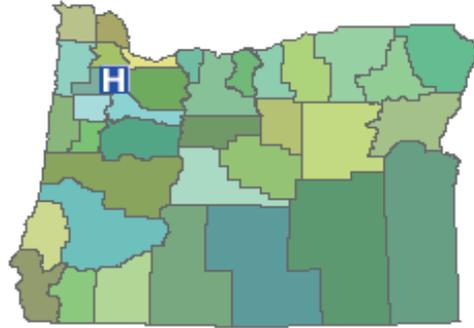


SAMPLE DATA

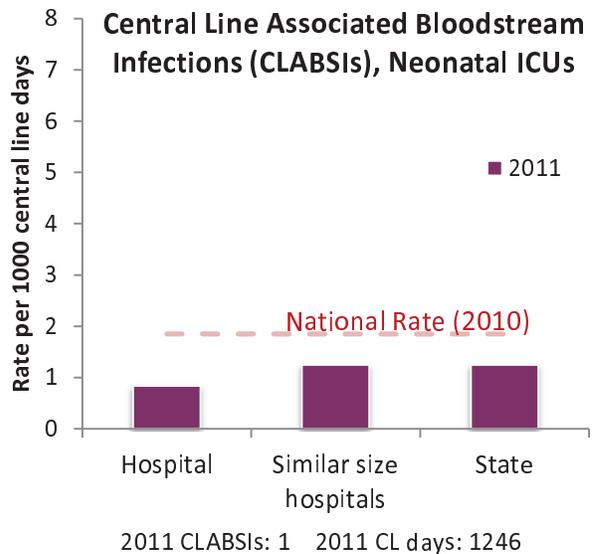
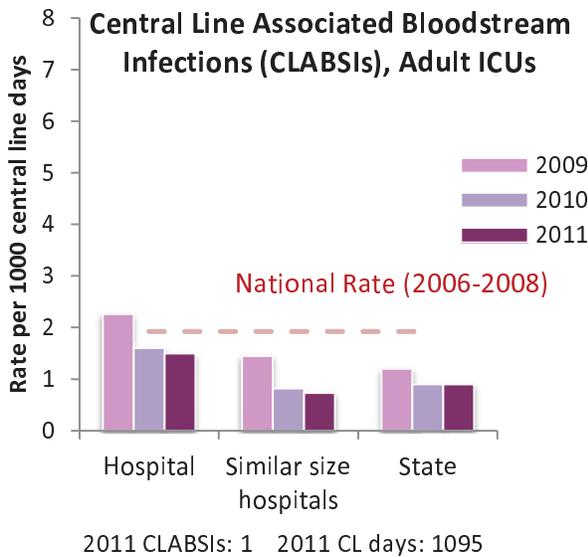
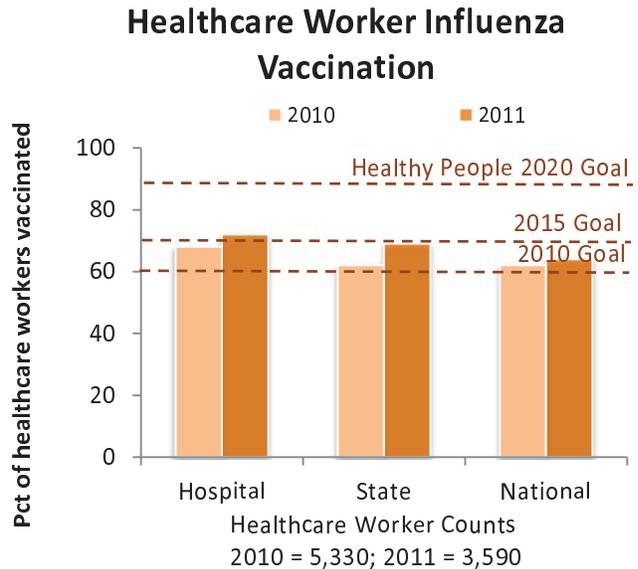
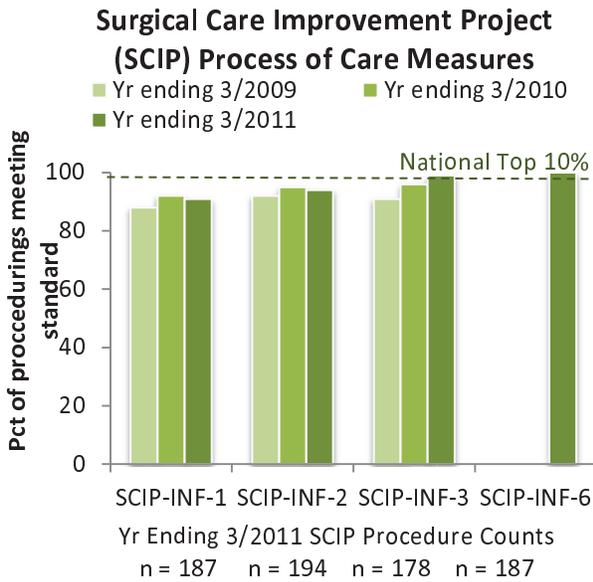
Hospital A Name

Location: Town
 Ownership: Not for Profit
 Medical School Affiliation: None

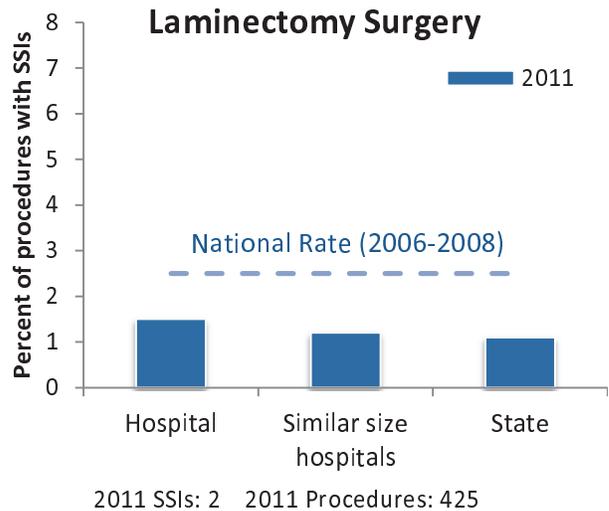
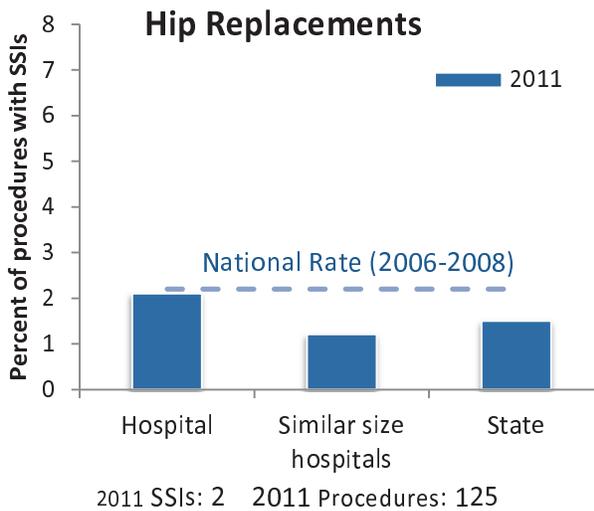
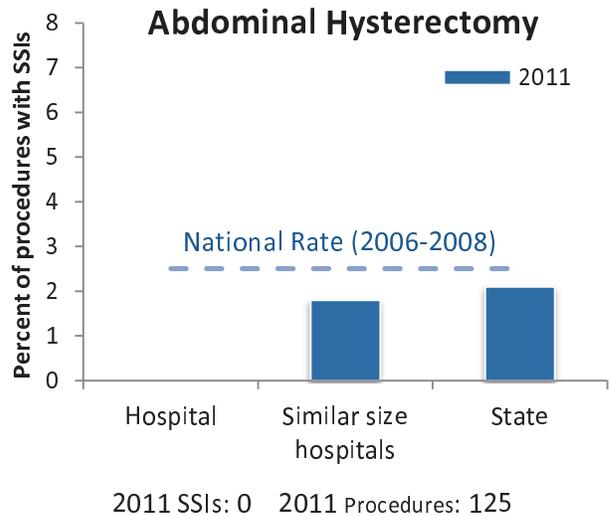
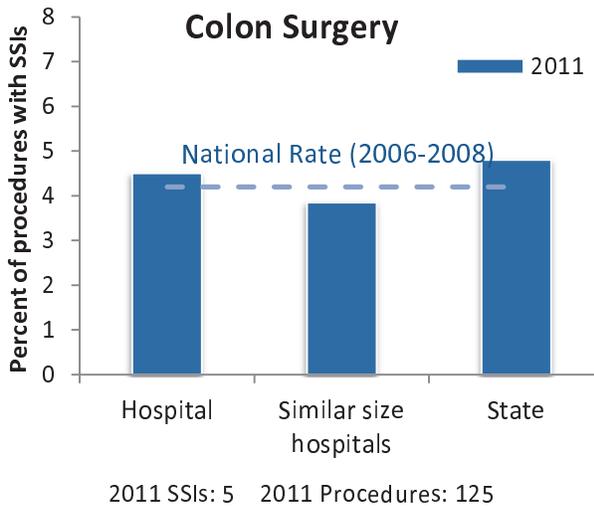
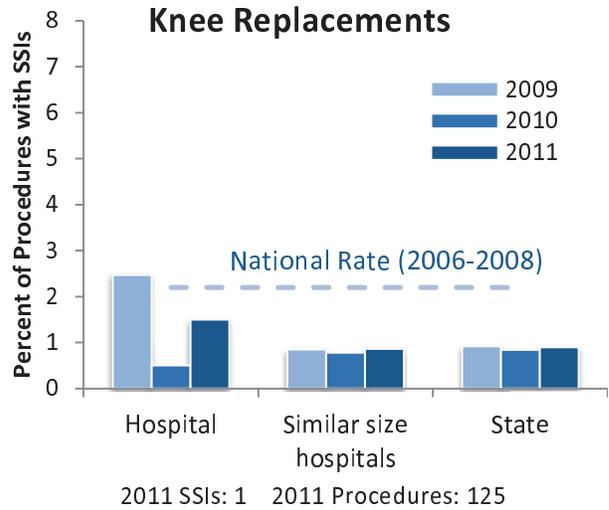
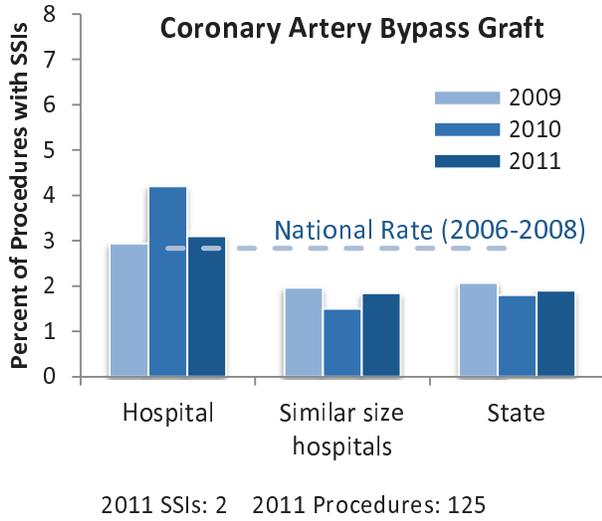
ICU Beds: 40
 Specialty Care Beds: 10
 Total Staffed Beds: 125
 Infection Control Professional FTE: 2



[Follow this link to view hospital comments.](#)



SAMPLE DATA



Cascade Healthcare Community (CHC)



Health Care Acquired Infections Advisory Committee November 13, 2007

The vision to publicly report quality data

- Local media relentless
- Reporting 2 year old data
- Lack of educational component

- Discussions started about one year ago
 - Pam Steinke, VP Quality of CHC
 - Jim Diegel, CEO of CHC
 - Board of Directors
- Transparency, openness, honesty, integrity - CHC goals
- Approach is to over-report, rather than under-report

Decision to collaborate with local media

- Started meeting with local media in March and April 2007
- Commitment made to local media
- Meet quarterly
- Provide current information and statistics

Choosing processes and outcomes to report:

- Potentially publicly reported
- Evidence based
- Data currently being tracked

Published first quality reports on external website in June 2007 -- www.scmc.org

A Message About Quality from James A. Diegel, FACHE, President/CEO Cascade Healthcare Community

"To improve the health of those we serve in a spirit of love and compassion" is the mission of Cascade Healthcare Community. We accomplish this through the dedication of our physicians and caregivers and their commitment to compassion, excellence, relationships, customer service, sanctuary, and stewardship. CHC is an excellent, award-winning healthcare system that leads the nation in a number of areas of quality. Yet, like any complex organization, we can be even better.



This Web site is one avenue for CHC's "transparency commitment" to keep the public informed about what we do well and also where we need to improve. We will use the best data we have available and focus whenever possible on standard national metrics that provide regional and national comparisons. This website will be under constant construction as we add more and more information, update data periodically, and refine our reports to best meet your needs.

What does "transparency" mean?

It means having the courage to be open and honest about what we do and how we do it. It means celebrating publicly both our large and smaller successes, even if we might sometimes appear boastful. It means acknowledging where we need to improve and having clear action plans to do it. It means letting our community inside our quality improvement efforts and seeking their input on solutions. It means fostering an internal culture that strikes a balance between rewarding courage and demanding accountability.

Why is transparency important?

Consumers deserve to know if they are receiving a high-quality product or service. In addition to the ethical imperative of providing quality information, it can help consumers decide where to spend their money. CHC believes healthcare consumers should not be an exception, although historically they have been considered so. Undoubtedly, measuring key aspects of quality such as safety, effectiveness, reliability, and efficiency is more difficult in healthcare than other industries. There are many uncontrollable factors that make it difficult to compare hospitals apples-to-apples, such as patient differences and vast disparities in federal funding across the United States. Nevertheless, transparency is a journey that is in everyone's best interest and we must use the best metrics available currently, with the trust that accuracy will improve with practice.

