This transcript is intended to provide webinar content in an alternate format to aid accessibility. We apologize for any inaudible or unclear content as a result of audio quality.

**Required Infection Reporting for Minnesota CAHs, Session 4**

Presented by:

Vicki Tang Olson Program Manager, Stratis Health; Janet Lilleberg Quality Data Specialist, Stratis Health; Marilyn Grafstrom, RN, BSN, MPA, Safety/Quality Specialist, MHA; Katie Banks, Patient Safety/Quality data analyst, MHA, and Jane Hirst, RN, IP Life Care Medical Center

(1- hr 18 min webinar) [January 9, 2014]

**Janet Lilleberg:** Welcome to our fourth session. We’ll be talking about identifying CAUTI today. Let’s get started. Last we gave you a little homework about completing the review of the patient safety module and activating the patient safety component, how to do that and to map locations. We also talked a little about the monthly reporting plan.

Hopefully you’ve had an opportunity to do some of that. There’s a quick review on mapping locations, because that’s an important piece of this. The 80% rule is that at least 80% of the patients must be of the same type. An exception to this would for the med surge units 50/50 or 60/40. The mixed acuity for those units that don’t meet the 80% rule, you can assign them to a mixed acuity unit. We just wanted to review that real quickly with you.

**Katie Banks:** We’re going to take a few polls today for kicks.

I’ll be doing the topics of the polling questions, just a few, but if you would participate we would really appreciate the feedback which will help us understand our critical access hospitals a little better.

- We’d like to know how many of you have an ICU care facility. We will open the polls here for your response. Just put yes or no if you have an ICU in your facility. We can close that. So 38% of you answered yes and 52% answered no. Thank you. That’s higher than I expected and that’s great feedback.

- Let’s do another question. How many units do you have in your facility? One, two or three or more? Again, if this is a silly question I apologize, but I’m trying to learn more about you. Begin voting now. Let’s close the polls. Almost 60% have one and the others are split about 20/20% for two and three or more. Thank you.

- Last question for now is this. We’re wondering if the mixed acuity location best describes your unit or units. Yes, will have at least one of our units that’s under the mixed acuity definition. No, we have a single unit that fits in the definition of greater than 80% rule or exception to the rule. No, all our units fit into the other definition greater than 80%. Not sure. Okay, many of you said yes, we have one unit that fits in with that mixed acuity and 60% of you are unsure.

I believe Janet talked last time about how the best way is to figure that out, go back for one year to review the patient types.
Janet Lilleberg: Now I want to give you a short update. I received an email from NHSN that they are ready to add new users this month, so don’t apply for your digital certificates until they’ve switched over to SANS. They provided the link for the website for going through the SANS process and instructions, and I’ve included that link for you. Right now it still has the old instructions, but they are going to be going live soon. I wanted to provide you with that update in case you haven’t yet received your digital certificate.

The objectives today are:

- To know about the state requirement for reporting CAUTI, including the timeline and data that’s to be reported.
- I’ll be focusing on CAUTI and other key terms.
- I’ll be talking about collecting CAUTI data.
- We’ll talk also about how to report the data in NHSN and to understand how to access the output files.

Jane is with us today and she’ll be reviewing some case studies. She has worked with CAUTI and she’s from a critical access hospital in Minnesota. We think she’ll give us some hands-on practical background on it.

We also want to invite you to join the NHSN user group and the Minnesota Hospital Association Group in NHSN. There will be a group probably from Stratis that you will have the rights to join as well.

Marilyn will talk about the state requirements for reporting CAUTI.

Marilyn Grafstrom:

Hi everyone, this is Marilyn with MHA. I just wanted to get some background and I’m sure this is probably review for many of you, so bear with me. In 2008, the health reform law requires the commission of health to establish quality measures. This is kind of a follow up of that as part of that decision.

Back in the fall of 2012, aligned with the 2008 model was the decision to align Minnesota Inspection Reporting with Federal requirements that were out there. So critical access hospitals were originally asked to begin reporting on the employee influenza vaccination rights. Since that time we’ve learned that Minnesota is taking steps to align with NHSN solutions, but it wouldn’t be completed for a while.

