2015 Network Healthcare Associated Infection (HAI) Quality Improvement Activity (QIA) National Healthcare Safety Network (NHSN) Prevention Process Measures Reporting

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

National Center for Emerging and Zoonotic Infectious Diseases

Division of Healthcare Quality Promotion

Outline

- **QIA - Audit of Recommended Practices**
- **CDC Objectives for the QIA**
- **NHSN Prevention Process Measures (PPM) – what Networks need to know for the QIA**
- **Network reporting QIA facility data to CMS**
  - Customizing an NHSN report
- **PPM – what facilities need to know for the QIA**
  - Adding PPM to Monthly Reporting Plan
  - How to report PPM data to NHSN
  - NHSN alerts
  - How to “Confer Rights” to share data with Group(s)
    - Differences for QIA and non-QIA facilities
  - Basic analysis and available reports

Network Quality Improvement Activities – Audit of Recommended Practices

- **Goal 20% of Network facilities complete internal, monthly audits:**
  - ≥ 30 hand hygiene observations
  - ≥ 10 HD catheter connection/disconnection observations
  - ≥ 10 AV fistula/graft cannulation observations
- **Facilities tally numerators/denominators and report those to NHSN's Prevention Process Measure (PPM) module**
- **Networks report monthly progress to CMS**

Suggestions for Selecting 20% of Facilities

- **Select a variety of facility types:**
  - Include freestanding and hospital-based facilities
  - Varied sizes
- **Facilities without catheter patients will not be able to do catheter connection/disconnection audits**
- **For 2015, Networks can choose the facilities**
  - May continue with a subset of 2014 participants
  - May select new group of facilities

CDC Objectives

- **CDC objectives for audit tool use:**
  - Increase familiarity with CDC-recommended practices
  - Encourage habitual attention to and assessment of practices
  - Identify and address barriers to recommended practices

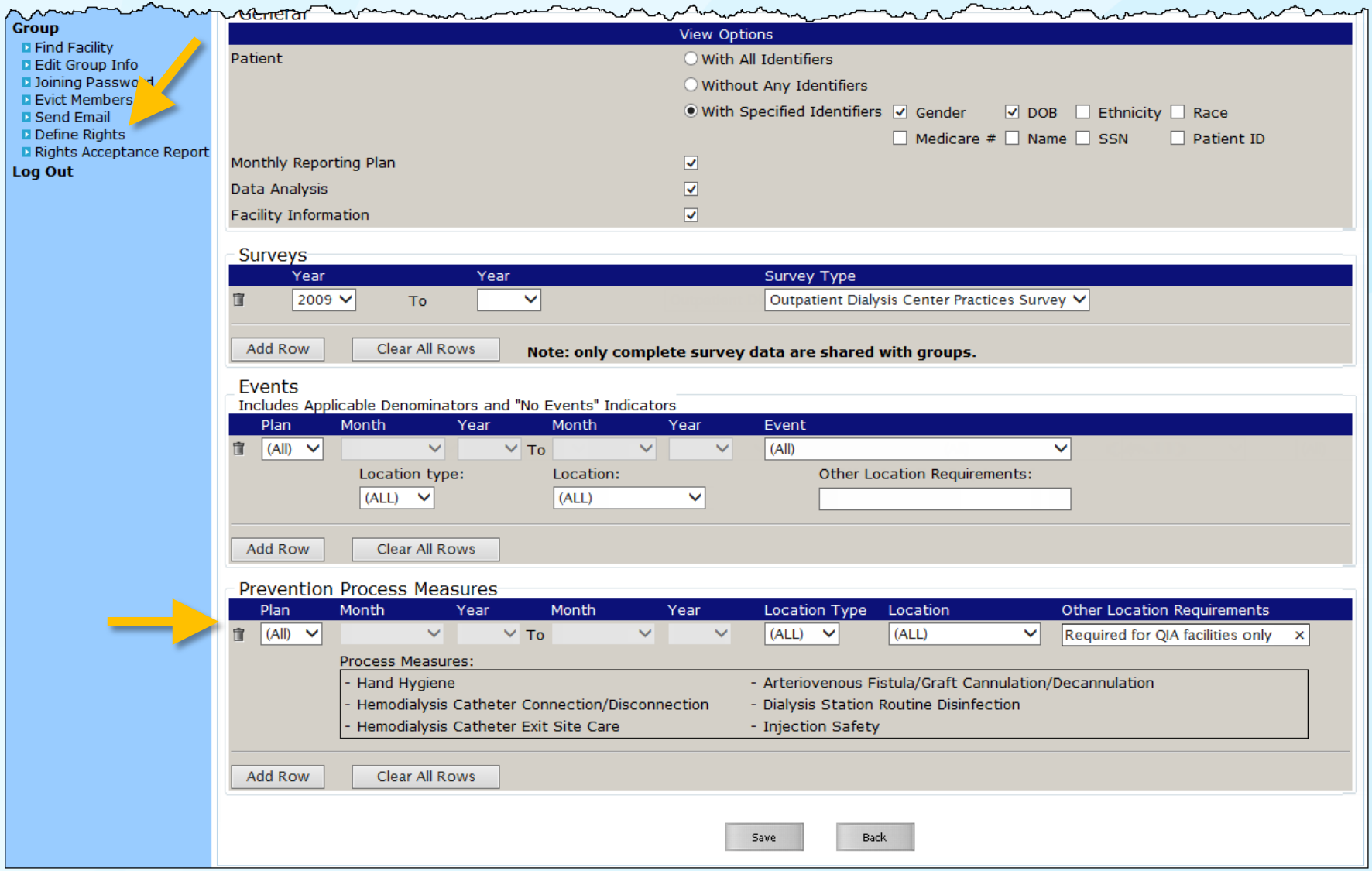
- **Networks should focus on audit *implementation***
  - More importance on facilities correctly doing audits, less emphasis on audit results
  - Encourage facilities to regularly review their audit results and share with staff
    - Promotes desired practices, helps identify areas for improvement, and engages staff with regular feedback

NHSN PPM MODULE – INFORMATION FOR NETWORKS

Outline of PPM Information for Networks

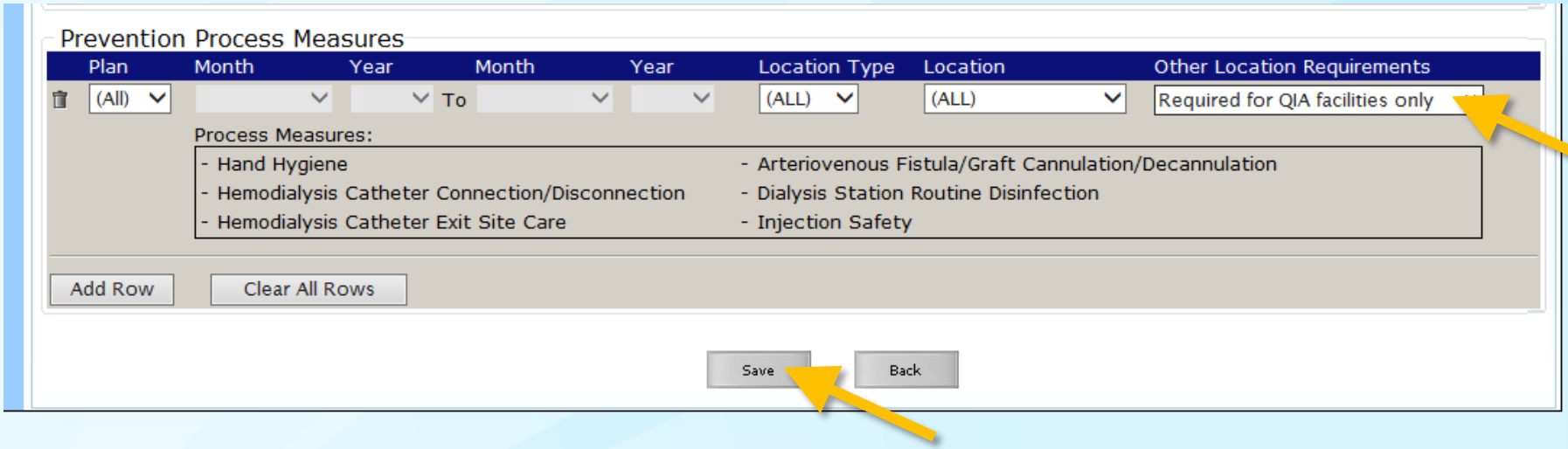
- **Network Group needs to "Define Rights" to request PPM data**
  - Suggestion: use the text field to let non-QIA facilities know they can opt out of sharing these data by selecting "N/A" for the PPM section and/or sharing data is required for non-QIA facilities
- **Reminder – Groups can use the NHSN "Membership Rights" report to monitor facilities' "N/A" selections on Confer Rights**

Network Group: “Define Rights” to Request PPM Data



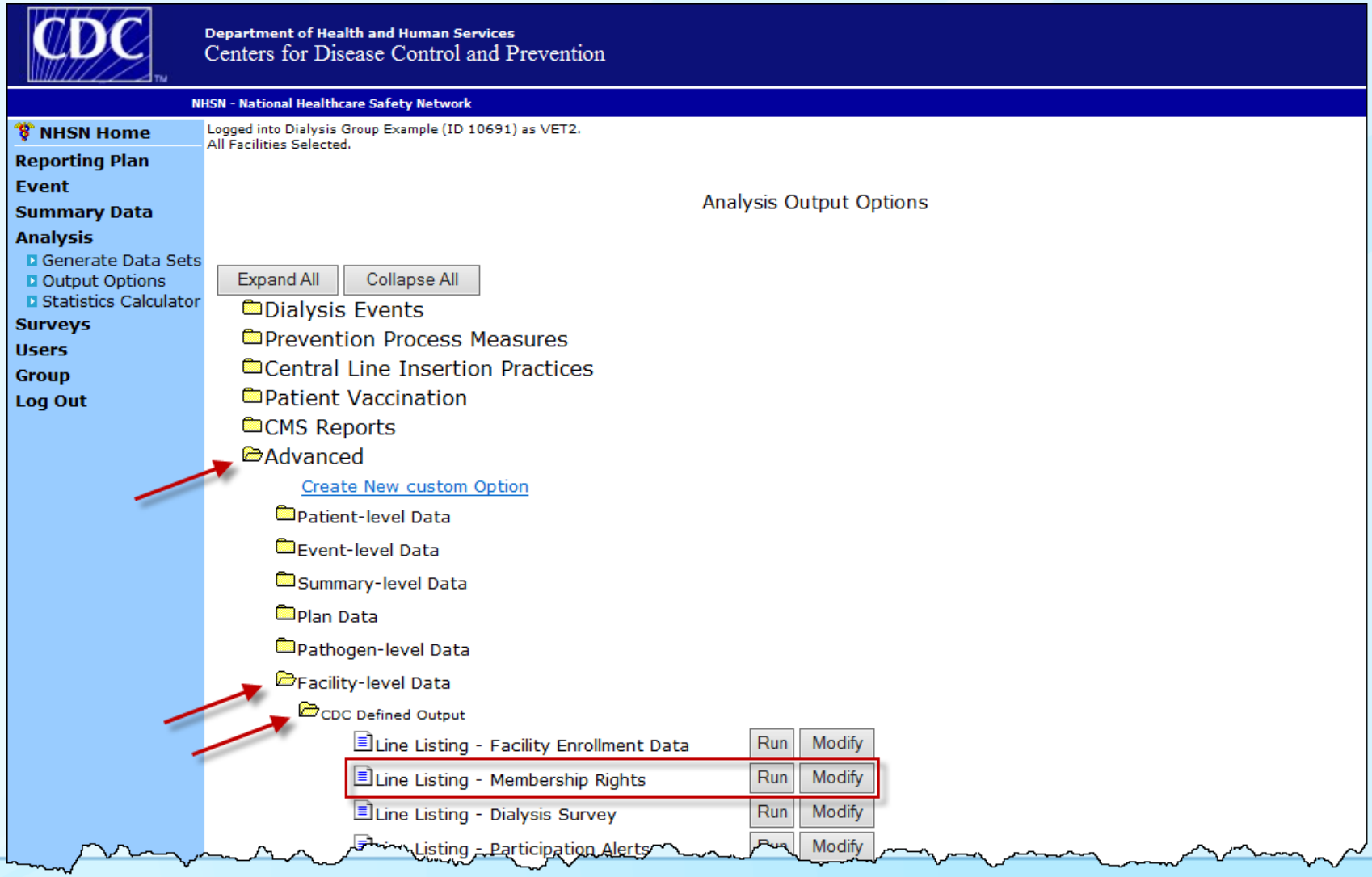
Suggestion to Networks – Indicate Conferring Rights to PPM Data is Mandatory Only for QIA Facilities

- Under "Other Location Requirements," use the free text field to indicate QIA facilities must confer rights
  - E.g., "Required for QIA facilities only"

