Last Revised: October 5, 2016

Rule of Record: Calendar Year (CY) 2016 ESRD Prospective Payment System (PPS) Final Rule (2015)

**Infection Monitoring: National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Patients Clinical Measure**

Lower rate desired

Safety subdomain

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | The Standardized Infection Ratio (SIR) of Bloodstream Infections (BSI) will be calculated among patients receiving hemodialysis at outpatient hemodialysis centers.<br>Based on NQF #1460 |
| **Numerator** | The number of new positive blood culture events based on blood cultures drawn as an outpatient or within 1 calendar day after a hospital admission. |
| **Denominator** | Expected number of infections in maintenance in-center hemodialysis patients treated in the outpatient hemodialysis unit on the first 2 working days of the month. |
| **Exclusions** | 1. Facilities that do not offer in-center hemodialysis<br>2. Facilities with a CCN open date on or after January 1, 2017<br>3. Facilities that treat fewer than 11 in-center hemodialysis patients during the performance period<br>4. Facilities with approved Extraordinary Circumstances Exception |
| **Minimum Data Reported to NHSN** | 12 months |
| **Data Source(s)** | 1. NHSN (for Risk-Adjusted Standardized Infection Rates)<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (form 2744 to obtain facility type and certification date)<br>3. Medicare claims and CROWNWeb (to determine patient-minimum exclusion) |

| SPECIFICATION | DETAIL |
|---|---|
| **Additional Information** | 1. Facilities are required to meet enrollment and training requirements, as specified at http://www.cdc.gov/nhsn/dialysis/enroll.html and http://www.cdc.gov/nhsn/Training/dialysis/index.html.<br>2. A positive blood culture is considered a new event and counted only if it occurred 21 days or more after a previously reported positive blood culture in the same patient.<br>3. Patients receiving inpatient hemodialysis are excluded from the measure.<br>4. Patients receiving only home hemodialysis or peritoneal dialysis are excluded from the measure.<br>5. Facilities that do not submit 12 months of accurately reported data receive zero points for the measure.<br>6. For more information about the methodology used to calculate risk-adjusted standardized infection rates, please see http://www.cdc.gov/nhsn/dialysis/. |

Last Revised: May 2, 2017

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Patient Experience of Care: In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey Clinical Measure**

Higher rate desired

Patient and Family Engagement/Care Coordination subdomain

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Percentage of patient responses to multiple testing tools.<br>Composite Score: The proportion of respondents answering each response option by item, summed across all items within a composite. Composites include: Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, and Providing Information to Patients,<br>Overall Rating: a summation of responses to the rating items grouped into 3 levels<br>NQF #0258 |
| **Exclusions** | 1. Facility attests that it treated fewer than 30 eligible in-center hemodialysis adult patients during the "eligibility period," which is defined as the year prior to the performance period<br>2. Facilities that treat 30 or more eligible in-center hemodialysis adult patients during the "eligibility period," but are unable to obtain at least 30 completed surveys during the performance period<br>3. Facilities with a CCN open date on or after January 1, 2017<br>4. Facilities not offering In-Center Hemodialysis<br>5. The following patients are excluded in the count of 30 eligible patients:<br>a) Patients less than 18 years on the last day of the sampling window for the semiannual survey<br>b) Patients receiving hemodialysis from their current facility for less than 90 days<br>c) Patients receiving hospice care<br>d) Patients currently residing in an institution, such as a residential nursing home or other long-term care facility, or a jail or prison |
| **Data Source(s)** | 1. ICH CAHPS<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (form 2744 to obtain certification date and facility type) |

| SPECIFICATION | DETAIL |
|---|---|
| **Additional Information** | 1. Facilities are required to register on the https://ichcahps.org website in order to authorize a CMS-approved vendor to administer the survey and submit data on their behalf.<br>2. Facilities are required to administer the survey twice during the performance period, using a CMS-approved vendor.<br>3. Facilities are required to ensure that vendors submit survey data to CMS by the date specified at https://ichcahps.org.<br>4. Adult and pediatric facilities that treat fewer than 30 eligible patients during the eligibility period must attest to this in CROWNWeb to not receive a score on the measure; facilities that do not attest that they are ineligible will be considered eligible and will receive a score on the measure.<br>5. Facilities that do not administer two surveys during the performance period will receive a score of 0 on the measure.<br>6. Facilities that administer two surveys during the performance period but receive less than 30 completed surveys will be excluded from the measure.<br>7. Additional specifications may be found at https://ichcahps.org. |