We also were aware that the CAUTI rate in Minnesota, if you’re to be hired in other parts of the country, since that time they have made some progress; however, we are still above the national benchmark and are doing everything we can to align our work with data that’s out there that reflects our performance.

So, given that measurement typically leads to improvement, awareness and having everyone know what their rates are, and also that CMS plans to expand its current NHSN reported CAUTI measure to hospital-wide. The CAUTI measure is a prime candidate to act of required submissions. Also, that the volume in critical access hospitals offer this particular measure with probably the most substantial than some other measures that we could choose.

The request to make the change was brought to us by the community of Infection Prevention professionals and discussed with critical access hospital representatives before being approved.
We’ve publicly reported that we pledge device utilization, which is what we consider a process measure is the number of catheter days over the number of patient days. That basically reflects one of the interventions to decrease CAUTIs is to decrease the amount of utilization, so that measure will reflect that practice. The outcome measure will be the number of infections over the number of patient days times a thousand, which is basically aligned with 1000 being a typical way to measure.

The reason we’re reflecting patient days instead of catheter days is that there’s a less likelihood that as we get better at not using catheters, if you use catheters as the denominator then sometimes that can make it look like you’re not doing good work, when actually you are. So to give a first general performance measure for a critical access hospital would be how many CAUTIs you have that are related to catheters with patient days as the denominator. That’s where that came from.

We were planning to sling bed patients and observation bed patients. Basically the rule should be, any patients located in an inpatient unit overnight, are to be included in your denominator and I think we had a few questions about that on our last call, but we can certainly entertain questions of that later on in the call as well.

Janet Lilleberg: Today we’ll talk about the CAUTI training. It’s accessible at the following link and part of the training will be from a NHSN training with the other part being slides that we created. This is the NHSN training site, and we aren’t doing the whole thing today because of time, but that’s good training that I would recommend. I’ve provided the site I recommend you go through to do your training. It has all the training resources, webinars, protocols and links to all the things like data collection forms, support materials, etc.

The support materials would be the location manual that we talked about earlier. It also talks about how to review your data analysis and that kind of thing, as well as how to use the data. Frequently asked questions and then on the bottom it’s a little obscure, but I also recommend you look at their training materials. You can sign up to receive their newsletters and emails.

Now I’ll talk a little using the training materials from that website. We don’t have time to go through the whole thing, but I would like to go through the key terms and touch on collecting the CAUTI data. I recommend you go through the other areas as well on your own.

For the key terms, I’ll be reading through some of them because that’s what you have to do to learn it. The key terms we’re looking at, we talked a little about HAI last time, present on admission, CAUTI, indwelling catheters, the transfer rule, symptomatic UTI and asymptomatic bacteriuria UTI. I haven’t worked in a hospital, so I apologize if I butcher some of these terms.

An HAI is an inspection. If all elements of the CDC NHSN site specific infection criteria were first present together on or after the third calendar day of admission to the facility. The day of the hospital admission is day one and for an HAI, an element of the infection criteria may be present during the first two hospital days as long as it’s also present on the third calendar day. If all elements used to meet the infection criteria must occur within the timeframe that does not exceed a gap of one calendar day between any two elements.

If all elements of an infection are present within the two calendar days of the transfer from one inpatient location to another in the same facility or a new facility, the infection is attributed to the transferring location. The second term, I believe we touched on last time, if present on admission. So in this case, if all elements of an infection are present during the two calendar days before the day of admission or the first day of the admission day and/or the day after admission, day two and are documented in the medical chart, the infection would be considered POA.
Infections that are POA should not be reported as HAIs, so you need to keep that in mind when you’re looking at your CAUTIs. Acceptable documentation is not self-reported symptoms by the patient, it must be documented by the healthcare professionals during the POA timeframe, so you can’t go back in time and add it to the chart.

The MD diagnosis can be accepted as evidence of an infection that is POA only, when an MD diagnosis an element of infection definition. In other words, a physician diagnosis is not an element of a UTI, so you can’t use a physician’s diagnosis. For example, admission history indicates that the physician suspects a UTI. The patient was documented to have a fever in the nursing home on Oct. 27. Upon admission Oct 29, a urine sample was collected and the urine yielded 100k colony forming units per milliliter of a pathogen.