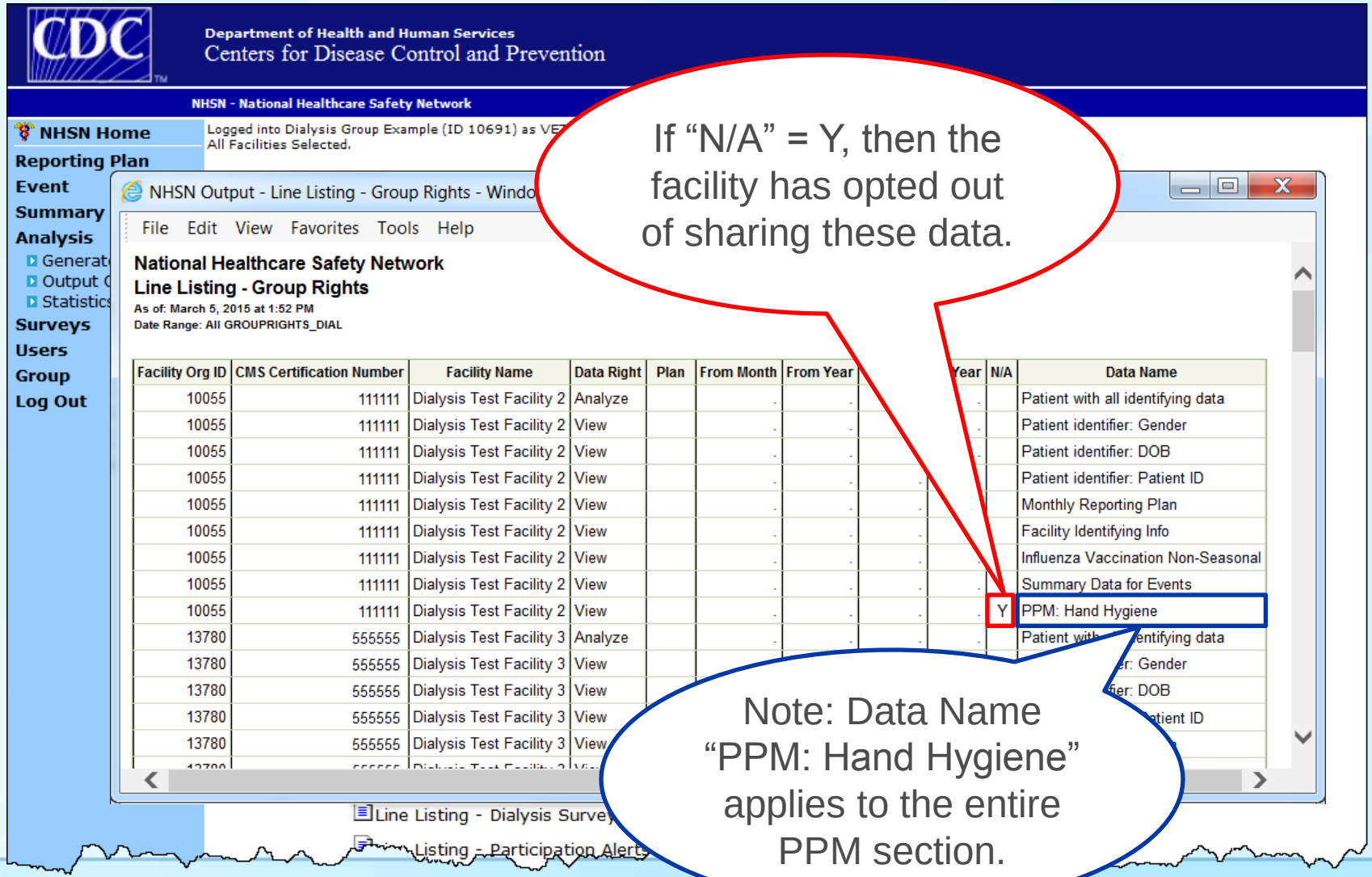


- Upon saving "Define Rights," facility users with administrator rights will be prompted to "Confer Rights" to the updated data sharing agreement

Reminder – Network Groups Can Use the "Membership Rights" Report Can be used to Monitor Facilities' "N/A" Selections



Reminder – Network Groups Can Use the "Membership Rights" Report Can be used to Monitor Facilities' "N/A" Selections



NETWORK REPORTING TO CMS

Network Reporting on QIA Goals

- **Goal: By the end of 3rd quarter 2015, 100% of QIA facilities are completing the minimum number of observations for three Audit Tools and reporting results to NHSN PPM module:**
  - Hand Hygiene (minimum 30 observations)
  - HD Catheter Connection/Disconnection (minimum 10 observations)
  - AV Fistula/Graft Cannulation (minimum 10 observations)

- **Each month, report on the CMS dashboard the proportion of QIA facilities that reported meeting or exceeding the minimum number of total observations for each audit tool:**
  - #QIA facilities with “HHOpport” ≥ 30 / total #QIA facilities x 100
  - #QIA facilities with “numCathConTot” ≥10 / total #QIA facilities x 100
  - #QIA facilities with “numFGCannTot” ≥10 / total #QIA facilities x 100

Network Report to CMS

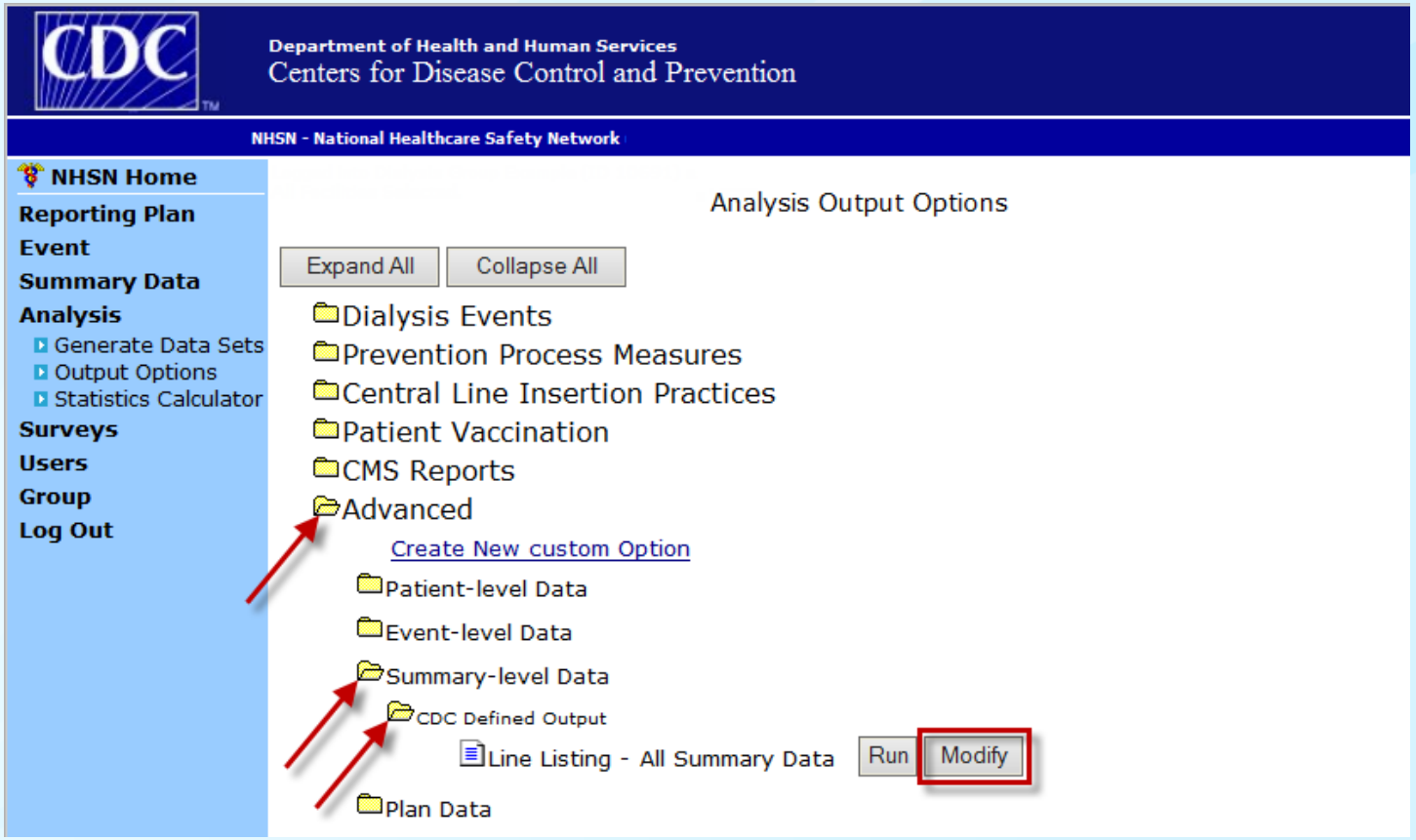
- #QIA facilities with “HHOpport” ≥ 30 / total #QIA facilities x 100
- #QIA facilities with “numCathConTot” ≥10 / total #QIA facilities x 100
- #QIA facilities with “numFGCannTot” ≥10 / total #QIA facilities x 100

Facility Org ID	Summary Year/ Month	HD Catheter Connection/ Disconnection # of Successful Observations	HD Catheter Connection/ Disconnection Total # of Observations	HD Catheter Connection/ Disconnection Percent Adherence
11111	2015M04	6	10	60.0
22222	2015M04	7	11	63.6
33333	2015M04	4	9	44.4
44444	2015M04	7	10	70.0
55555	2015M04	6	10	60.0

4/5 QIA facilities met the goal for the Catheter Connection/Disconnection in April 2015.

How to Customize NHSN an Report for CMS Reporting

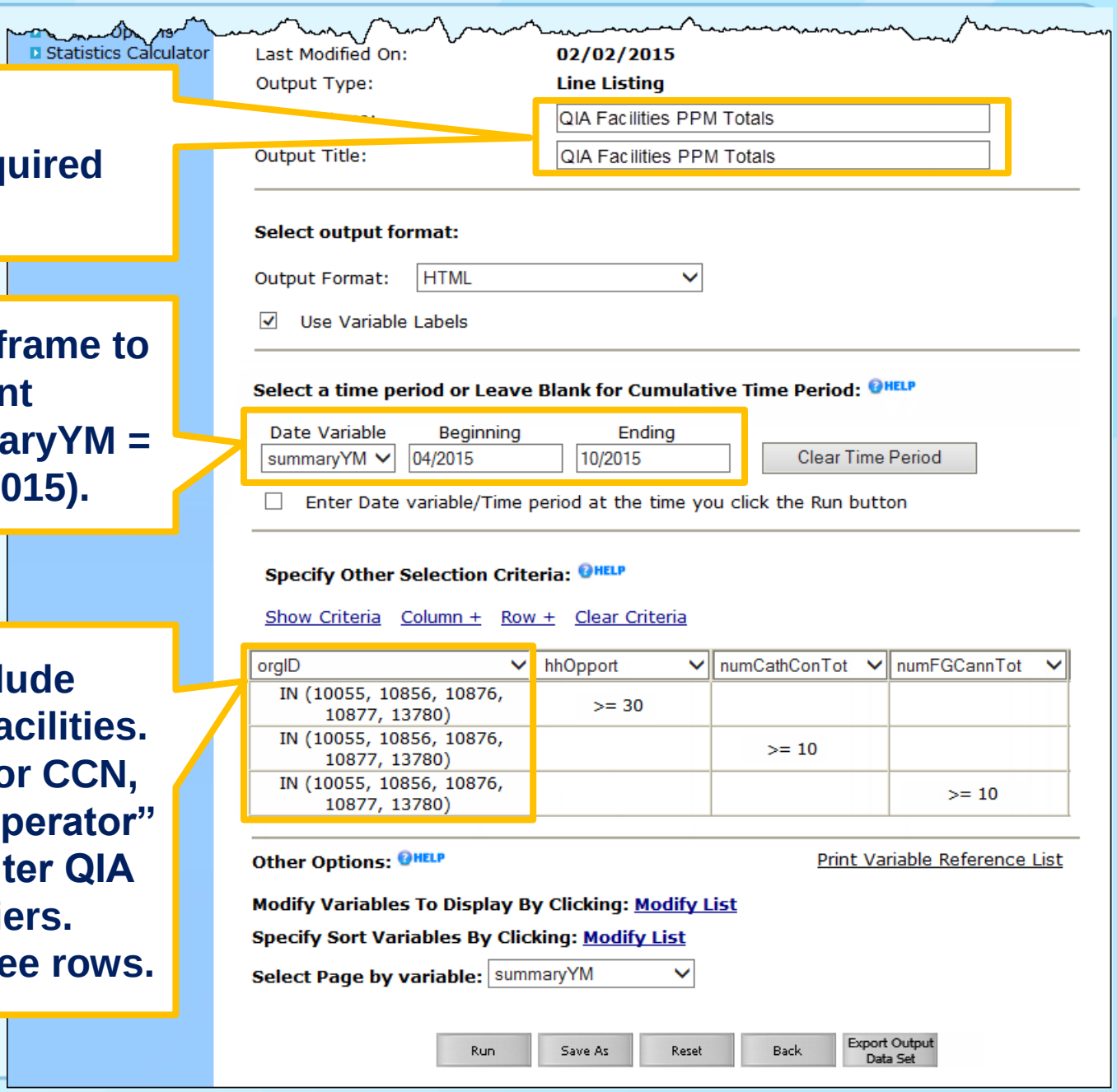
- Create a custom line listing report to display only QIA facilities that reported at least the minimum number of observations for each Audit Tool



1. **Modify output name/title (required for saving).**

2. **Limit the timeframe to the assessment period (summaryYM = 04/2015 – 10/2015).**

