Instructions for Completion of the Patient Safety Annual Facility Survey for LTAC (CDC 57.151)

Data Field	Instructions for Form Completion
Facility ID #	*Required.* The NHSN-assigned facility ID will be auto-entered by the computer.
Survey Year	*Required.* Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2020, a facility would complete a 2019 survey.
Facility Characteristics	
Ownership (check one)	*Required.* Select the appropriate ownership of this facility: • For profit • Not for profit, including church • Government • Veterans Affairs
Affiliation (check one)	*Required.* Select the appropriate affiliation for this facility: • Independent – The facility is a stand-alone facility that does not share a building, staff, or policies (such as infection control) with any other healthcare institution. • Hospital system – The facility is affiliated with a local healthcare system. Facility shares policies (such as infection control) with other institutions within the hospital system. Facility may or may not share staff as well as a building with other facilities that are part of that hospital system. • Multi-facility organization (specialty network) – The facility is part of a regional or national network of specialty facilities. Facilities share policies (such as infection control), corporate leadership, and a common business structure.
Setting/Classification: If classified as "Free-standing", does your LTAC hospital share physical housing with one or more of the following on-site facilities or units? (check all that apply)	*Required.* Select the physical setting of the facility: free-standing or within a hospital. *Conditionally Required.* If facility is classified as free-standing, select one or more of the following facility or unit types that share physical housing with your LTAC: • No (none) • Skilled nursing facility (SNF)/nursing home • Residential facility (assisted living) • Inpatient rehabilitation facility • Neuro-behavioral unit or facility • Other: specify
If classified as "Within a hospital", is your LTAC hospital located:	*Conditionally Required.* If facility is classified as within a hospital, indicate 'Yes' or 'No' if it is: • In a building that does not provide acute care services (e.g., psychiatric hospital) • Near (but not within) an acute care hospital
Facility Characteristics (continued)	
Number of Patient Days	*Required.* Enter the total number of patient days for your hospital during the last full calendar year.
Number of Admissions	*Required.* Enter the total number of inpatient admissions for your hospital during the last full calendar year.
Average daily census	*Required.* Enter the average number of patients housed each day during the last full calendar year. Please round to the nearest whole number.

Numbers of LTAC beds in the following categories (categories should equal total number of beds)	*Required.* Enter the total number of LTAC beds in each on the following categories during the last full calendar year: • Intensive care unit (ICU) or critical care beds • High observation/special care/high acuity beds (not ICU) • General LTAC beds
Total number of LTAC beds (licensed capacity)	*Required.* The total number of LTAC beds in the facility during the last full calendar year will be automatically summed based on the above counts.
Number of single occupancy rooms	*Required.* Enter the total number of single occupancy rooms during the last full calendar year.
Total number of admissions with one of the following conditions identified on admission	*Required.* Enter the total count of patients identified on admission or upon initial assessment and review of patient during admission with the following conditions (Note: these categories are not mutually exclusive). • Ventilator dependence • Hemodialysis For a list of ICD-10 and DRG codes associated with these conditions please review this spreadsheet: http://www.cdc.gov/nhsn/xls/DRGs-ICD-9s-NHSN-LTAC-Survey.xlsx
Facility Microbiology Laboratory Practices. *Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.*	
1. Does your facility have its own on-site laboratory that performs antimicrobial susceptibility testing? If No, where is your facility's antimicrobial susceptibility testing performed? (check one)	*Required.* Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'. *Conditionally Required.* If 'No', select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used, indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.

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)	*Required.* Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism. Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the 'Comments' column the number of times repeat testing is done using the same primary method. If your laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory. If 'Other' is selected as the method for any pathogen, use the 'Comments' column to describe the method used.
3. Does either the primary or secondary/supplemental antimicrobial susceptibility testing of *Pseudomonas* spp., include ceftolozane-tazobactam?	*Required.* Select 'Yes' if either the primary or secondary/supplemental antimicrobial susceptibility testing of *Pseudomonas* spp., includes ceftolozane-tazobactam
4. Has the laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
5. Has the laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?	*Required.* Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.
6. Does the laboratory perform a test for the presence of carbapenemase? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to detect carbapenemase (check all that apply)? If Yes, does the laboratory have a policy to routinely notify any of the following when CP-CRE are detected?	*Required.* Select 'Yes' if your laboratory performs a test for carbapenemase production; otherwise, select 'No'. *Conditionally Required.* If 'Yes', specify what is done if carbapenemase production is detected. *Conditionally Required.* If 'Yes', specify which test is performed to detect carbapenemase. *Conditionally Required.* If 'Yes', specify if laboratory has policy to notify Physician or Infection Control when CP-CRE are detected.
7. Does your facility perform	*Required.* Select 'Yes' if your facility performs extended-spectrum beta-lactamase

