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HEALTHCARE-ASSOCIATED INFECTIONS ADVISORY COMMITTEE

December 18, 2013
1:00 pm to 3:00 pm

Portland State Office Building, Room 1C
800 NE Oregon Street
Portland, OR 97232

MEMBERS PRESENT: Kelli Coelho, RN, CNOR (phone)
Jill Freeman
Jon Furuno, PhD
Tara Gregory, MS, FNP
Joan Maca
Csaba Mera, MD
Laurie Murray-Snyder
Pat Preston, MS
Dana Selover, MD, MPH
Janet Sullivan, RN
Dee Dee Vallier (phone)
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC
Bethany Walmsley, CPHQ, CPPS

MEMBERS EXCUSED: Paul Cieslak, MD
Jamie Grebosky, MD
Nancy O'Connor, RN, BSN, MBA, CIC
Rachel Plotinsky, MD

STAFF PRESENT: Dianna Appelgate, MS, MPH, CIC, CPHQ, Clinical Epidemiologist
Zintars Beldavs, MS, Healthcare-Associated Infections Program Manager
Monika Samper, RN, Healthcare-Associated Infections Reporting Coordinator
Ann Thomas, MD, MPH, Acute and Communicable Disease Medical Epidemiologist

ISSUES HEARD:

- **Call to Order**
- Introduce New OHA and Committee Members
- Approval of Minutes
- HAI Annual Report Changes/Ideas
- Standing Agenda: Oregon Patient Safety Commission
- Standing Agenda: Long Term Care Facilities

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- Standing Agenda: Oregon Association of Hospitals & Health Systems
- Standing Agenda: Acumentra
- Standing Agenda: Public Health Division
- HAI Map
- 2012-2013 Healthcare Worker Influenza Vaccination Survey Annual Report
- 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	Follow-Up
Call to Order	The meeting was called to order at approximately 1:00 pm. There was a quorum.	
Introduce New OHA and Committee Members OHA Staff	<p>Monika Samper introduced the new committee members/OHA staff and asked them to speak:</p> <ul style="list-style-type: none">• Joan Maca, Director of Nursing at Lifecare Center McMinnville, is replacing committee member Shantell Mason as the new long-term care representative. Ms. Maca, who has about 30 years of experience in long-term care, explained that the industry is now shifting toward providing substantial post-hospital patient services in the form of sub-acute rehab, including more medical-surgical care. Due to these changes, Ms. Maca believes a new term will evolve for long-term care in the near future to accurately reflect the services currently being provided.• Jill Freeman, Member Engagement and Support Specialist at the Oregon Coalition of Health Care Purchasers, is taking over Daniel Mitten's role on the committee as healthcare purchasing representative. Ms. Freeman's organization, consisting of individuals affiliated with public and private organizations that purchase group health benefits, are very interested in improving healthcare quality and outcomes for Oregonians.• Karen Kellar, filling the role of an administrator of a hospital with less than 100	

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	<p>beds, has resigned from the committee. The Oregon Health Authority is asking for suggestions for a replacement from members.</p> <ul style="list-style-type: none"> OHA recently hired Dianna Appelgate as a clinical epidemiologist to assume much of Monika Samper's role as an HAI reporting coordinator. Ms. Appelgate offers a strong statistical background and has many new ideas for the HAI annual report. 	
Approval of Minutes	The minutes for June 26, 2013 and September 25, 2013 meetings were unanimously approved.	
<p>HAI Annual Report Changes/Ideas</p> <p>OHA Staff</p>	<p>In the September meeting, members proposed ideas for the next HAI annual report such as improve readability, include gross numbers, and consider reducing the volume of the report. Taking these suggestions into account, examples of possible formats for the report are provided in the meeting materials:</p> <ul style="list-style-type: none"> 2009 central line-associated blood stream infections (CLABSI) and 2012 colon surgeries (COLO) SIRs for Oregon Hospitals are illustrated through a horizontal bar chart incorporating 3 different colors (page 28 and 30 respectively): <ul style="list-style-type: none"> Green bar indicates that the number of observed infections was lower than expected and was statistically significant (SIR is less than 1). Red bar signifies that the number of observed infections was higher than expected and statistically significant (SIR is greater than 1). Blue bar denotes that the number of observed infections was not significantly different from the expected number. An asterisk symbolizes that an SIR could not be calculated because the hospital did not report any CLABSI. CLABSI SIRs displayed in a forest graph for each institution are represented by dots and the 95% confidence intervals are illustrated through bars that transverse the dots (page 32). If the confidence interval crosses the dashed line —extends below and above the SIR value of 1 -- the interval is not statistically significant. Simulated 2009 COLO data is displayed through a forest chart (page 33). To 	

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	<p>address consumer desire for gross numbers, total COLOs and surgical site infections, as well as the SIR, are shown to the left of the chart.</p> <ul style="list-style-type: none"> • COLO 2012 SIRs with color-coded results are depicted in a vertical bar chart (page 34): green bars represent statistically significant positive results (less infections observed than expected), red bars signal statistically negative results (more infections observed than expected), and the black line marks an SIR of 1. • COLO SIR aggregate monthly data throughout 2009 for all Oregon hospitals is displayed in a line graph that utilizes vertical bars to portray confidence intervals (green – significantly better than the national average; gray – not significantly different from the national average (page 35). • Simulated 2012 aggregate catheter-associated urinary tract infections (CAUTI) rates by hospital unit are compared, using a bar chart, with the national SIR (page 36). <p>Comments from committee members about the graphs included:</p> <ol style="list-style-type: none"> 1. Attendees liked the 2012 COLO and CAUTI charts (on pages 34 and 36 respectively) and proposed including additional charts, formatted the same as the graph on page 36, to compare each hospital's data with the Oregon and national rates. 2. Terms such as SIR, statistical significance, and confidence intervals that readers may not be acquainted with, need to be explained at a 6th grade level to accommodate a diverse audience. Statistical appendices might be a good location for these definitions. 3. Employ both narratives with basic examples and color-coded graphs with simple terms such as good, better, and best to address different learning styles. 4. Include bar charts, in addition to line charts with confidence intervals, because consumers are familiar with them. 5. Replace large detailed HAI annual report with a clear and concise synopsis focused on user needs. 6. Exclusion of some of the charts in the HAI annual report may be possible due to the upcoming implementation of an online interactive map (refer to HAI Map presentation below for more information.) 	

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<p>Standing Agenda: Oregon Patient Safety Commission</p> <p>Bethany Walmsley</p>	<p>Bethany Walmsley provided an overview of the Oregon Patient Safety commission's current activities aimed at reducing HAIs:</p> <ul style="list-style-type: none"> • OPSC has been working with The Northwest Dialysis Blood Stream Infection Prevention Collaborative for about a year and a half. Out of the original 33 facilities, 25 are still engaged in the collaborative. Analysis of the collected data will be finished in the spring of 2014. • OPSC has been involved with The Oregon Antimicrobial Stewardship Collaborative for the last 18 months. The collaborative, which held its final learning session in November, is anxious to examine the data that is still being gathered. • For over two years, OPSC has been offering infection training and educational programs, funded by the Healthcare Regulation Quality Improvement grant, to help facilities achieve their goals for survey results. All classes are listed on their website on the events page for public viewing. Upcoming events include webinars focused on Norovirus for long-term care facilities in January and infection prevention training for ambulatory surgery centers on February 7, 2014. • On August 1, 2013, OPSC began a MDRO Prevention Collaborative, comprised of three different groups: north coast region targets the Astoria area, Linn-Benton region encompasses the Corvallis area, and south coast region covers the Bay area. These collaboratives were established not only to reduce infections, but also to provide a forum for different types of organizations to work together and learn from each other. OPSC supports these efforts through a collaborative model, which incorporates evidence-based resources, targeted learning sessions, and site visits. Preliminary results show that the groups have been very successful, and tangible data for the committee is expected to be available in the spring. <p>Due to the importance of their work, meeting attendees deliberated about the best method for disseminating information about these collaboratives. Although all published materials are available to the public through each group's website, some members questioned whether a more direct method such as email/mailings to the</p>	

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	target audience, utilizing databases maintained by various organizations, might be more effective. One member explained that they either partner with or rely on other organizations to forward messages/material to appropriate contacts in their mailing lists. Another option would be to channel information through the local the Association for Professionals in Infection Control and Epidemiology (APIC) chapter.	
<p>Standing Agenda: Long Term Care Facilities</p> <p>Joan Maca</p>	<p>Healthcare professionals at long-term care facilities (LTCF) encounter multiple obstacles in their struggle to control infections and adhere to CMS and state reporting rules. To begin with, access to basic Information regarding reporting requisites is often lacking. Although OHCA and other organizations send notices of CMS mandates to LTCF administrators, information may not trickle down to directors of nursing or nurses who are tasked with reporting and controlling infections. As a result, pertinent staff may have no idea of what to report, how to define their infections, or even aware that data needs to be collected. This disconnect is particularly evident in assisted living facilities where tracking tools and reporting guidelines are often unavailable. Limited clinically-trained personnel serve to compound the problem in all types of LTCFs. Infection control nurses in skilled nursing facilities are typically charged with multiple responsibilities within the constraints of part-time hours, leaving non-clinical staff to perform the majority of reporting activities. Assisted living facilities often do not have healthcare professionals on staff and certainly do not hire infection control nurses. Therefore, unlike the published government regulations distributed to healthcare administrators, any guidelines provided to staff must be at a level all personnel are able to understand. In an effort to fill the gap, Yamhill county offered its first workshop last week to educate LTCFs about CMS requisites for mandatory reporting of HAI data.</p> <p>To improve communication, committee members recommended partnering with the Oregon Health Care Association (OHCA), Leading Age, and APIC as an effective means of reaching directors of nursing (contact lists would need to be evaluated for completeness) regarding administrator alerts, reporting requisites, and important upcoming events. LTCF administrators, on the other hand, would benefit from communications sent by the Public Health Division and the Patient Safety Commission because these government agencies are tied to the Office of Licensing and Regulatory Oversight (OLRO), a state arm of CMS, who is responsible for issuing citations to</p>	

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	<p>facilities found to have violated federal regulations during inspections. Consequently, administrators are more likely to carefully read and forward information from these organizations to staff tasked with reporting and controlling infections.</p> <p>As with reporting mandates, lack of proper training and skilled nursing staff is probably the cause of continued infections. One solution might be for LTCFs to work more closely with hospitals as an opportunity to connect with experts or to have hospitals serve a central point for coordinating efforts and resources. However, collaborating with corporate-owned facilities, with their inherently complicated hierarchical infrastructure, is difficult because all relevant parties—such as corporate leadership, corporate nurses, and facility nurses—must be involved for tasks to be accomplished. Another option, which the industry might be more responsive to, would be to broach education about federal regulations as a means to avoid F Tags/CMS citations and to reduce infections thereby increasing profits.</p> <p>LTCFs are not cited for infections, an inevitable outcome in healthcare organizations, but for not following their own policies including failure to: implement established policies, identify infections in a timely manner, or closely adhere to protocols. The most common citation given by CMS is F Tag 441, which focuses on preventing and controlling the spread of infections through such measures as hand hygiene, laundry management, and employee work restrictions.</p> <p>Committee members expressed the need for CMS input in order to proceed with training for nursing homes (the statute does not apply to assisted living facilities). Consequently, OHA will contact the Manager of the Nursing Facilities Licensing Unit at the DHS Office of Licensing & Regulatory Oversight to determine the best resource for advising the committee.</p>	

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<p>Standing Agenda: Oregon Association of Hospital & Health Systems (OAHHS)</p> <p>Diane Waldo</p>	<p>For the last two years, OAHHS has been partnering with the American Hospital Association (AHA) and the Health Research and Education trust (HRET), the quality arm of the AHA, on the CMS Partnership for Patients (PfP) initiative to reduce hospital-acquired conditions in ten target areas including: central line-associated blood stream infections (CLABSI), catheter-acquired urinary tract infections (CAUTI), surgical site infections (SSI), ventilator-associated pneumonia (VAP), preventable readmissions and pressure ulcers. The national HRET Hospital Engagement Network (HEN) is comprised of 31 states with over 1600 hospitals. In Oregon there are four HENs: Intermountain Healthcare Network, Premier Network, Washington State Hospital Association Network, and the OAHHS-HRET Network. 31 hospitals, which is over half of the acute care facilities in Oregon, belong to the latter network.</p> <p>As a result of hard work over the last two years, hospitals in the OAHHS-HRET Network have achieved the difficult milestone of at least a 40% reduction in five of the ten target areas: CAUTI, CLABSI, early elective deliver, VAP, and SSI. This achievement has led Oregon to become the top performer of all states participating in the national HEN based on recent results.</p> <p>In 2014, adverse drug events and surgical cases, two of the ten PfP areas of focus, will be expanded slightly and the emphasis will be somewhat different. For example, instead of SSIs associated with hip and knee procedures, infection data already being reported by hospitals--such as spinal operations, hysterectomies, and other types of surgeries--will be analyzed in order to share more surgical outcomes with the public.</p>	
<p>Standing Agenda: Acentra Health</p> <p>Laurie Murray-Snyder</p>	<p>Acentra Health, the Medicare Quality Improvement Organization (QIO) for Oregon, is working with hospitals and other stakeholders to encourage antimicrobial stewardship and to reduce <i>Clostridium difficile</i> (CDI), catheter-associated urinary tract infections (CAUTI), and surgical site infections (SSI) related to knee and hip surgeries. These efforts include:</p> <ul style="list-style-type: none"> • Collaborating with the Oregon Hospital Engagement Networks to assist hospitals participating in the Partnership for Patient's safety and quality initiative. • Working through the Oregon HAI Prevention Coalition with selected hospitals to improve patient outcomes: 8 hospitals are focusing on CAUTIs, 11 hospitals are 	

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	<p>targeting SSIs (knees and hips), and 6 hospitals are striving to reduce CDIs.</p> <p>During the CMS measurement period, which ended August 31, 2013, CAUTI rates of participating hospitals varied widely, particularly during the last 6 months, leading Acumentra Health to wonder whether facilities would meet benchmarks. In addition, CDI rates were also high. Fortunately, hospitals passed with SIRs of 0.9 for CAUTI and 0.8 for CDI and with a SDUR--the device utilization rate--of 1.0 (an SDUR equal to or less than 1.0 was required to pass).</p> <p>To celebrate the completion of the PfP CAUTI initiative and to learn about the National ED Improvement Intervention program aimed at reducing catheter utilization and decreasing overall CAUTI rates, Acumentra Health will be hosting a meeting in February. Dr. Mohamad Fakih, a national expert on healthcare-acquired infections, will be the featured speaker.</p> <p>Acumentra Health will be able to proceed with efforts to reduce HAIs as a result of a new 5-year contract with CMS. Staff will continue to work on CAUTIs--hospital units will be expanded from ICUs to multiple units—CDI, and antimicrobial stewardship, but SSIs will be eliminated from their program.</p>	
<p>Standing Agenda – Public Health Division</p> <p>OHA Staff</p>	<p><u>Healthcare Acquired Infections Reporting Poster</u></p> <p>The HAI poster, with information listed by facility type, will allow healthcare professionals to easily identify both Oregon and CMS reporting requirements pertaining to their organization (page 37 of meeting materials). Included in the hospital category is Vibra Specialty Hospital of Portland, a long-term acute care facility licensed as a hospital.</p> <p>Committee members discovered an error in the poster. CAUTIs are listed as reportable for long-term care facilities; however, only hospitals are obligated to inform CMS and the State of these infections. Corrections will be made prior to the publication of the poster.</p> <p><u>HAI Annual Report</u></p> <p>Although Oregon Revised Statutes (ORS) mandate the publication of the HAI annual report no later than April 30th of each year, the deadline is impossible to meet.</p>	<p>Zints Beldavs will research process for altering ORS and present findings at next meeting.</p>

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	<p>Facilities have until April 15th to enter their infection data into the National Healthcare Safety Network (NHSN) and then have 30 days to review reports created by OHA from finalized NHSN data. Due to the onerous process involved with modifying ORS, OHA has not pursued changing the statute, but staff will investigate further and report findings at the next meeting.</p> <p><u>OARs 333-019-0052</u></p> <p>OHA staff has been collaborating with stakeholders to develop policies to encourage better inter-facility communication during the transfer/discharge of patients. The resulting policies have been incorporated into the new Oregon Administrative Rule (OAR) 333-019-0052 that will become effective January 1, 2014 (refer to page 39 in meeting materials). To summarize the rule, when a referring facility transfers or discharges a patient who is infected or colonized with a multidrug-resistant organism (MDRO) that warrants transmission-based precautions, a written notification --readily accessible to all parties involved with the transfer (e.g., medical transport personnel)—must be included in the transfer documents to the receiving facility. The OARs focus on communicable pathogens rather than conditions requiring contact precautions because infection prevention policies differ between long-term and acute care facilities. In support of the new rule, a standard inter-facility communication form to accompany patients during transfer/discharge is being developed by a work group led by OHA. MDROs applicable to the rule include but are not limited to:</p> <ul style="list-style-type: none"> • Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) • Vancomycin-resistant <i>Enterococcus</i> (VRE) • Carbapenem-resistant Enterobacteriaceae (CRE) • Multidrug-resistant <i>Acinetobacter baumannii</i> • Multidrug-resistant <i>Pseudomonas aeruginosa</i> • Drug-resistant <i>Streptococcus pneumoniae</i> • Other gram-negative bacteria producing extended-spectrum beta-lactamases (ESBL) • Toxin-producing <i>Clostridium difficile</i> 	

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	<p>Facilities obligated to abide by the new Oregon Administrative Rule encompass organizations that provide 24-hour patient care including adult foster homes, residential care, and mental health agencies. These organizations only need to communicate MDRO infections during patient transfers; the rule does not require any specific action with the exception of laboratory-confirmed carbapenemase-producing Enterobacteriaceae (CPE). In this case, the referring facility must notify the local health department (LHD) within one working day after the patient is transferred or discharged. Initially, due to limited resources, OHA will only investigate violations to the new MDRO communication rule when a complaint is received. OHA will also most likely be enforcing the reporting of lab-confirmed CPE to LHDs.</p> <p>Although all licensed facilities should have received the complete text of the new Oregon Administrative Rule, OHA will also be offering instructional webinars to explicate crucial elements. OHA is also working on developing materials to better educate the healthcare community about MDROs, particularly carbapenemase-producing CRE. As communication about patients' health status improves, facilities lacking knowledge of the risks associated with each MDRO, may reject patients solely based on fear.</p>	
<p>HAI Map</p> <p>OHA Staff</p>	<p>In response to the need for a user-friendly data abstraction tool, Magdalena Scott Kendall developed an interactive state map that will provide consumers with a number of options to easily view HAI data extracted from NHSN's tracking system for Oregon hospitals (refer to meeting material for the semi-final version beginning on page 44). When initiated, the software will display an Oregon map with all hospitals represented by red pins. From this screen, utilizing an array of tools, consumers will be able to:</p> <ul style="list-style-type: none"> • Examine a listing of an individual hospital's statistics for all reportable HAIs--such as the incidence of <i>clostridium difficile</i> or the percentage of laminectomies resulting in a surgical site infection--for a specific year. • Scrutinize a hospital's infection trends illustrated through a line graph for a particular HAI over multiple years. • Compare data of multiple hospitals displayed in a bar chart for a single HAI and year. • Create, sort, and export a table containing all reportable HAIs for individual or 	

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	<p>multiple hospitals in a given year.</p> <p>A software tool developed by a different company, InstantAtlas, is also under consideration. An example of the initial screen this software might display for CLABSI data shows a US map and a table--similar to those in our annual report—with SIR, count, predicted infections, and total by state. OHA liked this report and has forwarded data in response to Instant Atlas’ offer to produce additional sample reports for free.</p> <p>Due to the simplicity, report options, and ease-of use, committee members discussed replacing the detailed data given for each hospital in the HAI annual report with an online interactive map. Several meeting attendees, impressed with the maps, would like to investigate providing access to them on insurance websites, where consumers are making decisions about their healthcare options, through transparent linking software tools. The mapping software is expected to be available on OHA’s website by the time the 2013-2014 HAI Annual Report is published.</p>	
<p>2012-2013 Healthcare Working Influenza Vaccination Survey Annual Report</p> <p>OHA Staff</p>	<p>More healthcare workers are being vaccinated for influenza every year in Oregon facilities (refer to report beginning on page 49 of meeting materials). Based on benchmarks established by U.S. Department of Health and Human Services (HHS) for vaccination rates—60% for 2010, 75% for 2015, and 90% for 2020—Oregon hospitals are doing well. Since the 2011-2012 reporting period, hospital have improved by 8% and, for the first time, met the 2015 benchmark by vaccinating 77% of their personnel. In addition, 52% of hospitals, 27% of long-term care facilities, and 41% of ambulatory surgery centers have fulfilled the 2015 Healthy People Targets for vaccination rates set by HHS.</p> <p>Some especially noteworthy results gathered from the survey include:</p> <ul style="list-style-type: none"> The most common reason given by healthcare workers for declining a vaccination in 2012-2013 was, “other” whereas the most frequent response in the previous reporting year was, “I decline to provide a reason”. This variance can be attributed to the elimination of the latter reason--an attempt to encourage workers to provide a more informative answer-- leading respondents to chose the “other” category instead. 	