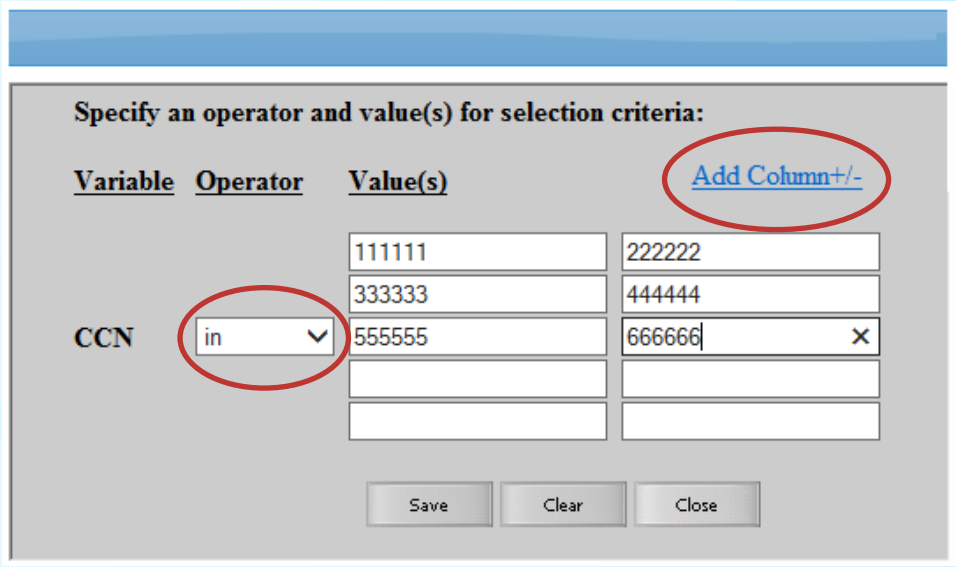
3. **a. Filter to include only the QIA facilities. (Select orgID or CCN, change the "operator" to "IN" and enter QIA facility identifiers. Repeat for three rows.**

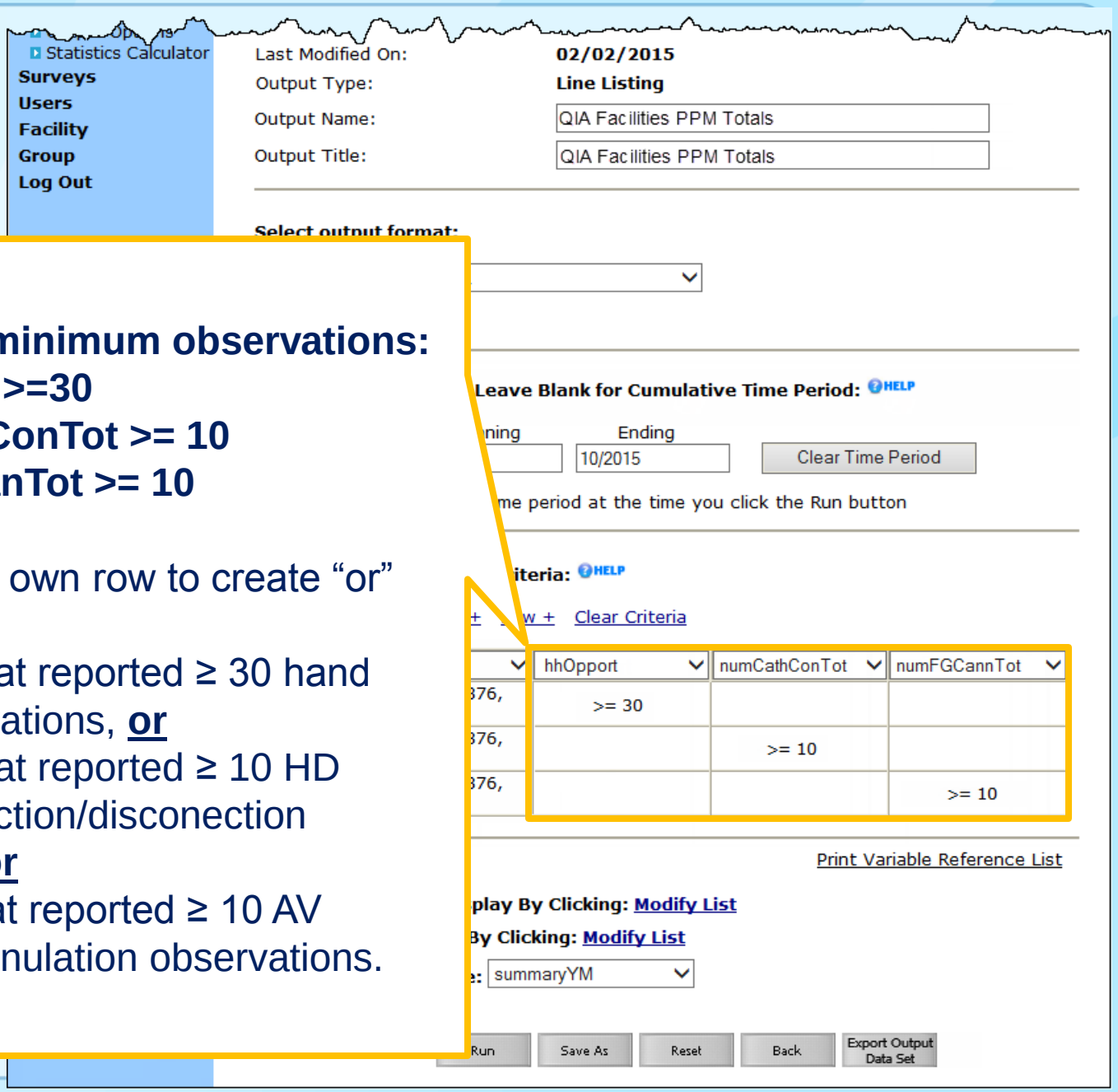


Details for Suggested Modifications (Filter Table)

3.a. Filter by CCN or orgID for QIA facilities:

- Select the “in” operator (i.e., include) from the dropdown.
- Type the QIA facility CCNs (or orgIDs) into each cell.
- Use “Add Column+/-” to create additional cells.
- Click “Save.”



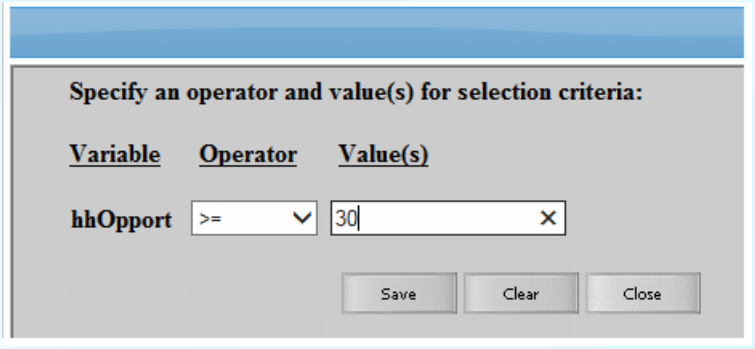


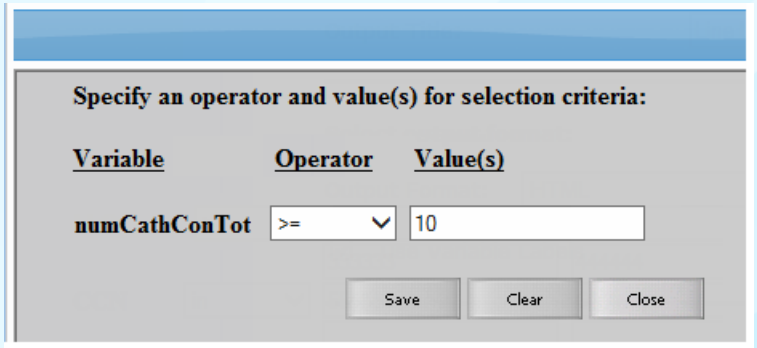
3. **b. Filter by ≥ minimum observations:**
   - **hhOpport >=30**
   - **numCathConTot >= 10**
   - **numFGCanTot >= 10**

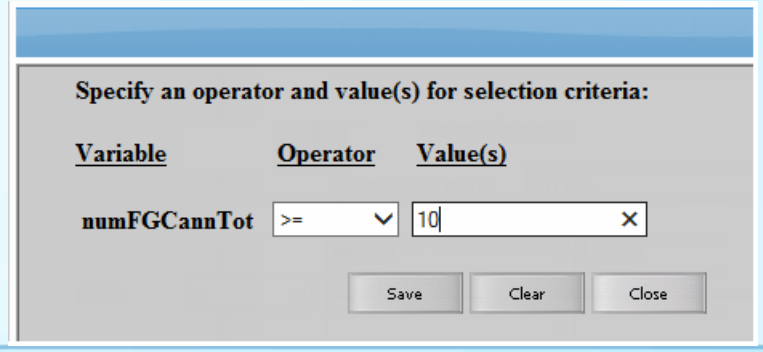
Each filter is in it's own row to create "or" statements:

- QIA facilities that reported ≥ 30 hand hygiene observations, **or**
- QIA facilities that reported ≥ 10 HD catheter connection/disconection observations, **or**
- QIA facilites that reported ≥ 10 AV fistula/graft cannulation observations.

Details for Suggested Modifications (Filter Table)







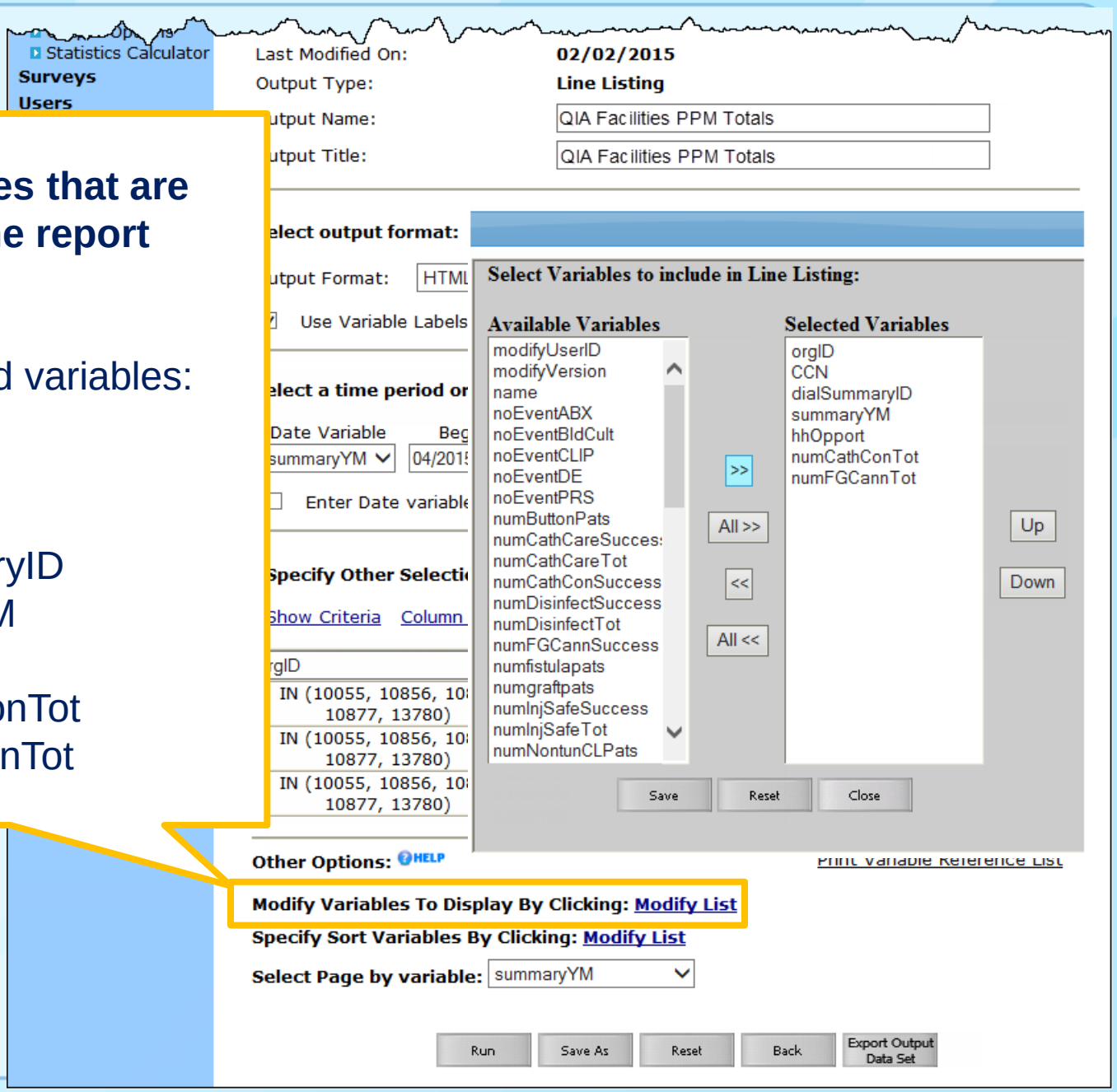
3.b. Filter by ≥ minimum number of observations:

- Select the “>=” operator (i.e., greater than or equal to) from the dropdown.
- Type the minimum number of required observations:
  - “hhOpport” >= 30
  - “numCathConTot” >= 10
  - “numFGCannTot” >= 10
- Click “Save.”