Last Revised: May 2, 2017

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Standardized Readmission Ratio (SRR) Clinical Measure**

Lower rate desired

Patient and Family Engagement/Care Coordination subdomain

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Ratio of the number of observed unplanned 30-day hospital readmissions to the number of expected unplanned 30-day hospital readmissions. NQF #2496 |
| **Numerator** | Number of unplanned 30-day hospital readmissions |
| **Denominator** | The expected number of unplanned 30-day hospital readmissions in each facility, which is derived from a model that accounts for patient characteristics, the dialysis facility to which the patient is discharged and the discharging acute care or critical access hospitals involved. |
| **Exclusions** | The measure excludes readmissions in the numerator that:<br>1. Occurred more than 30 days after the index discharge<br>2. Are considered "planned"<br>3. Occur within the first three days following discharge from the acute care hospital<br><br>The measure excludes index hospital discharges from the denominator that:<br>1. End in death<br>2. Result in a patient dying within 30 days with no readmission<br>3. Are against medical advice<br>4. Include a primary diagnosis for certain types of cancer, mental health conditions or rehabilitation<br>5. Occur after a patient's 12th admission in the calendar year<br>6. Are from a PPS-exempt cancer hospital<br>7. Result in a transfer to another acute care or critical access hospital on the same day, or the day after the discharge date<br>8. Result in an unplanned readmission occurring within the first three days following discharge from the acute care hospital |
| **Minimum Data Requirements** | Facilities with fewer than 11 index hospital discharges in the calendar year are not eligible for the measure. |

| SPECIFICATION | DETAIL |
|---|---|
| **Data Source(s)** | 1. Medicare Claims<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data |
| **Additional Information** | 1. A hospitalization is counted as an event in the numerator if it (a) occurred within 4 to 30 days of an index hospital discharge; and (b) is not considered a "planned" readmission<br>2. Additional information about the measure can be found in the SRR Measure Methodology Report posted at [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html]. |

Last Revised: October 5, 2016

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Standardized Transfusion Ratio (STrR) Clinical Measure**

Lower rate desired

Clinical Care subdomain

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Risk adjusted facility level transfusion ratio (STrR) for all adult Medicare dialysis patients. STrR is a ratio of number of observed eligible red blood cell transfusion events occurring in patients dialyzing at a facility to the number of eligible transfusions that would be expected from a predictive model that accounts for patient characteristics within each facility. |
| **Numerator** | Number of observed red blood cell transfusion events (defined as transfer of one or more units of blood or blood products into recipient's blood stream) among patients dialyzing at the facility during the reporting period. |
| **Denominator** | Number of eligible red blood cell transfusion events (as defined in the numerator statement) that would be expected among patients at a facility during the reporting period, given the patient mix at the facility. |
| **Exclusions** | 1. Patients less than 18 years old<br>2. Patients on ESRD treatment for fewer than 90 days<br>3. Patients treated at the facility for fewer than 60 days<br>4. Patients who receive a transplant<br>5. Patients who have not been treated by any facility for a year or longer<br>6. Patients with a Medicare claim for one of the following conditions in the past year: hemolytic and aplastic anemia, solid-organ cancer (breast, prostate, lung, digestive tract and others), lymphoma, carcinoma in situ, coagulation disorders, multiple myeloma, myelodysplastic syndrome and myelofibrosis, leukemia, head and neck cancer, other cancers (connective tissue, skin, and others), metastatic cancer, or sickle cell anemia |
| **Minimum Data Requirements** | Facilities with fewer than 10 patient-years at risk will not be eligible to receive a score on the measure. |

| SPECIFICATION | DETAIL |
|---|---|
| **Data Source(s)** | 1. Medicare Claims<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), Long Term Care Minimum Data Set, form 2728 to obtain the dialysis date of ESRD, and other CMS ESRD administrative data |
| **Additional Information** | 1. Eligible transfusion events are those that do not have any claims pertaining to the comorbidities identified for exclusion, in the one year look back period prior to each observation window.<br>2. When a patient transfers from one facility to another, the patient continues to be attributed to the original facility for 60 days, at which point the patient is attributed to the destination facility.<br>3. A patient-month is considered eligible if it is within two months of a month in which a patient has $900 of Medicare-paid dialysis claims or at least one Medicare inpatient claim.<br>4. Additional information about the measure can be found in the STrR Measure Methodology Report posted at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html. |

