Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

June 19, 2019
1:00 - 3:00 pm

PSOB – Room 1B
800 NE Oregon St.
Portland, OR 97232

Agenda, materials, minutes, recordings, and transcriptions for meetings are available at: http://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/HAI/Prevention/Pages/Meetings.aspx.

MEMBERS PRESENT:

- Joshua Bardfield, Supply Chain Services Manager, The Oregon Clinic, P.C. (phone)
- Genevieve Buser, MD, Pediatric Infectious Disease Physician, Providence St. Vincent Medical Center
- Paul Cieslak, MD, Medical Director, Oregon Public Health Division, Oregon Health Authority
- Pamela Cortez, MBA, BSN, RN, CNE, BC, Director of Patient Safety and Clinical Support, Salem Health (phone)
- Dennis Drapiza, MPH, BSN, RN, CIC, Regional Director - Northwest Infection Prevention and Control, Kaiser Permanente Northwest
- Jon Furuno, PhD, Associate Professor, Department of Pharmacy Practice, Oregon State University/College of Pharmacy, Oregon Health and Science University
- Vicki Nordby, RN, BSN, Nurse Consultant, Marquis Companies, Inc

- Kirsten Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante (phone)

MEMBERS EXCUSED:

- Deborah Cateora, BSN, RN, Healthcare EDU/Training Coordinator and RN Consultant, Safety, Oversight and Quality Unit (SOQ Unit), Oregon Department of Human Services
- Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center
- Wendy L. Edwards, RN, BSN, Patient Safety Surveyor, Health Facility Licensing and Certification, Oregon Public Health Division, Oregon Health Authority
- Jordan Ferris, BSN, RN, CMSRN, Nursing Practice Consultant, Oregon Nurses Association
- Lisa Freeman, Executive Director, Connecticut Center for Patient Safety
- Laurie Polneau, RN, MHA, CPHRM, Director, Quality/Risk Management/Infection Control, Vibra Specialty Hospital Portland
- Pat Preston, MS, Executive Director, Center for Geriatric Infection Control

OTHER PARTICIPANTS PRESENT:

- Jackson Baures, Public Health Division Manager, Jackson County (phone)
- Joyce Caramella, RN, CPHQ, CHC, Project Manager, HealthInsight Oregon
- Kari Coe, RN, BSN, IP Nurse, Communicable Disease Program, Deschutes County Health Services (phone)
- Sydney Edlund, MS, Director of Analytics and Research, Oregon Patient Safety Commission (phone)
- Mesa Greenfield, BSN, RN, CWOCN, Infection Prevention/Employee Health Nurse, Lake District Hospital (phone)

- Ryan Grimm, Director of Surgical Services, Ambulatory Surgery Centers, The Portland Clinic (phone)
- Stacey Karvoski, RN, BSN, Infection Control/Employee Health/Outpatient Therapy Manager, Wallowa Memorial Hospital (phone)
- Jesse Kennedy, RN, Nurse Practice Consultant, Oregon Nurses Association (phone)
- Karen Keuneke, RN, MSN, Supervisor of Infection Prevention, Good Samaritan Regional Medical Center (phone)
- Chitra Kanchagar, pharmacy student, OSU/OHSU
- Gretchen Koch, MSN, RN, Policy Analyst, Nursing Practice and Evaluation, Oregon State Board of Nursing (phone)
- Julie Koch, RN, MSN, BSN, CIC, Manager Infection Prevention, Salem Health Hospitals and Clinics
- L Dianne Long, Med/Surg Supervisor, St. Alphonsus Baker City (phone)
- Lauren Ogden, MPH, CIC, Infection Preventionist, Oregon Health and Science University
- Mary Post, RN, MS, CNS, CIC, Infection Prevention/Employee Health Coordinator, Shriners Hospitals for Children – Portland (phone)
- Kristine B. Rabii, MSc., Infection Preventionist, Tuality Healthcare (phone)
- Jessica Symank, RN, MPH, Senior Director, Patient Safety and Quality Partnerships, Washington State Hospital Association

OHA STAFF PRESENT:

- Zintars Beldavs, MS, ACDP Section Manager
- Alyssa McClean, AWARE Coordinator
- Valerie Ocampo, RN, MIPH, HAI Public Health Nurse
- Diane Roy, HAI Data and Logistics Coordinator
- Monika Samper, RN, Flu Vax Coordinator and Clinical Reviewer

- Lisa Takeuchi, MPH, HAI/AR Monitoring & Prevention Epidemiolgist
- Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist
- Dat Tran, MD, HAI Outbreak Response Physician/Interim HAI & EIP Program Manager
- Alexia Zhang, MPH, HAI EIP Epidemiologist

ISSUES HEARD:

- Call to order and roll call
- Logistics update
- Approve March 2019 minutes
- Oregon Health Authority (OHA) National Healthcare Safety Network (NHSN) reporting requirements
- 2018 OHA NHSN reporting
- Injection practices and needle use in Jackson County
- Discussion: topics for future meetings and reports
- Public comment
- Adjourn

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Item	Discussion	Action Item
Call to Order and Roll Call Genevieve Buser, Providence St. Vincent (Chair)	8 members (53 percent) and 17 participants present.	No action items

Logistics Update Roza Tammer, Oregon Health Authority	HAIAC membership updates: • Labor Representative position open; Jordan Ferris, Oregon Nursing Association, transitioning from role. • Health Insurer Representative position still vacant.	No action items
Approve March 2019 Minutes All Committee Members	March 2019 meeting minutes were approved by 53 percent of members.	No action items

OHA NHSN Reporting Requirements
 	
Roza Tammer, Oregon Health Authority
 	
(See pages 19-28 of meeting materials)
	➢ OHA mandates hospitals report HAI outcome measures listed below to NHSN as specified in Oregon Administrative Rules (OARs):
	• Central line-associated bloodstream infections (CLABSIs)
	• Catheter-associated urinary tract infections (CAUTIs)
	• Laboratory-identified methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections (BSIs)
	• Laboratory-identified *Clostridium difficile* infections (CDI)
	• Surgical site infections (SSIs) resulting from following procedures:
	  ○ Coronary artery bypass graft (CBGB)
	  ○ Knee prosthesis (KPRO)
	  ○ Colon surgery (COLO)
	  ○ Hip prosthesis (HPRO)
	  ○ Abdominal hysterectomy (HYST)
	  ○ Laminectomy (LAM)
		Send questions and comments regarding reporting requirements to Roza Tammer.

