

### Clostridium Difficile Infection (CDI) Validation Template

As proposed in support of validation of laboratory-identified CDI events reported for the Hospital Inpatient Quality Reporting program for the Fiscal Year (FY) 2016 payment determination. According to this proposal, each hospital selected for CDI validation is to produce a list of all final results for stool specimens that are toxin positive for CDI in either an intensive care unit (ICU) or non-ICU location during their stay.

[Proposed FY2016 -CDI Validation Template \(stool specimens toxin positive for CDI for discharges beginning 4Q13\)](#)

FIELD (* indicates required field)	DESCRIPTION	SECTION
<b>NHSN Facility ID*</b>	The National Healthcare Safety Network (NHSN)-assigned facility ID under which your hospital submits NHSN data.	<b>Hospital Information Section</b> These cells only need to be completed for the first row in the spreadsheet. They will be applied to all toxin positive stool specimens listed on this template.
<b>Provider ID/CCN*</b>	Hospitals CMS Certification Number.	
<b>Hospital Name*</b>	Hospital Name associated with CCN.	
<b>State*</b>	Enter the 2 character abbreviation for the state in which the hospital is located.	
<b>Calendar Quarter*</b>	Select the calendar quarter to which the blood culture list pertains.	
<b>Hospital Contact Name*</b>	Hospital contact name for CMS to contact with questions.	
<b>Contact Phone*</b>	Phone number for hospital contact listed.	
<b>Contact Email*</b>	Email address for hospital contact listed.	
<b>Assay Type*</b>	The type of test used to detect CDI	
<b>Positive Stool Cultures (Y/N)*</b>	Select Yes or No from the dropdown list. Does the hospital have any final stool cultures toxin positive for CDI for patients in the calendar quarter referenced?	
<b>Patient HIC*</b>	The patient's Medicare Beneficiary Number, also known as the health insurance claim (HIC) number. No dashes, spaces or special characters should be included. Must be between 7 and 12 characters. This field is required for Medicare patients when the HIC number is known.	<b>Stool Specimen Section</b> Complete for every final specimen toxin positive for CDI
<b>Patient Identifier*</b>	The patient identifier assigned by the hospital. Use the same patient identifier that would be submitted to NHSN if the episode of care (EOC) would be reported as a laboratory-identified CDI event.	
<b>Birthdate*</b>	The patient date of birth using MM/DD/YYYY format.	
<b>Sex*</b>	Select Female, Male or unknown from the dropdown list to indicate sex of patient.	
<b>Admit Date*</b>	Enter date patient was admitted to hospital in MM/DD/YYYY format.	<b>Patient Information Section</b> Complete these cells once per patient episode of care.
<b>Discharge Date*</b>	Enter date patient was discharged from the hospital in MM/DD/YYYY format.	
<b>First Name</b>	First name of patient.	
<b>Last Name</b>	Last name of patient.	
<b>NHSN Location*</b>	Select from the drop down list, the NHSN location to which the patient was assigned when the stool specimen was collected.	<b>Stool Specimen Section</b> Complete for every final specimen toxin positive for CDI
<b>Lab ID*</b>	Lab ID, accession number or specimen number corresponding to toxin positive for CDI stool specimen.	
<b>Stool Specimen Collection Date*</b>	Provide the date the stool specimen was collected in MM/DD/YYYY format.	
<b>Stool Specimen Collection Time</b>	Provide the time the stool specimen was collected if easily available.	

NHSN Facility ID*	Provider ID/CCN*	Hospital Name*	State*	Calendar Quarter*	Hospital Contact Name*	Contact Phone*	Contact Email*	Assay Type*	Stool Specimens Toxin Positive for C. difficile (Y/N)*
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Patient HIC*	Patient Identifier*	Birthdate*	Sex*	Admit Date*	Discharge Date*	First Name	Last Name	NHSN Location*
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**Lab ID\***      **Stool Culture Date\***      **Stool Culture Time**