	extended-spectrum beta-lactamase (ESBL) testing for *E. coli* and/or *Klebsiella spp.* either routinely or using a testing algorithm?	(ESBL) testing for E. coli or Klebsiella spp. or through an algorithm; otherwise, select 'No'.
	If Yes, indicate what is done if ESBL is detected.	*Conditionally Required.* If 'Yes', indicate what is done if ESBL is detected.
8.	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)	*Required.* Select from the choices listed one or more the method(s) used for yeast identification at your facility's laboratory the outside laboratory serving your facility. If 'Other' is selected, please specify.
9.	Which of the following methods are used for yeast identification? (check all that apply)	*Required.* Select from the choices listed, one or more method (s) used for yeast identification
10.	Does the laboratory routinely use Chromagar for the identification or differentiation of *Candida* isolates?	*Required.* Select 'Yes' if the laboratory routinely uses Chromagar for the identification or differentiation of *Candida* isolates; otherwise, select 'No'. Select 'Unknown' if not known.
11.	*Candida* isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)	*Required.* Select from the choices listed, one or more body sites from which *Candida* is routinely identified to the species level without a specific request from a clinician. If 'Other' is selected, please specify.
12.	Does the laboratory employ any culture-independent diagnostic tests (CIDT) to identify *Candida* from blood specimens?	*Required.* Select 'Yes' if the laboratory employ any culture-independent diagnostic tests (CIDT) to identify *Candida* from blood specimens; otherwise, select 'No'. Select 'Unknown' if not known.
	If yes, which culture-independent diagnostic tests (CIDT) are used to identify *Candida* from blood specimens? (check all that apply)	*Conditionally Required.* If 'Yes', select which culture-independent diagnostic tests (CIDT) are used to identify *Candida* from blood specimens. If 'Other' is selected, please specify. Select 'Unknown' if not known.

13. Are any culture-independent diagnostic tests (CIDT) used to specifically identify *Candida auris* from clinical specimens?	*Required.* Select 'Yes' if there any culture-independent diagnostic tests (CIDT) used to specifically identify *Candida auris* from clinical specimens; otherwise, select 'No'. Select 'Unknown' if not known.
If yes, which culture-independent diagnostic tests (CIDT) are used to identify *Candida auris* from clinical specimens? (check all that apply)	*Conditionally Required.* If 'Yes', select which culture-independent diagnostic tests (CIDT) are used to identify *Candida auris* from clinical specimens. If 'Other' is selected, please specify. Select 'Unknown' if not known.
14. Where is antifungal susceptibility testing (AFST) performed for specimens collected at your facility? (check the most applicable)	*Required.* Select from the choices listed about where antifungal susceptibility testing (AFST) is performed for specimens collected at your facility. Select 'AFST not available if AFST is not performed onsite or at any affiliate/commercial/other laboratory.
15. What method is used for antifungal susceptibility testing (AFST)? (check all that apply)	*Required.* Select from the choices listed, one or more method (s) used for antifungal susceptibility testing at your facility's laboratory the outside laboratory serving your facility. If 'Other' is selected, please specify.
If Vitek is used for AFST, which *Candida* species do you test with it? (check all that apply)	*Conditionally Required.* If Vitek is used for AFST, select which *Candida* species you test with it.
16. AFST is performed for which of the following antifungal drugs? (check all that apply)	*Required.* Select the antifungal drugs for which AFST is performed.
17. AFST is performed on fungal isolates in which of the following situations:	*Required.* For each of the *Candida* species listed (*Candida albicans*, *Candida glabrata*, and all other *Candida species*), select the most appropriate response for when antifungals susceptibility testing is performed. Chose "Always" if susceptibility testing is routinely performed without a clinician order on at least the first isolate of that species from the patient, regardless of the source of clinical specimen. Chose "Only when isolated from a sterile site" if susceptibility testing is performed routinely without a clinician order. Chose "only when ordered by a clinician" if susceptibility testing is only performed after a clinician specifically orders antifungal susceptibility testing. On that particular species of *Candida* when isolated from a sterile site. If 'Other' is selected, please specify.

