Proposed PY 2018 Clinical Measure

Kt/V Dialysis Adequacy Measure Topic: Hemodialysis

Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy--HD Adequacy-- Minimum Delivered Hemodialysis Dose Higher rate desired	
Measure Description	Percentage of hemodialysis patient-months with spKt/V greater than or equal to 1.2. NQF#0249
Numerator	Patient-months in the denominator for patients whose delivered dose of hemodialysis (spKt/V) was greater than or equal to 1.2 during the measurement period.
Denominator	Number of Medicare patients-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 years 2. Peritoneal patients 3. Patients on dialysis for fewer than 90 days 4. Patients dialyzing 4 times or more per week on average 5. Patients dialyzing 2 times or fewer per week on average 6. Patients having a spKt/V value less than 0.5 7. Patients having a spKt/V value greater than 2.5 8. Patients treated at the facility fewer than twice during the claim month 9. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	1
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. Calculated from the last measurement of the month. 2. Must be calculated using UKM or Daugirdas II method. 3. Dialysis sessions per week is calculated as the number of dialysis sessions in the claim divided by the time period covered by the claim, with no rounding for the number of sessions per week. Frequent dialysis (4 or more sessions per week) is determined by (i) calculated sessions per week is 4 or more; (ii) Kt/V is 8.88 on claim; (iii) Other administrative data (e.g. CROWNWeb) indicates 4 or more sessions per week. 4. The reported spKt/V should not include residual renal function. 5. Patients with missing spKt/V values or spKt/V=9.99 (not reported) are included in the denominator.

Proposed PY 2018 Clinical Measure

Kt/V Dialysis Adequacy Measure Topic: Peritoneal Dialysis

Peritoneal Dialysis Adequacy Clinical Performance Measure III - Delivered Dose of Peritoneal Dialysis Above Minimum Higher rate desired	
Measure Description	Percentage of peritoneal dialysis patient-months with Kt/V greater than or equal to 1.7 Kt/V (dialytic + residual) during the four month study period. NQF#0318
Numerator	Patient-months in the denominator for patients whose delivered dose of peritoneal dialysis was equal to or greater than 1.7 Kt/V (dialytic + residual) during the measurement period.
Denominator	Number of Medicare patient-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 years 2. Hemodialysis patients 3. Patients on dialysis for fewer than 90 days 4. Patients having a Kt/V value less than 0.5 5. Patients having a Kt/V value greater than 5.0 6. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	1
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. If no Kt/V value is reported for a given patient in a claim month, the most recent Kt/V value in the prior 4 months is applied to the calculation for that month. 2. Patients with missing Kt/V values or Kt/V=9.99 (not reported) are included in the denominator.

Proposed PY 2018 Clinical Measure

Kt/V Dialysis Adequacy Measure Topic: Pediatric Dialysis

Minimum spKt/V for Pediatric Hemodialysis Patients Higher rate desired	
Measure Description	Percentage of pediatric in-center hemodialysis patient-months with spKt/V greater than or equal to 1.2. NQF#1423
Numerator	Patient-months in the denominator for patients whose delivered dose of hemodialysis (spKt/V) was greater than or equal to 1.2 during the measurement period.
Denominator	Number of Medicare patient-months at the facility during the measurement period. Exclusions: 1. Patients 18 years or older 2. Peritoneal patients 3. Home hemodialysis patients 4. Patients on dialysis for fewer than 90 days 5. Patients having a spKt/V value less than 0.5 6. Patients having a spKt/V value greater than 2.5 7. Patients dialyzing 5 times or more per week on average 8. Patients dialyzing 2 times or less per week on average 9. Patients treated at the facility fewer than twice during the claim month 10. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	1
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. Calculated from the last measurement of the month. 2. Must be calculated using UKM or Daugirdas II method. 3. Dialysis sessions per week is calculated as the number of dialysis sessions in the claim divided by the time period covered by the claim, with no rounding for the number of sessions per week. Frequent dialysis (5 or more sessions per week) is determined by (i) calculated sessions per week is 5 or more; (ii) Kt/V is 8.88 on claim; (iii) Other administrative data (e.g. CROWNWeb) indicates 4 or more sessions per week.The reported spKt/V should not include residual renal function. 4. Patients with missing spKt/V values or spKt/V=9.99 (not reported) are included in the denominator.

