HOSPITAL-ACQUIRED INFECTION REPORTING PROGRAM
Getting Started Guide

January 2015

PURPOSE

This guide is intended to help orient new hospital Infection Preventionists to the New York State Department of Health (NYSDOH) Hospital-Acquired Infection (HAI) Reporting Program. This guide provides a brief background of the program, gives tips on how to get started reporting, and describes the role of the hospital and NYSDOH in validating the data.

BACKGROUND

In July of 2005, Public Health Law 2819 was enacted mandating that New York hospitals report selected HAIs to NYSDOH. The HAIs to be reported are selected with the help of a Technical Advisory Workgroup (TAW). The TAW is made up of a panel of professionals representing experts in the prevention, identification, and control of HAIs, and the public reporting of performance data as prescribed in the public health legislation. The list of members is published in the annual HAI report. The TAW meets at least once a year to review public reporting requirements. NYSDOH also solicits and considers public comment regarding proposed changes to reporting requirements. NYSDOH will notify hospitals in writing of changes to any reporting requirements.

HAI INDICATORS TO BE REPORTED

The following indicators must be reported in 2015 to meet NYSDOH requirements:

- Central line-associated blood stream infections (CLABSIs) in
  - Adult and pediatric intensive care units (ICUs)
  - Neonatal ICUs (level 2/3 and level 3)
  - Adult and pediatric medical, surgical, and medical-surgical wards

    - Adult and pediatric step down units
- Colon surgical site infections
- Coronary artery bypass graft surgical site infections
- Hip replacement surgical site infections
- Abdominal hysterectomy surgical site infections
- Laboratory identified *Clostridium difficile* infections (CDI), facility wide inpatient
- Laboratory identified carbapenem-resistant Enterobacteriaceae (CRE) from all specimen types. facility wide inpatient, for the following species: *Escherichia coli, Klebsiella oxytoca, Klebsiella pneumonia, and Enterobacter*

Because of increased interest in multidrug-resistant organisms (MDROs), particularly Gram negative organisms, and the lack of baseline surveillance data for New York State, NYSDOH is asking NYS hospitals not already doing so to consider voluntarily reporting laboratory-identified multidrug-resistant *Acinetobacter* and cephalosporin resistant *Klebsiella* infections.

All indicators must be reported using the Center for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). NYS follows NHSN surveillance definitions.

NATIONAL HEALTHCARE SAFETY NETWORK

NHSN Public Website

- NHSN, at the public website, focuses on education regarding the NHSN reporting requirements and provides a variety of resources.
    - Tools on the public website include HAI reporting protocols, self-learning training modules providing direction for each of the protocol reporting requirements, newsletters that contain helpful clarifications and tips, and operational guidance for fulfilling Centers for Medicare and Medicaid Services (CMS) reporting requirements.

- Bookmark NHSN Public Website (http://www.cdc.gov/nhsn) as a favorite. If you are not sure how to bookmark, ask someone from your information technology (IT) department to assist you.

NHSN Secure Website

- NHSN has a separate secure website for hospital data entry that is accessed through Secure Access Management Services (SAMS)

- Follow the instructions on the NHSN website to apply for a SAMS card. You will be required to email or fax notarized personal identifying information to CDC. Within 10 days you will receive a SAMS grid card by mail. The grid card is the size of a credit card, and lists a table of unique letters and numbers. Each time you log into NHSN you will be asked to enter three of the letters/numbers from the table as proof of your identity. You may access NHSN from any computer using your gridcard.
- Bookmark the secure website (https://auth.cdc.gov) as a favorite. This secure data website provides a variety of data analysis tools generating specific reports for your hospital using data you have entered in NHSN.

Hospital Designated NHSN Facility Administrator

- An individual in your hospital is assigned as the administrator for overall management of the NHSN secure data functions for your hospital. This individual is referred to as the Facility Administrator (FA) and is responsible for the integrity and security of the data entered by your authorized hospital personnel into NHSN. The FA is also responsible for:
    - Enrolling the healthcare facility into NHSN
    - Adding users, and assigning level of user access to data reporting, editing, and analysis components
    - Approving the sharing of some or all data with other entities (e.g., hospital consortiums, CMS, Island Peer Review Organization (IPRO) Projects, Health Association of New York State (HANYS), and/or Greater New York Hospital Association (GNYHA)
    - The FA should give at least one other user administrative rights in case the FA becomes temporarily unavailable. If the FA is no longer able to perform the duties, he/she must transfer the FA role to another person using NHSN.