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	<ul style="list-style-type: none">• A high percentage of facilities offered vaccinations at no cost to employees: 100% of hospitals, 93% of long-term care facilities, and 73% of ambulatory surgery centers.• Delivery methods for vaccinations varied between the three types of facilities: 85% of hospitals employed mobile carts and provided vaccinations in congregate areas; ambulatory surgery centers favored peer-administered vaccinations; and long-term care facilities chose to primarily offer vaccinations in congregate areas.• The percentage of hospitals providing formal education on influenza vaccination dropped from 62% to 48% in the last year for unknown reasons; in contrast, the percentage of long-term care facilities and ambulatory surgery centers offering instruction increased.	
Public Comment / Adjourn	No public comments	

Next meeting will be March 26, 2:00 pm to 4:00 pm, at the Portland State Office Building, Room 1E.

Submitted By: Diane Roy

Reviewed By: Dianna Appelgate
Zintars Beldavs

EXHIBIT SUMMARY

A – Agenda

B – June 26, 2013 Minutes

C – September 25, 2013 Minutes

D – HAI Annual Report Changes/Ideas

E – HAI Reporting Poster

F – New OAR 333-019

G – HAI Map Examples

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H – Healthcare Worker Influenza Vaccination Rates 2012-2013 Season

OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 18

DISEASE REPORTING

[OAR 333-018-0000 – 333-018-0035]

Health Care Acquired Infection Reporting and Public Disclosure

333-018-0100

Definitions

The following definitions apply to OAR 333-018-0100 through 333-018-0145:

- (1) “ASC” means an ambulatory surgical center as defined in ORS 442.015 and that is licensed pursuant to ORS 441.015.
- (2) “Authority” means the Oregon Health Authority.
- (3) “CBGB” means coronary bypass graft surgery with both chest and graft incisions, as defined in the NHSN Manual.
- (4) “CAUTI” means catheter-associated urinary tract infection as defined in the NHSN Manual.
- (5) “CDC” means the federal Centers for Disease Control and Prevention.
- (6) “CDI” means *Clostridium difficile* infection as defined in the NHSN Manual.
- (7) “CLABSI” means central line associated bloodstream infection as defined in the NHSN Manual.
- (8) “CMS” means the federal Centers for Medicare and Medicaid Services.
- (9) “COLO” means colon procedures as defined in the NHSN Manual.
- (10) “Committee” means the Health Care Acquired Infections Advisory Committee as defined in section 4, chapter 838, Oregon Laws 2007.
- (11) “Dialysis facility” means outpatient renal dialysis facility as defined in ORS 442.015.
- (12) “Follow-up” means post-discharge surveillance intended to detect CBGB, COLO, HPRO, HYST, KRPO, and LAM surgical site infection (SSI) cases occurring after a procedure.
- (13) “HAI” means health care acquired infection as defined in section 2, chapter 838, Oregon Laws 2007.
- (14) “Health care facility” means a facility as defined in ORS 442.015.
- (15) “Hospital” means a facility as defined in ORS 442.015 and that is licensed pursuant to ORS 441.015.
- (16) “Hospital Inpatient Quality Reporting Program” means the initiative administered by CMS and formerly referred to as RHQDAPU.
- (17) “HPRO” means hip prosthesis procedure as defined in the NHSN Manual.
- (18) “HYST” means abdominal hysterectomy procedure as defined in the NHSN Manual.
- (19) “ICU” means an intensive care unit as defined in the NHSN Manual.
- (20) “KPRO” means knee prosthesis procedure as defined in the NHSN Manual.
- (21) “Lab ID” means laboratory-identified event as defined in the NHSN Manual.
- (22) “LAM” means laminectomy procedure as defined in the NHSN Manual.
- (23) “LTC facility” means long term care facility as defined in ORS 442.015.

- (24) “MDS” mean the Centers for Medicare and Medicaid Services’ minimum data set nursing home resident assessment and screening tool, version 2.0 or its successor, including but not limited to manuals, forms, software, and databases.
- (25) “Medical ICU” means a non-specialty intensive care unit in which at least 80 percent of patients served are adult medical patients.
- (26) “Medical/Surgical ICU” means a non-specialty intensive care unit in which less than 80 percent of patients served are adult medical, adult surgical, or specialty patients.
- (27) “MRSA” means methicillin-resistant *Staphylococcus aureus* as defined in the NHSN Manual.
- (28) “NHSN” means the CDC’s National Healthcare Safety Network.
- (29) “NHSN Inpatient” means a patient whose date of admission to the healthcare facility and the date of discharge are different days as defined in the NHSN Manual.
- (30) “NHSN Manual” means the Patient Safety Component Protocol of the NHSN manual, version January 2013.
- (31) “NICU” means a specialty intensive care unit that cares for neonatal patients.
- (32) “Oregon HAI group” means the NHSN group administered by the Authority.
- (33) “Overall-facility wide” means data are collected for the entire facility as defined in the NHSN Manual.
- (34) “Patient information” means individually identifiable health information as defined in ORS 179.505.
- (35) “Person” has the meaning given that term in ORS 442.015.
- (36) “Procedure” means an NHSN operative procedure as defined in the NHSN Manual.
- (37) “Provider” means health care services provider as defined in ORS 179.505.
- (38) “QIO” means the quality improvement organization designated by CMS for Oregon.
- (39) “RHQDAPU” means the Reporting Hospital Quality Data for Annual Payment Update initiative administered by CMS.
- (40) “SCIP” means the Surgical Care Improvement Project.
- (41) “SCIP-Inf-1” means the HAI process measure published by SCIP defined as prophylactic antibiotic received within one hour prior to surgical incision.
- (42) “SCIP-Inf-2” means the HAI process measure published by SCIP defined as prophylactic antibiotic selection for surgical patients.
- (43) “SCIP-Inf-3” means the HAI process measure published by SCIP defined as prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac patients).
- (44) “SCIP-Inf-4” means the HAI process measure published by SCIP defined as cardiac surgery patients with controlled 6 a.m. postoperative serum glucose.
- (45) “SCIP-Inf-6” means the HAI process measure published by SCIP defined as surgery patients with appropriate hair removal.
- (46) “SCIP-Inf-9” means urinary catheter removed on postoperative day 1 or postoperative day 2 with day of surgery being day zero.
- (47) “SCIP-Inf-10” means the HAI process measure published by SCIP defined as surgery patients with perioperative temperature management.
- (48) “Specialty ICU” means an intensive care unit in which at least 80 percent of adult patients served are specialty patients, including but not limited to oncology, trauma, and neurology.
- (49) “SSI” means a surgical site infection event as defined in the Patient Safety Component Protocol of the NHSN manual, version January 2013.

(50) “Staff” means any employee of a health care facility or any person contracted to work within a health care facility.

(51) “State agency” has the meaning given that term in ORS 192.410.

(52) “Surgical ICU” means a non-specialty intensive care unit in which at least 80 percent of patients served are adult surgical patients.

Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 & 12

Stats. Implemented: ORS 179.505, 192.410, 192.496, 192.502, 441.015, 442.011, 442.400, 442.405, & OL 2007, Ch. 838 § 1-6 & 12

333-018-0105

Review

Unless otherwise directed by the Authority, the committee shall review these rules (OAR 333-018-0100 through 333-018-0145) at least biennially.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1-6 & 12

Stats. Implemented: 2007 OL Ch. 838 § 1-6 & 12

333-018-0110

HAI Reporting for Hospitals

(1) All hospitals shall collect data for HAI outcome and process measures for the HAI reporting program in accordance with these rules, except:

(a) Hospitals shall report facility-wide inpatient MRSA bacteremia data using the Lab-ID method for MRSA bacteremia in the NHSN MDRO and CDI Module protocol for services provided in hospitals on or after January 1, 2014.

(b) Hospitals shall report NHSN inpatient CAUTI events in adult and pediatric ICUs for services provided on or after January 1, 2014.

(2) Reportable HAI outcome measures are:

(a) SSIs for NHSN Inpatient CBGB, COLO, HPRO, HYST, KPRO, and LAM procedures.

(b) CLABSI in medical ICUs, surgical ICUs, and combined medical/surgical ICUs.

(c) NHSN Inpatient CDI facility-wide.

(d) NHSN Inpatient MRSA bacteremia facility-wide.

(e) CAUTI in adult and pediatric ICUs.

(3) The infection control professional (ICP), as defined by the facility, shall actively seek out infections defined in subsections (2)(a) and (e) of this rule during a patient’s stay by screening a variety of data that may include but is not limited to:

(a) Laboratory;

(b) Pharmacy;

(c) Admission;

(d) Discharge;

(e) Transfer;

(f) Radiology;

(g) Imaging;

(h) Pathology; and

(i) Patient charts, including history and physical notes, nurses and physicians notes, and temperature charts.

(4) The ICP shall use follow-up surveillance methods to detect SSIs for procedures defined in subsection (2)(a) of this rule using at least one of the following:

- (a) Direct examination of patients' wounds during follow-up visits to either surgery clinics or physicians' offices;
 - (b) Review of medical records, subsequent hospitalization records, or surgery clinic records;
 - (c) Surgeon surveys by mail or telephone;
 - (d) Patient surveys by mail or telephone; or
 - (e) Other facility surveys by mail or telephone.
- (5) Others employed by the facility may be trained to screen data sources for these infections, but the ICP must determine that the infection meets the criteria established by these rules.
- (6) The HAI reporting system for HAI outcome measures shall be NHSN. Each Oregon hospital shall comply with processes and methods prescribed by CDC for NHSN data submission. These include but are not limited to definitions, data collection, data reporting, and administrative and training requirements. Each Oregon hospital shall:
- (a) Join the Oregon HAI group in NHSN.
 - (b) Authorize disclosure of NHSN data to the Authority as necessary for compliance with these rules, including but not limited to summary data and denominator data for all SSIs, the annual hospital survey and data analysis components for all SSIs, and summary data and denominator data for all medical ICUs, surgical ICUs, and combined medical/surgical ICUs.
 - (c) Report its data for outcome measures to NHSN no later than 30 days after the end of the collection month. The NHSN field "Discharge Date" is mandatory for all outcome measures.
- (7) Each hospital shall report on a quarterly basis according to OAR 333-018-0110(1) the following HAI process measures:
- (a) SCIP-Inf-1;
 - (b) SCIP-Inf-2;
 - (c) SCIP-Inf-3;
 - (d) SCIP-Inf-4;
 - (e) SCIP-Inf-6;
 - (f) SCIP-Inf-9; and
 - (g) SCIP-Inf-10.
- (8) The reporting system for HAI process measures shall be the Hospital Inpatient Quality Reporting Program, formerly referred to as the RHQDAPU program as configured on July 1, 2008. Each Oregon hospital shall:
- (a) Comply with reporting processes and methods prescribed by CMS for the RHQDAPU program. These include but are not limited to definitions, data collection, data reporting, and administrative and training requirements; and
 - (b) Report data quarterly for HAI process measures. Data must be submitted to and successfully accepted into the QIO clinical warehouse no later than 11:59 p.m. central time, on the 15th calendar day, four months after the end of the quarter.
- (9) For NICUs, the HAI reporting system for outcome measures shall be NHSN. Each Oregon hospital with a NICU shall comply with processes and methods prescribed by NHSN for the CLABSI reporting, including but not limited to definitions, data collection, data submission, and administrative and training requirements. Each Oregon hospital shall:
- (a) Authorize disclosure of NHSN data to the Authority as necessary for compliance with these rules, including but not limited to facility identifiers.
 - (b) Submit NICU data to NHSN according to the NHSN Manual.
- (10) Each hospital shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include

but not be limited to the following questions regarding influenza vaccine coverage of facility staff:

- (a) Number of staff with a documented influenza vaccination during the previous influenza season;
- (b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;
- (c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and
- (d) Facility assessment of influenza vaccine coverage of facility staff during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 442.405 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0115

HAI Reporting for Ambulatory Surgery Centers

- (1) Each ASC shall complete a survey of evidenced-based elements of patient safety performance as defined by the Authority.
- (2) The survey shall be submitted annually by each ASC to the Authority no later than 30 days after receipt of the survey.
- (3) Each ASC shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include but not be limited to the following questions regarding influenza vaccine coverage of facility staff:
 - (a) Number of staff with a documented influenza vaccination during the previous influenza season;
 - (b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;
 - (c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and
 - (d) Facility assessment of influenza vaccine coverage of facility staff during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.

Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 and 12

Stats. Implemented: ORS 442.405 & OL 2007, Ch. 838 § 1-6 and 12

333-018-0120

HAI Reporting for Long Term Care Facilities

- (1) The HAI Reporting System for outcome measures shall be MDS.
- (2) Reportable HAI outcome measures are from MDS and include the data element, “urinary tract infection in the last 30 days.”
- (3) Each LTC facility shall comply with reporting processes and methods prescribed by CMS for MDS. These include but are not limited to definitions, data collection, data submission, and administrative and training requirements.
- (4) Each LTC facility shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include

but not be limited to the following questions regarding influenza vaccine coverage of facility staff:

- (a) Number of staff with a documented influenza vaccination during the previous influenza season;
- (b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;
- (c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and
- (d) Facility assessment of influenza vaccine coverage of facility staff and volunteers during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 442.405 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0125

HAI Reporting for Other Health Care Facilities

Dialysis facilities shall submit data for the HAI reporting program for services provided on or after January 1, 2013. Dialysis facilities that report events data to the Centers for Medicare and Medicaid (CMS) shall be considered to comply with HAI reporting requirements if these dialysis facilities provide the same data to the Authority, or permits the Authority to have access to the same data, as is reported to CMS.

Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 and 12

Stats. Implemented: ORS 442.405 & OL 2007, Ch. 838 § 1-6 and 12

333-018-0130

HAI Public Disclosure

- (1) The Authority shall disclose to the public updated facility-level and state-level HAI rates at least quarterly.
- (2) The Authority may disclose state-level and facility-level HAI data, including but not limited to observed frequencies, expected frequencies, proportions, and ratios.
- (3) The Authority shall summarize HAI data by facilities subject to this reporting in an annual report. The Authority shall publish the annual report no later than April 30 of each calendar year.
- (4) The Authority shall disclose data and accompanying explanatory documentation in a format that facilitates access and use by the general public and health care providers.
- (5) The Authority may use statistically valid methods to make comparisons by facility, and to state, regional, and national statistics.
- (6) The Authority shall provide a maximum of 30 calendar days for facilities to review facility-reported data prior to public release of data.
- (7) The Authority shall provide facilities the opportunity to submit written comments and may include any submitted information in the annual report.
- (8) Pending recommendations from the committee, the Authority may publish additional reports intended to serve the public's interest.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 442.405, 192.496, 192.502, 192.243, 192.245 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0135

HAI Data Processing and Security

- (1) The Authority shall obtain hospital outcome measure data files directly from NHSN at least quarterly.
- (2) The Authority shall obtain hospital process measure data files from the CMS hospital compare website at least quarterly.
- (3) The Authority shall calculate state-level and facility-level statistics to facilitate HAI public disclosure. These statistics may include but are not limited to observed frequencies, expected frequencies, proportions, rates, and ratios. The Authority shall make public the methods used to calculate statistics and perform comparisons.
- (4) The Authority shall use statistically valid risk adjustment methods recommended by the committee including but not limited to NHSN methodology.
- (5) The Authority shall undertake precautions to prevent unauthorized disclosure of the raw data files. These precautions include but are not limited to:
 - (a) Storing the raw data files on the internal storage hardware of a password-protected personal computer that is physically located within the Authority;
 - (b) Restricting staff access to the raw data files;
 - (c) Restricting network access to the raw data files; and
 - (d) If applicable, storing patient information within a strongly-encrypted and password-protected virtual drive or using other methods to reliably achieve the same level of security.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 192.496, 192.502 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0140

Prohibited Activities

Unless specifically required by state or federal rules, regulations, or statutes, the Authority is prohibited from:

- (1) Disclosing individually identifiable patient, health care professional, or health care facility employee information;
- (2) Intentionally linking or attempting to link individual providers to individual HAI events; and
- (3) Providing patient-level or provider-level reportable HAI data to any state agency for enforcement or regulatory actions.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 192.496, 192.502 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0145

Compliance

- (1) Health care facilities that fail to comply with these rules or fail to submit required data shall be subject to civil penalties not to exceed \$500 per day per violation.
- (2) The Authority shall annually evaluate the quality of data submitted, as recommended by the committee.

Stat. Auth.: ORS 442.445 & 442.420

Stats. Implemented: ORS 442.445

OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 18

DISEASE REPORTING

[OAR 333-018-0000 – 333-018-0035]

Health Care Acquired Infection Reporting and Public Disclosure

333-018-0100

Definitions

The following definitions apply to OAR 333-018-0100 through 333-018-0145:

(1) “Adult ICU” means all specialty and non-specialty intensive care units that care for adults as defined in the NHSN Manual.

(21) “ASC” means an ambulatory surgical center as defined in ORS 442.015 and that is licensed pursuant to ORS 441.015.

(23) “Authority” means the Oregon Health Authority.

(34) “CBGB” means coronary bypass graft surgery with both chest and graft incisions, as defined in the NHSN Manual.

(45) “CAUTI” means catheter-associated urinary tract infection as defined in the NHSN Manual.

(56) “CDC” means the federal Centers for Disease Control and Prevention.

(67) “CDI” means *Clostridium difficile* infection as defined in the NHSN Manual.

(78) “CLABSI” means central line associated bloodstream infection as defined in the NHSN Manual.

(89) “CMS” means the federal Centers for Medicare and Medicaid Services.

(10) “Collection Month” means the month in which the infection was identified.

(9110) “COLO” means colon procedures as defined in the NHSN Manual.

(40124) “Committee” means the Health Care Acquired Infections Advisory Committee ~~as defined established~~ in section 4, chapter 838, Oregon Laws 2007.