This UTI would be considered a POA because the elements of the infection definition for symptomatic urinary tract infection were first present during the two calendar days before admission. The fever documented by history is they had a fever from the nursing home and they also have a positive urine culture.

The key terms for CAUTI is it’s a UTI where an indwelling catheter was in place for more than two calendar days. When all elements of a UTI infection criteria were first present, together with the day of the device placement being day one, and an indwelling urinary catheter was in place on the day of the event or the day before. If an indwelling urinary catheter was in place for greater than two calendar days and then removed, the UTI criteria must be fully met on the day of discontinuation or the next day.

This just defines what an indwelling catheter is it’s also called a ‘Foley’ catheter.

The transfer rule, we talked about this last call. If all elements of a CAUTI are present within two calendar days of transfer from one inpatient location to another in the same facility or a new one, the infection is attributed to the transferring location. Receiving facilities should share the information about such HAIs with the transferring facility to enable reporting.

I think for critical access hospitals this might come into effect if you’re transferring your patients to another facility and maybe there should be some way to communicate with that facility if a CAUTI is identified in the unit that they were transferred to.

Urinary tract infections (UTI) – there are four criteria for defining a UTI. These are located in the protocol. There are algorithms for determining whether it’s a UTI and I find it easier to look at those, but let me give you the definition here.

SUTI criteria 1A – patient had an indwelling urinary catheter in place for more than two calendar days and with the device placement being day one, and a catheter was in place on the day when all elements of the criteria were first present together, and they have at least one of the following signs and symptoms, and have a positive urine culture of greater than 10 to the fifth colony forming units with no more than two species of micro-organisms. Elements of the criteria must occur within the timeframe and does not exceed a gap of one calendar day between any two elements.

These are the signs of everything and all the criteria are based on the signs and symptoms, as well as the lab information.

An example is… March 1st, Mr. Sharp is four days post-op after a gastrectomy. He has a fever of 38.3 on his Foley catheter, which was placed in the OR and is draining clear urine and he’s complaining of feeling like he has to urinate constantly. A urine culture is collected and two days later is positive for the bacteria; otherwise, Mr. Sharp is feeling well.
In this case, Mr. Sharp fits the criteria for a SUTI, discounting the urgency he is feeling, which can be due to the presence of the Foley heat itself. He does have a fever and he has a positive urine culture, which meets the criteria. Because the urinary catheter was in place more than two calendar days, this is a CAUTI.

Example 1A, this is pretty much the same as the other where the patient has an indwelling urinary catheter in place for more than two catheter days, but they had it removed the day of or the day before all the criteria were present together. So in this case, they would go through the signs and symptoms as well as the urine culture and the elements of the criteria must occur within the timeframe. It’s very similar except for when the catheter was removed.

In this case, Ms. Jones was admitted eight days ago following an auto accident, in which she sustained fractures. The catheter was inserted on admission into the hospital and discontinued yesterday. This morning she had requested assistance to get up and use the restroom several times and has a burning feeling when she urinates. She is afebrile and her lungs are clear. A urine specimen was obtained for culture, which is later reported to have greater than 10 to the fifth colony units.

Ms. Jones meets the criteria for a SUTI. Her catheter was removed the previous day and she has a urinary frequency and dysuria as well as urine culture positive, for the required number of colony’s forming units, with no more than two species of organisms. This is a CAUTI.

Criteria 1B for a SUTI, this patient did not have a urinary catheter in place on the day of or the day before all elements of the criteria were in place. So there is no indwelling catheter, so you wouldn’t count it as a CAUTI.

The patient has an indwelling catheter in place with the day of the device being day one and the catheter was in place on the day when all elements were present together. At least one of the following symptoms, they had the symptoms and urine analysis with a positive dipstick in at least one of the following… Pyuria and microorganisms. They also had a positive urine culture, this time the urine culture is lower at greater than 10 to the third but not quite 10 to the fifth. So this is a lower urine culture.

In this case, George is a stroke patient in the medical ward and he has a Foley catheter in place since admission. On hospital day 11, he complains about pain just above his pubic synthesis. Upon examination and a urinary analysis, he shows a greater than 10 white blood cell count of unspun urine and he grew 10k colony forming units of the bacteria, so George meets the SUTI criteria 2A. He has tenderness and a positive urinalysis.