NHSN Help Desk

- Submit any questions about NHSN via email to nhsn@cdc.gov. Be sure to include your name and NHSN assigned facility ID #, which is found on your hospitals NHSN secure data network "landing page", located under your name. NHSN does not accept phone calls.

Frequently Asked Questions about NHSN Data

- **Can Centers for Medicare and Medicaid Services (CMS) access my NHSN data?** NHSN sends all the data required for the Inpatient Prospective Payment System (IPPS) to

CMS. You can see and verify the data that CMS will receive by following the "Helpful Tips" provided on the NHSN website under "CMS Supporting Materials".

- **Can NYS view my hospital data?** Yes. When your hospital joined NYS Group #10570, your FA accepted a template (referred to as conferred rights) that lists exactly which data NYSDOH can see. To see the template, go to NHSN, click "Group" select "Confer Rights". Highlight "NYS Group" from the "Groups that have access to this facility's data" box and click "Confer Rights" on the right. NYS does not have the ability to edit any individual hospital reported NHSN data. In addition, the NYSDOH HAI Reporting Program has a data use agreement with CDC allow us to view voluntarily reported data entered into NHSN. Data obtained under this agreement will not be publicly reported in a manner that identifies individual institutions and will not be used for punitive or regulatory actions; rather, these data provide NYSDOH greater insight into indicators that are not subject to NYS mandated reporting and allows for better focus of prevention activities.

- **Can other hospitals view my hospital data?** No, even if you are part of another NHSN group, other hospitals cannot view your data.

- **If my hospital belongs to multiple NHSN groups that want access to the same data as reported to NYS, do I have to enter the data again?** No, the advantage of hospitals using NHSN is entering data once.

- **Are there any differences between NYS and NHSN reporting requirements and published rates?** Yes, the differences are summarized in Table 1.

Table 1: National Healthcare Safety Network (NHSN) and New York State (NYS) Reporting Requirement Differences/Clarifications

Reporting Issue	NYS	NHSN
Timeliness of reporting	Report events **within sixty (60)** days after close of reporting surveillance month include appropriate summary or denominator data.	Report events to CDC **within thirty (30)** days of month include appropriate summary or denominator data.
Post discharge surveillance (PDS) reporting	NYS Public Health Law **mandates** inter-facility communication. "For HAIs for which the department requires tracking and reporting as permitted in this section, hospitals shall be required to report a suspected or confirmed HAI associated with another hospital to the originating hospital. Documentation of reporting should be maintained for a minimum of six years." SSI events that meet NHSN criteria must be entered into NHSN by the hospital where the procedure was originally performed. The law does not specify what SSI criteria to document. However, we recommend that the following information be communicated and documented by the secondary hospital infection prevention program: • name of patient • admission date to the secondary hospital • event date • NHSN SSI criteria met (SIP,SIS, DIP, DIS, OS) • culture and sensitivity results • surgical intervention needed to resolve the SSI.	Protocol states that PDS **should** be used to detect SSIs following operative procedures, but doesn't stipulate the specific PDS methods that should be used. All SSIs identified as part of a hospital PDS reporting program are reported to NHSN.
Risk adjustment	Answers question "How did each hospital perform in 2013 compared to the NYS 2013 average?" Risk adjustment variables are different. For SSIs, excludes SSIs detected using post discharge surveillance and not readmitted to any hospital. Time period is calendar year. Facilities are identified by unique NHSN number.	Answers question "How did each hospital perform in the most recent time period compared to the historical National baseline?" For SSIs, excludes children, patients with outlying risk adjustment variables, superficial infections. Time period is rolling year, updated quarterly. Facilities are identified by unique CMS number.