	➢ Standardized infection ratios (SIRs) calculated using 2015 baseline data reveal Oregon hospitals need to improve on five metrics (SIR greater than one): • CLABSIs in critical access hospitals (CAHs) • MRSA BSIs in CAHs • KPRO SSIs • HPRO SSIs • HYST SSIs ➢ National 2017 acute care hospital (ACH) SSI data show infections are higher than predicted for a many adult and/or pediatric procedures including: craniotomy, cesarean section, open reduction of fracture, and kidney transplant. ➢ HAIAC members/participants proposed changes to current reporting requirements. • Hospitals: ○ Remove laminectomy ○ Add Non-Ventilator-Associated Pneumonia (PNEU) ○ Add Antibiotic Use/Antibiotic Resistance • Add SSI reporting for ambulatory surgery centers: ○ Hernia ○ Breast ○ Cholecystectomy ○ Cataract and other eye procedures ○ Joint procedures (e.g., hip, knee) ○ Laminectomy	

	<u>Question</u> ➢ Paul Cieslak: What is the baseline for SIR? Roza Tammer: Baseline is 2015 national HAI data. SIR is observed number of infections divided by predicted number of infections. Predicted infections are estimated based on risk-adjusted national baseline data for each HAI metric and facility type. <u>Question</u> ➢ Roza Tammer: Comments on proposed changes to mandated reporting or additional ideas? Monika Samper: ASCs should report SSIs because of high volume and increasing complexity of cases. Julie Koch: Laminectomies mostly performed in outpatient setting. Risk is mainly when spinal fusion is done with laminectomy so recommend only reporting fusions. Paul Cieslak: SIR is a relative rate so does not indicate absolute rate. Less impressed by an SIR that increased since 2015 than a rise in absolute rate of an infection. Favor eliminating laminectomies without fusion. Believe infection rates from breast and routine hernia surgeries are low. Should focus on surgeries with more infections and greater mobidity such as open reduction internal fixation of fracture (ORIF) regardless of whether inpatient or outpatient setting. Kristen Schutte: Agree, need to target procedures with high morbidity and poor outcomes, including fusions in ASCs as well as inpatient settings. Tracking ORIF would be	

	interesting, but situations that put patients at risk are complicated. If ORIF used to treat open fracture, might be difficult to determine amount of risk reducible through proper antibiotic use or better infection prevention practices. <u>Question</u> ➢ Roza Tammer: Are proposed procedures high-volume and high-risk in ASCs? Dennis Drapiza: Our ASCs perform surgeries previously done in inpatient settings: laminectomy, breast, and hernia procedures. Also, do high volume of cataract surgeries. ASCs recommended starting with reporting a few SSIs rather than all seven at once. Genevieve Buser: Perhaps begin with highest morbidity or frequency like joint procedures previously done in inpatient locations. Julie Koch: Some of our ASCs will be providing two-night stays. Already considering moving inpatient joint procedures to these ASCs. Joint procedures are my highest level of concern based on inpatient outcomes. Dennis Drapiza: Would be helpful to know type and number of procedures being done in ASCs, how we're doing, and ways to improve outcomes. <u>Question</u> ➢ Genevieve Buser: Do hospital outpatient units currently fall under NHSN inpatient reporting?	

	Julie Koch: Outpatient units are not required to report data. Genevieve Buser: So ambulatory surgery center reporting would not encompass outpatient hospital settings? Roza Tammer: Would only include procedures done in licensed ASCs, regardless of duration of stay. Hospitals only required to report HAIs for inpatient procedures. Inpatient defined as patient is admitted and discharged on different calendar days. <u>Comment</u> ➢ Roza Tammer: Reporting requirements could be expanded to include outpatient hospital procedures. Julie Koch: Need to restrict reporting to essential HAIs because IP resources limited. Ryan Grimm: To understand outpatient procedure infection rates, need to look at hospital outpatient departments as well as outpatient industry. However, staffing is a big issue so need to effectively analyze and tailor reporting requirements. Proposed reporting not highly burdensome, but we’re bigger than most independent ASCs. On board with reporting proposals, but not all procedures at once. <u>Question</u> ➢ Genevieve Buser: Any procedures you are concerned about due to frequency or morbidity? Ryan Grimm: Infection rates low at our multi-specialty surgery centers. Perform large number of cataract surgeries.	

	Only remember one hernia and no breast procedure infections. Ortho surgeries might have more infections but possibly volume dependent. Paul Cieslak: Most interested in ASCs reporting joint procedures due to incidence of infection. <u>Question</u> ➢ Dat Tran: Any significant differences in type and frequency of procedures performed in ASCs versus hospital outpatient units? Should know if we're going to mandate reporting for both facility types. Lauren Ogden: Would need to look at actual data. <u>Question</u> ➢ Julie Koch: What about antibiotic use? Lisa Takeuchi: 21 Oregon hospitals currently report antibiotic use (AU); fewer report antibiotic resistance (AR). Nationwide only Missouri and Tennessee have mandated select hospitals report AU data. Tennessee first requiring AU data from larger acute care hospitals, followed by smaller acute care hospitals, and eventually critical access hospitals. Challenge is purchase of expensive software or development of homegrown system to enable AU reporting. Lauren Ogden: We proposed AU reporting requirement to committee to help justify purchase of necessary software to hospital administration.	

