PIN
Montana Flex
PERFORMANCE IMPROVEMENT NETWORK
A PROGRAM OF MHA

APPENDIX C

Paper Tools

CASE #: _____

Facility Name: _____

Facility Contact: **Phone #:** _____

Montana Rural Healthcare Performance Improvement Network

1. **Administrative Communication** (NQF 291): Does the medical record documentation indicate that the following communication occurred ***prior to the departure of the patient from the ED to another healthcare facility*** ?	**Yes**	**No**	**NA**
a. Evidence of communication between the transferring ED and the receiving hospital (this does not need to be a full report, acceptable communication includes assuring the availability of appropriate bed and staff for the patient).			
b. evidence of the Physician/Advanced, Practice Nurse/Physician, Assistant, (Physician/APN/PA) to Physician/APN/PA communication			
2. **Patient Information** (NQF # 294): Does the medical record documentation indicate that the following patient information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	**Yes**	**No**	**NA**
a. patient name			
b. patient address			
c. patient age or date of birth			
d. patient gender			
e. patient contact information (family member/significant other/friend)			
f. patient health insurance information			
3. **Vital Signs** (NQF # 292) Does the medical record documentation indicate that the following patient's vital signs were taken and the information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	**Yes**	**No**	**NA**
a. pulse			
b. respiratory rate			
c. blood pressure			
d. oxygen saturation			
e. temperature			
f. glasgow coma scale or other neurologic assessment (trauma, cognitively altered, or neurology patients only)			
4. **Medication Information** (NQF # 293): Does the medical record documentation indicate that the following patient's medication information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge? *note: if it is* ***documented*** *that patient is not on any home medications, no ED medications were perscribed or does not have any allergies select "yes" Also: if it is* ***documented*** *that it is unknown if patient is on home medication or has allergies/reactions select "yes"*	**Yes**	**No**	**NA**
a. medications administered in the ED			
b. allergies/reactions (includes food, medication, other and allergic reactions)			
c. home medications (including home scripts, PRN, OTC, herbals,etc)			
5. **Physician Information** (NQF # 295): Does the medical record documentation indicate that the following physician or practitioner generated information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	**Yes**	**No**	**NA**
a. history and physical (Must minimally include history of the current ED episode, a focused physical exam and relevant chronic conditions. Chronic conditions may be excluded if the patient is neurologically altered)			
b. reason for transfer and/or plan of care			
6. **Nurse Generated Information** (NQF # 296): Does the medical record documentation indicate that the following nurse generated information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	**Yes**	**No**	**NA**
a. nursing notes (examples: assessments/interventions/patient response or SOAP notes			
b. sensory status (impairments) (includes mental, speech,lllhearing, vision, sensation)			
c. catheters/ IV			
d. immobilizations			
e. respiratory support			
f. oral restrictions			
7. **Procedures and Tests Information** (NQF # 297): Does the medical record documentation indicate that the following procedures and tests information went with the patient or was communicated via fax or phone or internet/Electronic Health Record within 60 minutes of the patient's discharge?	**Yes**	**No**	**NA**
a. tests and procedures performed			
b. tests and procedure results			

Complete one extraction form per chart reviewed. See Guidelines for number of cases to submit or sample for each month of the reporting period.

BLANK PAGE

ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

This paper abstraction tool is provided as an informal mechanism to aid hospital outpatient departments in the collection of Hospital Outpatient Quality Measures. It should be noted that skip logic is not contained within the paper abstraction tool. If there are any questions or concerns regarding use of this paper abstraction tool, please contact the Hospital Outpatient Quality Reporting Program Support Contractor (Hospital OQR Program SC) at oqrsupport@hsag.com.

What was the date the patient arrived in the hospital outpatient setting? (*Outpatient Encounter Date*)
_____Dates are in MM-DD-YYYY. UTD is not an allowable entry.

What was the earliest documented time the patient arrived at the outpatient or emergency department? (*Arrival Time*) _____HH:MM (with or without colon) or ☐ UTD

First Name _____

Last Name_____

What was the patient's sex on arrival? (*Sex*) ☐ Female ☐ Male ☐ Unknown

What is the patient's date of birth? (*Birthdate*)_____
MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What is the patient's race? (*Race*) (Select one option)

☐ 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
☐ 2 Black or African American: Patient's race is Black or African American.
☐ 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.
☐ 4 Asian: Patient's race is Asian.
☐ 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander.
☐ 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (*Hispanic Ethnicity*)

☐ Yes Patient is of Hispanic ethnicity or Latino.
☐ No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What is the postal code of the patient's residence? (*Postal Code*) _____
Five or nine digits, HOMELESS or NON-US

What was the number used to identify this outpatient encounter? (*Patient Identifier*)

_____

CMS Certification Number (Format six digits) _____

ACUTE MYOCARDIAL INFARCTION (AMI) CART PAPER TOOL

1. **What was the E/M Code documented for this outpatient encounter? (EMCODE)**

   ☐ 99281 Emergency department visit, new or established patient
   ☐ 99282 Emergency department visit, new or established patient
   ☐ 99283 Emergency department visit, new or established patient
   ☐ 99284 Emergency department visit, new or established patient
   ☐ 99285 Emergency department visit, new or established patient
   ☐ 99291 Critical care, evaluation and management

2. **What was the patient's discharge code from the outpatient setting? (DISCHGCODE?**) (Select one option)

   ☐ 1 Home
   ☐ 2 Hospice – Home
   ☐ 3 Hospice – Health Care Facility
   ☐ 4a Acute Care Facility – General Inpatient Care
   ☐ 4b Acute Care Facility – Critical Access Hospital
   ☐ 4c Acute Care Facility – Cancer Hospital or Children's Hospital
   ☐ 4d Acute Care Facility – Department of Defense or Veteran's Administration
   ☐ 5 Other Health Care facility
   ☐ 6 Expired
   ☐ 7 Left Against Medical Advice/AMA
   ☐ 8 Not Documented or Unable to Determine (UTD)

3. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)** (Format eight digits, without a decimal point)

   _____

4. **What were the ICD-10-CM other diagnoses codes selected for this medical record? (OTHRDX#)** (Format eight digits, without a decimal point)

   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

5. **What is the patient's source of payment for this outpatient encounter? (PMTSRCE)**

   ☐ 1 Source of payment is Medicare
   ☐ 2 Source of payment is Non-Medicare

6. **Is there documentation of ST-segment elevation on the electrocardiogram (ECG) performed closest to emergency department arrival? (INITECGINT)**

   ☐ Yes ST-segment elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival.
   ☐ No No ST-segment elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival, no interpretation or report available for the ECG performed closest to emergency department arrival, or unable to determine from medical record documentation.