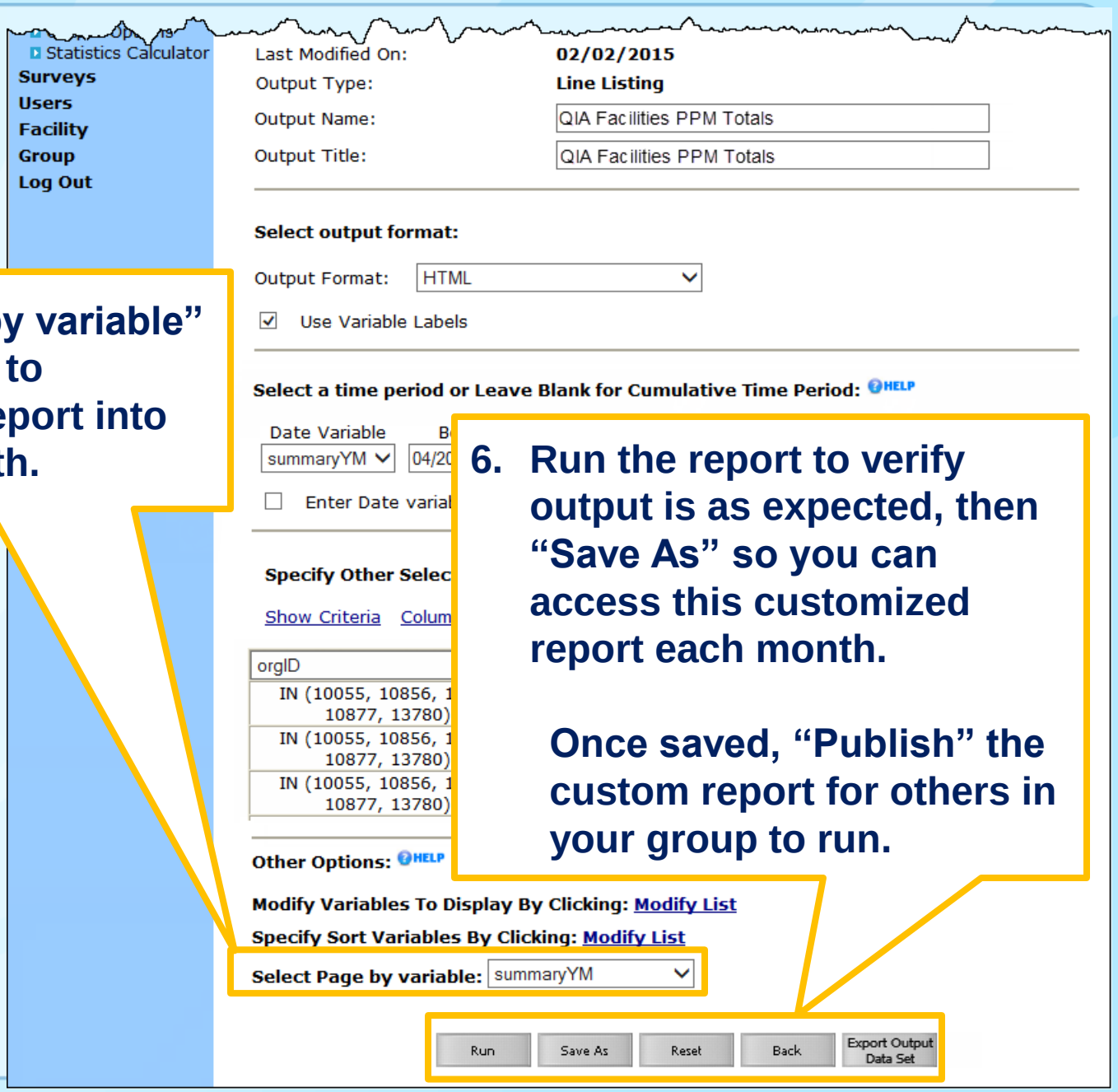
4. **Modify variables that are displayed in the report (optional).**

Suggested selected variables:

- orgID
- CCN
- Name
- dialSummaryID
- summaryYM
- hhOpport
- numCathConTot
- numFGCannTot



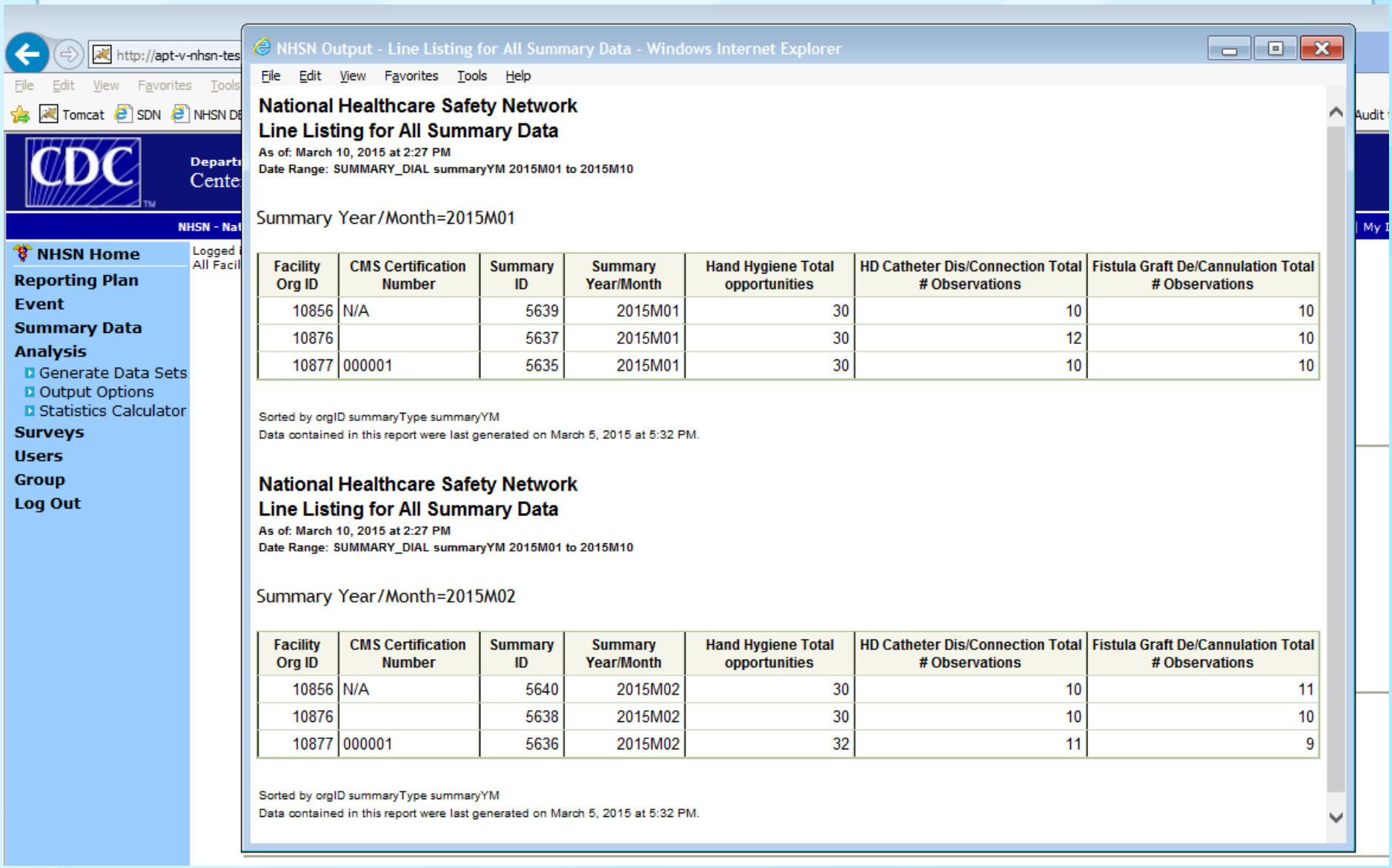
5. “Select Page by variable” = summaryYM to separate the report into tables by month.



6. Run the report to verify output is as expected, then “Save As” so you can access this customized report each month.

   Once saved, “Publish” the custom report for others in your group to run.

Example of Customized Output



SUMMARY

Summary

- **QIA goal is for 20% of facilities to complete a minimum of internal, monthly audits on CDC recommended practices:**
  - ≥ 30 hand hygiene opportunities
  - ≥ 10 HD catheter connection/disconnection observations
  - ≥ 10 AV fistula/graft cannulation observations
- **CDC Audit Tool results are reported to the NHSN Prevention Process Measures Module under "Summary Data"**
  - CDC can assist with facility training
  - Groups need to update Define Rights
    - Suggest including text about which facilities are required to share PPM data and which can select "N/A"
  - Facilities should report in-plan: creates alerts to remind them to report
  - Customize and save the "All Summary Data" report to determine the number of QIA facilities meeting the goal and report the results to CMS

TRAINING INFORMATION FOR QIA FACILITIES

CDC can assist with PPM facility training!

The Value of Auditing CDC Recommended Infection Prevention Practices

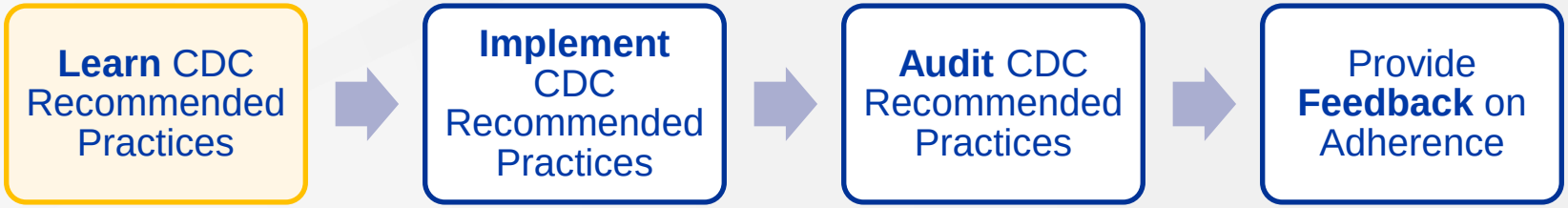
- **Increased adherence to CDC recommended practices can prevent infections:**
  - Outpatient hemodialysis facilities that implemented the package of CDC recommended practices saw a 32% reduction in BSIs and a 54% reduction in access-related BSIs.[1]
- **Auditing adherence to recommended practices:**
  - Promotes and reinforces recommended practices among staff.
  - Ensures complete and correct implementation.

1. Am J Kidney Dis. August 2013, 62(2): 322–330

CDC Infection Prevention Audit Tools

- **Facilities begin by learning recommended practices:**
  - CDC Recommended Interventions to Prevent Bloodstream Infections in Dialysis Settings:
    - http://www.cdc.gov/dialysis/prevention-tools/core-interventions.html
  - CDC recommended checklists:
    - http://www.cdc.gov/dialysis/prevention-tools/index.html
    - Simple reference tools useful for training staff.

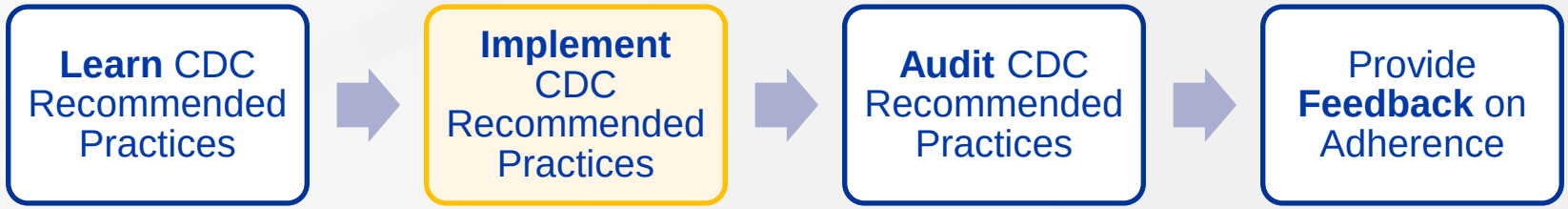
- **Then use the audit tools as part of a planned series of observations within their hemodialysis facility.**



Tips for Facilities to Successfully Implement New Practices

- **Facilities should review current practices to identify discrepancies between current practices and CDC recommended practices.**

- **Facilities should develop an implementation strategy, they may consider:**
  - Input from patient care staff
  - Training needs
  - How to inform patients of changes
  - Whether necessary supplies (e.g., chlorhexidine) are available



Available CDC Dialysis Infection Prevention Audit Tools: http://www.cdc.gov/dialysis/prevention-tools/index.html

Hand Hygiene

HD Catheter Connection/ Disconnection

AV Fistula/ Graft Cannulation/ Decannulation

Although the audit tool includes both cannulation and decannulation, *only cannulation is included in the QIA*

Learn CDC Recommended Practices → **Implement** CDC Recommended Practices → **Audit** CDC Recommended Practices → Provide **Feedback** on Adherence

Data Collection

- **All audits – observer(s) should try to ensure that observations are as representative as possible of normal practice at the facility:**
  - Observe different staff members on different days and shifts.
  - Consider observing during particularly busy times (e.g., shift change), when staff may be less attentive to proper practices.

How to Use the Audit Tool: Opportunities

- **Each audit includes multiple observations.**
  - An observation is an opportunity to perform hand hygiene (when warranted)
- **If an opportunity is observed and hand hygiene is performed, the observation is marked a success:**

Audit Tool: Hemodialysis hand hygiene observations

(Use a "√" for each 'hand hygiene opportunity' observed. Under 'opportunity successful', use a "√" if successful, and leave blank if not successful)

Discipline	Hand hygiene		Describe any missed attempts (e.g., during medication prep, between patients, after contamination with blood, etc.):
	Hand hygiene opportunity	Opportunity successful	
N	√	√	
T	√	√	
N	√		missed opportunity before administering medication

The first two observations were successful because hand hygiene was warranted and was performed.

The third observation was not successful because the warranted opportunity for hand hygiene was missed.

Tallying Opportunity Audit Results

- Number of Successful Opportunities: Sum of observed instances during which staff hand hygiene was warranted and was successfully performed.
- Total Number Opportunities: Total number of observed instances during which staff hand hygiene was warranted.