	Dennis Drapiza: Agree, would like AU module to support our antimicrobial stewardship program. Roza Tammer: What about initially requiring hospitals with larger bed size to report AU data and then periodically expand mandate to smaller hospitals? Dennis Drapiza: Great idea. Kirsten Schutte: Agree with comments. However, need to improve how we benchmark and use this information. Complicated in terms of defining when antibiotic should be prescribed and which drug is appropriate. How would data be employed to improve outcomes and quality of care? <u>Question</u> ➢ Dat Tran: Do facilities have opinion about AU versus AR reporting? Julie Koch: Would suggest AU because AR much more complicated. State could help facilities with benchmarking. Dat Tran: Oregon Antimicrobial Stewardship Network (ORASN) collaborative tasked with developing benchmarks. All facilities reporting AU will have a voice in determining standards. Paul Cieslak: Perhaps best to delay implementation of AU reporting until committee has determined how data will be used.	

	Genevieve Buser: Recommend selecting well-defined area, such as sepsis, with nationally developed guidelines on appropriate antibiotic use.	
2018 OHA NHSN Reporting Lisa Takeuchi, Oregon Health Authority (See pages 29-45 of meeting materials)	<u>Review of HAI Data</u> ➢ CDC's 2017 report compares Oregon data to national data for acute care hospitals on six HAIs reportable to CMS. Report reveals: • Oregon SIR significantly higher than national SIR for CAUTI. • Difference between Oregon SIR and national SIR statistically insignificant for: ○ CLABSI ○ HYST SSI ○ COLO SSI ○ MRSA BSI ○ CDI ➢ Oregon's 2018 data show: • Acute care and critical access hospitals – Oregon's observed infections compared to predicted infections for all HAI categories either statistically insignificant or statistically lower. • Dialysis facilities – Oregon 2018 SIR significantly lower than national 2017 SIR for BSIs. <u>Considerations for 2018 HAI Report</u> ➢ Goal for annual report is to provide clear and concise information that allows:	

	• Patients to make healthcare choices • Healthcare facilities to improve patient safety ➢ Content of report: • Online report published annually contains executive summary, aggregate data, and facility-specific data. • Formal report published about every three to five years includes trend data. What topics should be included? ○ NHSN annual survey data such as facility characteristics or antimicrobial stewardship metrics? ○ Recommendations for providers and patients on how to minimize HAI risks like 2016 report? ○ Overview of how HAI Program uses data to inform and prioritize projects and activities? ○ Other topics? <u>Responses:</u> Dennis Drapiza: Recommendations are important, especially since report is meant for public. Zintars Beldavs: Can statistics be obtained on how public is using online report? Information would help OHA improve outreach. Jon Furuno: Important to know how report being utilized: some may view it to inform healthcare decisions while others interested in how data is used. However, utilization statistics will not capture missing data/topics sought by users; what information should be included is fairly intuitive. Also, need	

	to consider whether a topic should be incorporated in report or placed elsewhere on website. Genevieve Buser: Offering aggregate NHSN data from annual survey (perhaps separate from report) would be useful. Advantage of posting information online independent of report is that it can be updated in real time rather than when report produced. Zintars Beldavs: Maybe include HAI Program activities and HAI prevention efforts of hospitals and collaboratives. ➢ Should OHA censor data of facilities who perform relatively few procedures? • Concern about patient identification when numbers small? • Useful to present small numbers? • Data not censored in previous OHA reports or Center for Medicare and Medicaid Services' (CMS) Hospital Compare online reports. <u>Responses:</u> Julie Koch: Don't think it's an issue. Lauren Ogden: Problem if, for example, a hospital had 50 central line days and reported 10 CLABSIs. When I scanned data, did not find any issues. Lisa Takeuchi: Based on responses, will not censor data. ➢ How often should formal HAI report be produced?	

	<u>Responses:</u> Jon Furuno: Frequency should be based on indications such as marked changes in trend data, modifications to HAI definitions, new HAI categories, and addition of facility types. Lisa Takeuchi: So, will revisit question yearly. This year, OHA will generate formal report with trend data so reader can see how facilities doing. ➢ Provide printer-friendly PDF or web-based report? Latter would permit tracking report usage. <u>Responses:</u> Julie Koch: We utilize both. Use web-based at my desk but give chief officers paper copy in monthly public reporting meetings. Lauren Ogden: Online is fine. Receive many calls from public asking for general information. Could place links to OHA recommendations on hospital website.	
Injection Practices and Needle Use in Jackson County Roza Tammer, Oregon Health Authority	➢ OHA developed and implemented project to improve safety of injections and needle use in healthcare facilities using funds from CDC's One and Only Campaign. • Created survey to assess needle use and injection practices to inform educational activities. • Devised online toolkit for public and health professionals. ➢ Mailed or emailed surveys three times to Jackson County licensed providers, businesses, and facilities providing health-related services.	OHA asked attendees to review Injection and Needle Safety Toolkit and provide feedback.

(See pages 46-66 of meeting materials)	• 9% response rate • 272 surveys have sufficient data for analysis ➢ Analysis of surveys reveal diverse respondents, services, and practices. • Providers and services: ○ Business/facility types encompassed: 47.8% inpatient, 50% outpatient, and 2.2% acupuncture. ○ Common provider types included: CNA, RN, NP, MD, and LAc. ○ Common needle-based or injection services included: biopsy, dialysis, blood draw/phlebotomy, surgery, and acupuncture. • Injection and needle-based practices: ○ Injectable medications/treatments administered in 97% inpatient and 25% outpatient settings. ○ Medication vials “never” used on more than one patient in majority of inpatient and outpatient locations. ○ Safety syringes used by 76% inpatient and 46% outpatient facilities. ○ Needle-based treatment without injection provided in: 9% inpatient, 5% outpatient, and 50% acupuncture settings. • Medication practices: ○ Mix/reconstitute injectable medications less than one hour before administration: 47% inpatient, 34% outpatient, and 17% acupuncture.	