7. Did the patient receive fibrinolytic therapy at this emergency department? (FIBADMIN)

☐ Yes Fibrinolytic therapy was initiated at this emergency department.
☐ No There is no documentation fibrinolytic therapy was initiated at this emergency department, or unable to determine from medical record documentation.

8. What was the date primary fibrinolytic therapy was initiated during this hospital stay? (FIBADMINDT)

_____MM-DD-YYYY (includes dashes) or ☐ UTD

9. What was the time (military time) primary fibrinolytic therapy was initiated during this hospital stay? (FIBADMINTM)

_____HH:MM (with or without colon) or ☐ UTD

10. Is there a reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival? (REASONDELFIB)

☐ Yes Reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival.
☐ No No reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival, or unable to determine from medical record documentation.

11. Was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention? (TRANSFERCORINT)

☐ 1 There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention.
☐ 2 There was documentation the patient was admitted to observation status prior to transfer.
☐ 3 There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention, or the specific reason for transfer was unable to be determined from medical record documentation.

12. What is the date the patient departed from the emergency department? (EDDEPARTDT)

_____MM-DD-YYYY (includes dashes) or ☐ UTD

13. What is the time (military time) the patient departed from the emergency department? (EDDEPARTTM) _____ HH:MM (with or without colon) or ☐ UTD

14. Select one of the following potential contraindications or reasons for not administering fibrinolytic therapy. (REASONNOFIBADMIN)

☐ 1 Documented contraindication/reason
☐ 2 Cardiogenic Shock
☐ 3 No documented contraindication/reason or UTD

15. Was the patient's chest pain presumed to be cardiac in origin? (PROBCARDCP)

☐ Yes There was nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin.
☐ No There was no nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin, or unable to determine from medical record documentation.

16. Was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer? (ECGDONE)

☐ Yes There was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer.
☐ No There was not an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer, or unable to determine from medical record documentation.

17. What is the date the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGDT)

_____MM-DD-YYYY (includes dashes) or ☐ UTD

18. What is the time (military time) the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGTM)

_____HH:MM (with or without colon) or ☐ UTD

19. What is the first physician identifier? (PHYSICIAN_1)

_____

20. What is the second physician identifier? (PHYSICIAN_2)

_____

CHEST PAIN (CP) CART PAPER TOOL

This paper abstraction tool is provided as an informal mechanism to aid hospital outpatient departments in the collection of Hospital Outpatient Quality Measures. It should be noted that skip logic is not contained within the paper abstraction tool. If there are any questions or concerns regarding use of this paper abstraction tool, please contact the Hospital Outpatient Quality Reporting Program Support Contractor (Hospital OQR Program SC) at oqrsupport@hsag.com.

What was the date the patient arrived in the hospital outpatient setting? (*Outpatient Encounter Date*)
_____MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What was the earliest documented time the patient arrived at the outpatient or emergency department? (*Arrival Time*)
_____ HH:MM (with or without colon) or ☐ UTD

First Name _____

Last Name_____

What was the patient's sex on arrival? (*Sex*) ☐ Female ☐ Male ☐ Unknown

What is the patient's date of birth? (*Birthdate*)
_____MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What is the patient's race? (*Race*) (Select one option)

☐ 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
☐ 2 Black or African American: Patient's race is Black or African American.
☐ 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.
☐ 4 Asian: Patient's race is Asian.
☐ 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander.
☐ 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (*Hispanic Ethnicity*)

☐ Yes Patient is of Hispanic ethnicity or Latino.
☐ No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What is the postal code of the patient's residence? (*Postal Code*)_____
Five or nine digits, HOMELESS or NON-US

What was the number used to identify this outpatient encounter? (*Patient Identifier*)
_____

CMS Certification Number (CCN) (Format six digits) _____

CHEST PAIN (CP) CART PAPER TOOL

1. **What was the E/M Code documented for this outpatient encounter? (EMCODE)**

   ☐ 99281 Emergency department visit, new or established patient
   ☐ 99282 Emergency department visit, new or established patient
   ☐ 99283 Emergency department visit, new or established patient
   ☐ 99284 Emergency department visit, new or established patient
   ☐ 99285 Emergency department visit, new or established patient
   ☐ 99291 Critical care, evaluation and management

2. **What was the patient's discharge code from the outpatient setting? (DISCHGCODE?**) (Select one option)

   ☐ 1 Home
   ☐ 2 Hospice – Home
   ☐ 3 Hospice – Health Care Facility
   ☐ 4a Acute Care Facility – General Inpatient Care
   ☐ 4b Acute Care Facility – Critical Access Hospital
   ☐ 4c Acute Care Facility – Cancer Hospital or Children's Hospital
   ☐ 4d Acute Care Facility – Department of Defense or Veteran's Administration
   ☐ 5 Other Health Care facility
   ☐ 6 Expired
   ☐ 7 Left Against Medical Advice/AMA
   ☐ 8 Not Documented or Unable to Determine (UTD)

3. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)** (Format eight digits, without a decimal point)

   _____

4. **What were the ICD-10-CM other diagnoses codes selected for this medical record? (OTHRDX#)** (Format eight digits, without a decimal point)

   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

5. **What is the patient's source of payment for this outpatient encounter? (PMTSRCE)**

   ☐ 1 Source of payment is Medicare
   ☐ 2 Source of payment is Non-Medicare

6. **Was the patient's chest pain presumed to be cardiac in origin? (PROBCARDCP)**

   ☐ Yes There was nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin
   ☐ No There was no nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin, or unable to determine from medical record documentation.