Is this SUTI also a CAUTI? Yes, because it meets the criteria. The SUTI criteria, the patient with an indwelling catheter in place for greater than two calendar days and had it removed the day of or the day before all the elements of the criteria were first present together in at least one of the following signs or symptoms, so again they have the fever and urinalysis and the culture.

So in this case, Ms. Martz is recovering from 28:30 and has been in the hospital for six weeks and is just regaining bowel and bladder functions. Her urinary catheters have been in place since admission and was discontinued last evening. She is complaining of pain upon urination and urinalysis was completed, which is positive for nitrates.

Which of the following best describes this case? It’s no culture is done, so she doesn’t meet the definition of a CAUTI.

I know this is a lot of reading, but it’s the only way to describe what’s going on.
For criteria 2B, the patient didn’t have a urinary catheter in place the day of or the day before all the elements of the criteria were present together. They had at least one of the following signs and symptoms. They have the urinalysis and culture between 10 to the third and 10 to the fifth colony units. They did not have an indwelling catheter, so this would not be a CAUTI.

So for Joe, Joe is 59 years of age and has been in your unit for five days following a transfer after coronary artery bypass grafting. His urinary catheter was discontinued three days ago and today he’s been running a fever of 100 degrees. His urine was analyzed and shows greater than five white blood cells from a sample. The urine culture also shows 100 colony forming units. Does this individual meet the criteria? Joe does not have at least 1000 colony forming units, so that would be a no.

Criteria three is basically the same as criteria one. It’s for infants. They do have different signs and symptoms we’re not asking them how they feel, etc. so basically they still have to have the positive urine culture and it’s the same except for the different symptoms.

Criteria four, the patient is less than one year of age with or without an indwelling catheter and it has at least one of the following signs and symptoms. So it has signs and symptoms for an infant and urinalysis and urine culture, which are this criteria elements.

Ninth month old Chelsea has been hospitalized for six days. She has a fever and is lethargic. Her pediatrician ordered a catheter urine specimen to be sent to the lab for culture and the specimen shows 50k colony forming units and the urinalysis results are positive for leukocyte estuary and nitrates. Does Chelsea have a SUTI? Yes.

The last criteria we’re looking at is asymptomatic bacteriuria. Patients with or without indwelling catheters, but don’t have any signs or symptoms, so you’re going strictly by the lab results. Here they have positive urine culture and in addition to that they have to have a positive blood culture with at least one matching uropathogen microorganism to the urine culture, or at least two matching blood cultures. Elements of the criteria must occur within the timeframe.

We won’t go through all the collection for the specimens for the CAUTI in the interest of time, but I will say also that they do go through the forms rather nicely in this training session and show you how to complete the UTI forms, which is on the website I referred you to. I think it provides a nice explanation on how to complete it. The first part is just demographics. Then it goes on to them already having filled in the event type as a UTI and the location must be inpatient. The date of the event is the date when the last element used to meet the UTI criteria occurred.

MDRO, you’re probably not doing that at this time. My guess is that you say no here. The risk factors you want to check if the catheter is in place or has been removed. Indicate which type of UTI you’re looking at and whether it’s symptomatic or asymptomatic, which are the criteria we just reviewed.

Next are the signs and symptoms as you can tell, the one year old has different signs and symptoms, so for that criteria you would use that for their age range. This form is also used for secondary bloodstream infection, which is important for the BUTI, so you would say it could be no but if you’re using it for determining if it’s an ABUTI it would be yes and you should also notice that they ask if the patient died.

That’s pretty much what you’ll be reporting for the event for the numerator.

We have a lot to cover, I’m a little off track but now I’d like to go briefly through some things.
Start with the urine cultures and if the lab accurately reports the location. You want to make sure they know where they the patient was at the time the sample was collected. Verify that your report is in line with what NHSN requires for what the infection is and that you’re getting the right information you need for a positive culture.

Next are the four algorithms I’ve talked about within the protocol. I’ll go quickly through that. There is the symptoms and lab and then you simply go through the flow chart to make sure it meets the criteria in determining whether it’s a CAUTI. There are four within the protocol and I’ve referenced it so you can find the link to that manual.