Last Revised: May 2, 2017

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Kt/V Dialysis Adequacy Comprehensive Clinical Measure**

Higher rate desired

Clinical Care subdomain

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Percentage of all patient months for patients whose delivered dose of dialysis (either hemodialysis or peritoneal dialysis) met the specified threshold during the reporting period. |
| **Numerator** | Number of patient months in the denominator for patients whose delivered dose of dialysis met the specified thresholds.<br>The thresholds are as follows:<br>• Hemodialysis (all ages): spKt/V ≥ 1.2 (calculated from the last measurement of the month using UKM or Daugirdas II)<br>• Peritoneal dialysis (pediatric <18 years): Kt/V ≥ 1.8 (dialytic + residual, measured within the past 6 months)<br>• Peritoneal dialysis (adult >= 18 years): Kt/V ≥ 1.7 (dialytic + residual, measured within the past 4 months) |
| **Denominator** | • All adult hemodialysis patients who received dialysis greater than two and less than four times a week (adults, ≥ 18 years), and all pediatric in –center hemodialysis patients who received dialysis greater than two and less than four times a week (pediatric, <18 years), and did not indicate frequent dialysis.<br>• All patients (both HD and PD) who are assigned to the facility for the entire month, and have had ESRD for 90 days or more |

| SPECIFICATION | DETAIL |
|---|---|
| **Denominator Exclusions** | 1. For adult HD patients, those receiving dialysis less than or equal to 2 or greater than or equal to 4 times weekly<br>2. For pediatric in-center HD patients, those receiving dialysis less than or equal to 2 or greater than or equal to 4 times weekly<br>3. Pediatric home hemodialysis patients<br>4. All patients indicated as a frequent dialyzer for the reporting month (see additional information below)<br>5. Patients on ESRD treatment for fewer than 90 days<br>6. Patient-months where the patient is not assigned to the facility for the entire month.<br>7. Patient-months where the patient is assigned to more than one facility<br>8. Patient-months where there is more than one treatment modality. Note: For adult HD patients, a change from in-center to home HD (or vice versa) is not considered a modality change. |
| **Data Source(s)** | 1. CROWNWeb<br>2. REMIS, Enrollment Data Base (EDB), and other CMS ESRD administrative data<br>3. Medicare Claims |

| SPECIFICATION | DETAIL |
|---|---|
| **Additional Information** | 1. Hemodialysis (all ages) must be calculated from the last measurement of the month using UKM or Daugirdas II method, or the last valid value of the month when using claims.<br>2. Weekly dialysis should be determined using the Prescribed Sessions per Week in CROWNWeb. If Kt/V is missing from CROWNWeb, then dialysis sessions per week is calculated using claims, as the number of dialysis sessions in the claim divided by the time period covered by the claim, with no rounding for the number of sessions per week. The calculated sessions per week must be 4 or more for claims greater than 7 days, and total sessions is 4 or more for claims with 7 days or fewer. Frequent dialysis is also defined when Kt/V=8.88 on the claim.<br>3. For hemodialysis patients, the reported spKt/V should not include residual renal function.<br>4. Patients with missing values or with Kt/V values=9.99 (i.e. not reported when claims are used) are included in the denominator, but not the numerator.<br>5. For peritoneal dialysis patients, if a value was not found in CROWNWeb for the patient during the four-month study period (adults) or six-month study period (pediatric), then the last reported non-missing and non-expired value reported on the eligible Medicare claim for the patient during the four-month or six-month study period respectively is selected (when available).<br>6. For all in-center hemodialysis patients, Kt/V must be reported during the reporting month; if a Kt/V value is not found in CROWNWeb, it will be obtained from the last reported non-missing and non-expired value from eligible Medicare claims (when available). For all home HD patients, if a Kt/V value is not found in CROWNWeb for the four-month study period, then Kt/V must be reported within four months prior to the claim through date. |