7. Was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer? (ECGDONE)

☐ Yes There was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer.

☐ No There was not an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer, or unable to determine from medical record documentation.

8. What is the date the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGDT)

_____MM-DD-YYYY (includes dashes) or ☐ UTD

9. What is the time the earliest 12-lead Electrocardiogram (ECG) was performed? (ECGTM)

_____HH:MM (with or without colon) or ☐ UTD

13. What is the first physician identifier? (PHYSICIAN_1)

_____

14. What is the second physician identifier? (PHYSICIAN_2)

_____

BLANK PAGE

ED-THROUGHPUT CART PAPER TOOL

This paper abstraction tool is provided as an informal mechanism to aid hospital outpatient departments in the collection of Hospital Outpatient Quality Measures. It should be noted that skip logic is not contained within the paper abstraction tool. If there are any questions or concerns regarding use of this paper abstraction tool, please contact the Hospital Outpatient Quality Reporting Program Support Contractor (Hospital OQR Program SC) at oqrsupport@hsag.com.

What was the date the patient arrived in the hospital outpatient setting? (*Outpatient Encounter Date*)
_____MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What was the earliest documented time the patient arrived at the outpatient or emergency department? (*Arrival Time*)
_____HH:MM (with or without colon) or ☐ UTD

First Name _____

Last Name_____

What was the patient's sex on arrival? (*Sex*) ☐ Female ☐ Male ☐ Unknown

What is the patient's date of birth? (*Birthdate*)_____
MM-DD-YYYY (includes dashes). UTD is not an allowable entry.

What is the patient's race? (*Race*) (Select one option)

☐ 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
☐ 2 Black or African American: Patient's race is Black or African American.
☐ 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.
☐ 4 Asian: Patient's race is Asian.
☐ 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander.
☐ 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (*Hispanic Ethnicity*)

☐ Yes Patient is of Hispanic ethnicity or Latino.
☐ No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What is the postal code of the patient's residence? (*Postal Code*)_____
Five or nine digits, HOMELESS or NON-US

What was the number used to identify this outpatient encounter? (*Patient Identifier*)

_____

CMS Certification Number (Format six digits) _____

ED-THROUGHPUT CART PAPER TOOL

1. **What was the E/M Code documented for this outpatient encounter? (EMCODE)**

   ☐ 99281 Emergency department visit, new or established patient
   ☐ 99282 Emergency department visit, new or established patient
   ☐ 99283 Emergency department visit, new or established patient
   ☐ 99284 Emergency department visit, new or established patient
   ☐ 99285 Emergency department visit, new or established patient
   ☐ 99291 Critical care, evaluation and management

2. **What was the patient's discharge code from the outpatient setting? (DISCHGCODE?**) (Select one option)

   ☐ 1 Home
   ☐ 2 Hospice – Home
   ☐ 3 Hospice – Health Care Facility
   ☐ 4a Acute Care Facility – General Inpatient Care
   ☐ 4b Acute Care Facility – Critical Access Hospital
   ☐ 4c Acute Care Facility – Cancer Hospital or Children's Hospital
   ☐ 4d Acute Care Facility – Department of Defense or Veteran's Administration
   ☐ 5 Other Health Care facility
   ☐ 6 Expired
   ☐ 7 Left Against Medical Advice/AMA
   ☐ 8 Not Documented or Unable to Determine (UTD)

3. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)**
   (Format eight digits, without a decimal point) _____

4. **What is the patient's source of payment for this outpatient encounter? (PMTSRCE)**

   ☐ 1 Source of payment is Medicare
   ☐ 2 Source of payment is Non-Medicare

5. **What is the date the patient departed from the emergency department? (EDDEPARTDT)**
   _____ MM-DD-YYYY (includes dashes) or ☐ UTD

6. **What is the time the patient departed from the emergency department? (EEDDEPARTTM)**
   _____ HH:MM (with or without colon) or ☐ UTD

7. **What is the first physician identifier? (PHYSICIAN_1)**

   _____

8. **What is the second physician identifier? (PHYSICIAN_2)**

   _____

EMERGENCY DEPARTMENT (ED)

CART PAPER TOOL

Provider Name: _____

CMS Certification Number (CCN): _____

National Provider Identifier (NPI): _____

Health Care Organization Identifier (HCOID): _____
(Joint Commission Required)

First Name: _____

Last Name: _____

Sex: _____ Female _____ Male _____ Unknown

Birthdate:_____/_____/_____
All dates are in MM-DD-YYYY. UTD is not an allowable entry.

Race: (Select one option)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ UTD

Hispanic Ethnicity:

☐ No
☐ Yes

Patient Identifier: _____
Up to 40 letters, numbers, and/or characters

Admission Date:_____/_____/_____
All dates are in MM-DD-YYYY. UTD is not an allowable entry.

Discharge Date:_____/_____/_____
All dates are in MM-DD-YYYY. UTD is not an allowable entry.

Abstractor ID: _____

Abstraction Date:_____/_____/_____
All dates are in MM-DD-YYYY. UTD is not an allowable entry.

Vendor Tracking Identifier: _____

(Joint Commission Required)

1. **Would you like the questions to be enabled or disabled appropriately per the measure algorithms, or do you want all questions enabled? (SKIPPATTERN)** (Data Entry Question Only)

2. **What was the ICD-10-CM code selected as the principal diagnosis for this record? (PRINDX)** (Format: 3–7 characters without decimal point or dot)

   _____

3. **Were there ICD-10-CM Other Diagnosis Codes (OTHRDX#A)** (Format: 3–7 characters without decimal point or dot)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. **Was there an ICD-10-PCS code selected as the principal procedure for this record? (PRINPXA)** (Format: 3–7 characters without decimal point or dot)
   All dates are in MM-DD-YYYY.