Hospitals are interested in transparency for another important reason: it helps us know which hospitals are the best, and, more importantly, what we can learn from them. A culture of courage includes always trying to be better by seeking out the best and replicating their successes. At CHC, we coined the phrase "Be the Benchmark" to reflect this constant striving for top-tier performance.

What will our transparency look like to you?

You will see more data on a regular basis about CHC's quality, customer service, and charges as compared to other hospitals in Oregon and nationally. Will we be opening up our internal records completely? Of course not. Patient privacy will be our first priority, so we will release aggregate statistics only, making it impossible to identify an individual patient. Also, even though CHC is not-for-profit, healthcare can be a ferociously competitive industry. In such an environment, we must maintain responsible business acumen.

What do we need from you, our community?

First, we need your trust. CHC has always been a not-for-profit organization and healthcare above all is a "caring" profession, so you can assume good intentions on our part. Second, we need your

understanding that healthcare will never be perfect. However, this will not deter us from pursuing perfection and that is what you should expect from us. Third, we need you to be an advocate for quality healthcare. Educate yourself about standards of good care by visiting websites of major quality organizations such as the Institute for Healthcare Improvement, National Quality Forum, Agency for Healthcare Research and Quality, Department of Health and Human Services, and the Joint Commission.

When you visit a doctor or come to our hospitals, don't be embarrassed to ask about quality and safety practices. This can be as simple as "I've read that there are some basic things that nurses and doctors can do to keep patients from getting an infection during their visit. What do you do here?" We will be able to tell you. Fourth, we need you to take good care of yourself. Exercise regularly, eat well-balanced meals, and don't smoke. Get regular check-ups with your doctor and follow their advice for keeping healthy. Responsible self-care is the first and most important step in preventing overuse of the American healthcare system.

Cascade Healthcare Community's commitment to you—our patients, our customers, our community—is simply this: In a spirit of love and compassion, we will do our best to improve your health.

Quarterly Community Update

September 15th, 2007



At Cascade Healthcare Community (CHC) we have a “transparency commitment” to keep the public informed about what we do well and also where we need to improve. This Web site is one avenue we use to keep that commitment to our patients and their families. We will use the best data we have available and focus whenever possible on standard national metrics that provide regional and national comparisons. This Web site will be under constant construction as we add more and more information, update data periodically and refine our reports to best meet your needs.

So, we encourage you to check back often for the latest in quality information from CHC.

What’s new this quarter?

- The summary scorecard (below) provides a quick gauge of how CHC compares nationally, if we are improving and if we have met our lofty “stretch targets”—since we do not aim for average quality.
- A quality report for the St. Charles Regional Cancer Treatment Center shows our performance on the four national cancer quality measures endorsed recently by the National Quality Forum.
- Patient satisfaction data from our outpatient surgery centers and our emergency room.
- Updated quality data for heart attack, heart failure, pneumonia and surgical care sites. We also changed the format of these reports so we now report the same time period for both hospitals and show the overall average across all measures.

Summary Performance Scorecard (updated September 2007):

Area (click area to view report)	Exceeding national average?		Improving (or at top)?		Meeting our <i>STRETCH</i> target?	
	Bend	Redmond	Bend	Redmond	Bend	Redmond
QUALITY AND PATIENT SAFETY						
HEART ATTACK CARE	✓	✓*	✓	✓*		
HEART FAILURE CARE	✓	✓	✓	✓		
PNEUMONIA CARE				✓		

SURGICAL CARE	✓	✓				
CANCER CARE	✓	✓*	✓	✓*	✓	✓*
INFECTION PREVENTION	?	?	✓	✓		✓
CUSTOMER SERVICE						
INPATIENT SATISFACTION	✓	✓		✓	✓	✓
OUTPATIENT SURGERY SATISFACTION		✓		✓		
ER PATIENT SATISFACTION	✓			✓		

* Regional treatment program based in Bend.

"Stretch" target defined as being in top 10th percentile

Infection Control Department Quality Overview

- Process measures -
- Outcomes measures -
- Decision made early on to only provide annual report...
 - doesn't match up well with other data being reported in Surgical Care report

- Data originates from Infection Control Department's data base
- CDC definitions used to determine hospital acquired infections (with additional input by epidemiologist)
- No risk stratification performed
- Organism stratification done, but not reported publicly

- St. Charles Medical Center - Bend
 - Targeted surveillance
 - Ventilator Associated Pneumonias
 - C. difficile infections
 - Non-peripheral IV infections - including PICC line infections, over the wire infections, MD inserted catheters, CVC combined, NICU line infections
 - Surgical Site Infections
 - Look at all SSI's by service (only publicly report SCIP measure procedures)
 - Rely on culture results and/or readmissions to identify SSI's after discharge
 - Cultures processed for 3 county region
 - # of SSI's may be higher than reported
 - Considering F/U phone calls with CABG patients

- St. Charles Medical Center - Redmond
 - Total house surveillance
 - Ventilator and non-ventilator associated pneumonias
 - All IV infections
 - Surgical site
 - Look at all by service (only publicly report SCIP measure procedures)
 - Rely on culture results and/or readmissions to identify SSI's after discharge
 - Cultures processed for 3 county region
 - # of SSI's may be higher than reported
 - C.difficile
 - UTI
 - Difficult to get accurate # catheter days

CHC Quality Reporting

Information about Infection Control



The risk of wound infection after surgery can significantly be reduced by making sure patients get the right medications at the right time on the day of their surgery.

Quality and Safety

Cascade Community Healthcare is committed to providing safe, high quality care. Measuring how we provide patient care allows us to evaluate and improve care. We measure care that experts agree is the best treatment for each condition.

CHC Quality Reporting

Infection Control Quality Report

The risk of wound infection after surgery can significantly be reduced by making sure patients get the right medications at the right time on the day of their surgery.

HOSPITAL ACQUIRED INFECTIONS											
Procedure	St. Charles-BEND				St. Charles-REDMOND				COMPARISON GROUPS		
	Procedures (2006)	Infections (2006)	Rate per 1000	Change from 2005	Procedures (2006)	Infections (2006)	Rate per 1000	Change from 2005	Oregon	U.S.	Top 10%
Coron. Artery Bypass Graft (CABG)	198	1	5.05	-9.51	0	n/a	n/a	n/a	n/a	n/a	n/a
Total Hip Replacement	306	3	9.80	2.79	46	0	0.00	0.00	n/a	n/a	n/a
Total Knee Replacement	529	3	5.67	-0.97	57	0	0.00	0.00	n/a	n/a	n/a
Hysterectomy	365	5	13.70	7.34	60	0	0.00	0.00	n/a	n/a	n/a
Central Lines (Central Venous Catheters)	11,534 (lines days)	19	1.65	-0.17	n/a	1	n/a	n/a	n/a	n/a	n/a
AVERAGE ACROSS ALL MEASURES											
			7.17	-0.10			0.00	0.00			

CHC Quality Reporting Information about Surgical Care Improvements



Hospitals can improve surgical care and reduce the risk of wound infection after surgery by providing the right medicines at the right time on the day of surgery.

There are also steps that you, as a patient, can take to make sure the surgery is as safe as possible. For example, your doctor or nurse can tell you how to wash with an antibiotic soap the day before surgery. You can also give your doctor or nurse a list of all your medications, including vitamins, herbal medicines, and over-the-counter medications. You should also tell your doctor or nurse about any allergies and bad reactions to anesthesia.

Sometimes patients get an infection after surgery, even if the hospital took steps to prevent it. Here are signs to look out for:

- The surgical wound is red, hot, and swollen.
- You have a fever of over 100 degrees after you go home.
- A smelly or yellow/green fluid is coming out of the wound.
- Your pain is increasing even though you are taking pain medication.

Call your doctor or local hospital immediately if you have any of these signs.

More information about surgery

- **"THINKING ABOUT SURGERY?"**
- **ST. CHARLES SURGERY INFO CENTER**
- **AMERICAN LUNG ASSOCIATION**
- **THE NATIONAL LIBRARY OF MEDICINE AND THE NATIONAL INSTITUTES OF HEALTH**

Information from **WWW.HOSPITALCOMPARE.GOV**.

Surgical Care and Surgical Infection Prevention Quality Report

Getting an antibiotic within one hour before surgery reduces the risk of wound infections. Hospitals should check to make sure surgery patients get antibiotics at the right time.

It is important for hospitals to stop giving preventative antibiotics within 24 hours after surgery to avoid side effects and other problems associated with antibiotic use. For certain surgeries, however, antibiotics may be needed for a longer time.

= too few patients to report a rate.

SURGICAL CARE											
Measure	St. Charles-BEND				St. Charles-REDMOND				COMPARISONS (Oct 2005-Sept 2006)		
	4Q 2006	1Q 2007 (N/D)	Change	4Q 2006	1Q 2007 (N/D)	Change	Oregon	U.S.	Top 10%		
Percent of Surgery Patients Who Received Preventative Antibiotic(s) One Hour Before Incision	83%	87% (183/211)	3.7%	91%	94% (46/49)	2.9%	71%	77%	95%		
Percent of Surgery Patients who Received the Appropriate Preventative Antibiotic(s) for Their Surgery	97%	97% (205/212)	-0.3%	91%	94% (46/49)	2.9%	89%	90%	100%		
Percent of Surgery Patients Whose Preventative Antibiotic(s) are Stopped Within 24 hours After Surgery	83%	84% (136/162)	1.0%	75%	76% (31/41)	0.6%	65%	72%	95%		
Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	90%	85% (147/173)	-5.0%	94%	80% (37/46)	-13.6%	n/a	n/a	n/a		
Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to	90%	80% (139/173)	-9.7%	94%	70% (32/46)	-24.4%	n/a	n/a	n/a		

Surgery to 24 Hours After Surgery											
AVERAGE ACROSS ALL MEASURES	89%	87%		-2%	89%	83%		-6%	75%	80%	97%

Data from IHI SCIP procedures.

Barriers / Challenges

- Resources to get data
 - 2.5 FTE's to gather CMS data (abstraction, collection of core measures)
 - inpatient only
 - unknown when we will gather outpatient data
 - How to educate public in a way that's understandable to broad audience
 - one size doesn't fit all
- Infection Control department
 - 1.5 FTE's
 - 80% of time spent gathering data
 - No automated system - everything is manual
 - Lag time from submission of data to CMS reports
 - Lack of epidemiology software program with our current EMR system
- CHC hospitals serve unique populations and treat varied conditions and illnesses
- CHC hospitals offer different services, specialties and expertise
- Government data may be two or three years old... doesn't mean it's wrong, but much may be changed since it was reported
 - Public can't really compare apples to apples

Ideas / discussion ongoing:

- Surveillance cultures -
 - Which patients?
 - Which sites?
 - Who pays?
 - Hospital wide versus unit specific versus procedure specific?
- Report specific organisms -
 - MRSA
 - VRE
 - C. Difficile
 - Others

Public reaction to external reporting:

- Media (attached)
- Written letters
- Inquiries to IC nurses and other caregivers
- Physician offices

Future state:

- Develop quality portals under CHC quality reporting on website
 - www.cascadehealthcare.org
 - St. Charles Medical Center - Bend (SCMC-B)
 - St. Charles Medical Center - Redmond (SCMC-R)
 - Pioneer Memorial Hospital - Prineville (PMH)
 - Mountain View Hospital - Madras (MVH)

- January / February 2008
 - Initiate public launch to actively promote the new sites through the media and our own marketing tools, including FOCUS magazine

HEALTH CARE LEGISLATIVE WORKGROUP TO IMMUNIZE HEALTHCARE WORKERS

Presented by Lorraine Duncan, Oregon Immunization Manager

<http://flu.oregon.gov/articles/Pages/HCWInfluenzaWorkgroup.aspx>

Meeting Details

Legislative Workgroup Members

7.19.2010 meeting notes

8.27.2010 meeting notes

8.25.2011 meeting notes

Office for Oregon Health Policy & Research Survey

HCW Immunization Resources

Legislative Workgroup on Health Care Worker Influenza Vaccination

For more information contact:

Carlos.Quintanilla@state.or.us

971-673-0287

Workgroup Statement

We support annual influenza vaccinations among health care workers as an important way to protect our patients, our communities and ourselves. Influenza vaccination of health care workers is proven to reduce death and disease in clinical settings and in communities (1). In 2009, about half of Oregon health care workers were vaccinated for influenza (2). This turnout is below the levels needed to prevent an outbreak. The health of our patients, friends and families are at stake.

Together, we are taking action. We are:

1. Actively promoting annual influenza vaccinations of all Oregon health care workers;
2. Joining forces to educate all health care workers regarding the benefits of influenza vaccination;
3. Monitoring vaccine coverage in hospitals and long term care facilities through facility use of declination forms and aggregate reporting;
4. Measuring patient safety by a facility's health care worker vaccination rate;
5. Evaluating Oregon health care worker concerns about influenza vaccinations in order to improve our communications about vaccine safety and efficacy;
6. Celebrating institutional and organizational successes through a web-based honor roll; and
7. Meeting quarterly to review progress and set objectives for increases in health care worker influenza vaccination rates over the next two years.

Influenza vaccination saves lives. In the last flu season, 1,316 Oregonians were hospitalized and 67 died of influenza-related illnesses (3). Health care workers care for vulnerable patients in hospitals, medical practices, long term care facilities, and in homes across the State. Annually vaccinated health care workers can stop the spread of disease in their clinics and facilities. Our patients deserve the best care possible. Promoting patient safety through an annual health care worker vaccination program provides a firm foundation for advancing this goal.

1) See Joint Commission Monograph at <http://www.jcrinc.com/fluchallenge/>

2) Preliminary analysis of Behavioral Risk Factor Survey Surveillance, Oregon Immunization Program.