(4132) “Dialysis facility” means outpatient renal dialysis facility as defined in ORS 442.015.

(14) “Dialysis Event” means an event that occurs in individuals that receive dialysis as defined by the NHSN Manual.

(421543) “Follow-up” means post-discharge surveillance intended to detect CBGB, COLO, HPRO, HYST, KRPO, and LAM surgical site infection (SSI) cases occurring after a procedure.

(43164) “HAI” means health care acquired infection as defined in section 2, chapter 838, Oregon Laws 2007.

(44175) “Health care facility” means a facility as defined in ORS 442.015.

(45186) “Hospital” means a facility as defined in ORS 442.015 and that is licensed pursuant to ORS 441.015.

(46197) “Hospital Inpatient Quality Reporting Program (HIQRP)” means the initiative administered by CMS that provides a financial incentive to hospitals to report designated quality measures, mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and formerly referred to as RHQDAPU.

(~~472018~~) “HPRO” means hip prosthesis procedure as defined in the NHSN Manual.

(~~482149~~) “HYST” means abdominal hysterectomy procedure as defined in the NHSN Manual.

(~~49229~~) “ICU” means an intensive care unit as defined in the NHSN Manual.

(~~20234~~) “KPRO” means knee prosthesis procedure as defined in the NHSN Manual.

(~~21242~~) “Lab ID” means laboratory-identified event as defined in the NHSN Manual.

(~~22253~~) “LAM” means laminectomy procedure as defined in the NHSN Manual.

(~~23264~~) “LTCF-facility” means a long term care facility as defined in ORS 442.015.

(~~24275~~) “MDS” means the CMS Centers for Medicare and Medicaid Services’ minimum data set nursing home resident assessment and screening tool, version 2.0 or its successor, including but not limited to manuals, forms, software, and databases.

(~~25286~~) “Medical ICU” means a non-specialty intensive care unit in which at least 80 percent of patients served are adult medical patients.

(~~26297~~) “Medical/Surgical ICU” means a non-specialty intensive care unit in which less than 80 percent of patients served are adult medical, adult surgical, or specialty patients.

(~~273028~~) “MRSA” means methicillin-resistant *Staphylococcus aureus* as defined in the NHSN Manual.

(~~283129~~) “NHSN” means the CDC’s National Healthcare Safety Network.

(~~29320~~) “NHSN Inpatient” means a patient whose date of admission to the healthcare facility and the date of discharge are different days as defined in the NHSN Manual.

(~~30334~~) “NHSN Manual” means the 2014 patient safety component protocols, established by the CDC’s NHSN, that govern the HAIs and other information required by CMS to be reported by health care facilities, found at Patient Safety Component Protocol of the NHSN manual, version January 2014, consisting of protocols posted to <http://www.cdc.gov/nhsn/Training/patient-safety-component/>, and incorporated by reference.

(~~31342~~) “NICU” means a specialty intensive care unit that cares for neonatal patients.

(~~353~~) “Non-specialty ICU” means an intensive care unit in which patients are medical, surgical, or medical/surgical patients.

(~~32364~~) “Oregon HAI group” means the NHSN group administered by the Authority.

(~~33375~~) “Overall-facility wide” means data are collected for the entire facility as defined in the NHSN Manual.

(~~34386~~) “Patient information” means individually identifiable health information as defined in ORS 179.505.

(~~397~~) “Pediatric ICU” means a specialty intensive care unit that cares for pediatric patients.

(~~353408~~) “Person” has the meaning given that term in ORS 442.015.

(~~364139~~) “Procedure” means an NHSN-operative procedure as defined in the NHSN Manual.

(~~37420~~) “Provider” means health care services provider as defined in ORS 179.505.

(~~38434~~) “QIO” means the quality improvement organization designated by CMS for Oregon.

(~~39442~~) “RHQDAPU” means the Reporting Hospital Quality Data for Annual Payment Update initiative administered by CMS.

(~~40453~~) “SCIP” means the Surgical Care Improvement Project, established by the Joint Commission, through collaborative efforts of the Joint Commission and CMS

(~~41464~~) “SCIP-Inf-1” means the HAI process measure published by SCIP defined as prophylactic antibiotic received within one hour prior to surgical incision, published by SCIP effective July 1, 2006.

(~~42475~~) “SCIP-Inf-2” means the HAI process measure published by SCIP defined as prophylactic antibiotic selection for surgical patients, published by SCIP effective July 1, 2006.

(43486) “SCIP-Inf-3” means the HAI process measure ~~published by SCIP~~ defined as prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac patients), published by SCIP effective July 1, 2006.

(497) “SCIP-Inf-4” means the HAI process measure ~~published by SCIP~~ defined as cardiac surgery patients with controlled 6 a.m. postoperative serum glucose, published by SCIP effective July 1, 2006.

(454508) “SCIP-Inf-6” means the HAI process measure ~~published by SCIP~~ defined as surgery patients with appropriate hair removal, published by SCIP effective July 1, 2006.

(465149) “SCIP-Inf-9” means the HAI process measure defined as urinary catheter removed on postoperative day 1 or postoperative day 2 with day of surgery being day zero, published by SCIP effective July 1, 2006.

(47520) “SCIP-Inf-10” means the HAI process measure ~~published by SCIP~~ defined as surgery patients with perioperative temperature management, published by SCIP effective July 1, 2006.

(48534) “Specialty ICU” means an intensive care unit in which at least 80 percent of adult patients served are specialty patients, including but not limited to oncology, trauma, and neurology.

(49542) “SSI” means a surgical site infection event as defined in the Patient Safety Component Protocol of the NHSN manual, version January 2013.

(50553) “Staff” means any employee of a health care facility or any person contracted to work within a health care facility.

(51564) “State agency” has the meaning given that term in ORS 192.410.

(52575) “Surgical ICU” means a non-specialty intensive care unit in which at least 80 percent of patients served are adult surgical patients.
 Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 & 12
 Stats. Implemented: ORS 179.505, 192.410, 192.496, 192.502, 441.015, 442.011, 442.400, 442.405, & OL 2007, Ch. 838 § 1-6 & 12

333-018-0105

Review

Unless otherwise directed by the Authority, the committee shall review these rules (OAR 333-018-0100 through 333-018-0145) at least biennially.
 Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1-6 & 12
 Stats. Implemented: 2007 OL Ch. 838 § 1-6 & 12

333-018-0110

HAI Reporting for Hospitals

~~(1) All hospitals shall collect data for HAI outcome and process measures for the HAI reporting program in accordance with these rules, except:~~

~~(a) Hospitals shall report facility wide inpatient MRSA bacteremia data using the Lab ID method for MRSA bacteremia in the NHSN MDRO and CDI Module protocol for services provided in hospitals on or after January 1, 2014.~~

~~(b) Hospitals shall report NHSN inpatient CAUTI events in adult and pediatric ICUs for services provided on or after January 1, 2014.~~

~~(2) Reportable HAI outcome measures are:~~

~~(a) SSIs for NHSN Inpatient CBGB, COLO, HPRO, HYST, KPRO, and LAM procedures.~~

~~(b) CLABSI in medical ICUs, surgical ICUs, and combined medical/surgical ICUs.~~

(c) NHSN Inpatient CDI facility-wide;
 (d) NHSN Inpatient MRSA bacteremia facility-wide;
 (e) CAUTI in adult and pediatric ICUs;
 (3) The infection control professional (ICP), as defined by the facility, shall actively seek out infections defined in subsections (2)(a) and (e) of this rule during a patient's stay by screening a variety of data that may include but is not limited to:
 (a) Laboratory;
 (b) Pharmacy;
 (c) Admission;
 (d) Discharge;
 (e) Transfer;
 (f) Radiology;
 (g) Imaging;
 (h) Pathology; and
 (i) Patient charts, including history and physical notes, nurses and physicians notes, and temperature charts;
 (4) The ICP shall use follow-up surveillance methods to detect SSIs for procedures defined in subsection (2)(a) of this rule using at least one of the following:
 (a) Direct examination of patients' wounds during follow-up visits to either surgery clinics or physicians' offices;
 (b) Review of medical records, subsequent hospitalization records, or surgery clinic records;
 (c) Surgeon surveys by mail or telephone;
 (d) Patient surveys by mail or telephone; or
 (e) Other facility surveys by mail or telephone;
 (5) Others employed by the facility may be trained to screen data sources for these infections, but the ICP must determine that the infection meets the criteria established by these rules;
 (6) The HAI reporting system for HAI outcome measures shall be NHSN. Each Oregon hospital shall comply with processes and methods prescribed by CDC for NHSN data submission. These include but are not limited to definitions, data collection, data reporting, and administrative and training requirements. Each Oregon hospital shall:
 (a) Join the Oregon HAI group in NHSN;
 (b) Authorize disclosure of NHSN data to the Authority as necessary for compliance with these rules, including but not limited to summary data and denominator data for all SSIs, the annual hospital survey and data analysis components for all SSIs, and summary data and denominator data for all medical ICUs, surgical ICUs, and combined medical/surgical ICUs;
 (c) Report its data for outcome measures to NHSN no later than 30 days after the end of the collection month. The NHSN field "Discharge Date" is mandatory for all outcome measures;
 (7) Each hospital shall report on a quarterly basis according to OAR 333-018-0110(1) the following HAI process measures:
 (a) SCIP-Inf-1;
 (b) SCIP-Inf-2;
 (c) SCIP-Inf-3;
 (d) SCIP-Inf-4;
 (e) SCIP-Inf-6;
 (f) SCIP-Inf-9; and
 (g) SCIP-Inf-10.

(8) The reporting system for HAI process measures shall be the Hospital Inpatient Quality Reporting Program, formerly referred to as the RHQDAPU program as configured on July 1, 2008. Each Oregon hospital shall:

(a) Comply with reporting processes and methods prescribed by CMS for the RHQDAPU program. These include but are not limited to definitions, data collection, data reporting, and administrative and training requirements; and

(b) Report data quarterly for HAI process measures. Data must be submitted to and successfully accepted into the QIO clinical warehouse no later than 11:59 p.m. central time, on the 15th calendar day, four months after the end of the quarter.

(9) For NICUs, the HAI reporting system for outcome measures shall be NHSN. Each Oregon hospital with a NICU shall comply with processes and methods prescribed by NHSN for the CLABSI reporting, including but not limited to definitions, data collection, data submission, and administrative and training requirements. Each Oregon hospital shall:

(a) Authorize disclosure of NHSN data to the Authority as necessary for compliance with these rules, including but not limited to facility identifiers.

(b) Submit NICU data to NHSN according to the NHSN Manual.

(10) Each hospital shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include but not be limited to the following questions regarding influenza vaccine coverage of facility staff:

(a) Number of staff with a documented influenza vaccination during the previous influenza season;

(b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;

(c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and

(d) Facility assessment of influenza vaccine coverage of facility staff during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.

(1) Hospitals must report to the Authority the following HAIs:

(a) SSIs for Inpatient COLO and HYST;

(b) CLABSI in all adult, pediatric medical, surgical, and medical/surgical wards, and adult, pediatric, and neonatal ICUs;

(c) Inpatient CDI facility-wide, excluding neonatal and well-baby units;

(d) CAUTI in:

(A) Adult and pediatric ICUs; and

(B) On or after January 1, 2015, all adult and pediatric medical, surgical, and medical/surgical wards;and

(e) SSIs for HPRO, LAM, CBGB and KPRO procedures.

(2) Hospitals must report to the Authority all fields required to be reported by NHSN in accordance with the NHSN manual, including discharge dates.

(3) A hospital must report the information required in section (1) of this rule to the Authority no later than 30 days after the end of the collection month.

(4) A hospital must have an infection control professional (ICP) who actively seeks out HAIs required to be reported under this rule by screening a variety of data from various sources that may include but is not limited to:

(a) Laboratory;
(b) Pharmacy;
(c) Admission;
(d) Discharge;
(e) Transfer;
(f) Radiology;
(g) Imaging;
(h) Pathology; and
(i) Patient charts, including history and physical notes, nurses and physicians notes, and temperature charts.

(5) An ICP shall use follow-up surveillance methods to detect SSIs for procedures listed in section (1) of this rule using at least one of the following:

(a) Direct examination of patients' wounds during follow-up visits to either surgery clinics or physicians' offices;
(b) Review of medical records, subsequent hospitalization records, or surgery clinic records;
(c) Surgeon surveys by mail or telephone;
(d) Patient surveys by mail or telephone; or
(e) Other facility surveys by mail or telephone.

(6) A hospital may train others employed by the facility to screen data sources for these infections required to be reported in section (1) of this rule but the ICP must determine that the infection meets the criteria established by these rules.

(7) Hospitals that report the information in section (1)(a) to (d) of this rule through NHSN in order to meet CMS reporting requirements, may in lieu of reporting this information directly to the Authority, permit the Authority to access the information through NHSN. A hospital that permits the Authority to access the information through NHSN must:

(a) Join the Oregon HAI group in NHSN;
(b) Authorize disclosure of NHSN data to the Authority as necessary for compliance with these rules, including but not limited to summary data and denominator data for all SSIs, the annual hospital survey and data analysis components for all SSIs, and summary data and denominator data for all adult, pediatric and neonatal ICUs; and
(c) Permit the Authority access to data reported through NHSN dating back to when reporting was first required by CMS for the different HAIs.

(8) All hospitals must report to the Authority on a quarterly basis the following HAI process measures, including but not limited to definitions, data collection, data reporting and training requirements:

(a) SCIP-Inf-1;
(b) SCIP-Inf-2;
(c) SCIP-Inf-3;
(d) SCIP-Inf-4;
(e) SCIP-Inf-6;
(f) SCIP-Inf-9; and
(g) SCIP-Inf-10.

(9) Hospitals that report the information in section (8) of this rule to CMS or the Joint Commission do not have to provide the information directly to the Authority, the Authority will access the information through CMS or the Joint Commission. If a hospital is not reporting the

information in section (8) of this rule to CMS or the Joint Commission, in accordance with CMS or Joint Commission reporting requirements, it must provide the information to the Authority no later than on the 15th calendar day, four months after the end of the quarter.

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Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 442.405 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0115

HAI Reporting for Ambulatory Surgery Centers

~~(1) Ambulatory Surgical Center ASCs that report events data to CMS shall be considered to comply with HAI reporting requirements if these facilities provide the same data to the Authority, or permit the Authority to have access to the same data, as is reported to CMS.~~

~~(12) Each ASC shall complete a survey of evidenced-based elements of patient safety performance as defined by the Authority. All Ambulatory Surgical Centers must complete the report to the Authority the following:~~

~~(a) The Evidence-Based Elements of Patient Safety Performance Survey (EBEPSP) provided by the Authority, annually.~~

~~(2) The survey reporting system shall be the Authority.~~

~~(23) The survey shall be submitted annually by each ASC to the Authority no later than 30 days after receipt of the survey.~~

~~(34) Each ASC shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include but not be limited to the following questions regarding influenza vaccine coverage of facility staff:~~

~~(a) Number of staff with a documented influenza vaccination during the previous influenza season;~~

~~(b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;~~

~~(c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and~~

~~(d) Facility assessment of influenza vaccine coverage of facility staff during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.~~

Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 and 12

Stats. Implemented: ORS 442.405 & OL 2007, Ch. 838 § 1-6 and 12

333-018-0120

HAI Reporting for Long Term Care Facilities

(1) All LTCFs must report urinary tract infectionsto the Authority except as provided in subsection (b) of this section.

(a)A LTCFmust report infections to the Authority in the same manner established byMDS, including but not limited to reporting definitions, data collection, data submission, and administrative and training requirements.

(b) If a LTCF reports infections in accordance with MDS to CMS, the LTCF is not required to report that information directly to the Authority, the Authority will access the information through CMS.

(2) All LTCFs must submit the ~~Evidence-Based Elements of Patient Safety Performance to the Authority annually, no later than 30 days after receipt of the survey.~~ Infection Prevention Program Survey to the Authority annually, no later than 30 days after receipt of the survey.

~~(6) The survey shall be submitted annually by each LTC facility to the Authority no later than 30 days after receipt of the survey.~~

~~(47) Each LTC facility shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include but not be limited to the following questions regarding influenza vaccine coverage of facility staff:~~

~~(a) Number of staff with a documented influenza vaccination during the previous influenza season;~~

~~(b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;~~

~~(c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and~~

~~(d) Facility assessment of influenza vaccine coverage of facility staff and volunteers during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.~~

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1-6 & 12

Stats. Implemented: ORS 442.405 & 2007 OL Ch. 838 § 1-6 & 12

333-018-0125

HAI Reporting for Other Health Care Facilities

~~(1) All dialysis facilities shall report to the Authority the following:~~

~~(a) Dialysis events with reporting starting on January, 2012.~~

~~(2) A dialysis facility that reports dialysis events to NHSN may, in lieu of reporting the information directly to the Authority, permit the Authority access to NHSN. The Reporting System for Dialysis Events shall be NHSN~~

~~(3) Dialysis facilities that report events data to the Centers for Medicare and Medicaid (CMS) shall be considered to comply with HAI reporting requirements if these dialysis facilities provide the same data to the Authority, or permits the Authority to have access to the same data, as is reported to CMS.~~

~~(34) All Inpatient Rehabilitation Facilities (IRF) shall report to the Authority the following:~~

~~(a) CAUTIs for adult and pediatric wards; and~~

~~(54) The Reporting System for IRFs shall be NHSN~~

~~(5) Dialysis facilities and IRFs that report information in order to meet CMS reporting requirements, may in lieu of reporting information directly to the Authority, permit the Authority to access the information through NHSN. A IRF that permits the Authority to access the information through NHSN must:~~

~~(a) Join the Oregon HAI group in NHSN;~~

(b) Authorize disclosure of NHSN data to the Authority as necessary for compliance with these rules, including but not limited to summary data and denominator data for all dialysis events and CAUTIs in LTCF, the annual infection preventions survey and data analysis components.

(c) Permit the Authority access to data reported through NHSN dating back to when reporting was first required by CMS for the different HAIs.

5

Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 and 12

Stats. Implemented: ORS 442.405 & OL 2007, Ch. 838 § 1-6 and 12

333-018-XXXX

Annual Influenza Summary

Each hospital, ASC, LTCF and IRFLTCF must submit an annual survey to the Authority, no later than May 31, on a form prescribed by the Authority, regarding influenza vaccination of staff. Facilities must report at least the following information:

(1) Number of staff with a documented influenza vaccination during the previous influenza season;

(2) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;

(3) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and

(4) Facility assessment of influenza vaccine coverage of facility staff during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.

333-018-0130

HAI Public Disclosure

(1) The Authority shall disclose to the public ~~updated~~ facility-level and state-level HAI outcomes ~~rates at least~~ quarterly.

(2) The Authority may disclose state-level and facility-level HAI data, including but not limited to observed frequencies, expected frequencies, proportions, and ratios.

(3) The Authority shall summarize HAI data by facilities subject to this reporting in an annual report. The Authority shall publish the annual report no later than April 30 of each calendar year.

(4) The Authority shall disclose data and accompanying explanatory documentation to facilities and the general public in a format that facilitates access and use by the general public and health care providers.

(5) The Authority may use statistically valid methods to make comparisons by facility, and to state, regional, and national statistics.

(6) The Authority shall provide a maximum of 30 calendar days for facilities to review facility-reported data prior to public release of data.

Comment [SoO1]: Can we change this date or is it in the ORS?

Comment [sko2]: Appears to be in statute

Comment [SoO3]: Is this still correct?