HAI REPORTING PROGRAM REPRESENTATIVES

NYS HAI Regional Representatives are assigned to different regions of the state to help verify the completeness and accuracy of the data submitted to NHSN, answer questions regarding reporting requirements, monitor HAI rates and surveillance and prevention practices, and provide recommendations as needed. The names of the representatives follow:

LOCATION	NAME	NUMBER	EMAIL
Western, NY	Peggy Hazamy	716-855-7502	peggy.hazamy@health.ny.gov
Central Islip, NY	Marie Tsivitis	631-851-3652	marie.tsivitis@health.ny.gov
Capital District, NY	Valerie Haley	518-474-3343	valerie.haley@health.ny.gov
Central, NY	Robin Knab	716-847-2282	robin.knab@health.ny.gov
New Rochelle, NY	Rosalie Giardina	914-654-4362	rosalie.giardina@health.ny.gov
New York, NY	Vacant, covered by Marie Tsivitis and Rosalie Giardina		

Please let these Representatives know when there are changes to your contact information, so that they can keep you informed of validation issues and program changes.

VALIDATION OF REPORTED DATA

Things that I can do

Here are some tips to ensure that your data are accurate.

1) Every month, check the NHSN Alerts page and correct any data omissions or errors that NHSN has identified.
2) Check the data each month that you do surveillance and report the data so that you don't forget to enter data for a month. A sample check list is provided below.
3) Periodic (quarterly, yearly) check that all blood cultures have been reviewed and reportable CLABSI have been entered.
4) Periodic (quarterly, yearly) verification that all laboratory-identified *C. difficile* cases have been entered.
5) Periodic (quarterly, yearly) verification that all laboratory-identified CRE cases have been entered.
6) Ask your IT department to provide you with a list of patients assigned discharge ICD-9 codes related to infections. Review these cases to determine if they meet NHSN criteria.
7) When there are changes in your hospital, verify that the NHSN location labels and the number of beds per location are correctly entered.
8) Periodically perform a check that central line days are correctly counted.

NYS HAI REPORTING PROGRAM 2015 DATA SUBMISSION TIMELINE		Date submitted Use these columns to help you track your data entry dates! Remember to check "No Events" if you have no infections to report.						
		Procedure data & Events				CLABSI		LabID Events
Data from….	Enter by…..	CABG	Colon	HPRO	Abd Hyst	ICU Summary data & events	Nursing Unit summary data & events	C difficile/ CRE Event & Summary data (Inpt/ER/Obs)
January, 2015	April 1st, 2015							
February	May 1st							
March	June 1st							
April	July 1st							
May	August 1st							
June	September 1st							
July	October 1st							
August	November 1st							
September	December 1st							
October	January 1, 2016							
November	February 1, 2016							
December	March 1, 2016							

NYSDOH Checks for data consistency

NYSDOH runs data consistency checks approximately every two months. When inconsistencies are identified for your hospital, you will receive an automated report from the HAI Central Office located in Albany. This report is sent to the IP who is the primary contact for your hospital. It is expected that you will address any issues on the report using the comments box and send your response back to your Regional Representative. The completed *report is due* to your Regional Representative prior to *the first of the next month*. If your facility requires that you send the completed report via a secure portal, please use the HPN secure file transfer portal. (Go to https://commerce.health.state.ny.us, select Applications/Secure File Transfer Application/"I want to send someone else a file")

Some potential issues you may see on the report and instructions on how to document the corrections are listed in Table 2.

Table 2: Potential data consistency issues

Issue	Resolution	Instructions
Missing plan	There must be a plan for every indicator for every month. Enter missing plans for the months indicated.	Enter comments in the comments box to demonstrate you have addressed the issue in the NHSN.
Missing procedure data: no procedures entered for the specified month(s)	If there are no procedures for the month identified on the report, enter or click **No Procedures** were performed on the NHSN alert page. This can also be found by going to Summary Data then Incomplete/Missing List and choosing the Missing Procedures tab.	Enter comments in the comments box to demonstrate you have addressed the issue in the NHSN.
Missing CLABSI, CDI, or CRE Summary data: no summary data entered for the specified month(s)	Enter your summary data for the month/months indicated.	Enter comments in the comments box to demonstrate you have addressed the issue by entering the missing summary data in the NHSN.
Missing Events: Zero events entered for the specified month(s). NOTE: a Surgical Site Infection (SSI) event is linked to the procedure date, not the date you enter the event	If there are zero events, (SSI/CLABSI/CDI/CRE*)* for the month identified on your report, enter or click **No events** on the NHSN alert page. This can also be found by going to Summary Data then Incomplete/Missing List and choosing one of the Missing Events tabs.	Enter comments in the comments box to demonstrate you have addressed the issue in the NHSN.
Procedure date equals Date of Birth (DOB)	Verify that the DOB is correct, if not enter the correct DOB.	Enter comments in the comments box to demonstrate you have addressed the issue in the NHSN.
Duplicate procedures	Verify that the procedure does not have multiple entries. **Delete the duplicate**	Enter comments in the comments box to demonstrate you have addressed the