Legislation

ORS 433.407 - 433.416

433.407 Definitions for ORS 433.407 to 433.423. As used in ORS 433.407 to 433.423 unless the context requires otherwise:

1. "Authority" means the Oregon Health Authority.
2. "Health care facility" means a facility as defined in ORS 442.015 and a mental health facility, alcohol treatment facility or drug treatment facility licensed or operated under ORS chapter 426 or 430.
3. "Worker" means a person who is licensed or certified to provide health care under ORS chapter 677, 678, 679, 680, 684 or 685 or ORS 682.216, an employee of a health care facility, of a licensed health care provider or of a clinical laboratory as defined in ORS 438.010, a firefighter, a law enforcement officer as

defined in ORS 414.805, a corrections officer or a parole and probation officer. [1989 c.949 §2; 1993 c.196 §8; 2005 c.264 §24; 2009 c.595 §671; 2011 c.720 §195]

Note: 433.407 to 433.423 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 433 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

433.411 Legislative finding. The Legislative Assembly finds that by reason of and in the course of their employment, health care workers and emergency response employees, are subject to exposure to infectious diseases, that this exposure is not fully preventable due to the nature of their duties and that health care workers should be informed of exposure to infectious diseases as soon as is practicable to initiate appropriate medical care and to prevent exposing other persons to infectious diseases. [1989 c.949 §1]

433.416 When employer to provide preventive immunization.

1. An employer of a health care worker at risk of contracting an infectious disease in the course of employment shall provide to the worker preventive immunization for infectious disease if such preventive immunization is available and is medically appropriate.
2. Such preventive immunization shall be provided by the employer at no cost to the worker.
3. A worker shall not be required as a condition of work to be immunized under this section, unless such immunization is otherwise required by federal or state law, rule or regulation. [1989 c.949 §3]

Health Care Legislative Workgroup to Immunize Healthcare Workers

Last	First	Representing
Bell	Jo	Northwest Organization of Nurse Executives
Carlson	Jim	Oregon Health Care Association
Carmella	Joyce	CareOregon
Cervenka	Margaret	Oregon Alliance of Senior & Health Services
Cole	Gina	Legacy Health
Cosgrove	Paul	Lindsay Hart Neil & Weigler, LLP
Dameron	Jim	Oregon Patient Safety
Daniels	Jody	Glaxo Smith Kline
Davidson	Sue	Oregon Nurses Association
Dayton	Gwen	Oregon Medical Association
Dempsey	Jack	Oregon Nurses Association
Fiskum	Dave	Conkling, Fiskum & McCormick
Goodin	Bryan	Legacy Health Systems/OAIC
Hagins	Felisa	Service Employees International Union
Holt	Tom	Oregon Association of Hospitals and Health Systems
Jones	Karen	Acumentra
Lentz	Temple	Oregon Federation of Nurses and Health Professionals
Lowe	Ellen C.	Oregon Association of Hospitals and Health Systems
Mallik	Shah	Oregon State Pharmacy Association Oregon Society of Health System Pharmacists
Moritz	Stacy	Acumentra
Negley	Jeanne	Office for Oregon Health Policy & Research
Rhoades	Lauren	Oregon Health Care Association
Ruona	Pamela	Oregon Health Care Association
Sveinbjornsson	Joanie	Lindsay Hart Neil & Weigler, LLP
Thalhofer	Teri	Oregon Conference of Local Health Officials
Waldo	Diane	Oregon Association of Hospitals and Health Systems

Oregon Health Authority/Division of Public Health

Alexander	Alison	OHA/Immunization Program
Bradley	Katherine	Oregon Health Authority (OHA)/Office of Family Health
Cieslak	Paul	OHA/Acute and Communicable Disease Prevention
Duncan	Lorraine	OHA/Immunization Program
Groom	Holly	OHA/Immunization Program
King	Katy	OHA/Legislative Liaison
Selover	Dana	OHA/Health Services Licensing & Certification
Quintanilla	Carlos	OHA/Immunization Program
Whitney	Jeanine	OHA/Immunization Program

NOTE: Matter within { + braces and plus signs + } in an amended section is new. Matter within { - braces and minus signs - } is existing law to be omitted. New sections are within { + braces and plus signs + } .

LC 173

A-Engrossed

Senate Bill 1503
Ordered by the Senate February 9
Including Senate Amendments dated February 9

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Health Care, Human Services and Rural Health Policy for the Oregon Nurses Association)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires health care worker to provide health care { - employer - } { + facility for or at which health care worker provides services + } with evidence that worker received annual seasonal influenza vaccination or written declaration that worker declines vaccination.

Requires health care { - employer - } { + facility + } to report to Oregon Health Authority on vaccination of health care workers.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to influenza vaccinations; and declaring an emergency.
Be It Enacted by the People of the State of Oregon:

SECTION 1. { + (1) For purposes of this section:

(a) 'Health care facility' has the meaning given that term in ORS 442.015.

(b) 'Health care worker' means an individual who:

(A)(i) Is an employee, contractor, volunteer or student providing services for or at the premises of a health care facility; or

(ii) Is a health care practitioner granted privileges by a health care facility; and

(B) Has contact with patients or infectious materials.

(2) Each year, a health care worker providing services for or at the premises of a health care facility shall provide the health care facility with:

(a) Evidence that the health care worker received an annual

seasonal influenza vaccination; or

(b) A written declaration on a form approved by the Oregon Health Authority stating that the health care worker declines the vaccination, stating the reason for the declination and including any other information required by the authority by rule.

(3) A health care facility shall electronically transmit to the authority an annual report containing the following information for the preceding year:

(a) The number of health care workers providing services for or at the premises of the health care facility who received an annual seasonal influenza vaccination;

(b) (A) The number of health care workers providing services for or at the premises of the health care facility who submitted a written declaration declining the vaccination; and

(B) The stated reasons for the declinations;

(c) The number of health care workers providing services for or at the premises of the health care facility who neither received an annual seasonal influenza vaccination nor submitted a written declaration declining the vaccination; and

(d) Other information required by the authority by rule.

(4) Information regarding a health care worker's vaccination status in the possession or control of a health care facility:

(a) Is protected health information under ORS 192.553 to 192.581.

(b) Is not subject to disclosure pursuant to ORS 192.410 to 192.505.

(5) (a) The authority may adopt rules as necessary to implement this section, including but not limited to rules establishing the dates by which a health care worker must comply with subsection (2) of this section.

(b) The rules adopted under this subsection may not be enforced when the State Health Officer of the Oregon Health Authority implements the Oregon Vaccine Education and Prioritization Plan in a vaccine shortage as described in ORS 433.040. + }

SECTION 2. { + This 2012 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2012 Act takes effect on its passage. + }

Work Notes from Health Care Worker Legislative Workgroup July 17, 2010

Attendees: Bryan Goodin, Jeanine Whitney, Katherine Bradley, Katy King, Lauren Rhodes, Hai Ta from CLHO, Joyce Carmella, Jack Dempsey, Tom Holt, Stacy Moritz

HCW Survey

Survey Update - JEANINE

Take out Q 7&8, Q1?,

Intro letter to participants - COLLETTE

Intro letter to facilities and institutions with instructions on how to by in (through survey tool with contact information) BRYAN

BUY IN Administrator survey tool SCOTT

- Contact Info & Planning
- Facility name
- Number of HCW

Set up individualized facility surveys in survey monkey – SCOTT & BRYAN

Check in August 3rd with Scott and Holly, too

Draft to IPAT, OAIC, OPIC for review

Kick off mid August, including public health through Mel

OHPR Survey

Share our survey to add to theirs COLLETTE

FLU Talking Points

H1N1 is in seasonal SUSAN AND BRYAN

Work with Susan and Christine for media messaging around Flu Summit

Outreach Plan – matrix with newsletters, summit, flu.or.gov

Sign on Letter for support of HCW vaccine for Mel's talk and media. BRYAN

FLU SUMMIT

Templates for HCW education - BRYAN AND JEANINE

Pay check stuffers

Pre-written press releases

Pre-written declinations

Pre-written newsletter articles

FOG access

Outreach template for them to us

Honor Roll -JEANINE

ASK TO SHARE RESOURCES FOR PRE-SEASON EDUCATION – JEANINE

Draft recommendations for workgroup review on August 27.

Health Care Legislative Work Group to Immunize Health Care Workers
August 27, 2010
10:00-12:00

Attendees: Katerine Bradley, Paul Cieslak, Gwen Dayton, Lorraine Duncan, Lynda Enos, Jody Fisher, Bryan Goodin, Nan Heim, Karen Jones, Katy King, Steve Moore, Lauren Rhodes, Nathien Tourdmam, Collette Young

Via phone: Joyce Caramella, Senator Bill Morrisette, Jeanie Negley, Alyssa Tran, Paul from Legacy

Notes: Heidi O'Shaughnessy

Senator Morrisette said he is open to possible legislation, and is hopeful that the influenza vaccination requirement for healthcare workers is part of the work group's recommendations. Senator believes this is something that has to be done; he looks forward to hearing from the work group in the September meeting. We can submit a committee bill if we have to.

Updates – Flu talking points, Flu Summit, WA decision, Open Letter:
On Monday August 30, 2010, postcards from Immunization Program are going to be mailed out to 230,000 families. The postcard have information about persons 6 months and older getting the influenza vaccination and low or no cost immunizations for your child.

The 2010-2011 Flu Talking Points are available. The Immunization Program is sharing these talking points with local health departments and with the media. The first talking point is that H1N1 is included in the flu this year. Manufacturing began in August and will continue thru the rest of the year. Pharmacists can now immunize down to 15 years of age and down to 11 years of age January 1, 2011. Included in the talking points are the Safenet phone number and the influenza web address.

Flu Summit was August 26, 2011: 300 people attended, it was an all day event with lots of good information. Binders with Influenza information can be requested on the influenza website.

Washington State Hospital Association adopted a measure asking healthcare workers to provide annual vaccination or wear a surgical mask. All hospitals in Washington will be reporting influenza vaccinations to the registry. Jocye Caramella went on the Washington State website to get more information, and on the website it looks like a voluntary sign on, not a requirement. The Immunization Program will check on that information and get that information out to everyone.

The Immunization Program has used an open letter for the last four or five months, it has general statements about getting immunized. The Immunization Program has asked people to sign on to the letter as an individual or as a clinic or organization. We would like to use the open letter as a model and make one for the work group to have people sign onto. The Immunization Program has a draft of the open letter, the letter will be sent out to the work group for review. The idea of the letter is to use as ongoing model for immunizations.

OPHR: Jeanie Nagley's office sent out the OPHR surveys to 59 hospitals. The first question was about the definition of healthcare workers, 40% said they could provide vaccination data and 60% said they couldn't. Most of the healthcare workers that weren't counted were made up of volunteers, contractors and students and trainees. The second question was about the seasonal and H1N1 documented vaccinations, the total vaccinations for seasonal was 51,000 and 52,000 for the H1N1. The estimated rate for seasonal vaccinations is 55% and H1N1 56%. They will share aggregate data. The annual dead line for this survey is required by this time each year. We can use this as a baseline when reviewing data collected the next year.

Education and Outreach – Templates, Honor Roll: Bryan Goodin has packets with ideas for outreach. The packet provides a couple of different

declinations. Research shows having someone sign a declination sign causes people to pay attention to what their signing. We have lots of campaign ideas such as: Give the gift of flu, promoting the honor roll, and sharing innovative work by facilities. On the website we could post a feel good story, which is also a way to highlight partners. October is National Pharmacy month and focusing on the help they provide to people with chronic conditions. In the packet is a draft press release and draft paycheck stuffer, things that can be used as handouts in a lounge or doctors office. Most of the documents are on the Flu website already and can be accessed by all partners.

It was just announced that PHER funding has been extended until July 2011.

Health Care Worker Survey tool: In July we discussed health care worker attitudes, the Immunization Program drafted a quick survey on the knowledge, attitudes, and practices. The survey is accessed through a survey monkey link. The Immunization Program can setup the link and use what ever data is gathered to give the facilities the feed back on how they are doing. There is a cover letter the in the packet to send out to your users. If we can get everyone on board it is a great planning tool. This is a great way for facilities to get information on their own workers and give us information on the national trend. One of the primary goals is trying to find out why healthcare workers are not getting vaccinated against influenza. We are currently working with 11 clinics on their vaccine distribution and working with them to get their input will help see what kind of improvements there will be in the next couple of years.

Legislative Recommendations: It might be time to consider legislation if we don't see improvements in rates. Senator Morrisette would like some of the partners in this work group to come forward to speak about what they do and talk about the process and at the work group meetings and talk about measures identified. Start with a presentation from Shawn Collmer on the base rates and then look at the measures presented to improve rates. It would be nice to know the date the survey can go out before the

September meeting or have a timeline or date for the survey to go out. It would be nice to have a timeline to work with each measure.

The work group should have a goal. The question is do we set the goal we want to achieve or something that is achievable in one year? Some hospitals are able to meet the rates but some smaller hospitals are not. It would be nice to have an achievable goal. A short term goal of 5% increase per year was suggested. Another goal was suggested at 75% being immunized. Possible to set goals with specific facilities, improve their rates each year. Administratively the work group needs to set a goal to focus on, encourage everyone to get a 5-10 percent goal and see where it we are the next year. Any improvement is great, but we want to meet the 2020 goal. There needs to be a goal of 90% of health care workers to be vaccinated against the seasonal flu. We need to look at what works best, where we need to push, facilities sharing info on what works best.

Accessibility is a huge concern. Having the nurses available to give the vaccine. Staffing is an issue everywhere. How can we best assist a facility, whether it is a staff issue or the organization? The survey needs to provide information on what works for different settings, small clinics to large hospitals. In a year from now it will be interesting to see where we stand and the feedback, what worked and what didn't and why it didn't work.

Next Steps: The work group should meet quarterly. Next meeting could be in October.