Last Revised: October 5, 2016

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Vascular Access Type (VAT) Measure Topic –**
**Arteriovenous Fistula (AVF) Clinical Measure**

Higher rate desired

Clinical Care subdomain

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Percentage of patient-months on hemodialysis during the last hemodialysis treatment of the month using an autogenous AV fistula with two needles. NQF#0257 |
| **Numerator** | Patient-months in the denominator where an autogenous AV fistula with two needles was the means of access. |
| **Denominator** | Number of Medicare patient-months at the facility during the measurement period. |
| **Denominator Exclusions** | 1. Patients younger than 18<br>2. Patients not on Hemodialysis<br>3. Claims with both a fistula and graft reported<br>4. Claims with fistula, graft, and catheter reported<br>5. Claims with missing access type<br>6. Patients not on ESRD treatment as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims |
| **Minimum Claims** | 4 months |
| **Data Source(s)** | 1. Medicare Claims<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth) |
| **Additional Information** | 1. If claim indicates fistula and catheter, then only the fistula is counted.<br>2. Last claim of the month used for calculation. |

Last Revised: October 5, 2016

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Vascular Access Type (VAT) Measure Topic –**
**Catheter ≥ 90 Days Clinical Measure**

Lower rate desired

Clinical Care subdomain

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Percentage of patient-months for patients on hemodialysis during the last hemodialysis treatment of month with a catheter continuously for 90 days or longer prior to the last hemodialysis session.<br>NQF#0256 |
| **Numerator** | Patient-months in the denominator for patients continuously using a catheter for hemodialysis access for 90 days or longer prior to the last hemodialysis treatment during the month. |
| **Denominator** | Number of Medicare patient-months at the facility during the measurement period. |
| **Denominator Exclusions** | 1. Patients younger than 18 years and 90 days<br>2. Patients not on Hemodialysis<br>3. Claims with both a fistula and graft reported<br>4. Claims with fistula, graft, and catheter reported<br>5. Claims with missing access type<br>6. Patients not on ESRD treatment as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims |
| **Minimum Claims** | 4 consecutive months |
| **Data Source(s)** | 1. Medicare Claims<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth) |
| **Additional Information** | 1. If claim indicates fistula and catheter, then only the fistula is counted.<br>2. If a claim indicates catheter and graft, then only the graft is counted.<br>3. Measure uses claims data from October, November, and December of the year prior to the performance or comparison period (e.g., October – December 2016 for performance period) to determine catheter history<br>4. Last claim of the month used for calculation. |

Last Revised: May 2, 2017

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Hypercalcemia Clinical Measure**

Lower rate desired

Clinical Care subdomain

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Proportion of patient-months with 3-month rolling average of total uncorrected serum or plasma calcium greater than 10.2 mg/dL.<br>NQF #1454 |
| **Numerator** | Number of patient-months in the denominator with 3-month rolling average of total uncorrected serum or plasma calcium greater than 10.2 mg/dL. |
| **Denominator** | Number of patient-months at the facility during the measurement period. |
| **Denominator Exclusions** | 1. Patients younger than 18<br>2. Patients present at the facility for fewer than 30 days during the 3-month study period<br>3. Patients on ESRD treatment for fewer than 90 days<br>4. Patients not on ESRD treatment as defined by a completed 2728 form or a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims<br>5. Patients who have died or been discharged prior to the end of the reporting month. |
| **Minimum Data Reported to CROWNWeb** | 3 months |
| **Data Source(s)** | 1. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (to obtain the diagnosis date of ESRD, time at facility, and date of birth) |

| SPECIFICATION | DETAIL |
|---|---|
| **Additional Information** | 1. November and December of the previous year will be used in calculating the three-month rolling average for January and February of the baseline and performance period.<br>2. Includes all patients (i.e., not just those patients on Medicare).<br>3. The last value reported in the month is used for calculation.<br>4. Any value reported during the two months prior to the reporting month will be used to calculate the 3-month rolling average.<br>5. No interpolation between uncorrected serum or plasma calcium values for peritoneal dialysis patients.<br>6. The uncorrected serum or plasma calcium value reported by the facility is used. The facility may obtain this value from an external source.<br>7. "Uncorrected" indicates albumin is not considered in the calculation.<br>8. Patient-months with missing values in the reporting month and the two months prior are included in the denominator and the numerator to minimize any incentive favoring non-measurement of serum or plasma calcium in the preceding three months. |