ICD-10-PCS Principal Procedure Code	***ICD-10-PCS Principal Procedure Date or UTD***
_____	_____/_____/_____ ☐ UTD

5. Were there ICD-10-PCS Other Procedure Codes? (OTHRPX#A)

ICD-10-PCS Other Procedure Codes (Format: 3–7 characters without decimal point or dot)	***ICD-10-PCS-Other Procedure Dates*** All dates are in MM-DD-YYYY or UTD.	
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD
_____	_____ /_____/_____	☐ UTD

6. What is the patient's source of payment for this episode of care? (PMTSRCE)

- ☐ Source of payment is Medicare.
- ☐ Source of payment is Non-Medicare.

7. **What is the postal code of the patient's residence? (POSTALCODE)**
(Five or nine digits, HOMELESS OR NON-US) _____

8. **Does this case represent part of a sample? (SAMPLE)**

☐ Yes. The data represents part of a sample.

☐ No. The data is not part of a sample; this indicates the hospital is performing 100 percent of the discharges eligible for this measure set.

ED Data Elements

9. **Was the patient an ED patient at the facility? (EDPATIENT)**

☐ Yes. There is documentation the patient was an ED patient.

☐ No. There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

10. **What was the earliest documented month, day, and year of the decision to admit? (DCNADMITDT**: MM-DD-YYYY or UTD)_____/_____/_____ ☐ UTD

11. **What was the earliest documented time of the decision to admit? (DCNADMITTM**: Military format HH:MM or UTD)_____ ☐ UTD

12. **What is the date the patient departed from the emergency department? (EDDEPARTDT**: MM-DD-YYYY or UTD)_____/_____/_____ ☐ UTD

13. **What is the time the patient departed from the emergency department?** (**EDDEPARTTM**: Military format HH:MM or UTD)_____ ☐ UTD

14. **What is the first physician identifier? (PHYSICIAN_1)**

_____

15. **What is the second physician identifier? (PHYSICIAN_2)**

_____

Form Approved
OMB No. 0920-0666
Exp. Date: 11/30/2021
www.cdc.gov/nhsn

Patient Safety Component—Annual Hospital Survey

Instructions for this form are available at: http://www.cdc.gov/nhsn/forms/instr/57_103-TOI.pdf

*required for saving | Tracking #:

Facility ID: | *Survey Year:

Facility Characteristics (completed by Infection Preventionist)

*Ownership (check one):

☐ For profit ☐ Not for profit, including church ☐ Government

☐ Military ☐ Veterans Affairs ☐ Physician owned

If facility is a Hospital:

*Number of patient days: _____

*Number of admissions: _____

For any Hospital:

*Is your hospital a teaching hospital for physicians and/or physicians-in-training? ☐ Yes ☐ No

If Yes, what type: ☐ Major ☐ Graduate ☐ Undergraduate

*Number of beds set up and staffed in the following location types (as defined by NHSN):

ICU (including adult, pediatric, and neonatal levels II/III and III): _____

b. All other inpatient locations: _____

Facility Microbiology Laboratory Practices (completed with input from Microbiology Laboratory Lead)

*1. Does your facility have its own on-site laboratory that performs bacterial antimicrobial susceptibility testing? ☐ Yes ☐ No

If No, where is your facility's antimicrobial susceptibility testing performed? (check one)

☐ Affiliated medical center

☐ Commercial referral laboratory

☐ Other local/regional, non-affiliated reference laboratory

Continued >>

Patient Safety Component—Annual Hospital Survey

Facility Microbiology Laboratory Practices (continued)

*2. For the following organisms please indicate which methods are used for:
(1) Primary susceptibility testing and
(2) Secondary, supplemental, or confirmatory testing (if performed).
If your laboratory does not perform susceptibility testing, please indicate the methods used at the outside laboratory.

Please use the testing codes listed below the table.

Pathogen	(1) Primary	(2) Secondary	Comments
Staphylococcus aureus	_____	_____	_____
Enterobacteriaceae	_____	_____	_____

1 = Kirby-Bauer disk diffusion	5.1 = MicroScan -WalkAway	10 = E test
2 = Vitek (Legacy)	5.2 = MicroScan autoSCAN	12 = Vancomycin agar screen (BHI + vancomycin)
2.1 = Vitek 2	6 = Other broth micro dilution method	13 = Other (describe in Comments section)
3.1 = BD Phoenix	7 = Agar dilution method	
4 = Sensititre		

*3. Has the laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010? ☐ Yes ☐ No

*4. Has the laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010? ☐ Yes ☐ No

*5. Does the laboratory perform a test for presence of carbapenemase? (this does not include automated testing instrument expert rules) ☐ Yes ☐ No

If Yes, please indicate what is done if carbapenemase production is detected: (check one)

☐ Change susceptible carbapenem results to resistant

☐ Report carbapenem MIC results without an interpretation

☐ No changes are made in the interpretation of carbapenems, the test is used for epidemiological or infection control practices

If Yes, which test is routinely performed to detect carbapenemase: (check all that apply)

☐ PCR ☐MBL Screen

☐ Modified Hodge Test ☐ Carba NP

☐ mCIM/CIM ☐ Rapid CARB Blue

☐ E test ☐ Other (specify): _____

☐ Cepheid, BioFire array, Verigene®

If Yes, does the laboratory have a policy to routinely notify any of the following when CP-CRE are detected?