Health Care Legislative Work Group to Immunize Healthcare Workers

August 25, 2011

1:00-2:30

Attendees:

Members

Joyce Carmella	Oregon Adult Immunization Coalition
Gina Cole	Legacy Health System
Jody Daniels	Glaxo SmithKline
Gwen Dayton	Oregon Medical Association
Jack Dempsey	Oregon Nurses Association
Ruth Gulyas	Oregon Alliance of Senior & Health Services
Ellen C. Lowe	Oregon Association of Hospitals and Health Systems
Senator Laurie Monnes Anderson	Oregon State Senate
Jeanne Negley	Office for Oregon Health Policy & Research
Lauren Rhoades	Oregon Health Care Association
Pam Ruona	Oregon Health Care Association
Dana Selover	Oregon Health Care Regulation and Quality Improvement Program
Jeffrey Scroggin	Legislative Aide to Senator Alan C. Bates
Teri Thalhofer	Oregon Conference of Local Health Officials
Elyssa Tran	Office for Oregon Health Policy & Research

Oregon Health Authority/Division of Public Health

Katherine Bradley

Administrator, Office of Family Health

Paul Cieslak	Medical Director, Oregon Immunization Program
Lorraine Duncan	Manager, Oregon Immunization Program
Katy King	Government Relations Manager, Division of Public Health
Carlos Quintanilla	Public Health Advisor, Oregon Immunization Program
Jeanine Whitney	Adult Immunization Coordinator, Oregon Immunization Program

Guests

Lisa Angus	Office for Oregon Health Policy & Research
Kevin Buntman	Pacific University School of Pharmacy
Hilie Calvert	Kaiser Permanente Northwest Region
Toni Chistianson	Three Rivers Community Hospital
Rose Cox	Pac/West
Diane Davis	Rogue Valley Medical Center
Holly Groom	Senior Researcher, Oregon Immunization Program
Julie Koch	Peace Health
Naomi Lam	Oregon State University College of Pharmacy
Nancy Malone	Three Rivers Community Hospital
Jane O'Glasser	Multnomah County Health Department
Catherine Whalen	Mid-Columbia Medical Center

Notes: Anne Van Curen

A 1989 Oregon law (ORS 433.407) states that facilities employing healthcare workers (HCWs) have to offer vaccines but can't require employees to get immunized. A national survey shows that the Oregon law differs from other states, which have been able to

mandate healthcare worker immunization. The Washington State Hospital Association enacted a policy last year which requires that HCWs either be vaccinated for influenza or wear masks. Uptake data should be available soon.

Updates – CDC's Morbidity and Mortality Weekly Report (MMWR) published an article last week (*Influenza Vaccination Coverage Among Health-Care Personnel — United States, 2010–11 Influenza Season*, Aug. 19, 2011) that presented HCW influenza vaccine coverage rates. The article reiterated recommendations for HCW influenza vaccination. The HCW immunization rate in 2009-10 was 61.9%, and 63.5% for 2010-11. Nationwide, 13% of health care providers required staff flu immunization. Those with a requirement have a 98% coverage rate compared to 58.3% for those with no required immunization. The article provides a further breakdown by professional category.

Office for Oregon Health Policy & Research:

The OHPR conducted its annual influenza vaccine survey for Oregon, looking at hospital and long-term care facilities for the 2009-10 and 2010-11 seasons. The surveys were distributed to hospitals human resources directors and long-term care facility administrators. The survey defined healthcare worker as "All paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air." For the 2010-11 survey, workers were divided into three categories: Employees; Non-employees/credentialed; and Non-employees/other. Only the Employee category had good collection rates, however. Rates were:

	Hospitals	Long-term Care
2009-10	62%	55%
2010-11	69%	52%

The survey also inquired about reasons for vaccine refusal, vaccine delivery methods, vaccine promotion and formal HCW education programs. The survey full presentation and final report can be seen at

<http://flu.oregon.gov/articles/Pages/HCWInfluenzaWorkgroup.aspx>

Discussion:

For facilities with high rates, would they share information on how they reached those levels? *The hospital association will be contacted about that information.*

Voluntary measures will likely only achieve a 75% influenza vaccination rate.

Among the credentialed non-employees, are any of those groups doing anything to advance immunization, perhaps through the licensing agency, or through other organizations? No examples were shared.

The 2010-11 report will be available this fall.

HCW Immunization Mini-Grants –

The initial outcomes of this spring's Oregon Adult Immunization Coalition (OAIC) mini-grants have been collected. Seven organizations received funding through Public Health Emergency Response (PHER):

- ♦ Legacy Healthcare
- ♦ Deschutes County Health Department
- ♦ Linn County Health Department
- ♦ Oregon Nurses Association
- ♦ Multnomah County Health Department
- ♦ Silverton Hospital Network
- ♦ Adventist Health/Tillamook Hospital

Activities included onsite vaccine promotion strategies and an HCW survey. The summary and project resources can be seen at

<http://flu.oregon.gov/articles/Pages/HCWResources.aspx>

The Oregon Adult Immunization Coalition (OAIC) has announced the availability of new mini-grant funds. Grant awards will be announced in September. Work must be completed by December 30 and final reports will be available in April 2012.

Discussion:

- ♦ Good job from all participants
- ♦ A variety of funding amounts were awarded
- ♦ Final reports will be available on the flu.gov site (<http://flu.oregon.gov/Pages/index.aspx>)

- ♦ Since their initial program, Multnomah has moved to requiring that all health department employees be immunized for influenza and that those who choose not to be immunized sign a declination form.
- ♦ It would be helpful to maintain all the resources developed by the grantees in a central location for user access.

Legislative Recommendations:

What is an acceptable amount of uptake with the voluntary policy before looking at other measures, i.e. mandatory vaccination?

Discussion:

It's important to know what hospitals/long-term facilities are working on.

Peace Health achieved an 88% vaccination rate with a mandated vaccination or declination policy. Decliners had to mask in patient contact areas. They would like to see a similar policy as a condition of employment.

The Oregon Hospital Association was neutral in the last legislative session. Policy committee will revisit the issue shortly, and may have something in place for February legislative session.

Healthcare consumers expect that HCWs be vaccinated.

The Immunization Program will provide needed support in any policy discussion with partners.

What exactly does the existing Oregon statute prohibit? What can an employer do voluntarily?

There has been good participation from a variety of stakeholders since this workgroup started.

Would interim coverage rate goals be more manageable as we work toward the 2020 Healthy People goal?

Waiting until 2020 to get to 90% does not serving the public. That coverage level should be reached sooner.

Any chance Oregon could reach 90% by voluntary means? It was suggested to look at methods used by facilities that realized high rates through voluntary means. About 75% was the highest anyone knew of, and the facility worked extremely hard to get there.

Resistance from workers is not always logical and hard to develop strategies to overcome.

Data collection has helped to understand what is being done and where focus needed. Goals are needed – stronger messages and progress that can be tracked.

Need to show flexibility, instead of one-size-fits-all approach.

Next Steps:

Resource center to make data easier to access and share

Explore legislative approaches

The Legislative Workgroup will convene a smaller group to discuss possible coverage rate goals. A notice will be sent out for interested persons.

Influenza Vaccine Update:

Vaccine is arriving. Providers should begin vaccinating once they have vaccine. No shortage as of this time.

Next meeting: Katy King will get the Interim Committee schedule and determine a Workgroup meeting date.

**Health Care Legislative Work Group to Immunize Health Care Workers
Jan. 12, 2012**

Attendees:

Glaxo SmithKline	Jody Daniels
Legacy Health Systems/OAIC	Bryan Goodin
Oregon Adult Immunization Coalition	Alison Alexander Joyce Caramella
Oregon Alliance of Senior & Health Services	Margaret Cervenka
Oregon Association of Hospitals and Health Systems	Diane Waldo
Oregon Health Authority, Health Services Licensing & Certification	Dana Selover
Oregon Health Authority, Acute and Communicable Disease Program	Paul Cieslak
Oregon Health Authority, Immunization Program	Lorraine Duncan Holly Groom Carlos Quintanilla Jeanine Whitney
Oregon Health Authority, Legislative Liaison	Katy King
Office for Oregon Health Policy & Research	Jeanne Negley
Oregon Medical Association	Gwen Dayton
Oregon Nurses Association	Jack Dempsey
Oregon State Pharmacy Association	Shah Malik
Oregon Society of Health System Pharmacists	

Updates

Lorraine Duncan

National Vaccine Advisory committee (NVAC) Adult Immunization Working Group subgroup on Health Care Personnel Influenza Vaccination released a series of recommendations to achieve the Healthy People 2020 goal of 90% influenza vaccination coverage for health care personnel. (NVAC is made up of representatives of agencies within the U.S. Department of Health and Human Services, provider

organizations, vaccine manufacturers, organized labor, long-term care organizations and hospital associations.)

1. Establish comprehensive influenza infection prevention programs as recommended by CDC.
2. Integrate influenza vaccination programs into existing infection prevention or occupational health programs.
3. The U.S. Assistant Secretary of Health should encourage CDC and Center for Medicare and Medicaid Services (CMS) to continue efforts to standardize methodology to measure HCW influenza vaccination rates across settings.
4. Those facilities that have implemented Recommendations 1, 2 and 3 but cannot achieve and maintain the goal of 90% strongly consider an employee requirement for influenza immunization.
5. Encourage ongoing efforts to develop new and improved influenza vaccines and vaccine technologies.

The Association of Immunization Managers (AIM) subcommittee on HCW immunization will recommend to NVAC "that Recommendation 4 must be strengthened in order to achieve the 90% vaccination goal. Many institutions have enacted comprehensive education and vaccination programs but still failed to reach the 90% coverage goal. Organizations that have required vaccination as a condition of employment have achieved the goal (as documented by the National Influenza Vaccine Summit). NVAC recommendations should be for healthcare employers and facilities to 'enact' rather than 'strongly consider' a requirement for influenza immunization."

The November 25, 2011 MMWR published the ACIP recommendations on influenza of health care personnel. These include providing influenza vaccine at no cost to personnel, and influenza vaccination of personnel should be regularly measured and reported.

Included in the packet is a document of comments from around US regarding health care personnel vaccination and an article on a California hospital's shift from voluntary to mandatory influenza vaccination for its health care workers.

The Public Health Division now has a public meeting notice website. <http://www.oregon.gov/transparency/PublicMeetingNotices.shtml> The Workgroup meetings will be posted there in the future.

Oregon Nurses Association (ONA) Legislative Concept Jack Dempsey

The legislative concept includes requiring health care workers to provide their employers with evidence that they have received an annual influenza vaccination or a written declination form. The concept requires health care employers to report vaccine coverage levels to the Oregon Health Authority (OHA). It includes definitions of both healthcare workers and healthcare employers. The concept would mandate a signed declination for those with patient contact who wish not to be vaccinated. This extends statewide for all health care facilities for workers. ONA prefers not to use a "shame approach," (masks, lists indicating who has declined vaccination). The statewide declination form will raise rates, and all vaccine administration information will be de-identified. ONA sees this as a first step, and will look at the data to see where to go from there. Neither vaccination nor declination will be required as condition of employment, and is not meant to change the existing law (which prohibits an employer making vaccination a condition of employment). In ONA's opinion, without the existing law, nurses could be vulnerable to losing their jobs if they don't get vaccinated.

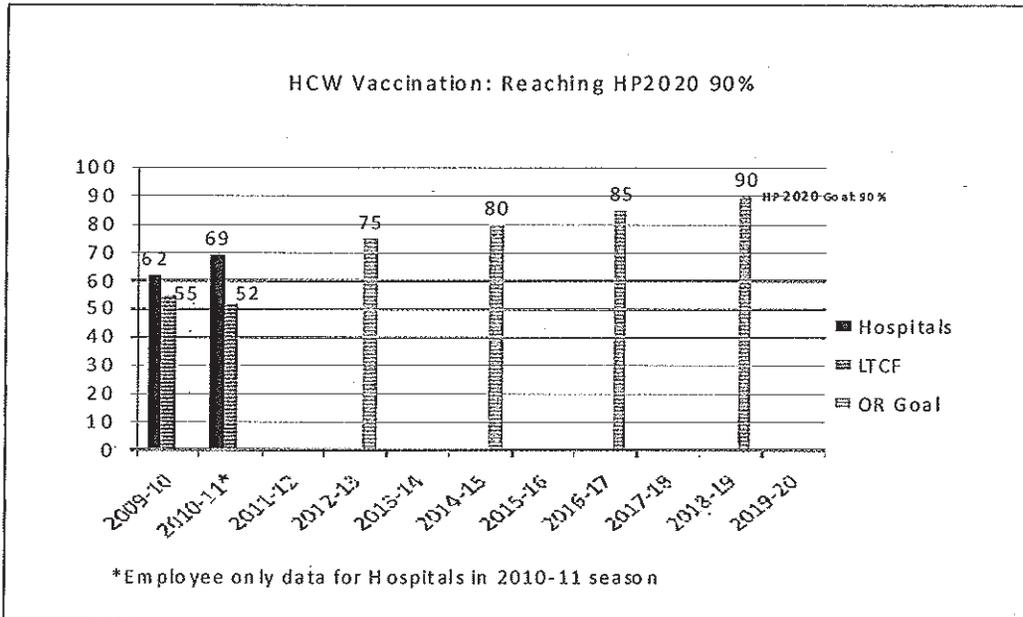
ONA's legislative concept also includes language that prohibits an employer making vaccination a condition of employment.

Discussion included:

- ♦ Should this concept be enacted, moving toward voluntary mandates would require the amendment of two laws.
- ♦ Employers are not allowed to publish names of those who declined.
- ♦ The Oregon Hospital Association would like original law to be repealed. It is barrier to reaching improved vaccination rates and increasing patient safety. This concept does not contain a strong enough message. Approaching this issue from a patient safety perspective could be stronger approach.
- ♦ The Oregon Adult Immunization Coalition (OAIC) is also in favor of repealing the existing law. Declinations do not protect patients. Existing bill definition of HCW leaves out a lot of HCWs who have patient contact.
- ♦ The Oregon Hospital Association, Glaxo SmithKline and OAIC representatives disagreed with prohibiting employers from making vaccination a condition of employment.
- ♦ The existing law applies to vaccines other than influenza; therefore, no vaccines can be required as a condition of employment.
- ♦ Oregon is the only state that has such a law that expressly forbids requiring vaccination as a condition of employment.