Issue	Resolution	Instructions
	entries.	issue in the NHSN and indicate which if any procedures were deleted.
Duplicate events	Review list of possible duplicates and delete the duplicate entries.	Enter comments in the comments box to show the events that have been deleted.
Potential age (DOB) issue in CDI events	Check the date of birth and correct it in NHSN. *No surveillance for CDI will be performed in Neonatal Intensive Care Unit (NICU) or well baby nurseries.*	Enter comments in the comments box to demonstrate you have addressed the issue in the NHSN.
Procedure duration too long or too short	Verify the surgical duration time (incision to closure) and make any corrections in NHSN.	Enter comments in the comments box to demonstrate you have addressed the issue and note if duration is correct or corrections were made in the NHSN.
Unusual summary data	Verify that there was not a typo in the summary data for the specified month and indicator, and make corrections in NHSN as needed.	Enter comments in the comments box to demonstrate you have addressed the issue in the NHSN or the entry was correct.
CDI or CRE admission, specimen, or discharge date	Verify the admission and specimen date if there was more than one year from admission to specimen date, and make corrections in NHSN. The last discharge date should be **prior to the specimen date.** Verify the discharge date and make corrections in NHSN.	Enter comments in the comments box to demonstrate you have addressed the issue in the NHSN.

<u>NYSDOH Audits</u>

The purposes of audit are to:

- Validate accuracy of infection rates and risk adjustment variables.
- Evaluate current surveillance methods used to detect infections.
- Determine the reliability and consistency of surveillance definitions.
- Evaluate intervention strategies designed to reduce or eliminate specific infections.
- Provide education on definitions, surveillance mechanisms, and use of the NHSN.

Audits may be performed either through on-site visits or off-site access to electronic medical records. All hospitals will be audited every 1 to 2 years, if staffing allows. HAI Regional representatives select hospitals for audits in his/her region each calendar quarter based on established criteria. NHSN patient safety protocol criteria are used for reviewing medical records. The following table describes the procedure.

Table 3: NYSDOH HAI Audit

Topic	Procedure for on-site audit	Procedure for off-site audit
Hospital audit and visit preparation	The HAI regional representative will make an initial phone call to Infection Preventionist (IP) to schedule the audit and explain audit process. A follow-up email will be sent to the IP within 3 business days to confirm the audit date(s). On the day of audit, HAI regional representative will require access to the complete patient medical record(s) (electronic and/or paper) requested including readmissions, diagnostic/laboratory results, clinical documentation and ICD-9 CM codes.	The HAI regional representative will make an initial phone call to Infection Preventionist (IP) to confirm method of external access: electronic medical record, external information system, or full medical records on DVD/flash drive. The IP will provide the name of a contact who will supply passwords/permissions. An email will confirm the audit date and method. On the day of audit, HAI regional representative will require access to the complete patient medical record(s) (electronic and/or paper) requested including readmissions, diagnostic/laboratory results, clinical documentation and ICD-9 CM codes.
CEO audit notification letter	The HAI regional staff will send via fax, email, or NYS Commerce secure data transmission, an audit notification letter, patient medical record request list, and audit instructions to the CEO at least 2 weeks prior to the on-site audit visit. A copy of the letter is sent to the designated IP program leader. The letter will include the purpose of the audit, and access to the requested medical records described in the audit letter.	same