Comment [sko4]: This is not a statutory requirement so you could change it.

- (7) The Authority shall provide facilities the opportunity to submit written comments and may include any submitted information in the annual report.
- (8) Pending recommendations from the committee, the Authority may publish additional reports intended to serve the public's interest.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 442.405, 192.496, 192.502, 192.243, 192.245 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0135

HAI Data Processing and Security

~~(1) The Authority shall obtain hospital outcome measure data files directly from NHSN at least quarterly.~~

~~(2) The Authority shall obtain hospital process measure data files from the CMS hospital compare website at least quarterly.~~

~~(3) The Authority shall calculate state level and facility level statistics to facilitate HAI public disclosure. These statistics may include but are not limited to observed frequencies, expected frequencies, proportions, rates, and ratios. The Authority shall make public the methods used to calculate statistics and perform comparisons.~~

~~(4) The Authority shall use statistically valid risk adjustment methods recommended by the committee including but not limited to NHSN methodology.~~

~~(5)~~ The Authority shall undertake precautions to prevent unauthorized disclosure of the raw data files. These precautions include but are not limited to:

- (a) Storing the raw data files on the internal storage hardware of a password-protected personal computer that is physically located within the Authority;
- (b) Restricting staff access to the raw data files;
- (c) Restricting network access to the raw data files; and
- (d) If applicable, storing patient information within a strongly-encrypted and password-protected virtual drive or using other methods to reliably achieve the same level of security.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 192.496, 192.502 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0140

Prohibited Activities

Unless specifically required by state or federal rules, regulations, or statutes, the Authority is prohibited from:

- (1) Disclosing individually identifiable patient, health care professional, or health care facility employee information;
- (2) Intentionally linking or attempting to link individual providers to individual HAI events; and
- (3) Providing patient-level or provider-level reportable HAI data to any state agency for enforcement or regulatory actions.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 192.496, 192.502 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0145

Compliance

(1) Health care facilities that fail to comply with these rules or fail to submit required data shall be subject to civil penalties not to exceed \$500 per day per violation.

(2) The Authority shall annually evaluate the quality of data submitted, as recommended by the committee.

Stat. Auth.: ORS 442.445 & 442.420

Stats. Implemented: ORS 442.445

DRAFT

OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 18

DISEASE REPORTING

[OAR 333-018-0000 – 333-018-0035]

Health Care Acquired Infection Reporting and Public Disclosure

333-018-0100

Definitions

The following definitions apply to OAR 333-018-0100 through 333-018-0145:

(1) “Adult ICU” means all specialty and non-specialty intensive care units that care for adults as defined in the NHSN Manual

(1) “ASC” means an ambulatory surgical center as defined in ORS 442.015 and that is licensed pursuant to ORS 441.015.

(2) “Authority” means the Oregon Health Authority.

(3) “CBGB” means coronary bypass graft surgery with both chest and graft incisions, as defined in the NHSN Manual.

(4) “CAUTI” means catheter-associated urinary tract infection as defined in the NHSN Manual.

(5) “CDC” means the federal Centers for Disease Control and Prevention.

(6) “CDI” means *Clostridium difficile* infection as defined in the NHSN Manual.

(7) “CLABSI” means central line associated bloodstream infection as defined in the NHSN Manual.

(8) “CMS” means the federal Centers for Medicare and Medicaid Services.

(9) “Collection Month” means the month in which an infection was identified.

(9) “COLO” means colon procedures as defined in the NHSN Manual.

(10) “Committee” means the Health Care Acquired Infections Advisory Committee as defined in section 4, chapter 838, Oregon Laws 2007.

(11) “Dialysis Event” means an event that occurs in individuals that receive dialysis as defined by the NHSN Manual.

(11) “Dialysis facility” means outpatient renal dialysis facility as defined in ORS 442.015.

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

(13) “HAI” means health care acquired infection as defined in section 2, chapter 838, Oregon Laws 2007.

(14) “Health care facility” means a facility as defined in ORS 442.015.

(15) “Hospital” means a facility as defined in ORS 442.015 and that is licensed pursuant to ORS 441.015.

(16) “Hospital Inpatient Quality Reporting Program” (HIQRP) means the initiative administered by CMS that provides a financial incentive to hospitals to report designated quality measures, mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and formerly referred to as RHQDAPU.

Comment [SoO1]: Specifying new collection locations for HAI reporting

Comment [SoO2]: Help to identify time frame for reporting in section (3)

Comment [SoO3]: DE added to reportable HAIs in Jan. 2012

Comment [SoO4]: No longer called RHQDAPU. Added CMS rule section for reference

- (17) "HPRO" means hip prosthesis procedure as defined in the NHSN Manual.
- (18) "HYST" means abdominal hysterectomy procedure as defined in the NHSN Manual.
- (19) "ICU" means an intensive care unit as defined in the NHSN Manual.
- (20) "Infection Prevention Program Survey" means the annual survey each LTCF must submit to the Authority
- (20) "KPRO" means knee prosthesis procedure as defined in the NHSN Manual.
- (21) "Lab ID" means laboratory-identified event as defined in the NHSN Manual.
- (22) "LAM" means laminectomy procedure as defined in the NHSN Manual.
- (23) "LTCF facility" means long term care facility as defined in ORS 442.015.
- (24) "MDS" means the Centers for Medicare and Medicaid Services' minimum data set nursing home resident assessment and screening tool, version 2.0 or its successor, including but not limited to manuals, forms, software, and databases.
- (25) "Medical ICU" means a non-specialty intensive care unit in which at least 80 percent of patients served are adult medical patients.
- (26) "Medical/Surgical ICU" means a non-specialty intensive care unit in which less than 80 percent of patients served are adult medical, adult surgical, or specialty patients.
- (27) "MRSA" means methicillin-resistant *Staphylococcus aureus* as defined in the NHSN Manual.
- (28) "NHSN" means the CDC's National Healthcare Safety Network.
- (29) "NHSN Inpatient" means a patient whose date of admission to the healthcare facility and the date of discharge are different days as defined in the NHSN Manual.
- (30) "NHSN Manual" means the 2014 patient safety component protocols, established by the CDC's NHSN, that govern the HAIs and other information required by CMS to be reported by health care facilities, found at: <http://www.cdc.gov/nhsn/Training/patient-safety-component> and incorporated by reference, the Patient Safety Component Protocol of the NHSN manual, version January 2013.
- (31) "NICU" means a specialty intensive care unit that cares for neonatal patients.
- (32) "Non-specialty ICU" means an intensive care unit in which patients are medical, surgical, or medical/surgical patients.
- (32) "Oregon HAI group" means the NHSN group administered by the Authority.
- (33) "Overall-facility wide" means data are collected for the entire facility as defined in the NHSN Manual.
- (34) "Patient information" means individually identifiable health information as defined in ORS 179.505.
- (35) "Pediatric ICU" means a specialty intensive care unit that cares for pediatric patients.
- (35) "Person" has the meaning given that term in ORS 442.015.
- (36) "Procedure" means an NHSN operative procedure as defined in the NHSN Manual.
- (37) "Provider" means health care services provider as defined in ORS 179.505.
- (38) "QIO" means the quality improvement organization designated by CMS for Oregon.
- (39) "RHQDAPU" means the Reporting Hospital Quality Data for Annual Payment Update initiative administered by CMS.
- (40) "SCIP" means the Surgical Care Improvement Project, established through collaborative efforts of the Joint Commission and CMS.
- (41) "SCIP-Inf-1" means the HAI process measure published by SCIP defined as prophylactic antibiotic received within one hour prior to surgical incision, published by SCIP effective July 1, 2006.

Comment [SoO5]: The Patient Safety Component Protocol manual no longer exists as a single document. Changed the reference to the website for all HAI protocols.

Comment [SoO6]: Specifying collection locations for HAI reporting

Comment [SoO7]: Specifying new collection locations for HAI reporting

Comment [SoO8]: RHQDAPU is no longer the data warehouse for CMS.

Comment [SoO9]: Identified both parties that require SCIP data submission.

Comment [SoO10]: Specifying dates when collection criteria were published.

(42) “SCIP-Inf-2” means the HAI process measure published by SCIP defined as prophylactic antibiotic selection for surgical patients published by SCIP effective July 1, 2006.

(43) “SCIP-Inf-3” means the HAI process measure published by SCIP defined as prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac patients) published by SCIP effective July 1, 2006.

(44) “SCIP-Inf-4” means the HAI process measure published by SCIP defined as cardiac surgery patients with controlled 6 a.m. postoperative serum glucose published by SCIP effective July 1, 2006.

(45) “SCIP-Inf-6” means the HAI process measure published by SCIP defined as surgery patients with appropriate hair removal published by SCIP effective July 1, 2006.

(46) “SCIP-Inf-9” means urinary catheter removed on postoperative day 1 or postoperative day 2 with day of surgery being day zero published by SCIP effective July 1, 2006.

(47) “SCIP-Inf-10” means the HAI process measure published by SCIP defined as surgery patients with perioperative temperature management published by SCIP effective July 1, 2006.

(48) “Specialty ICU” means an intensive care unit in which at least 80 percent of adult patients served are specialty patients, including but not limited to oncology, trauma, and neurology.

(49) “SSI” means a surgical site infection event as defined in the Patient Safety Component Protocol of the NHSN manual, version January 2013.

(50) “Staff” means any employee of a health care facility or any person contracted to work within a health care facility.

(51) “State agency” has the meaning given that term in ORS 192.410.

(52) “Surgical ICU” means a non-specialty intensive care unit in which at least 80 percent of patients served are adult surgical patients.

Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 & 12

Stats. Implemented: ORS 179.505, 192.410, 192.496, 192.502, 441.015, 442.011, 442.400, 442.405, & OL 2007, Ch. 838 § 1-6 & 12

Comment [SoO11]: Specifying dates when collection criteria were published.

Comment [SoO12]: Specifying dates when collection criteria were published.

Comment [SoO13]: Specifying dates when collection criteria were published.

Comment [SoO14]: Specifying dates when collection criteria were published.

Comment [SoO15]: Specifying dates when collection criteria were published.

Comment [SoO16]: Specifying dates when collection criteria were published.

333-018-0105

Review

Unless otherwise directed by the Authority, the committee shall review these rules (OAR 333-018-0100 through 333-018-0145) at least biennially.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1-6 & 12

Stats. Implemented: 2007 OL Ch. 838 § 1-6 & 12

333-018-0110

HAI Reporting for Hospitals

(1) Hospitals must report to the Authority the following HAIs: (1) All hospitals shall collect data for HAI outcome and process measures for the HAI reporting program in accordance with these rules, except:

Comment [SoO17]: Reworded and took out outcomes and process measures.

(a) Hospitals shall report facility wide inpatient MRSA bacteremia data using the Lab ID method for MRSA bacteremia in the NHSN MDRO and CDI Module protocol for services provided in hospitals on or after January 1, 2014.

(b) Hospitals shall report NHSN inpatient CAUTI events in adult and pediatric ICUs for services provided on or after January 1, 2014.

Comment [SoO18]: No longer a upcoming HAI. Is a current rule.

(a) SSIs for Inpatient COLO and HYST:

(b) CLABSI in all adult, pediatric, medical, surgical, and medical surgical wards and adult, pediatric, and neonatal ICUs

(A) On or after January 1, 2015, all adult and pediatric, medical, surgical, and medical/surgical wards; and

(c) Inpatient CDI facility-wide, excluding neonatal and well-baby units;

(d) CAUTI in:

(A) Adult and pediatric ICUs; and

(B) On or after January 1, 2015, all adult and pediatric, medical, surgical and medical/surgical wards; and

(e) SSIs for HPRO, LAM, CBGB, and KPRO procedures

(2) Reportable HAI outcome measures are:

(a) SSIs for NHSN Inpatient CBGB, COLO, HPRO, HYST, KPRO, and LAM procedures.

(b) CLABSI in medical ICUs, surgical ICUs, and combined medical/surgical ICUs.

(c) NHSN Inpatient CDI facility wide.

(d) NHSN Inpatient MRSA bacteremia facility wide.

(e) CAUTI in adult and pediatric ICUs.

(2) Hospitals must report to the Authority all fields required to be reported by NHSN in accordance with the NHSN manual, including discharge dates.

(3) A hospital must report the information required in section (1) of this rule to the Authority no later than 30 days after the end of the collection month.

(4) A hospital must have an infection control professional who actively seeks out HAIs required to be reported under this rule by screening a variety of data from various sources that may include, but is not limited to: The infection control professional (ICP), as defined by the facility, shall actively seek out infections defined in subsections (2)(a) and (e) of this rule during a patient's stay by screening a variety of data that may include but is not limited to:

(a) Laboratory;

(b) Pharmacy;

(c) Admission;

(d) Discharge;

(e) Transfer;

(f) Radiology;

(g) Imaging;

(h) Pathology; and

(i) Patient charts, including history and physical notes, nurses and physicians notes, and temperature charts.

(5) The ICP shall use follow-up surveillance methods to detect SSIs for procedures defined in subsection (1)(2)(a) of this rule using at least one of the following:

(a) Direct examination of patients' wounds during follow-up visits to either surgery clinics or physicians' offices;

(b) Review of medical records, subsequent hospitalization records, or surgery clinic records;

(c) Surgeon surveys by mail or telephone;

(d) Patient surveys by mail or telephone; or

(e) Other facility surveys by mail or telephone.

(6) A hospital may train others employed by the facility to screen data sources for these infections required to be reported in section (1) of this rule, but the ICP must determine that the infection meets the criteria established by this rule. Others employed by the facility may be

Comment [SoO19]: a-d are HAIs reportable to CMS and OHA. Section (e) was distinguished from the rest because these are only required by OHA. Also added changes upcoming in 2015 with the addition of wards to CAUTI and CLABSI reporting.

Comment [SoO20]: Moved here from section 6(c). These two items were split into two separate rules and added to all facility requirements, rather than ICP requirements.

Comment [SoO21]: Identified the facility requirement for an ICP. Reworded.

Comment [SoO22]: Identified the facility as the responsible party. Reworded.

~~trained to screen data sources for these infections, but the ICP must determine that the infection meets the criteria established by these rules.~~

~~(7) Hospitals that report the information in section (1)(a) to (d) of this rule through NHSN in order to meet CMS reporting requirements, may in lieu of reporting this information directly to the Authority, permit the Authority to access the information through NHSN. A hospital that permits the Authority to access the information through NHSN must:~~

~~(6) The HAI reporting system for HAI outcome measures shall be NHSN. Each Oregon hospital shall comply with processes and methods prescribed by CDC for NHSN data submission. These include but are not limited to definitions, data collection, data reporting, and administrative and training requirements. Each Oregon hospital shall:~~

~~(a) Join the Oregon HAI group in NHSN.~~

~~(b) Authorize disclosure of NHSN data to the Authority as necessary for compliance with these rules, including but not limited to summary data and denominator data for all SSIs, the annual hospital survey and data analysis components for all HAISSIs, and summary data and denominator data for all adult, pediatric, and neonatal ICUs; and~~

~~(c) Permit the Authority access to data reported through NHSN dating back to when reporting was first required by CMS for different HAIs, medical ICUs, surgical ICUs, and combined medical/surgical ICUs.~~

~~(e) Report its data for outcome measures to NHSN no later than 30 days after the end of the collection month. The NHSN field "Discharge Date" is mandatory for all outcome measures.~~

~~(7) Each hospital shall report on a quarterly basis according to OAR 333-018-0110(1) the following HAI process measures:~~

~~(8) All hospitals must report to the Authority on a quarterly basis the following HAI process measures, including, but not limited to, definitions, data collections, data reporting and training requirements:~~

~~(a) SCIP-Inf-1;~~

~~(b) SCIP-Inf-2;~~

~~(c) SCIP-Inf-3;~~

~~(d) SCIP-Inf-4;~~

~~(e) SCIP-Inf-6;~~

~~(f) SCIP-Inf-9; and~~

~~(g) SCIP-Inf-10.~~

~~(9) Hospitals that report the information in section (8) of this rule to CMS or the Joint Commission do not have to provide the information directly to the Authority, the Authority will access the information through CMS or the Joint Commission. If a hospital is not reporting the information in section (8) of the this rule to CMS or the Joint Commission, in accordance with CMS or Joint Commission reporting requirements, it must provide the information to the Authority no later than the 15th calendar day, four months after the end of each quarter.~~

~~(8) The reporting system for HAI process measures shall be the Hospital Inpatient Quality Reporting Program, formerly referred to as the RHQDAPU program as configured on July 1, 2008. Each Oregon hospital shall:~~

~~(a) Comply with reporting processes and methods prescribed by CMS for the RHQDAPU program. These include but are not limited to definitions, data collection, data reporting, and administrative and training requirements; and~~

Comment [SoO23]: Establishing reporting through NHSN and allowing for retrospective data collection in alignment with CMS definition changes.

Comment [SoO24]: Broadening locations to be in alignment with CMS required locations.

Comment [SoO25]: Moved to HAI Reporting for Hospitals section

Comment [SoO26]: Rewording previous (7)

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(b) Report data quarterly for HAI process measures. Data must be submitted to and successfully accepted into the QIO clinical warehouse no later than 11:59 p.m. central time, on the 15th calendar day, four months after the end of the quarter;

Comment [SoO27]: RHQDAPU is not longer the data warehouse. Reworded to include JC.

(9) For NICUs, the HAI reporting system for outcome measures shall be NHSN. Each Oregon hospital with a NICU shall comply with processes and methods prescribed by NHSN for the CLABSI reporting, including but not limited to definitions, data collection, data submission, and administrative and training requirements. Each Oregon hospital shall:

(a) Authorize disclosure of NHSN data to the Authority as necessary for compliance with these rules, including but not limited to facility identifiers;

(b) Submit NICU data to NHSN according to the NHSN Manual;

Comment [SoO28]: Identified as redundant.

(10) Each hospital shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include but not be limited to the following questions regarding influenza vaccine coverage of facility staff:

(a) Number of staff with a documented influenza vaccination during the previous influenza season;

(b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;

(c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and

(d) Facility assessment of influenza vaccine coverage of facility staff during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season;

Comment [SoO29]: Moved to the Annual Influenza Summary section

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1-6 & 12

Stats. Implemented: ORS 442.405 & 2007 OL Ch. 838 § 1-6 & 12

333-018-0115

HAI Reporting for Ambulatory Surgery Centers

(1) All Ambulatory Surgical Centers must complete the Evidence-Based Elements of Patient Safety Performance Survey provided by the Authority annually, no later than 30 days after receipt of the survey

(1) Each ASC shall complete a survey of evidenced-based elements of patient safety performance as defined by the Authority;

(2) The survey shall be submitted annually by each ASC to the Authority no later than 30 days after receipt of the survey.

Comment [SoO30]: Combined wording to single statement.

(3) Each ASC shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include but not be limited to the following questions regarding influenza vaccine coverage of facility staff:

(a) Number of staff with a documented influenza vaccination during the previous influenza season;

(b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;

(c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and

~~(d) Facility assessment of influenza vaccine coverage of facility staff during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season;~~

Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 and 12

Stats. Implemented: ORS 442.405 & OL 2007, Ch. 838 § 1-6 and 12

Comment [SoO31]: Moved to the Annual Influenza Summary section

333-018-0120

HAI Reporting for Long Term Care Facilities

(1) All LTCFs must report urinary tract infections to the Authority except as provided in subsection (b) of this section.

(a) A LTCF must report infection to the Authority in the manner established by MDS, including, but not limited to, reporting definitions, data collections, data submission, and administrative and training requirements.

