.gov to clarify your question.

- 51) DOES THE 14 DAY RULE CROSS MONTHS? EXAMPLE, POSITIVE ON 3/24 AND POSITIVE 4/2. IS THIS A COUNT OF 2, ONE FOR MARCH AND ONE FOR APRIL OR ONLY 1 FOR MARCH?

The 14 day rule applies across months. For the first positive on 3/24, a LabID event would be reported. For the second positive on 4/2, it would not count as a LabID event since there was a positive in the 14 days prior.

- 52) for c.diff, is there a timeframe for c.diff toxin positive specimens where that particular specimen is ignored as in the MRSA blood culture lab event of 14 days

Yes. The same 14 day rule applies for both MRSA and CDI.

- 53) if patient has both temporary and permanent CVL's, do you use the temporary rather than permanent CVL as the attributing device - would this be similar to NICU in which umbilical takes precedence over the non-umbilical line

Yes. The temporary takes precedence over the permanent CVL.
http://www.cdc.gov/nhsn/PDFs/pscManual/4PSC_CLABScurrent.pdf

- 54) if a facility has BMT, heme, and oncology patients, are these patients separated as different specialty care unit?

See question 71).

55) (1) is heme/onc reporting based on LOCATION or by PATIENT TYPE

Both. See definition for SCA in question 71). If 80% of patients in a location are of a certain type (hem/onc in this example), then it is considered a hem/onc SCA. If there is no location that fits the definition of a hem/onc SCA, reporting would be for the location where they are housed or facility wide.

56) How will collecting the C diff data, specifically related to the ER encounters, decrease infections?

There is an increase in the amount of Community onset CDI. It is important to monitor this and better describe the epidemiology of this emerging pathogen and determine the effect on transmission within the hospital setting. Reduction of transmission within the hospital setting also reduces the incidence of community-onset [healthcare associated] CDI. Less going out means less coming in. The effect of reducing inappropriate antibiotic use is also important to measure.

57) Is there a plan to formally send written requirements for surveillance as well as system requirements for automated computer reporting to our facilities? If so, when will this occur?

Yes. Surveillance requirements will be posted on the TDH website in April and a notice will be sent out to all facilities through existing distribution lists and THAN. For the automated electronic reporting, information will be provided after the contract is awarded and the approach is defined.

58) What IP resources are going to be mandated by the State of TN in order to perform these required functions?

No IP resources will be mandated by the TDH. However, see question 2) for information on presenting a business case to hospital leadership for IP resources.

59) While the initial slide on proposed surveillance expansion noted adding severe CDI events (result in death, toxic megacolon, etc), yet the next slide noted requiring reporting of ALL C diff + tests. Should this latter point be only those tests in those with severe CDI or all tests?

TDH will require reporting for LabID Event for CDI surveillance. This includes all positive tests that have not had a positive in your facility in the 14 days prior.

60) If the communicable disease rule is used to justify additional reporting of events by facility, How does this reconcile with the separate regulation on publically reported HAIs by facility?

TDH is currently consulting with the Office of General Council to best answer this question and will send a response to the group as soon as possible. The goal of all reporting rules is to mitigate public health threats in a timely manner.

61) Will there be a validation process for data in the 2009 CLABSI report as there was for the initial report?

A draft of the 2009 CLABSI report will be sent to facilities for their review and input before it is published. Facilities will be able to review their information and reconcile any issues prior to publication. We will not be able to perform extensive additional on-site data validation before this report is published. Please note that there is 6 month

overlap with the previous report (July 2008-Dec 2008. This 6 month period was included in our previous on site validation. We will perform on-site validation before the next report is published, covering the time-period Jan 2009-Dec 2009.

- 62) On the Lab ID event - besides the date of the culture - what other information is required and will the lab ID events be counted as HAI's ?

The required information for LabID Event is included on a slide in the presentation. This slide is the most up-to-date illustration of the data elements that will be required from July 2010 onward.

LabID events are proxy measures of MDRO infections, exposures, and healthcare acquisition. NHSN does allow you to collect data related to infection-based surveillance. In Tennessee, LabID Event was chosen because of decreased reporting burden as compared to infection surveillance. LabID Event reporting applies only to specimens collected for clinical purposes, not Active Surveillance Culture/Testing (ACS/AST). ACS/AST can be monitored under Process and Outcome Measures, but is not required by TDH. For more information, see the protocol at NHSN.

http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf

- 63) Will the HPRO template for import to NHSN be the same as the one we use for CBGB? In otherwords can we use the CBGB report format without any changes and will it import to NHSN?

The file structure is the same. When data are pulled from the surgical software, HPRO will be added to the current NHSN procedure codes which are being extracted (CBGB, CBGC). There is 1 additional variable (which are included as null for CBGB/CBGC in the current extract) which will need to be populated for HPRO. They include: Type of HPRO - (TP, PP, TR, PR are the associated values). Operative Procedure codes (ICD-9-CM) may need to be updated, as well as non-autologous transplant (if your IT group hard coded a default "N" in the extract, this could be an issue since it may sometimes be "Y" for HPRO). In the TDH focus group for SSI Surveillance, we would also like to address recommendations for tracking which limb was affected (L or R) in the option variables which can be included. This was not an issue with CBGB and CBGC. Information on the file format can be found at:

http://www.cdc.gov/nhsn/PDFs/ImportingProcedureData_current.pdf.