	○ Draw up injectable medications/treatments less than one hour before administration: 54% inpatient, 51% outpatient, and 17% acupuncture. • Education: ○ Most inpatient and outpatient settings provide education on needle use/injection practices once per year. ○ Majority of acupuncture clinics do not offer instruction. ○ Inpatient respondents more interested in educational topics listed in survey than outpatient respondents. ➢ Conclusions: • Outpatient settings less likely to adhere to best practices. • Facilities/businesses/providers need ongoing education. ➢ Next steps: • Perform additional analyses and publish final report. • Continue to review, update, and expand information and resources in online toolkit. • Continue to offer in-person and remote education/training. • Ask licensing boards to promote education to lend legitimacy and impetus to efforts.	

	<u>Question</u> ➢ Genevieve Buser: Will survey results be sent to respondents? Roza Tammer: Great idea.	
Discussion: Topics for Future Meetings and Reports All attendees	➢ Kirsten Schutte: • Presentation on how to screen for measles; statewide guidelines would be helpful. • Guidance from state on pandemics; unable to generate alerts within health system when cases reach U.S. ➢ Julie Koch: Review Pandemic and All Hazards Preparedness Act (PAHPA) and discuss how facilities managing recommendations.	No action items
Public Comment	No public comment	No action items
Adjourn		

Next meeting will be September 18, 2019, 1:00 pm - 3:00 pm, at Portland State Office Building, Room 1B

Submitted by: Diane Roy
Reviewed by: Roza Tammer

Oregon Healthcare Associated Infections Program Updates

Roza Tammer, MPH, CIC

HAI Advisory Committee Meeting

September 18, 2019

Oregon Health Authority

Goals

- Ensure our reporting requirements are addressing the priorities of Oregon's patients and infection control community
- Respond to feedback provided by HAI Advisory Committee, OSWAPIC, and other infection prevention partners and stakeholders

Review and vote

- Removal of post-laminectomy SSIs from reporting requirements

- Review impact statement
- Changes to definitions in OAR 333-018-0100:

(15) “Follow-up” means post-discharge surveillance intended to detect CGBG, COLO, HPRO, HYST, and KPRO~~KRPO, and LAM~~ surgical site infection (SSI) cases occurring after a procedure.

~~(26) “LAM” means laminectomy procedure as defined in the NHSN Manual.~~(need to renumber subsequent subparagraphs)

- Changes to OAR 333-018-0110(1)(b):

SSIs for inpatient CGBG, COLO, HPRO, HYST, and KPRO ~~and LAM~~ procedures.

Ongoing discussion: Other proposals

- Any support for this change?
  - Major challenges and opportunities posed by the change?
- If a change were to be made
  - What would the ideal proposal look like (e.g., which procedures, etc.)
  - Over what time period would we want to implement any new requirements?
  - What kinds of capacity building activities would be most useful for facilities?

Discussion: Add AU to hospital reporting

Tentative rollout:

Acute care hospitals with total beds >150	January 2022
Acute care hospitals with total beds 50-150	January 2023
All acute care hospitals	January 2023
Acute care hospitals with total beds <50 and critical access hospitals	January 2024

Discussion: Add select SSIs to hospital reporting

- Add currently reportable inpatient procedures to outpatient procedure hospital reporting requirement (COLO, HYST, KPRO, HPRO, ~~LAM~~)
- Add new procedures to hospital reporting requirement – inpatient and/or outpatient (FUSN, others)

