ID		Task Name	Duration	Start	Finish	Resource Names
1		**Administrative Rules**	**190 days?**	**Tue 10/9/07**	**Mon 6/30/08**	
2	✓	Prioritization of facility type	1 day?	Tue 10/9/07	Tue 10/9/07	
3		**Hospitals**	**111 days?**	**Tue 10/9/07**	**Tue 3/11/08**	
4		**Outcome measures**	**66 days**	**Tue 12/11/07**	**Tue 3/11/08**	**TWG**
5		**NHSN collection methodology**	**66 days**	**Tue 12/11/07**	**Tue 3/11/08**	**TWG**
6	✓	CABG (both incisions & chest incision only)	21 days	Tue 12/11/07	Tue 1/8/08	TWG
7		**Central line related bloodstream infections**	**45 days**	**Wed 1/9/08**	**Tue 3/11/08**	**TWG**
8		Location for collection	45 days	Wed 1/9/08	Tue 3/11/08	TWG
9		Additional SSI procedures	4 days	Thu 2/7/08	Tue 2/12/08	TWG
10		**Process measures**	**66 days?**	**Tue 10/9/07**	**Tue 1/8/08**	**TWG**
11		Collection Methods	1 day?	Tue 10/9/07	Tue 10/9/07	TWG
12		Process measures	1 mon	Wed 12/12/07	Tue 1/8/08	TWG
13		**Ambulatory Surgery Centers**	**66 days?**	**Tue 2/12/08**	**Tue 5/13/08**	**TWG**
14		**Outcome measures**	**66 days?**	**Tue 2/12/08**	**Tue 5/13/08**	**TWG**
15		Collection methodology	66 days?	Tue 2/12/08	Tue 5/13/08	TWG
16		Surgeries to include	66 days?	Tue 2/12/08	Tue 5/13/08	TWG
17		**Process measures**	**66 days?**	**Tue 2/12/08**	**Tue 5/13/08**	**TWG**
18		Collection Methods	66 days?	Tue 2/12/08	Tue 5/13/08	TWG
19		Process measures	66 days?	Tue 2/12/08	Tue 5/13/08	TWG
20		**Outpatient Dialysis Centers**	**60 days**	**Tue 2/12/08**	**Mon 5/5/08**	**TWG**
21		**NHSN collection methodology**	**60 days**	**Tue 2/12/08**	**Mon 5/5/08**	**TWG**
22		Outcome measures	3 mons	Tue 2/12/08	Mon 5/5/08	TWG
23		Process measures	3 mons	Tue 2/12/08	Mon 5/5/08	TWG
24		Rules public meetings	1 mon	Tue 5/6/08	Mon 6/2/08	
25		Submit final rules to AG	20 days	Tue 6/3/08	Mon 6/30/08	
26		**Reporting**	**144 days?**	**Tue 2/12/08**	**Fri 8/29/08**	
27		Comparison methods	93.5 days?	Tue 4/22/08	Fri 8/29/08	RWG,TWG
28		Thresholds for reporting	144 days?	Tue 2/12/08	Fri 8/29/08	RWG,TWG
29		Annual report requirements	144 days?	Tue 2/12/08	Fri 8/29/08	RWG,TWG
30		**Implement reporting program**	**120 days**	**Wed 7/2/08**	**Tue 12/16/08**	
31		Training facilities	6 mons	Wed 7/2/08	Tue 12/16/08	TWG
32		Build/test/beta test reporting	3 mons	Wed 7/2/08	Tue 9/23/08	

Project: HCAIAC timeline 07 to 10
Date: Mon 2/11/08

Task		Milestone		External Tasks	
Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

ID		Task Name	Duration	Start	Finish	Resource Names
33		Facilities begin reporting	1 day	Thu 1/1/09	Thu 1/1/09	
34		Finalize reporting system	66 days	Wed 10/1/08	Wed 12/31/08	
35		**Public reporting (Year 1)**	**506 days?**	**Fri 1/2/09**	**Fri 12/10/10**	**RWG,TWG**
36		**Annual report**	**266 days?**	**Fri 1/2/09**	**Fri 1/8/10**	**RWG,TWG**
37		Format	266 days?	Fri 1/2/09	Fri 1/8/10	RWG
38		Audience	1 day?	Fri 1/2/09	Fri 1/2/09	RWG
39		Benchmarking/Comparisons	1 day?	Fri 1/2/09	Fri 1/2/09	TWG,RWG
40		Update reporting #1	6 mons	Mon 1/11/10	Fri 6/25/10	RWG,TWG
41		Update reporting #2	6 mons	Mon 6/28/10	Fri 12/10/10	RWG,TWG
42		**Public reporting (Year 2)**	**240 days?**	**Mon 12/13/10**	**Fri 11/11/11**	
43		Annual report	1 day?	Fri 4/29/11	Fri 4/29/11	RWG,TWG
44		Update #1	3 mons	Mon 12/13/10	Fri 3/4/11	RWG,TWG
45		Update #2	3 mons	Mon 3/7/11	Fri 5/27/11	RWG,TWG
46		Update #3	3 mons	Mon 5/30/11	Fri 8/19/11	RWG,TWG
47		Update #4	3 mons	Mon 8/22/11	Fri 11/11/11	RWG,TWG