Last Revised: October 5, 2016

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Mineral Metabolism Reporting Measure**

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Number of months for which facility reports serum or plasma phosphorus values for each Medicare patient. Based on NQF #0255 |
| **Exclusions** | 1. Facilities with a CCN open date on or after July 1, 2017<br>2. In-center hemodialysis patients treated at facility fewer than 7 times during claim month<br>3. Home dialysis patients for whom a facility does not submit a claim during the claim month<br>4. Facilities treating fewer than 11 patients during the performance period who are (i) in-center Medicare patients who have been treated at least 7 times by the facility during the reporting month; or (ii) home dialysis Medicare patients for whom the facility submits a claim during the reporting month.<br>5. Patients not on ESRD treatment as defined by a completed 2728 form or a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims |
| **Data Source(s)** | 1. Medicare Claims<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (form 2744 to obtain certification date, form 2728 to obtain the diagnosis date of ESRD) |
| **Additional Information** | 1. The serum or plasma phosphorus values reported by the facility are used. The facility may obtain these values from an external source.<br>2. The measure will be scored according to the following formula:<br>$\left(\frac{Number\ of\ Months\ Facility\ Successfully\ Reports}{Number\ of\ Months\ in\ the\ Performance\ Period\ Facility\ has\ CCN} \times 12\right) - 2$ |

Last Revised: October 5, 2016

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Anemia Management Reporting Measure**

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Number of months for which facility reports ESA dosage (as applicable) and hemoglobin/hematocrit for each Medicare patient at least once per month. |
| **Exclusions** | 1. Facilities with a CCN open date on or after July 1, 2017<br>2. In-center hemodialysis patients treated at a facility fewer than 7 times during claim month<br>3. Home dialysis patients for whom a facility does not submit a claim during the claim month<br>4. Facilities treating fewer than 11 patients during the performance period who are (i) in-center Medicare patients who have been treated at least 7 times by the facility during the reporting month; or (ii) home dialysis Medicare patients for whom the facility submits a claim during the reporting month<br>5. Patients not on ESRD treatment as defined by a completed 2728 form or a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims |
| **Data Source(s)** | 1. Medicare Claims<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (form 2744 to obtain certification date, form 2728 to obtain the diagnosis date of ESRD) |
| **Additional Information** | 1. Hemoglobin value of 99.99 is not considered valid for purposes of measure.<br>Note: we will not penalize facilities for using the default 99.99 value for a patient in his/her first month of treatment at that facility.<br>2. The hemoglobin/hematocrit reported by the facility is used. The facility may obtain this value from an external source.<br>3. No ESA dosage need be recorded if patient is not treated with ESAs.<br>4. ESA dosage must be reported via HCPCS codes and corresponding units, as applicable.<br>5. The measure will be scored according to the following formula:<br>$\left(\frac{Number\ of\ Months\ Facility\ Successfully\ Reports}{Number\ of\ Months\ in\ the\ Performance\ Period\ Facility\ has\ CCN} \times 12\right) - 2$ |

Last Revised: October 5, 2016

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Pain Assessment and Follow-Up Reporting Measure**