Physician ☐ Yes ☐ No

Infection Control ☐ Yes ☐ No

Patient Safety Component—Annual Hospital Survey

Facility Microbiology Laboratory Practices (continued)

*6. Does the laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant Gram-negative bacilli? ☐ Yes ☐ No

If Yes, please indicate methods: (check all that apply; answers listed are generic antimicrobial susceptibility testing methods and do not imply they are recommended for use in polymyxin susceptibility testing)

☐ Vitek 2
☐ BD Phoenix
☐ Sensititre
☐ MicroScan- WalkAway
☐ MicroScan autoSCAN
☐ Other broth microdilution method
☐ Agar dilution method
☐ E test
☐ Kirby-Bauer disk diffusion
☐ Accelerate Pheno
☐ Other (specify): _____

7*. Which of the following methods are used for yeast identification at your facility's laboratory or at the outside laboratory serving your facility? (check all that apply)

☐ MALDI-TOF MS System (Vitek MS)
☐ MALDI-TOF MS System (Bruker Biotyper)
☐ Vitek-2
☐ BD Phoenix
☐ MicroScan
☐ Non-automated Manual Kit (e.g., API 20C, RapID, Germ Tube, PNA-FISH, etc.)
☐ DNA sequencing
☐ Other (specify) _____

8*. *Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)

☐ Blood
☐ Other normally sterile body site (e.g.: CSF)
☐ Urine
☐ Respiratory
☐ Other (specify) _____
☐ None are fully identified to the species level

9*. What method is used for antifungal susceptibility testing (AFST) at your facility's laboratory or the outside laboratory serving your facility? (check all that apply)

☐ Broth microdilution
☐ Disk diffusion
☐ YeastOne colorimetric microdilution
☐ Other (specify): _____
☐ E test
☐ Vitek 2 card

Continued >>

Patient Safety Component—Annual Hospital Survey

*10. Antifungal susceptibility testing is performed on fungal isolates in which of the following situations:
Candida albicans:

☐ Always ☐ Only when isolated from sterile sites (eg: blood, CSF, etc) ☐ Only when ordered by a clinician; ☐ Other (specify):_____

Candida glabrata:

☐ Always ☐ Only when isolated from sterile sites (eg: blood, CSF, etc) ☐ Only when ordered by a clinician; ☐ Other (specify):_____

All other *Candida* species:

☐ Always ☐ Only when isolated from sterile sites (eg: blood, CSF, etc) ☐ Only when ordered by a clinician; ☐ Other (specify):_____

Facility Microbiology Laboratory Practices (continued)

*11. What is the primary testing method for *C. difficile* used most often by your facility's laboratory or the outside laboratory where your facility's testing is performed? (check one)

☐ Enzyme immunoassay (EIA) for toxin

☐ Cell cytotoxicity neutralization assay

☐ Nucleic acid amplification test (NAAT) (e.g., PCR, LAMP)

☐ NAAT plus EIA, if NAAT positive (2-step algorithm)

☐ Glutamate dehydrogenase (GDH) antigen plus EIA for toxin (2-step algorithm)

☐ GDH plus NAAT (2-step algorithm)

☐ GDH plus EIA for toxin, followed by NAAT for discrepant results

☐ Toxigenic culture (*C. difficile* culture followed by detection of toxins)

*12. Please indicate the primary and definitive method used to identify microbes from blood cultures collected in your facility. (**SELECT ONE ANSWER**)

☐ MALDI-TOF MS System (Vitek MS)

☐ MALDI-TOF MS System (Bruker Biotyper)

☐ Automated Instrument (e.g., Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.)

☐ Non-automated Manual Kit (e.g., API, Crystal, RapID, etc.)

☐ Rapid Identification (e.g., Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.)

☐16S rRNA Sequencing

*13. Please indicate any additional secondary methods used for microbe identification from blood cultures collected in your facility (e.g., a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary method). (**SELECT ALL THAT APPLY**)

☐ MALDI-TOF MS System (Vitek MS)

☐ MALDI-TOF MS System (Bruker Biotyper)

☐ Automated Instrument (e.g., Vitek, MicroScan, Phoenix, OmniLog, Sherlock, etc.)

☐ Non-automated Manual Kit (e.g., API, Crystal, RapID, etc.)

☐ Rapid Identification (e.g., Verigene, BioFire FilmArray, PNA-FISH, Gene Xpert, etc.)

☐16S rRNA Sequencing

Patient Safety Component—Annual Hospital Survey

Infection Control Practices
(completed with input from Hospital Epidemiologist and/or Quality Improvement Coordinator)

*14. Number or fraction of infection preventionists (IPs) in facility:

a. Total hours per week performing surveillance: _____

b. Total hours per week for infection control activities other than surveillance: _____

*15. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility: _____

Infection Control Practices
(completed with input from Hospital Epidemiologist and/or Quality Improvement Coordinator)

*16. Is it a policy in your facility that patients infected or colonized with MRSA are routinely placed in contact precautions while these patients are in your facility? (check one)

☐ Yes, all infected or colonized patients

☐ No

☐ Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while I your facility (check one):

☐ All infected or colonized patients

☐ Only all infected patients

☐ Only infected or colonized patients with certain characteristics (check all that apply)

☐Patients admitted to high risk settings

☐Patients at high risk for transmission

*17. Is it a policy in your facility that patients infected or colonized with VRE are routinely placed in contact precautions while these patients are in your facility? (check one)

☐ Yes, all infected or colonized patients

☐ No

☐ Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while I your facility (check one):

☐ All infected or colonized patients

☐ Only all infected patients

☐ Only infected or colonized patients with certain characteristics (check all that apply)

☐Patients admitted to high risk settings

☐Patients at high risk for transmission

Patient Safety Component—Annual Hospital Survey

*18. Is it a policy in your facility that patients infected or colonized with CRE (regardless of confirmatory testing for carbapenemase production) are routinely placed in contact precautions while these patients are in your facility? (check one)

☐ Yes, all infected or colonized patients

☐ No

☐ Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while I your facility (check one):

☐ All infected or colonized patients

☐ Only all infected patients

☐ Only infected or colonized patients with certain characteristics (check all that apply)

☐Patients admitted to high risk settings

☐Patients at high risk for transmission

*19. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae are routinely placed in contact precautions while these patients are in your facility? (check one)

☐ Yes, all infected or colonized patients

☐ No

☐ Not applicable: my facility never admits these patients

If Yes, please check the type of patients that are routinely placed in contact precautions while I your facility (check one):

☐ All infected or colonized patients

☐ Only all infected patients

☐ Only infected or colonized patients with certain characteristics (check all that apply)

☐ Patients admitted to high risk settings

☐ Patients at high risk for transmission

Infection Control Practices
(completed with input from Hospital Epidemiologist and/or Quality Improvement Coordinator)

*20. Does the facility routinely perform screening testing (culture or non-culture) for CRE?