Project: HCAIAC timeline 07 to 10
Date: Mon 2/11/08

Task		Milestone		External Tasks	
Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

Guiding principles for the
Oregon Health Care Acquired Infections Program Reporting

1. Focus should be for lay audience
    - "Technical first" approach is insufficient for developing an effective tool for the public.
    - Content development is just as important as the "data" to clearly lead the reader to understand the data and the context

2. Detailed data should be readily available for "high end" users

3. Web-based interactive report
    - Allow public to more easily get information desired and create user experience
    - Need to have printable documents as well

4. Comparisons
    - Clear comparisons should be made in order to provide context to the information presented between facilities
    - Suggestions include
        - By Geography
        - By "peer" grouping
        - National benchmarks
        - State benchmark
        - Top 5 performers
        - Percentiles

5. There should be a feedback mechanism for facilities for process improvement

6. Verification of data essential
    - Facilities should have multiple ways to verify the data prior to public release

7. Facilities should be able to provide feedback to be posted with the data

Surgical Site Infection Recommendations

Recommendation from Staff

- Goal of surgery site recommendations
  - Select procedure(s) that will be begin surgery site infection reporting in as many hospital as possible
  - Select procedure that potentially has high value to the public
  - Select procedures that potentially have buy-in from hospital staff
  - Select procedures demonstrated to have high infection rates

- Information used for selection of procedures for SSI
  - National Infections System Rates for SSI
  - 2006 Oregon inpatient discharge data
  - Input from other states programs
  - Input from Technical advisory group to staff

Procedure	Volume (overall rank)*	NIS infection rate (RC 2,3)**	Hospitals impacted with 1 or more procedures*	Potential "0.0" rate** (all risk categories)	Recommendation from staff	Rationale from Staff
Approved by Committee						
CABG (coronary artery bypass) both chest & donor incision	2973 (#15)	5.43	11 (19%)	NO	**Recommended for 2009**	**(December 2007 meeting) Approved by Committee**
CABG (coronary artery bypass) only chest incision	2525 (#17)	3.72	11 (19%)	YES	**Recommended for 2009**	**(December 2007 meeting) Approved by Committee**
Under Consideration						
Colon surgery	5791 (#11)	8.54, 11.25	52 (91%)	NO	**Recommended for 2009 or 2010**	**Pros**: High infection rate, Large hospital involvement, Consensus from TAG **Cons**: Contamination concerns, Potential to not reach "0.0", No other states reporting
Abdominal Hysterectomy	1825 (#21)	5.17	47 (83%)	YES	**Recommended for 2009 or 2010**	**Pros:** High infection rate, Large hospital involvement, Other state recommendations (VT, SC, MO) **Cons**: Technical difficulties for implementation
Knee replacement	6614(#3)	2.26	49 (86%)	YES	**Recommended for 2010**	**Pros**: Large hospital involvement, high consumer/provider interest, Interest from TAG, Other states implementing 2nd year **Cons**: 1 year follow-up protocol
Hip replacement	5645 (#6)	2.52	49 (86%)	YES	**Recommended for 2010**	**Pros**: Large hospital involvement, high consumer/provider interest, Other states implementing 2nd year, MO year 1 **Cons**: 1 year follow-up protocol
Not being considered						
Cesarean Section	13666 (#1)	7.53	52 (91%)	NO	**No recommendation**	**Pros:** High infection rate, Large hospital involvement, Impacts highest volume procedure in State **Cons**: Implementation burden, Volume burden

*Source: 2006 Oregon inpatient hospital discharge data, OHPR **Source: National Nosocomial Infections Surveillance (NNIS) System Report, data summary from January 1992 through June 2004, issued October 2004; American Journal of Infection Control 2004;32:470-85.