(b) If a LTCF reports infections in accordance with MDS to CMS, the LTCF is not required to report that information directly to the Authority, the Authority will access the information through CMS.

(2) All LTCFs must submit the Infection Prevention Program Survey to the Authority annually, no later than 30 days after receipt of the survey.

(1) The HAI Reporting System for outcome measures shall be MDS.

(2) Reportable HAI outcome measures are from MDS and include the data element, "urinary tract infection in the last 30 days."

(3) Each LTC facility shall comply with reporting processes and methods prescribed by CMS for MDS. These include but are not limited to definitions, data collection, data submission, and administrative and training requirements.

(4) Each LTC facility shall complete an annual survey, as defined by the Authority, of influenza vaccination of staff and submit the completed survey to the Authority. The survey shall include but not be limited to the following questions regarding influenza vaccine coverage of facility staff:

(a) Number of staff with a documented influenza vaccination during the previous influenza season;

(b) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;

(c) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and

(d) Facility assessment of influenza vaccine coverage of facility staff and volunteers during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1-6 & 12

Stats. Implemented: ORS 442.405 & 2007 OL Ch. 838 § 1-6 & 12

Comment [SoO32]: This is a survey that will need to be vetted through the HAIAC approval process. Mary Post has the particulars.

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Comment [SoO33]: Reworded.

Comment [SoO34]: Moved to Annual Influenza Summary section.

333-018-0125

HAI Reporting for Other Health Care Facilities

(1) All dialysis facilities shall report to the Authority dialysis events.

(2) A dialysis facility that reports dialysis events to NHSN may, in lieu of reporting the information directly to the Authority, permit the Authority access to NHSN.

(3) All Inpatient Rehabilitation Facilities (IRF) shall report to the Authority CAUTIs for adult and pediatric wards.
(4) The Reporting System for IRFs shall be NHSN
(5) IRFs that report information in order to meet CMS reporting requirements may, in lieu of reporting information directly to the Authority, permit the Authority to access the information through NHSN.
(6) A dialysis facility or IRF that permits the Authority to access the information through NHSN must:
(a) Join the Oregon HAI group in NHSN
(b) Authorize disclosure of NHSN data to the Authority as necessary for compliance with the rules, including, but not limited to, summary data and denominator data for all dialysis events and CAUTIs.
(c) Permit the Authority access to data reported through NHSN dating back to when reporting was first required by CMS for the different HAIs.
Dialysis facilities shall submit data for the HAI reporting program for services provided on or after January 1, 2013. Dialysis facilities that report events data to the Centers for Medicare and Medicaid (CMS) shall be considered to comply with HAI reporting requirements if these dialysis facilities provide the same data to the Authority, or permits the Authority to have access to the same data, as is reported to CMS.

Stat. Auth.: ORS 442.420 & OL 2007, Ch. 838 § 1-6 and 12

Stats. Implemented: ORS 442.405 & OL 2007, Ch. 838 § 1-6 and 12

333-018-XXXX

Annual Influenza Summary

Each hospital, ASC, LTCF and IRF must submit an annual survey to the Authority, no later than May 31, on a form prescribed by the Authority, regarding influenza vaccination of staff. Facilities must report at least the following information:

- (1) Number of staff with a documented influenza vaccination during the previous influenza season;
- (2) Number of staff with a documented medical contraindication to influenza vaccination during the previous influenza season;
- (3) Number of staff with a documented refusal of influenza vaccination during the previous influenza season; and
- (4) Facility assessment of influenza vaccine coverage of facility staff during the previous influenza season and plans to improve vaccine coverage of facility staff during the upcoming influenza season.

Comment [SoO35]: Added further details for reporting in IRFs

Comment [SoO36]: Since several facilities are required to report Influenza vaccination, a section was created specifically to that data element.

333-018-0130

HAI Public Disclosure

- (1) The Authority shall disclose to the public ~~updated~~ facility-level and state-level HAI outcomes rates at least quarterly.
- (2) The Authority may disclose state-level and facility-level HAI data, including but not limited to observed frequencies, expected frequencies, proportions, and ratios.
- (3) The Authority shall summarize HAI data by facilities subject to this reporting in an annual report. The Authority shall publish the annual report no later than April 30 of each calendar year.

(4) The Authority shall disclose data and accompanying explanatory documentation in ~~to facilities and the general public, a format that facilitates access and use by the general public and health care providers.~~

(5) The Authority may use statistically valid methods to make comparisons by facility, and to state, regional, and national statistics.

(6) The Authority shall provide a maximum of 30 calendar days for facilities to review facility-reported data prior to public release of data.

(7) The Authority shall provide facilities the opportunity to submit written comments and may include any submitted information in the annual report.

(8) Pending recommendations from the committee, the Authority may publish additional reports intended to serve the public's interest.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 442.405, 192.496, 192.502, 192.243, 192.245 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0135

HAI Data Processing and Security

~~(1) The Authority shall obtain hospital outcome measure data files directly from NHSN at least quarterly.~~

~~(2) The Authority shall obtain hospital process measure data files from the CMS hospital compare website at least quarterly.~~

~~(3) The Authority shall calculate state level and facility level statistics to facilitate HAI public disclosure. These statistics may include but are not limited to observed frequencies, expected frequencies, proportions, rates, and ratios. The Authority shall make public the methods used to calculate statistics and perform comparisons.~~

~~(4) The Authority shall use statistically valid risk adjustment methods recommended by the committee including but not limited to NHSN methodology.~~

(5) The Authority shall undertake precautions to prevent unauthorized disclosure of the raw data files. These precautions include but are not limited to:

- (a) Storing the raw data files on the internal storage hardware of a password-protected personal computer that is physically located within the Authority;
- (b) Restricting staff access to the raw data files;
- (c) Restricting network access to the raw data files; and
- (d) If applicable, storing patient information within a strongly-encrypted and password-protected virtual drive or using other methods to reliably achieve the same level of security.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 192.496, 192.502 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0140

Prohibited Activities

Unless specifically required by state or federal rules, regulations, or statutes, the Authority is prohibited from:

- (1) Disclosing individually identifiable patient, health care professional, or health care facility employee information;
- (2) Intentionally linking or attempting to link individual providers to individual HAI events; and

Comment [SoO37]: Reporting requirements change and how the data is processed is dynamic. We took this section out.

(3) Providing patient-level or provider-level reportable HAI data to any state agency for enforcement or regulatory actions.

Stat. Auth.: ORS 442.420 & 2007 OL Ch. 838 § 1–6 & 12

Stats. Implemented: ORS 192.496, 192.502 & 2007 OL Ch. 838 § 1–6 & 12

333-018-0145

Compliance

(1) Health care facilities that fail to comply with these rules or fail to submit required data shall be subject to civil penalties not to exceed \$500 per day per violation.

(2) The Authority shall annually evaluate the quality of data submitted, as recommended by the committee.

Stat. Auth.: ORS 442.445 & 442.420

Stats. Implemented: ORS 442.445

Executive Summary



In 2007, the Oregon Legislative Assembly passed House Bill 2524 with the aim of keeping Oregonians free of infections acquired during the administration of health care. These types of infections are commonly called “healthcare-associated infections” or HAIs. Oregon set out to establish a mandatory HAI reporting program that will:

- Raise awareness of HAIs
- Promote transparency of healthcare information
- Aid hospitals in reducing and preventing HAIs

In January of 2009, the Healthcare Associated Infection Advisory Committee (HAIAC) was formed to advise the Oregon Health Authority in development of a HAI reporting program. The HAIAC is comprised of leaders from Oregon’s healthcare facilities including healthcare directors, managers, and other medical professionals, all with the aim of preventing harm to individuals accessing healthcare. In keeping with the Centers for Medicare and Medicaid Services’ mandatory reporting, the HAIAC identified important types of infections that have the potential to impact patients in Oregon hospitals. This report includes the following performance measures:

- Surgical Care Infection Prevention (SCIP)
 - Prophylactic antibiotic received within one hour prior to surgical incision (2009)
 - Prophylactic antibiotic selection for surgical patients (2009)
 - Prophylactic antibiotics discontinued within 24 hours after surgery end time (2009)
 - Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (2011)
 - Urinary catheter removed by postoperative day 2 (2012)
 - Surgery patients with perioperative temperature management (2011)
- Healthcare-associated infections
 - CLABSI – Central line-associated bloodstream infections
 - Both neonatal and adult intensive care units (2009)
 - SSI – Surgical site infections
 - HYST – Abdominal hysterectomy (2011)
 - COLO – Colon surgery (2011)
 - CBGB – Coronary artery bypass grafting (2011)
 - HPRO – Hip replacement (2011)
 - KPRO – Knee replacement (2009)
 - LAM – Laminectomy (2011)
 - CDI – *Clostridium difficile* infections (2012)
 - DE – Dialysis Event (2013)
- Healthcare worker influenza vaccination rate

Beginning in January, 2014, the HAIAC has identified two additional performance measures for mandatory reporting:

- CAUTI – Catheter-associated urinary tract infections
- MRSA LabID – Methicillin-resistant *Staphylococcus aureus* laboratory identification

DRAFT

Methods

Data sets

CMS Hospital Compare

The surgical care improvement project (SCIP) infection data is collected from the CMS website. These measures were developed by the federal agency CMS and the Joint Commission, an independent, not-for-profit organization, recognized nationwide as a sign of quality.

<https://data.medicare.gov/data/hospital-compare>

Healthcare Worker Influenza Vaccination Survey

Healthcare worker influenza vaccination measures are collected using a survey based on the protocols provided by the ACIP and the CDC. Hospitals, ambulatory surgical centers, and long-term-care facilities receive the survey in October and are required to report in May, after the end of the Influenza season.

National Healthcare & Safety Network

Oregon hospitals are required to report CLABSIs, SSIs, and CDI to the National Healthcare Safety Network (NHSN), a healthcare-associated infection surveillance and prevention system developed by the Centers of Disease Control and Prevention (CDC).

Exemptions

Oregon hospitals were given the opportunity to request exemption to reporting HAIs if they met the following criteria

- Facilities which perform less than 20 specific surgical procedures (i.e.: Laminectomy) may request an exemption from reporting that surgical site infection.
- Facilities which have less than 50 central line (CL) days per year may request an exemption from reporting CL-associated blood stream infections

<http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Pages/Reporting-Forms.aspx>

Internal & External Validation

Hospital Review

Oregon hospitals were provided the opportunity to verify the accuracy of their data. The aggregate numbers of infections and denominators as well as possible database errors were sent to each hospital to be reviewed by the chief executive officer and the lead infection prevention professional. Facilities were given 14 days to provide any corrections prior to

publication. In addition, facilities were given the opportunity to submit written comments to be included in the annual report.

CLABSI Validation

The Oregon Public Health Division is currently validating ICU CLABSI data by retrospective chart review. This evaluation is similar to the statewide validation of ICU CLABSI reported for 2009. In the 2009 validation, 44 hospitals were assessed for consistency and reliability of applying NHSN definitions to patients identified with blood cultures positive for a microorganism.

<https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Documents/clabsi-oh-article.pdf>

The SIR

Historically, we have reported HAI rates. Comparing this type of measure between hospitals can be misleading as it cannot account for the diversity of each hospital population. For example, we expect the rate of HAIs in a hospital that has an older population to have a higher rate of infection than a hospital with a younger population. We expect this because older patients are at greater risk of infection for reasons other than the type of care given. The Standardized Infection Ratio (SIR) measurement is used in an attempt to remove effects of differences in hospital populations such as differences in age composition.

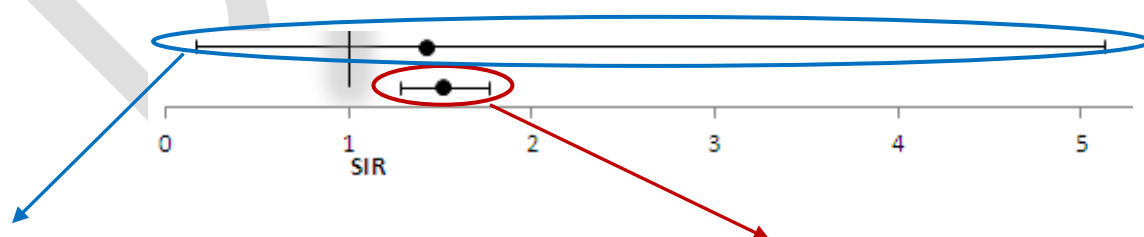
How to Interpret the SIR

There are two important calculations for the SIR: the ratio itself and its confidence intervals.

SIR (ratio): If the observed number of HAIs in a hospital equals what is expected based on national data, we would have an SIR = 1.0.

$$\text{SIR} = \text{Observed HAI} / \text{Expected HAI}$$

Confidence Interval: This is a range around the SIR estimate that conveys how precise and stable the SIR estimate is. If the confidence interval includes the value 1.0 (ie: 0.5-1.5), then the SIR estimate is considered not statistically significant. There are many reasons an estimate is not statistically significant, but for the purposes of this report, non-significance denotes that the SIR estimate is no different than the national baseline. If the confidence interval does not include 1.0 (0.5-0.8), then the SIR estimate is different than the national baseline.



SIR = 1.41

Confidence interval = 0.2-1.4

The SIR estimate for this hospital is 1.41. This means this hospital had 41% more HAIs than the national baseline. However, the confidence interval is not statistically significant which means the SIR estimate should be interpreted as no different than the national baseline.

SIR = 1.51

Confidence interval = 1.29-1.76

The SIR estimate for this hospital is 1.51. This means this hospital has 50% more HAIs than the national baseline. The confidence interval is statistically significant which means the SIR estimate is different than the national baseline.

Guidelines For Understanding This Report

Type of Measure	Data Tables	Explanation
Surgical Care Improvement Project	Higher Score is Better	These measures show how well a hospital does in implementing ways to prevent surgical complications
Healthcare-Associated Infections	Lower Rate or SIR is Better	These measures show the number of infections that are acquired by patients while receiving hospital care
Healthcare Worker Influenza Vaccination	Higher Score is Better	This measure shows the number of HCWs that received the Influenza Vaccination in an effort to prevent the spread of the disease

Limitations of this report

There are two significant limitations of this report:

1. Each hospital's data is self-reported. The OHA implemented both internal and external validation in an effort to maintain data integrity.
2. A hospital's ability to detect HAI cases varies between hospitals. This can be due to several causes including, but not limited to:
 - a. Resources available for surveillance
 - b. Methods of surveillance (software)
 - c. Microbiology practices

Future implications

Over the past 5 years, Oregon numbers of HAIs have decreased due in large part to the extraordinary efforts of Infection Preventionists to educate hospital staff and implement process improvement programs. Prevention collaboratives have been established to continue reducing HAIs in Oregon. A list of Oregon efforts is located on the following CDC website:

<http://www.cdc.gov/HAI/stateplans/state-hai-plans/or.html>

Surgical Care Improvement Project (SCIP)

Hospitals that perform surgical procedures identified by CMS for mandatory reporting must submit data for Recommended Care Measures. These measures examine the number of times a patient receives appropriate care before, during, and after a surgical procedure. Information is collected from patient medical records and is reviewed by CMS for consistency. The percentage of eligible patients receiving recommended treatment is reported in this document. Higher percentages are better.

SCIP-INF-1 (Prophylactic antibiotic received within 1 hour prior to surgical incision)

- This measures the percent of eligible surgical patients who receive prophylactic antibiotics within one hour prior to surgical incision. Patients who receive antibiotics at the appropriate time prior to surgery are less likely to get wound infections

SCIP-INF-2 (Prophylactic antibiotic selection for surgical patients)

- This measures the percent of eligible surgical patients who receive appropriate antibiotics specific to each type of surgical procedure. Patients who receive surgery specific preventative antibiotics reduce their risk of infection.

SCIP-INF-3 (Prophylactic antibiotic discontinued within 24 hours after surgery end time)

- This measures the percent of eligible surgical patients whose antibiotics were discontinued within 24 hours after a surgical procedure. Patients whose antibiotics are discontinued within 24 hours reduce their risk of side effects including stomach aches and serious type of diarrhea. Also, continual use of unnecessary antibiotics can lead to bacteria becoming resistant and the antibiotic may not work as well.

SCIP-INF-4 (Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose)

- This measures the percent of eligible surgical patients whose blood sugar is kept within normal range in the days following a surgery. Patients who have uncontrolled blood glucose levels have a higher risk of infection.

SCIP-INF-9 (Urinary catheter removed on postoperative day 1 or postoperative day 2 with the day of surgery being day zero)

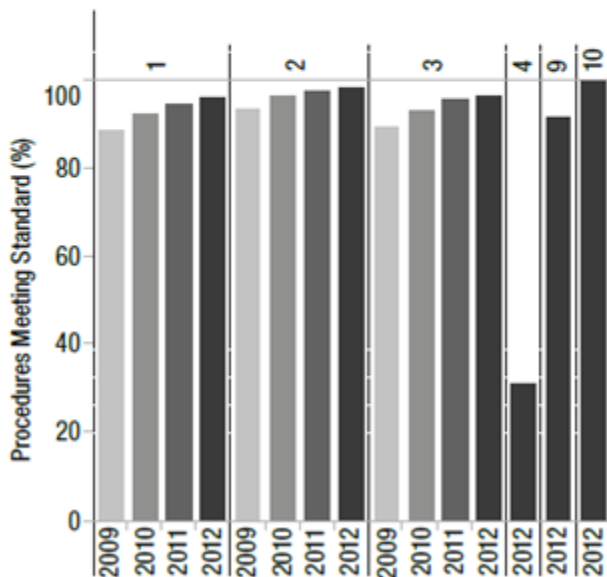
- This measures the percent of eligible surgical patients who had a urinary catheter removed on the first or second day after surgery. The risk for a urinary tract infection increases with longer durations of indwelling urinary catheters.

Patients who no longer require an indwelling urinary catheter decrease the risk of an infection by removing the catheter.

SCIP-INF-10 (Surgery patients with perioperative temperature management)

- This measures the percent of eligible surgical patients who required active warming in the operating room or those whose body temperature was normal within 30 minutes immediately before and 15 minutes immediately after anesthesia end time. Patients that have normal body temperatures before, during, and after an operation have a decreased risk of infection and decreased risk of delayed wound closures.

Figure 19: Surgical Care Improvement Project (SCIP) Process of Care Measures 2009 – 2012



Surgical Care Improvement (SCIP) Scores

The scores summarize the percent of time that a hospital gave patients the correct care for preventing infection in surgical patients in 2012. The Overall Score is a composite of the nine surgical care improvement scores.