☐ Yes ☐ No

If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)

☐ Surveillance testing at admission for all patients

☐ Surveillance testing of epidemiologically-linked patients of newly identified CRE patients (e.g., roommates)

☐ Surveillance testing at admission of high-risk patients (e.g., admitted from LTAC or LTCF)

☐ Surveillance testing at admission of patients admitted to high-risk settings (e.g. ICU)

☐ Other (please specify): _____

Patient Safety Component—Annual Hospital Survey

*21. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to non-NICU settings? ☐ Yes ☐ No

If yes, in which situations does the facility routinely perform screening testing for MRSA for non-NICU settings? (check all that apply)

- ☐ Surveillance testing at admission for all patients
- ☐ Surveillance testing at admission of high-risk patients (e.g., admitted from LTAC or LTCF)
- ☐ Surveillance testing at admission of patients admitted to high-risk settings (e.g. ICU)
- ☐ Surveillance testing of pre-operative patients to prevent surgical site infections
- ☐ Other (please specify): _____

*22.Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings? ☐ Yes ☐ No

If yes, in which situations does the facility routinely perform screening testing for MRSA for NICU settings? (check all that apply)

- ☐ Surveillance testing at admission for all transferred patients
- ☐ Surveillance testing of patients from known MRSA positive mothers
- ☐ Surveillance testing of high-risk patients (e.g. infants born premature)
- ☐ Routine active surveillance testing (i.e., point prevalence surveys)
- ☐ Other (please specify): _____

*23. Does the facility routinely use chlorhexidine bathing on any patient to prevent infection or transmission of MDROs at your facility? (Note: this does not include the use of such bathing in pre-operative patients to prevent SSIs) ☐ Yes ☐ No

*24. Does the facility routinely use a combination of topical chlorhexidine AND intranasal mupirocin (or equivalent agent) on any patients to prevent infection or transmission of MRSA at your facility? (Note: this does not include the use of these agents in pre-operative surgical patients or dialysis patients) ☐ Yes ☐ No

Facility Neonatal Patient Care Practices and Neonatal Admission Information

(To be completed with input from the NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, and/or Lead Neonatal Nurse Practitioner)*

*25. Was this section completed in collaboration with your facility's neonatal patient care team (i.e. was input sought from at least one of the following neonatal patient care team members: NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, Lead Neonatal Nurse Practitioner)?

- ☐ Yes
- ☐ No
- ☐ N/A, my facility does not provide neonatal patient care services

If N/A was selected in question 25 above, questions 26-30 below do not apply to your facility and should be skipped. If your facility does care for neonates (at any level), please complete questions below.

Patient Safety Component—Annual Hospital Survey

Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.

*26. Excluding Level I units (well newborn nurseries), record the number of neonatal admissions to Special Care Nurseries (Level II) and Intensive Care Units (Level II/III, Level III, Level IV):

a. Inborn Admissions: _____

b. Outborn Admissions: _____

*27. Excluding Level I units (well newborn nurseries), record the number of neonatal admissions (both inborn and outborn) to Special Care (Level II) and Intensive Care (Level II/III, Level III, Level IV) in each of following birth weight categories:

a. Less than or equal to 750 grams: _____

b. 751-1000 grams: _____

c. 1001-1500 grams: _____

d. 1501-2500 grams: _____

e. More than 2500 grams: _____

*28. Does your facility provide Level III (or higher) neonatal intensive care as defined by the American Academy of Pediatrics (e.g. capable of providing sustained life support, comprehensive care for infants born <32 weeks gestation and weighing <1500 grams, a full range of respiratory support that may include conventional and/or high-frequency ventilation)? ☐ Yes ☐ No

*29 Does your facility accept neonates as transfers for any of the following procedures: Omphalocele repair; ventriculoperitoneal shunt; tracheoesophageal fistula (TEF)/esophageal atresia repair; bowel resection/reanastomosis; meningomyelocele repair; cardiac catheterization. ☐ Yes ☐ No

*30. If your facility administers antimicrobials (oral or parenteral) to newborns residing in their mother's room, to which NHSN location(s) is the baby mapped? (Select all that apply)

☐ N/A, my facility requires that newborns be transferred to a higher level of care (i.e. special care nursery or neonatal intensive care unit) in order for antimicrobials to be administered

☐ Level I neonatal unit (well newborn nursery)

☐ Labor and Delivery Ward, Postpartum Ward, or Labor, Delivery, Recovery, Postpartum Suite

Antibiotic Stewardship Practices

(completed with input from Physician and Pharmacist Stewardship Champions)

31*. Our facility has a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board). ☐ Yes ☐ No

32*. Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by: (Check all that apply.)

☐ Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues.

☐ Providing opportunities for staff training and development on antibiotic stewardship.

☐ Allocating information technology resources to support antibiotic stewardship efforts.

☐ None of the above

Patient Safety Component—Annual Hospital Survey

33*. Our facility has a committee responsible for antibiotic stewardship. ☐ Yes ☐ No

If Yes, membership in our facility's antibiotic stewardship committee includes: (Check all that apply.)