Proposed PY 2018 Clinical Measure

Kt/V Dialysis Adequacy Measure Topic: Pediatric Peritoneal Dialysis

Minimum Kt/V for Pediatric Peritoneal Patients Higher rate desired	
Measure Description	Percentage of pediatric peritoneal dialysis patient-months with Kt/V greater than or equal to 1.8 (dialytic + residual) during the performance period
Numerator	Patient-months in the denominator for patients whose delivered dose of peritoneal dialysis was a weekly Kt/V urea (dialytic + residual) of at least 1.8 during the performance period
Denominator	Number of Medicare patient-months at the facility during the performance period. Exclusions: 1. Patients 18 years and older 2. Hemodialysis patients 3. Patients on dialysis for fewer than 90 days 4. Patients having a Kt/V value less than 0.5 5. Patients having a Kt/V value greater than 5.0 6. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	1
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. If no Kt/V value is reported for a given patient in a claim month, then the most recent Kt/V value in the prior 6 months is applied to the calculation for that month. 2. Patients with missing Kt/V values or Kt/V=9.99 (not reported) are included in the denominator.

Proposed PY 2018 Clinical Measure

Vascular Access Type: AV Fistula

Hemodialysis Vascular Access – Maximizing Placement of Arterial Venous Fistula Higher rate desired	
Measure Description	Percentage of patient-months on hemodialysis during the last hemodialysis treatment of the month using an autogenous AV fistula with two needles. NQF#0257
Numerator	Patient-months in the denominator where an autogenous AV fistula with two needles was the means of access.
Denominator	Number of Medicare patient-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 2. Peritoneal patients 3. Claims with both a fistula and graft reported 4. Claims with fistula, graft, and catheter reported 5. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	4 months
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. If claim indicates fistula and catheter, then only the fistula is counted. 2. Last claim of the month used for calculation.

Proposed PY 2018 Clinical Measure

Vascular Access Type: Catheter ≥ 90 Days

Hemodialysis Vascular Access – Minimizing Use of Catheters as Chronic Dialysis Access Lower rate desired	
Measure Description	Percentage of patient-months for patients on hemodialysis during the last hemodialysis treatment of month with a catheter continuously for 90 days or longer prior to the last hemodialysis session. NQF#0256
Numerator	Patient-months in the denominator for patients continuously using a catheter for hemodialysis access for 90 days or longer prior to the last hemodialysis treatment during the month.
Denominator	Number of Medicare patient-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 years and 3 months 2. Peritoneal patients 3. Claims with both a fistula and graft reported 4. Claims with fistula, graft, and catheter reported 5. Patients not on chronic dialysis as defined by a completed 2728 form, a REMIS/CROWNWeb record, or a sufficient amount of dialysis reported on dialysis facility claims
Minimum Claims	4 consecutive months
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD and date of birth)
Additional Information	1. If claim indicates fistula and catheter, then only the fistula is counted. 2. If a claim indicates catheter and graft, then only the graft is counted. 3. Measure uses data prior to performance or comparison period (e.g., October – December 2015 for the performance period) to determine catheter history. 4. Last claim of the month used for calculation.

Proposed PY 2018 Clinical Measure

Hypercalcemia

Proportion of Patients with Hypercalcemia Lower rate desired	
Measure Description	Proportion of patient-months with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL. NQF #1454
Numerator	Number of patient-months in the denominator with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL.
Denominator	Number of patient-months at the facility during the measurement period. Exclusions: 1. Patients younger than 18 2. Patients present at facility for fewer than 30 days 3. Patients on dialysis for fewer than 90 days 4. Patients without an uncorrected serum calcium value at that facility in the reporting month 5. Patients not on chronic dialysis as defined by a completed 2728 form or a REMIS/CROWNWeb record
Minimum Claims	3 months
Data Source(s)	1. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2728 to obtain the diagnosis date of ESRD, time at facility, and date of birth)
Additional Information	1. November and December of the previous year will be used in calculating the three-month rolling average for January and February of the performance period. 2. Includes all patients (i.e., not just those patients on Medicare). 3. The last value reported in the month is used for calculation. 4. A patient need only have an uncorrected serum calcium value for the reporting month to be included in the measure. Any value reported during the two months prior to the reporting month will be used to calculate the 3-month rolling average. 5. No interpolation between uncorrected serum calcium values for peritoneal dialysis patients. 6. The uncorrected serum calcium value reported by the facility is used. The facility may obtain this value from an external source. 7. “Uncorrected” indicates albumin is not considered in the calculation.