We talked about the numerator formed in the other training. I’m providing the links for that as well as instructions for how to collect it. It’s all on that one page that I showed you in the beginning. I’ve included that these are the things you’re required to report on, on that form. I made you a list.

CAUTI data reporting, I’d like to go through a little because it’s not on that training. After you get your digital certificate or SANS, you’ll go into the secure website. It enter on this screen and you’ll see NHSN reporting. When you go to map your locations you’ll enter that. We’re going through along the blue pane here and most of the things will be there.

You’ll be mapping your locations using the facility link and then the monthly reporting plan, using the blue navigation bar you’ll select add and you’ll enter the fields marked with an asterisk. If you don’t intend to report just mark on there you don’t intend to report that month and click save.

Then, when you’re reporting the event you’ll use the form that you collected everything on and under the blue part you will find how to report an event, which I’ve circled for you. In this you’ll enter the urinary tract infection, date of the event, when the last elements of the criteria occurred, the location where the sample was taken and the date admitted which must be an inpatient location.

The last thing I want to go through is the denominator. Again, the information is located on that same web page, the forms for collecting the data. The only thing you have to collect on that is the number of patients and the number of patients with a urinary catheter. It should be collected for all locations at the same time each day; that’s important.

These are just some of the rules. It doesn’t have to be you collecting the data, but it has to be done the same time each day. You can use, counting the device day, same time each day. If you’re collecting the data electronically, they want you to check and verify that by manually collecting the data for three months and making sure it’s within 5% of the electronic data collected.

To report the denominator data, you simply go in using your password and go to the NHSN reporting. They call it summary data and you’re reporting on device associated intensive care or other units. On the slides is a screenshot of what you have to complete on that and if there were no CAUTIs reported you still need to report that and that’s important to be counted as having reported and this is the field where you would report there were no CAUTIs.

Otherwise, you simply report the total number of patient days and total urinary catheter days for that month. Finally, for quality improvement purposes I want to mention that you will want to generate your data sets to look at… NHSN, one of their strengths is that right on the spot you can use their data. It’s available for you, you simply have to generate a new dataset to be up and you can do it in the output files where it says generate new datasets.
After you’ve generated the new datasets whatever you’ve put in will be current. You can go to the CAUTI output files. There are line listings, which is the patient data that you entered for events and you will be able to see all patient level data, the rates tables will give you the rates the state is looking for, the information you need. I think you can run it or modify it in order to do a different time period, so it’s flexible and can be used to report to your administration.

These are how the CAUTI rates are calculated with a formula for the device utilization ratio and now let’s hear what Jane has to say.

**Jane Hirst:**

Let’s get started reporting HAI CAUTI to NHSN. If you haven’t already started now is the time to get organized and sometimes a little helpful hint from others that have been there are handy. Make sure you have completed the NHSN modules because they’re very valuable and let’s you know what you need to know.

Have the NHSN UTI definitions handy for your use, whether paper or electronic copies, whichever works best for you. As professionals we need to hold ourselves and our facility to the stated definition so we’re all using the same reporting criteria. The narrative definitions are good, and the algorithms work well also for some.

So your active surveillance then you would check daily for Foley catheters. Go to the unit, connect with your direct care staff and see what’s going on, be visible and if you can’t get there physically then make a call to your charge nurse and ask who has the Foley’s. It’s important that you know what’s going on. With the electronic medical records we have seen a lot of improvements in getting information, so we have the effect charting system and with that we have to document full sheets which includes an INO sheet. That’s the one I go to find so I can see if someone has a Foley catheter.

Other reports that have been setup electronically work very well. One is called ‘active lines drains airways’ and the other is ‘remove lines drains airways’. They are pretty self-explanatory, but these reports are wonderful for me because when I’m monitoring, not being here everyday, I can go in and see what’s been going on.

The culture reports, of course, we have to review those daily and once we find the patients that have the Foley catheters then those culture reports will make sense, so look at them. Communication is so important. Everyone is responsible for infection control, it’s not just you. Encourage your staff to call if they want to report any CAUTI and I get a call every now and then, actually.