- ☐ Non-infectious diseases trained prescriber(s)
- ☐ Infectious disease physician(s)
- ☐ Pharmacist(s)
- ☐ Nurse(s)
- ☐ Infection preventionist(s)
- ☐ Microbiologist(s)
- ☐ Information technologist(s)
- ☐ A patient representative
- ☐ None of the Above

34*. Our facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes. ☐ Yes ☐ No

If Yes, what is the position of this leader? (Check one.)

- ☐ Physician
- ☐ Pharmacist
- ☐ Co-led by both Pharmacist and Physician
- ☐ Other (please specify):_____

If Physician or Co-led is selected, which of the following describes your antibiotic stewardship **physician** leader? (Check all that apply.)

- ☐ Has antibiotic stewardship responsibilities in their contract or job description
- ☐ Is physically on-site in your facility (either part-time or full-time)
- ☐ Completed an ID fellowship
- ☐ Completed a certificate program or other coursework
- ☐ None of the above

If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (Check all that apply.)

- ☐ Has antibiotic stewardship responsibilities in their contract or job description
- ☐ Is physically on-site in your facility (either part-time or full-time)
- ☐ Completed a PGY2 ID residency and/or ID fellowship
- ☐ Completed a certificate program or other coursework
- ☐ None of the above

If Physician or Other, is there at least one pharmacist responsible for improving antibiotic use at your facility? ☐ Yes ☐ No

Patient Safety Component—Annual Hospital Survey

35*. Our facility has a policy or formal procedure for: (Check all that apply.)

☐ Required documentation of indication for antibiotic orders.

If selected: Our stewardship team monitors adherence to the policy or formal procedure for required documentation of indication for all antibiotic orders. ☐ Yes ☐ No

☐ Required documentation of duration for antibiotic orders.

☐ The treating team to review antibiotics 48-72 hours after initial order (i.e., antibiotic time-out).

☐ The stewardship team to review courses of therapy for specific antibiotic agents and provide real-time feedback and recommendations to the treating team (i.e., prospective audit and feedback).

If selected: For which categories of antimicrobials? (Check all that apply.)

☐ Cefepime, ceftizidime, or piperacillin/tazobactam

☐ Ertapenem, imipenem/cilastatin, or meropenem

☐ Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, or other recently FDA-approved beta-lactam/beta-lactamase inhibitors

☐ Colistin or polymyxin B

☐ Quinolones

☐ Vancomycin

☐ Daptomycin, linezolid, or other anti-MRSA agents

☐ Anidulafungin, caspofungin, or micafungin

☐ Isavuconazole, posaconazole, or voriconazole

☐ Amphotericin B and/or lipid-based amphotericin B

☐ None of the above

☐ Required authorization by the stewardship team before restricted antibiotics on the formulary can be dispensed (i.e., prior authorization).

If selected: For which categories of antimicrobials? (Check all that apply.)

☐ Cefepime, ceftizidime, or piperacillin/tazobactam

☐ Ertapenem, imipenem/cilastatin, or meropenem

☐ Ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, or other recently FDA-approved beta-lactam/beta-lactamase inhibitors

☐ Colistin or polymyxin B

☐ Quinolones

☐ Vancomycin

☐ Daptomycin, linezolid, or other anti-MRSA agents

☐ Anidulafungin, caspofungin, or micafungin

☐ Isavuconazole, posaconazole, or voriconazole

☐ Amphotericin B and/or lipid-based amphotericin B

☐ None of the above

☐ None of the above

Patient Safety Component—Annual Hospital Survey

36*. Providers have access to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections. ☐ Yes ☐ No

If Yes: Our stewardship team monitors adherence to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections. ☐ Yes ☐ No

37*. Our facility targets select diagnoses for active interventions to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response). ☐ Yes ☐ No

38*. Our stewardship team monitors: (Check all that apply.)

- ☐ Antibiotic resistance patterns (either facility- or region-specific)
- ☐ *Clostridioides difficile*
- ☐ Antibiotic use in days of therapy (DOT) per 1000 patient days or days present, at least quarterly
- ☐ Antibiotic use in defined daily doses (DDD) per 1000 patient days, at least quarterly
- ☐ Antibiotic expenditures (i.e., purchasing costs), at least quarterly
- ☐ Antibiotic use in some other way (please specify): _____
- ☐ None of the above

If antibiotic use in DOT, DDD, or some other way is selected: Our stewardship team provides individual-, unit-, or service-specific reports on antibiotic use to prescribers, at least annually. ☐ Yes ☐ No

If Yes is selected: Our stewardship team uses individual-, unit-, or service-specific antibiotic use reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually. ☐ Yes ☐ No

39*. Our stewardship team provides the following updates or reports, at least annually: (Check all that apply.)

- ☐ Updates to facility leadership on antibiotic use and stewardship efforts.
- ☐ Outcomes for antibiotic stewardship interventions to staff.
- ☐ None of the above

40*. Which of the following groups receive education on appropriate antibiotic use at least annually? (Check all that apply.)

- ☐ Prescribers
- ☐ Nursing staff
- ☐ Pharmacists
- ☐ None of the above

Optional Antibiotic Stewardship Practices Questions

Responses to the following questions are not required to complete the annual survey.

Please provide additional information about your facility's antibiotic stewardship activities and leadership.

41. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives. ☐ Yes ☐ No

Patient Safety Component—Annual Hospital Survey

42. Our facility accesses targeted remote stewardship expertise (e.g., tele-stewardship) to obtain facility-specific support for our antibiotic stewardship efforts. ☐ Yes ☐ No

43. Our facility has a clinical decision support tool embedded in the electronic health record for antibiotic use or stewardship interventions available to prescribers. ☐ Yes ☐ No

44. Our stewardship team works with the microbiology laboratory to inform cascade and/or selective reporting protocols for isolate susceptibilities. ☐ Yes ☐ No ☐ Not applicable, our facility does not use cascade and/or selective reporting

45. Our stewardship team monitors compliance with appropriate surgical prophylaxis. ☐ Yes ☐ No

46. If you selected 'Yes' to question 34 (your facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes): Which committees or leadership entities provide oversight of your facility's antibiotic stewardship efforts? (Check all that apply.)