- ♦ Part of the concept is collecting data on which categories of HCWs are not getting vaccinated and at what facilities.
- ♦ Other states have not had success with voluntary vaccination and declinations. Why would Oregon be different?
- ♦ Fifteen of sixty (25%) of the hospitals that reported HCW influenza vaccination rates for 2010-2011 had rates \geq 80%. However, these rates reflect only hospital employees and do not include credentialed or non-credentialed on-employees.
- ♦ The Oregon Hospital Association sent a letter to Public Health Division Director Mel Kohn requesting that he work to repeal the current law which prohibits an employer making vaccination a condition of employment.
- ♦ Healthcare worker vaccination doesn't just apply to flu vaccine. Other vaccines as appropriate to facility/patient population are included in the discussion.

State agencies are currently reviewing the ONA concept. Katy expressed appreciation of the efforts to improve rates and to ONA for bringing forward a concept. There are some technical questions regarding healthcare workers who work in several facilities, lack of any sanction for not signing a declination form, and development of form and data collection. The conversation is ongoing. There is an informational hearing next week in the Senate Healthcare committee.



Subcommittee on Influenza Vaccination Coverage Rates Goals Holly Groom

The subcommittee met in October to discuss the Healthy People 2020 goal of 90% vaccination rates for HCWs, and the annual rate goals Oregon should have to reach that benchmark. The subcommittee concluded that several incremental goals were needed to monitor progress. An overall goal of 75% was set for the end of 2012-13, with 80% by 2014-15, 85% by 2016-17, and 90% by 2018-2019. Discussion included the importance of working with long term care facilities, as their rates lag behind hospitals and other facilities. The subcommittee also recommended an expanded HCW definition. Updated subcommittee meeting notes will be sent to workgroup when completed.

Announcements

CMS will start requiring hospitals to report HCW vaccination rates in January 2013 for employees, credentialed non-employees, and non-employee categories.

Next steps

The informational hearing on the legislative concept will be held next week. Testimony will occur several weeks later. When available, information will be sent on the legislative hearing at which testimony will be accepted.

This workgroup will meet again in March, specific date to be determined.

Evaluation of Ambulatory Surgical Center HAI Reporting Options

Background

The following represents a brief history of an evaluation of the ASC reporting options by the HAI Advisory Committee:

- January 2009: Kecia Rardin presents to HAI Advisory Committee infection rates for selected Oregon ASCs. During 2009, the Committee evaluated several options and recommended that the Oregon Health Authority’s Office for Oregon Health Policy and Research (OHPR) conducted a survey on Elements of Patient Safety Performance
- July 2010: issued first draft of survey for committee review.
- December 2010: Survey fielded and results obtained from all 86 free-standing ASCs in the state.
- January 2011-January 2012: reviewed results of the survey during committee meetings.
- December 2011: OHPR contacted the Agency for Healthcare Research and Quality (AHRQ), and learned it is testing an algorithm for “all-cause readmission” metrics for ASCs.
- January and February 2012: Oregon was one of six states interviewed regarding ASC reporting by the CDC. Like AHRQ, CDC is considering developing an all-cause readmission metric for ASCs in the National Healthcare Safety Network (NHSN).

A summary of states’ ASC reporting is presented below:

State HAI ASC Reporting									
State	Procedures								Notes
	HER	BRST	KPRO	HPRO	HYST	VHST	FX	LAM	
CO	x	x	x	x	x	x			started 9/2008; phased in; BRST to add 9/2011.
MA	x								started 6/2011
NH		x					x		started 6/2011
TX									still in process; voluntary
NJ		x		x				x	waiting for NHSN ICD-9/CPT crosswalk
MO	x	x							not using NHSN

Issues of Concern

- Need to identify metrics that represent what Oregon ASCs do, noting that there are a wide variety of specialties.
- Need to identify metrics with demonstrated high infection rates (Note: many of the states that are reporting ASC HAI rates are reporting mostly zeros.)
- Lack of reporting mechanisms.

ASC Infection Reporting Measures Options

1. Process measures. The ASC quality collaborative includes two process measures related to infection control. Measures are:

- **Percentage of ASC patients who received ASC antibiotics on time (98%)**
- **Percentage of ASC admissions with appropriate hair removal (98%)**

Considerations

- Would apply to all or most facilities.
- Rates are already close to 100% (CMS is dropping this measure for hospitals)
- No reporting tool for free-standing ASCs. (i.e., is not on Hospital Compare)

2. Collect outcome measures for limited surgeries.

Considerations

- Could adapt protocol from NHSN.
- Likely to result in mostly zeros.
- Only a subset of facilities included (approximately 17% for hernia and breast surgeries).
- Would be limited to surgeries in NHSN (not representative of ASCs surgeries).

ASC 2010 data were analyzed, and highest volumes were identified for breast and hernia procedures. Applying a threshold of 20 procedures per year, breast surgery would have 10 ASCs reporting, and hernia procedures would have 14 hospitals reporting. An estimated total of 15 facilities would be reporting with both measurements.

3. Have ASCs report overall infection rate and methodology

Considerations

- Would apply to all ASCs.
- Data would not be comparable.
- Unclear of use for the public.
- Would only be the first step towards more standardized surveillance (to be followed by work on standardizing definitions and methods).

4. Pilot test CDC's proposal for an all-cause readmission metric

Considerations

- After pilot, would apply to all ASCs.
- Could potentially be used to evaluate/validate All Payers All Claims data.
- Offers alignment with what appears to be Federal reporting agenda.
- Would need to obtain funding for pilot.

State of Colorado
Status Report on the Health Facility-Acquired
Infections Disclosure Initiative

January 13, 2012

Submitted to the Colorado General Assembly

By the Health Facilities and Emergency Medical Services Division

Colorado Department of Public Health and Environment



Colorado Department
of Public Health
and Environment

Participating Facilities

There are currently 259 hospitals, hospital units, ambulatory surgical centers and dialysis treatment clinics targeted for infection reporting. Of those, 69 hospitals (90%), 9 long-term acute care hospitals (100%), 38 ambulatory surgical centers (37.6%), and 61 dialysis treatment clinics (100%) report infection data. Certain hospitals and ambulatory surgical centers do not report to the Department because they do not have adult critical care units, neonatal critical care units or do not perform reportable procedures. Tables 3 – 5 describe the number of health facilities in Colorado that report infection data for the specific critical care units and long-term acute care hospitals (Table 3), perform the reportable procedures (Table 4), and the number of outpatient dialysis facilities in Colorado (Table 5). For a full list of reporting healthcare facilities in Colorado, refer to Appendix B.

Table 3: Number of Colorado hospitals reporting central line associated bloodstream infections by critical care unit.

Critical Care Unit	Number of facilities
Medical	6
Surgical	2
Medical/Surgical	45
Medical Cardiac	3
Cardiothoracic surgery	2
Level II/III Neonatal Critical Care	12
Level III Neonatal Critical Care	5
Long-term Acute Care Hospitals	9

Table 4: Number of Colorado hospitals and ambulatory surgical centers performing the reportable procedures

Procedure	Hospitals	Ambulatory Surgical Center	Total
Abdominal hysterectomy	58	4	62
Coronary artery bypass graft	18	0	18
Hernia repair	69	37	106
Hip replacement	56	5	61
Knee replacement	56	7	63
Vaginal hysterectomy	52	5	57

Table 5: Number of Colorado dialysis treatment centers.

Dialysis centers	Number of facilities: 61
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Table 11: Hip Replacement (total or partial), Outpatient Procedures for Ambulatory Surgery Centers, 2009 – 2010 and 2010 – 2011

Health Facility and Region		2009-2010				2010-2011			
		Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	National Comparison	Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	National Comparison
Loveland Surgery Center	Loveland	1	***	***	***	0	***	***	***
Orthopaedic Center of the Rockies	Fort Collins	128	0	0.0	Same	142	0	0.0	Same
Rocky Mountain Surgery Center	Englewood	0	***	***	***	1	***	***	***
Skyline Surgery Center	Loveland	0	***	***	***	2	***	***	***
Surgical Center at Premier	Colorado Springs	0	***	***	***	2	***	***	***

The standardized infection ratio (SIR) is the ratio of observed to expected infections, and is adjusted for procedure risk factors.

National comparison based on data collected and reported by NHCN-participating hospitals from 2006-2008.

See "National Healthcare Safety Network (NHSN) Report, Data Summary for 2006-2008, Issued December 2009" (Am J Infect Control 2009;37:783-805).

*** Indicates value not shown due to suppression of infections data.

Infections data for ASCs with fewer than 20 procedures performed in a 12-month period are suppressed to protect confidential health information. These ASCs have met the reporting requirements.

Source: National Healthcare Safety Network (NHSN) Database.

Prepared By: Colorado Patient Safety Initiatives Program, Colorado Department of Public Health and Environment.

Table 13: Knee Replacement (total or partial), Outpatient Procedures for Ambulatory Surgery Centers, 2009 – 2010 and 2010 – 2011

Health Facility and Region	Surgical Site Infections (SSI) in Knee Replacement Procedures (total or partial) in Ambulatory Surgery Centers (Outpatient) Reporting Period: August 1, 2009-July 31, 2011					
	2009-2010			2010-2011		
	Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	Procedure Count	Infection Count	Standardized Infection Ratio (SIR)
ASC Durango at Mercy Medical Center	0	***	***	1	***	***
Denver Midtown Surgery Center	1	***	***	0	***	***
Loveland Surgery Center	3	***	***	3	***	***
Orthopaedic Center of the Rockies	280	0	0.0	329	0	0.0
Rocky Mountain Surgery Center	3	***	***	9	***	***
Skyline Surgery Center	6	***	***	7	***	***
Surgical Center at Premier	9	***	***	14	***	***

The standardized infection ratio (SIR) is the ratio of observed to expected infections, and is adjusted for procedure risk factors.

National comparison based on data collected and reported by NHSN-participating hospitals from 2006-2008.

See "National Healthcare Safety Network (NHSN) Report, Data Summary for 2006-2008, Issued December 2009" (Am J Infect Control 2009;37:783-805).

*** Indicates value not shown due to suppression of infections data

Infections data for ASCs with fewer than 20 procedures performed in a 12-month period are suppressed to protect confidential health information. These ASCs have met the reporting requirements.

Source: National Healthcare Safety Network (NHSN) Database.

Prepared By: Colorado Patient Safety Program, Colorado Department of Public Health and Environment.

Table 15: Hernia Repair Procedures, Outpatient Procedures for Ambulatory Surgery Centers, 2009 – 2010 and 2010 – 2011

Health Facility and Region		Surgical Site Infections (SSI) in Hernia Procedures in Ambulatory Surgery Centers (Outpatient) Reporting Period: August 1, 2009-July 31, 2011							
		2009-2010				2010-2011			
		Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	National Comparison	Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	National Comparison
ASC Durango at Mercy Medical Center	Durango	46	0	0.0**	Same	56	0	0.0**	Same
Aberdeen Ambulatory Surgical Center	Pueblo	2	***	***	***	2	***	***	***
Arkansas Valley Surgery Center	Canon City	86	0	0.0	Same	84	0	0.0	Same
Audubon Ambulatory Surgery Center	Colorado Springs	29	0	0.0	Same	18	***	***	***
Audubon Ambulatory Surgery Center at St. Francis	Colorado Springs	441	0	0.0	Same	522	3	1.3	Same
Black Canyon Surgical Center	Montrose	34	1	6.2	Same	36	0	0.0	Same
Boulder Medical Center	Boulder	57	0	0.0	Same	68	0	0.0	Same
Centrum Surgical Center	Greenwood Village	7	***	***	***	9	***	***	***
Children's North Surgery Center	Broomfield	13**	***	***	***	24	0	0.0	Same
Clear Creek Surgery Center	Wheat Ridge	388	2	1.4	Same	383	1	0.7	Same
Colorado Springs Surgery Center	Colorado Springs	18	***	***	***	1	***	***	***
Crown Point Surgery Center	Parker	264	0	0.0	Same	309	1	0.8	Same
Denver Midtown Surgery Center	Denver	235	0	0.0	Same	225	0	0.0	Same
First Choice Outpatient Surgery Center at Community Hospital	Grand Junction	116	0	0.0	Same	121	1	1.6	Same
Grand Valley Surgical Center	Grand Junction	199	0	0.0	Same	221	0	0.0	Same

Surgical Site Infections (SSI) in Hernia Procedures in Ambulatory Surgery Centers (Outpatient) Reporting Period: August 1, 2009-July 31, 2011									
Health Facility and Region		2009-2010				2010-2011			
		Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	National Comparison	Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	National Comparison
Harmony Ambulatory Surgery Center	Fort Collins	475	1	0.4*	Same	490	1	0.5	Same
Kaiser Permanente Ambulatory Surgery Center	Denver	879	6	1.3	Same	770	5	1.3	Same
Lakewood Surgical Center	Lakewood	24	0	0.0	Same	0	***	***	***
Lincoln Surgery Center	Parker	21	0	0.0	Same	73	0	0.0	Same
Longmont Surgery Center	Longmont	141	0	0.0	Same	165	0	0.0	Same
MCR Surgery Center	Loveland	7	***	***	***	1	***	***	***
Midvalley Ambulatory Surgery Center	Basalt	0	***	***	***	3	***	***	***
Minimally Invasive Spinal Institute	Lafayette	6	***	***	***	1	***	***	***
North Suburban Surgery Center	Thornton	123	0	0.0	Same	108	0	0.0	Same
Parkwest Surgery Center	Pueblo	22	0	0.0	Same	8	***	***	***
Peak One Surgery Center	Frisco	33	0	0.0	Same	41	0	0.0	Same
Pueblo Surgery Center	Pueblo	15	***	***	***	14	***	***	***
Renewal Surgery Center	Lone Tree	0	***	***	***	7	***	***	***
Rocky Mountain Surgery Center	Englewood	183	0	0.0**	Same	362	1	1**	Same
Rose Surgical Center	Denver	478	1	0.5	Same	459	0	0.0	Same
Sky Ridge Surgical Center	Lone Tree	188	0	0.0	Same	240	0	0.0	Same
Skyline Surgery Center	Loveland	160	0	0.0	Same	142	0	0.0	Same
Summit View Surgery Center	Littleton	293	1	0.9	Same	286	0	0.0	Same
Surgery Center At Lutheran	Wheat Ridge	129	0	0.0	Same	130	0	0.0	Same

Surgical Site Infections (SSI) in Hernia Procedures in Ambulatory Surgery Centers (Outpatient) Reporting Period: August 1, 2009-July 31, 2011									
Health Facility and Region		2009-2010				2010-2011			
		Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	National Comparison	Procedure Count	Infection Count	Standardized Infection Ratio (SIR)	National Comparison
Surgery Center At Printers Park	Colorado Springs	43	0	0	Same	28	0	0	Same
Surgery Center of Fort Collins	Fort Collins	7	***	***	***	8	***	***	***
Surgical Center at Premier	Colorado Springs	75	0	0	Same	62	0	0	Same

The standardized infection ratio (SIR) is the ratio of observed to expected infections, and is adjusted for procedure risk factors.