Data trends in Oregon – CBGB, LAM, KPRO

Figure 9. Oregon SIRs for SSI following CBGB: 2009–2016

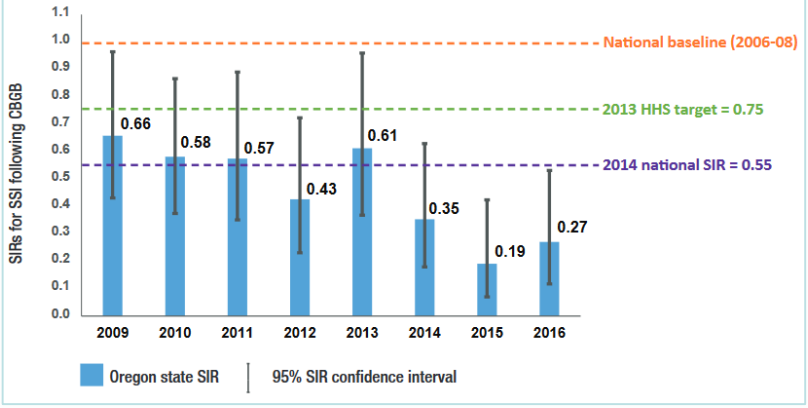


Figure 14. Oregon SIRs for SSI following KPRO: 2009–2016

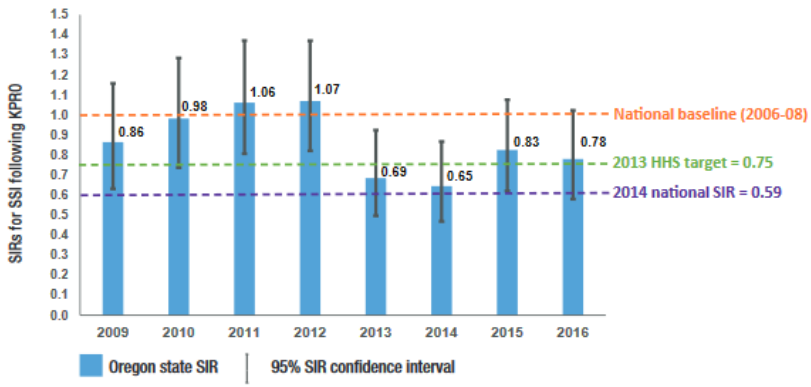
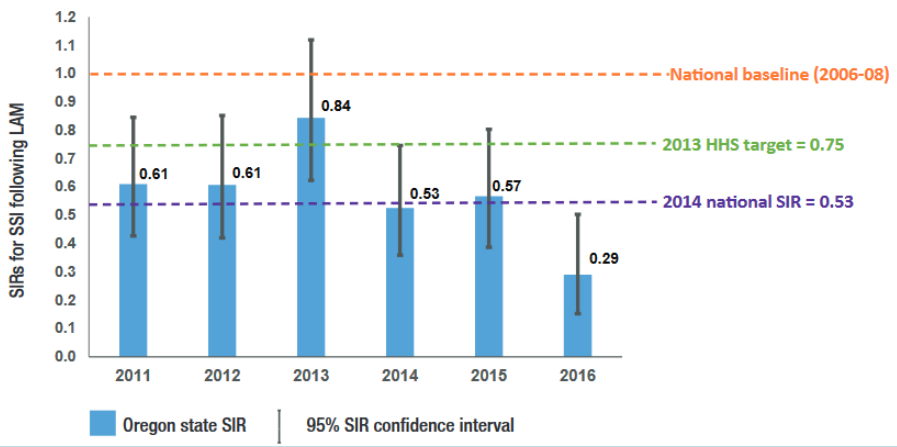


Figure 10. Oregon SIRs for SSI following LAM: 2011–2016



Oregon Health Authority

Data trends in Oregon – HYST, HPRO, COLO

Figure 11. Oregon SIRs for SSI following HYST: 2011–2016

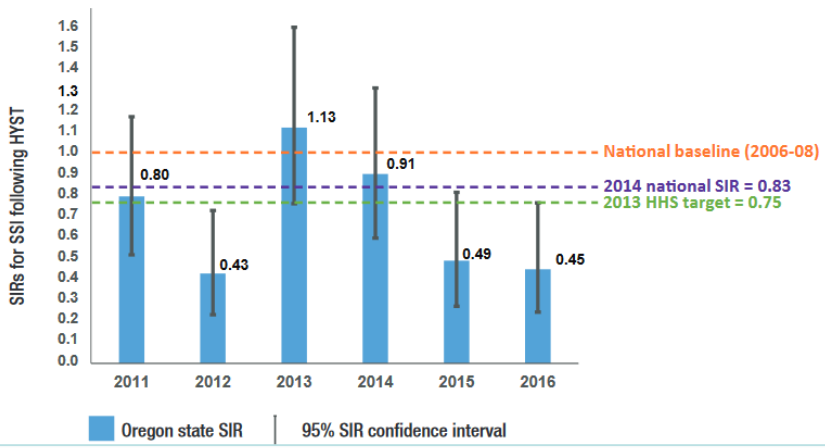


Figure 12. Oregon SIRs for SSI following COLO: 2011–2016

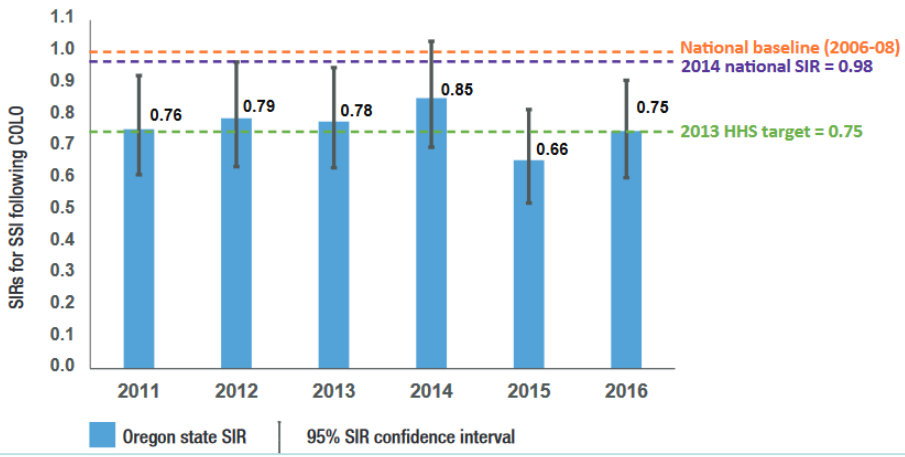
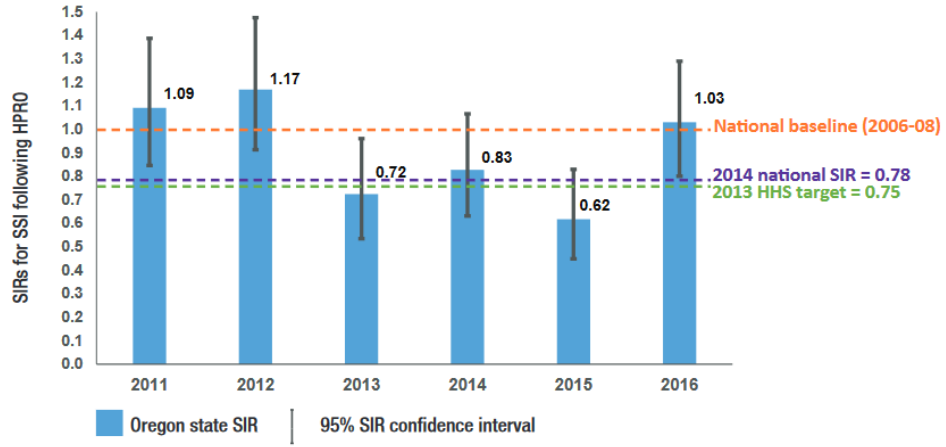