Hospital Name	Overall %	Prophylactic antibiotic started %	Appropriate antibiotic received %	Prophylactic antibiotic stopped %	Controlled blood sugar %	Urinary catheter removed %	Temp. managed %
Providence Hood River Memorial Hospital	99.8	100	100	99	---	100	100
Mercy Medical Center	99.8	100	99	100	---	100	100
McKenzie-Willamette Medical Center	99.5	100	99	100	97	99	100
Tillamook County Hospital	99.5	100	97	100	---	100	100
Willamette Valley Medical Center	99.4	100	100	98	---	99	100
Peace Harbor Hospital	99.4	99	100	99	---	99	100
Kaiser Permanente Sunnyside Medical Center	99.2	99	100	99	99	98	100
Tuality Community Hospital	99.1	98	99	100	86	100	100
Providence Portland Medical Center	98.5	99	100	97	98	96	100
Asante Rogue Valley Medical Center	98.5	99	99	99	98	92	100
Providence Newberg Medical Center	98.3	100	98	98	---	93	100
Mid-Columbia Medical Center	98.3	98	99	99	---	94	100
Adventist Medical Center	98.0	99	98	95	98	97	100
Ashland Community Hospital	97.9	98	99	98	---	88	100
Salem Hospital	97.9	96	99	104	98	91	99
Asante Three Rivers Medical Center	97.9	99	98	99	---	82	100
Providence Milwaukie Hospital	97.9	100	99	99	---	91	100
Legacy Good Samaritan Medical Center	97.8	94	100	99	92	98	100
Samaritan Albany General Hospital	97.6	97	100	98	---	92	100
Providence St. Vincent Medical Center	97.5	98	99	99	99	87	100
Legacy Emanuel Medical Center	97.4	96	99	99	89	94	100
Silverton Hospital	97.3	93	97	97	---	98	100
Good Samaritan Regional Medical Center	97.3	97	99	97	87	95	100
Oregon Health & Science University	97.0	97	98	96	97	95	98
Providence Medford Medical Center	96.9	96	97	99	---	70	100
Legacy Meridian Park Medical Center	96.8	91	100	99	---	91	100
Sky Lakes Medical Center	96.8	97	99	96	---	92	99
Providence Willamette Falls Medical Center	96.8	95	99	99	---	87	99
Samaritan North Lincoln Hospital	96.2	96	97	91	---	97	100
Legacy Mount Hood Medical Center	96.1	95	95	96	---	92	100
St. Alphonsus Medical Center - Ontario	96.0	98	96	92	---	98	96

Surgical Care Improvement (SCIP) Scores

The scores summarize the percent of time that a hospital gave patients the correct care for preventing infection in surgical patients in 2012. The Overall Score is a composite of the nine surgical care improvement scores.

Hospital Name	Overall %	Prophylactic antibiotic started %	Appropriate antibiotic received %	Prophylactic antibiotic stopped %	Controlled blood sugar %	Urinary catheter removed %	Temp. managed %
Sacred Heart Medical Center - RiverBend	96.0	99	99	92	96	84	99
Samaritan Pacific Communities Hospital	95.6	86	97	100	---	92	100
Good Shepherd Medical Center	95.6	96	97	89	---	94	100
Bay Area Hospital	95.5	91	96	95	---	94	100
St. Charles Medical Center - Bend	95.5	94	98	91	96	95	99
Overall 2012	95.2	95	97	92	96	92	99
St. Charles Medical Center - Redmond	94.4	94	96	92	---	89	98
Columbia Memorial Hospital	94.3	89	93	92	---	97	100
Samaritan Lebanon Community Hospital	93.5	100	100	83	---	65	100
St. Anthony Hospital	93.2	96	94	90	---	---	---
Coquille Valley Hospital District	93.2	92	100	94	---	84	97
Grande Ronde Hospital	92.2	90	87	94	---	82	100
Santiam Memorial Hospital	91.3	91	97	97	---	62	100
Cottage Grove Community Hospital	Hospital does not perform these procedures						
Lake District Hospital	Hospital does not perform these procedures						
Sacred Heart University District	Hospital does not perform these procedures						
Shriner's	Hospital does not perform these procedures						
West Valley	Hospital does not perform these procedures						
Blue Mountain Hospital	Too few procedures to report						
Harney District Hospital	Too few procedures to report						
Lower Umpqua Hospital District	Too few procedures to report						
Pioneer Memorial Hospital - Prineville	Too few procedures to report						
Providence Seaside Hospital	Too few procedures to report						
Southern Coos Hospital and Health Center	Too few procedures to report						
St. Charles Medical Center - Madras	Too few procedures to report						
Wallowa Memorial Hospital	Too few procedures to report						
St. Alphonsus Medical Center - Baker City	No data submitted						

Healthcare Worker Influenza Vaccination

The number of healthcare workers receiving the Influenza vaccine is recorded in each healthcare facility. Knowing the vaccination counts and rates helps healthcare facilities determine strategies and set goals to achieve the benchmark established by the OHA of 90% of all healthcare workers receiving the Influenza vaccine every year. Higher numbers and rates are better.

Figure 1: Employee influenza vaccination percentages, 2010–2013 seasons

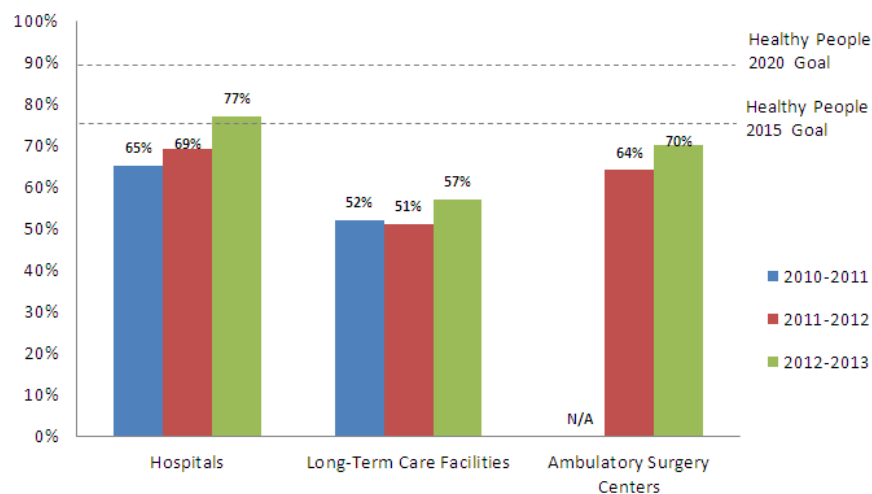
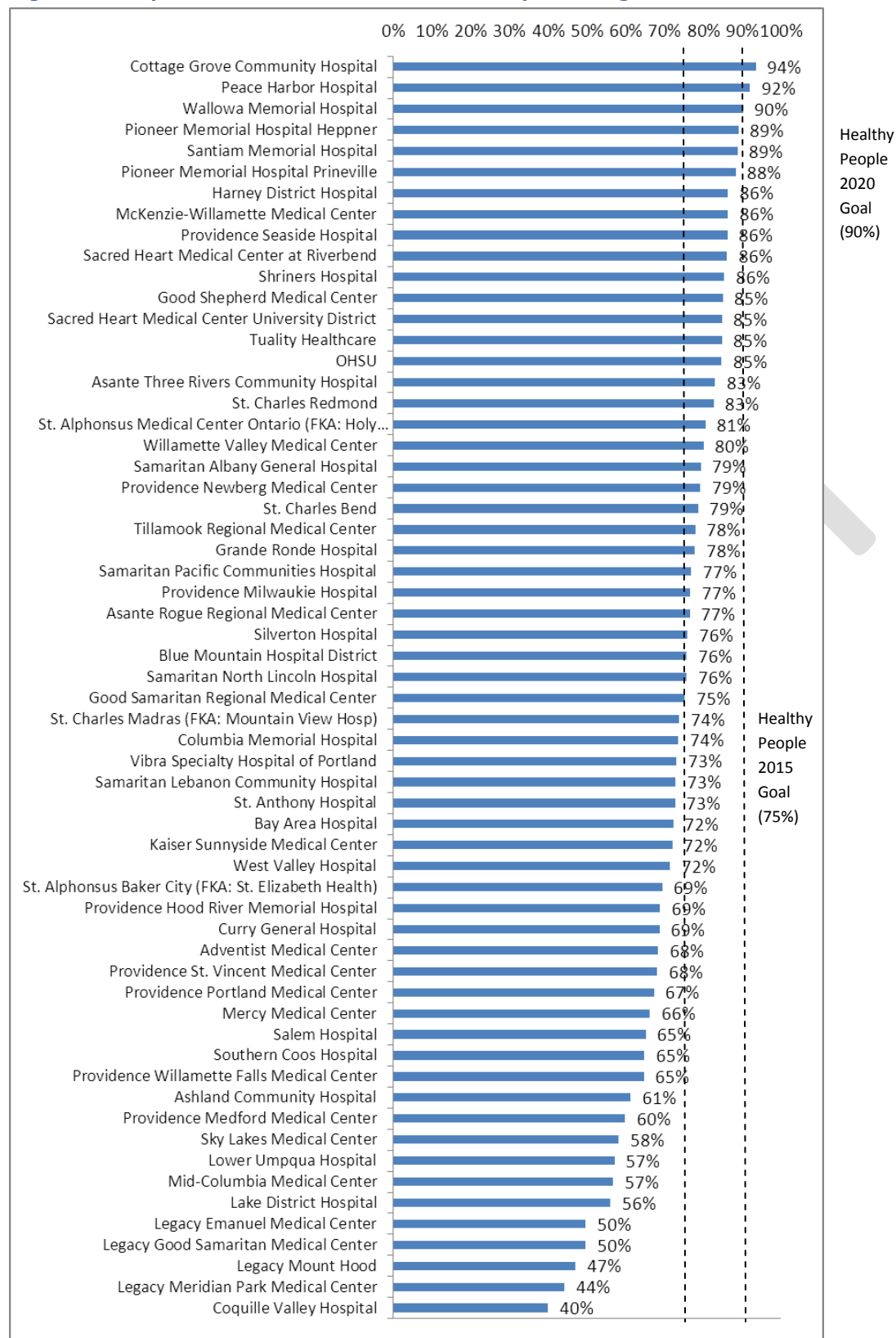


Table 6: Facilities meeting Healthy People targets for employees, 2010–2013 seasons

Facility Category	Count of Facilities	60% or Greater Vaccination		75% or Greater Vaccination		90% or Greater Vaccination	
		Count	Percent	Count	Percent	Count	Percent
Hospitals							
2010-2011	60	44	73%	29	48%	4	7%
2011-2012	60	55	92%	43	72%	4	7%
2012-2013	60	57	95%	42	70%	5	8%
Long-Term Care Facilities							
2010-2011	128	48	38%	35	27%	3	2%
2011-2012	140	54	39%	36	26%	8	6%
2012-2013	139	82	59%	37	27%	8	6%
Ambulatory Surgery Center							
2010-2011	Not Collected						
2011-2012	87	51	59%	38	44%	7	8%
2012-2013	84	55	65%	38	45%	17	20%

Figure 2: Hospital overall influenza vaccination percentages, 2012–2013 season



Fifty-two percent (31/60) of hospitals met the 75% overall vaccination goal for Healthy People 2015 (Figure 2). In addition, 5% (3/60) of hospitals met the 90% overall vaccination goal for 2020.

Healthcare-Associated Infections (HAI)

HAIs are infections that a patient acquires during their stay in a healthcare facility such as a hospital. These are infections that they did not have prior to admission to the facility.

Measuring the number of infections and describing the rates of infection over time help healthcare facilities assess how well they are doing in preventing HAIs. For this document, we use individual healthcare facility Standardized Infection Ratio (SIR) to compare an individual hospital to what is happening nationally in other hospitals (see page ?). Lower number, rates, and ratios are better.

HO-CDI LabID (Hospital Onset - *Clostridium difficile* infection laboratory identification)

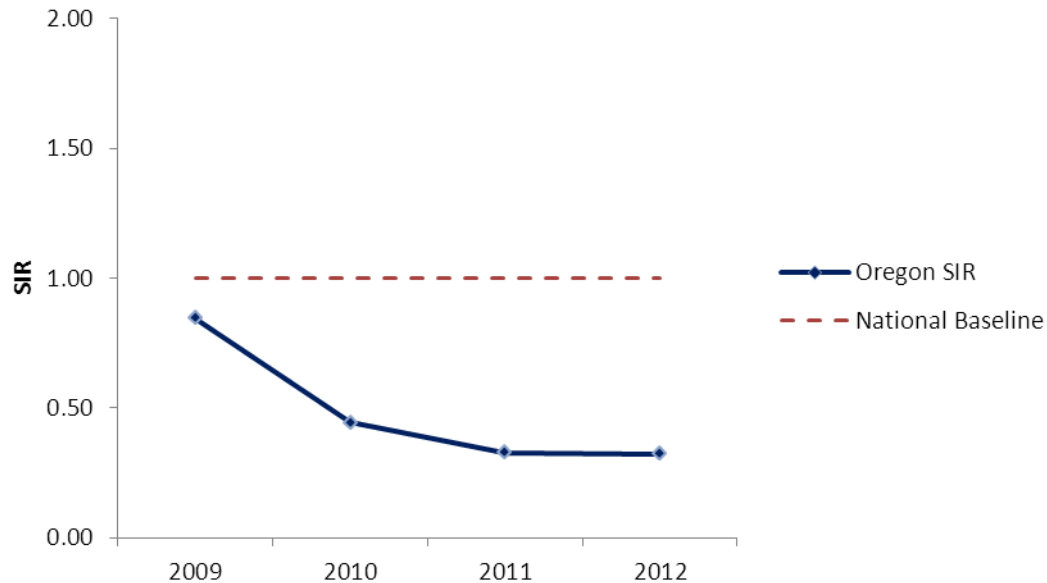
- Hospital onset-*Clostridium difficile* infections (HO-CDI) are caused when a patient acquires the *C. difficile* bacteria during their hospital stay. This type of bacterial infection can cause watery diarrhea, fever, nausea, and abdominal pain. In this document, HO-CDI rates and SIRs are assessed for the entire healthcare facility where a patient is housed overnight.

SSI (Surgical site infection)

- A surgical site infection (SSI) is an infection that occurs in the body location where the surgery took place. These types of infections can happen at the surface of the skin (superficial), in the deep soft tissues such as the fascial and muscle layers, and in the organ space located below the muscle layers. In this document, SSI rates and SIRs are assessed for the following procedures:
 - CABG – Coronary artery bypass graft surgery
 - COLO – Colon surgery
 - HPRO – Hip replacement surgery
 - HYST – Abdominal hysterectomy surgery
 - KPRO – Knee replacement surgery
 - LAM – Laminectomy surgery

Central line-associated blood stream infections (CLABSIs)

Oregon Hospitals CLABSI SIR for 2009-2012



CLABSIs are blood stream infections caused by the introduction of a central vascular catheter (CVC). CVCs are used to deliver medication, withdraw blood for medical tests, and monitoring of vital signs such as blood pressure and temperature. A blood stream infection can occur when a microorganism such as bacteria enter and attach to the CVC tubing. In this document, CLABSI rates and SIRs are assessed for the adult and neonatal intensive care units (ICU).

Over the previous 4 years, the number of Oregon CLABSIs has decreased and remain statistically better than the national baseline. In 2012, there was a total of 33 CLABSIs identified in the hospitals across Oregon in adult critical care units. In comparison to other hospitals across the United States, 102.4 total CLABSIs were predicted for the state of Oregon. Our SIR for is $33 \div 102.4 = .32$. This means in 2012, 68 % less CLABSIs were identified in Oregon's critical care patients.

Table 1. The expected and observed number of CLABSI and the SIR for Oregon hospitals for 2012

Hospital	Expected	Observed	SIR
Sacred Heart Medical Center - Riverbend	10.51	2	● 0.19
Providence Medford Medical Center	3.33	1	● 0.30
Oregon Health & Science University	20.15	7	● 0.35
Legacy Emanuel Medical Center	12.91	5	● 0.39
Legacy Good Samaritan Medical Center	4.70	2	● 0.43
Legacy Meridian Park Medical Center	1.30	1	● 0.77
Providence St. Vincent Medical Center	3.53	3	● 0.85
Good Samaritan Regional Medical Center	3.01	4	● 1.33
Legacy Mount Hood Medical Center	1.08	2	● 1.86
Providence Portland Medical Center	7.07	0	● 0.00
Salem Hospital	6.58	0	● 0.00
St. Charles Medical Center - Bend	4.00	0	● 0.00
Assante Rogue Regional Medical Center	3.95	0	● 0.00
Kaiser Permanente Sunnyside Medical Center	2.92	0	● 0.00
Adventist Medical Center	2.28	0	● 0.00
McKenzie-Willamette Medical Center	1.35	0	● 0.00
Tuality Community Hospital	1.16	0	● 0.00

●	SIR is below 1.0 and is better than the national baseline
●	SIR is below 1.0, but no different than the national baseline
●	SIR is above 1.0, but not idfferent than the national baseline
●	SIR is above 1.0 and is worse than the national baseline
●	SIR 0.0 because the facility had no CLBASI in 2012

Footnote: The expected number of CLABSIs is a prediction based on the national HAI experience for all hospitals reporting to NHSN. The observed number is the total number of CLABSIs identified during 2012. The SIR = Observed ÷ Expected. It is better to have a lower SIR

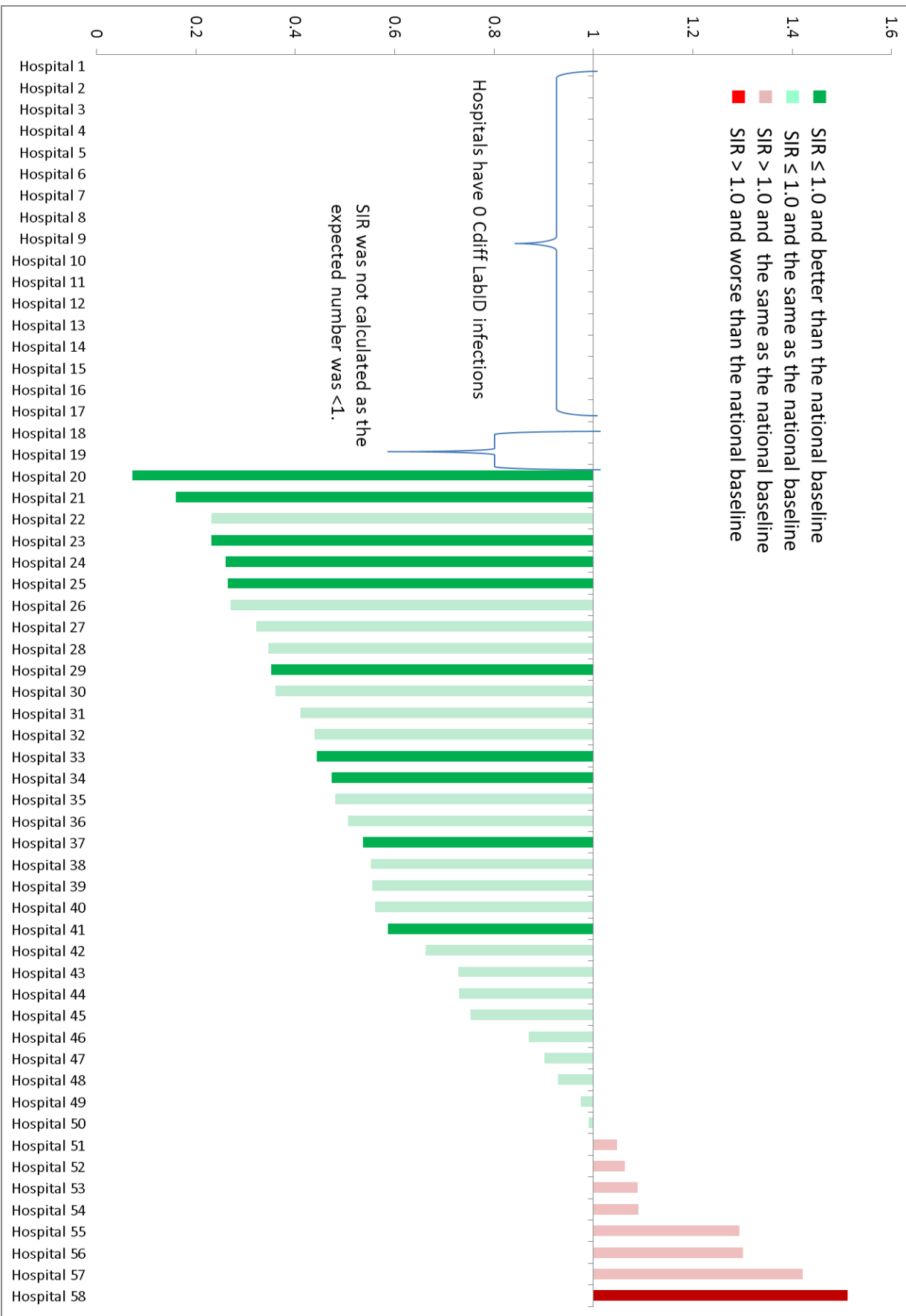
Table 2. Hospitals that had an expected number of CLABSI <1.

