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Information Collection Review Office
Centers for Disease Control and Prevention
1600 Clifton Road NE, MS H21-8
Atlanta, GA 30329

June X, 2024

SUBMITTED VIA REGULATIONS.GOV

Re: Encompass Health Comments on Centers for Disease Control and Prevention Docket No. CDC-2024-0030

Dear Jeffery Zirger:

We present the Centers for Disease Control and Infection ("CDC") with the following comments on the agency's "Proposed Data Collection Submitted for Public Comment and Recommendations" (Docket No. CDC-2024-0030) (89 Fed. Reg. 30367) (April 3, 2024). Encompass Health is the nation's leading provider of inpatient rehabilitation hospital care and services. We operate 162 rehabilitation hospitals in 37 states and Puerto Rico. In 2023, our hospitals had over 220,000 inpatient discharges, more than 80% of whom were Medicare beneficiaries. Our patients arrive at our rehabilitation hospitals almost exclusively from acute care hospitals.

We appreciate the opportunity to provide feedback to the Office of Management and Budget (OMB) on certain aspects of the CDC's data collection activity through the National Healthcare Safety Network (NHSN) program. Our comments primarily focus on ways CDC could reduce burden for some of the reporting requirements, which would also help increase the accuracy, utility, and clarity of information reported.

Increasing efficiency in automated reporting

When adding new reporting questions, NHSN should endeavor to include any in the automated reporting function (instead of starting them out as manually-entered responses). We have found the process to submit required information through automated reporting methods inconsistent. In previous years, we have encountered issues when new data elements are required to be reported, but when the elements are first introduced, they cannot be completed through the automated reporting (CDA Direct). We have seen several instances of this occurrence, and in some cases, the inability to report required information through automated/electronic methods would persist for years before being included in CDA Direct. For example, in 2021 the question 'Does your facility have a CMS-certified Inpatient Psychiatric (IPF) Unit?' was added to the Patient Safety 'Facility Wide Inpatient' summary data reporting as a required field. This question is used to put the hospital's performance in context of its size. But because the new IPF question could not be submitted via CDA, summary infection data could not be completed and submitted via CDA either, forcing all IRFs to manually enter the data in order to comply with CMS IRF QRP measure requirements. The inability to report via CDA monthly greatly increased the reporting burden, but was likely not accounted for in the estimated burden of reporting.

When we discussed this issue with NHSN, we learned that this IPF question was added to the form in order to account for a single free-standing IRF that operates an IPF unit within its hospital. However, this form modification for a single IRF resulted in a requirement for the other ~1200 IRFs to also manually complete the checkbox on a monthly basis to say "N-No, they did not have an IPF in their hospital," effectively eliminating the possibility of automated CDA reporting for this IPF question. The addition of this question to the automated CDA process was not completed until several years later in January 2024. The delay in automated reporting increased documentation burden and cost by requiring manual completion of this single question.

This IPF scenario mirrored a previous requirement to affirmatively check a "no events" box in the Patient Safety module in order to report that there were no reportable CAUTI/CDI events for a given month. On an ongoing basis, most providers do not have any CAUTI/CDI events to report in most months. Like the IPF questions, this "no CAUTI/CDI events" information was required for a hospital's NHSN data submission to be considered complete for purposes of the CMS IRF QRP completion threshold requirements. But IRFs could not complete this reporting using the CDA automation process for more than 5 years due to the inability to transmit this required field with the rest of the data. This delay prolonged the burden of documentation on frontline hospital staff, particularly when a more efficient method was available.

Based on these inefficiencies, we recommend an emphasis on consistency of reporting requirements and the ability to complete all requirements through automated reporting modalities. CDC should ensure that any new reporting requirements can be completed via automated CDA and will not hinder a provider's ability to submit other required data via automated CDA.

<u>Improvements to reporting using CSV</u>

Another way CDC could reduce burden of reporting for IRFs would be to allow reporting of the healthcare personnel influenza vaccination data using the Group function CSV upload process. IRFs are currently prevented from using the Group function to report this data for multiple facilities through a single upload. When attempting to upload through the Group, we receive the error message:

> "*CSV Uploads by a Group are not allowed for this facility type ('HOSP-REHAB'). Facility must be of type LTC SNF or DIAL*."

Data can be reported by CSV for an individual IRF, but not as a group of IRFs. Reporting data with a single upload through the Group function would not only reduce reporting burden but also reduce the opportunity for human error and/or missed reporting.

CDC should also consider expanding the type and variety of data that can be submitted using the CSV upload process. Data submission through CSV submission was first introduced as a reporting option in 2020 for reporting COVID-19-related Patient Safety data. This modality was efficient, included a validation process, and allowed reporting data for multiple facilities simultaneously through a single upload. For providers with multiple facilities this is a simple and streamlined approach to upload data. This reporting option has since been implemented for reporting Healthcare Personnel Safety data for vaccination reporting of both Influenza and COVID-19. CSV uploads as an additional reporting option for other data types would improve the reporting process while also reducing human error. The CDA Direct reporting process is more efficient than manual reporting, however, this process requires specialized technical knowledge that may not be realistic for some providers to expend resources on and the implementation and maintenance of the reporting process itself can become an ongoing burden. However, the ability to log in to NHSN and upload this data as a CSV file (particularly through Groups)

would be less labor and technically intensive while also providing the security necessary for sensitive data. The validation process and report function would help provide data clarity and confirmation of reporting in a method that clinicians are more familiar with.