Figure 13. Oregon SIRs for SSI following HPRO: 2011–2016



Oregon Health Authority

National NHSN ACH SSI data - 2017

Adult SSIs with SIR >1	Pediatric SSIs with SIR >1
CRAN – Craniotomy	CRAN – Craniotomy
CSEC – Cesarean section	CSEC – Cesarean section
FX – Open reduction of fracture	FX – Open reduction of fracture
KTP – Kidney transplant	KTP – Kidney transplant

National NHSN ACH SSI data - 2017

Adult SSIs with SIR >1	Pediatric SSIs with SIR >1
AMP – Limb amputation	
APPY – Appendix surgery	
BILI – Bile duct, liver, or pancreatic surgery	
CEA – Carotid endarterectomy	
FUSN – Spinal fusion	
KPRO – Knee arthroplasty	
NECK – Neck surgery	
OVRY – Ovarian surgery	
PACE – Pacemaker surgery	
PRST – Prostate surgery	
PVBY – Peripheral vascular bypass surgery	
XLAP – Abdominal surgery	
	HPRO – Hip arthroplasty
	LTP – Liver transplant
	THOR – Thoracic surgery

Discussion: Create SSI reporting requirements for ASCs

- Add currently reportable inpatient procedures to outpatient procedure ASC reporting requirement (COLO, HYST, KPRO, HPRO, ~~LAM~~)
- Add new outpatient procedures to ASC reporting requirement
  - High-risk, high volume procedures potentially including HER, BRST, CHOL, FX, FUSN
- Based on feedback from ASCs, consider 1-2 procedures from 30-day surveillance list

Table 2. Surveillance Periods for SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

30-day Surveillance			
Category	**Operative Procedure**	**Category**	**Operative Procedure**
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THYR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory laparotomy

Oregon Health Authority

All Payers All Claims data, 2017

Frequency of select procedures, 2017

Procedure	No. in Ambulatory Surgery Centers (%)	No. in Hospital Outpatient (%)	No. in Hospital Inpatient (%)	Total Counts
HER	13897 (59%)	7006 (30%)	2511 (11%)	23414
BRST	13457 (66%)	6064 (30%)	892 (4%)	20413
LAM	12098 (45%)	4762 (18%)	10008 (37%)	26868
FX	8413 (46%)	3022 (17%)	6866 (37%)	18301
CHOL	7721 (46%)	5192 (31%)	3910 (23%)	16823
HYST	6062 (54%)	3514 (31%)	1591 (14%)	11167
KPRO	1722 (9%)	285 (2%)	16920 (89%)	18927
FUSN	1441 (12%)	646 (5%)	10325 (83%)	12412
HPRO	811 (6%)	38 (0.3%)	13410 (94%)	14259
COLO	212 (3%)	42 (1%)	5921 (96%)	6175

Procedures based on CPT codes, using NHSN code mapping crosswalk
Setting type based on APAC healthcare group codes

Reporting Next Steps

- Send your thoughts and feedback to the HAI Program
  - Roza Tammer: roza.p.tammer@state.or.us

- Review proposals for AU and outpatient SSI in hospitals and ASC
- Have thoughts? Data to share to inform discussion? Know folks who want to give feedback?

Questions?

Roza Tammer, MPH, CIC

Roza.p.tammer@state.or.us

971-673-1074

Oregon Health Authority

NEED FOR THE RULE:

The Oregon Health Authority's Healthcare-Associated Infections (HAI) Program collects selected HAI data from Oregon hospitals, including following six surgical procedures: abdominal hysterectomies, laminectomies, coronary artery bypass graft surgeries, colon surgeries, and hip and knee arthroplasties. Based on data comparing Oregon hospitals to hospitals nationally as well as to national prevention targets, Oregon hospitals have made excellent progress towards preventing SSIs following laminectomy surgeries, particularly in the last three years. Additionally, the Oregon Health Authority has received recommendations from Oregon infection prevention partners and stakeholders that removing this reporting requirement would (a) not impact their access to useful data for HAI prevention and (b) free existing resources that could be used to perform SSI surveillance for higher-priority procedures. Based on the data and recommendations, this Division is proposing to remove laminectomy surgical site infections (SSIs) from reporting requirements for Oregon hospitals (333-018-0100).

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

- 2017 National and State Healthcare-Associated Infections Progress Report (2018 CDC): https://www.cdc.gov/hai/data/portal/progress-report.html
- 2017 Oregon Healthcare-Associated Infections Facility-Specific Maps and Tables and 2017 Oregon Healthcare-Associated Infections Data Summary (2018 Oregon Health Authority)
- https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/HAI/Pages/Reports-and-Data.aspx
- National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination (2016 U.S. Department of Health and Human Services): https://health.gov/hcq/prevent-hai-action-plan.asp

FISCAL AND ECONOMIC IMPACT:

Statement of Cost of Compliance:

- Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):
  This rule change is expected to marginally reduce costs to the Oregon Health Authority as well as the Oregon hospitals and health systems that have been required to report surgical site infections following laminectomies. This requirement will reduce burden on facility staff time needed for training, data collection, and reporting, and will reduce public health staff time needed for technical assistance, data validation, analysis, and publication.

- Cost of compliance effect on small business (ORS 183.336):
  Because it is unlikely that the facilities subject to this reporting requirement are considered small businesses based on feedback received at this time, this rule change is not expected to significantly impact small business.