We rarely see CAUTIs but I get calls about everything so that’s my mantra, call extension 4112 to report to report anything to me. I do use a monitoring sheet, something I received when our facility joined the Stratis Health CAUTI initiative over a year ago. I’m not sure who developed the sheet but I thank them, because it’s made work easier for me. I’ve made changes from the original that work well for our facility and you can do so as well for your own.

This helps me keep track of many things and it comes in very handy when I’m going to NHSN to do my reporting. The yellow bar, you want to check daily and you can come up with your own time, I just happened to use 12:30 a.m. checking for Foley catheters. Of course, I’m not here at 12:30 a.m. but with the electronic record I can tell what time the patients Foley catheter was put in.

When doing your monitoring at whatever time you pick, if the patient has an order to have that removed and it’s not removed at your time, then they would still have that catheter in and that would be counted. Always keep the same criteria when doing your monitoring.

I did put the appropriate reasons and indications on here and I know facilities may be at different places with this process, but we hit it hard and I just wanted everyone to be following the indications and we have seen great improvement in our facility from the
beginning of this past year to the end, in the number of Foley catheters that were
inserted and the inappropriate reason that we saw. I don’t believe I’ve seen an
inappropriate catheter inserted since May. These indications come out of the hic pac
guidelines and apic guidelines, so that’s what we decided to go with.

Further down is the in and out time of the catheter and then the total days present and
the total days present is something you’ll be using for your catheter days when you
report to NHSN and then down here you’ll see these things and I’m trying to move
fast, but this will say your number of patient days because you’ll need that too. I
generally get the number of patient days from statistics and they are not ready with
that until the third week of the month, so we need to report by the end of the month
then which gives me a week to get my reporting in.

Let’s talk about the next example. Janet did a great job explaining and going through
examples earlier, the next ones are simply a different way to look at it. A patient was
admitted and on 4/1 a Foley was placed. On 4/2 the patient developed a fever, which
would have to be greater than 38 degrees centigrade and on day three the Foley was
removed. On day four the patient developed a super pubic tenderness and had a urine
culture done which was positive and that would be greater than 100k colonies.

Would this be a CAUTI? Yes and if you’re wondering you simply pull off your
algorithms or definitions and go through each thing on there if there are signs and
symptoms or if there’s a culture to go along with it and how about the Foley catheter,
because remember that’s what we’re looking at is catheter associated UTIs. So yes,
all elements were present on or after the third day with no more than a single gap day.
The Foley was removed the next day so there wasn’t even that gap day.

The next example is a little different type of situation. This patient came in and had the
Foley placed. No UTI criteria. Did develop a fever on the second day but the infection
prevention as pointed out to the physician is that that patient didn’t meet the criteria for
an appropriate Foley and the physician said let’s take it out. The fever continued and
got a little higher on day three and maybe even a little higher on day four. It was
decided to do a urine culture. Is this a CAUTI? You would pull out your definiti ons and
no, this is not a CAUTI, the Foley was not in greater than two days.

For each situation you have you simply look at your definitions and it always works
out.

In example three it’s basically the same thing Foley was in, no criteria. Day three no
criteria and it was removed on day four. The patient developed symptoms on day five,
had a positive urine culture, would this be a CAUTI? That should be easy to answer,
as a yes as well as asymptomatic UTI.

That’s one way you can look at your information. Always use your definitions.

Let’s go to Katie.

Katie Banks: In order for MHA, for us to see that you are reporting you’ll have to join the MHA group
once you’re setup on NHSN. Once you get everything entered and you’re ready to
map your location, you have to allow MHA. There’s action that needs to be taken on
your part, so we’ll go through that. This is called Conferring Right. There are some
quick instructions here. It’s not intuitive unfortunately, because you need our group
name and group password, but if for any reason you don’t have these when you go to
do it, simply email someone here at MHA and we’ll get you the instructions.

It’s quick, you simply go through the steps but one thing you have to make sure you
do is not click on the NA button, especially for the CAUTI. If you do this we’ll only be
able to see blank spaces. So you’ll join our group but we won’t be able to see any of
the data and that would lead us to believe potentially you’re not entering it. We will go
through that and let you know who we can and can’t see, in regards to data.
We don’t have access to all the specifics you’re entering, because that’s for NHSN not for our use. We’re also going to go over the deadlines we’re going to ask you to report by. The PPS hospitals follow this deadline and we’ll have you follow it as well. It’s by quarter and the deadline is four and a half months after the end of the quarter. However, we recommend that you do it monthly so you can keep up with everything and that you have everything available to you and you don’t have to go back quickly right before the deadline.