Proposed PY 2018 Clinical Measure

Infection Monitoring: NHSN Bloodstream Infection in Hemodialysis Patients

NHSN Bloodstream Infection in Hemodialysis Outpatients Lower Adjusted Ranking Metric (ARM) value desired	
Measure Description	Adjusted Ranking Metric (ARM) of Bloodstream Infection will be calculated among patients receiving hemodialysis at outpatient hemodialysis centers. Based on NQF #1460
Numerator	The observed number of new positive blood culture events based on blood cultures drawn as an outpatient or within 1 calendar day after a hospital admission and adjusted for vascular access type, unmeasured variation and patient exposure volume reported by a given facility to NHSN for the entire year.
Denominator	The number of positive blood culture events predicted to have occurred in a given facility for the entire year. Calculation for this denominator incorporates the number of in-center hemodialysis patients treated in the outpatient hemodialysis facility for the year stratified by vascular access type. Exclusions: 1. Facilities that do not offer in-center hemodialysis 2. Facilities with a CCN open date after January 1, 2016
Data Source(s)	1. NHSN 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain facility type and certification date)
Additional Information	1. Facilities are required to meet enrollment and training requirements, as specified at http://www.cdc.gov/nhsn/dialysis/enroll.html and http://www.cdc.gov/nhsn/Training/dialysis/index.html. 2. Data are collected as specified by the NHSN Dialysis Event Surveillance Protocol: http://www.cdc.gov/nhsn/PDFs/pscManual/8pscDialysisEventcurrent.pdf. 3. A positive blood culture is considered a new event and counted only if it occurred 21 days or more after a previous positive blood culture in the same patient. 4. Patients receiving inpatient hemodialysis or peritoneal dialysis are excluded from the measure. 5. Patients receiving home hemodialysis are excluded from the measure. 6. Facilities who do not submit 12 months of accurately reported data receive zero points for the measure. 7. For more information about the methodology used to calculate the Adjusted Ranking Metric (ARM), please see http://www.cdc.gov/nhsn/dialysis/ and http://www.cdc.gov/nhsn/PDFs/dialysis/NHSN-ARM.pdf.

Proposed PY 2018 Clinical Measure

Standardized Readmission Ratio

Standardized Readmission Ratio Lower rate desired	
Measure Description	Standardized hospital readmissions ratio of the number of observed unplanned readmissions to the number of expected unplanned readmissions.
Numerator	Number of observed and unplanned hospital readmissions
Denominator	The expected number of unplanned readmissions in each facility, which is derived from a model that accounts for patient characteristics and the discharging acute care hospitals involved. Index hospital discharges that: 1. End in death 2. Result in a patient dying within 30 days with no readmission 3. Are against medical advice 4. Include a primary diagnosis for certain types of cancer, mental health condition or rehabilitation 5. Occur after a patient's 12th admission in the calendar year 6. Are from a PPS-exempt cancer hospital 7. Result in a transfer to another hospital on the same day
Minimum Claims	Facilities with fewer than 11 index hospital discharges are not eligible for the measure.
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data
Additional	1. Hospitalizations are counted as events in the numerator if they (a) occurred within 30 days of a hospital discharge; and (b) are not considered a "planned" readmission. 2. Additional information about the measure can be found in the SRR Measure Methodology Report posted at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-

Proposed PY 2018 Clinical Measure: Standardized Transfusion Ratio

Standardized Transfusion Ratio **Lower rate desired**	
Measure Description	Risk adjusted facility level transfusion ratio (STrR) for all adult Medicare dialysis patients. STrR is a ratio of number of observed eligible red blood cell transfusion events occurring in patients dialyzing at a facility to the number of eligible transfusions that would be expected from a predictive model that accounts for patient characteristics within each facility.
Numerator	Number of observed red blood cell transfusion events (defined as transfer of one or more units of blood or blood products into recipient's blood stream) among patients dialyzing at the facility during the reporting period.
Denominator	Number of eligible red blood cell transfusion events (as defined in the numerator statement) that would be expected among patients at a facility during the reporting period, given the patient mix at the facility. Exclusions: 1. Patients less than 18 years old 2. Patients on ESRD treatment for 90 days or fewer 3. Patients treated at the facility for fewer than 60 days 4. Patients who receive a transplant 5. Patients who have not been treated by any facility for a year or longer 6. Patients with a Medicare claim for one of the following conditions in the past year: hemolytic and aplastic anemia, solid-organ cancer (breast, prostate, lung, digestive tract and others), lymphoma, carcinoma in situ, coagulation disorders, multiple myeloma, myelodysplastic syndrome and myelofibrosis, leukemia, head and neck cancer, other cancers (connective tissue, skin, and others), metastatic cancer, or sickle cell anemia
Minimum Claims	Facilities with fewer than 10 patient-years at risk will not be eligible to receive a score on the measure.
Data Source(s)	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data
Additional Information	1. Eligible transfusion events are those that do not have any claims pertaining to the comorbidities identified for exclusion, in the one year look back period prior to each observation window. 2. When a patient transfers from one facility to another, the patient continues to be attributed to the original facility for 60 days, at which point the patient is attributed to the destination facility. 3. A patient-month is considered eligible if it is within two months of a month in which a patient has $900 of Medicare-paid dialysis claims or at least one Medicare-paid inpatient claim. 4. Additional information about the measure can be found in the STrR Measure Methodology Report posted at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/061_TechnicalSpecifications.html.