National comparison based on data collected and reported by NHCN-participating hospitals from 2006-2008.

See "Improving Risk-Adjusted Measures of Surgical Site Infection for the National Healthcare Safety Network" (Inf Control and Hosp Epi. October 2011, Vol 32, No 10, pp. 970-986).

* Indicates that the expected number of infections used in SIR is not accurately calculated due to very high risk procedures being excluded from the calculation

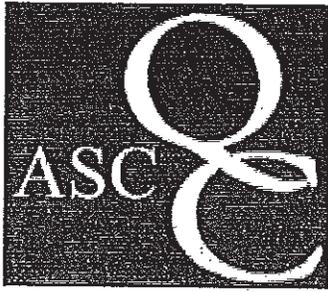
++ Indicates that the facility did not provide all data needed to calculate an accurate SIR

*** Indicates value not shown due to suppression of infections data, or no National or historical rate, or an expected count of zero, to which to compare facility rate.

Infected data for ASCs with fewer than 20 procedures performed in a 12-month period are suppressed to protect confidential health information. These ASCs have met the reporting requirements.

Source: National Healthcare Safety Network (NHSN) Database.

Prepared By: Colorado Patient Safety Program, Colorado Department of Public Health and Environment.



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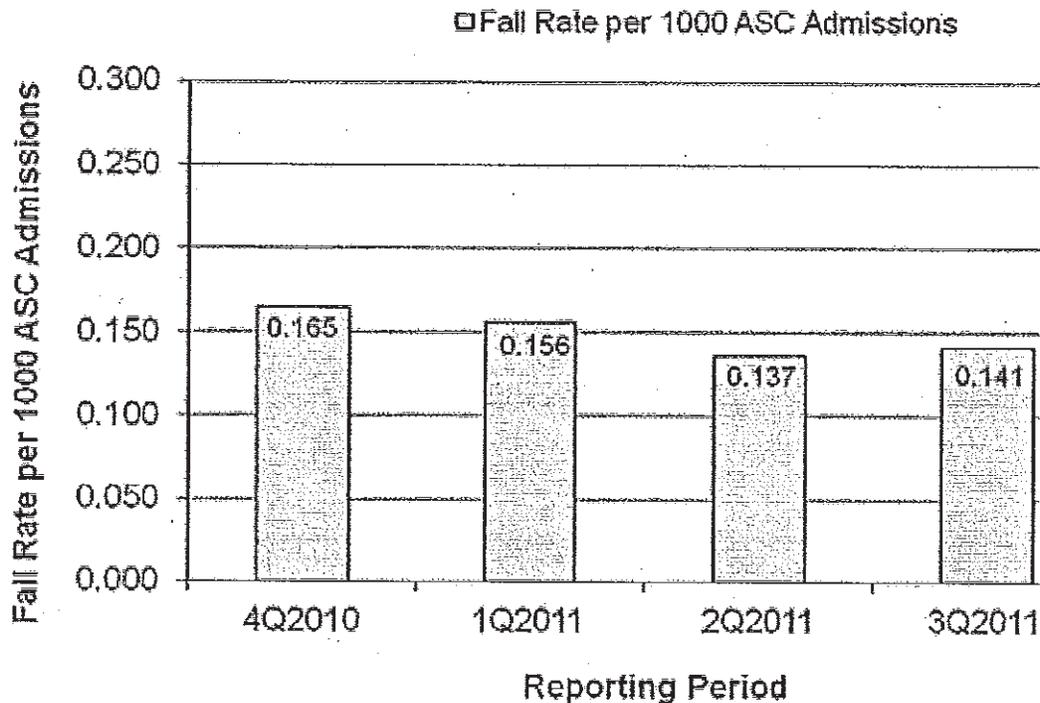
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ASC Quality Collaboration Quality Report 3rd Quarter 2011

This public report of ambulatory surgical center (ASC) quality data has been made possible through the voluntary efforts of participants in the ASC Quality Collaboration. The following organizations agreed to collect and submit clinical quality data reflecting patient admissions* from July 1, 2011 through September 30, 2011: Ambulatory Surgery Center Association; Ambulatory Surgical Centers of America (ASCOA); AmSurg; Healthcare Facilities Accreditation Program (HFAP); Health Inventures; HCA Ambulatory Surgery Division; Nueterra; Surgical Care Affiliates (SCA); Symbion and United Surgical Partners International (USPI).

Patient Fall Rate per 1000 ASC Admissions	0.165	0.156	0.137	0.141
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Patient Fall in the ASC



Patient Burn

Burns are an important issue for patients having outpatient procedures or surgery because the equipment and supplies routinely used in providing these types of services can increase the risk that a patient will experience an unintended burn.

The frequency of ASC admissions experiencing a burn, regardless of severity, while in the care of participating ASCs is shown below as a rate per 1000 admissions. Lower rates are better.

Rate of patient burns 0.031 per 1000 admissions

Represents the experience of 1,409,331 ASC admissions seen at 1,232 facilities between July 1 and September 30, 2011

The data trends for this measure over the last four quarters are presented below in both tabular and graphical formats.

Rate of hospital transfers/admissions 1.143 per 1000 admissions

Represents the experience of 1,513,158 ASC admissions seen at 1,292 facilities between July 1 and September 30, 2011

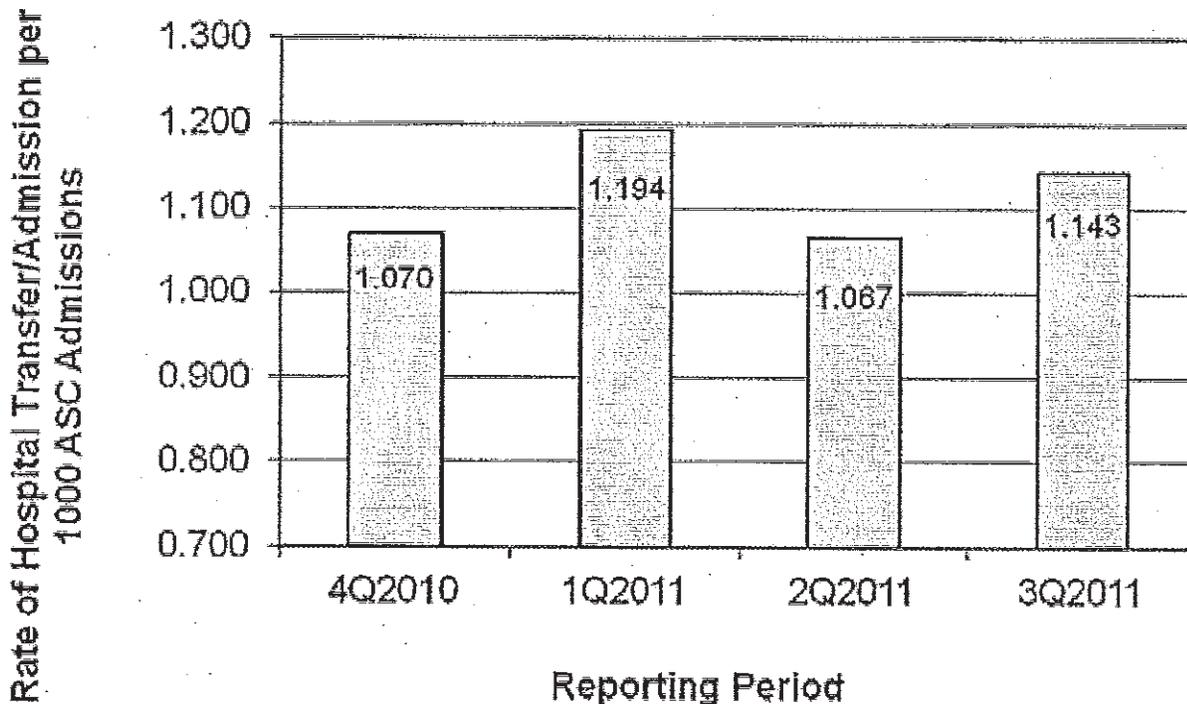
The data trends for this measure over the last four quarters are presented below in both tabular and graphical formats.

Data Summary: Hospital Transfer/Admission

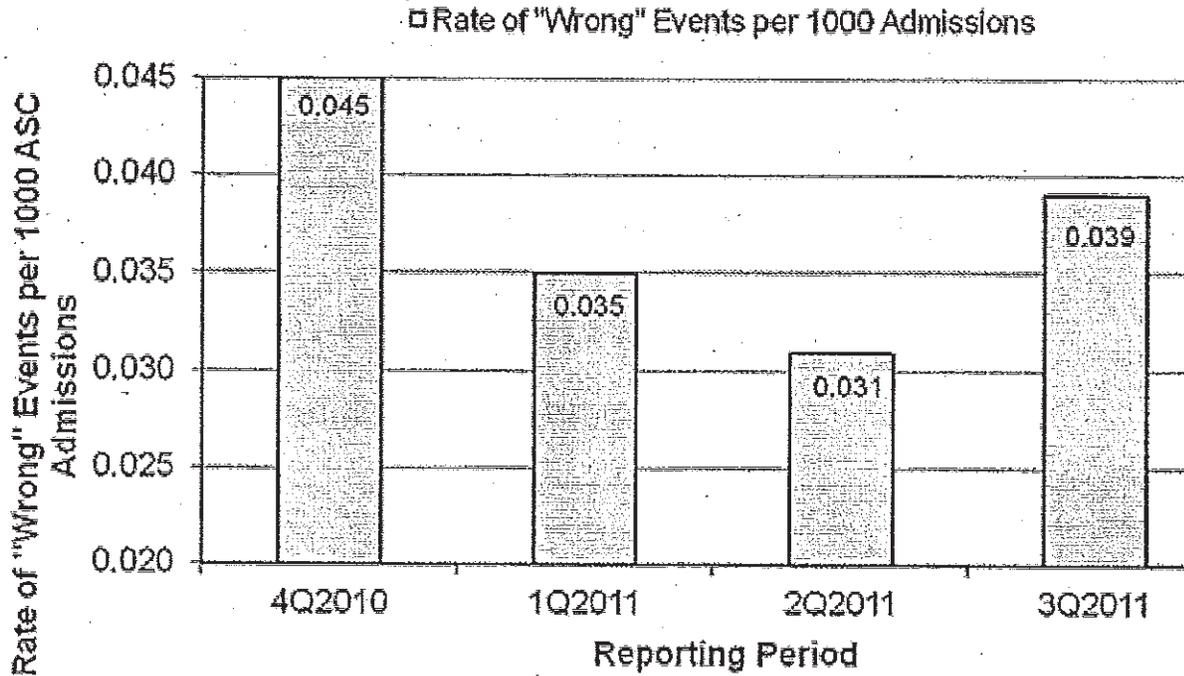
Reporting Period	4Q2010	1Q2011	2Q2011	3Q2011
Number of Participating ASCs	1,350	1,206	1,277	1,292
Number of ASC Admissions Represented	1,592,793	1,442,322	1,457,395	1,513,158
Hospital Transfer/Admission Rate per 1000 ASC Admissions	1.070	1.194	1.067	1.143

Hospital Transfer/Admission

□ Rate of Hospital Transfer/Admission per 1000 ASC Admissions



Wrong Site, Side, Patient, Procedure and Implant



Prophylactic IV Antibiotic Timing

Prevention of surgical wound infections is an important issue for patients having outpatient procedures or surgery. In cases where the physician has determined that an antibiotic should be given to help prevent a surgical wound infection, giving the antibiotic at the right time is important. Research indicates that antibiotics given too early, or after the surgery begins, are not as effective.

The percentage of ASC admissions having an order for an antibiotic to help prevent surgical wound infection that received the antibiotic in the appropriate timeframe is displayed below. Higher percentages are better.

Percentage of ASC admissions with antibiotics ordered who received antibiotics on time 98%

Represents the experience of 1,030,200 ASC admissions with antibiotics ordered seen at 1,034 facilities between July 1 and September 30, 2011

The data trends for this measure over the last four quarters are presented below in both tabular and graphical formats.