Audit Tool: Hemodialysis hand hygiene observations

(Use a "√" for each 'hand hygiene opportunity' observed. Under 'opportunity successful', use a "√" if successful, and leave blank if not successful)

	Discipline	Hand hygiene		Describe any missed attempts (e.g., during medication prep, between patients, after contamination with blood, etc.):
		Hand hygiene opportunity	Opportunity successful	
1	N	√	√	
2	T	√	√	
3	~~N~~	√		missed opportunity before administering medication
4	P	√	√	
5	N	√	√	

Discipline: **P**=physician, **N**=nurse, **T**=technician, **S**=student, **D**=dietitian, **W**=social worker, **O**=other

Duration of observation period = _____ minutes Number of successful hand hygiene opportunities observed = 4

Total number of patients observed during audit = _____ Total number of hand hygiene opportunities observed during audit = 5

** See hand hygiene opportunities on back page

Audit Results Reported to NHSN

- Number of Successful Opportunities: Sum of observed i… which staff hand hygiene was warranted and was s…
- Total Number Opportunities: Total number of ob… which staff hand hygiene was warranted.

These are the numbers reported to NHSN

Audit Tool: Hemodialysis hand hygiene observation…

(Use a "√" for each 'hand hygiene opportunity' observed. Under 'opport… leave blank if not successful)

	Discipline	Hand hygiene		Describe any mis… between patients, a…	…):
		Hand hygiene opportunity	Opportunity successful		
1	N	√	√		✓
2	T	√	√		✓
3	~~N~~	~~√~~		~~missed opportunity before adminis…~~	~~medication~~
4	P	√	√		✓
5	N	√	√		✓

Discipline: **P**=physician, **N**=nurse, **T**=technician, **S**=student, **D**=dietit…, **W**=social worker, **O**=other

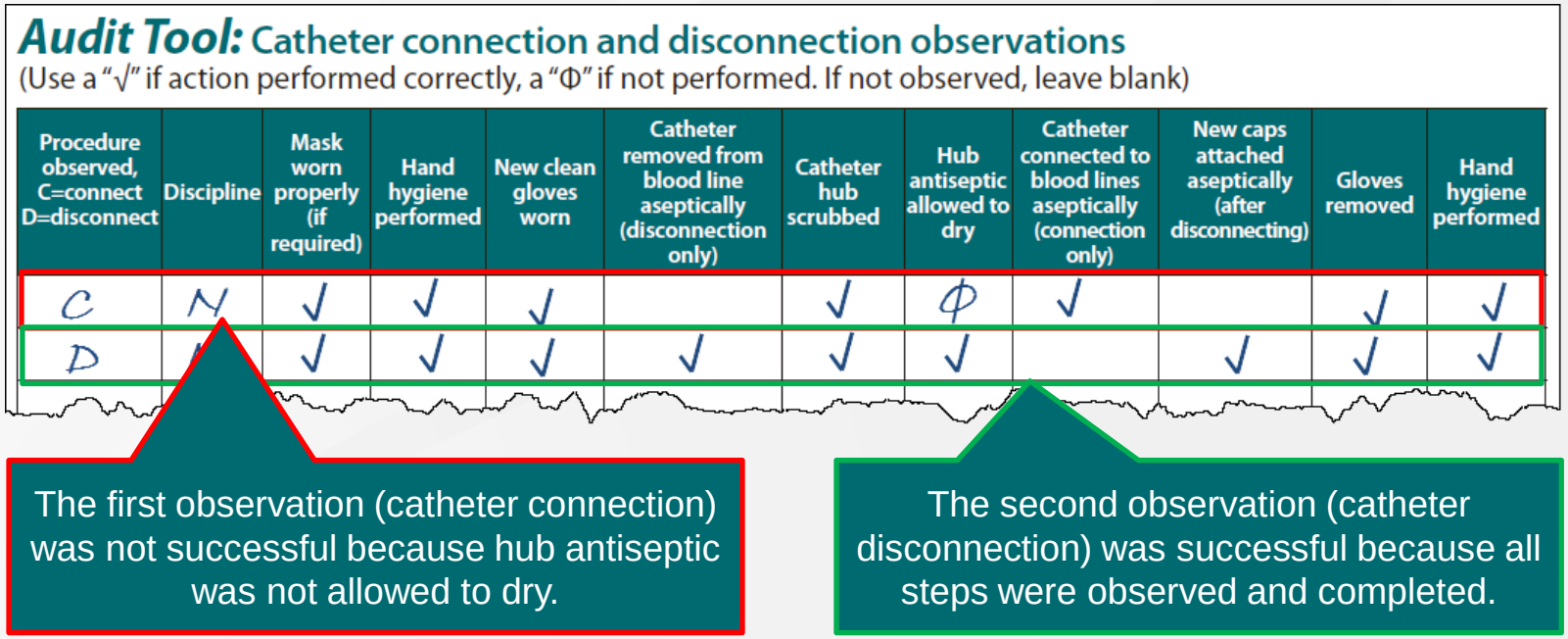
Duration of observation period = _____ minut… Number of successful hand hygiene opportunities observed = 4

Total number of patients observed during audit = _____ Total number of hand hygiene opportunities observed during audit = 5

** See hand hygiene opportunities on back page

How to Use the Audit Tools: Procedures

- **Each audit includes multiple observations.**
  - An observation is the review of a procedure to indicate which steps were performed correctly or incorrectly.
- **If each step of a procedure is observed and correctly performed, the observation is marked a success:**



Audit Tool: Catheter connection and disconnection observations

(Use a "√" if action performed correctly, a "Φ" if not performed. If not observed, leave blank)

	Procedure observed, C=connect D=disconnect	Discipline	Mask worn properly (if required)	Hand hygiene performed	New clean gloves worn	Catheter removed from blood line aseptically (disconnection only)	Catheter hub scrubbed	Hub antiseptic allowed to dry	Catheter connected to blood lines aseptically (connection only)	New caps attached aseptically (after disconnecting)	Gloves removed	Hand hygiene performed
1.	C	N	√	√	√		√	Φ	√		√	√
2.	D		√	√	√	√	√	√		√	√	√

The first observation (catheter connection) was not successful because hub antiseptic was not allowed to dry.

The second observation (catheter disconnection) was successful because all steps were observed and completed.

Tallying Procedure Audit Results

- Once all observations have been completed, add the successful observations and note the total number of observations performed:

Audit Tool: Catheter connection and disconnection observations

(Use a "√" if action performed correctly, a "Φ" if not performed. If not observed, leave blank)

	Procedure observed, C=connect D=disconnect	Discipline	Mask worn properly (if required)	Hand hygiene performed	New clean gloves worn	Catheter removed from blood line aseptically (disconnection only)	Catheter hub scrubbed	Hub antiseptic allowed to dry	Catheter connected to blood lines aseptically (connection only)	New caps attached aseptically (after disconnecting)	Gloves removed	Hand hygiene performed
1	C	N	√	√	√		√	Φ	√		√	√
2	D	N	√	√	√	√	√	√		√	√	√
3	C	N	Φ	√	√		√	Φ	√		√	√
4	D	N	√	√	√	√	√	√		√	√	√
5	C	T	√	√	√		√	√	√		√	√
6	C	N	√	√	√		√	√	√		√	√
7	C	N	√	√	√		√	√	√		√	√

Discipline: **P**=physician, **N**=nurse, **T**=technician, **S**=student, **O**=other

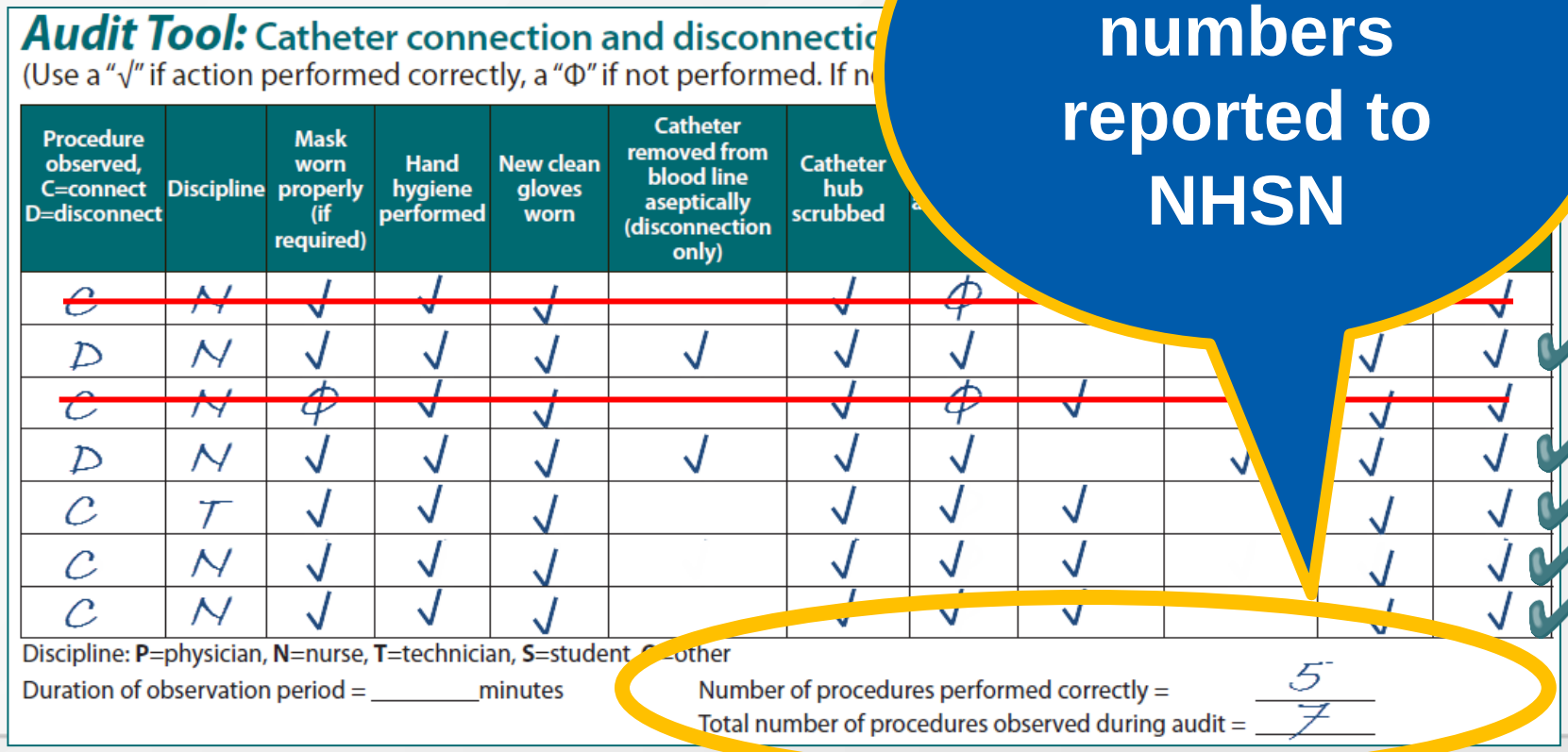
Duration of observation period = _____minutes

Number of procedures performed correctly = 5

Total number of procedures observed during audit = 7

Audit Results Reported to NHSN

- Once all observations have been com[illegible]dd the successful observations and not[illegible] of observations performed:



Audit Tool: Catheter connection and disconnecti[illegible]

(Use a "√" if action performed correctly, a "Φ" if not performed. If n[illegible]

	Procedure observed, C=connect D=disconnect	Discipline	Mask worn properly (if required)	Hand hygiene performed	New clean gloves worn	Catheter removed from blood line aseptically (disconnection only)	Catheter hub scrubbed	[illegible]				
1	C	N	√	√	√		√	Φ				√
2	D	N	√	√	√	√	√	√			√	√
3	C	N	Φ	√	√		√	Φ	√		√	√
4	D	N	√	√	√	√	√	√		√	√	√
5	C	T	√	√	√		√	√	√		√	√
6	C	N	√	√	√		√	√	√		√	√
7	C	N	√	√	√		√	√	√		√	√

Discipline: **P**=physician, **N**=nurse, **T**=technician, **S**=student, **O**=other