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before August 1, 2017 and once before February 1, 2018.<br>Based on NQF #0420 |
| **Exclusions** | 1. Patients who are younger than 18 years<br>2. Patients treated at the facility for fewer than 90 days<br>3. Facilities with a CCN open date on or after July 1, 2017<br>4. Facilities treating fewer than 11 eligible patients during the performance period |
| **Data Source(s)** | 1. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data |
| **Additional Information** | 1. Facilities must report one of the following conditions for each eligible patient:<br>a) Pain assessment using a standardized tool is documented as positive and a follow-up plan is documented<br>b) Pain assessment documented as positive, a follow-up plan is not documented, and the facility possesses documentation that the patient is not eligible<br>c) Pain assessment documented as positive using a standardized tool, a follow-up plan is not documented, and no reason is given<br>d) Pain assessment using a standardized tool is documented as negative, and no follow-up plan required<br>e) No documentation of pain assessment, and the facility possesses documentation the patient is not eligible for a pain assessment using a standardized tool<br>f) No documentation of pain assessment, and no reason is given<br>2. Conditions covering the first six months of the performance period must be reported in CROWNWeb before August 1, 2017, and the conditions covering the second six months of the performance period must be reported in CROWNWeb before February 1, 2018. |

Last Revised: October 5, 2016

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**Clinical Depression Screening and Follow-Up Reporting Measure**

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before February 1, 2018.<br>Based on NQF #0418 |
| **Exclusions** | 1. Patients who are younger than 12 years<br>2. Patients treated at the facility for fewer than 90 days<br>3. Facilities with a CCN open date on or after July 1, 2017<br>4. Facilities treating fewer than 11 eligible patients during the performance period |
| **Data Source(s)** | 1. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data |
| **Additional Information** | 1. Facilities must report one of the following conditions for each eligible patient before February 1, 2018:<br>a) Screening for clinical depression is documented as being positive, and a follow-up plan is documented<br>b) Screening for clinical depression documented as positive, and a follow-up plan not documented, and the facility possess documentation stating the patient is not eligible<br>c) Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given<br>d) Screening for clinical depression is documented as negative, and a follow-up plan is not required<br>e) Screening for clinical depression not documented, but the facility possesses documentation stating the patient is not eligible<br>f) Clinical depression screening not documented, and no reason is given |

Last Revised: October 5, 2016

Rule of Record: CY 2016 ESRD PPS Final Rule (2015)

**NHSN Healthcare Personnel Influenza Vaccination Reporting Measure**

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Facility submits Healthcare Personnel Influenza Vaccination Summary Report to CDC's NHSN system, according to the specifications of the Healthcare Personnel Safety Component Protocol, by May 15, 2017<br>Based on NQF #0431 |
| **Exclusions** | 1. Facilities with a CCN open date on or after January 1, 2017 |
| **Data Source(s)** | 1. NHSN<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (form 2744 to obtain facility type and certification date) |
| **Additional Information** | 1. A "qualifying healthcare personnel" is defined as an employee, licensed independent practitioner, or adult student/trainee/volunteer who works in a facility for at least one day between October 1, 2016 and March 31, 2017 (designated as the "flu season")<br>2. NHSN Summary Reports submitted by May 15, 2017 would document actions taken during the flu season that spans October 2016 to April 2017, and would count toward facilities' PY 2019 NHSN Healthcare Personnel Influenza Vaccination reporting measure scores<br>3. Additional information about the Protocol and Summary Report can be found at: http://www.cdc.gov/nhsn/PDFs/HPS-manual/vaccination/HPS-flu-vaccine-protocol.pdf. |

Last Revised: May 2, 2017

Rule of Record: CY 2017 ESRD PPS Final Rule (2016)

**NHSN Dialysis Event Reporting Measure**

| SPECIFICATION | DETAIL |
|---|---|
| **Description** | Number of months for which facility reports National Healthcare Safety Network (NHSN) Dialysis Event data to the Centers for Disease Control and Prevention (CDC). |
| **Exclusions** | 1. Facilities which do not treat at least 11 in-center hemodialysis patients.<br>2. Facilities with a CMS open date on or after January 1, 2017. |
| **Data Source(s)** | 1. CDC's NHSN<br>2. REMIS, CROWNWeb, Enrollment Data Base (EDB), and other CMS ESRD administrative data (form 2744 to obtain certification date) |
| **Additional Information** | 1. Scoring Distribution for the NHSN Dialysis Event Reporting Measure:<br>a) 10 points for reporting 12 months<br>b) 2 points for reporting 6-11 months<br>c) 0 points for reporting 0-5 months<br>2. Additional details on the specifications for the NHSN Dialysis Event Reporting measure can be found at the following website: http://www.cdc.gov/nhsn/Training/dialysis/index.html |