18. 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)	*Required.* Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility's laboratory or the outside laboratory where your facility's testing is done. If 'Other' is selected, please specify. **Note**: "Other" should not be used to name specific laboratories, reference laboratories, or the brand names of C. *difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report.
19. Please indicate the primary and definitive method used to identify microbes from blood cultures collected in your facility. (check one)	*Required.* Select from the choices listed to indicate the primary and definitive method used to identify microbes from blood cultures collected in your facility.
20. 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). (check all that apply)	*Required.* Select from the choices listed to 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).
Infection Control Practices. *Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.*	
21. Number or fraction of infection preventionists (IPs) in facility	*Required.* Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an "IP" on this survey.
a. Total hours per week performing surveillance	Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results.
b. Total hours per week for infection control activities other than surveillance	Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.

22. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility	*Required.* Enter the number or fraction of individuals (full-time employees) who perform the functions of a hospital epidemiologist in the facility. An official title of "hospital epidemiologist" is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.
For detailed description about the use of Contact Precautions, please refer to the CDC/HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf).	
23. 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) If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one):	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with MRSA on Contact Precautions at your facility. If your facility never admits patients with MRSA, select 'Not applicable'. *Conditionally Required.* If Yes, check the type of patients that are routinely placed in contact precautions while in your facility. *Conditionally Required.* If 'Only infected or colonized patients with certain characteristics', check the type of patients' characteristics.
24. 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) If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility	*Required*. Select 'No' if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with VRE on Contact Precautions at your facility. If your facility never admits patients with VRE, select 'Not applicable'. *Conditionally Required.* If Yes, check the type of patients that are routinely placed in contact precautions while in your facility. *Conditionally Required.* If 'Only infected or colonized patients with certain characteristics', check the type of patients' characteristics.
25. 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) If Yes, please check the type of patients that are routinely placed in contact precautions	*Required*. Select 'No' if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with CRE on Contact Precautions at your facility. If your facility never admits patients with CRE, select 'Not applicable'. *Conditionally Required.* If Yes, check the type of patients that are routinely placed in contact precautions while in your facility.

while in your facility (check one)	*Conditionally Required.* If 'Only infected or colonized patients with certain characteristics', check the type of patients' characteristics.
26. 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) If Yes, please check the type of patients that are routinely placed in contact precautions while in your facility (check one)	*Required.* Select 'No' if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae, select 'Not applicable'. *Conditionally Required.* If Yes, check the type of patients that are routinely placed in contact precautions while in your facility. *Conditionally Required.* If 'Only infected or colonized patients with certain characteristics', check the type of patients' characteristics.
27. Does the facility routinely perform screening testing (culture or non-culture) for CRE? If Yes, in which situations does the facility routinely perform screening testing for CRE? (check all that apply)	*Required.* Select 'Yes' if your facility **routinely** (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for CRE; select no if either testing is not routinely performed or not performed at all. *Conditionally required*. If 'Yes', select **all** the situations for which screening testing is done **routinely**. If 'Other' is selected, please specify the situation(s) in which CRE screening is performed. **Note**: 'Epidemiologically-linked' patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.
28. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to non-NICU settings? If yes, in which situation does the facility routinely perform screening testing for MRSA for non-NICU settings? (check all that apply)	*Required.* Select 'Yes' if the facility **routinely** (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA in non-NICU settings; select no if either testing is not routinely performed or not performed at all. *Conditionally required.* If 'Yes', select **all** the situations for which screening testing is done **routinely** for non-NICU settings. If 'Other' is selected, please specify the situation(s) in which MRSA screening is performed.
29. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients	*Required.* Select 'Yes' if the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings.

admitted to NICU settings?	
If yes, in which situations does the facility routinely perform screening testing for MRSA for NICU settings? (check all that apply)	*Conditionally required.* If 'Yes', select which situations the facility routinely perform screening testing for MRSA for NICU settings.
30. Does your facility have a policy to routinely use chlorhexidine bathing for any adult patients? (Note: this does not include the use of such bathing in pre-operative patients to prevent surgical site infections (SSIs))	*Required.* Select 'Yes' if your facility **routinely** uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the infection or transmission of any MDRO; otherwise, select 'No'. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent SSIs. Select 'No' if this agent is not used routinely or is not used at all or if it is only used to prevent surgical site infections in pre-operative patients.
31. Does the facility have a policy to routinely use a combination of topical chlorhexidine <u>AND</u> an intranasal antistaphylococcal agent (mupirocin, iodophor, or an alcohol based intranasal agent) for any adult patients to prevent healthcare-associated infections or reduce transmission of resistant pathogens? (Note: this does not include the use of these agents in pre-operative surgical patients or dialysis patients)	*Required.* Select 'Yes' if the facility have a policy to routinely use a combination of topical chlorhexidine <u>AND</u> an intranasal antistaphylococcal agent (mupirocin, iodophor, or an alcohol based intranasal agent) for any adult patients to prevent healthcare-associated infections or reduce transmission of resistant pathogens. Please do not include the use of these agents in dialysis patients or patients undergoing surgery if the purpose is to prevent surgical site infections. Select 'No' if these combined agents are not used routinely or are not used at all or if they are only used to prevent surgical site infections in pre-operative patients or to prevent infection in dialysis patients.