Duration of observation period = _____ minutes

Number of procedures performed correctly = 5

Total number of procedures observed during audit = 7

These are the numbers reported to NHSN

NHSN PREVENTION PROCESS MEASURES (PPM) MODULE – INFORMATION FOR FACILITIES

Prevention Process Measures (PPM) Module

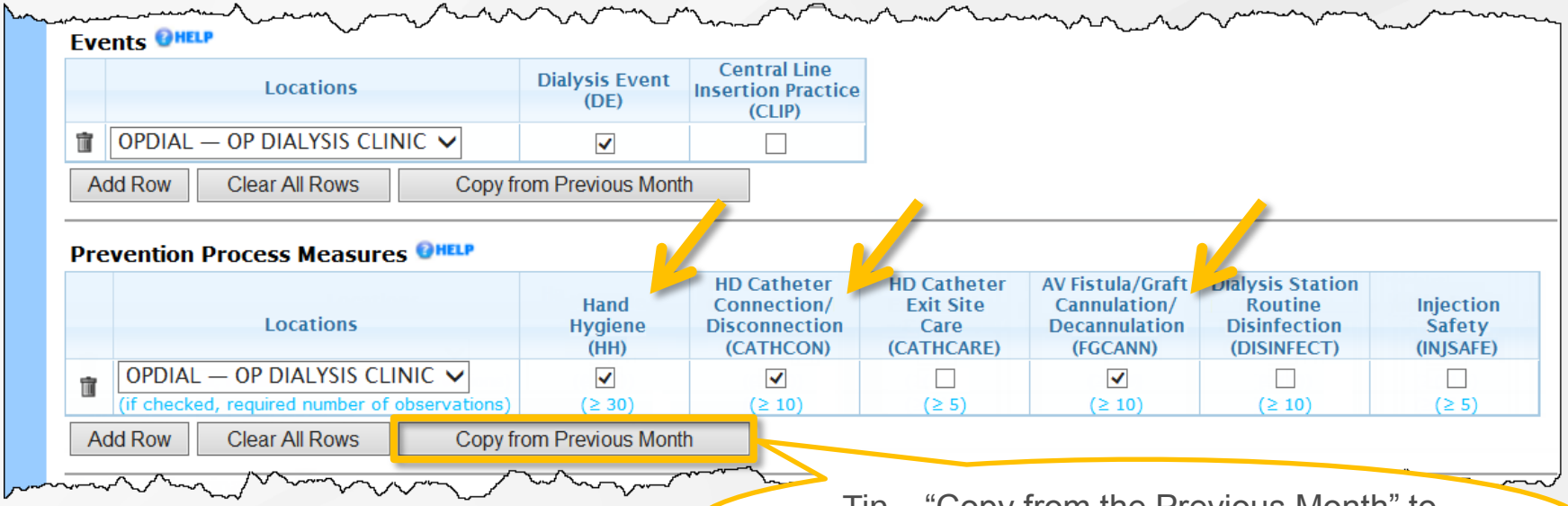
- **How facilities add PPM to Monthly Reporting Plans**
- **How facilities report PPM data to NHSN**
- **How to interpret NHSN missing/incomplete data alerts**
- **How facilities Confer Rights to share data with Groups**
  - Differences for QIA vs. non-QIA facilities
- **Analysis: available reports and percent adherence**

Facilities Report Audit Results to NHSN

- **Audit results can be reported to NHSN either "in-plan" or "off-plan."**
- **In-plan refers to the selections made on the NHSN Monthly Reporting Plan:**
  - By making a selection on the Monthly Reporting Plan, facilities agree to follow the NHSN Protocol for monitoring and reporting of that prevention process measure.
    - NHSN Dialysis Prevention Process Measures Protocol
  - In-plan reporting requires a minimum number of observations for each audit each month and will generate alerts to remind facility users to report additional data
- **In-plan reporting is suggested for QIA facilities.**

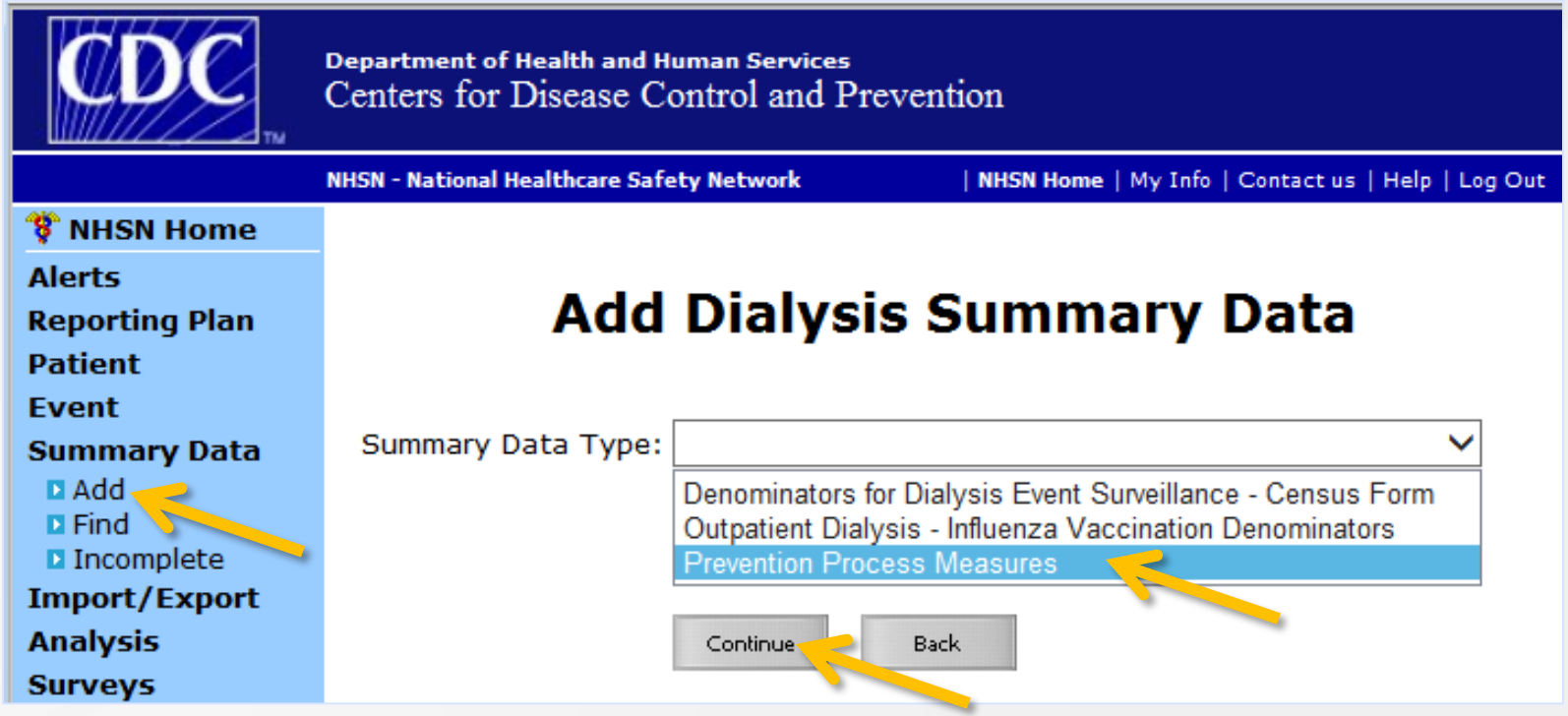
Monthly Reporting Plan: Prevention Process Measures

- **Facilities indicate which audits will be performed during the month by checking the corresponding box(es):**
  - By checking the box, the facility agrees to follow the NHSN protocol for monitoring and reporting of that prevention process measure.
  - There are a minimum number of observations for in-plan reporting, specified below each checkbox.



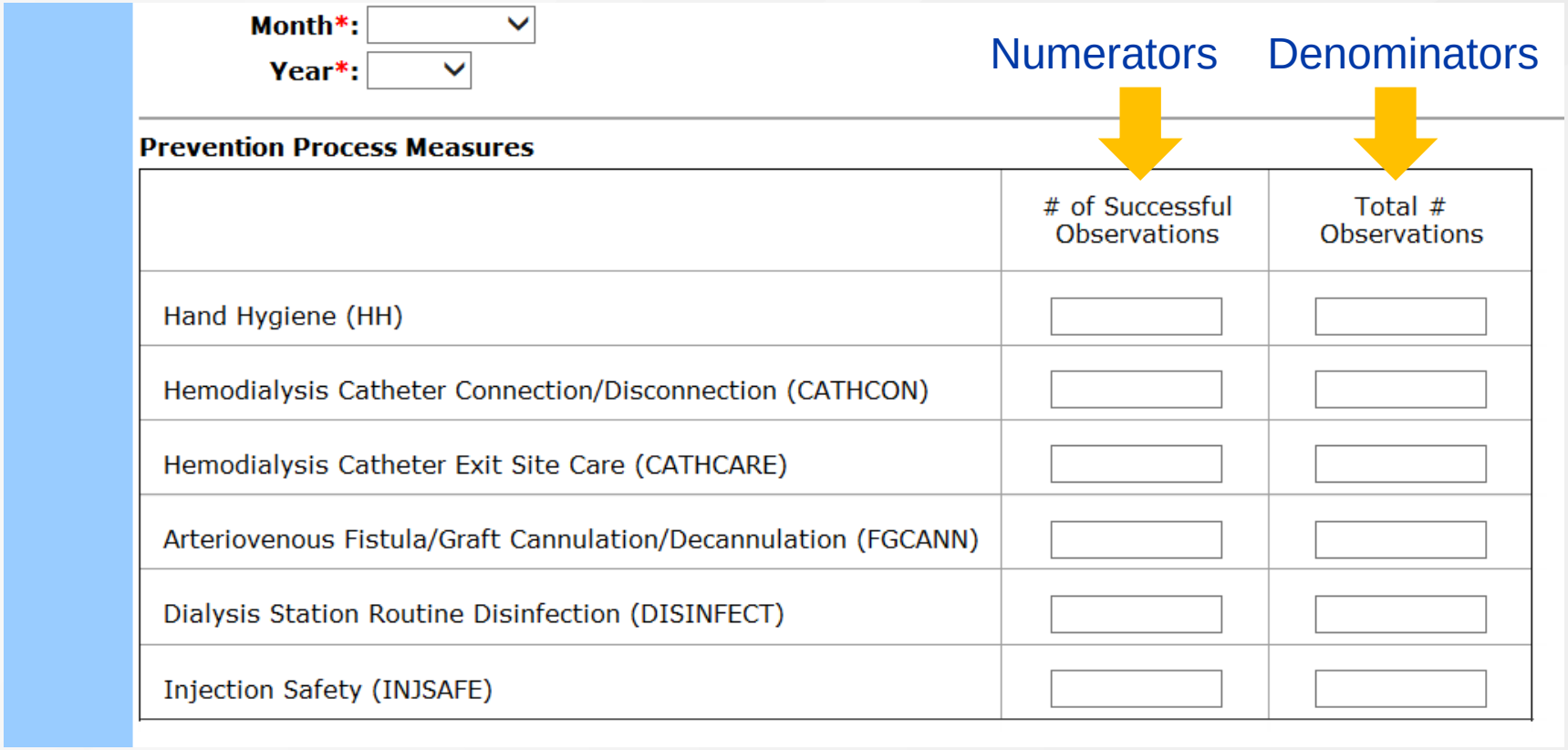
How Facilities Report Audit Results to NHSN

- From the navigation bar, select “Summary Data,” then “Add.”
- Select “Prevention Process Measures” from the menu.
- Click the “Continue” button.



Numerators and Denominators

- Facilities report the sum of successful observations and the total number of observations that month on the Prevention Process Measures form in NHSN



Month*:

Year*:

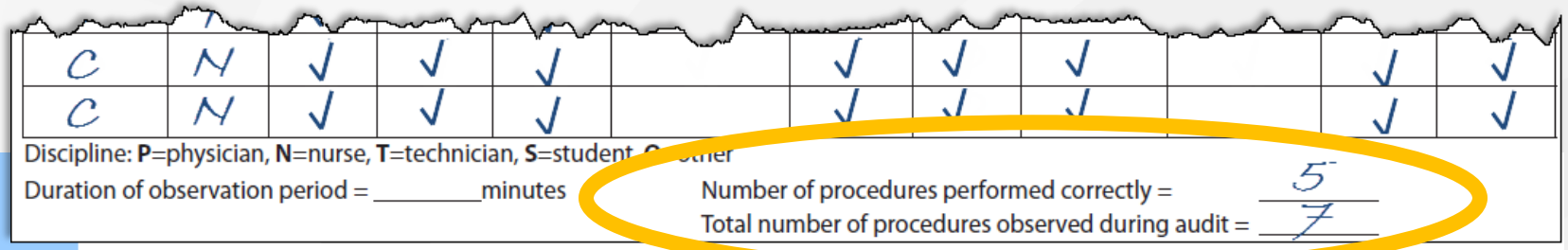
Numerators

Denominators

Prevention Process Measures

	# of Successful Observations	Total # Observations
Hand Hygiene (HH)		
Hemodialysis Catheter Connection/Disconnection (CATHCON)		
Hemodialysis Catheter Exit Site Care (CATHCARE)		
Arteriovenous Fistula/Graft Cannulation/Decannulation (FGCANN)		
Dialysis Station Routine Disinfection (DISINFECT)		
Injection Safety (INJSAFE)		

Example of Reporting Audit Results to NHSN



C	N	√	√	√		√	√	√		√	√
C	N	√	√	√		√	√	√		√	√

Discipline: **P**=physician, **N**=nurse, **T**=technician, **S**=student, **O**=other

Duration of observation period = _____minutes

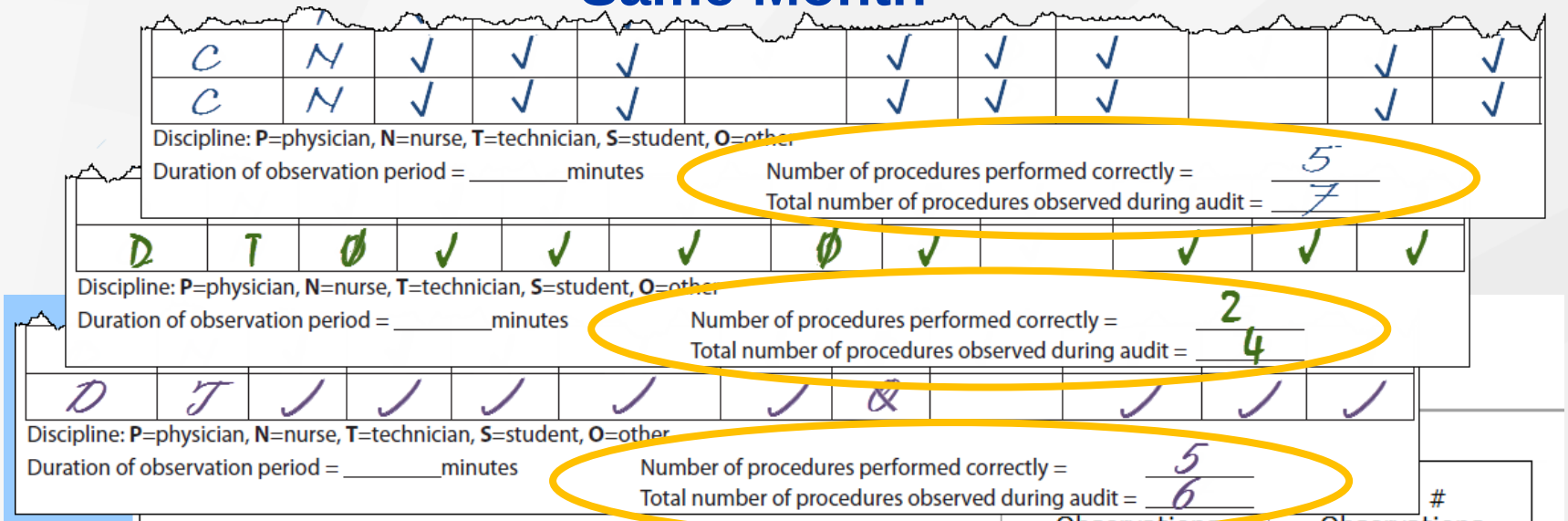
Number of procedures performed correctly = 5