Hospital	Expected	Observed
Asante Three Rivers Medical Center	0.84	1
Ashland Community Hospital	0.18	1
Bay Area Hospital	0.81	0
Blue Mountain Hospital	0.01	0
Columbia Memorial Hospital	0.09	0
Coquille Valley Hospital District	0.00	0
Good Shepherd Medical Center	0.11	0
Mid-Columbia Medical Center	0.26	0
Peace Harbor Hospital	0.26	0
Pioneer Memorial Hospital - Prineville	0.05	0
Providence Hood River Memorial Hospital	0.12	0
Providence Milwaukie Hospital	0.37	0
Providence Newberg Medical Center	0.43	0
Providence Seaside Hospital	0.05	0
Providence Willamette Falls Medical Center	0.56	1
Samaritan Albany General Hospital	0.98	1
Samaritan Lebanon Community Hospital	0.48	0
Samaritan North Lincoln Hospital	0.05	0
Samaritan Pacific Communities Hospital	0.35	0
Silverton Hospital	0.21	0
St. Alphonsus Medical Center - Ontario	0.44	0
St. Anthony Hospital	0.27	0
St. Charles Medical Center - Madras	0.02	0
St. Charles Medical Center - Redmond	0.42	0
Tillamook County Hospital	0.06	0
Willamette Valley Medical Center	0.88	0

Hospitals exempt from reporting in 20012 include:

Cottage Grove Community Hospital, Curry General Hospital, Grande Ronde Hospital, Harney District Hospital, Kaiser Permanente Westside Medical Center, Lake District Hospital, Lower Umpqua Hospital District, Mercy Medical Center, Pioneer Memorial Hospital – Heppner, Sacred Heart University District, Santiam Memorial Hospital, Shriner’s, Sky Lakes Medical Center, Southern Coos Hospital and Health Center, St. Alphonsus Medical Center – Baker City, Vibra Specialty Hospital of Portland, Wallowa Memorial Hospital, and West Valley Hospital.

CLABSI SIR for Oregon Hospitals in 2012



EXAMPLE: Not all hospitals included

Table #. Individual hospital SIR by year and trends from 2009-2012

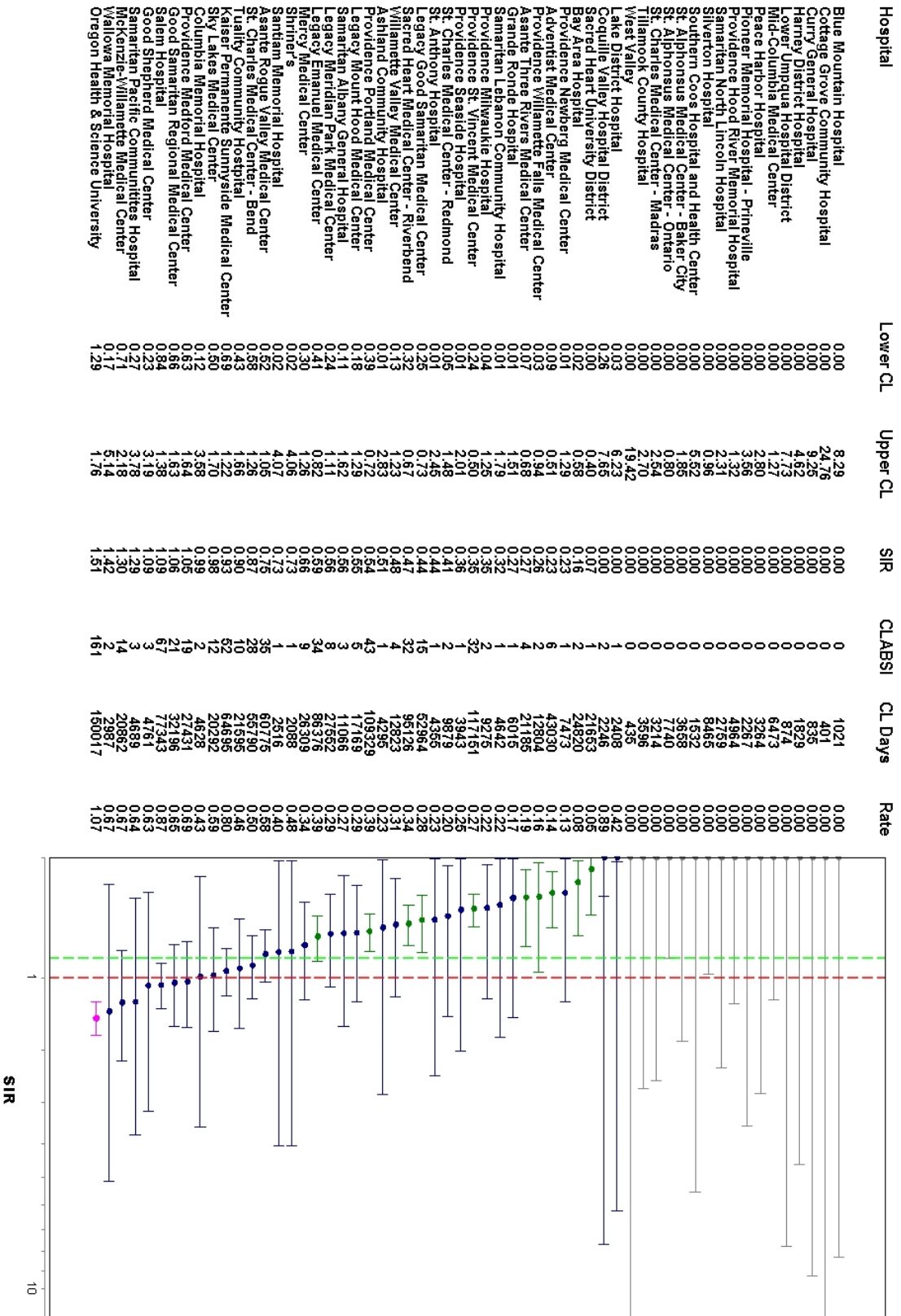
	SIR				Trend
	2009	2010	2011	2012	
Bay Area Hospital	0.00	0.00	0.00	0.00	
Leagacy Mount Hood Medical Center	1.15	1.16	0.00	1.86	
Sky Lakes Medical Center	0.00	0.00	0.00	0.56	
Tuality Community Hospital	2.00	0.00	1.77	0.00	
Willamette Valley Medical Center	0.00	0.00	0.93	0.00	
Asante Three Rivers Medical Center	0.96	0.00	0.00	0.00	
Good Samaritan Regional Medical Center	0.30	0.28	0.32	1.33	

National SIR Percentile (2011 report)

10% of US hospitals have a lower SIR
25% of US hospitals have a lower SIR
50% of US hospitals have a lower SIR
75% of US hospitals have a lower SIR
90% of US hospitals have a lower SIR

Footnote: A hospital with a green box is in the 10th percentile for the SIR measurement. This means only 10% of US hospitals had a lower SIR. Conversely, 90% of US hospitals had a higher SIR. Being in a lower percentile is better

Oregon Hospital CLABSI SIR for 2012



GRANT UPDATES

Jessica Lenar
Collaborative Director

Current Grant Timeline

Grant Funded Initiative	Feb 2013	Mar 2013	Apr 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	June 2014	July 2014
NW Renal Dialysis Collaborative (CDC funding)																		
Antimicrobial Stewardship Collaborative (DOJ funding)																		
Infection Prevention Training and Education (OHA–HCRQI funding)																		
Regional MDRO Collaboratives (CDC Funding)																		

Contributors

NW Dialysis BSI Prevention Collaborative

Mary Post

Antimicrobial Stewardship Initiative

Melissa Parkerton

Infection Prevention Training and Education

Mary Post

Regional MDRO Prevention Collaboratives

Jessica Lenar

NW DIALYSIS BSI PREVENTION COLLABORATIVE

About the Collaborative

- 33 dialysis facilities in Oregon and Washington
 - 18 nonprofit
 - 15 large dialysis organizations
- Partnership with the Northwest Renal Network

Monthly Data Collection

Type of data	What facilities report...	What we feed back...
Process measures	Hand Hygiene # Successful opportunities (SO) # Total opportunities (TO)	Percent compliance $= SO/TO \times 100\%$
NHSN data	# Events # IV antimicrobial starts # Positive blood cultures # Access site pus, redness, swelling # Patients	# Infections per 100 patient-months $= \# \text{ Events} / \# \text{ Patients} \times 100$

Interventions

CDC Approach to BSI Prevention in Dialysis Facilities

(i.e., the Core Interventions for Dialysis Bloodstream Infection (BSI) Prevention)

1. Surveillance and feedback using NHSN

Conduct monthly surveillance for BSIs and other dialysis events using CDC's National Healthcare Safety Network (NHSN). Calculate facility rates and compare to rates in other NHSN facilities. Actively share results with front-line clinical staff.

2. Hand hygiene observations

Perform observations of hand hygiene opportunities monthly and share results with clinical staff.

3. Catheter/vascular access care observations

Perform observations of vascular access care and catheter accessing quarterly. Assess staff adherence to aseptic technique when connecting and disconnecting catheters and during dressing changes. Share results with clinical staff.

4. Staff education and competency

Train staff on infection control topics, including access care and aseptic technique. Perform competency evaluation for skills such as catheter care and accessing every 6-12 months and upon hire.

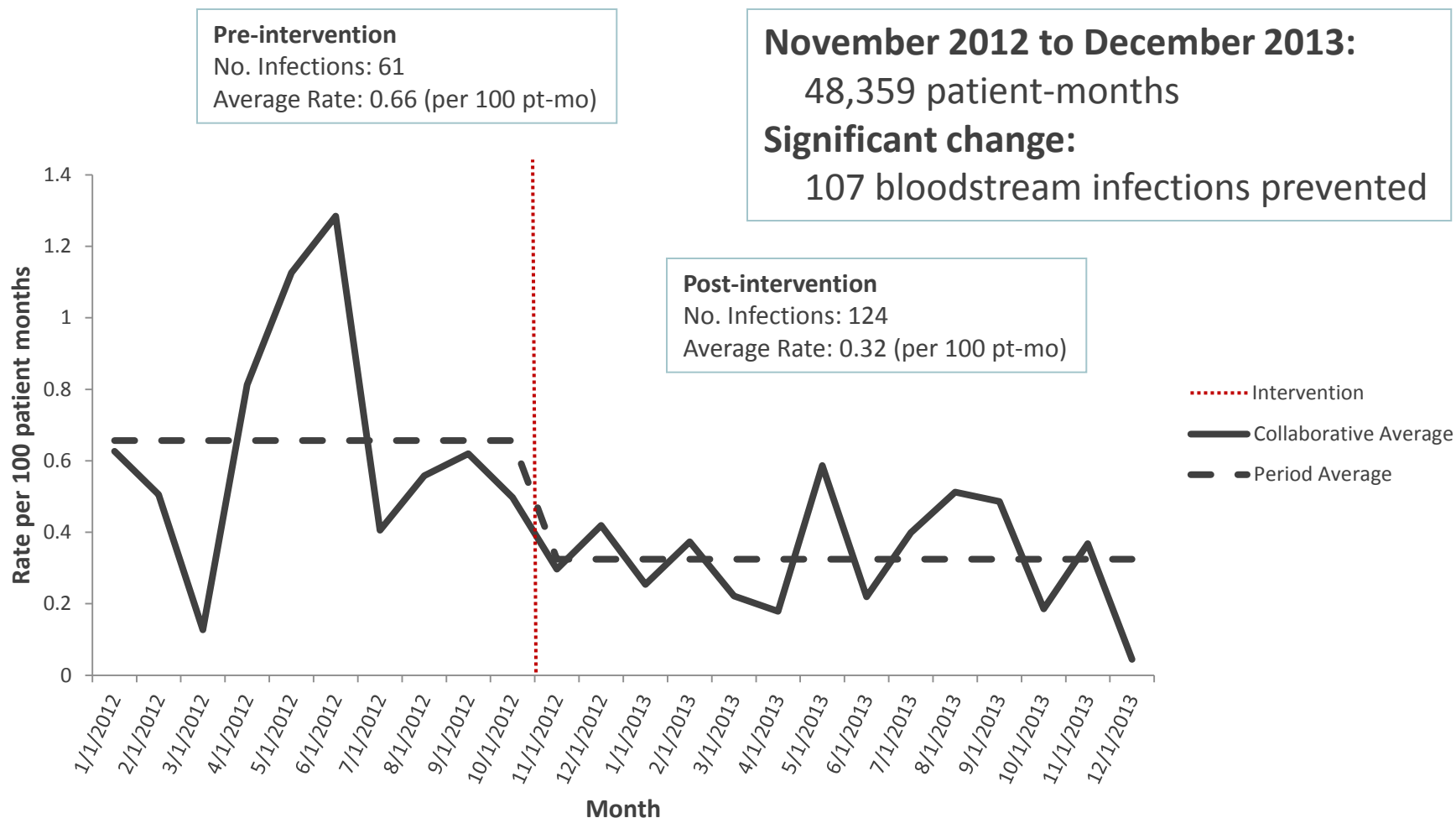
5. Patient education/engagement

Provide standardized education to all patients on infection prevention topics including vascular access care, hand hygiene, risks related to catheter use, recognizing signs of infection, and instructions for access management when away from the dialysis unit.

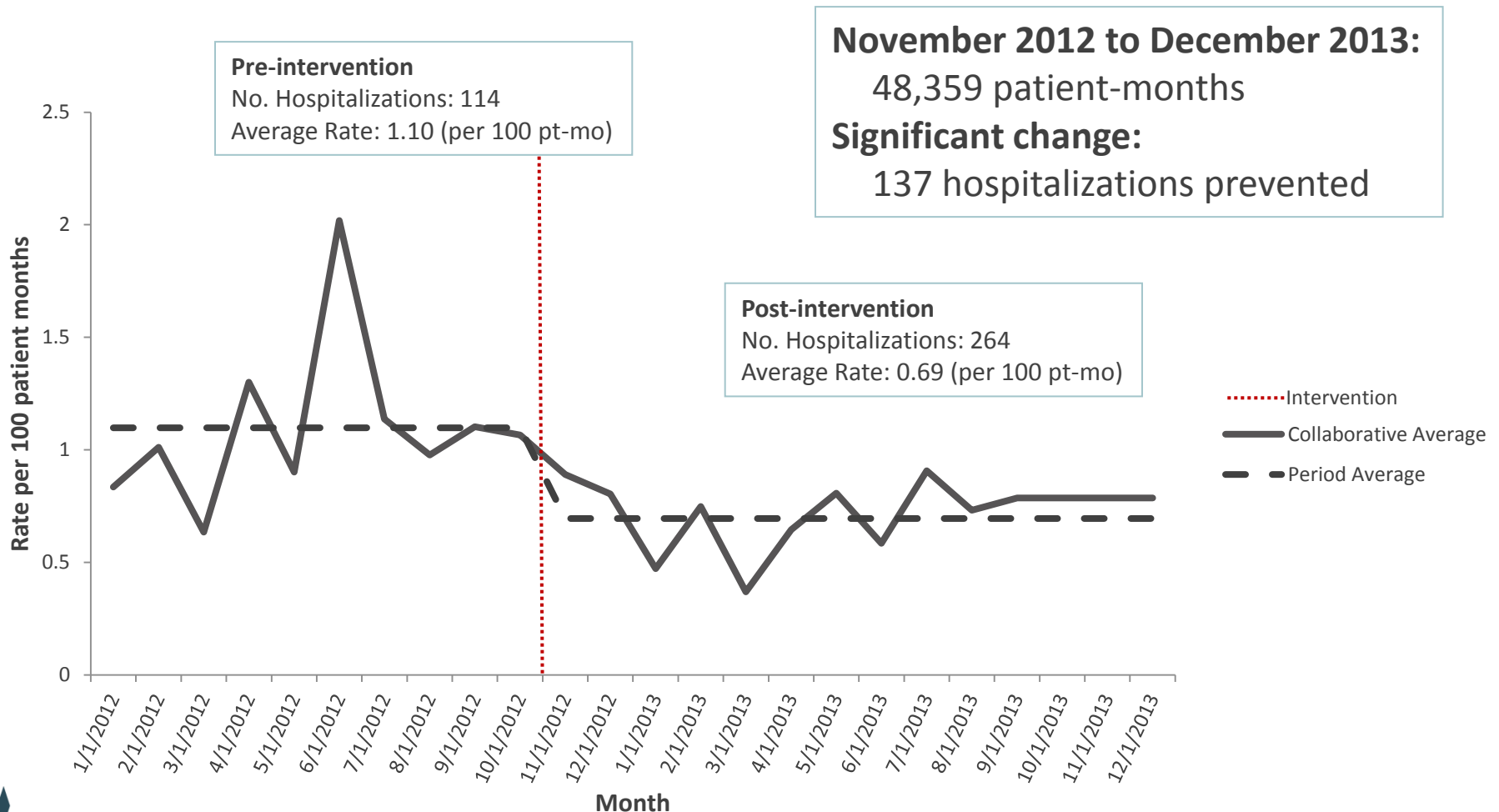


<http://www.cdc.gov/dialysis/prevention-tools/core-interventions.html>

Events Prevented: Access-Related Bloodstream Infection



Events Prevented: Hospitalizations



OREGON ANTIMICROBIAL STEWARDSHIP INITIATIVE

About the Initiative

- Oregon Antimicrobial Stewardship Collaborative (OASC)
 - Four learning sessions (one optional)
 - Two site visits per hospital
 - Monthly conference call or webinar
- Individual trainings
 - Two stand alone trainings for Oregon hospitals
 - March 2013 and May 2013

Data Submission

- Data collection is complete
 - 12/13 hospitals completed the collaborative
 - 10/12 submitted full data
 - 1 could not engage IT support following EPIC launch
 - 1 critical access hospital had turnover that impacted their ability to access data

Data Analysis

- Trends in defined daily dosage and days of therapy
- Trends in usage of specific classes of antimicrobials
- IV:PO rates
- *Clostridium difficile* (CDI) rates
- Facility perceptions of stewardship programs and activities
- Number and timing of stewardship interventions

MDRO INFECTION PREVENTION ASSESSMENT AND SUPPORT

Targeted Infection Prevention Support

- Partnership with Drug-Resistant Organism Prevention and Coordinated Regional Epidemiology (DROP-CRE) Network
- Infection prevention support for facilities that need assistance with active multidrug-resistant organisms (MDROs)
- Collaborating with DROP-CRE team to clarify interfacility transfer communication requirements and accompanying educational/communication materials
- Coordinating website resources and materials with Oregon Health Authority
- Support tools and resources in pilot stage

INFECTION PREVENTION EDUCATION AND TRAINING FOR HEALTHCARE FACILITIES

Grant Funding

- Grant received from Oregon's Health Care Regulatory and Quality Improvement Program
- Funds infection prevention education and resources for all Oregon health care facilities
- Online Ambulatory Surgery Center (ASC) toolkit developed
- Online toolkit for long term care facilities available this summer