Antibiotic Stewardship Practices. Completion of this section should involve the leader(s) of the Antibiotic Stewardship Program (ASP), such as a pharmacist and/or physician; if your facility does not have an ASP program leader, completion should involve other leaders of the work, such as a pharmacist or physician who focuses on antibiotic stewardship or infectious diseases and/or members of the Pharmacy and Therapeutics Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to the newly updated 2019 Core Elements of Hospital Antibiotic Stewardship Programs (https://www.cdc.gov/antibiotic-use/core-elements/hospital.html). For additional implementation guidance for small and critical access hospitals, see https://www.cdc.gov/antibiotic-use/healthcare/implementation/core-elements-small-critical.html.

32. Did the antibiotic stewardship leader(s) participate in completing these questions? (Check one.)	*Required.* Please indicate which antibiotic stewardship leader(s), if any, participated in completing the 'Antibiotic Stewardship Practices' portion of the survey. If no antibiotic stewardship leader participated, either because your facility does not have an appointed leader or the appointed leader(s) did not participate, select 'No.'

33. Facility leadership has demonstrated commitment to antibiotic stewardship efforts by: (Check all that apply.)	*Required*. Select, from the choices listed, the ways in which facility leadership demonstrated their commitment to antibiotic stewardship efforts in your facility during the past calendar year. Clarification on some of the response options can be found below. Select 'Having a senior executive that serves as a point of contact or "champion" to help ensure the program has resources and support to accomplish its mission' if a senior executive, such as a clinical administrator, Chief Medical Officer, or other senior-level management, at your facility supports your program and is responsible for ensuring availability of necessary resources. Select 'Information on stewardship activities and outcomes is presented to facility leadership and/or board at least annually' if your program reports stewardship activities and outcomes to senior leadership and/or the facility board at least once per year (e.g., including stewardship measures in facility quality dashboard reports). This presentation may be during a meeting, or otherwise sharing reports or information up the chain to leadership. Select 'Communicating to staff about stewardship activities, via email, newsletters, events, or other avenues' if there is evidence of broad-reaching communication from senior-level management to facility staff about antibiotic stewardship efforts within the past calendar year. Examples include written communication to facility staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes, updates on the facility's stewardship efforts. Select 'Providing opportunities for facility staff training and development on antibiotic stewardship' if facility leadership or management has provided staff antibiotic stewardship education in-house (e.g., workshops, lectures) or access to antibiotic stewardship trainings (e.g., by approving time and/or providing funds to attend stewardship conferences, webinars) within the past calendar year. Select 'Providing a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board)' if there is evidence of senior-level management support focused on antibiotic use, prescribing, and/or stewardship (e.g., formal letter of support for antibiotic stewardship efforts, written support in an annual report, communication of support in executive-level meetings notes). Select 'Ensuring that staff from key support departments and groups (e.g., IT) are contributing to stewardship activities' if your facility ensures other groups and departments in the facility are aware of stewardship efforts and collaborate with the stewardship program.
34. Our facility has a leader or co-leaders responsible for antibiotic stewardship program management and outcomes.	*Required*. Select 'Yes' if at least one individual has been identified to lead antibiotic stewardship activities, as evidenced by responsibility for improving antibiotic use in their job description or performance review, authority to coordinate activities of staff from multiple departments (e.g., laboratory, pharmacy, information technology), and/or responsibility to report to senior-level management on antibiotic stewardship planning and outcomes; otherwise, select 'No.'