Data Summary: Prophylactic IV Antibiotic Timing

Percentage of ASC admissions with appropriate surgical site hair removal 98%

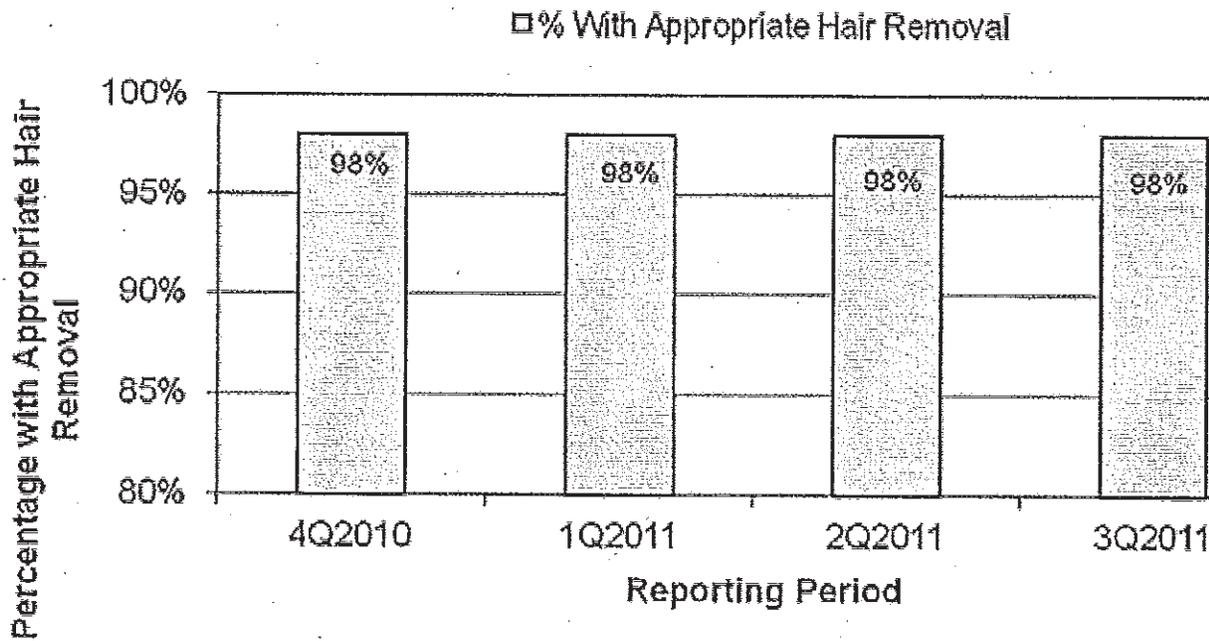
Represents the experience of 917,541 ASC admissions with surgical site hair removal seen at 968 facilities between July 1 and September 30, 2011

The data trends for this measure over the last four quarters are presented below in both tabular and graphical formats.

Data Summary: Appropriate Surgical Site Hair Removal

Reporting Period	4Q2010	1Q2011	2Q2011	3Q2011
Number of Participating ASCs	843	815	859	968
Number of ASC Admissions Represented	922,530	837,333	900,730	917,541
Percentage of ASC Admissions with appropriate surgical site hair removal	98%	98%	98%	98%

Appropriate Surgical Site Hair Removal



For more detailed information on these measures, please review the implementation guide found on the home page of the ASC Quality Collaboration website at www.ascquality.org.

* For purposes of this quality report, "admission" is defined as completion of registration upon entry

NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Measure Information Form

Measure Set: Hospital Outpatient Surgery

Measure ID#: OP- 6

Outpatient Setting: Hospital Outpatient Department Surgery

Performance Measure Name: Timing of Antibiotic Prophylaxis

Description: Surgical patients with prophylactic antibiotics initiated within one hour* prior to surgical incision.

*Patients who received vancomycin or a fluoroquinolone for prophylaxis should have the antibiotic initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.

Rationale: Multiple studies have demonstrated that timing is critical to the effectiveness of surgical antimicrobial prophylaxis and current guidelines recommend dosing within 1 hour before incision. It has been demonstrated that antibiotics to prevent experimental infections were effective only if administered during the 3 to 4 hour period after inoculation of bacteria into the wound (Miles, 1957). Furthermore, it has been reported that a variety of antimicrobials could prevent the development of experimental infections, but only if given within about 3 hours following wound contamination (Burke, 1961). In randomized clinical trials reported in 1964 and 1969, antimicrobials given before, during, and shortly after abdominal surgery were effective in preventing surgical site infection (SSI). The lowest rates of SSI in abdominal operations were associated with prophylaxis started within one hour prior to the incision (Stone, 1976). Similar findings have also been reported for cardiac operations (Classen, 1992). In a recent review of data from a European total joint arthroplasty registry, antibiotic delivery just before surgical incision was the most important factor in reducing surgical site infection rates.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if initiating vancomycin, in Appendix C, OP Table 6.12, or a fluoroquinolone, in Appendix C, OP Table 6.11).

Included Populations: Not Applicable

Excluded Populations: None

Data Elements:

- *Antibiotic Timing*

Hospital OQR Specifications Manual

SRG-OP-6-1

Encounter dates 07-01-12 (3Q12) through 12-31-12 (4Q12) v.5:1a

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Denominator Statement: Surgical patients with no evidence of prior infection.

Included Populations:

- Patients with a CPT® Code of selected surgeries as defined in Appendix A, OP Table 6.0

Excluded Populations:

- Patients who are less than 18 years of age
- Patients whose procedure is canceled prior to incision as defined in the Data Dictionary
- Patients with a CPT® Code of gastrostomy placement that represents a *Replacement* only, as defined in the Data Dictionary
- Patients enrolled in a *Clinical Trial* as defined in the Data Dictionary
- Patients with an *Infection Prior to Anesthesia* as defined in the Data Dictionary
- Patients who receive oral or intramuscular antibiotics only

Data Elements:

- *Antibiotic*
- *Antibiotic Name*
- *Antibiotic Route*
- *Birthdate*
- *Case Canceled*
- *Clinical Trial*
- *CPT® Code*
- *Infection Prior to Anesthesia*
- *Outpatient Encounter Date*
- *Replacement*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Abstracted antibiotics are those administered from the time of arrival until patient leaves from the outpatient setting. Refer to Appendix C, OP Table 6.0 which contains a complete listing of antibiotics.

Measure Analysis Suggestions: Consideration may be given to relating this measure to OP-7 in order to evaluate which aspects of antibiotic prophylaxis (i.e., timing, selection) would most benefit from an improvement effort. The process-owners for timing of administration of antibiotics, as assessed in this measure, may include clinicians and support staff on the nursing unit as well as in the presurgical holding area, as well as in the operating room itself. Opportunities may exist in any of these arenas which, when addressed jointly, can generate true process improvement.

Sampling: Yes, for additional information see the Population and Sampling Specifications Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion

Hospital OQR Specifications Manual

SRG-OP-6-2

Encounter dates 07-01-12 (3Q12) through 12-31-12 (4Q12) v.5.1a

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Selected References:

- Bratzler DW, Houck PM, for the Surgical Infection Prevention Guidelines Writers Group. Antimicrobial prophylaxis for surgery: An advisory statement from the National Surgical Infection Prevention Project. *Clin Infect Dis*. 2004;38(15 June):1706-1715.
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- Mangram AJ, Horan TC, Pearson ML, et al. Guidelines for prevention of surgical site infection, 1999. *Infect Control Hosp Epidemiol*. 1999;20:247-280.
- Silver A, Eichorn A, Kral J, et al. Timeliness and use of antibiotic prophylaxis in selected inpatient surgical procedures. *Am J Surg*. 1996;171:548-552.
- Larsen RA, Evans RS, Burke JP, et al. Improved perioperative antibiotic use and reduced surgical wound infections through use of computer decision analysis. *Infect Control Hosp Epidemiol*. 1989;10:316-320.
- Finkelstein R, Reinhertz G, Embom A. Surveillance of the use of antibiotic prophylaxis in surgery. *Isr J Med Sci*. 1996;32:1093-1097.
- Matuschka PR, Cheadle WG, Burke JD, et al. A new standard of care: administration of preoperative antibiotics in the operating room. *Am Surg*. 1997;63:500-503.
- Gorecki P, Schein M, Rucinski JC, et al. Antibiotic administration in patients undergoing common surgical procedures in a community teaching hospital: the chaos continues. *World J Surg*. 1999;23:429-432.
- Bernard HR, Cole WR. The prophylaxis of surgical infections: the effect of prophylactic antimicrobial drugs on the incidence of infection following potentially contaminated operations. *Surgery*. 1964;56:151-157.
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- Stone HH, Hooper CA, Kolb LD, et al. Antibiotic prophylaxis in gastric, biliary, and colonic surgery. *Ann Surg*. 1976;184:443-452.
- Miles AA, Miles EM, Burke J. The value and duration of defense reactions of the skin to the primary lodgement of bacteria. *Br J Exp Pathol*. 1957;38:79-96.
- Burke JF. The effective period of preventive antibiotic action in experimental incisions and dermal lesions. *Surgery*. 1961;50:161-168.
- Bernard HR, Cole WR. The prophylaxis of surgical infection: the effect of prophylactic antimicrobial drugs on the incidence of infection following potentially contaminated operations. *Surgery*. 1964;56:151-157.
- Marjo E, van Kasteren E, Manniën J, et al. Antibiotic prophylaxis and the risk of surgical site infections following total hip arthroplasty: timely administration is the most important factor. *Clin Infect Dis*. 2007; 44:921-7.

NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Measure Information Form

Measure Set: Hospital Outpatient Surgery

Measure ID #: OP-7

Outpatient Setting: Hospital Outpatient Department Surgery

Performance Measure Name: Prophylactic Antibiotic Selection for Surgical Patients

Description: Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).

Rationale: A goal of prophylaxis with antibiotics is to use an agent that is safe, cost-effective, and has a spectrum of action that covers most of the probable intraoperative contaminants for the operation. First- or second-generation cephalosporins satisfy these criteria for most operations, although quinolones are recommended for some urologic operations. Vancomycin is not recommended for routine use because of the potential for development of antibiotic resistance, but is acceptable if a patient is allergic to beta-lactams, as are fluoroquinolones and clindamycin in selected situations.

Type of Measure: Process

Improvement Noted As: An increase in the rate.

Numerator Statement: Surgical patients who received prophylactic antibiotics recommended for their specific operation.

Included populations: Not Applicable

Excluded Populations: None

Data Elements:

- *Antibiotic Allergy*
- *Antibiotic Name*
- *Vancomycin*

Denominator Statement: Surgical patients with no evidence of prior infection.

Included Populations:

- Patients with a *CPT® Code* of selected surgeries as defined in Appendix A, OP Table 6.0.

Excluded Populations:

- Patients less than 18 years of age

- Patients whose procedure is canceled prior to incision as defined in the Data Dictionary
- Patients with a CPT® Code of gastrostomy placement that represents a *Replacement* only, as defined in the Data Dictionary
- Patients enrolled in a *Clinical Trial* as defined in the Data Dictionary
- Patients with an *Infection Prior to Anesthesia* as defined in the Data Dictionary
- Patients who do not receive any antibiotics during the encounter

Data Elements:

- *Antibiotic*
- *Antibiotic Route*
- *Birthdate*
- *Case Canceled*
- *Clinical Trial*
- *CPT® Code*
- *Infection Prior to Anesthesia*
- *Outpatient Encounter Date*
- *Replacement*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Abstracted antibiotics are those administered from the time of arrival until the patient leaves the outpatient setting. Refer to Appendix C, OP Table 6.0, which contains a complete listing of antibiotics.

Measure Analysis Suggestions: Consideration may be given by relating this measure to OP-6 in order to evaluate which aspects of antibiotic prophylaxis would most benefit from an improvement effort. The process owners for selection of appropriate antibiotics could include physicians/APNs/PAs and committees (e.g., QA, Infection Control, Pharmacy and Therapeutics, Surgical Section Subcommittees, etc.), any of which may choose to address this physician/APN/PA practice issue as part of a larger surgical infection prevention initiative.

Sampling: Yes, for additional information see the Population and Sampling Specifications Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion

Selected References:

- Bratzler DW, Houck PM, for the Surgical Infection Prevention Guidelines Writers Group. Antimicrobial prophylaxis for surgery: An advisory statement from the National Surgical Infection Prevention Project. *Clin Infect Dis.* 2004;38(15 June): 1706-1715.
- Mangram AJ, Horan TC, Pearson ML, et al. Guidelines for prevention of surgical site infection, 1999. *Infect Control Hosp Epidemiol.* 1999; 20:247-280.
- American Society of Health-System Pharmacists. ASHP therapeutic guidelines on antimicrobial prophylaxis in surgery. *Am J Health Syst Pharm.* 1999; 56:1839-1888.

Hospital OQR Specifications Manual

SRG-OP-7-2

Encounter dates **07-01-12 (3Q12)** through **12-31-12 (4Q12)** v.5.1a

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- American Urological Association. Best practice policy statement on urologic surgery antimicrobial prophylaxis. Updated September 2008.
- The Medical Letter. Antimicrobial prophylaxis for Surgery. *Med Lett Drugs Ther.* 2009; 82: 47-52.
- Dellinger EP, Gross PA, Barrett TL, et al. Quality standard for antimicrobial prophylaxis in surgical procedures. *Clin Infect Dis.* 1994; 18:422-427.
- Gilbert DN, Moellering RC Jr., Eliopoulos GM, Chamber HF, Saag MS, Eds. *The Sanford Guide to Antimicrobial Therapy 2009.* 39th ed. Sperryville, VA: Antimicrobial Therapy, Inc. 2009.
- Page CP, Bohnen JM, Fletcher JR, et al. Antimicrobial prophylaxis for surgical wounds. *Arch Surg.* 1993; 128:79-88.
- ASGE Standards of Practice Committee, Banerjee S, Shen B, Baron TH, Nelson DB, Anderson MA, Cash BD, Dominitz JA, Gan SI, Harrison ME, Ikenberry SO, Jagannath SB, Lichtenstein D, Fanelli RD, Lee K, van Guilder T, Stewart LE. Antibiotic prophylaxis for GI endoscopy. *Gastrointest Endosc* 2008 May; 67(6):791-798.
- Johns Hopkins Antibiotic Guide: Surgical Prophylaxis.
- American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins. ACOG Practice Bulletin No. 104. Antibiotic prophylaxis for gynecologic procedures. *Obstet Gynecol* May 2009; 113(5): 1180-1189.