Topic	Procedure for on-site audit	Procedure for off-site audit
ICU CLABSI audit	Per audit instructions the IP will provide a line list of patients with positive blood cultures obtained during the ICU or specified ward admission and for the period of time specified, and also show ICU/ward admit date and central line insertion dates. These patient medical records will be made available for review during the on-site hospital audit. HAI regional staff will enter all data reviewed at the time of the on-site audit review and determine whether the reviewed blood cultures meet NHSN criteria. A unique hospital identified Access™ data file is used to record audit findings.	The IP will send a laboratory line list of all patients with a positive blood culture for the selected time frame, and completed table showing ICU/ward admit date and central line insertion dates, via the Health Commerce System (HCS) secure file transfer or fax. HAI regional staff will enter all data reviewed at the time of the off-site audit review and determine whether the reviewed blood cultures meet NHSN criteria. A unique hospital identified Access™ data file is used to record audit findings.
CDI audit	Per audit instructions the IP will provide a laboratory data mined line list of all positive CDI lab reports for the audited time period. No patient chart review will be conducted. HAI staff will compare this laboratory list to the list of CDI LabID events entered into the NHSN for the facility for the requested time period.	The IP will send a data mined line list of all positive CDI lab reports for the audited time period, via the Health Commerce System (HCS) secure file transfer or fax.
CRE audit	Per audit instructions the IP will provide a laboratory data mined or laboratory line list of all positive CRE lab reports for the audited time period. No patient chart review will be conducted. HAI staff will compare this laboratory list to the list of CRE LabID events entered into the NHSN for the facility for the requested time period.	The IP will send a data mined or laboratory line list of all positive CRE lab reports for the audited time period, via the Health Commerce System (HCS) secure file transfer or fax.

Topic	Procedure for on-site audit	Procedure for off-site audit
Surgical procedure audit	List of pre-selected medical records for each procedure (coronary artery bypass, colon, hip replacement and abdominal hysterectomy) are sent to the hospital. Medical records for the initial surgical admission, all outpatient visits, and subsequent readmissions (as stated on the procedure request list) should be made available for the entire audit. Prior to the audit visit, NYSDOH downloads surgical procedure and infection data from NHSN into a unique hospital identified Access™ data file. Data entered by hospital is compared to patient medical record documentation and assessed for accuracy and meeting NHSN criteria. Results are recorded in the data file.	List of pre-selected medical records for each procedure (coronary artery bypass, colon, hip replacement and abdominal hysterectomy) are sent to the hospital. Electronic medical records for the initial surgical admission, all outpatient visits, and subsequent readmissions (as stated on the procedure request list) should be made available. The following documentation is required: discharge ICD-9 codes (diagnosis and procedure); intraoperative report (surgeon dictation, ASA score, wound class, procedure time, anesthesia); height and weight, laboratory results, microbiology results, radiology results, physician progress notes, physician consult reports, physician orders, nursing assessment (admissions and routine progress). Prior to the audit visit, NYSDOH downloads surgical procedure and infection data from NHSN into a unique hospital identified Access™ data file. Data entered by hospital is compared to patient medical record documentation and assessed for accuracy and meeting NHSN criteria. Results are recorded in the data file.
On-site audit review findings and data corrections	All NHSN corrections and additional reporting are reviewed on-site with the IP and additional hospital staff at the completion of the audit visit. A written summary of corrections is given to the IP prior to leaving the facility or shortly thereafter. All NHSN edits/corrections must be made by the IP within 30 days of the on-site audit visit.	All NHSN corrections and additional reporting are reviewed with the IP and additional hospital staff during a phone call within 3 days of completion of the audit. A summary of corrections are emailed to the IP. All NHSN edits/corrections must be made by the IP within 30 days of the off-site audit.
If there is a disagreement	If NYSDOH and the facility do not agree on the required data corrections, NHSN can provide the final determination. The facility should send an email to NHSN with a detailed description of the case, describing the reason for the disagreement, and cc'ing the Regional Staff member. NHSN will respond by email.	same

Topic	Procedure for on-site audit	Procedure for off-site audit
Post audit CEO communication	Regional HAI staff sends post-audit follow-up letter to CEO with identified findings, recommendations for improvement, and data corrections identified as a result of the audit visit: • letter sent by email within 2 weeks of the audit visit completion • copy of same letter sent to IP.	same
HAI program follow-up	HAI Regional staff finalizes the individual hospital audit data files. Central office data staff will review the finalized audit files to determine if the corrections/additions have been completed by the hospital. The HAI regional representative will contact the hospital IP to ensure the corrections to the NHSN data file will be completed. Further written communication with the IP and/or the CEO will be initiated when the requested NHSN information is not corrected.	same

Table 4 describes some common errors identified during audits, and highlights how to correctly report the data.