34a. If Yes, what is the position of this leader? (Check one.)	*Conditionally Required*. If 'Yes' to question 33, specify the qualification or job title of the leader(s). If 'Other' is selected, please specify the position.
34b. If Physician or Co-led is selected, which of the following describes your antibiotic stewardship **physician** leader? (Check all that apply.)	*Conditionally Required*. If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected for question 33a, specify, from the choices listed, the qualities of your facility's **physician** leader. Clarification on some of the response options can be found below.
	Select 'Has antibiotic stewardship responsibilities in their contract or job description' if the **physician** stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the **physician** stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review.
	Select 'Is physically on-site in your facility (either part-time or full-time)' if the **physician** stewardship leader works on-site at the facility, whether full-time or part-time, versus solely engaging remotely in your facility's stewardship activities.
	Select 'Completed an ID fellowship' if the **physician** stewardship leader completed an ID fellowship, i.e., a postdoctoral training program (typically 2–3 years) in infectious diseases.
	Select 'Completed a certificate program on antibiotic stewardship' if the **physician** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or continuing education credit(s).
34c. What percent time for antibiotic stewardship activities is specified in the **physician** (co) leader's **contract or job description**? (Check one.)	*Conditionally Required.* If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for question 33b, specify the percent time (or equivalent) stipulated in the **physician** stewardship leader's contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select 'Not specified.' This percent time should reflect the stated <u>expectation</u> for stewardship efforts, not necessarily actual time worked.
34d. **In an average week**, what percent time does the **physician** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one.)	*Conditionally Required.* If 'Physician' or 'Co-led by both Pharmacist and Physician' was selected for question 33a, specify the percent time (or equivalent) that the **physician** stewardship leader, on average, <u>actually spends</u> on antibiotic stewardship activities in your facility during an average week. This may be the same, more, or less than what is reported in Q33b(a). An estimate is fine.

34e. If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship **pharmacist** leader? (Check all that apply.)	*Conditionally Required*. If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was selected for question 33a, specify, from the choices listed, the qualities of your facility's **pharmacist** leader. Clarification on some of the response options can be found below. Select 'Has antibiotic stewardship responsibilities in their contract or job description' if the **pharmacist** stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the pharmacist stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review. Select 'Is physically on-site in your facility (either part-time or full-time)' if the **pharmacist** stewardship leader works on-site at the facility, whether full-time or part-time, versus solely engaging in your facility's stewardship activities remotely. Select 'Completed a PGY2 ID residency and/or ID fellowship' if the **pharmacist** stewardship leader completed a PGY2 ID residency and/or ID fellowship, i.e., a postdoctoral training program (typically 2–3 years) in infectious diseases. Select 'Completed a certificate program on antibiotic stewardship' if the **pharmacist** stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or continuing education credit(s).
34f. What percent time for antibiotic stewardship activities is specified in the **pharmacist** (co) leader's **contract or job description**? (Check one.)	*Conditionally Required.* If 'Has antibiotic stewardship responsibilities in their contract or job description' was selected for question 33d, specify the percent time (or equivalent) stipulated in the **pharmacist** stewardship leader's contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select "Not specified." This percent time should reflect the stated <u>expectation</u> for stewardship efforts, not necessarily actual time worked.
34g. **In an average week**, what percent time does the **pharmacist** (co) leader **spend** on antibiotic stewardship activities in your facility? (Check one.)	*Conditionally Required.* If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was selected for question 33a, specify the percent time (or equivalent) that the **pharmacist** stewardship leader, on average, <u>actually spends</u> on antibiotic stewardship activities in your facility during an average week. This may be the same, more, or less than what is reported in Q33d(a). An estimate is fine.
34h. If Pharmacist or Other is selected: Does your facility have a designated physician who can serve as a point of contact and support for the non-physician leader?	*Conditionally Required*. If 'Pharmacist' or 'Other' was selected for question 33a, select 'Yes' if your facility has at least one **physician** who dedicates time <u>distinct from general physician duties</u> to provide antibiotic stewardship support to the non-physician leader and serve as a point of contact for antibiotic stewardship efforts; otherwise, select 'No'.
34i. If a pharmacist is **not** the leader or co-leader for the program, is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Conditionally Required*. If 'Pharmacist' or 'Co-led by both Pharmacist and Physician' was <u>not</u> selected for question 33a, select 'Yes' if your facility has at least one **pharmacist** who dedicates time <u>distinct from general pharmacy duties</u> to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select 'No'.

