

**Summary of Oregon Hospital Initiatives
Related to Introduction of HAI/HAC Reduction Practices, May 2011**

Project Title	Description of Project	Lead Agencies/ Contact	Timeline/ Participation
(1) American Professionals in Infection Control (APIC), Oregon SW Washington Chapter	APIC provides training and mentoring of infection control professionals. The local APIC chapter provides a web site with infection prevention tools, hosts monthly 2.5-hour meeting. The standing agenda includes an invited speaker-led training related to infection control, NHSN training issues, and brainteaser infection cases (to promote reporting consistency). It also has an active listserv with postings regarding infection control practices.	2011 APIC President, Molly Hale, OHSU 2010 APIC President, Janet Sullivan, PeaceHealth http://www.oswapic.org/ Note: access to Chapter web site requires login and password.	Ongoing Membership is unknown, but it is believed to include most hospitals and ambulatory surgical centers.
(2) APIC and Oregon Hospital and Health System Association (OAHHS) Partnership for NHSN Training	APIC and OAHHS have a partnership that has launched and sustained NHSN training in Oregon. NHSN training began in the fall of 2008. It has included face-to-face conferences and webinars, including refresher webinars.	APIC Members and OAHHS/Diane Waldo 2010 training materials archived on OAHHS web site for members.	Ongoing Includes most hospitals; 2010 training invited representatives from ambulatory surgical centers.
(3) Hand Hygiene Project	The program provides strategies for both patients and caregivers to increase hand hygiene compliance. Product use and secret shopper methods are used to collect and validate hand hygiene rates.	OAHHS/Diane Waldo http://www.oahhs.org/quality/initiatives/hand-hygiene-project.html	2007-ongoing 15 hospitals currently participating; up to 18 hospitals have participated.
(4) Methicillin-resistant Staphylococcus aureus (MRSA) Collaborative	Used the National Healthcare Safety Network (NHSN) to report MRSA rates using lab-identified and event-identified MRSA. Featured monthly conference calls regarding MRSA reduction/infection control strategies and guest speakers on a variety of topics, including antibiotic stewardship.	Acumentra Health, Kathy Phipps http://www.acumentra.org/provider/initiatives/mrsa.php	3 year contract, ending July 2011. 5 hospitals participating
(5) Multi-drug resistant	An eight-chapter toolkit that addresses topics ranging from	OAHHS/Diane Waldo	Fall of 2009 introduction.

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organism (MDRO) Toolkit	risk assessment, antibiotic stewardship, to active surveillance. OAHHS held two conference calls for its members to introduce items in the kit. Many of the concepts were used in foundational package for the Oregon HAI Collaborative	http://www.oahhs.org/quality/initiatives/file-library/mdro-member-toolkit.pdf	Toolkit mailed to all OAHHS members. Toolkit available on OAHHS web site.
(6) Oregon Healthcare Acquired Infection Collaborative	Program is addressing three HAI targets: CLABSI, SSIs, and Clostridium difficile. It includes regular conference calls, training webinars, site visits, face-to-face and virtual learning sessions. It includes STOP BSI methodology in its program, and process and outcome data are collected from a variety of sources, including NSHN. Performance data is feedback to participants monthly.	Oregon Patient Safety Commission/Melissa Parkerton http://www.oregon.gov/OPSC/index.shtml	2010-2011 9 hospitals participating
(7) Oregon National Surgical Improvement Program (NSQIP)	The Oregon NSQIP group is working on glycemic control to reduce surgical complications. Although it may not be directly related to infection prevention, future initiatives may be more closely aligned.	The American College of Surgeons (ASC) leads the national group; Oregon Patient Safety Commission leads the Oregon NSQIP group/Leslie Ray http://www.acsnsqip.org/	Ongoing 8 hospitals participating.
(8) Oregon Patient Safety Commission (OPSC) Adverse Event Reporting Program	One element of the OPSC's reporting program is to collect data on "serious" healthcare-acquired infections. If these are identified, facilities are to perform a root cause analysis.	Oregon Patient Safety Commission/Leslie Ray	Ongoing 54 hospitals
(9) Oregon Public Health Division CLABSI Validation	Public Health is conducting a CLABSI validation study of data entered into NHSN. Feedback is provided directly to facilities. Public Health is	Oregon Public Health Division/Zintars Beldavs and Margaret Cunningham	44 hospitals participating in CLABSI validation study