If you do it for the month prior, just within 30 days, that’s great and that’s what a lot of the PPS hospitals are doing and we suggest you do it that way as well, otherwise, the deadlines are out there for specific reporting periods. You’ll receive pop-ups saying quarter three data is due at this time, which can be helpful if you are waiting longer to enter.

Let’s take another polling question real quick.

We’re looking to see now, with this information coming from NHSN about waiting for SANS, we’re wondering where everyone is. Let’s go to the polls.

Do you have access to NHSN? There are four options. You have access, you’re waiting for the digital certificate you’ve already applied, waiting for SANS or you have not identified a facility administrator. About 54% of you are waiting for SANS. Wherever you are in the process that’s fine with the new information coming from NHSN, we’ll work with it. You should be able to sign up when you’re ready.

Janet Lilleberg: We would also like to invite you to the NHSN user group which meets every other month. This would be with the PPS hospitals as well and they just talk about timely issues. We invite you to participate. We discuss case studies and different things like that, so it’s a good opportunity to meet other infection preventions and learn more about the work, as well as become more familiar with it.

Stratis Health will also be forming a group in NHSN, which you would be able to confer rights to that group as well. More information is coming on that later.

Now it’s a matter of you customizing the process for your facility and working towards being ready to report on it.

Let’s move on to questions.

Katie Banks: What is the national benchmark since we’re going to be using patient days in the denominator? I have to do more research on that for you. The national benchmarks using catheter days for CAUTI in critical care unit, the pulled Meaningful Use is .07 and for non-critical it’s 1.7. I don’t know if that’s helpful but we’ll know more once we start getting the data in. You can email me if you want more information on that.

Vicki Olson: I just add two for value-based purchasing, the benchmark, which is the Meaningful Use is the top file so pretty much the 95th percentile actually zeroes and that’s obviously our goal.

Katie Banks: Does NHSN have data with patient days now? They do. There is a place to enter the patient days.

Janet Lilleberg: Do you need to count observation patients who do not stay overnight? You would count any observation patients that are staying in an inpatient location. You’re only counting them at the same time everyday, so if in your example 7:00 a.m. you’re taking count at 8:00 a.m. they would be staying there and they’re in an inpatient location then you would count them.
Should we include observation swing bed patients in the NHSN annual hospital survey? I’m not familiar with the question you’re asking. If it’s an inpatient location then you would count it. Typically, swing beds are not inpatient locations.

Marilyn Grafstrom:
They’re on an inpatient location if they’re on an inpatient unit. My initial response to this is yes, that you would report consistently with what you consider your population but I’m not totally clear on what the annual hospital survey is. Jane are you familiar with this?

Jane Hirst:
I have filled it out a couple years but I haven’t looked at it for this year, so I hate to say anything because there’s quite a bit on there and I’d have to review it first. I’m with you, be consistent in what you’re doing. When you fill out the survey make a copy and save it because you’ll need it next year and it will be easier to follow through, and then you’ll know what you’re using.

Guest:
When you go to fill that survey out and you feel it’s not a correct answer to be consistent and include your swing bed days, could you let me know so we can pass it along?

Jane Hirst:
Yes. I believe I have used the swing bed days, because that’s my definition of my unit too.

Guest:
Perfect.

Janet Lilleberg:
Can we report observation care patients by numbers or calculate an adjusted patient day by the total number of observation hours?

Vicki Olson:
Right, so you would not do the adjusted patient day, you would do, if the patient was there at the time that you were calculating the patient days.

Janet Lilleberg:
Are the key terms in the handouts? The key terms are in the training session that was on the website which I provided to you earlier. They’re also in the protocol manual, so you can use either one. Betsy says this is taken directly from the NHSN CAUTI training and I did that on purpose because I think their training is good and that it would have the information you needed for reporting.