35. Our facility has the following priority antibiotic stewardship interventions: (Check all that apply.)	*Required*. Please select the intervention(s), from the choices listed, that your facility has implemented over the past calendar year. Clarification on some of the response options can be found below.
	Select 'Prospective audit and feedback for specific antibiotic agents' if the stewardship team (or physicians or pharmacists knowledgeable in antibiotic use and who are overseen by the stewardship team and are <u>not</u> part of the treating team) conducts a prospective review of the appropriateness of antibiotic use for any antibiotic (whether or not it is on formulary) and then provides feedback in real-time to the front-line clinicians with recommendations based on the culture results, clinical status of the patient, and other important factors. Facilities may implement prospective audit and feedback in different ways, depending on the level of expertise available (e.g., on a limited number of floors/units, for at limited number of agents, on limited days, or across the entire facility).
	Select 'Preauthorization for specific antibiotic agents' if an approval is required prior to using certain antibiotics that are <u>on formulary</u>. Facilities may implement preauthorization in different ways. Examples include:
	- your facility has at least one antibiotic agent that requires the stewardship team, or a physician or pharmacist overseen by the stewardship team, to review and approve administration of the drug due to its spectrum of activity or associated toxicities before the agent can be dispensed; - preauthorization is required immediately, or within a specified short timeframe such a 24 hours; - there are specific indications or restrictive criteria in the computer entry process. *Note:* It is assumed that non-formulary drugs already require preauthorization.
	Select 'Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilities, to assist with antibiotic selection for common clinical conditions' if your facility has or accesses (e.g., via your health system or a neighboring facility), and uses guidelines or recommendations for antibiotic treatment selection that are based on national guidelines and take into account facility-specific factors such as formulary, resistance patterns, etc. for ANY common clinical conditions.
35a. For which categories of antimicrobials? Please answer for the following categories of antimicrobials, *whether or not* they are on formulary. (Check all that apply.)	*Conditionally Required*. If 'Prospective audit and feedback for specific antibiotic agents' was selected for question 34, specify for which categories of antimicrobials the stewardship team reviews courses of therapy for specified agents and provides feedback and recommendations to the treating team (i.e., prospective audit and feedback). Please select all categories containing at least one relevant antimicrobial that undergoes prospective audit and feedback <u>regardless of whether or not it is on formulary</u> in your facility.
35b. Our antibiotic stewardship program monitors prospective audit and feedback interventions (e.g., by tracking antibiotic use, types of interventions, acceptance of recommendations).	*Conditionally Required*. If 'Prospective audit and feedback for specific antibiotic agents' was selected for question 34, select 'Yes' if your antibiotic stewardship program monitors prospective audit and feedback interventions through means such as tracking antibiotic use, the types of interventions implemented, and/or the acceptance of recommendations; otherwise, select 'No'.

35c. For which categories of antimicrobials? Please *only* answer for categories of antimicrobials that are *on formulary*. (Check all that apply.)	*Conditionally Required*. If 'Preauthorization for specific antibiotic agents' was selected for question 34, specify for which categories of antimicrobials the stewardship team reviews and approves administration prior to dispensing. Please <u>only</u> select categories containing at least one relevant antimicrobial requiring preauthorization that is <u>on formulary</u>.
35d. Our antibiotic stewardship program monitors preauthorization interventions (e.g., by tracking which agents are requested for which conditions).	*Conditionally Required*. If 'Preauthorization for specific antibiotic agents' was selected for question 34, select 'Yes' if your antibiotic stewardship program monitors preauthorization interventions through means such as tracking which agents are being requested for which conditions; otherwise, select 'No'.
35e. Our stewardship program monitors adherence to our facility's treatment recommendations for antibiotic selection for common clinical conditions (e.g., community-acquired pneumonia, urinary tract infection, skin and soft tissue infection).	*Conditionally Required*. If 'Facility-specific treatment recommendations, based on national guidelines and local pathogen susceptibilites, to assist with antibiotic selection for common clinical conditions' was selected for question 34, select 'Yes' if audits have been conducted to confirm adherence to facility-specific treatment guidelines or recommendations for ANY common clinical conditions; otherwise, select 'No'.
36. Our facility has a policy or formal procedure for other interventions to ensure optimal use of antibiotics: (Check all that apply.)	*Required*. Select, from the choices listed, the policies or formal procedures that your facility had in place during the past calendar year. Clarification on some of the response options can be found below. Select 'Early administration of effective antibiotics to optimize the treatment of sepsis' if your antibiotic stewardship program works with sepsis experts in the facility, as well as pharmacy and microbiology lab, to optimize the treatment of sepsis. Select 'Stopping unnecessary antibiotic(s) in new cases of *Clostridioides difficile* infection (CDI)' if your facility reviews antibiotics in patients with new diagnoses of CDI infection to identify opportunities to stop unnecessary antibiotics and to ensure that patients receive guideline-recommended therapy. Select 'Review of culture-proven invasive (e.g., bloodstream) infections' if your facility conducts prospective audit and feedback of new culture or rapid diagnostic results to reduce the time needed to discontinue, narrow, or broaden antibiotic therapy as appropriate. Select 'Review of planned outpatient parenteral antibiotic therapy (OPAT)' if OPAT is reviewed by your antibiotic stewardship program to determine if it is necessary and optimize therapy. Select 'The treating team reviews antibiotics 48-72 hours after initial order (i.e., antibiotic time-out)' if providers at your facility reassess the continuing need and choice of antibiotics after more data (including clinical results) become available.