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Study and HAI Research Programs	conducting a number of research studies, including healthcare associated and community associated Clostridium difficile.	http://www.oregon.gov/DHS/ph/acd/index.shtml	
(10) Surgical Care Improvement Project (SCIP) and heart failure project	Acumentra is leading an effort to improve SCIP rates. The program includes monthly calls, webinars, and guest speakers. (Note: During the development of this effort, Acumentra learned that hospitals did not want face-to-face meetings.) Currently, the program is issuing quality awards to strong performers.	Acumentra Health, Ruth Medak http://www.acumentra.org/provider/initiatives/hospital.php	3 year contract, ending July 2011. 11 hospitals participating
(11) STOP BSI Comprehensive Unit-based Safety Program (CUSP) and Bloodstream Infections (BSI)	Funded by Agency for Healthcare Research and Quality (AHRQ), OAHHS leads a national program to reduce catheter associated bloodstream infections. The program consists of a culture change element [the Comprehensive Unit-based Safety Program (CUSP)] and evidence-based activities to reduce CLABSIs. The Oregon HAI Collaborative uses STOP BSI methodology for its CLABSI target and some hospitals are dually enrolled in the Oregon HAI Collaborative and the STOP BSI collaborative.	OAHHS/Diane Waldo http://www.oahhs.org/quality/initiatives/preventing-blood-stream.html	2009 – ongoing 8 hospitals participating
(12) World Health Organization (WHO) Safe Surgery Checklist	Initiative to implement the WHO Safe Surgical Checklist in all Oregon Hospitals. The checklist has surgical team members verify aloud key elements of the surgery and that they are performing the right procedure on the right part of the right patient.	Oregon Institute for Healthcare Improvement Network/Leslie Ray, Kathy Phipps, Diane Waldo http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html	2009- ongoing 54 Oregon hospitals are using checklist; 2 more working to implement

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(13) Legislative Workgroup on Healthcare Worker Influenza Vaccinations	The focus of the workgroup is to promote and educate providers on the safety and efficacy of healthcare worker influenza vaccination. It is also creating a web site honor roll to highlight providers with strong vaccination rates.	Oregon Public Health Immunization Program, Collette Young Oregon Public Health Division, Ann Thomas http://www.flu.oregon.gov/Pages/index.aspx	Educational outreach is performed for all Oregon hospitals and long-term care facilities
(14) Health System and Hospital Initiatives	Hospitals have developed their own infection prevention programs. Many hospitals report participation in other HAI reduction initiatives; some are sponsored by their Health System and others are national programs that they join. A complete list of Oregon Health System initiatives related to HAI reduction could not be prepared for this report.	Not applicable	Not applicable
(15) Hospital Quality Network	Consists of three collaboratives with targets to improve language services, increasing throughput, and reducing readmissions.	Oregon Health Care Quality Corp, Mylie Christensen and Diane Waldo, Oregon Association of Hospitals and Health Systems http://q-corp.org/programs/hospital-collaboratives/hospital-quality-network	15 hospitals participating; initiated November 2010; funding through 2012
(16) Oregon Transitional Care Collaborative	Oregon Transitional Care Collaborative addresses care transitions in the state	Oregon Health Care Quality Corp, Mylie Christensen and Diane Waldo, Oregon Association of Hospitals and Health Systems http://q-corp.org/programs/hospital-collaboratives/otcc	Six counties are participating; ongoing.
(17) Releasing Time to Care and Care	Releasing Time to Care is a program developed by the National Health System in the	Care Oregon, http://www.careoregon.org/TransformingHealth	4 hospitals in Releasing Time to Care;

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Support and System Innovation	UK with the goal of increasing patient safety by increasing time for bedside care. Care Support and System Innovation (CSSI) is a 6-year program that supports project teams; this tool has been used to address HAI in hospitals.	hcare/Providers/CSSI.aspx	
(18) Acumentra 10 th Scope of Work	The Oregon QIO is currently planning its next scope of work; OHPR is providing data to Acumentra to support its program development to address CLABSI, SSIs, CAUTI, and CDI in the state.	Acumentra Health, Stacy Mortiz http://www.acumentra.org/	This Medicare contract is focused on the 31 PPS hospitals in the state; it will also include LTCF and may include critical access hospitals. Next scope of work to be initiated in July 2011.
(19) Transforming Care at Bedside (TCAB)	This collaborative is currently focusing on reducing pressure ulcers and falls.	OAHHS/Diane Waldo Oregon Patient Safety Commission/Melissa Parkerton http://www.oahhs.org/quality/initiatives/transforming-care-at-the.html	9 hospitals are participating (14 teams; more than 1 team per hospital). To be initiated June 2011.
(20) Oregon Partnership for Patient Safety	A group of Oregon organizations is meeting to determine how they can work together to meet the national Partnership for Patients goals of reducing readmissions and reducing adverse events.	OAHHS/Diane Waldo has convened this group.	Currently, five organizations are included in this group: the hospital association, QIO, OHPR, Oregon Patient Safety, and Oregon Quality Corporation. The first meeting is May 27, 2011.