Trainings

2012-Present

Meeting Topics

- Fundamentals of Infection Prevention: A Comprehensive Training Course for Infection Prevention Professionals
- Infection Prevention in ASCs: Innovative Tools for Program Improvement
- Staying Ahead of the Curve: Strategies for Preventing, Measuring and Reducing Infections in Nursing Homes

Webinar Topics

- Preventing Norovirus and tuberculosis transmission
- Influenza vaccination strategies for residents and healthcare personnel
- Preventing UTIs in the elderly
- Medication compounding updates

OREGON REGIONAL MDRO PREVENTION COLLABORATIVES

About the Collaborative

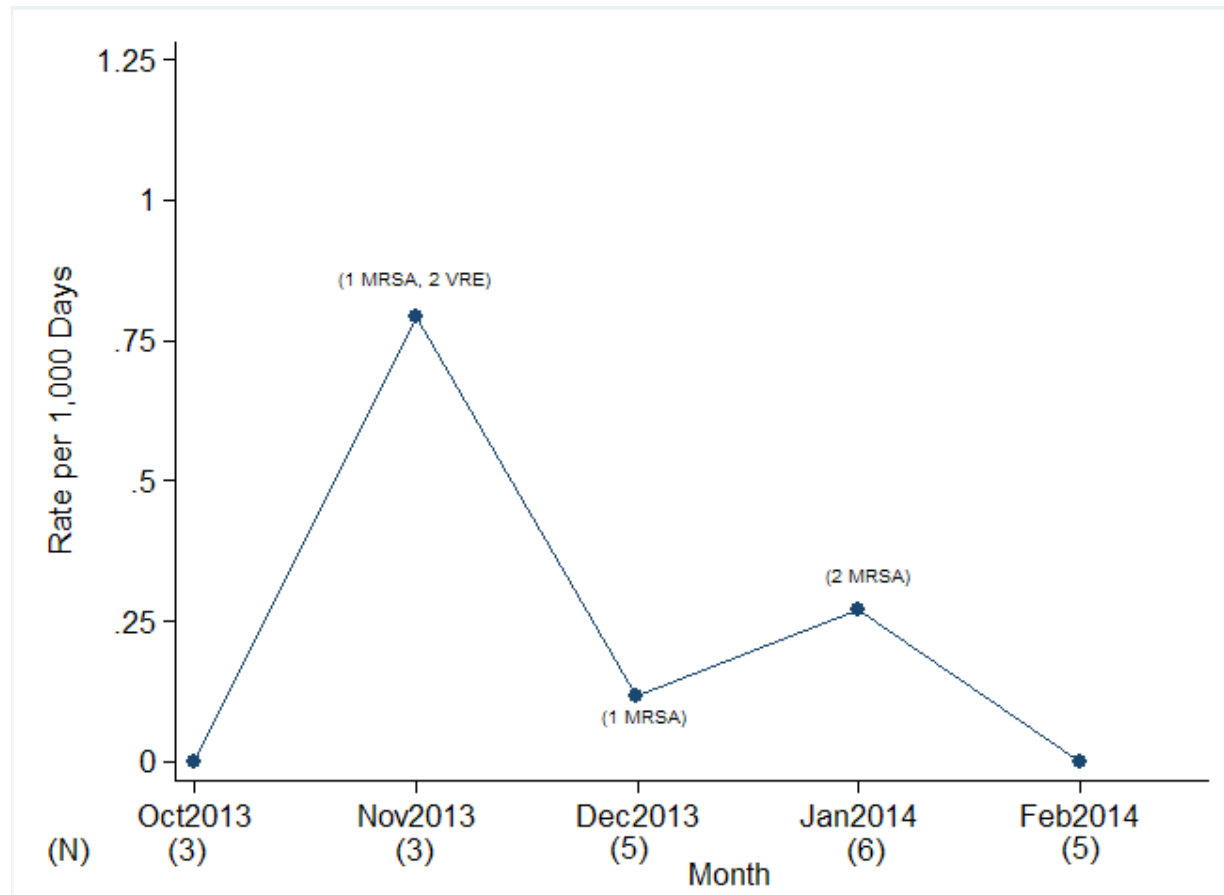
- Three regional efforts
 - North Coast
 - Linn/Benton
 - South Coast
- Variety of healthcare stakeholders
 - Hospitals
 - Long term care facilities
 - Medical transport
 - Outpatient Clinic

Monthly Data Collection

Type of data	What facilities report...	What we feed back...
Process measures	Hand Hygiene # Successful opportunities (SO) # Total opportunities (TO)	Percent compliance $= \text{SO} / \text{TO} \times 100\%$
	Transfer Form Use # of transfer forms sent # of patients or residents transferred	Transfer form usage $= \text{\# of forms sent} / \text{\# of transfers} \times 100\%$
NHSN data	# Events # Facility onset (FO) MDROs # FO <i>Clostridium difficile</i> infections (CDI) # Patient or Resident days	MDRO Rate $= \text{\# MDROs} / \text{Days} \times 1,000$ CDI Rate $= \text{\# CDI} / \text{Days} \times 10,000$

Facility-onset MDRO Rate

Collaborative to date



Data Collection Notes

- Still gathering data from facilities
- Staggered data collection timelines
- Transfer form use is a new process and many facilities are developing tracking methods

Questions?

Jessica Lenar

Collaborative Director

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MDRO Nursing Home Qualitative Questions

1. Tells us about you!
 - a. Name:
 - b. Job title:
 - c. What is your role in your facility?
 - d. How long have you been working for this nursing home?
 - e. How long have you been working in the nursing home setting in general?
2. What are the three most common infection control practices in your nursing home?

List your top three most common infection control practices	How often do you employ this practice? <i>Choose one</i>	Do you think it is effective in reducing transmission of infections? <i>Choose one</i>
1.	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually	<input type="checkbox"/> Yes <input type="checkbox"/> Not on its own <input type="checkbox"/> Not at all
2.	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually	<input type="checkbox"/> Yes <input type="checkbox"/> Not on its own <input type="checkbox"/> Not at all
3.	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually	<input type="checkbox"/> Yes <input type="checkbox"/> Not on its own <input type="checkbox"/> Not at all

3. Who is the person primarily involved in infection control decisions?
4. Have you recently provided care for a resident who had an active infection? Tell us about your experience.
 - a. What type of infection did the resident have? (Please provide location and pathogen, if known.)
 - b. What types of infection control practices were used when caring for this resident?
 - c. Were there any issues that arose regarding how to implement infection control practices when caring for the resident?
 - d. Were you able to resolve these challenges and if so, how?
5. Is the experience you described in question 4 an example of how your nursing home would typically implement infection control practices?

Yes No

a. If no, how was it different from other, more typical cases?

6. In your opinion, what are some effective methods of preventing transmission and acquisition of infections in nursing homes?

a. Do you use tools or guidelines to help make decisions regarding infection control? If so, what are they?

b. In your opinion, what kinds of tools or materials are most helpful in improving or facilitating effective infection control practices?

7. What are some challenges you experience in trying to implement infection control practices in your nursing home?

Are there any comments or advice you would give us in terms of infection control practices/policies in the nursing home.

Is there anything that we missed?

Is there anything else you'd like us to know?



Infection Prevention Program Survey

ABOUT YOU

Your Job Title: _____

Your credentials (select all that apply): MD MSN RN BSN CNA LPN PA Other: _____

How long have you worked at this facility: _____ years _____ months

How long have you worked in your current role (at your current facility and elsewhere): _____ years _____ months

FACILITY INFORMATION

1. What hospital do you most frequently transfer residents to? (if more than one, indicate both and estimate the % of residents referred to each)

2. Our facility has:
 _____ beds _____ rooms (total shared, private, and semi-private rooms)
 _____ private rooms _____ semi-private rooms

3. Does your facility have an electronic medical record (EMR) system? Yes No Unk

INFECTION IDENTIFICATION

4. Our facility uses standard definitions (such as McGeer criteria or CDC NHSN definitions) to determine if a resident has an infection. Yes No Unk

5. Our facility uses new antibiotic prescriptions (starts) to determine if a resident has an infection. Yes No Unk

6. Our facility reviews provider notes to determine if a resident has an infection. Yes No Unk

7. Our facility uses another method to determine if a resident has an infection (please describe):

8. When a microbiology lab is ~~drawn~~ collected at our facility, we receive results from the testing facility. Yes No Unk

9. When a resident has a positive microbiology culture, we receive a copy of the susceptibility pattern. Does your facility receive notification on positive results if the results are not available at time of discharge? Yes No Unk

10. Does your facility receive notification of positive microbiology results if the lab was performed at a hospital and results were not available at time of discharge and transfer to your facility? When a resident/patient has a positive culture, we receive a copy of the susceptibility pattern. Yes No Unk

11. Does your facility have a designated person to review lab culture reports? Yes No Unk

12. Our facility reviews all lab culture reports (including both positive and negative culture reports) Yes No Unk

12a. Who performs lab culture reviews?

DNS Charge Nurse Designated IP Residential Care Provider Other: _____

12b. How often is this person reviewing lab culture reports?

During the same shift it was received Daily Weekly Other: _____

12.d. The physician ordering the microbiology culture is notified of positive test results by:

Fax from LTCF Fax from Lab Phone call from LTCF Phone call from Lab Email from LTCF
Placement of Lab result in resident's medical record

INFECTION TRACKING& SURVEILLANCE

In the questions below, tracking means a method for compiling infection data and surveillance means the general act of monitoring infections at your facility.

13. Our facility performs house-wide surveillance (<u>i.e., all infections</u>) of infections among our residents	Yes	No	Unk
14. Our facility performs targeted surveillance for the following specific infections/organisms among our residents:			
a. <i>Staphylococcus aureus</i> , methicillin-resistant (MRSA)	Yes	No	Unk
b. Vancomycin-Resistant <i>Enterococcus</i> spp. (VRE)	Yes	No	Unk
c. Cephalosporin-Resistant <i>Klebsiella</i> spp. (CephR-Klebsiella)	Yes	No	Unk
d. Carbapenem-Resistant <i>Klebsiella</i> spp. (CRE-Klebsiella)	Yes	No	Unk
e. Carbapenem-Resistant <i>E coli</i> (CRE-Ecoli)	Yes	No	Unk
f. Multidrug-Resistant <i>Acinetobacter</i> spp (MDR-Acinetobacter)	Yes	No	Unk
g. <i>Clostridium difficile</i> (CDI)	Yes	No	Unk
h. Urinary Tract Infections (UTI)	Yes	No	Unk
15. Our facility uses a different surveillance method than listed above (please describe):			
16. Our facility maintains a list of residents with infections in a log book.	Yes	No	Unk
16a. Where does your facility keep this list?			
Electronic spreadsheet Electronic Database Paper Logbook Other: _____			
17. Our facility keeps a record of healthcare-associated infections in the resident's chart (paper or electronic)	Yes	No	Unk

DATA COLLECTION AND REPORTING PROCESSES

18. Our facility tracks rates of infection over time to identify trends – (e.g., monthly rate, quarterly rate, annual rate).	Yes	No	Unk
18a. How do you track infection rates over time? Monthly Quarterly Annually Other: _____			
19. Our facility creates summary reports (e.g., trends) of healthcare-associated infections.	Yes	No	Unk
20. Our facility has a process for tracking the number of resident days/month	Yes	No	Unk
21. Our facility has a process to track the number of MDRO infections/month	Yes	No	Unk
22. Our facility has a process to track the number of <i>Clostridium difficile</i> infections/month	Yes	No	Unk
23. Our facility reports rates of specific infections (e.g., # UTIs/ 1000 resident days/ <u>per month</u>).	Yes	No	Unk
24. Our facility reports rates of infections by device days (e.g., # <u>CA</u> UTIs/ 1000 urinary catheter days/ <u>per</u> month).	Yes	No	Unk

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25. Our facility measures adherence to hand hygiene policies in at least one <u>resident</u> patient care area by staff observation or volume measurement	Yes	No	Unk
26. Our facility measures adherence to transmission-based precautions among staff (i.e., the percentage of those who comply with wearing of gloves or gowns).	Yes	No	Unk
27. Our facility monitors/observes environmental cleaning practices to ensure consistent cleaning and disinfection practices are followed.	Yes	No	Unk
28. Our facility has a mechanism to identify, at admission, residents previously infected or colonized with MDROs (e.g., MRSA, VRE, <i>C. difficile</i>).	Yes	No	Unk
29. Our facility tracks the use of interfacility transfer forms.	Yes	No	Unk
30. Our facility collects data on compliance with communication of isolation requirements to facilities upon transfer.	Yes	No	Unk
31. Our facility collects data on compliance with communication of history of multi-drugresistant organisms and <i>Clostridium difficile</i> upon transfer to other facilities.	Yes	No	Unk

INTERFACILITY COMMUNICATION

32. Our facility has a process for communicating with other facilities about residents with colonization or infection with MDROs <u>and C.difficile</u> at the time of transfer.	Yes	No	Unk
32a. The type of communication is (select all that apply): Written and sent with resident Written and sent separately Verbally Provided Other: _____			
33. Our facility communicates when a resident is			
a.in isolation	Yes	No	Unk
b. colonized with a MDRO and <u>or</u> <i>C. difficile</i> infection	Yes	No	Unk
c. infected with a MDRO and <u>or</u> <i>C. difficile</i> infection	Yes	No	Unk
34. Staff know who to contact at the referring or receiving facility when a resident has an infection	Yes	No	Unk
34a. Who do you contact at the referring facility (e.g., infection preventionist): _____			
34b. Who do you contact at the receiving facility (e.g., infection preventionist): _____			
35. Staff know who to contact at the referring facility when a resident arrives with inadequate documentation	Yes	No	Unk
35a. Who do you contact (e.g., infection preventionist, treating physician, etc.): _____			
36. Staff know who to contact at the referring facility when lab results are needed	Yes	No	Unk
36a. Who do you contact (e.g., lab supervisor, infection preventionist, etc.): _____			

TRANSMISSION-BASED PRECAUTIONS

Transmission-based precautions include contact, droplet, airborne precautions in addition to Standard Precautions

37. When a patient is on transmission-based precautions, our facility uses signage to communicate this to staff entering the room	Yes	No	Unk
38. Staff at our facility receive at least annual training about the use of precautions	Yes	No	Unk

QUALITY IMPROVEMENT

39. Our facility uses bundles for urinary catheter care/insertion	Yes	No	Unk
40. Our facility uses bundles for central line care	Yes	No	Unk
41. Our facility assesses the need for urinary catheters on daily rounds	Yes	No	Unk
42. Our facility assesses the need for central lines on daily rounds	Yes	No	Unk
43. Our facility reviews appropriate antibiotic use (drug, dose and duration)	Yes	No	Unk
44. Our facility has a dedicated infection preventionist on site	Yes	No	Unk
45. Our facility has an infection preventionist consultant (not on site)	Yes	No	Unk
46. Our facility has a physician to consult with about infection control practices	Yes	No	Unk
47. Our facility has a physician to consult with about patients with MDROs	Yes	No	Unk
48. I am satisfied with the amount of infection control consultation and support our facility has	Yes	No	Unk

Comment [MP1]: For both question #39 & 40, I don't think I would ask about "bundles" since they don't really exist for LTCFs and the central line bundle is primarily associated with insertion, which most nursing homes aren't placing. I thought about asking more specific questions, but I think for purposes of this audit, let's leave it out. However, I think it's okay to ask about the assessing the need for the devices (though I would remove daily rounds and reword it as , Our facility does a daily assessment of the residents continued need for urinary catheters or central lines". Some residents are not seen by their MD other than every three months.

HHS 2020 HAI Targets

The U.S. Department of Health and Human Services (HHS) created a Federal Steering Committee for the Prevention of Health Care-Associated Infections. This committee developed the National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination in 2009. This document detailed 8 metrics and 5 year goals for the following HAIs:

1. Central-line Associated Bloodstream Infection (NHSN)
2. C. difficile Hospitalizations (NAHQ)
3. C. difficile LabID (NHSN)
4. Catheter-associated Urinary Tract Infections (NHSN)
5. MRSA invasive infections (EIP/ABC)
6. MRSA LabID (NHSN)
7. Surgical Site Infections (NHSN)
8. Surgical Care Improvement Project Measures (CMS Hospital Compare)

In 2013, the Steering Committee established new targets and recommendations for continued monitoring and target setting (Appendix A). The Oregon Healthcare-Associated Infection Advisory Committee (HAIAC) proposes to adopt these metrics as a part the 2014 Oregon HAI Plan. This would include, but is not limited to, the metrics 1-8.

The current data and projected outcomes to meet the HHS 2020 goals are recorded below:

Table 1. HAIs reported to NHSN that HHS has identified as requiring continued monitoring and target setting

HAI	2013* SIR	HHS Goal	Percentage difference of 2013* data and the national 2008 baseline	2013 Goal
CLABSI Adult	0.28	0.5	-72%	met
CLABSI NICU	0.25	0.5	-75%	met
Cdiff_LabID	0.75	0.7	-25%	not met
CBGB	0.49	0.75	-51%	met
COLO	0.73	0.75	-27%	met
HPRO	0.70	0.75	-30%	met
HYST	0.78	0.75	-22%	not met
LAM	0.72	0.75	-28%	met
KPRO	0.66	0.75	-34%	met

* 2013 data, SIR is subject to change

Table 2. The overall percent change in SIR between the beginning year of reporting and 2013 for HAIs reported to NHSN

HAI	SIR in the year reporting		Percent change between	
	began SIR	2013* SIR	when reporting began to 2013* for Oregon	P-value
CLABSI Adult (2009)	0.85	0.28	-67.0%	<.01
CLABSI NICU (2011)	0.42	0.25	-40.0%	0.38
Cdiff_LabID (2012)	0.70	0.75	6.1%	0.29
CBGB (2009)	0.63	0.49	-21.1%	0.36
COLO (2011)	0.74	0.73	-1.2%	0.91
HPRO (2011)	1.13	0.70	-37.9%	<.01
HYST (2011)	0.67	0.78	16.5%	0.47
LAM (2011)	0.67	0.72	6.7%	0.71
KPRO (2009)	0.88	0.66	-25.7%	0.11

Table 3. Actual and projected HAI SIRs for the state of Oregon

HAI	Proposed 2020 Target	2013*	Project 2020*	Projected to meet
CLABSI Adult	50% reduction from 2015 baseline	0.28	0.00	Yes
CLABSI NICU	50% reduction from 2015 baseline	0.25	0.00	Yes
Cdiff_LabID	30% reduction from 2015 baseline	0.75	1.05	No
CBGB	30% reduction from 2015 baseline	0.49	0.15	Yes
COLO	30% reduction from 2015 baseline	0.73	0.72	No
HPRO	30% reduction from 2015 baseline	0.70	0.00	Yes
HYST	30% reduction from 2015 baseline	0.78	1.14	No
LAM	30% reduction from 2015 baseline	0.72	0.86	No
KPRO	30% reduction from 2015 baseline	0.66	0.55	No
CAUTI	25% reduction from 2015 baseline	N/A		
MRSA LabID	50% reduction from 2015 baseline	N/A		
MRSA Invasive Infections**	75% reduction from 2015 baseline			
Cdiff hospitalizations **	30% reduction from 2015 baseline			

* 2013 data is not finalized and may change

** Currently processing data

Oregon HAI SIRs from initiation of reporting to projected 2015 & 2020 SIR

- Oregon SIR
- Projected SIR
- 2020 Goal
- SIR baseline