To improve in efficiency and accuracy of data collection, CDC should allow CSV uploading for additional required data/information reporting, in particular Patient Safety summary data and reportable events (CAUTI and CDI/LAB ID, for example).

CAUTI CMS Reports

The current logic for data inclusion in the "NHSN CAUTI CMS Report" makes tracking compliance with CMS reporting difficult for newly opened hospitals. Currently the "CAUTI CMS Report" only includes data for a facility if a standardized infection ratio (SIR) can be generated for that hospital. However, a facility must first have a completed Annual Survey for NHSN to generate the SIR, and the Annual Survey cannot be completed until the hospital has been open for at least 6 months. That means a facility can be in compliance with reporting requirements that would not be reflected in the report, which is the main way to confirm compliance with CMS QRP requirements. The exclusion of new facilities from the CAUTI report is inconsistent with the other CMS Reports carried out via CDC NHSN and creates potential gaps in reporting compliance that require additional manual confirmation, increasing burden for new providers.

The NHSN CMS Reports are the primary way of assessing compliance with the IRF Quality Reporting Program (QRP) and ensuring that all necessary data is reported successfully in a timely manner to avoid significant financial penalties from CMS. It is important to make sure these NHSN CMS Reports reliably and accurately indicate IRF QRP compliance. CMS IRF QRP reporting requires IRFs to report the counts of infections (rather than the SIR). Therefore, the NHSN CMS Reports should reflect the data as reported, even before an SIR can be generated for new providers. Allowing for new providers to report their counts of infection prior to receiving a SIR would align reporting more closely with the requirements of CMS, which looks at counts of infection, and also reduce the burden of manually reporting this information.

Issues with Legacy System Requirements

The NSHN legacy system was originally designed for voluntary reporting and not for mandatory infection reporting. Accordingly, there are legacy features which may have made sense for a voluntary reporting system but now create additional burden when reporting mandatory QRP data. IRFs and other providers are financially penalized for incorrect or incomplete QRP data, including those reported through NHSN. However, because CDC, not CMS, is the "owner" of NHSN, CDC is the entity that dictates what reporting is required for purposes of QRP completeness; CDC's requirements include many elements that do not align with and go further than required data elements under the IRF QRP.

A prime example of unnecessary NHSN burden is the monthly reporting plan. Every month, each IRF is required to submit a "monthly reporting plan" to declare what it plans to report to NHSN before actually reporting it. IRFs are required to submit multiple monthly reporting plans because each NHSN reporting module requires its own separate monthly reporting plan, and IRF QRP reporting falls into multiple NHSN reporting modules. When the NHSN was a voluntary system, these monthly reporting plans were a way for IRFs to indicate they were submitting complete and accurate data for a specific time period. That way, the NHSN would know which time periods were intended to be included in any aggregate data analysis.

Now that data reporting is predominantly mandatory, this additional monthly reporting plan step takes significant time to complete and creates an additional and arbitrary way for an IRF to fall out of compliance with regulatory requirements. If an IRF does not complete an initial monthly reporting plan for a particular month (of which there are multiple), its data for that month, even if entered into NHSN as required by the CMS measure, will not be transmitted to CMS, triggering non-compliance with QRP reporting. Indeed, the most frequent error that requires correction for our IRFs is a failure to set up a monthly reporting plan, regardless of whether there is any actual quality data required. Since a facility's type (i.e., short acute care hospital, pediatric, rehabilitation hospital, etc.) determines NHSN reporting requirements, and since IRFs must indicate their facility type during NHSH registration, the NHSN reporting system could be altered to remove these extraneous monthly reporting plans and instead use system logic based on facility type to determine whether the numerator and denominator data were submitted appropriately for each respective facility.

Monthly reporting plans were previously required in the Healthcare Personnel Safety component for both Influenza and COVID-19 vaccination reporting but have since been removed as a requirement to streamline the reporting process. This simple change has resulted in a noticeable reduction in the burden of data collection. CDC should remove the unnecessary monthly reporting plan requirements for other NHSN reports as well.

Conclusion

We appreciate the opportunity to recommend ways the CDC can improve data quality and reduce burden for providers reporting through NHSN. We reiterate that CDC should consider ensuring consistency in automated reporting requirements and that when new data elements are added, that they do not impact the ability of providers to report using CDA. To reduce burden, especially for small providers, CSV reporting should be available for more data reports. Group reporting should also be expanded to IRFs. CDC should also reduce the reporting burden for new providers by allowing for CAUTI count reporting to be submitted prior to receiving an SIR.

Finally, we encourage CDC to pursue burden reduction through broader updates to the reporting requirements, such as removing unnecessary "monthly reporting plans" and considering what data is required to be collected under CMS quality programs versus what CDC is requiring providers submit. Aligning required data elements between CMS and CDC would greatly reduce reporting burden for many providers. If you would like to further discuss the suggestions and recommendations in this letter, please contact us via email or phone: Andrew.Baird@encompasshealth.com or 202-448-0449.

Sincerely,

Andrew Baird
SVP, Public Policy, Legislation & Regulations
Encompass Health