Marilyn Grafstrom:
Are you able to share the Foley catheter tracking sheet used by Jane? I will ask her for a copy of that form and then share it with the group.

Janet Lilleberg:
Where do we find the role of the administrator?

Vicki Olson:
I think that was in enrollment. The person who actually signs up as the facility administrator would have that role with NHSN through the application process, but if you wanted to give administrative rights to other users you can do that as well, you simply would add users.

Janet Lilleberg:
I think if they’re using for the definition of the administrator role, they would look in the enrollment information.

Assigning patient type to map locations, do we consider swing beds a patient type or do we look at their diagnosis to determine if they’re med surge or other patient type? When you’re looking at location type you would look at the 80% rule to see what type of patient is staying there, in terms of what type of care they’re receiving. That’s the way the protocol defines it.

Jane Hirst:
I see Cindy said swing bed patient days wouldn’t be included in the inpatient days and on our statistics it is not. I have to add the two.
Janet Lilleberg: We also have a question, what benefit would there be to be in part of the MHA and/or Stratis Groups?

Marilyn Grafstrom: If you’re a part of the hospital engagement network that is one of the criteria as part of your data collection. We would ask you to join and share your NHSN data as all the PPS hospitals who are a part of the hospital engagement network are doing. That’s the way we’re collecting your data for sections you report to NHSN, which starts with CAUTI.

Vicki Olson: MHA is responsible for doing the reporting for the required measure, so this is a Minnesota required measure and that would be the additional reason for joining the MHA group, so the required reporting can be met. For Stratis Health, signing up for that group, what we’re doing for PPS hospitals is pulling the NHSN data into our hospital profile reports.

Right now you’re getting hospital profile reports, but we’re not able to share the NHSN data with you because we don’t have a mechanism now to get access to that data, so signing up would be a way to feed the data back to you with charts as to how you’re doing on the measures.

Rona: Hi from Long Prairie. So, if we don’t join the Stratis group we won’t get any feedback?

Vicki Olson: Right, we would have no way to get the NHSN data if you didn’t join the group.

Marilyn Grafstrom: However, I believe as a hospital engagement network and as a publicly reported measure you would get benchmarking data by submitting it to NHSN and sharing it with MHA. I think Stratis often has a picture of other measures that are related to value-based purchasing and Meaningful Use that would allow them to be able to give you a nicer picture than we can with the scope of our work.

Rona: Okay, so that would mean that there wouldn’t be extra to do, it just means you would get information back.

Vicki Olson: Right. So as Marilyn said you would get the required measurements information back from MHA and if you’re part of HEN, however, that reporting is happening with Stratis would simply be to have the convenience of having it on your hospital profile reporting and having all the data in one place.

Sandy: Hi from Little Falls. Could you cover again, if you’re a critical access hospital, the part about location reporting? Does it make sense to just report six ICU beds versus the whole hospital?

Marilyn Grafstrom: As part of the state law you will have to consider your whole hospital and then by reading the different definitions of on the locations, you would determine by the 80% rule if you would then call yourself a mixed acuity. You do have to include all your beds.

Sandy: In critical access all 25 beds are inpatient beds. Do you go through the whole population in the last year and then decide if 80% are of the same? That’s the part I don’t get.

Marilyn Grafstrom: Yes, if they’re all the same type then you would choose that location type.
Vicki Olson: The first thing to decide is how many units you want to report, if you just want one, which would be more typical with critical access hospitals. Then you would look at the patient population and decide how to map that location into what type of unit it is.

Sandy: Okay, so if there are six ICU and the rest is a med surge unit, more typically you’d say we just look at the med surge unit?

Vicki Olson: Right, it would go by the 80/20 rule, so whatever 80% of your population is.

Sandy: Okay, I think.

Guest: If the beds are ICU, it would depend on what your census is in those beds compared to the others. You almost have to look at a percentage of ICU to the rest of your beds to see which carries the most patient days.

Sandy: Okay.

Janet Lilleberg: Any other questions?

Vicki Olson: Where is the SANS information on the website? Janet provided a link to that in the slides.

We appreciate you staying over. We’re all available for questions. Thank you for participating and being with us today.

This material was prepared by Stratis Health, the Quality Improvement Organization for Minnesota, under a contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.