Proposed PY 2018 Clinical Measure

Patient Experience of Care: ICH CAHPS Survey

ICH CAHPS Administration	
Measure Description	Percentage of patient responses to multiple testing tools. Composite Score: The proportion of respondents answering each of response options for each of the items summed across the items within a composite to yield the composite measure score. (Nephrologists' Communication and Caring, Quality of Dialysis Center Care and Operations, Providing Information to Patients) Overall Rating: a summation of responses to the rating items grouped into 3 levels NQF #0258
Exclusions	1. Facilities treating fewer than 30 eligible in-center hemodialysis adult patients during the "eligibility period," which is defined as the year prior to the performance period 2. Facilities with a CCN open date on or after January 1, 2016 3. The following patients are excluded in the count of 30 eligible patients: a) Patients less than 18 years on the last day of the sampling window for the semiannual survey b) Patients receiving hemodialysis from their current facility for less than 3 months c) Patients receiving hospice care d) Patients currently residing in an institution, such as a residential nursing home or other long-term care facility, or a jail or prison
Data Sources	1. ICH CAHPS 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date and facility type)
Additional Information	1. Facilities are required to register on the https://ichcahps.org website in order to authorize a CMS-approved vendor to administer the survey and submit data on their behalf. 2. Facilities are required to administer the survey twice during the performance period, using a CMS-approved vendor. 3. Facilities are required to ensure that vendors submit survey data to CMS by the date specified at https://ichcahps.org. 4. Facilities that do not administer two surveys during the performance period will receive a score of 0 on the measure. 5. Facilities that administer two surveys during the performance period but receive less than 30 completed surveys will not receive a score on the measure. 6. Additional specifications may be found at https://ichcahps.org.

Proposed PY 2018 Reporting Measure

Mineral Metabolism

Mineral Metabolism Reporting	
Measure Description	Number of months for which facility reports serum or plasma phosphorus values for each Medicare patient.
Exclusions	1. Facilities with a CMS certification on or after July 1, 2016 2. In-center hemodialysis patients treated at facility fewer than 7 times during claim month 3. Home dialysis patients for whom a facility does not submit a claim during the claim month 4. Facilities treating zero patients during the performance period who are (i) in-center Medicare patients who have been treated at least 7 times by the facility during the reporting month; or (ii) home dialysis Medicare patients for whom the facility submits a claim during the reporting month 5. Patients not on chronic dialysis as defined by a completed 2728 form or a REMIS/CROWNWeb record
Data Sources	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date)
Additional Information	1. The serum phosphorus values reported by the facility are used. The facility may obtain these values from an external source. 2. If a facility treats less than 11 eligible patients, then it must report data for all but one patient. 3. If a facility treats 11 or more patients, then it must report data for all patients. 4. The measure will be scored according to the following formula: $\left(\frac{Number\ of\ Months\ Facility\ Successfully\ Reports}{Number\ of\ Months\ in\ the\ Performance\ Period\ Facility\ has\ CCN}\ x\ 12\right) - 2$