Total number of procedures observed during audit = 7

Prevention Process Measures

	# of Successful Observations	Total # Observations
Hand Hygiene (HH)		
Hemodialysis Catheter Connection/Disconnection (CATHCON)	5	7
Hemodialysis Catheter Exit Site Care (CATHCARE)		
Arteriovenous Fistula/Graft Cannulation/Decannulation (FGCANN)		
Dialysis Station Routine Disinfection (DISINFECT)		
Injection Safety (INJSAFE)		

Combine Multiple Audits of the Same Type, from the Same Month



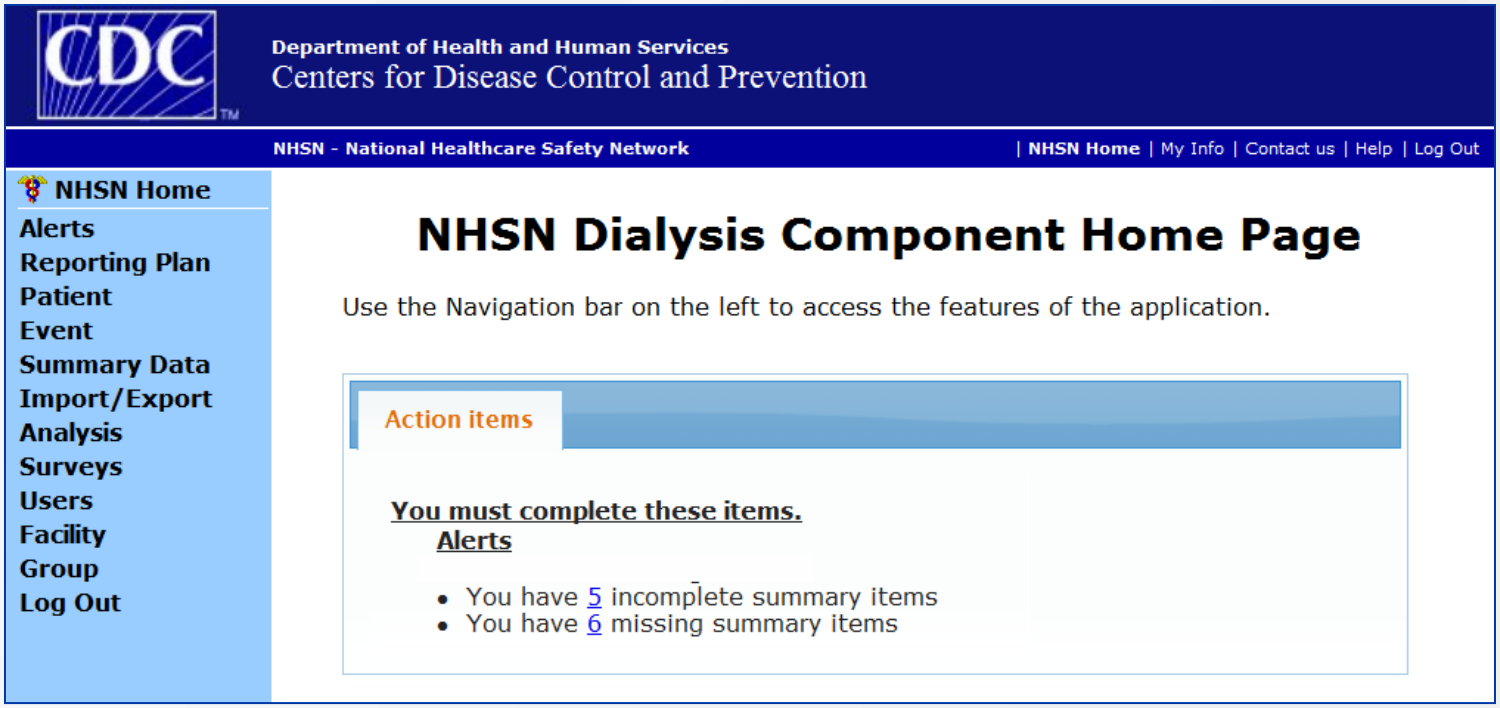
Successful Obs. = 5 + 2 + 5 = 12

Total Obs. = 7 + 4 + 6 = 17

	Observations	# Observations
	12	17
Arteriovenous Fistula/Graft Cannulation/Decannulation (FGCANN)		
Dialysis Station Routine Disinfection (DISINFECT)		
Injection Safety (INJSAFE)		

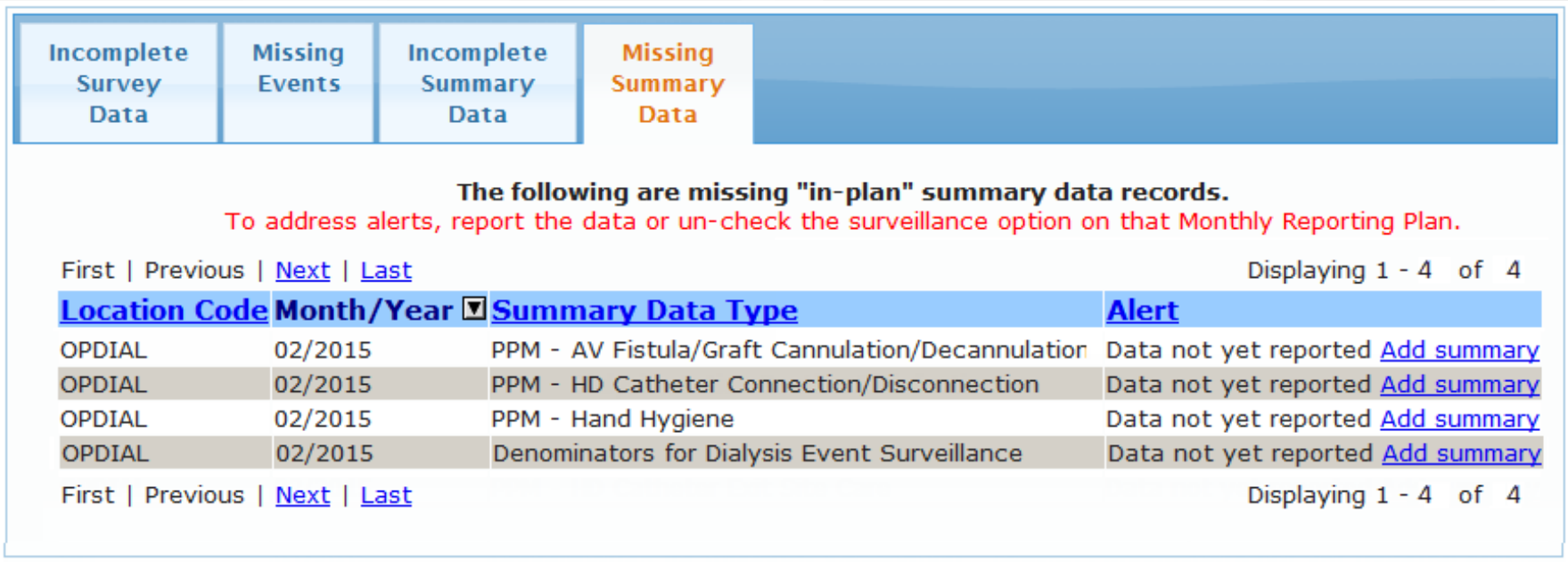
NHSN Action Items and Alerts

- **If facilities make a Prevention Process Measure (PPM) selection on the Monthly Reporting Plan, but do not:**
  - Report data for it, NHSN will show a *Missing* Summary Data alert
  - Report the minimum number of total observations required by the Protocol, NHSN will show an *Incomplete* Summary Data alert



Prevention Process Measure Alerts

- ***Missing* Summary Data alerts can be removed by:**
  - Reporting the additional data required by the Protocol
  - Un-checking the surveillance option from that Monthly Reporting Plan (i.e., making the data “off-plan”)



Incomplete Survey Data | Missing Events | Incomplete Summary Data | Missing Summary Data

The following are missing "in-plan" summary data records.

To address alerts, report the data or un-check the surveillance option on that Monthly Reporting Plan.

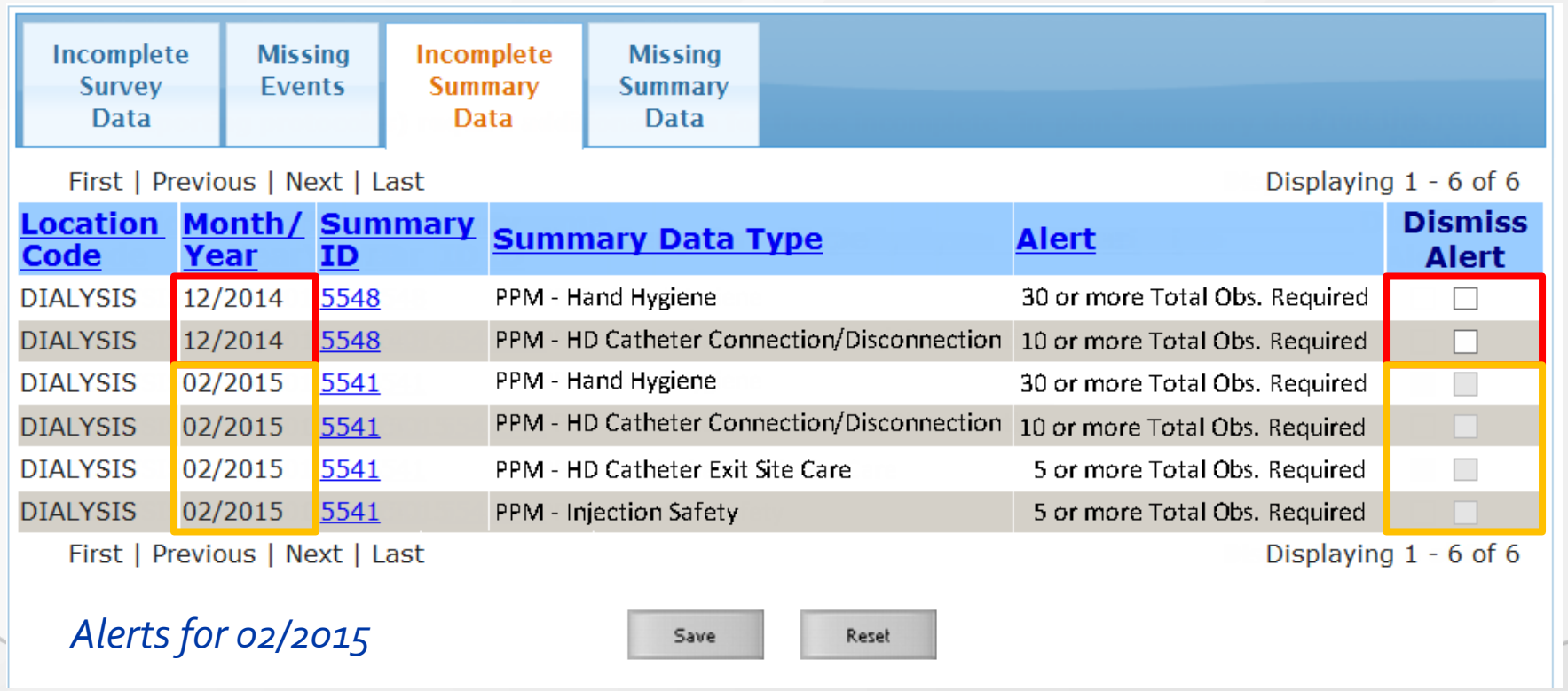
First | Previous | Next | Last — Displaying 1 - 4 of 4

Location Code	Month/Year	Summary Data Type	Alert
OPDIAL	02/2015	PPM - AV Fistula/Graft Cannulation/Decannulation	Data not yet reported Add summary
OPDIAL	02/2015	PPM - HD Catheter Connection/Disconnection	Data not yet reported Add summary
OPDIAL	02/2015	PPM - Hand Hygiene	Data not yet reported Add summary
OPDIAL	02/2015	Denominators for Dialysis Event Surveillance	Data not yet reported Add summary

First | Previous | Next | Last — Displaying 1 - 4 of 4

Prevention Process Measure Alerts

- ***Incomplete* summary data alerts can be removed by:**
  - Reporting the additional data required by the Protocol
  - Un-checking the surveillance option from that Monthly Reporting Plan (i.e., making the data “off-plan”)
  - Selecting “Dismiss Alert” after the month has ended



Prevention Process Measure Alerts

- ***Incomplete* summary data alerts can be removed by:**
  - Reporting the additional data required by the Protocol
  - Un-checking the surveillance optic… eporting Plan (i.e., making the data "off-
  - Selecting "Dismiss Alert" after…

If too few observations were collected and the month has passed, incomplete alerts can be dismissed.