Prophylactic Antibiotic Regimen Selection for Surgery

Surgical Procedure (Appendix A)	Approved Antibiotics (Appendix C)
Cardiac (Pacemakers or AICDs) or Vascular	
OP Table 6.1	Cefazolin or Cefuroxime, OP Table 6.6 or Vancomycin* OP Table 6.12 If β -lactam allergy: Vancomycin OP Table 6.12 or Clindamycin OP Table 6.7
Orthopedic/Podiatry	
OP Table 6.2	Cefazolin or Cefuroxime OP Table 6.6 or Vancomycin* OP Table 6.12 If β -lactam allergy: Vancomycin OP Table 6.12 or Clindamycin OP Table 6.7
Genitourinary	
Prostate biopsy ^{††} OP Table 6.3	Quinolone [†] OP Table 6.11 OR 1 st Generation cephalosporin OP Table 6.6a OR 2 nd Generation cephalosporin OP Table 6.6b OR 3 rd Generation cephalosporin OP Table 6.6c OR Aminoglycoside OP Table 6.2 + Metronidazole OP Table 6.9 OR Aminoglycoside OP Table 6.2 + Clindamycin OP Table 6.7 OR Aztreonam OP Table 6.5 + Metronidazole OP Table 6.9 OR Aztreonam OP Table 6.5 + Clindamycin OP Table 6.7
Penile prosthesis insertion, removal, revision OP Table 6.3a	Ampicillin/Sulbactam or Ticarcillin/Clavulanate or Piperacillin/Tazobactam OP Table 6.3 OR Aminoglycoside OP Table 6.2 + 1 st Generation cephalosporin OP Table 6.6a OR Aminoglycoside OP Table 6.2 + 2 nd Generation cephalosporin OP Table 6.6b OR Aminoglycoside OP Table 6.2 + Vancomycin OP Table 6.12 OR Aminoglycoside OP Table 6.2 + Clindamycin OP Table 6.7 OR Aztreonam OP Table 6.5 + 1 st Generation cephalosporin OP Table 6.6a OR Aztreonam OP Table 6.5 + 2 nd Generation cephalosporin OP Table 6.6b OR Aztreonam OP Table 6.5 + Vancomycin OP Table 6.12 OR Aztreonam OP Table 6.5 + Clindamycin OP Table 6.7
Gastric/Biliary	
PEG placement OP Table 6.4	Cefazolin OP Table 6.6 OR Cefuroxime OP Table 6.6 OR Cefoxitin OP Table 6.4 OR Cefotetan OP Table 6.4 OR Ampicillin/Sulbactam OP Table 6.3a OR Cefazolin OP Table 6.6 + Metronidazole OP Table 6.9 OR Cefuroxime OP Table 6.6 + Metronidazole OP Table 6.9 OR Vancomycin* OP Table 6.12 If β -lactam allergy: Clindamycin OP Table 6.7 \pm Aminoglycoside OP Table 6.2 OR Clindamycin OP Table 6.7 \pm Quinolone OP Table 6.11 OR Vancomycin OP Table 6.12 \pm Aminoglycoside OP Table 6.2 OR Vancomycin OP Table 6.12 \pm Quinolone OP Table 6.11

Surgical Procedure (Appendix A)	Approved Antibiotics (Appendix C)
Gynecological	
Laparoscopically-assisted hysterectomy, Vaginal hysterectomy OP Table 6.5	Cefazolin or Cefuroxime OP Table 6.6, Cefoxitin or Cefotetan OP Table 6.4 OR Ampicillin/Sulbactam OP Table 6.3a If β -lactam allergy: Metronidazole OP Table 6.9 + Aminoglycoside OP Table 6.2 OR Metronidazole OP Table 6.9 + Quinolone OP Table 6.11 OR Clindamycin OP Table 6.7 + Aminoglycoside OP Table 6.2 OR Clindamycin OP Table 6.7 + Aztreonam OP Table 6.5 OR Clindamycin OP Table 6.7 + Quinolone OP Table 6.11
Pubovaginal sling OP Table 6.5a	1 st Generation cephalosporin OP Table 6.6a OR 2 nd Generation cephalosporin OP Table 6.6b OR Ampicillin/Sulbactam OP Table 6.3a OR Quinolone [†] OP Table 6.11. OR Aminoglycoside OP Table 6.2 + Clindamycin OP Table 6.7 OR Aminoglycoside OP Table 6.2 + Metronidazole OP Table 6.9 OR Aztreonam OP Table 6.5 + Clindamycin OP Table 6.7 OR Aztreonam OP Table 6.5 + Metronidazole OP Table 6.9
Head and Neck	
OP Table 6.6	Cefazolin or Cefuroxime OP Table 6.6 OR Ampicillin/Sulbactam OP Table 6.3a OR Clindamycin OP Table 6.7 \pm Aminoglycoside OP Table 6.2 OR Vancomycin* OP Table 6.12
Neurological	
OP Table 6.7	Nafcillin or Oxacillin OP Table 6.8, Cefazolin or Cefuroxime OP Table 6.6, OR Vancomycin* OP Table 6.12 OR Clindamycin OP Table 6.7
Special Considerations	
<p>*Vancomycin is acceptable with a physician/APN/PA/pharmacist documented justification for its use (see data element <i>Vancomycin</i>).</p> <p>[†]The only operations for which oral antibiotics alone are acceptable are the Prostate biopsy and Pubovaginal sling procedures.</p> <p>^{††} The only operations for which intramuscular antibiotics alone are acceptable are the Prostate biopsy procedures.</p>	

409-023-0010

HAI Reporting for Hospitals

- (1) Hospitals shall begin collecting data for HAI outcome and process measures for the HAI reporting program for services provided on and after January 1, 2009, except:
 - (a) NICU shall begin collecting data for HAI outcome and process measures for the HAI reporting program for services provided on and after January 1, 2010.
 - (b) Hospitals shall report the SCIP-Inf-6 process measure for the HAI reporting program for services provided on and after January 1, 2010.
 - (c) Hospitals shall report the SCIP-4-Inf and SCIP-10-Inf process measures for services provided on and after January 1, 2011.
 - (d) Hospitals shall report the NHSN Inpatient COLO, HPRO, HYST, and LAM outcome measures for services provided on and after January 1, 2011.
 - (e) Hospitals shall report facility-wide NHSN Inpatient CDI data using the Lab-ID method for CDI in NHSN for services provided on or after January 1, 2012.
 - (f) Hospitals shall report SCIP-Inf-9 performance measures for services provided on or after January 1, 2012.

- (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.

- (3) The infection control professional (ICP), as defined by the facility, shall actively seek out infections defined in sections (2)(a) and (b) 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 section (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.



Pat Quinn, Governor
Damon T. Arnold, M.D., M.P.H., Director

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MEMORANDUM

DATE: April 26, 2010

TO: NHSN Facility Administrators

FROM: Mary Driscoll, RN MPH
Division Chief, Patient Safety and Quality
Illinois Department of Public Health

RE: Minimum Surveillance Requirements for SSI Reporting in Illinois Hospitals

Surgical site infections (SSIs) cannot be reliably identified from laboratory data alone, as the diagnosis depends on the presence of signs and symptoms of infection in the wound. Therefore, for the purpose of mandated SSI reporting through NHSN in Illinois, the **minimum** surveillance required is as follows:

1) SSI identified during index hospitalization

Prospective surveillance of patients with designated operative procedures. Patient is followed through index hospitalization.

Review of microbiology reports for positive blood cultures and submission of wound or wound-like cultures (abscess, soft tissue, etc) for evidence of pus (moderate or many white blood cells or polymorphonuclear leukocytes on gram stain) or bacterial growth **and**

one or more of the following methods must be used for SSI surveillance:

- a) Infection control rounds on nursing units;
- b) Routine review of admission/transfer/discharge data for:
 - 1) transfer of patients who have undergone a procedure to a more acute care setting (e.g., ICU);
 - 2) return to the OR; and/or
 - 3) prolonged stay (based on a nationwide inpatient sample from the Agency for Healthcare Research and Quality [AHRQ], expected

inpatient duration of stay following CABG is 9.3 days and 4 days following total knee replacement).

- c) Operating room reports of surgeries and repeat surgery on a patient who has undergone total knee arthroplasty or coronary artery bypass surgery.
- d) Electronic surveillance system

2) SSI identified upon readmission to same hospital where initial surgical procedure performed

According to the NHSN SSI module protocol, the time period for tracking SSIs depends on the type of operative procedure performed. For those operative procedures where no implant is left in place, the follow-up period is 30 days. For those operative procedures where an implant is in place, such as a CBGB/CBGC where sternal wires or clips are placed, and for all KPROs, the follow-up period is one year (365 days).

Each hospital must establish a protocol for identifying patients who have an implant placed and are readmitted within 365 days of the index surgery. According to the NHSN definition an implant is a nonhuman-derived object, material, or tissue that is permanently placed in a patient during an operative procedure and is not routinely manipulated for diagnostic or therapeutic purposes. Examples include: porcine or synthetic heart valves, mechanical heart, metal rods, mesh, sternal wires, screws, cements, and other devices.

Routine review of admission/transfer/discharge data to identify these patients and at least one or more of the following methods must be used for SSI surveillance:

- a) Review of microbiology reports (wound or wound-like cultures and blood cultures)
- b) Infection control rounds on nursing units
- c) Electronic surveillance system

SSI detected solely by post-discharge surveillance

SSI detected solely by post-discharge surveillance can be entered into NHSN, however IDPH will not include these cases in the calculation of hospital-specific SSI rates. This will allow for a fair comparison of hospitals and not penalize facilities with more robust surveillance systems.

According to the NHSN SSI module protocol, SSI identified at a facility other than the hospital where the initial surgical procedure was performed is categorized as being detected through post-discharge surveillance.

Documenting SSI surveillance method

The Surgical Site Infection (SSI) form used in the NHSN SSI reporting module collects information concerning the detection method used to identify the SSI.

This field is named "Detected". There are three options:

A – SSI was identified before the patient was discharged from the facility following the operation.

R – SSI was identified due to patient readmission to the facility where the operation was performed.

P – SSI was identified during post-discharge surveillance. This includes SSIs identified at another facility. These cases will not be included in the calculation of SSI rates for public reporting.

Outpatient Procedure Module Development State Users of NHSN Call, April 2012

Ryan Fagan

Outpatient Procedure Module

- New NHSN Surveillance Module under development since Jan 2011 in partnership with ASC Quality Collaboration
- Targeted for full implementation by CY 2014
 - Piloting and phase-in mid to late 2013
- Free standing Ambulatory Surgery Centers (ASCs) and Hospital Outpatient Depts (HOPDs)
 - Assume lack of comparability between ASCs and HOPDs until more is known
 - Inherent differences in patient risk
 - Differences in eligible procedures based on operative setting

Considerations for Surveillance in ASCs

- Tend to be specialty-specific
 - Most common include: GI endoscopy, ophthalmology, orthopedics, plastic-reconstructive, pain management centers
- Majority of ASCs lack dedicated IT or Infection control
- Post discharge surveillance is not standardized, though some form of patient followup is the industry norm
 - 24-48 hour patient calls
 - Followup appointments with surgeon
 - Heavily dependent on surgeon self-report

Most ASCs are not Enrolled in NHSN: Some Participate through State SSI Mandates SSI

- Herniorrhaphy, breast, and orthopedic procedures (FX, HPRO, KPRO) more commonly mandated
- Minority of ASCs are eligible
- Few SSIs reported: poor measure or poor case ascertainment?
- Facility or patient risk adjustment variables missing or not applicable

Plans for a 3-Part Outpatient Procedure Module

1. Process measures (track events during the ASC/HOPD visit)
2. New outcome measure: hospitalization or emergency dept encounter after procedure
3. SSI surveillance, to support states with pre-existing SSI reporting mandates for outpatient procedures

The 6 Current NQF-Endorsed ASC QC Quality Measures

- Appropriate Surgical Site Hair Removal
- (Direct) Hospital Transfer/Admission
- Patient Burn
- Patient Fall in the ASC
- Prophylactic IV Antibiotic Timing (preoperative abx)
- Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

□ *Note: except for Hair Removal, these measures to be tracked through ASC claims forms for Medicare beneficiaries beginning FY 2012

ED Visits / Hospitalization as Initial ASC Outcome Measure Targeted for NQF Endorsement

- SSI alone may be too narrow in scope and too rare to be a good indicator of quality for many types of outpatient procedures
- Advantages of tracking ED visits / hospitalization
 - Relatively simple to define and identify through claims data (low burden)
 - Could be used to track a variety of important adverse outcomes: SSI, bleeding, thrombosis, medication errors, inadequate pain control, other complications
 - Not dependent on post discharge surveillance/surgeon report
- Automated use of claims data for NHSN denominator fields

Candidate ASC Procedures for Hospitalization Measure

- 13 Common ASC procedures
 - Cataract
 - Upper Endoscopy
 - Colonoscopy
 - Spinal Injection
 - Cystoscopy
 - Knee Arthroscopy
 - Shoulder Arthroscopy
 - Rotator Cuff
 - Carpal Tunnel
 - Herniorrhaphy
 - Cholecystectomy
 - Tonsil/Adenoids
 - Myringotomy
- CMS analysis of Medicare Claims data to be used to inform:
 - Candidate procedure list
 - Followup period
 - Common primary diagnoses for hospital admissions and ED visits
 - Type and volume of ASC and HOPD procedures

Outpatient Procedure Module Development: Next Steps

- Continue to discuss with ASC QC the use of NHSN to report NQF-endorsed process measures and expand surveillance to all payers (FY 2012, will be Medicare beneficiaries only)
- Current SSI module does not appear to be useful or appropriate for the ASC setting; additional work needed to develop SSI module for ASCs/HOPDs that will better support State mandates