36a. Our stewardship program monitors adherence to use of shortest effective duration of antibiotics at discharge for common clinical conditions (e.g. community-acquired pneumonia, urinary tract infections, skin and soft tissue infections), at least annually.	*Conditionally Required.* If 'Using the shortest effective duration of antibiotics at discharge for common clinical conditions' was selected for question 35, select 'Yes' if your facility's antibiotic stewardship program reviews how often patients are discharged on antibiotics for the shortest effective duration; these are retrospective reviews of patterns within the facility. Otherwise, select 'No'.
37. Our facility has in place the following specific 'pharmacy-based' interventions: (Check all that apply.)	*Required*. Select, from the choices listed, the interventions that your facility had in place, over the past calendar year, that are initiated by pharmacists and/or embedded into pharmacy sections of electronic health records.
38. Our stewardship program has engaged bedside nurses in actions to optimize antibiotic use.	*Required*. Select 'Yes' if your facility engaged bedside nurses in actions to optimize antibiotic use over the past calendar year; otherwise, select 'No'.
38a. Our facility has in place the following specific 'nursing-based' interventions: (Check all that apply.)	*Conditionally Required*. If 'Yes' to question 37, select, from the choices listed, the interventions that your facility had in place to engage nurses in antibiotic stewardship efforts.
38b. Is that information available at the bedside (e.g., on a whiteboard in the room)?	*Conditionally Required*. If selected "Nurses track antibiotic duration of therapy" for question 37a, select 'Yes' if the information about antibiotic duration of therapy was available at the patient's bedside (e.g., on a whiteboard in the room, on a clipboard, etc.); otherwise, select 'No.'
39. Our stewardship program monitors: (Check all that apply.)	*Required*. Select, from the choices listed, the measures that your facility's stewardship team monitored over the past calendar year. Clarification on some of the response options can be found below.
	For 'Antibiotic resistance patterns (either facility- or region-specific), at least annually': Monitoring antibiotic resistance patterns can include antibiograms, either in the facility or at the regional level (e.g., receiving local data from a neighboring facility); or use of the NHSN AR Option.
	For '*Clostridioides difficile* infections (or *C. difficile* LabID events), at least annually': Monitoring *Clostridioides difficile* includes infection rates or LabID events in your facility.
	If monitoring antibiotic use in a way other than DOT, DDD, or expenditures at the unit-, service-, and/or facility-wide level, select 'antibiotic use in some other way' and specify the metric.
40. Our stewardship program provides the following reports on antibiotic use to prescribers, at least annually: (Check all that apply.)	*Required*. Specify the reports on antibiotic use that the program shared with prescribers over the past calendar year, from the choices listed. These reports are intended to be targeted towards specific prescribers, units, or services rather than generic facility-wide reports.
40a.Our stewardship program uses these reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually.	*Conditionally Required*. If 'Individual, prescriber-level reports' or 'Unit- or service-specific reports' is selected for question 39, select 'Yes' if your facility's stewardship program provides data-driven, targeted feedback to any prescribers about how they can improve their antibiotic prescribing (e.g., academic detailing, prescriber-specific feedback and recommendations), at least annually; otherwise, select 'No.'