Table 4: Guidance on Common Data Errors from Medical Record Reviews

Data	Common reasons for incorrect responses	Reporting Instructions
Duration of procedure	Incorrect OR times frequently related to: • filtered reports using OR time "in" to OR time "out" • using Anesthesia start and stop • miscalculations. • inclusion of non-surgical portion of operative time, such as preincision cystoscopy for laparoscopic surgery.	Duration of Procedures: Interval in hours and minutes between the skin incision and skin closure. Deduct time of cytoscopy if it was included in the OR reported duration of procedure. **Tip:** If this data is given to you in a report, conduct periodic review to validate internal processes accurately capture duration "incision to closure" times.

Data	Common reasons for incorrect responses	Reporting Instructions
Wound class	Incorrect wound class entries were most frequently related to incorrect surgical wound classifications documented in the OR record.	An assessment of the likelihood and degree of contamination of a surgical wound at the time of the operation. Adapted from the American College of Surgeon's wound classification schema. If the OR record documentation is incorrect, enter the correct classification into the NHSN and review the definitions with your OR staff. **Tip:** Review annually with OR staff how surgical wound classifications are assigned.
Primary closure	This was most often related to: • select surgeon operative reports not being reviewed • no process in place to review operative reports.	Primary closure is defined as closure of the skin level during the original surgery, regardless of the presence of wires, wicks, drains, or other devices or objects extruding through the incision. This category includes surgeries where the skin is closed by some means. Thus, if any portion of the incision is closed at the skin level, by any manner, a designation of primary closure should be assigned to the surgery.
Scope	Incorrect responses related to: • not reviewing how donor vessels were harvested for CABG surgery • not reviewing if colon procedure was totally laparoscopic • responding “Yes” if endoscopy was performed at the beginning of the procedure.	Beginning in 2015, if a scope site has to be extended for hand assist or removal of specimen this will still meet scope = Yes. If the procedure is converted to an open procedure it will be scope = No.
Extent	Not updating the Extent of the SSI. Patient initially met criteria for a superficial infection, and then progressed to a deep or organ space.	The Extent field must be updated to reflect the deeper SSI event. Edit the event.
When detected	Not updating “When detected” if patient is readmitted for SSI to the facility that performed the procedure or at another facility.	If SSI was detected on post-discharge surveillance (P), and patient is readmitted for treatment of SSI, the When detected field must be updated to reflect the readmission to same facility (RF) or readmission to other facility (RO).

Data	Common reasons for incorrect responses	Reporting Instructions
Date of Event	Incorrect event date.	Beginning in 2015, this is the date when the first element used to meet the SSI infection criterion occurs.Date of event must be within 30 days or 90 days of the date of procedure, depending on the operative procedure category.
Trauma	Responding "No" to trauma if HPRO was related to a fall.	Check Y if operative procedure was performed because of blunt or penetrating traumatic injury to the patient. A patient fall that results in a hip procedure is considered a traumatic injury.
Unreported CDI and CRE events	Misinterpretation of definition.	Use NHSN's MDRO and CDI LabID Event Calculator for assistance in determining which results should be reported. Ensure that your laboratory contact is following the NHSN LabID definitions. **Tip***:* Run an NHSN Analysis report for: Line Listing for All CDI or CRE LabID Events and reconcile the line list against a laboratory or data mined generated line list.
Unreported SSIs	Inadequate surveillance of imaging test results.	It is not sufficient to only review laboratory test results. IPs should also review imaging test results.
Unreported CLABSIs	Misinterpretation of criteria for infection at another site.	The NHSN Secondary Bloodstream Infection Guide and CDC Surveillance definitions of HAIs must be used when determining if the positive blood culture was related to an infection at another body site.
Physician interpretation of positive blood culture	Physician determines that positive blood culture should not be counted as a CLABSI.	NHSN does not recognize physician diagnosis as an acceptable reason to exclude a CLABSI from being reported to NHSN if CLABSI meets reporting criteria.

WHAT DOES NYSDOH DO WITH THE DATA?

The NYS law was created to provide the public with fair, accurate, and reliable HAI data to compare hospital infection rates, and to support quality improvement and infection control activities in

hospitals. Annual reports, summarizing hospital-specific infection rates, are posted on the DOH website (http://www.health.ny.gov/statistics/facilities/hospital/hospital_acquired_infections) in September each year. For information on how NYSDOH handles hospitals with HAI rates that significantly higher than the state average, see the NYSDOH Policy on High Rates.