Incomplete Survey Data | Missing Events | Incomplete Summary Data | Missing Summary Data

First | Previous | Next | Last

…aying 1 - 6 of 6

Location Code	Month/ Year	Summary ID	Summary Data Type	Alert	Dismiss Alert
DIALYSIS	12/2014	5548	PPM - Hand Hygiene	30 or more Total Obs. Requir…	☐
DIALYSIS	12/2014	5548	PPM - HD Catheter Connection/Disconnection	10 or more Total Obs. Required	☐
DIALYSIS	02/2015	5541	PPM - Hand Hygiene	30 or more Total Obs. Required	☐
DIALYSIS	02/2015	5541	PPM - HD Catheter Connection/Disconnection	10 or more Total Obs. Required	☐
DIALYSIS	02/2015	5541	PPM - HD Catheter Exit Site Care	5 or more Total Obs. Required	☐
DIALYSIS	02/2015	5541	PPM - Injection Safety	5 or more Total Obs. Required	☐

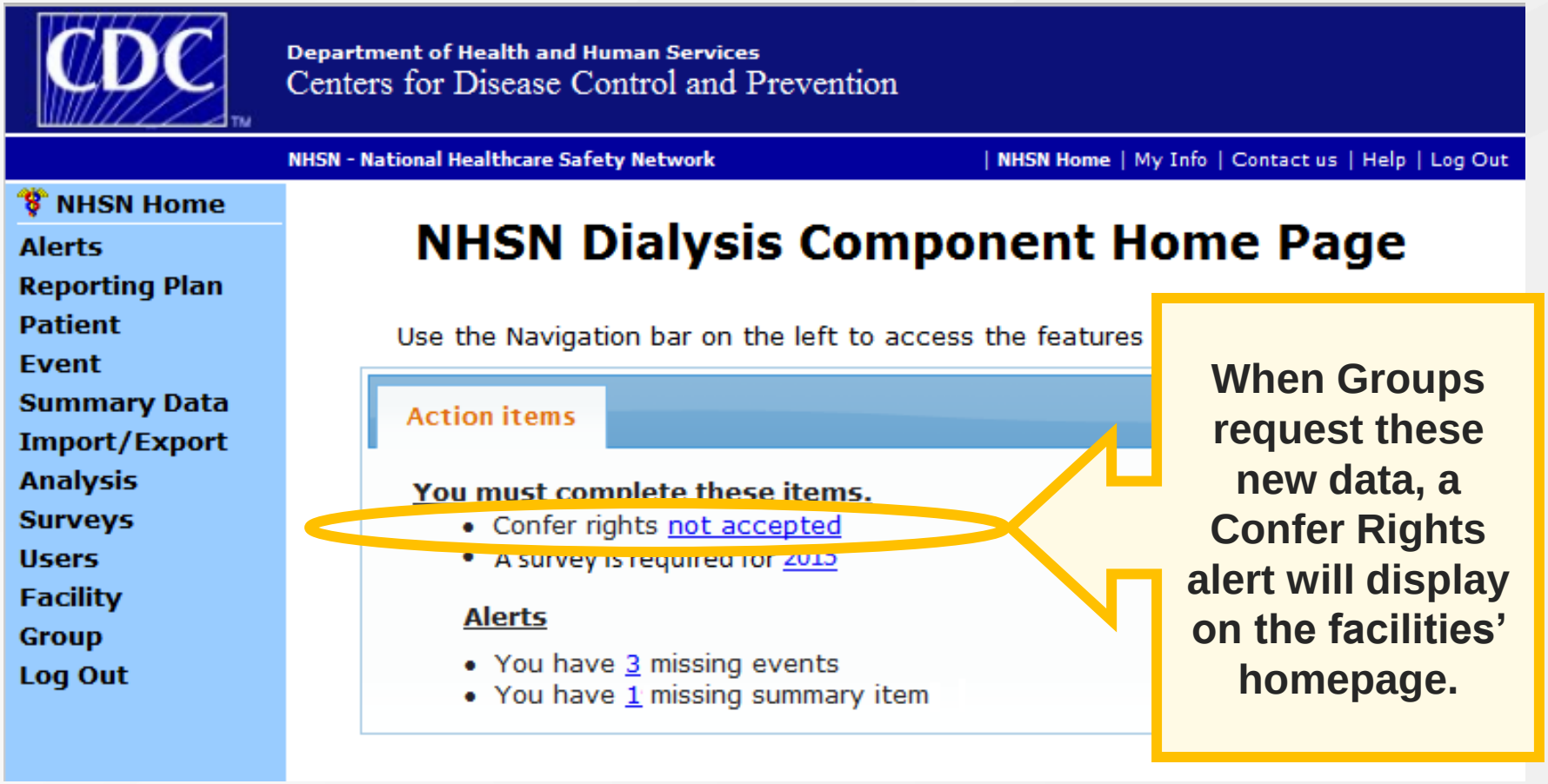
First | Previous | Next | Last

Displaying 1 - 6 of 6

Alerts for 02/2015

Save | Reset

“Confer Rights” Alert for Facility Users with Administrator Rights



“Confer Rights” Alert for Facility Users with Administrator Rights

- Facility users should click “not accepted” to see all Groups that have modified their data sharing requests

“Confer Rights” Not Accepted List

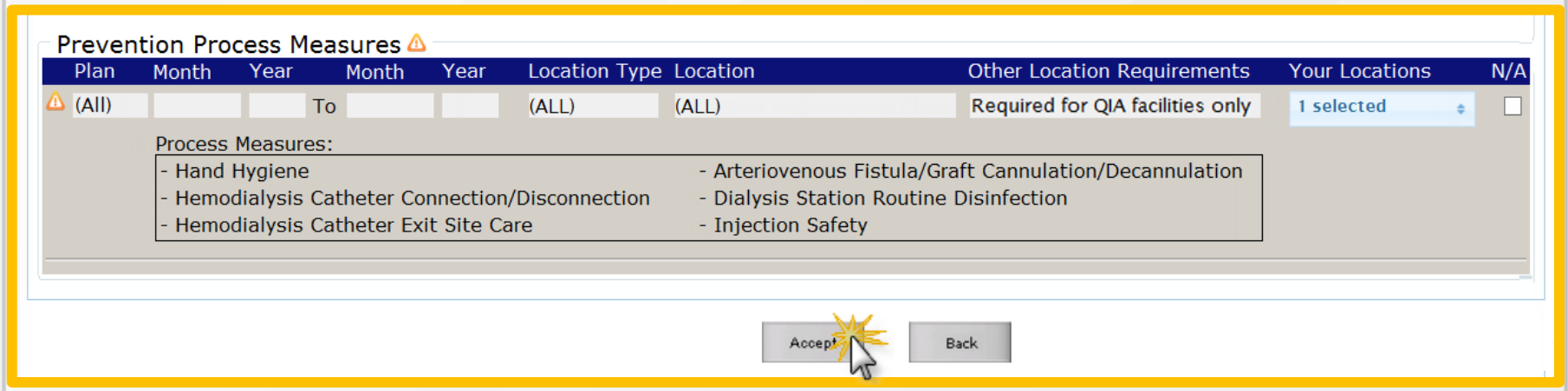
- Facility administrative users should click on the Group’s name to view the new request

Facilities "Confer Rights" to Share PPM Data with Group(s)

- Facility users should review their Confer Rights screen to see which data the Group is requesting.
- All changes are marked: ⚠

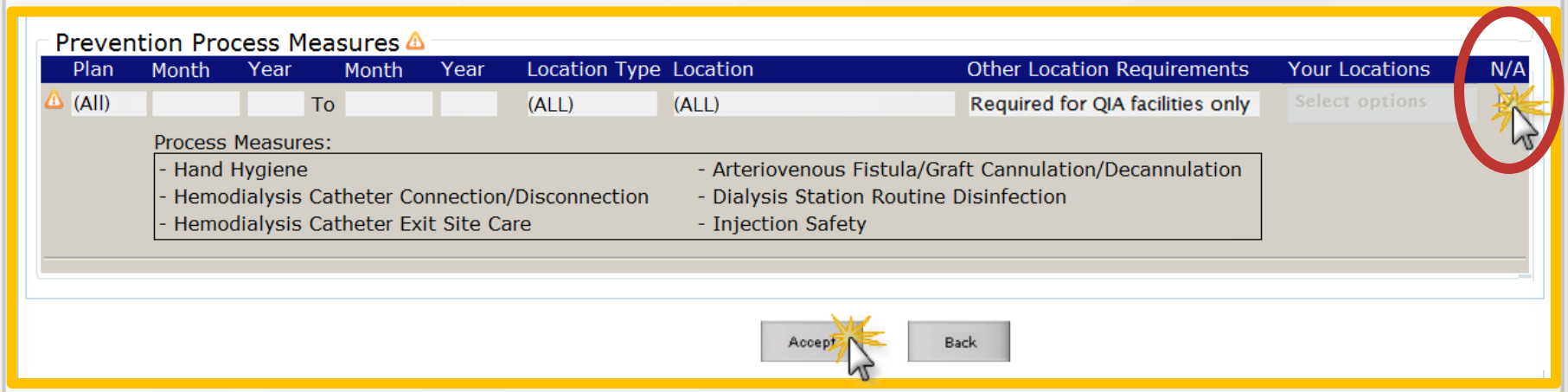
Facilities "Confer Rights" to Share PPM Data with Groups

- If the facility agrees to share all data specified on the Confer Rights page, they should scroll to the bottom and click the "Accept" button.



Non-QIA Facilities Can Opt Out of Sharing PPM Data with Network Groups

- If the a facility does not agree to share all data specified on the Confer Rights page, they may select “N/A” for the applicable section(s), then scroll to the bottom and click the “Accept” button.



New PPM Reports

- ***Scheduled for April 2015* – Line Listings that calculate percent adherence by month:**
  - Hand Hygiene Percent Adherence
  - HD Catheter Connection/Disconnection Percent Adherence
  - AV Fistula/Graft Cannulation/Decannulation Percent Adherence
  - HD Catheter Exit Site Care Percent Adherence
  - Dialysis Station Routine Disinfection Percent Adherence
  - Injection Safety Percent Adherence

For QIA

- ***Scheduled for July 2015* – Line Listing to review what's been reported:**
  - All Prevention Process Measures

Interpreting NHSN PPM Reports

- **Percent adherence is calculated by dividing the number of successful observations by the total number of observations and multiplying by 100.**

$$Percent\ Adherence = \frac{Number\ of\ Successful\ Observations}{Total\ Number\ of\ Observations}\ x\ 100$$

Example NHSN Report for HD Catheter Connection/Disconnection

Facility Org ID	Summary Year/ Month	HD Catheter Connection/ Disconnection # of Successful Observations	HD Catheter Connection/ Disconnection Total # of Observations	HD Catheter Connection/ Disconnection Percent Adherence
12345	2015M01	6	10	60.0
12345	2015M02	7	10	70.0
12345	2015M03	8	10	80.0

Online Reporting Resources

- **Resources for PPM reporting are being updated**
  - E.g., Protocol, training, etc.

http://www.cdc.gov/nhsn/dialysis/prevention-process-measures.html

Thank you!

Questions?

NHSN Helpdesk: nhsn@cdc.gov

Specify “dialysis” in the subject line.

For more information please contact Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Telephone, 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov Web: www.cdc.gov

MONTHLY DATA CHECKS & BIANNUAL SURVEY

Review of Monthly Data Check and Bi-Annual Survey Activities for 2015

- **Monthly Data Checks**
  - Use the same checklist as used in 2014
  - Similar timeframes will be recommended for review
  - Once a quarterly CMS freeze date has passed, feel free to discontinue contacting potential outlier facilities from that quarter's data
- **Bi-Annual Survey**
  - Based on your feedback, aiming to make changes to streamline the survey
    - Will still administer the survey to the 10 highest and 10 lowest BIS rate facilities
  - The same access database and overarching questions will be submitted to CMS
  - Similar timeframes will be used in 2015, as in 2014

Monthly Data Checklist: Timelines to Review Data

Month of review	Month of report to CMS	Recommended reporting months to be reviewed in NHSN
Apr 2015	May 2015	Dec 2014, Jan - Feb 2015
May 2015	Jun 2015	Jan – Mar 2015
Jun 2015	Jul 2015	Jan – Apr 2015
Jul 2015	Aug 2015	Jan – May 2015
Aug 2015	Sep 2015	Jan – Jun 2015
Sep 2015	Oct 2015	Jan – Jul 2015
Oct 2015	Nov 2015	Jan – Aug 2015
Nov 2015	Dec 2015	Jan – Sep 2015

- Include December data during April's review to include 3 months of data
- Include previous months in order to provide additional data points and serve as a reminder if unusual values have not been addressed

Determine Which Facilities to Survey for Bi-annual Survey Activity

- **Rate Table – Bloodstream Infection Data**
- **During May 2015 survey: review data from July 2014 to December 2014**
- **During October 2015 survey: review data from January 2015 to June 2015**
- **Modify the report to show the specified timeframe and then sort by "All" access type to identify the 10 highest BSI rate facilities and 10 lowest BSI rate facilities**
- **If more than 10 facilities are identified in one or both categories**
  - Prioritize contact with those facilities with high census
  - In October, prioritize contact with facilities with high census who were not surveyed in May