41. Our facility distributes an antibiogram to prescribers, at least annually.	*Required*. Select 'Yes' if your facility distributed an antibiogram (a facility cumulative antibiotic resistance report that presents data from lab reports in a way that supports optimal antibiotic use and is consistent with facility guidelines) to prescribers at least once in the past calendar year; otherwise, select 'No.'
42. Information on antibiotic use, antibiotic resistance, and stewardship efforts is presented to facility staff, at least annually.	*Required*. Select 'Yes' if your facility's stewardship program shared updates with <u>facility staff</u> on antibiotic use, antibiotic resistance, and stewardship efforts either via in-person presentations or distribution of written materials, at once in the past calendar year; otherwise, select 'No.'
43. Which of the following groups receive education on optimal prescribing, adverse reactions from antibiotics, and antibiotic resistance at least annually? (Check all that apply.)	*Required*. Select, from the choices listed, the groups in your facility that received education specifically about appropriate antibiotic use, adverse reactions, and antibiotic resistance (e.g., Grand Rounds, in-service training, direct instruction) within the past calendar year. 'Prescribers' includes both prescribers employed by the facility and licensed independent practitioners.
44. Are patients provided education on important side effects of prescribed antibiotics?	*Required*. Select 'Yes' if patients received education on important side effects of prescribed antibiotics; otherwise, select 'No.'
44a. How is education to patients on side effects shared? (Check all that apply.)	*Conditionally Required*. If 'Yes' to question 43, specify, from the choices listed, how education on side effects of prescribed antibiotics is regularly provided to patients.
45. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives.	*Optional*. Select 'Yes' if your facility's antibiotic stewardship activities are developed or implemented in conjunction with quality improvement and/or patient safety initiatives in the facility (e.g., the stewardship team works with the quality improvement or patient safety team to implement stewardship interventions, the stewardship team participates in quality improvement meetings regarding sepsis core measures); otherwise, select 'No.'
46. Our facility accesses remote stewardship expertise (e.g. tele-stewardship) to obtain support for our antibiotic stewardship efforts.	*Optional.* Select 'Yes' if, over the past calendar year, your facility ever accessed remote stewardship expertise that was specifically targeted for your facility's antibiotic stewardship efforts. This does *not* include generic stewardship resources (e.g., webinars); otherwise, select 'No.'
47. Our stewardship program works with the microbiology laboratory to implement the following interventions: (Check all that apply.)	*Optional*. Select, from the choices listed, the ways in which your stewardship program worked with your facility's microbiology laboratory to implement antibiotic stewardship interventions over the past calendar year. Select 'Selective reporting of antimicrobial susceptibility testing results' if your facility tailors facility susceptibility reports to show antibiotics that are consistent with facility treatment guidelines or recommendations by the stewardship program. Select 'Placing comments in microbiology reports to improve prescribing' if, for example, information is included to help providers know which pathogens might represent colonization or contamination.
48. Which committees or leadership entities provide oversight of your facility's antibiotic stewardship program? (Check all that apply.)	*Optional*. Select, from the choices listed, the group(s) that provide(s) oversight of your facility's antibiotic stewardship efforts and to whom the antibiotic stewardship leader is accountable. If 'Other' is selected, please specify the committee or job title. Select 'None' if no further oversight is provided to the antibiotic stewardship leader(s).

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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.)	
49. Has your facility ever conducted an environmental assessment to identify where *Legionella* and other opportunistic waterborne pathogens (e.g., *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (e.g., piping infrastructure)? This may include a basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points.and fungi) could grow and spread in the facility water system (e.g., piping infrastructure)? If Yes, when was the most recent assessment conducted? *(Check one)*	*Required*. Select 'Yes' if your facility has conducted a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens (for example, *Pseudomonas*, *Acinetobacter*, *Burkholderia*, *Stenotrophomonas*, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (for example, piping infrastructure); Otherwise, select 'No' *Conditionally Required*. If 'Yes', specify the time period in which the most recent assessment was conducted. If 'Other' is selected, please specify the time period.
50. Has your facility ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and program preparedness?	*Required.* Select 'Yes' if your facility has ever conducted a water infection control risk assessment (WICRA) to evaluate water sources, modes of transmission, patient susceptibility, patient exposure, and program preparedness. *Conditionally Required*. If 'Yes', specify when the most recent assessment was conducted.
51. Does your facility have a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens? If Yes, who is represented on the team? *(Check all that apply)*	*Required.* Select 'Yes' if your facility has a water management program to prevent the growth and transmission of *Legionella* and other opportunistic waterborne pathogens; Otherwise, select 'No' *Conditionally Required*. If 'Yes', specify the roles of the team members represented on the water management program team. If 'Other' is selected, please specify the role of the team member.

52. Do you regularly monitor the following parameters in your building's water system? *(Check all that apply)*
 	
If Yes, do you have a plan for corrective actions when specific parameters are not within acceptable limits as determined by your water management program?
	Required. Select 'Yes' if your facility regularly monitors the following parameters in your building's water system; Otherwise, select 'No'
	   • Disinfectant (such as residual chlorine)
	   • Temperature
	   • Heterotrophic plate counts
	   • Specific tests for *Legionella*
	
	Conditionally Required. For each parameter, if 'Yes', specify if your facility has a plan for corrective actions when the specific parameter is not within acceptable limits as determined by your water management program?