- ☐ Pharmacy director
- ☐ Pharmacy & therapeutics
- ☐ Patient safety
- ☐ Quality improvement
- ☐ Executive leadership (e.g., CEO, CMO)
- ☐ Board of directors
- ☐ Other (please specify): _____
- ☐ None

47. If you selected 'Physician' or 'Co-led…' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Physician): On average, what percent time does the **physician** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)

- ☐ 1-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%

48. If you selected 'Pharmacist' or 'Co-led…' (your facility's leader (or co-leader) responsible for antibiotic stewardship outcomes is a Pharmacist): On average, what percent time does the **pharmacist** (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)

- ☐ 1-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%

49. If you selected that the physician (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **physician** (co) leader's contract or job description? (Check one.)

- ☐ 1-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%
- ☐ Not specified

Patient Safety Component—Annual Hospital Survey

50. If you selected that the pharmacist (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's contract or job description? (Check one.)

☐ 26-50%
☐ 51-75%
☐ 76-100%
☐ Not specified

Water Management Program (prevent legionella)

(*Optional section. Responses to the following questions are not required to complete the annual survey. Completed with input from facility water management team.)

51. Have you performed an assessment of the water systems in your facility to identify areas of risk for growth and transmission of Legionella and other opportunistic waterborne pathogens? (e.g. pseudomonas, acinetobacter, burkholderia, and nontuberculous mycobacteria) ☐ Yes ☐ No

If Yes, when? (Check one)

☐ ≤ 1 year ago ☐ ≥ 1-3 years ago

☐ ≥ 3 years ago ☐ Other (please specify): _____

52. Has your hospital established a team specifically for the purpose of developing and implementing a water management program to prevent the growth and transmission of Legionella and other waterborne pathogens? ☐ Yes ☐ No

If Yes, who is represented on the team? (Check all that apply)

☐ Hospital Epidemiologist/ Infection Preventionist
☐ Hospital Administrator
☐ Facilities Manager/ Engineer
☐ Compliance Officer
☐ Risk/Quality Management Staff
☐ Infectious Disease Clinician

53. Do you regularly monitor the following parameters in your building's water system? (Check all that apply)

Disinfectant (such as residual chlorine): ☐ Yes ☐ No

If Yes, do you have a plan for corrective actions when the following parameters are not within acceptable limits as determined by your water management program? ☐ Yes ☐ No

Temperature: ☐ Yes ☐ No

If Yes, do you have a plan for corrective actions when the following parameters are not within acceptable limits as determined by your water management program? ☐ Yes ☐ No

Patient Safety Component—Annual Hospital Survey

(Question 53 continued.)

If Yes, do you have a plan for corrective actions when the following parameters are not within acceptable limits as determined by your water management program?	☐ Yes	☐ No
Specific tests for *Legionella:*	☐ Yes	☐ No
If Yes, do you have a plan for corrective actions when the following parameters are not within acceptable limits as determined by your water management program?	☐ Yes	☐ No

Healthcare Personnel Influenza Vaccination Summary

*required for saving, ^conditionally required for saving

Record the number of healthcare personnel (HCP) for each category below for the influenza season being tracked.

*Facility ID#:		^Location:	
*Vaccination type: Influenza	*Influenza subtype[a]: ☐ Seasonal	*Influenza Season[b]:	Date Last Modified: __/__/____

	Employee HCP	Non-Employee HCP		
	*Employees (staff on facility payroll)	*Licensed independent practitioners: Physicians, advanced practice nurses, & physician assistants	*Adult students/ trainees & volunteers	Other Contract Personnel
1. Number of HCP who worked at this healthcare facility for at least 1 day between October 1 and March 31				
2. Number of HCP who received an influenza vaccination at this healthcare facility since influenza vaccine became available this season				
3. Number of HCP who provided a written report or documentation of influenza vaccination outside this healthcare facility since influenza vaccine became available this season				
4. Number of HCP who have a medical contraindication to the influenza vaccine				
5. Number of HCP who declined to receive the influenza vaccine				
6. Number of HCP with unknown vaccination status (or criteria not met for questions 2-5 above)				

Custom Fields

Label		Label	
_____	____/____/____	_____	____/____/____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments

[a] For the purposes of NHSN, influenza subtype refers to whether seasonal or non-seasonal vaccine is used. Seasonal is the default and only current choice.
[b] For the purposes of NHSN, a flu season is defined as July 1 to June 30.

CDC 57.214 v2, R8.2

Healthcare Personnel Influenza Vaccination Summary

Question 1 (Denominator) Notes:

- Include all HCP who have worked at the facility for at least 1 working day during the reporting period, regardless of clinical responsibility or patient contact. This includes HCP who joined after October 1 or left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours a day counts as one working day.
- Include both full-time and part-time persons. If a HCW works in two or more facilities, each facility should include the HCW in their denominator. Count HCP as individuals rather than full-time equivalents.
- Licensed practitioners who receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees.
- The HCP categories are mutually exclusive. Each HCP should be counted only once in the denominator (question 1).

Questions 2-6 (Numerator) Notes:

- Questions 2-6 are mutually exclusive. The sum of the HCP in questions 2-6 should equal the number of HCP in question 1 for each HCP category. Questions 2-6 are to be reported separately for each of the three HCP categories.
- Only the following HCP should be counted in question 4: HCP with (1) a severe allergic reaction to eggs or other vaccine component(s) or (2) a history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination.
- The following should be counted in question 5 (declined to receive influenza vaccine):
  - HCP who declined vaccination because of conditions **other than** those included in question 4.
  - HCP who declined vaccination and did not provide any other information.
  - HCP who did not receive vaccination because of religious or philosophical exemptions.
  - HCP who deferred vaccination for the entire influenza season (for example, from October 1 through March 31).