Proposed PY 2018 Reporting Measure

Anemia Management

Anemia Management Reporting	
Measure Description	Number of months for which facility reports ESA dosage (as applicable) and hemoglobin/hematocrit for each Medicare patient at least once per month.
Exclusions	1. Facilities with a CMS certification on or after July 1, 2016 2. In-center hemodialysis patients treated at a facility fewer than 7 times during claim month 3. Home dialysis patients for whom a facility does not submit a claim during the claim month 4. Facilities treating zero patients during the performance period who are (i) in-center Medicare patients who have been treated at least 7 times by the facility during the reporting month; or (ii) home dialysis Medicare patients for whom the facility submits a claim during the reporting month 5. Patients not on chronic dialysis as defined by a completed 2728 form or a REMIS/CROWNWeb record
Data Sources	1. Medicare Claims 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain certification date)
Additional Information	1. Hemoglobin value of 99.99 is not considered valid for purposes of measure. Note: we will not penalize facilities for using the default 99.99 value for a patient in his/her first month of treatment at that facility. 2. The hemoglobin/hematocrit reported by the facility is used. The facility may obtain this value from an external source. 3. No ESA dosage need be recorded if patient is not treated with ESAs. 4. ESA dosage must be reported via HCPCS codes and corresponding units, as applicable. 5. If a facility treats less than 11 eligible patients, then it must report data for all but one patient. 6. If a facility treats 11 or more patients, then it must report data for all patients. 7. The measure will be scored according to the following formula: $\left(\frac{Number\ of\ Months\ Facility\ Successfully\ Reports}{Number\ of\ Months\ in\ the\ Performance\ Period\ Facility\ has\ CCN}\ x\ 12\right) - 2$

Proposed PY 2018 Reporting Measure

Pain Assessment and Follow-Up

Pain Assessment and Follow-Up Reporting	
Measure Description	Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before August 1, 2016 and once before February 1, 2017. Based on NQF #0420
Exclusions	1. Patients who are younger than 18 years 2. Patients treated at the facility for fewer than 90 days 3. Facilities with a CCN open date after July 1, 2016
Data Sources	1. REMIS, CROWNWeb, and other CMS ESRD administrative data
Additional Information	1. Facilities must report one of the following conditions for each eligible patient: a) Pain assessment using a standardized tool is documented as positive and a follow-up plan is documented b) Pain assessment documented as positive, a follow-up plan is not documented, and the facility possesses documentation that the patient is not eligible c) Pain assessment documented as positive using a standardized tool, a follow-up plan is not documented, and no reason is given d) Pain assessment using a standardized tool is documented as negative, and no follow-up plan required e) No documentation of pain assessment, and the facility possesses documentation the patient is not eligible for a pain assessment using a standardized tool f) No documentation of pain assessment, and no reason is given 2. Conditions covering the first six months of the performance period must be reported in CROWNWeb before August 1, 2016, and the conditions covering the second six months of the performance period must be reported in CROWNWeb before February 1, 2017.

Proposed PY 2018 Reporting Measure

Clinical Depression Screening and Follow-Up

Clinical Depression Screening and Follow-Up Reporting	
Measure Description	Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before February 1, 2017. Based on NQF #0418
Exclusions	1. Patients who are younger than 12 years 2. Patients treated at the facility for fewer than 90 days 3. Facilities with a CCN open date after July 1, 2016
Data Sources	1. REMIS, CROWNWeb, and other CMS ESRD administrative data
Additional Information	1. Facilities must report one of the following conditions for each eligible patient: a) Screening for clinical depression is documented as being positive, and a follow-up plan is documented b) Screening for clinical depression documented as positive, and a follow-up plan not documented, and the facility possess documentation stating the patient is not eligible c) Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given d) Screening for clinical depression is documented as negative, and a follow-up plan is not required e) Screening for clinical depression not documented, but the facility possesses documentation stating the patient is not eligible f) Clinical depression screening not documented, and no reason is given

Proposed PY 2018 Reporting Measure

NHSN Healthcare Personnel Influenza Vaccination

NHSN Healthcare Personnel Influenza Vaccination Reporting	
Measure Description	Facility submits Healthcare Personnel Influenza Vaccination Summary Report to CDC's NHSN system, according to the specifications of the Healthcare Personnel Safety Component Protocol, by May 15, 2016 Based on NQF #0431
Exclusions	1. Facilities with a CCN open date after January 1, 2016
Data Sources	1. NHSN 2. REMIS, CROWNWeb, and other CMS ESRD administrative data (form 2744 to obtain facility type and certification date)
Additional Information	1. A "qualifying healthcare personnel" is defined as an employee, licensed independent practitioner, or adult student/trainee/volunteer who works in a facility for at least one day between October 1, 2015 and March 31, 2016 (designated as the "flu season") 2. NHSN Summary Reports submitted by May 15, 2016 would document actions taken during the flu season that spans October 2015 to April 2016, and would count toward facilities' PY 2018 NHSN Healthcare Personnel Influenza Vaccination reporting measure scores 3. Additional information about the Protocol and Summary Report can be found at: http://www.cdc.gov/nhsn/PDFs/HPS-manual/vaccination/HPS-flu-vaccine-protocol.pdf.