DRAFT

Central Line Blood Stream Infection

Rationale and Recommendation from Staff

- Infection inclusion
  - Impact
    - CDC estimates 200,000 per year
    - Increased mortality (~14,000-28,000 deaths) [1]
    - Increased cost (~ additional $3,700-29,000)[1]
    - Process changes can lead to quality improvement[1]
  - Recommended for reporting
    - National organizations
      - AHRQ (with support from AARP, Consumer's Union, SEIU, NAHDO and 17 others)
      - APIC (Association for Professionals in Infection Control and Epidemiology)
      - CDC
      - CMS
    - 63% of states require as part of reporting
  - Collection methods
    - Readily available collection and risk adjustment methodology through National Healthcare Safety Network (CDC)
    - Over 50% of state use NHSN as collection method
    - Ability for adjustment of collection schedule
      - NHSN only requires 1 month per location of data
    - Training and support provided by NHSN staff
    - Requires minimal technology changes from the facility (i.e., internet connection)

Staff Recommendation to Committee

- Central line blood stream infection should be implemented in year 1 of the reporting program for hospitals
- NHSN is the most appropriate, scientifically valid method to collect CLABSI data

[1] Institute for Healthcare Improvement, Getting Started Kit: Prevent Central Line Infections, 2007.

- Collection Location/unit of hospital (defined by NHSN)
    - Recommends targeted unit collection
        - ICU
        - Specialty care units (i.e. hematology, oncology, transplant wards)
        - NICU
        - Inpatient locations (general medical/surgical wards)

Rank of units by CL days (NHSN)	Rank of CLABSI rate (NHSN)	By inclusion of Oregon hospitals with type of unit (AHA survey, 2005)
Medical/Surgical ICU (~326,000)	Burn ICU (6.8/1,000 CL days)	Medical/Surgical wards (57)
Medical ICU (~170,000)	Peds Medical/Surgical ICU (5.3/1,000 CL days)	Medical/Surgical ICU (47)
Surgical ICU (~137,000)	Trauma ICU (4.6/1,000 CL days)	NICU (8)
Peds Medical/Surgical ICU (~48,000)	Neurosurgical ICU (3.5/1,000 CL days)	Peds Medical/Surgical ICU (3)

Staff Recommendation to Committee

- Collection in Medical/Surgical ICU (most CL days, most inclusive of hospitals)
- Collection in Peds Medical/Surgical & NICU (high rate location)
- For hospitals not included
    - Committee develop a collection format using IHI guidelines for CLABSI bundle process measures to be submitted on identical schedule
- Committee outline collection outside of designated ICUs

Catheter Associated Urinary Tract Infection

Rationale and Recommendation from Staff

- Infection inclusion
  - Impact
    - CDC estimates 400,000 per year[1]
    - Most common HAI (over 30%)[1]
    - Not significant cause of mortality even in seriously ill patients[2]
    - Process changes can lead to quality improvement
  - Recommended for reporting
    - National organizations
      - CDC
      - CMS
      - Leapfrog (process measures)
    - 20% of states require as part of reporting (only 1 reports UTI outcomes to date)
  - Collection methods
    - Readily available collection and risk adjustment methodology through National Healthcare Safety Network (CDC)
    - Over 50% of state use NHSN as collection method
    - Ability for adjustment of collection schedule
      - NHSN only requires 1 month per location of data
    - Training and support provided by NHSN staff
    - Requires minimal technology changes from the facility (i.e., internet connection)

Staff Recommendation to Committee

- Although highest percentage of overall HAI, only one current state reports this measure. Collection of denominator data can be troublesome and facilities may need more time to prepare systems for this data collection. In light of other measures approved, CAUTI should not be addressed after year 1 of reporting.
- When appropriate, NHSN is the most appropriate, scientifically valid method to collect CAUTI data

[1] Klevens, Edwards, Richards, et al. *Pub Health Rep* 2007;122:160-6

[2] Laupland et al. ***Critical Care*** February 2005; 9(2):R60-65

- Collection Location/unit of hospital (defined by NHSN)
    - Recommends targeted unit collection
        - ICU
        - Specialty care units (i.e. hematology, oncology, transplant wards)
        - NICU
        - Inpatient locations (general medical/surgical wards)

Rank of units by UC days (NHSN)	Rank of CLABSI rate (NHSN)	By inclusion of Oregon hospitals with type of unit (AHA survey, 2005)
Medical/Surgical ICU (~360,000)	Burn ICU (7.5/1,000 UCD)	Medical/Surgical wards (57)
Medical ICU (~150,000)	Inpatient Medical Ward (7.1/1,000 UCD)	Medical/Surgical ICU (47)
Surgical ICU (~125,000)	Neurosurgical ICU (6.5/1,000 UCD)	NICU (8)
Surgical cardiothoracic ICU (~70,000)	Trauma ICU (5.5/1,000 UCD)	Peds Medical/Surgical ICU (3)

Staff Recommendation to Committee

- When appropriate:
    - CAUTI should be initially implemented in medical ICU
    - After initial medical ICU reporting, full medical ward reporting should be implemented due to high rate.