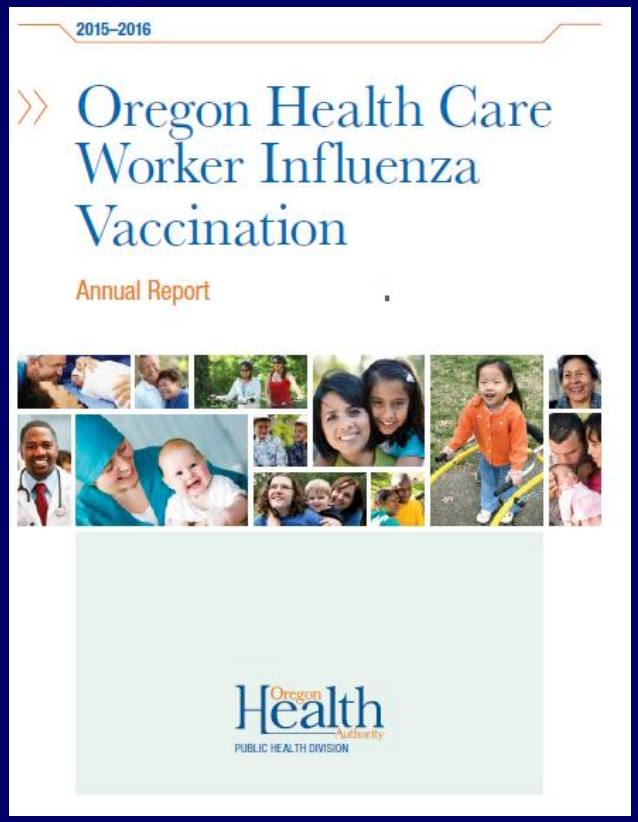
- How were small businesses involved in the development of this rule?
  Twenty-one of Oregon's 61 hospitals reported laminectomy to OHA during the most recently published year of data (2017). These 21 facilities have been contacted to determine whether they are considered small businesses; all 12 respondents thus far have indicated that they are not.

PROPOSED LANGUAGE:

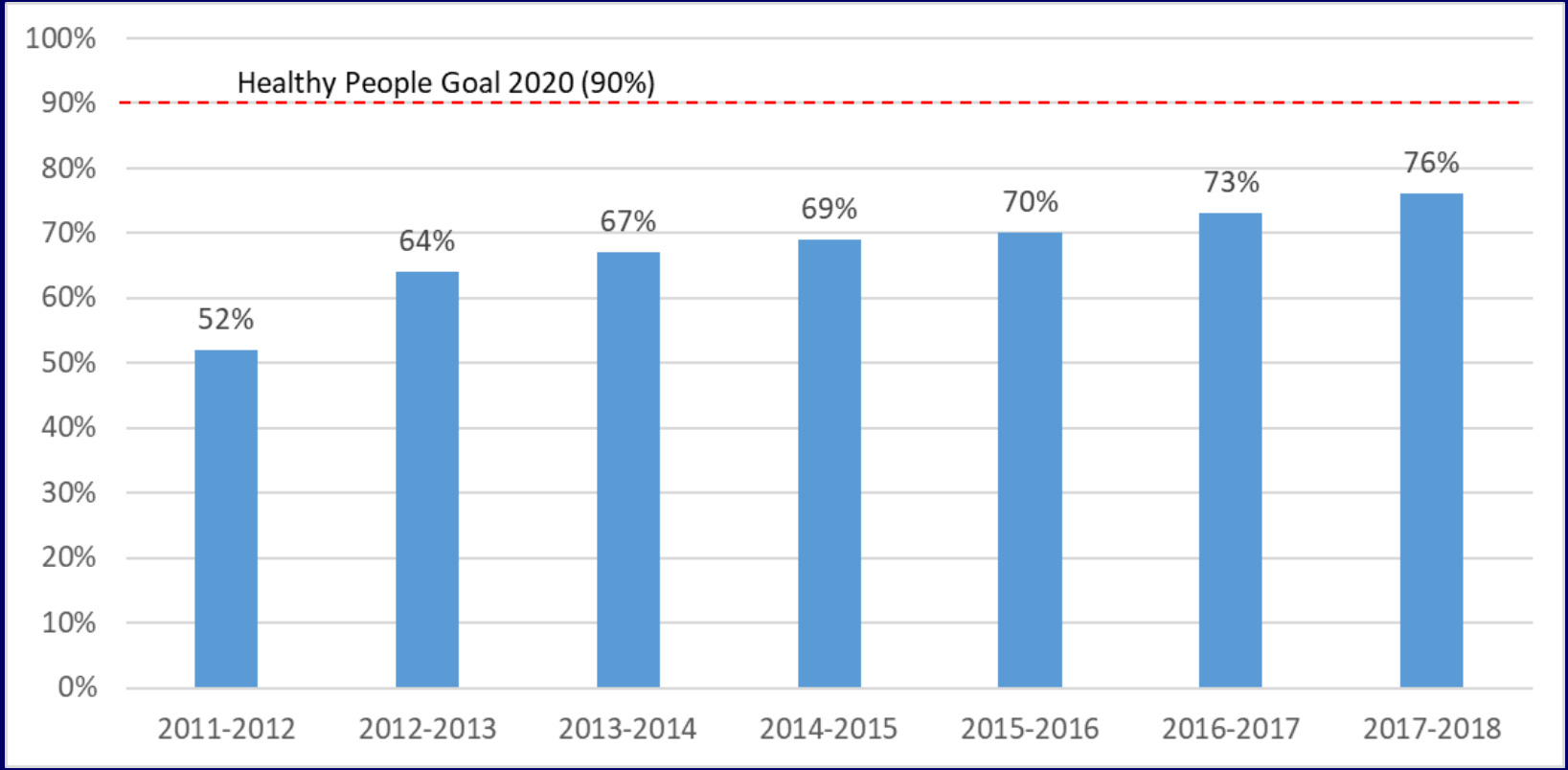
- From definitions in OAR 333-018-0100:
  (15) "Follow-up" means post-discharge surveillance intended to detect CGBG, COLO, HPRO, HYST, and KPRO~~, and LAM~~ surgical site infection (SSI) cases occurring after a procedure.
  (26) ~~"LAM" means laminectomy procedure as defined in the NHSN Manual~~
- From OAR 333-018-0110(1)(b):
  SSIs for inpatient CGBG, COLO, HPRO, HYST, and KPRO ~~and LAM~~ procedures.