- 64) Will LTACs also report MRSA and Clostridium difficile beginning in July 2010.

LTACs should begin reporting in July 2010, regardless of ADC.

- 65) Will training be scheduled for NHSN data entry prior to July ?

Training will begin in April and continue throughout the year. TDH is sending out a survey this week to collect information on preferences (i.e. full day training versus multiple half-day trainings, webinar versus in-person, etc). Information on training dates will be released by the last week of March.

- 66) Does the # of admissions include observation patients?

Yes.

67) I have not reported in the past due to low ADC. How do I now get set up on computer to report?

There is an NHSN enrollment process. Facilities may initiate enrollment with NHSN directly or TDH can help new facilities begin the enrollment process. Below is a link to the NHSN enrollment FAQ (http://www.cdc.gov/nhsn/FAQ_enrollment.html). Once enrollment has begun, TDH will assist new facilities in conferring rights to the TDH group, allowing TDH to access NHSN data for your facility to meet the state reporting requirements. Please contact Crystal Johnson-Brockham (email:crystal.johnson-brockman@tn.gov) at TDH to assist with enrollment or to confer rights to TDH once enrollment is completed.

68) I am from a small hospital of less than 25 ADC. Will I need to report C-diff and MRSA starting July 2010?

Beginning in July 2010, the initial focus will be on Long Term Acute Care facilities and facilities with an ADC of 25 or greater. For hospitals with an ADC less than 25, TDH will work with the Multidisciplinary Advisory Group to develop a tiered approach to bring those facilities on. TDH will propose that facilities with an ADC less than 25 begin reporting in January 2011. However, non-LTAC facilities with an ADC less than 25 are encouraged to begin attending training and after July 1, enrolling their facilities in NHSN.

69) how have the hospital information technology leaders been involved in the development of the RFP for the automated reporting of LabID data for MRSA and CDI? How will the hospitals be involved?

Up to this point, the scope of work within the RFP specifies the use of standards to facilitate information exchange independent of any one facility's technical infrastructure (e.g. ADT software, Lab Information management System, etc) and hospital IT leaders have not been involved in development of the general scope of work. However, hospital IT leaders will be engaged when the contract has been awarded to help define requirements and implementation of the automated reporting. Going forward, hospitals will be engaged as trading partners to exchange the data required in NHSN in an electronic format to reduce the reporting burden on the facility.

70) does the data upload from the surgical system to NHSN include all procedures or only CABG and HIP?

From a technical perspective, NHSN can accept all procedures that are defined by NHSN. In TN, the current uploads, at a minimum, should contain CBGB and CBGC. With the new reporting requirements, the upload should contain CBGB, CBGC, and HPRO. If a facility chooses to use NHSN to monitor other procedures, denominator data for those procedures can also be included in the upload.

71) what is the definition for special care areas? Is there criteria which defines these areas?

The inpatient specialty care areas (SCAs) within NHSN include: Long Term Acute Care, Bone Marrow Transplant, Acute Dialysis, Hematology/Oncology, Solid Organ Transplant, Pediatric Bone Marrow Transplant, Pediatric Dialysis, Pediatric Hem/Onc, Pediatric Solid Organ Transplant. An 80% rule is applied to determine if your unit is considered a specific type of SCA. For example, if 80% of patients in a unit are on

inpatient-dialysis, the unit is considered an Inpatient-Acute Dialysis SCA. If your inpatient dialysis patients are spread throughout your facility and there is no 1 unit where 80% of the patients are on dialysis, then you do not have an Acute Dialysis SCA.

- 72) On HPRO, explain how data would be done for pt who has procedure one month but infection is identified a few months later.

For HPRO, since an implant is involved, if an SSI infection develops within 1 year of the procedure, the infection should be reported in NHSN. For a procedure where an implant is not involved, only infections developing within 30 days are reportable in NHSN.

- 73) In the CLIP requirement at 100% compliance do to track all CL insertions or only infected CLBSI

For the CLIP national HHS action plan metric, all CL insertions for one or more months in one of more locations need to be monitored. In TN, we ask that, at a minimum, that facilities include the CLIP data for lines which became infected, so that you can link process and outcome in educating your providers.

- 74) What if LTAC's get transfers from other facilities with known CDI or MRSA?

If the patient has a positive blood culture for MRSA or a positive stool specimen for CDI while an inpatient in your facility and has no previous positive at your facility within 14 days prior, you would report them in NHSN, regardless of their transfer status. If no testing is done in your facility, you would not report them.

- 75) Does all of this apply in the same manner for Rehab hospitals? Are we considered a special care area?

Reporting applies for Rehab hospitals in the same manner. To determine if you have any SCAs, refer to question 71)

Beginning in July 2010, the initial focus will be on Long Term Acute Care facilities and facilities with an ADC of 25 or greater. For hospitals with an ADC less than 25, TDH will work with the Multidisciplinary Advisory Group to develop a tiered approach to bring those facilities on. TDH will propose that facilities with an ADC less than 25 begin reporting in January 2011. However, non-LTAC facilities with an ADC less than 25 are encouraged to begin attending training and after July 1, enrolling their facilities in NHSN.

- 76) when will state begin NHSN training for new reporting requirements?

Training will begin in April and continue throughout the year. TDH is sending out a survey this week to collect information on preferences (i.e. full day training versus multiple half-day trainings, webinar versus in-person, etc). Information on training dates will be released by the last week of March.