HCW Influenza Vaccination

- Facilities included:
  - Hospitals
  - Ambulatory surgery centers
  - Skilled nursing facilities
  - Dialysis facilities
- HCW classifications:
  - Employees
  - Independent practitioners
  - Students and volunteers
  - Other contractors
- Definitions:
  - Eligible HCWs: those without documented medical contraindication
  - Rate of vaccination: $\frac{HCWs\ vaccinated\ at\ facility + HCWs\ vaccinated\ elswhere}{eligible\ HCWs}$



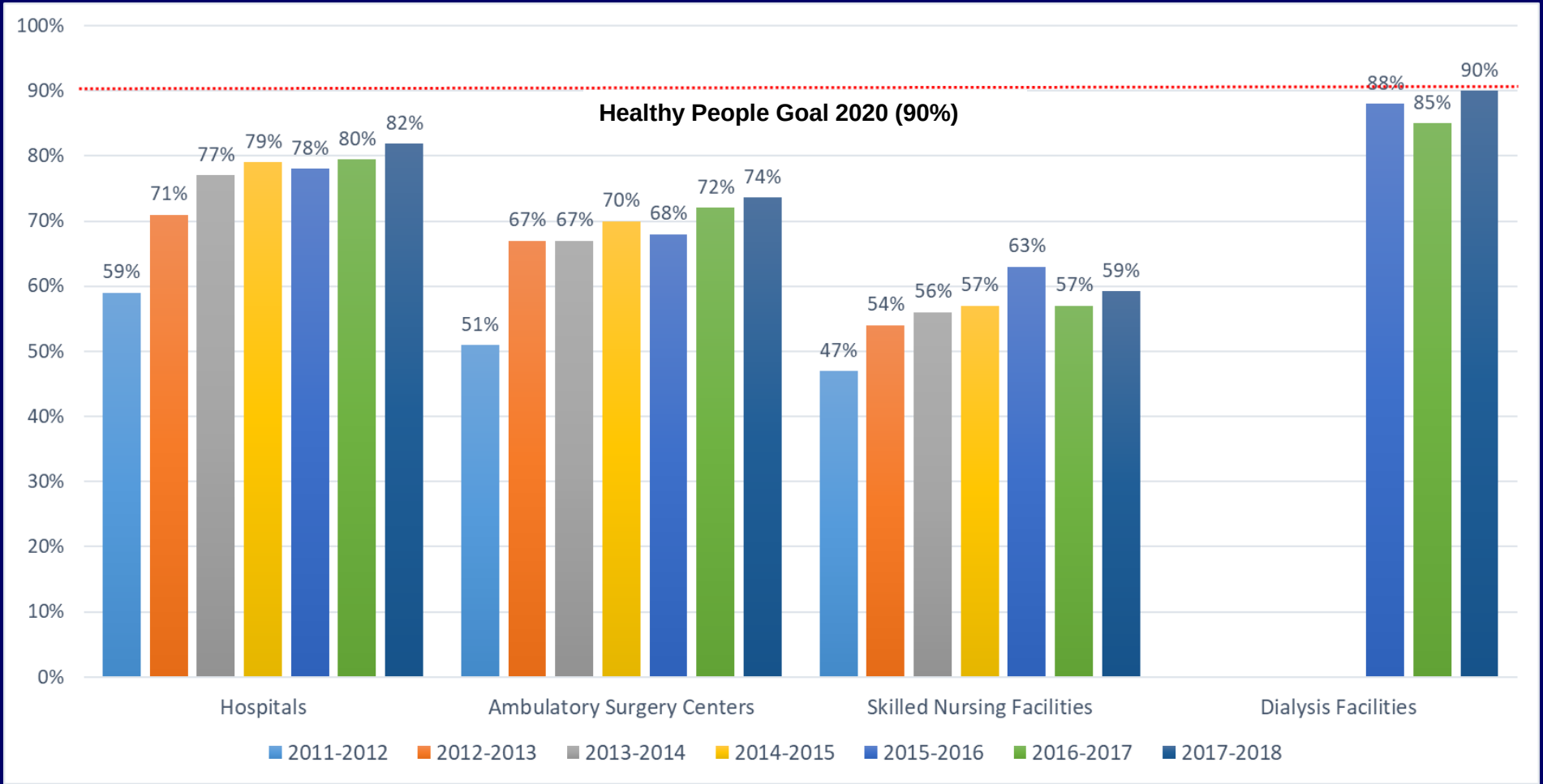
Mean health care worker influenza vaccination rates for all facility types



2017-2018 data are preliminary

Oregon Health Authority

Influenza vaccination rates for all health care workers by facility type and season



2017-2018 data are preliminary

Oregon Health Authority

Takeaways

- Overall influenza vaccination rate and facility-specific vaccination rates increased in 2017-2018.
- Dialysis facilities have met the 2020 goal (90% vs. 90%)
- Hospitals have met the 2015 Healthy People Goal (82% vs. 75%), but remain short of the 2020 goal (90%).
- Further improvement needed in HCW influenza vaccination in Skilled Nursing Facilities and Ambulatory Surgery Centers that remain short of 2015 (75%) and 2020 (90%) goals.

2017-2018 data are preliminary

OHA HCW vaccination promotion campaigns

- Ongoing dissemination of CDC and OHA toolkits to healthcare facilities
- Monthly convening of the flu workgroup to address vaccination challenges
- Presentations and educational webinars routinely provided to healthcare facilities
- Collaboration with Office of Rural Health to support vaccination promotion campaigns
- Prior to the 2018-2019 flu season, outreach conducted to 136 skilled nursing facilities to share toolkits for healthcare worker vaccination, provide data to motivate action, offer technical support, and trouble shoot ongoing challenges
- At the Dec. 11, 2018 Healthcare-Associated Infections Advisory Committee Meeting, we convened a panel of skilled nursing facility administrators to share their HCW vaccination success stories

Questions?

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